FAMILIES & CHANGE

Coping With Stressful Events and Transitions

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CHAPTER 13

Family Responses to School and Community Mass Violence

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Columbine. September 11. The Oklahoma City bombing. Sandy Hook. Whether directly or indirectly exposed, families are increasingly faced with the harsh reality associated with acts of mass violence in schools and communities. *Mass violence* is a term used to refer to a variety of events that typically include shootings, acts of terrorism, and other events that result in multiple fatalities and/or injuries (Fox & Levin, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Not only can exposure to mass violence contribute to transient feelings of posttraumatic distress (e.g., Rubin & Wessely, 2013), but long-term mental health and family functioning can also be significantly impaired (MacDermid & Wadsworth, 2010). Although individuals who personally experience the violence report the most profound adverse consequences, even those with no firsthand connection can report significant levels of psychological sequelae in response to these events (e.g., Galea et al., 2002; Norris et al., 2002; Yule et al., 2000).

Despite the deleterious consequences of community and school violence, the responses of families to these adverse situations are incredibly diverse. Some families demonstrate *resilience*, evidencing positive adaptation in the midst of tragedy. Considering the context in which families are situated, it is important to understand how families respond to mass violence and how professionals can foster family resilience. In this chapter, we begin with a hypothetical case study illustrating a family's experience with mass violence. Next, we describe the context of mass violence in the United States and delineate a theoretical framework to explain how it can impact families. Finally, we describe risk and protective factors that can influence family resilience, exploring implications for professionals working with families.

CASE STUDY

Two weeks ago, a 16-year-old adolescent entered Rivertown High School with a gun and fatally shot two students and one teacher and injured 26 others. Mr. Brown is a father to a 13-year-old daughter, Rory Brown, and they reside in a town 20 minutes from Rivertown in Mountain Top, where Rory attends Mountain Top High School. Even though the event did not occur in Rory's school, Mr. Brown and Rory are struggling to cope and have many concerns and fears. Mr. Brown is most concerned with providing the right supports for his daughter.

Immediately after the shooting, Rory's school, in collaboration with the Chamber of Commerce, the mayor, community mental health agencies, the hospital, and the police, disseminated information to community members. In addition to describing how key community agencies would communicate with community members, the documents provided resources for support. Additionally, one of the documents was designed to help adults understand warning signs for children and adolescents who may be struggling to cope with the traumatic event. Finally, families were encouraged to reflect on services that their family has previously used as initial resources for support. Because they had previously used the support network at the Mountain Top Community Church, Mr. Brown reached out to church professionals for assistance in the family's coping process.

Although Mr. Brown felt the supports from his church were helpful in guiding him and Rory to make meaning out of the event, he still saw signs that Rory and he were struggling. Rory's teacher expressed similar concerns, stating that since the event Rory had been more argumentative than usual, complaining of frequent stomachaches and displaying more inattention than usual. This prompted Mr. Brown to contact the school psychologist at Mountain Top High School. The school psychologist met with Mr. Brown and discussed his pre-event and post-event parenting style as well as his family's routines and roles. Mr. Brown felt this conversation was helpful since he did not recognize some of the changes that occurred since the event. The school psychologist also recommended minimizing certain types of media exposure, since the family's repeated revisiting of the event via the television appeared to trigger further anxiety. Finally, the school psychologist reminded Mr. Brown to continue to engage Rory in conversations about the event and monitor for additional signs of difficulty. At the end of the meeting, Mr. Brown was provided with a community and school resource guide for additional supports that he and Rory might use. Mr. Brown planned to seek out family counseling services in order to assist him and Rory in answering questions about why the event occurred and renew their feelings of security and hope.

MASS VIOLENCE: THE CONTEXT

Traumatic events, such as the shooting described in the case study, have a variety of social, psychological, physical, and economic consequences that disrupt numerous aspects of individual, family, and community functioning. Incidences of mass violence constitute one

of the more poignant examples of human-made disasters in our society. In conceptualizing the impact of mass violence on our society, it is instructive to briefly explore the recent trends in violence in our country. Incidences of mass violence take on many forms in our communities, and adopting a nuanced view of these differences holds important clinical implications for guiding prevention or intervention efforts. In this century, examples have included community shootings (e.g., Aurora, Colorado, movie theater), school shootings (e.g., Sandy Hook Elementary School or Virginia Tech), and terrorist attacks (e.g., September 11 attacks or Boston Marathon bombings). For the purposes of this discussion, we will differentiate between community and school violence more broadly. Although this differentiation is useful for exploring the impact of mass violence on families, many of the current understandings of how individuals and communities react to these events are derived from the broader trauma literature, which includes events such as natural disasters. For example, in a meta-analysis conducted by Norris et al. (2002), the researchers differentiated between disasters and mass violence in their study of population outcomes. Their conclusions suggest that incidences of mass violence were significantly more likely to result in severe impairment than either technological (i.e., human produced event without intention, such as an unintentional airplane crash) or natural disasters.

Regardless of the specific nature of the traumatizing event, the subsequent maladaptive or adaptive responses that follow frequently form a common constellation of symptoms (Neria, Nandi, & Galea, 2007). From a clinical perspective, this presentation may manifest in individuals and families along a continuum of severity that ranges from mild distress to functionally limiting maladaptive responses resulting in the development of diagnosable psychiatric disorders (Galea, Nandi, & Vlahov, 2005; Galea & Resnick, 2005). In general, research has noted that those exposed to a traumatic event show increased rates of acute stress disorder, posttraumatic stress disorder (PTSD), major depression, panic disorder, generalized anxiety disorder, and substance use disorders (Neria, Gross & Marshall, 2006; Norris et al. 2002; Schuster et al., 2001). However, the likelihood for maladaptive outcomes has been found to be influenced by certain conditions. These include the directness of exposure to a traumatic experience, proximity to the trauma or threat, duration of exposure, fear response, premorbid functioning, prior trauma exposure, genetic predispositions, and other factors (Institute of Medicine, 2003; Ozer, Best, Lipsey, & Weiss, 2008). Familial maladaptive coping strategies may include denial, expressions of negative emotion, substance use, behavioral disengagement, and self-blame. Furthermore, familial responses to crisis have been suggested to contribute to functional changes in the family system (Myer et al., 2014). In light of the literature concerning the particularly deleterious impact of mass violence, specific instances of these events will be reviewed as a means of providing a context for discussing both adaptive and maladaptive responses to these events.

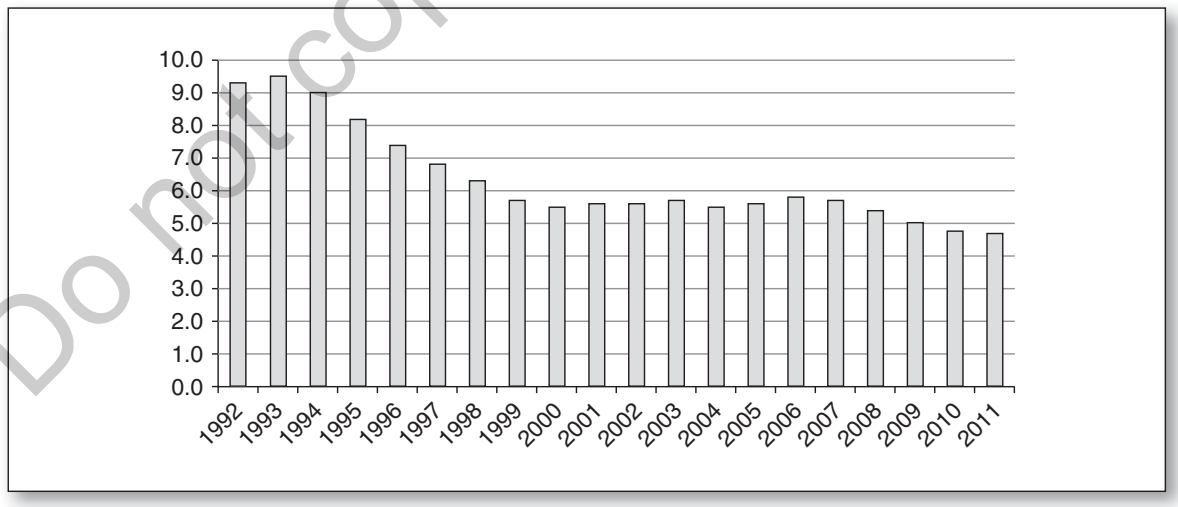
Despite heightened public attention, mass shootings in either the community or school setting are rare. However, the malicious intent and unpredictable nature of these violent acts in our communities produces a disproportionately adverse impact on those directly and indirectly affected (Hughes et al., 2011; Norris et al., 2002). According to a recent congressional report (Bjelopera, Bagalman, Caldwell, Finklea, & McCallion, 2013), there have been 78 public mass shootings between 1983 and 2012 that have resulted in 547 deaths. Among the 78 mass shootings, 26 occurred at workplaces of the identified shooter, while the next largest proportion of public mass shootings occurred at places of education.

Putting these statistics into perspective, the prevalence rate for murder in the United States has been declining. As illustrated in Figure 13.1, between the years of 1992 and 2011, the national murder rate dropped from 9.3 to 4.7 per 100,000 inhabitants (Federal Bureau of Investigation, 2012).

Consistent with national trends, the prevalence rate for violence in our nation's public schools has also demonstrated a decreasing trend between 1992 and 2006 (Modzeleski et al., 2008). Recent data trends indicate that from 2000–2001 to 2009–2010, 200 student homicides occurred in schools, with an average of 20 deaths per year. However, the student homicide rates have remained relatively stable since 2006 (Robers, Zhang, Truman, & Snyder, 2012). It is also relevant to note that the homicide rate in this setting is notably higher when adults are also taken into account (see Figure 13.2). When the annual homicide rate for youth ages 5 to 18 is taken into consideration, however, the average number of school homicides accounts for less than 1% of these deaths. In view of these data, the literature has consistently suggested that the perception of public safety has been negatively biased by the media publicizing horrific events (Duwe, 2005; Van Dyke & Schroeder, 2006) like the one at Sandy Hook Elementary School, where 20 students and six adults were killed by a lone gunman. In an effort to challenge these biased societal perceptions, researchers have provided rough estimates of the likelihood that a school will experience a student homicide based on the average number of deaths per year. They estimate the likelihood of a student homicide occurring at a school to be approximately "once every 6,000 years" (Borum, Cornell, Modzeleski, & Jimerson, 2010, p. 27).

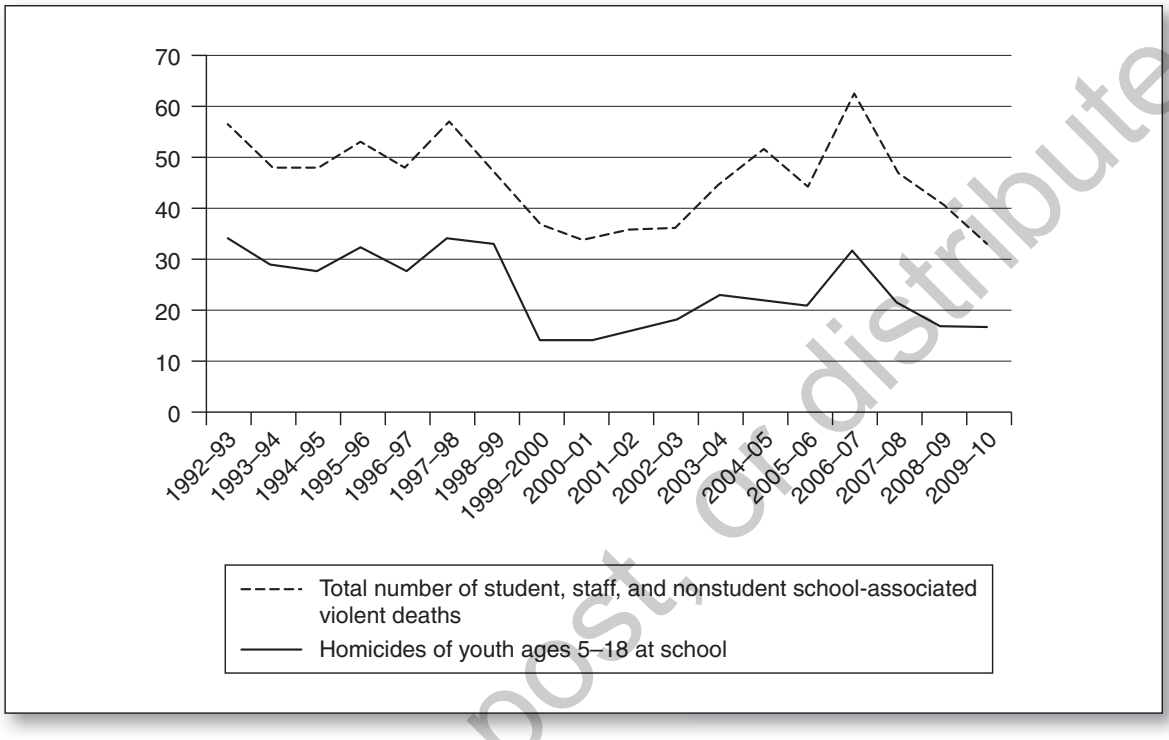
Therefore, events like those described in the chapter case study are rare; rather, general trends in the data reinforce the notion that schools remain one of the safest places for children. However, unlike prevalence rates for mass shootings in community settings

Figure 13.1 Homicide Rates in the United States per 100,000 Inhabitants



Source: Created with data obtained from *Uniform Crime Reports: Crime in the United States 2011* (Federal Bureau of Investigation, 2012).

Figure 13.2 Trends in Student and Total Homicides at School



Source: Created with data obtained from the *Indicators of School Crime and Safety: 2011 report* by the National Center for Educational Statistics (Robers et al., 2012).

(see Duwe, 2005), the current frequency of acts of targeted violence in primary and secondary education settings is a relatively recent phenomenon. According to a joint report from the U.S. Secret Service and the Department of Education (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002), there were 3 incidents of targeted school shootings in the 1970s, 5 in the 1980s, and 28 in the 1990s. Between 2000 and 2013, there have been 39 incidences of targeted school shootings in educational settings that have resulted in 117 deaths and 120 wounded individuals (Blair & Schweit, 2014). The significance of this evolving trend has fueled ongoing discussions concerning the psychological impact of these events on shaping our society's collective worldview (Warnick, Johnson, & Rocha, 2010). Considering the important role perceptions play in determining psychological outcomes, it is reasonable to expect that these trends will have important implications for exposed individual and families.

Recent research concerning the psychological impact of terrorism on perceptions of community safety also holds an increasingly important place when conceptualizing mass violence in this country. More specifically, when considering the relatively recent incidences of domestic terrorism that have been experienced since the turn of the century, researchers have suggested that there is a new sense of vulnerability in the country that contributes to increased levels of anxiety and stress concerning the possibility of another

attack (Institute of Medicine, 2003). It is relevant to note that the genesis of much of the attention paid to this topic in the professional literature began in response to the terrorist attacks on September 11, 2001. The media coverage of these attacks has been noted to contribute significantly to the number of individuals exposed to the events as well as the duration of that exposure. Reactions of fear and horror can spread rapidly and are not limited to those experiencing the event directly. It also includes family members of victims and survivors and people who are exposed through broadcast images (Institute of Medicine, 2003).

The psychological consequences of mass violence involve a range of cognitive, emotional, physical, and behavioral responses that occur in individuals and families as the result of exposure to a traumatic event or threat of an event (see Table 13.1). As noted previously, these consequences vary in terms of both severity and duration. Stress reactions immediately following a traumatic event are quite common and typically resolve rapidly. However, in instances where symptoms continue for more than 3 days, a formal diagnosis of acute stress disorder may be warranted (American Psychiatric Association, 2013). Cognitive reactions include difficulties with memory and attention, confusion, or indecisiveness. Emotional responses include fear, horror, shock, and anger. Physical experiences associated with trauma include nausea, dizziness, hyperarousal, or increased heart rate. Traumatized individuals may also demonstrate atypical behavioral responses such as increased argumentativeness, avoidance of activities or places, and changes in eating or substance use patterns (Brock, Lazarus, & Jimerson, 2002). In the chapter case study, Rory was observed to have several of these responses—including physical symptoms, argumentativeness, and inattention.

It is important to note that the family system has been demonstrated to play a critical role in mediating or buffering a child's vulnerability to maladaptive responses to stressors

Table 13.1 Common Stress Reactions Following Traumatic Events

Physical	Cognitive	Emotional	Behavioral
Chest pain	Blaming others	Affective dysregulation	Avoidance of triggers
Chills	Confusion	Agitation	Antisocial acts
Difficulty breathing	Disorientation	Anxiety	Changes in appetite
Dizziness	Heightened or lowered alertness	Apprehension	Changes in social activity
Elevated blood pressure	Hypervigilance	Denial	Exaggerated startle response
Fatigue	Intrusive images	Depression	Restlessness
Headaches	Nightmares	Emotional numbing	Substance use
Muscle tremors	Poor attention	Fear	Withdrawal
Nausea	Poor concentration	Feeling overwhelmed	
Perspiration	Suspiciousness	Grief	
Rapid heart rate		Guilt	
Shock symptoms		Irritability	
Thirst		Panic	

(Rutter, 1999). However, there is also a reciprocal interaction between the child and the family system that needs to be taken into consideration. For example, maladaptive responses to stressors may disrupt parenting practices by causing parents to be more irritable, controlling, and punitive. These maladaptive familial and parental responses have been demonstrated to increase the likelihood that a child will experience negative behavioral and mental health outcomes (Han & Shaffer, 2014; Shaffer, Lindhiem, & Kolko, 2013; Webster-Stratton, 1990).

THEORETICAL FRAMEWORK

The existence of mass violence in our society, and its unfavorable outcomes and correlates, is undeniable. However, individuals and families vary drastically in their responses to experienced or vicarious mass violence, with many demonstrating resilience in the midst of these stressors and adversities. Resilience has been defined as "patterns of desirable behavior in situations where adaptive functioning or development have been or currently are significantly threatened by adverse experiences" (Masten, 1999, p. 283). Rather than referring to a within-individual trait or characteristic, current ecological conceptualizations of the resilience construct recognize it as a dynamic and context-dependent process (e.g., Ungar, 2008). The study of resilience processes has historically occurred at the individual level. According to an interactive resilience model, resilience emerges for an individual when the relationship between an adversity and an unfavorable outcome is weakened by a protective factor (Fraser, Kirby, & Smokowski, 2004; Masten, Cutuli, Herbers, & Reed, 2002). Two types of interaction effects can occur: (1) an always-existing protective factor (e.g., individual temperament) moderates the impact of a risk, and/or (2) a risk-activated protective factor (e.g., involvement of child protective services in response to abuse) moderates the impact of a risk. Related to mass violence, an example of the former would be when an individual's personality characteristics buffer the psychological impact of a terrorist attack, whereas an example of the latter would be when a support group provided in response to the terrorist attack serves the same function. In both cases, the protective factor buffers the impact of mass violence on the development of psychopathology.

In addition to the importance of understanding individual resilience, resilience processes also occur at the family level. Family resilience refers to the successful coping of families in the midst of stress or adversity (Black & Lobo, 2008; McCubbin & McCubbin, 1988). According to Walsh (2012, p. 15), it is necessary to build families' capacity for resilience because "major stresses can derail the functioning of a family system, with ripple effects for all members and their relationships. . . . When families suffer, their children suffer." Integrating ecological and developmental perspectives, Walsh (2003) proposed a family resilience framework that recognizes three key processes for resilience: (1) family belief systems (e.g., making meaning of adversity, positive outlook, transcendence, and spirituality), (2) organizational patterns (e.g., flexibility, connectedness, and social/economic resources), and (3) communication/problem solving (e.g., clarity, open emotional expression, and collaborative problem solving). This strength-based framework recognizes that adversity and crises impact the entire family, and family processes mediate adaptation

of all members of the family and the family unit (Walsh, 2003, 2012). This model builds upon McCubbin and Patterson's (1983) double ABCX model—recognizing the importance of minimizing stressors, managing hardships, maintaining the family system morale, developing resources needed to meet demands, and developing structures to accommodate new demands (McCubbin & Patterson, 1983; Walsh, 1996)—but also extends it by proposing key processes within family belief systems, organizational patterns, and communication processes that contribute to resilience.

Due to the interaction of individual and family processes in resilience, coupled with the limited empirical research on family resilience to mass violence specifically, we next examine research revealing possible risk and protective factors that can impact both individual and family adaptation to the stress of mass violence.

RESILIENCE IN THE MIDST OF MASS VIOLENCE

As previously mentioned, research has uncovered a variety of unfavorable outcomes associated with exposure to community and school mass violence. Only more recently, however, have investigations focused on the adaptive responses—both within-individual and situational—that buffer individuals and families from developing debilitating conditions such as PTSD and anxiety. Although research on mass violence has historically occurred in the context of war and military intervention outside of the United States (e.g., Keresteš, 2006; MacDermid Wadsworth, 2010; Qouta, Punamaki, & El Sarraj, 2008), the types of terrorism and mass shootings that have been occurring domestically are increasingly serving as fertile ground for expanding our understanding of resilience processes in the United States.

Resilience and Terrorism

In the United States, research following the 9/11 attacks has furthered our understanding of situational factors that promote or impede resilience. For example, Silver, Holman, McIntosh, Poulin, and Gil-Rivas (2002) found that the degree of exposure (i.e., proximity to the attack sites, presence at a site, contact with a victim, and degree of watching events live on television) to the attacks significantly predicted subsequent psychological distress. In fact, degree of exposure was noted to be more predictive of distress than the degree of loss. Further substantiating the exposure effect, Schlenger et al. (2002) found that the amount of time spent watching television coverage of the 9/11 attack predicted both PTSD symptomatology and general distress. Interestingly, Holman, Garfin, and Silver (2014) found that children who were exposed to daily media coverage of the Boston Marathon bombings (6 or more hours) had higher acute stress than did children directly exposed to the bombing events. Together, these results suggest that television exposure to mass violence may increase individuals' risk for maladaptation. Furthermore, regarding the chapter case study, these findings support the school psychologists' recommendation that Mr. Brown limit the amount of coverage he and Rory watched.

Surveying parents in New York City before and after 9/11, Stuber et al. (2005) also found that disaster experiences were associated with subsequent child behavior problems. Furthermore, family demographics (e.g., income, single-parent status, ethnicity) and

parental reactions to the attacks were also related to behavioral problems. Parents who were unsure of how their child was responding to the attacks were also more likely to report behavior problems for that child following the attacks, and adolescents who observed a parent crying were more likely to evidence behavior problems 6 months following the attacks. Although youth may benefit from age-appropriate discussions about the attack, parental crying may communicate stress and therefore negatively impact child well-being in traumatic events when fear and uncertainty persist (as opposed to an isolated tragic event such as a natural disaster).

Bonanno, Galea, Bucciarelli, and Vlahov (2007) also studied resilience following the 9/11 attacks, with resilience being defined as having 1 or 0 posttraumatic stress symptoms along with lower levels of depression and substance use. Using data from a phone survey of 2,752 residents of the New York City area 6 months following the attacks, the researchers found that demographic variables, resources, and additional life stressors predicted resilience. Being male, Asian, and being over age 65 were demographic factors related to resilience. Furthermore, education was inversely related to resilience, suggesting education (or perhaps correlates of education such as work stress) hampered adaptation to the trauma in this sample. This finding contradicts some prior research and may be unique to the 9/11 attacks or similar types of large-scale violence. Resources positively related to resilience were lack of income loss, presence of social support, and the absence of chronic disease. Finally, the absence of additional life stressors was found to be most strongly related to resilience; participants with no prior trauma, no recent stressful events, and additional traumatic events since 9/11 were more likely to be resilient.

Resilience and Mass Shootings

Research subsequent to school and community mass shootings has also broadened our knowledge of factors contributing to long-term psychosocial outcomes. Hawdon, Räsänen, Oksanen, and Ryan (2012) studied three mass shootings and concluded that social solidarity emerging after the shootings decreased depressive symptoms and increased psychological well-being, even when controlling for other previously identified predictors of depression. Hawdon and Ryan's (2012) research following the Virginia Tech shooting further supports the importance of social connections with family and friends following a mass shooting. Using survey data from a sample of 460 students, they found that social solidarity, engaging in community events, and face-to-face interactions with family members all significantly enhanced well-being 5 months after the mass shooting that occurred on campus. Furthermore, virtual interactions with friends and family members were found to be beneficial provided they occurred along with face-to-face interactions. Together, these results reveal the important protective function families can serve in individual adaptation. In the chapter case study, these findings suggest that Mr. Brown's ongoing supportive interactions with Rory were likely beneficial to her well-being.

In another study following the Virginia Tech shooting, Littleton, Axsom, and Grills-Taquechel (2009) analyzed the degree to which interpersonal (e.g., companionship, loyalty of friends) and intrapersonal (e.g., optimism, life direction) resource loss and gain following the shooting predicted subsequent psychological distress in a sample of 193 female students at Virginia Tech. Structural equation modeling revealed that interpersonal and

intrapersonal resource loss within the first 2 months following the shooting positively predicted greater psychological distress 6 months after the shooting. Furthermore, participants who experienced resource loss in the first 2 months after the shooting experienced an increased likelihood of further resource loss during the subsequent 4 months. Although resource gain was positively related to decreases in psychological distress, this relationship was weaker than it was between resource loss and psychological distress.

The impact of a secure attachment style on functioning after a school shooting has also been examined as an interpersonal resource that might mitigate the effects of trauma. Based on attachment theory, the manner in which an individual responds to a traumatic event, such as mass violence, may be rooted in that individual's attachment style that was established with the primary caregiver in infancy (Turunen, Haravuori, Punama, Suomalainen, & Marttunen, 2014). Turunen et al. (2014) studied the degree to which attachment style predicted PTSD and dissociative symptoms in a sample of survivors of a school shooting in Finland. Participants were administered multiple survey assessments 4, 16, and 28 months following the shooting. Analyses revealed that a secure attachment style provided the strongest protection against PTSD and dissociative symptoms. The more negative outcomes associated with the two insecure attachment types (avoidant and preoccupied) differed based on the amount of time since the shooting. When discussing the reasons for the protective advantage of a secure attachment style, the authors suggested that this could be explained in part by securely attached individuals' ability to recognize that other people are available for help and comfort and to appraise their own situation and seek this help when needed. These findings suggest early caregiver–child relationships may play a role in subsequent responses to trauma.

Systemic Reviews of Family Resilience and Mass Trauma

Whereas the preceding studies primarily focused on *individuals'* capacity for resilience, little research has specifically focused on *family* processes as predictors or outcomes of resilience specifically related to mass violence. However, drawing upon the broader traumatic loss literature, Walsh (2007) proposed that belief systems, organizational patterns, and communication processes can either serve as risk or protective factors for family resilience to trauma. For example, where shattered assumptions or a sense of hopelessness are risk factors for maladaptation, a belief system that can meaningfully manage the loss and maintain a positive outlook can serve to protect a family from negative outcomes. Related to organizational patterns, families should be supported to be flexible in roles to deal with the new challenges yet should provide security and stability to reduce chaos; they should also strive to remain connected and rely on family and community resources (Walsh, 2007). The latter is demonstrated in the chapter case study when Mr. Brown sought out community resources to help him and his daughter cope with the trauma. Finally, communication processes should be characterized by clarity and consistency, and individual differences in emotional expression should be recognized (Walsh, 2007).

Gewirtz, Forgatch, and Wieling (2008) also drew from the related mass trauma research to discuss the impact of parenting practices on child resilience. The researchers proposed that the quality of parenting subsequent to an instance of mass trauma mediates the relationship between the trauma and child adjustment and that the family is important given

its role as "the most proximal social environment in which children learn patterns of adjustment" (p. 177). Gewirtz et al. proposed that exposure to mass trauma disrupts the family social system, and therefore recovery efforts after a traumatic event must strengthen parents' ability to promote positive family social interactions and draw upon available resources to facilitate posttraumatic functioning. For example, the authors suggested that parents who monitor, set limits, and problem solve after mass trauma are more likely have resilient children. Furthermore, the authors cited research suggesting that children use cues provided by parents to interpret whether a situation is safe or not; consequently, parental reactions to mass violence have the potential to influence child adaptation.

The more broadly defined adversity literature also reveals insights about the resilience of the family unit. For example, Black and Lobo (2008) conducted a literature review to identify recurrent and prominent factors that defined resilient families. They concluded that these factors included a positive outlook, spirituality or a shared value system, family member accord/cohesion, flexibility, harmonious family communication, sound financial management, family time, shared recreation, and routines and rituals, and a support network. These factors are consistent with Walsh's (2003) family resilience model, which focuses on enhancing communication processes (e.g., harmonious family communication), belief systems (e.g., positive outlook and spirituality or shared value system), and organizational patterns (e.g., routines and rituals and family member accord/cohesion).

Benzies and Mychasiuk (2009) also conducted an integrative review of research to identify risk and protective factors for family resilience at the individual, family, and community levels. At the individual level, malleable factors contributing to family resilience include an internal locus of control, an ability to regulate one's emotions, education, and coping skills. At the family level, being from a smaller family, having a mature mother, two-parent families, family cohesion, supportive parent–child interaction, social support, and stable/adequate income and housing have been shown to protect families from adversity. Finally, at the community level, involvement in the community, peer acceptance, supportive adult mentors, safe neighborhoods, and access to quality child-care and health care can serve a protective function for families. Although family resilience represents a complex interplay between protective factors like these and risk factors, Benzies and Mychasiuk contend that these identified factors offer an excellent starting point to inform family intervention.

Although these studies offer insights into factors that may help individuals and families adapt effectively, it is important to note that resilience is increasingly being viewed as a context- and culture-specific process. Therefore, factors that may contribute to the effective coping in one culture may not serve an equally protective role in another. Clauss-Ehlers and Lopez Levi (2002), for example, identified three cultural community resilience factors that may uniquely buffer community violence in Latino communities: *familismo* (i.e., putting family needs first, an obligation to family), *respeto* (i.e., acknowledging the authority of elders and people in positions of authority), *and personalismo* (i.e., recognizing the critical importance of positive relationships). Incorporating these values into support services could enhance psychosocial outcomes for Latino families (Clauss-Ehlers & Lopez Levi, 2002) and is consistent with the ecological nature of Walsh's (2003) family resilience model.

IMPLICATIONS FOR PROFESSIONALS WORKING WITH FAMILIES EXPOSED TO MASS VIOLENCE PREPAREDNESS

The National Child Traumatic Stress Network (2008) encourages professionals to ask three questions to assess their community's or school's preparedness to handle a violent event; however, in addition to professionals asking these important questions, they are also appropriate for families and communities to consider. First, if the violent event happened today, how ready is your family or community or school to respond? Second, what are your family, community, or school's resources and skills to respond to a violent event? And third, does your family, community, or school have the capacity to recover socially and emotionally?

In addition to giving consideration to these questions, professionals can preventatively help to prepare their system for the unfortunate circumstance of needing to support individuals and families in this capacity. Preparation should involve education, practice, and planning (Jimmerson, Brock, & Pletcher, 2005). In terms of education, there are a variety of crisis response trainings and resources available that provide appropriate models for families, communities, and schools to use. Although individual professionals may have training in this area, it is important that all members of the system are trained to respond within the specific family, community, or school environment. Furthermore, preventing mental health risk in the general population may help prevent future traumatic events. Mental Health First Aid (2014) and QPR Suicide Triage Training (2014) are two examples of trainings that are designed to assist professionals (i.e., counselors, teachers, administrators, etc.) and parents in recognizing risk factors in individuals and getting them the supports they need.

Enhancing protective factors is also key in the prevention of a traumatic event. Positive social relationships remain a key protective factor that can be enhanced through prosocial activities that encourage bonding and the development of positive peer and adult relationships. Families, schools, and communities can directly promote these interactions through structured after-school programs (i.e., youth groups, athletics, art/music groups, meditation or book clubs, etc.). Families have the opportunity to encourage these positive relationships by supporting children and adolescents when they engage appropriately with peers and adults by hosting an event or gathering at their home or transporting their child to an event or gathering. In the chapter case study, Mr. Brown reached out to his church network for social support that could be beneficial for him and Rory.

Beyond training and promoting prosocial relationships, professionals need to work together to practice the application of their skills. Professionals (i.e., counselors, teachers, administrators, etc.) should consider exploring Triage Assessment System (Myer, 2001), Seven-Stage Model of Crisis Intervention (Roberts, 2000), the National Incident Management System (Federal Emergency Management Agency, 2014), and/or PREPaRE (Brock et al., 2009). These resources provide frameworks and tools for prevention efforts prior to a crisis and support efforts after a crisis has occurred.

In addition to education and practice, professionals can plan ahead. For example, crisis response teams or interagency teams can be established to assist with response, a directory of resources can be created and maintained, methods for identifying and working with

high-risk students and/or groups of students can be identified, a caregiver training and information guide can be compiled, and an information decimation system can be created (Jimmerson et al., 2005). Several of these preventative strategies were used in the case study presented at the beginning of the chapter. Planning may also entail establishing a system of mental health support that has a variety of levels of support for families. Additionally, consideration for the anniversary may be included as a part of planning. Although the specific event and circumstances will dictate what is done, preparations may include collecting resources/ideas to assist in making key decisions about a memorial, rescreening for families at risk, reactivating interagency supports, and so on. Table 13.2 contains some resources to consider when planning.

Table 13.2 Violent Event Resources for Communities and Schools

Organization	Resource Link	Description of Resource
Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.samhsa.gov/trauma-violence	Facts and resources
National Center for Crisis Management	http://www.nc-cm.org/index.htm	Membership and online training resources
The National Child Traumatic Stress Network	http://nctsn.org/sites/default/files/assets/pdfs/Child_Trauma_Toolkit_Final.pdf	Child Trauma Toolkit for Educators
National Institute of Mental Health (NIMH)	http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-community-members-trifold-2/index.shtml	What Community Members Can Do
National Education Association Health Information Network	http://neahealthyfutures.org/wpcproduct/school-crisis-guide/	School Crisis Guide
Center for Mental Health in School, UCLA Center	http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf	Responding to Crisis at School
Office of Homeland Security	http://www.dhs.gov/topics	Relevant topics include preventing terrorism and resiliency
National Incident Management System (NIMS)	http://www.fema.gov/national-incident-management-system	Information on a systematic framework for interagency management of threats or hazards

Responding to Mass Violence: Enhancing Resilience

Individuals and families react differently to all types of violent events, regardless if they are directly or indirectly involved. Therefore, professionals should prepare for a wide variety of needs from families. As professionals work with individual family members, it is important for them to explore what resources an individual has previously accessed and to what extent those resources may be helpful to them as they begin the healing process (Walsh, 2007). For example, what connections does the individual have to family, community, cultural, and spiritual supports? Professionals must understand each individual's belief system to assist him or her in understanding perceptions and coping strategies within the context of the family system. Furthermore, professionals should be equipped to intervene with the family system to assist in making meaningful changes through counseling that focus on couple relationships, parenting roles and supports, and so on.

In terms of individual resilience, effective coping skills, belief systems, social support, emotional regulation, and internal loci of control have been found to be protective factors (Benzies & Mychasiuk, 2009; Bonanno et al., 2007). Therefore, professionals should consider preventatively encouraging individuals to continue to develop effective coping skills, establish a belief system, maintain and/or expand their social support system, practice social healthy responses to life events, and recognize to what extent they believe they can control an event. Professionals may consider identifying families in need of these individual supports by examining parenting subsystems that may be vulnerable (i.e., single parents, dual earning couples, financially unstable families).

At the family level, supportive parent–child interaction including secure attachment styles, family cohesion, and stable and adequate income are examples of family protective factors (Benzies & Mychasiuk, 2009; Black & Lobo, 2008; Turunen et al., 2014). Preventatively, professionals may consider offering education and intervention programs at both the family and community levels. Examples of preventative strategies may include improving relationships within the parenting subsystem (e.g., relationship between couples or single parent and his or her support system), parenting skills, family cohesion, and community family events and supports that encourage positive family interactions and cohesion. Additionally, professionals may consider compiling employment resources and/or creating a family resource room that is equipped with computers, printers, and other office materials to help support families in meeting their employment and income goals (Benzies & Mychasiuk, 2009; Black & Lobo, 2008; Turunen et al., 2014).

Community resilience, cohesion, and efficacy are essential factors in the prevention of a traumatic event. For example, safe neighborhoods; access to quality schools, child care, and health care; supportive mentors; and peer acceptance emerged as critical community protective factors within the literature (Benzies & Mychasiuk, 2009). Professionals may consider working with other community members to explore or enhance these factors within the community environment. Professionals may give consideration to using a community climate survey or creating a mentor program in the community.

In addition to these general recommendations regarding promoting family resilience in the aftermath of mass violence, the following are more specific recommendations to consider when working with families impacted by a violent event.

Mobilize Resources

Ideally, school and community teams will have engaged in planning prior to the occurrence of a violent event, which should include practice drills. If this has occurred, it is likely that teams have established interagency connections that are ready to be mobilized and have a mutual understanding of how the systems will be organized to support families. Mobilizing resources will likely involve a combination of emergency response for physical health needs (safe rooms, Kevlar blankets, etc.), basic resources (shelter, transportation, food), mental health supports, school and community agencies, and/or state and federal supports. Providing these types of outside resources is essential to counter the experience of loss often associated with a violent event (Hobfoll et al., 2007). It was evident in the case study at the beginning of the chapter that Mr. Brown and Rory were within a community that had prepared ahead of time and effectively mobilized resources after the traumatic event occurred.

Effective Parenting Style

It is reasonable to conclude that because violent events often create disruption to the family system, this in turn may threaten or compromise positive parenting within the family. According to Gewirtz et al. (2008), recovery efforts after a traumatic event must strengthen parents' ability to promote positive family social interactions. Therefore, professionals should encourage parents to effectively provide support, monitor, set limits, and problem solve after the event (Gewirtz et al., 2008), just like the school psychologist did in the chapter case study. Counseling supports should continue to be considered as a part of the efforts made to enhance effective parenting, as described in the case study.

Organization and Communication

Professionals can support their clients to establish a way to organize their response to the violent event (Walsh, 2007). How will the family maintain or change their routines? Are there any changes to the roles of individuals within the family? Are there changes to the rules the family previously followed? What levels of support will be most helpful to the family? Are they using all possible/needed supports? These questions relate to the notion in Walsh's (2012) family resilience model of enhancing family organizational patterns. In the case study, Mr. Brown likely asked himself several of these questions, as he engaged in effective organization and communication regarding his response to the violent event.

In addition to organization and communication within the family system, professionals must be aware of their own communication style. Hobfoll et al. (2007) cautions professionals against sharing rumors or "horror stories" as they are also working to process the event. Professionals may also consider working to support the community to prioritize efficient and accurate dissemination of information, which is helpful in supporting families with questions about their social support system (Hobfoll et al., 2007). This step is critical, because delays in linking individuals to their support networks have been found to increase the likelihood of symptoms associated with PTSD (Hobfoll et al., 2007).

Media Exposure

Research has found that frequency and duration of media exposure of the violent event is associated with negative outcomes, even when controlling for factors such as prior mental health status and media exposure prior to the violent event (e.g., Holman et al., 2014). Based on the research by Schlenger et al. (2002) reviewed earlier in this chapter, families should consider limiting the amount of time they spend watching television coverage of the violent event since it was found to predict both PTSD symptomatology and general distress. Although it is common to think of television when discussing media coverage, professionals are encouraged to help families examine all forms of media exposure, which also includes text messages, e-mail, Facebook, Twitter, YouTube, and so on. However, as revealed by Hawdon and Ryan's work (2012), virtual interactions with friends and family may be beneficial when concurrent with face-to-face interactions; thus, not all forms of media exposure are inherently negative. Consequently, professionals should help parents consider the effects of event media exposure, so that they can appropriately monitor exposure in themselves and their children. In the case study within this chapter, Mr. Brown recognized the need to set limits on Rory's television viewing related to the event.

Discover Meaning

Making meaning out of the violent event is considered a positive and adaptive response because it promotes resiliency and healing by making the event more comprehensible and manageable (Walsh, 2007). Therefore, professionals need to be prepared to support their clients to discover meaning of the violent experience (Walsh, 2007). It should be anticipated that clients may question their core beliefs, and guided discovery is essential to assist them in evaluating and possibly redefining them (Walsh, 2007). The examination of core beliefs is critical during this time since they are what individuals use to process the event as they provide people purpose and meaning in life (Walsh, 2007). Individuals may ask many "why" questions (i.e., "Why me?," "Why did this happen?," "Why did she do that?"). They may question their personal safety and the safety of their family, their personal legacy and/or mortality, the existence of a higher being such as God, and so on. (Walsh, 2007). Ultimately, the goal is for the professional to help guide the client to resolve these questions so that the client can positively cope and make meaning out of the experience for future events in life (Walsh, 2007). In the case study, Mr. Brown engaged in mental health supports to help Rory and himself discover meaning.

Therapy-Based Interventions

Cognitive Behavioral Therapy (CBT) has been found to be effective with individuals and family systems who are struggling to cope with a violent event (Follette & Ruzek, 2006). Some hypothesize CBT is effective because it encourages the individual and/or family system to use problem-solving skills that enhance self-efficacy and internal locus of control (Follette & Ruzek, 2006). Often individuals struggling to cope with a violent event display symptoms of PTSD. There has been some evidence in the literature for using exposure therapy and/or stress inoculation training with those struggling to cope with symptoms associated with PTSD (Hobfoll et al., 2007). As stated earlier, because the context of the

violent event, and the population or culture impacted by it, are unique to each situation, the findings that are generalizable are limited.

CONCLUSION

Acts of mass violence are an unfortunate reality in our world. Although these events remain rare, they produce a range of unfavorable psychological consequences in exposed individuals and families. A resilience framework reveals preventative strategies and enhancing protective factors to promote adaptive functioning in the midst of the stress and anxiety caused by these violent events. Professionals working with families should consider their preparedness to respond to a violent event and should assist families in identifying and promoting prevention strategies and protective factors in the midst of trauma-induced stress. Although the recommendations outlined in this chapter may serve as a starting point for enhancing family functioning following an act of mass violence, resilience is a dynamic and context-dependent process; therefore, the type and intensity of the response should be adapted based on the unique characteristics of the family, the event, and the culture.

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