

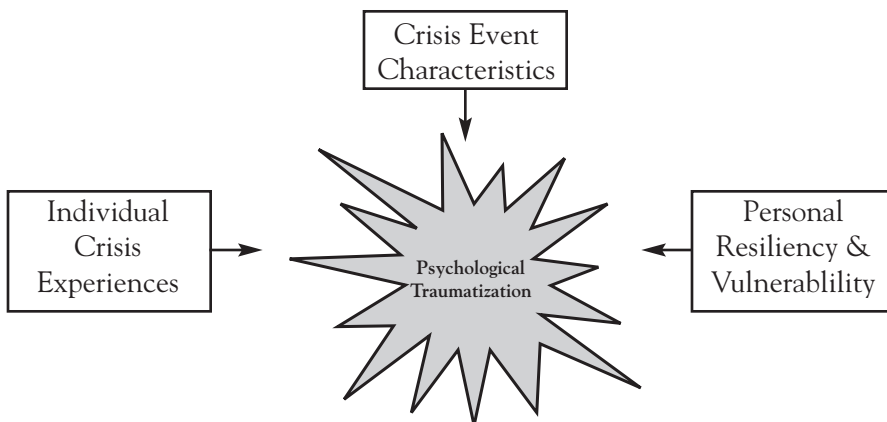
Identifying Individuals at Risk for Psychological Trauma

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As Chapter 18 illustrated, crisis events vary in their potential to traumatize. Even for a specific event, however, there is no simple cause-and-effect relationship between the crisis and subsequent traumatization (Carlson, 1997). In other words, a given crisis event will not result in the same degree of traumatization among all survivors. As illustrated in Figure 1, one conceptualization of traumatization is as a consequence of the interaction among the crisis event, the individual's unique crisis experience, and personal resiliency and vulnerability. Traumatization is not simply a consequence of what happened; it is also a consequence of how survivors experience the crisis (individual crisis experience variables) coupled with the personal characteristics of the survivors (personal resiliency and vulnerability variables).

Figure 1

Psychological traumatization is the result of the interaction among the characteristics of the crisis event, individual crisis experiences, and personal resiliency and vulnerability.



Individual Crisis Experience Variables

Individual crisis experience variables include *crisis exposure*, *relationships with crisis victims*, *crisis reactions*, and *perceived threat*. These variables are the unique, relatively subjective, crisis experiences of the individual. These variables can either increase or decrease the traumatizing potential of an event depending upon their presence or absence (see Table 1).

Table 1

Individual Crisis Experience Variables

Traumatization Minimized	Traumatization Maximized
<p>Low Crisis Exposure</p> <ol style="list-style-type: none"> 1. Not proximal to the crisis event 2. Brief exposure to the crisis event 	<p>High crisis exposure</p> <ol style="list-style-type: none"> 1. Proximal to the crisis event 2. Long exposure to the crisis event
<p>No relationship with victim(s)</p>	<p>Close relationship with victim(s)</p>
<p>No crisis reactions</p> <ol style="list-style-type: none"> 1. Management of initial reactions 2. Over time arousal normalizes 	<p>Severe crisis reactions</p> <ol style="list-style-type: none"> 1. Initial response of panic/dissociation 2. Over time arousal does not normalize
<p>Low perceived threat</p>	<p>High perceived threat</p>

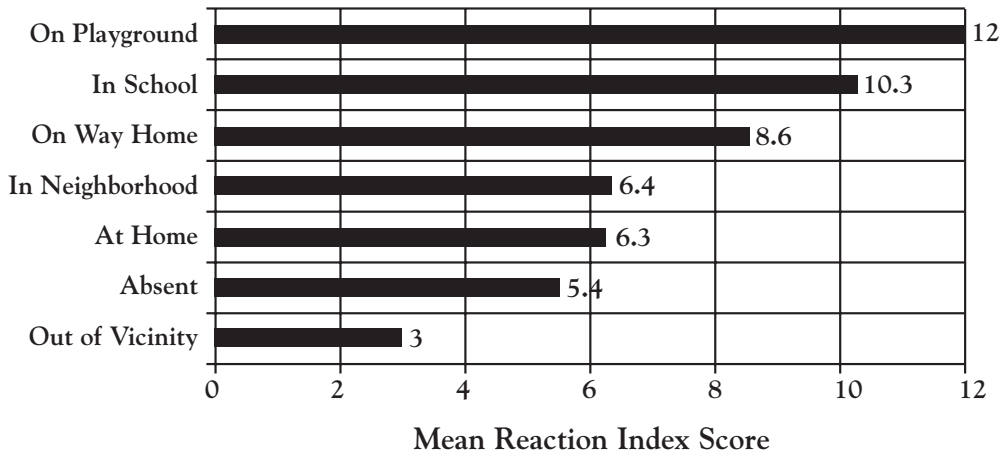
Crisis Exposure

Individual exposure includes proximity and duration of exposure to a crisis event. The closer the individual is to the crisis and the longer the duration of exposure, the greater the traumatization.

Proximity to the crisis. The effect of proximity has frequently been documented by traumatic stress research (Bloch, Silber, & Perry, 1956; Callahan, 2000; Green, Grace, & Lindy, 1983; Green et al., 1991; McFarlane, 1986; Nader, Pynoos, Fairbanks, & Frederick, 1990; Newman, 1976; Shore, Tatum, & Vollmer, 1986, 1990). Pynoos et al. (1987), for example, demonstrated the dominant influence of exposure to a crisis event in predicting the development of posttraumatic stress reactions. This study assessed the self-reports of children’s (ages 5 to 13) stress reactions following a sniper attack on a school playground that left one student and one passerby killed and 13 wounded. Making use of a Posttraumatic Stress Disorder (PTSD) Reaction Index, a strong (almost linear) relationship between proximity and PTSD symptoms was demonstrated (see Figure 2). Therefore, all individuals directly involved in and/or exposed to a crisis event should be given a high priority for crisis intervention assistance.

Figure 2

Mean PTSD Reaction Index scores (which reflect the number of PTSD symptoms reported) by exposure to a playground shooting. Number of symptoms increases as degree of exposure increases. ANOVA indicated significant differences between mean scores ($F = 16.06$, $df = 6$, $p < .001$).



Note

From "Life Threat and Posttraumatic Stress in School-Age Children," by R. S. Pynoos et al., 1987, *Archives of General Psychiatry*, 44, p. 1059. Copyright 1987 by the American Medical Association. Reprinted with permission.

Duration of exposure to the crisis. Generally speaking, crisis events that last longer are associated with more severe distress (Matsakis, 1994; Saylor, 1993). Thus, duration of exposure to the traumatic event is also an important consideration in determining crisis intervention service priority. For example, following a schoolyard shooting, relatively high crisis intervention priority would be given to students trapped on the playground by gunfire. In contrast, a relatively lower priority would be given to those who were quickly able to escape to a safe location.

Although crisis exposure is clearly a dominant factor in determining initial psychological traumatization, even individuals not exposed to the stressor may report distress. While the most severe PTSD reactions reported in the Pynoos et al. (1987) study were documented among children on the playground during the shooting, some children who were not even at school at this time also displayed PTSD reactions (17.5% reported moderate to severe reactions). Thus, it is clear that other factors must be considered when identifying psychological trauma victims. These factors will now be discussed.

Relationship With Crisis Victims

Besides exposure to the crisis event, relationship with the crisis victims is one of the most powerful traumatization risk factors. The stronger the relationships, the greater

the likelihood of traumatization (Nader & Pynoos, 1993). The importance of this factor has been demonstrated by Nader et al. (1990) and Pynoos et al. (1987), who found that greater acquaintance with the victim of a schoolyard shooting was positively correlated with higher PTSD Reaction Index scores. Similarly, Milgram, Toubiana, Klingman, Raviv, and Goldstein (1988) found both acute and chronic stress reactions, following a bus-train collision, to be more related to friendship with accident victims than to exposure to (witnessing) the school bus disaster. Therefore, individuals who are emotionally close to a trauma victim should also be given a high priority for crisis intervention assistance.

Severity of the Survivor's Acute Distress

The individual's emotional reaction to the crisis is also an important variable to consider. Not only does the immediate response to a crisis influence the capacity to respond adaptively, but it also appears that those who display more severe reactions are at greater risk for psychological traumatization (Matsakis, 1994). For example, research with veterans of the 1982 Lebanon War found that soldiers who became acutely distressed during the conflict had a much higher rate of PTSD. Conversely, soldiers who were able to manage their feelings during combat displayed a significantly lower rate of this disorder. Generally, individuals who display dissociative or panic reactions during a trauma are more vulnerable to posttraumatic reactions (McFarlane & Yehuda, 1996).

Research also suggests that specific types of trauma reactions may define high-risk trauma victims. Specifically, McFarlane and Yehuda (1996) found that "enduring exaggerated startle response, hypervigilance, increased irritability, sleep disturbance, and disturbed memory and concentration" (p. 172) differentiated trauma survivors who developed PTSD from those who did not. Conversely, they suggest that distressing and intrusive memories, in the initial days after the crisis event, were common indicators of normal reappraisal.

These data suggest that crisis victims who report or appear to be experiencing extreme stress reactions should be given a high priority for crisis intervention assistance. Particular attention should be directed to those who panic or dissociate during the trauma and who have ongoing difficulty regulating their arousal levels.

Perceived Threat

Finally, the crisis victim's subjective impression of the crisis can be more important than the crisis event itself (McFarlane & De Girolamo, 1996). Thus, it is important to assess not only objective traumatizing factors, such as exposure to the crisis, but also the subjective threat experienced by victims. Simply stated, traumatized individuals will have perceived the event as extremely negative (Caplan, 1964; Carlson, 1997; Mitchell & Everly, 1996). Conversely, individuals who did not perceive the event as severe, regardless of how dangerous and intense it actually was, will not be as traumatized. For example, Tatum, Vollmer, and Shore (1986) found that perceived threat resulting from

the Mount St. Helens' volcanic disaster was significantly correlated with stress reactions. In addition, King, King, Fairbank, Keane, & Adams (1998) reported a direct relationship between perceived threat and traumatic stress among male Vietnam veterans. It is important, therefore, to assess perceived threat when determining priorities for individual crisis intervention service.

Factors influencing children's threat perceptions. It is critical to keep in mind the impact of adult reactions on children's perceptions. Events that are initially not perceived as threatening may become such after observing the reactions of others. For example, Pynoos et al. (1987) reported that children who were dramatically confronted with indications of the severity of a school shooting (e.g., having their home used as emergency headquarters for a SWAT team) displayed more PTSD reactions than did other similarly trauma-exposed children. In this instance, the children's observations of extreme adult reactions may have elevated their perception of crisis threat.

In addition, it is important for crisis intervenors to keep in mind that children may view a crisis (such as being held at gunpoint) as nonthreatening because they are too developmentally immature to understand the potential danger. Given this circumstance, the event may become traumatic only if the danger of the situation is explained to them (Carlson, 1997). It appears that, at least when it comes to initial traumatization, developmental immaturity might be protective. Specifically, lack of cognitive sophistication may result in a child not understanding the magnitude of even the most severe of crises. Conversely, relative cognitive sophistication may make a young child more vulnerable to understanding the magnitude of a traumatic event (Masten & Coatsworth, 1998). Because of their higher levels of sensitivity to the environment, these children may be more susceptible to stressors (Luthar & Zigler, 1991). The observations of Green et al. (1991) support this hypothesis. These researchers, who examined the psychiatric reports of children made 2 years after a dam failure disaster, found younger children (ages 2 to 7) had fewer PTSD symptoms than did older youths (ages 8 to 15). They speculated that very young children's initial experience of disaster might have been limited by their cognitive abilities. These children may not have been aware of the threat presented by the dam failure. Further, they were found to be more influenced by parental reactions (i.e., severity of parents' PTSD symptoms) than by crisis exposure. Therefore, it is suggested that the interaction between students' developmental level and crisis threat perceptions should be considered when determining crisis intervention service priorities.

Personal Resiliency and Vulnerability Variables

Personal resiliency and vulnerability variables include both *external* and *internal* factors (see Table 2, on page 372). External factors are found within the individual's environment and include familial, social, and financial resources. Internal factors are more difficult to directly observe. These variables, which are relatively stable factors existing within the individual, include: coping style, mental health history, emotional self-regulation, developmental level, trauma history, self-esteem, locus of control, and

religious belief systems. Individuals who are less resilient will typically require more extensive services than do those with greater resilience.

Table 2

Personal Resiliency and Vulnerability Variables

	Resiliency Factors	Vulnerability Factors
External	Familial resources available	Familial resources unavailable
	1. Living with nuclear family member	1. Not living with nuclear family
	2. Effective & caring parenting	2. Ineffective & uncaring parenting
	3. Extended family relations/guidance	3. Family dysfunction (e.g., alcoholism, violence, mental illness)
	4. Caregivers cope well with trauma	4. Parental PTSD
		5. Child maltreatment
	Social resources available	Social resources unavailable
	1. Close peer friendships	1. Social isolation. Lack of perceived social support
	2. Access to positive adult models	
	3. Connection with prosocial institutions	
		Financial resources unavailable
Internal	1. Active coping style	1. Avoidance coping style
	2. Mental health	2. Preexisting mental illness
	3. Good self-regulation of emotion	3. Poor self-regulation of emotion
	4. Developmental maturity and higher IQ	4. Low developmental level
	5. Adaptive coping with prior trauma	5. History of prior traumatization
	6. High self-esteem	6. Low self-esteem
	7. Internal locus of control	7. External locus of control
	8. Religious belief system (faith)	

Personal resiliency and vulnerability variables play a role in both the initial and long-term reactions to a psychological trauma. My interpretation of current research suggests that these variables are a more powerful influence on long-term trauma reactions than on initial adjustment. Some crisis events may be so overwhelming that they result in *initial* traumatization in virtually everyone, and personal resiliency will not reduce their impact (Pynoos et al., 1987). In contrast, some researchers have concluded that maladaptive *long-term* adjustment to a trauma is not typical. For example, Breslau (1998) has documented that, although there was an 89% lifetime prevalence of exposure to traumatic events in her 1996 Detroit Area Survey of Trauma, only 10.2% of males and 18.3% of females developed PTSD. Findings such as these suggest that personal vulnerability distinguishes those who develop chronic PTSD from those who do not (Breslau, 1998; McFarlane, 1990; McFarlane & Yehuda, 1996).

External Personal Resiliency and Vulnerability Variables

Familial Resources

Living with nuclear family members. Simply being able to continue to live with a nuclear family member following a trauma appears to promote resiliency. Supporting this observation is the finding that traumatized Cambodian refugee youths not living with a nuclear family member, and instead residing with a foster family, had poorer long-term adjustment (Kinzie, Sack, Angell, Manson, & Rath, 1986). Conversely, those youths who were able to reestablish contact and live with any family member did much better. Kinzie et al. concluded that “. . . having reestablished some contact with family members in this setting mitigated some of the symptoms of the severe trauma, while being alone or in a foster family exacerbated the disorder” (p. 375). This finding may be related to the fact that the loss of a family member means not only the removal of an important attachment system, but also part of the individual’s “meaning system.” The individual can never again be son or brother, daughter or sister, if his or her family has been completely lost (Matsakis, 1994).

Family functioning. Level of family functioning plays an important role in determining the severity of posttraumatic symptomology (Caplan, 1964; Carlson, 1997; Luthar & Zigler, 1991; Terr, 1983). Especially important in how youths respond to stress is the quality of the parent-child relationship. Adaptive long-term outcomes require the involvement of caring, affectionate, and competent parents (or other primary caregivers) in the child’s life. Specific parenting characteristics that have been associated with resiliency include warmth, structure, and high expectations. Access to warm relationships and guidance from the extended family is also associated with resiliency (Doll & Lyon, 1998).

Family violence. Creating perhaps even more vulnerability than ineffective parenting are experiences with maltreatment. For example, a study of Vietnam combat veterans found that those with PTSD had higher rates of childhood physical abuse than did those without this disorder (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993).

Family mental health. The presence of mental illness within the family will increase vulnerability to a traumatic stressor (Bloch et al., 1956; Green et al., 1991). For example, following a school bus kidnapping, Terr (1983) found “... relationships between the clinical severity of the children’s posttraumatic conditions and their pre-existing family pathology ...” (p. 1550). Therefore, the mental health of family members should also be considered (Lystad, 1985; Nader & Pynoos, 1993).

Caregiver reactions to the trauma. Finally, how the family copes with a trauma is also important, because the reactions of others can have a significant impact on how youths view traumatic events. For example, Green et al. (1991) reported that greater maternal PTSD predicted greater child PTSD two years following a dam collapse and flood. Similarly, Nader and Pynoos (1993) point out that “there is a commonality in the level of anxiety among children and the adults in their environment” (p. 17).

Clearly, students from more stable families will demonstrate greater resilience following traumatic events (Luthar & Zigler, 1991). Conversely, youths who lack these protective family resources should be made a priority for crisis intervention services. Special attention should be directed toward persons not living with family members, from dysfunctional homes, with mental illness, and whose caregivers are having special difficulty coping with the trauma.

Social Resources

Several specific school and community social resources have been shown to promote resiliency (Doll & Lyon, 1998). These resources include close peer friendships, access to positive adult models outside of the family, and strong connections to prosocial organizations or institutions. Positive school experiences (academic or nonacademic) have also been found to be a protective factor (Luthar & Zigler, 1991). Individuals who have social supports available to them are expected to show lower levels of acute distress following a crisis event. Conversely, individuals who must face a crisis without supportive and nurturing friends or relatives have been shown to suffer more than those who have at least one source of such care (Caplan, 1964; Carlson, 1997; King et al., 1998; Lyons, 1991; Terr, 1983). Given these reports, individuals known to be socially isolated (or who perceive themselves as such) should be given crisis intervention service priority.

Financial Resources

Adequate financial support or services can also influence adjustment following trauma (Lyons, 1991; Slaikeu, 1990). Childhood poverty has been found to be a consistent predictor of dysfunction in adulthood (Doll & Lyon, 1998). An example of how this variable can influence the adjustment to a stressor is offered by Lewis (1970), whose qualitative study of a poor family dramatically illustrated how the stress associated with the death of a loved one was compounded by funeral and burial costs.

Internal Personal Resiliency and Vulnerability Variables

Coping Strategies

The types of strategies used by individuals to cope with problems may also serve to mediate the impact of a traumatic stressor. Resiliency research has suggested theoretical frameworks of coping that include distinctions between active (or approach) and avoidance coping strategies (Ayers, Sandler, West, & Roosa, 1996; Ebata & Moos, 1994). Active coping strategies include thoughts and actions that focus directly on problems (e.g., positive thinking, positive reappraisal of the stressor, making problem-solving decisions, and taking some direct action). Avoidance coping strategies include thoughts and actions that attempt to focus away from a stressful situation (e.g., to stop thinking about and/or dealing with the stressor; Sandler, Wolchik, MacKinnon, Ayers, & Roosa, 1997).

Resiliency research examining the effects of different coping strategies has found that the use of active coping, when dealing with stressful situations, is consistently associated with a reduced incidence of mental health problems (Sandler et al., 1997). In other words, confronting the traumatic stressor and engaging in cognitive and behavioral efforts to directly solve crisis-related problems is associated with better mental health outcomes. Conversely, the use of avoidance coping is consistently associated with an increased incidence of mental health problems in children and adolescents. Directing one's focus away from the traumatic stressor and engaging in cognitive and behavioral efforts to avoid crisis-related problems is associated with poorer mental health outcomes.

Although it appears that active coping is preferable to avoidant coping, avoidant coping may not be a risk factor in all circumstances. Sandler, Tein, and West (1994) suggest that in extremely high-stress situations, an initial avoidance coping response may be adaptive. Such a response may help to reduce negative arousal and thereby give the individual time to mobilize active coping resources. Thus, the individual who engages in avoidant coping immediately following a highly traumatic event may not necessarily be at increased risk for mental health problems. Clearly, however, the individual who continues to employ avoidance coping as a long-term, problem-solving strategy is more likely to have a poorer mental health outcome. These individuals should be given crisis intervention service priority.

Mental Health

Although entry into a crisis state is not in and of itself a sign of mental illness, a history of such illness can lower resistance to crises. There is evidence that a preexisting mental disorder influences the development of acute distress (American Psychiatric Association, 1994; Breslau, 1998), and psychiatric and personality disorders may increase vulnerability to traumatic crises (McFarlane, 1990; Nader & Pynoos, 1993).

For example, Breslau (1998) reports that preexisting major depression and anxiety disorders increase the risk of PTSD. Thus, individuals with mental illness should be given crisis intervention service priority.

Self-Regulation of Emotion

Masten and Coatsworth (1998) suggest that because of temperament, some children may be more prone to severe emotional reactions (e.g., anxiety and distress). These are children who have relative difficulty regulating negative emotions and do not regroup as readily when confronted with stressful experiences. Conversely, adaptive long-term outcomes are associated with a lower reactivity to stress and greater self-control of behavior. Thus, individuals known to have a negative temperament, be easily upset, and have difficulty calming down should be given crisis intervention service priority.

Developmental Level and Intellectual Functioning

While developmental immaturity may be a protective factor when it comes to initial traumatization (i.e., younger children may not comprehend the actual threat of the trauma), once an event is judged threatening, and all other factors are held constant, the younger the crisis survivor, the greater the traumatization (Carlson, 1997). Support for this observation is offered by Schwarz and Kowalski (1991), who found that while only 19% of adults exposed to a school shooting could be diagnosed as having PTSD, 27% of children could be diagnosed with this disorder. This difference may result from the greater vulnerability of younger children and their lack of experience coping with difficult problems. King, King, Foy, and Gudanowski (1996) found that soldiers who were younger when they went to war were more likely to have postwar PTSD symptoms, suggesting that younger men had not obtained a sufficient level of emotional development to cope with the stressors of combat.

Resiliency is clearly promoted by good intellectual functioning (Doll & Lyon, 1998). Masten and Coatsworth (1998) suggest that higher IQ scores may be associated with enhanced information-processing skills that help children cope with adversity. Children who are more intelligent may also be better able to solve problems and protect themselves. Conversely, children with lower IQ scores may find it more difficult to deal with threatening situations or fail to learn as much from prior experiences. Therefore, developmentally younger trauma victims (especially those with lower IQs) should be given relatively high crisis intervention service priority when compared with more mature (more intelligent) survivors.

Trauma History

A history of prior traumatization increases vulnerability to future traumatization (Bremner et al., 1993; Breslau, 1998; Matsakis, 1994). For example, a school shooting will be more traumatic for students who have previously been the victims of violence (e.g., child abuse). Children who have experienced repeated traumatic stressors are

more likely to disassociate and display mood swings than single-incident crisis survivors (Terr, 1991). Nader et al. (1990) reported that following a sniper attack on their school, children who had experienced previous traumas had renewed PTSD symptoms related to the earlier experiences. When exploring trauma history it is also important to identify individuals who have experienced prior crises similar in nature to the current crisis event, because these individuals may be at particular risk (Horowitz, 1986; Nader & Pynoos, 1993).

Although the role of prior traumatization is typically thought to increase vulnerability, some have suggested that prior life crises may inoculate individuals from future traumatization (Caplan, 1964; Carlson, 1997; Horowitz, 1986). In other words, the strategies developed to solve problems generated by prior crises may help the individual cope more effectively with future events. Norris and Murrell (1988) have conducted research supporting this “inoculation hypothesis.” In this study, 234 older adults (ages 55 to 75+) were interviewed both before and after a serious flood. Statistical analysis found that the flood exposure accounted for a significant amount of the variance in anxiety and distress only among those who had *no prior experience* with a flood. Among those who did have prior flood experience, the current flood did not account for a significant amount of variance in their emotional states. Flood survivors without prior flood experience had sharply increased anxiety and distress when faced with personal loss (as measured by victims’ perceptions). In contrast, symptoms of anxiety and distress among those with prior flood exposure remained close to preflood levels regardless of degree of personal loss. However, because this research was conducted with older adults, these findings may not be generalizable to children and/or other traumatic events.

While it is possible that prior exposure to a traumatic stressor (such as a flood) will facilitate coping with future traumatic events, it is also likely that traumatic stressors have some negative long-term effects. For example, among the flood victims studied by Norris and Murrell (1988), significant increases in anxiety and distress were seen only among those without prior experience with a disaster, but those with previous trauma experience had slightly higher levels of these emotions before the crisis event. Similarly, Luthar (1991) found high levels of distress among adolescents who, despite living in stressful environments, were judged successful. Masten and Coatsworth (1998) cite other research that did not find evidence of distress among adolescents who had successfully coped with adversity. Nevertheless, they conclude: “It remains an important question for future research whether, and under what conditions, children carry forward long-term consequences of adversity despite manifest competence and whether it is a sign for concern” (p. 213).

Other Internal Resiliency and Vulnerability Factors

A variety of other factors are identified by the resiliency literature as influencing adjustment to stressors; however, given the scope of this chapter, a thorough treatment of the resiliency literature is not possible. Nevertheless, I would like to briefly mention several other variables that have been suggested as important to the adjustment to

stressful life events. These factors are, however, often difficult to observe and may not have great practical utility during the initial psychological triage of crisis victims.

Self-confidence and esteem. Self-esteem has been found to be an important coping resource (Doll & Lyon, 1998; Masten & Coatsworth, 1998). According to Lutzke, Li, Ayers, and Sandler (1995, as cited in Lutzke, Ayers, Sandler, & Barr, 1997), high self-esteem significantly reduces depression, anxiety, and conduct disturbances following negative life events.

Locus of control. An internal locus of control has also been found to serve as a resiliency factor for youths (Doll & Lyon, 1998; Luthar & Zigler, 1991; Masten & Coatsworth, 1998). Specifically, youths who have faith in their ability to control their environment are better able to cope with stressful life events (Werner & Smith, 1982). Conversely, youths with an external locus of control have been found to display increased levels of psychological symptomatology following negative life events (Lutzke, Li, Ayers, & Sandler, 1995, as cited in Lutzke, Ayers, Sandler, & Barr, 1997; Silverman & Worden, 1992).

Resilient faith or belief system. Finally, the presence of a religious belief system during times of stress can be an important internal coping resource (Doll & Lyon, 1998; Luthar & Zigler, 1991; Masten & Coatsworth, 1998). Not only does it provide an intellectual framework that makes many events (e.g., the death of a loved one) more understandable, but it also typically includes a community (e.g., a congregation) that is able to provide needed support (Lutzke, Ayers, Sandler, & Barr, 1997). Research has found religion to be helpful for both adults (McIntosh, Cohen, Silver, & Wortman, 1993) and youths (Gray, 1987) following the death of a loved one.

Concluding Comments

The information presented in this chapter will be especially useful when responding to crises that have many more victims than crisis intervenors. In this circumstance crisis intervention treatment priority decisions must be made, because not all individuals affected by the crisis can be seen right away. Thus, those individuals at greatest risk for psychological trauma will need to be identified and made crisis intervention priorities. Conversely, those individuals judged at low risk for traumatization will need to be made relatively low crisis intervention priorities. Knowledge of the variables that result in traumatization is critical to conducting such “psychological triage.”

This chapter has suggested that a number of variables may play a role in psychological traumatization. Although crisis exposure has been suggested to play a primary role in traumatization, other variables such as familiarity with crisis victims, crisis reactions, threat perceptions, and personal resiliency and vulnerability factors are also involved. Thus, I suggest that these risk factors be considered collectively when determining crisis intervention service priorities. Further, I recommend that crisis experi-

ence and external resiliency and vulnerability variables be considered first when conducting an initial psychological triage. For school-based crisis intervenors, these factors are relatively easy to assess and thus are most helpful in making quick treatment priority decisions. Internal personal resiliency and vulnerability variables may have their greatest utility when it comes to making long-term treatment decisions. These variables may be especially helpful in making the distinction between those who are likely to successfully resolve a crisis from those who are likely to have ongoing difficulties (e.g., to develop chronic PTSD). For further information on conducting psychological triage, as well as specific psychological triage tools, the reader is referred to Brock, Sandoval, and Lewis (2000).

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