

Helping Newtown: Reopening a School in the Aftermath of Tragedy

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Abstract Four days after the Sandy Hook tragedy, the schools of Newtown, Connecticut reopened. The author discusses his work as a leader of a mental health team which supported the students, teachers, and parents in one elementary school. The goal was not just to restore the school system in its educational role, but also sustain it as a source of psychological and emotional support. The author illustrates the step by step process by which clinical and supportive services were developed and provided. Specific issues related to managing affect in an institution are demonstrated, and the special psychological demands on teaching staff are highlighted as is the significance of tapping into community resilience. The importance of a responsive empathic approach broadly applied and attuned to both community and individual needs is emphasized.

Keywords Trauma · Childhood bereavement · Crisis intervention · Psychological first aid

In this paper, I discuss the work of a disaster relief team at one of the elementary schools in Newtown, Connecticut, during the weeks after the Sandy Hook attack of December 14, 2012. I begin with an overview of the Connecticut Disaster Behavioral Health Response Network (DBHRN) and the circumstances of its mobilization and mission. A brief introduction to multi-disciplinary teamwork and psychological first aid is provided followed by thoughts regarding the complex needs of individuals and communities in the aftermath of disaster. The bulk of the paper is a firsthand report from the DBHRN team; it is written from my point of view in a narrative format and the sequence of

events described reflects the unfolding and fluid nature of the work. The account given and opinions expressed reflect my own perspective and are not those of any other individual or organization. In short, I offer a single case example. I share the thinking which informed the work as well as details from my experience at the school. As a psychoanalyst and clinical social worker, I relied on several key ideas from contemporary object relations and self-psychological thinking. However, holding theory lightly and being willing to respond flexibly were crucial. I hope this description of the strategies we used and the outcomes we experienced in our work with a single Newtown School can inform future disaster relief and response efforts.

On December 15, 2012, DBHRN was mobilized to provide services to the community and schools in Newtown. Under the joint oversight of the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Connecticut Department of Family and Children's Services (DCF), DBHRN is a network of mental health professionals from various agencies who are trained in the provision of clinical and supportive services to people and communities who have suffered disaster. The DBHRN network was established after September 11, 2001, and has been deployed a number of times in response to emergencies. As the DBHRN co-team leader of Fairfield County, Connecticut, I organized a local disaster response team. We went to Newtown the next day, Sunday, December 16, to join with the DBHRN leadership and other relief staff to develop a support plan for the schools that were to reopen 2 days later (Sandy Hook Elementary was closed until after the holidays and reopened at a new site).

The DBHRN plan for the Newtown school system was to assign a single multi-discipline mental health team to each school. This was consistent with findings that the complex needs of communities and schools after a disaster

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are best addressed by a cohesive, coordinated team of professionals with a variety of experience and skills (Paton and Flin 1999; North and Dingman 2000; Knox and Roberts 2005). I was assigned as the team leader at an elementary school across town from Sandy Hook. Our team was composed of clinicians from DCF, DMHAS, Emergency Mobile Psychiatric Services (EMPS), and the US Department of Public Health, roughly eight people. We were to help reopen the Newtown school system and restore not just its educational role, but also its role as a source of psychological and emotional support. We provided clinical and supportive assistance to students, teachers, staff, and families during those first days after the tragedy.

The clinical model DBHRN used at the Newtown schools was Psychological First Aid (Pynoos and Nader 1988; Ruzek et al. 2007; Vernberg et al. 2008; National Child Traumatic Stress Network 2009). PFA is a structured intervention developed as an alternative to debriefing approaches to disaster response. The goal of PFA is to reduce initial distress and promote short- and long-term functioning and coping. PFA emphasizes support, stress reduction, active outreach, and education. Uhernik and Husson (2009) devised eight interventions as part of PFA:

1. Contact and engagement
2. Safety and comfort
3. Stabilization
4. Information gathering
5. Practical assistance
6. Connection with social supports
7. Coping information
8. Link with collaborative services

In the following pages, I will illustrate how the DBHRN team provided these PFA interventions in a flexible, responsive manner to the various groups and individuals at the Newtown elementary school. As the reader will see, the provision of PFA is informed with other psychological and service models as appropriate. However, it is important to note that PFA is not primarily a psychotherapeutic intervention in the traditional sense. PFA emphasizes the natural healthy capacity and strength of people and communities, and all of the interventions are geared to support and facilitate the adaptation and healing of survivors. In fact, I found the PFA approach highly consistent with modern psychoanalytic clinical ideas, especially those that emphasize “environmental provision” and “holding”. As Winnicott (1965) taught us, facilitating healthy development depends on the maintenance of a secure and responsive social milieu. Creative psychological work such as learning and engagement in facilitative relationships depends on the continued survival of the caretaking environment. PFA is designed to respond on that basic level

(For an excellent guide to the use of PFA in schools, see the National Child Traumatic Stress Network, website www.nctsnet.org).

The attack and its aftermath had a broad impact on the school community, even those not directly involved in the violence, as with our school. In her study of New York City school children 6 months after September 11, Hoven et al. (2005) noted that children could be at risk of mental disorders despite their lack of proximity to ground zero. In the conclusion to her study, she noted:

Those in need of mental health intervention after this disaster were not confined to the immediate area of the attack. Consequently, future post disaster interventions should probably not be confined exclusively to children in close proximity to a disaster but should incorporate the disaster’s reach, both physically and psychologically (Hoven et al. 2005).

In another study, psychoanalyst and historian Charles Strozier (2011), writing in the aftermath of September 11, described “zones of sadness” which extend outward topographically and inward psychologically during and after such a horrific event. “Zone 1” included those who were directly threatened by death, “zone 2” were observers, “zone 3” suffered indirect, but serious effects, and in “zone 4” millions endured media reports and images of the suffering of others. Strozier learned that the psychological and social impact of mass murder could have disruptive, even traumatic, consequences at each level of the zones of sadness. Our school was clearly in zone 3. Despite no one at the school having been directly threatened or observing the death of others, many of the adults and children had ties to Sandy Hook which made the tragedy feel very close and acutely threatening. Fundamentally, everyone felt that their basic sense of safety and control had been shaken, in some instances shattered (Ulman and Brothers 1988). The deaths of friends and colleagues, the numerous memorials and funerals, the acute grief of family and neighbors, and the massive media intrusion threatened individual security and social coherence. Adding to the stress was the sense of being stigmatized by the unwanted and unanticipated encounter with horror. At the very least, many children and adults began to suffer stress responses. Tearfulness, deep sadness, nightmares, and appetite disturbances were common. For everyone, adults and children, the event was unprecedented and incomprehensible. Many began to experience persistent fear immediately after hearing of the attack. Adding to this stress was that families, and especially parents, were deeply affected. Many children had never seen their parents cry, let alone express fear or panic. Frightening affect states, acute feelings of vulnerability and exposure, loss of confidence in everyday institutions and protections, unrelenting fear, and a sense of the danger of

impending traumatic loss were common experiences the teachers and students shared with us.

The Sandy Hook murders threatened the capacity of the Newtown educational system to sustain the school's "holding function" (Winnicott 1965) so necessary to facilitate the normal developmental processes of students. Even more important was the threat to confidence in the school's ability to sustain "environmental provision", to be reliably available and responsive to the students and families' needs. Confidence in the school's most important function, protecting students from physical harm and maintaining a routine of care, was in doubt. The work of our team was to support the school's resumption of this "holding function" and to help restore the various roles that the school served in facilitating learning and development. Obviously, we were too small a group to "hold" the entire school, but I believed that if we positioned ourselves at key points in the school system and processes, we could encourage and support an atmosphere of safety and responsiveness that might augment the inherent health and strength of this little, traumatized community. Later, in the narrative of our work, I will discuss how we organized interventions targeting the needs of students, parents, teachers, and administrators that appeared to accomplish this goal.

In earlier work on mourning and traumatic loss in childhood, I identified factors that contribute either to the resolution or the disturbance of mourning (Hagman 2001). People's responses to loss and trauma are varied, complex, and highly personal. Anyone seeking to help must first attend to survivors' need for a social context that supports them in their personal struggles with bereavement. In this light, the continuity of relationships and social institutions is a crucial part of the context of survival and recovery. We mourn not alone but together. Survivors must find a way to hold onto or restore a sense of meaning in life and self. As part of this process, the continuity and integrity of remaining relationships and institutions are central. Dialogue and, most importantly, the experience of grieving together support the mourning process and the sense of connectedness to others and one's community—perhaps the most important human need. In this light, the continuity and vitality of a school system (not just the institution but relationships and services) can play an important role in creating a context for mourning and recovery. It offers a social milieu to process suffering, allows many opportunities for contact, to share feelings, and give meaning to experience, and assures the survivors that the integrity of the community and its social structures can survive and offer hope. Given this, our work in supporting the reopening of the Newtown school district had repercussions well beyond the resumption of educational services by the city; in our small way in that little school, we helped

the people of the town go on, endure, and eventually recover.

Our elementary school was a single-story building with two interior courtyards framed by long, bright hallways. About 24 teachers were assigned to the school, plus a number of assistants and specialists. The students and teachers were largely culturally and racially homogenous, from white, middle class families. Most of the teachers were Newtown residents and many were parents with children in the school system. Most of them knew staff at Sandy Hook, and some had children who were students there. The connections were numerous and varied, but most everyone identified with members of the Sandy Hook family. People often said, "It could have been our children and us. It could have been here". Grief over the losses and fear for their own safety dominated the mood of the school during the days before reopening on December 18. In addition, the teachers worried about the reactions of the students and having to address their questions and comfort their fears while struggling with their own grief. Not surprisingly, many of the teachers did not feel ready to return to work. However, the children and families needed the support and services that schools can provide, especially after such an event. By the end of the school week, most agreed that this was the right decision, at least for the children and families.

The members of my team were from various agencies around the state, and some of us were strangers. That first day we had only a few minutes to introduce ourselves and share our backgrounds. This is common when teams are organized in response to unexpected disasters or crises and it is necessary to assess the capability of team members in the midst of responding to events. We "hit the ground running," as they say, and I had to assess the members of my team and assign them duties as soon as we entered the school. Some could stay for the duration of the intervention; others had a fixed time limit. Some of us were family and child workers; others were adult clinicians and clinical managers. In response to the evolving situation, I assigned duties to team members consistent with their experience and interests. Several worked with families, others with staff, and most of us took turns with the children. Each morning we met as a group to evaluate our current staffing level, review the previous day, and plan for anticipated needs. I made specific assignments and we agreed to a process of communication, usually text messaging, so that we were able to respond quickly to events as they evolved. I reserved time to talk, share our feelings, encourage, and support each other when we were struggling. My role was to coordinate the activities of the group, work with the school administration, and help out as needed. Psychologically, for the school and the team, I was seen as the good father figure, the

embodiment of the mental health care that the team provided.

“True healing requires connectedness,” as Geist (2008) noted. Our first task was to establish a presence at the school, begin collaborating with the administration, and form relationships with the staff. We needed to become part of the community and connect with the people of the school as a “felt presence in their lives” (Geist 2008, p. 6). On Monday, December 17, the day before school reopened, we met with small groups of teachers and support staff. They were anxious and many felt they were not ready to teach, fearing an emotional breakdown in class. All the teachers had known at least one of the victims. One former staff member had recently transferred to Sandy Hook and was among the dead. Many of the teachers were parents, several with children at Sandy Hook. They were frightened and preoccupied with their own families and conflicted about turning their time and attention to the school. As a group, they were sad and fearful and some were emotionally fragile. These feelings would affect everyone and everything throughout the week. However, our goal was not to remove the fear and pain; rather, we needed to establish a connection, give them a sense of being listened to, and, potentially, offer the opportunity to make use of us and each other.

Tuesday was the first full day of school. After such a disaster, the needs are immediate, so we simultaneously implemented a broad array of services. Our team provided as-needed support, brief counseling, education, and referral. In response to the fluid, emotionally charged situation, we were flexible, responsive, and adaptive. These were perhaps our best qualities as each member stepped up and, without hesitation, reached out to anyone in need. Leaving their classes, teachers would present us with a distressed student and we would take charge, supporting the child and beginning counseling, as the teacher hurried back to the other students. Family members would appear at the principal’s office in tears. Some teachers would suddenly feel overwhelmed and have to talk to one of us. Each team member was willing and able to take on any need at a moment’s notice. Developing a relationship with the school administration was essential, so I worked closely with the principal and office staff throughout the week. The school psychologist and nurse were also important partners, especially with students who had prior family problems or mental health histories.

For the students, we organized a therapy/activities room where we provided toys and simple crafts and conducted small group counseling and, if necessary, individual sessions. We arranged a sequence of tables with different types of play or crafts on each. At the first table (which had clay and small toys), we conducted a quick triage to determine if a student needed group or individual attention.

Other tables included one where children could make paper snowflakes for Sandy Hook, another for small group discussion, and one to transition back to class. Throughout the week, teachers dropped off students who were in distress and we provided an opportunity to play as well as talk. In most instances, we got them settled down and when they were ready returned them to class.

Many of the students had detailed, often graphic information about the events at Sandy Hook which they could not make sense of. Some students were unable to engage in classes. During the week, we saw dozens of students struggling with sadness, anxiety, sleep disturbance, nightmares, and a range of behavioral problems. We had an open door policy so students could walk in and teachers could make quick drop-offs. We took each child on his or her own terms. Some wanted to talk, others just to sit together and play. We found the children to be open, frank, and resilient. Only a small number was unable to regroup and go back to class. I was repeatedly impressed by the ability of the children to manage their moods and take advantage of opportunities to play and learn from each other and us. Their suffering and fear would continue, but with a chance to talk, to feel safe, to laugh and play, virtually all were able to restore a sense of stability and reengage in school activities. On the other hand, some became regular customers, dropping by throughout the week. This service was most valued by the teachers, who were able to quickly deal with troubled students, access counseling, and be confident that we would help the students feel better and eventually return to class.

Despite the diversity of children and variety of reactions, we knew that the underlying issue was the same for all—the horror of Sandy Hook, the unknown motives of the killer, and the frightening reality that it was their peers and teachers who were the victims. Invariably, I found that a gentle but honest discussion regarding what the students knew of the tragedy and especially the nature of their fears and other reactions was very helpful. Not one child seemed to be more saddened or frightened by our approach. Most resumed play, engaged in banter with peers, and eventually returned to class.

For example, on Tuesday afternoon, I was sitting with a group of students at the table near the door. A teacher appeared with a 7-year-old boy who was shuffling sadly beside her with a long face and hunched shoulders. They approached me.

“This is Michael,” the teacher said. “He would like to talk to someone.”

Michael broke off from his teacher and pressed himself against my left side. I instinctively reached my arm around and held him. He did not pull away, but seemed to tuck himself under my shoulder. We looked at the clay and toys on the table.

“Looks like you’re feeling sad,” I commented. He nodded.

“You’ve been worried and sad since last Friday.” He nodded again.

“I can’t stop thinking about the children,” Michael said. “All the dead children. I can’t stop thinking about them.”

“Your probably feeling scared. Maybe that you are in danger, too.” He nodded.

Michael and I discussed how he heard about the attack and the confusion and fear he felt. He was haunted by the thought that he could be next. It was impossible for him to make any sense of what had happened. It was incomprehensible and thus the images of death, the violence and terror, plagued him. Deep within his little brain, his sense of safety had been crushed, shattered into thousands of pieces. Nonetheless, as we spoke, I saw his mood improve; he began to play with the clay and gradually reached out to other students. We moved to other tables where we made paper snowflakes for Sandy Hook and worked together with pipe cleaners, making funny colorful glasses. After a while, Michael asked about rejoining his classmates whom he knew were preparing for lunch. Then, with a bit of a swing in his step, he left the room. I had no doubt that he would continue to struggle and suffer, but being a basically healthy and well-adjusted child, he was able to mobilize his strengths and defenses and move on for a time. In fact, he sought our help the next day as well, eventually returning, reassured, to his class.

It is important to note that despite the fact that much of our work was focused on the distress that people were experiencing, at the same time there were many pleasurable, humorous, and fun interactions with the children, staff, and parents, but mostly with the students. They were engaging, lively, creative, and fun to be with. Some of the students were really clever, pleasantly disruptive, and irreverent. Laughter was a common affect, even dare I say, joy. Creating a space for these feelings to be expressed, engaging the students in light play, and resonating with their vitality was an important element in our work. They were full of life and this was, to say the least, infectious and healing.

Some teachers were emotionally fragile and struggling. Not surprisingly, the most vulnerable had close relationships with the victims and/or past histories of their own trauma and loss. We assigned a team member to link up with particular teachers and provide them with counseling and support, including “check-ins” throughout the week. Several teachers were particularly distressed. We stayed close to them for the first days; several team members worked alongside them in the classroom. As they settled in, we were able to titrate our involvement. By Friday, every teacher had managed to continue working and felt

increasingly confident. We also met with some teachers for individual counseling, with the goal of helping them continue working. Some of these counseling contacts were brief opportunities for reassurance and comfort, taking place in hallways, the teacher’s lounge, or even the parking lot. Providing information, guidance, and referral information was important for these people.

Several of our team members were officers from the federal Department of Health and Human Services, Public Health Service. They were experienced clinicians deployed throughout the country in response to disasters and other traumatic events. I found that they were expert at providing group counseling and education. On Wednesday, we began to conduct two classes each day for parents. The first class focused on parents of children in grades K through 2, the second for parents of children in grades 3 and 4. The intent was to provide age-related counseling to help support the parents and provide them with guidance regarding how to talk with their children and support them through the trauma and grieving process. These parents were quite anxious and worried; many had close links to Sandy Hook School and the murdered staff and children. They were eager to talk and get information. Several team members were available to family members who felt a need to meet with someone individually. However, we encouraged peer support since after our departure these people would need to rely on each other. The parents’ most common concern was how to talk with their children about the murders. None had ever experienced (or even imagined) anything like this and they were at a loss for words. They doubted their ability and emotional strength to discuss the subject. However, many of the children were insistent, asking questions about the murders and, most importantly, the motivation of the killer. Of course, no one had answers. For most of the parents, the potent combination of their own fear and grief, combined with their natural tendency to protect their children from harm, produced crippling doubt and, occasionally, paralysis. Informational material, practical guidance, reassurance, and support from fellow parents helped to guide and empower these people to talk with their children about the unspeakable. Materials available from the website of the National Child Traumatic Stress Network were very useful in both guiding our groups and providing informational handouts for parents.

The school staff valued our team, both as a resource for the students and as a therapeutic, supportive presence for them as well. On Friday, December 21, we met with teachers from each grade level to review the week and solicit suggestions for further services. It was clear to me that the teachers had sacrificed and suffered much. This was primarily because they had to be constantly focused on the needs of the students and their parents. There was little

opportunity for the teachers to express their own feelings and begin their own process of mourning. Virtually all of the teachers felt that despite the benefits of school to the students and parents, they, the teachers, had not gotten what they needed. Looking back, they felt neglected and unappreciated (at times anger overlaid the pain). I am not sure how we could have adequately responded to the teachers' needs at the same time we asked them to follow a normal school schedule for 450 students. Nevertheless, over the weeks, we had a variety of contacts with teachers, and many were able to talk about individual concerns and feelings. At the end of our work, we participated in an afternoon of soothing and healing with art therapy, yoga, and massage for all school staff.

The school functioned because of the professionalism of its staff. However, this very professionalism required staff members to suppress their feelings as they managed the classroom and attended to their charges. The unquestioning commitment of teachers to their students was abundantly evident throughout our time there. They sacrificed a great deal and some would need consideration, attention, and care over the following months.

We returned to the school in early January and continued to provide the services that we had that first week. It became clear that the school was settling down and that the sense of crisis was abating. We worked with fewer children, teachers, and parents. The following week, we decreased our staffing to one team member per day, and over the next weeks went down to 1 day a week. It was evident to me that the emotional struggles of every person in the school family, child and adult, would continue indefinitely, but our goal to help support the school's return to full operation had been a success.

As I come to the end of this paper, I want to reflect on the implications of my experience for psychoanalytically informed clinical social work practice. It is my hope that this critical analysis will inform similar future interventions.

1. Although our work at the school did not appear to be psychotherapeutic per se, nonetheless, our central concern was the emotional lives of the school community and its members. It is here that a clinical social worker, informed by contemporary analytic theory, can play an important role. Many analytic authors have stressed the importance of the "background of safety" (Sandler 1987), "environmental provision" (Winnicott 1965), and "containment" (Bion 1963) as functions of the context in which psychological life is possible. Fundamental to a psychoanalytic approach is first to attend to the availability and viability of basic supports, such as the emotional health of the teachers, the relationships between teachers and administrators, trauma-related

resources for parents, supports for distressed children, and access to specialized clinical agencies outside the school.

2. Assessment of the school's functionality and viability is essential to providing thoughtful and responsive services. The challenge was that we had to assess the school even as we began our work—and the needs were immediate and pressing. As participant observers, we were concerned with how the teachers and administrators viewed our team. If there was opposition, or distrust, our ability to engage and serve would be constrained accordingly. In addition, we actively embedded ourselves in the school's daily life, teacher meetings, staff meetings, classrooms, and parent meetings. We reached out to the policeman at the front door, the janitor, the school psychologist, and the nurse in an effort to find out about their role in the school and to get their viewpoint on the day-to-day operations. We observed and processed our observations, modifying our plans in response to developing events and changing needs; thus, it was important to understand the affective ecology of the school. How are feelings communicated? How is anxiety managed? To what extent are painful issues acknowledged, and what is the group's capacity to talk together about the tragedy? There is no normal, expected way for a school to function in such a situation. Our work was to understand the unique qualities of this school so that we could design an approach that targeted disruptions, augmented areas of vulnerability, and supported and encouraged resiliency and strength.
3. In the face of such tragedy, the survivors must believe that the relationships and institutions at the heart of the community will survive. This sense of "going on being" which Winnicott saw as the foundation of psychological health is threatened by such tragedies. To this end, our role as social workers was to facilitate the normal ability of the school to meet the needs of students and families. In brief, our goal was to help the school function as a facilitating environment within which relationships, activities, structures, and schedules can be taken for granted and people can be themselves again. Students and teachers can heal when the community of the school successfully plays its role in supporting and connecting people. These relationships offer a healing context for recovery.
4. However, the terrifying nature of the Sandy Hook murders challenged the normal capacity of the school to contain and manage people's emotional reactions. Clinically, our most important function was to attend to the affective responses of students, teachers, parents, and administrators. As described in my report, many

people in the school experienced disruptive affects: grief, fear, anger, and anxiety, among others. These affects were not just disturbing to the person but also challenged the ability of the normal school structures and relationships. We made ourselves available to provide comfort, an opportunity to interact in a low-stress environment, and a chance to talk, to give meaning to feelings. We made these services available in various ways, through play with the children, educational classes with parents, group discussions with teachers, collaborative meetings with administrators, or just walking around the halls and chatting with people. Even so, the goal was the same, to be available and respond to the emotional and practical needs of the school community. As the school became more secure, we titrated our engagement, allowing the normal relationships and structures to resume the regulation of feelings.

5. Soon after beginning our work, I experienced strong positive feelings from teachers and staff toward our mental health team. School communities are based on trust and an ongoing sense of certainty about daily life. The willingness to trust was shaken for this group. However, as experts in mental health, coming from the outside to help, we were granted a degree of trust, investing our interventions with an emotional power which was in and of itself healing. Most important, this sense of trust motivated people to make use of us and value our services. Looking back, this positive transference was our most powerful clinical tool. Our team was idealized, granted special status, and empowered with a healing aura that we welcomed and that gave clinical force to our interventions.
6. Unlike in individual therapy where we at times encourage the expression of negative, painful feelings, this is neither practical nor helpful in this type of crisis work. It wasn't just that we didn't have the resources. It was our job to restore confidence, give hope, and support the mobilizing of healthy defenses. Our goal was not to resolve the mourning and trauma but to set up the conditions where others would do this. For most people, a well-functioning school environment is the best therapy; for others, we provided short assessments, short-term counseling, and in a few cases referral to a local mental health agency. Clinical restraint was necessary in many instances where we might have been tempted to open up and explore people's feelings. However, when people were clearly in trouble and failing to function, we intervened more assertively. Being able to refer and assist with process of connecting to mental health agencies was important.
7. The team sustained an attitude of hope and belief in recovery throughout all our interventions. Maintaining

this positive attitude and articulating reasons for hope were clinically essential. At the same time, we had to recognize and address painful emotions and general feelings of fear and even despair. This required attention to our own reactions, which were also at times painful and hard to manage. Thus, the mutual support of the team was crucial. Each morning we met and discussed how we were feeling. I continually assessed how all of us were doing and stepped in if someone needed help. The team cared for and encouraged each other. We survived and did pretty well. The reality was that the school would also survive and virtually everyone in the school would find a way to recover and regain hope. The old illusions of certainty and safety would return, a bit tarnished, but viable once again. I believed this and my hope was based on the evidence of a well-run school, resourceful and resilient staff, and a student body of vigorous, fun-loving children. We, the team, never lost sight of this potential and we conveyed our hope through our attitude and the trajectory of our interventions, recognizing strength, providing resources, and expressing confidence and love.

8. Finally, a word of caution. In the aftermath of these types of events when institutions and groups are affected to such an extent, destructive emotions can also be activated. For example, at our school, the fear and rage of the teachers would periodically flare up and the latent political relationships would become overt. An intrusive media, political decision making, and labor relations problems were part of the background reality. Therefore, it was important that I be alert to ways in which the team might be pulled into disruptive political struggles. Specifically, our support and advocacy for the teachers had to be managed carefully if we were to avoid being viewed as taking sides. The principal had to navigate a difficult course between his supervisors, the teachers and their union, and the organized family groups, all of which were stressed and at times at odds. My relationship with him was one key to our success, so I worked hard to avoid the pitfalls that might ensnare us in local politics and disrupt our capacity to help.

In evaluating the results of our work in Newtown, I can say several things. By the 3rd week, the school functioned in a relatively normal manner, and the overall affective tone was positive and caring, not fearful and despairing. Everyone—teachers, students, parents, staff, and administrators—made use of our services. Most of the children who came to school were able to remain and, even if they used our services at times, the vast majority was able to participate in class work and other activities. When they

could not, we found that other factors (e.g., family conflict, additional losses, prior mental health history) contributed. After 6 weeks, there were no identified behavioral or academic problems that were solely the result of Sandy Hook. I was able to assess this by making contact with the principal, school nurse, psychologist, and teachers during each visit to the school. Also, no teacher was forced to leave work for emotional reasons. At the close of the week, the principal held a meeting where the staff reviewed the team's work; the general agreement was that our services were useful. The group expressed a desire for us to return after the holidays to continue to help with the transition back to school.

Conclusion

Like everyone, I was horrified and deeply saddened by the Sandy Hook murders. As did some of the teachers, I feared that I would be unable to manage my reactions. I had already been tearful at home, so I was uncertain how I would react. The first day was hard due to my anticipation of the magnitude of this community's suffering. As we began to work with the teachers on Tuesday and as my sense of the scope and nature of the work became clearer, however, I felt more confident. The resilience, strength, and professionalism of the teachers were obvious and impressive. The honesty of the children, their readiness to trust and accept help, was both heartbreaking and wonderful to experience. The competence and support of the principal made everyone feel cared for. Even the maintenance man and police officer participated in holding and nurturing the school as a special place. In fact, rather than depression and dread, the emotional tone of the school was vital and loving. A fragile but palpable feeling of hope prevailed in the school, punctuated by moments of doubt and unfathomable pain. However, the school functioned; adults and children connected, enjoyed, and loved each other. This "felt sense of sharing" and participating in one another's lives (Geist 2008) was the necessary context for mourning and reparation. The school was like a little world of profound and powerful connections, and these connections branched out endlessly and fatefully throughout the surrounding countryside. Although Newtown had suffered a terrible threat to those connections, its people endured and with each passing day these connections were strengthened. Interestingly, when colleagues asked me about my work in Newtown, they would comment about how painful it must have been. To the contrary, I would tell them: My team and I often talked about the strong, positive feelings we experienced and the renewed pleasure we felt from our work. The word we often used to refer to our feelings was honored; we felt honored to have been given this chance to help.

References

- Bion, W. (1963). *Elements of psychoanalysis*. London: Karnac.
- Geist, R. (2008). Connectedness, permeable boundaries, and the development of the self: Therapeutic implications. *The International Journal of Psychoanalysis Self Psychol*, 3, 129–152.
- Hagman, G. (2001). Beyond decathexis: Towards a new psychoanalytic understanding and treatment of mourning. In R. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss*. Washington, DC: American Psychological Association.
- Hoven, C. W., Duarte, C. S., Lucas, C. P., Wu, P., Mandell, D. J., Goodwin, R. D., et al. (2005). Psychopathology among New York City public school children 6 months after September 11. *Archives of General Psychiatry*, 62(5), 545.
- Knox, K. S., & Roberts, A. R. (2005). Crisis intervention and crisis team models in schools. *Children & Schools*, 27(2), 93–100.
- National Child Traumatic Stress Network (2009). *Psychological first aid for schools: Field operations guide*.
- North, C. S., Dingman, R. L., & Hong, B. A. (2000). The American red cross disaster mental health services: Development of a cooperative, single function, multidisciplinary service model. *Journal of Behavioral Health Services & Research*, 27(3), 314–320.
- Paton, D., & Flin, R. (1999). Disaster stress: An emergency management perspective. *Disaster Prevention and Management*, 8(4), 261–267.
- Pynoos, R. S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress*, 1(4), 445–473.
- Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counseling*, 29(1), 17–49.
- Sandler, J. (1987). *From safety to superego: The selected papers of Joseph Sandler*. London: Karnac.
- Strozier, C. (2011). *Until the fires stopped burning: 9/11 and New York City in the words and experiences of survivors and witnesses*. New York: Columbia University Press.
- Uhernik, J. A., & Husson, M. A. (2009). Psychological first aid: An evidence informed approach for acute disaster behavioral health response. *Compelling Counseling Interventions: Vistas*, 2009, Alexandria, Virginia: American Counseling Association, pp. 271–280.
- Ulman, R., & Brothers, D. (1988). *The shattered self: A psychoanalytic study of trauma*. Hillsdale, NJ: Analytic Press.
- Vernberg, E. M., Steinberg, A. M., Jacobs, A. K., Brymer, M. J., Watson, P. J., Osofsky, J. D., et al. (2008). Innovations in disaster mental health: Psychological first aid. *Professional Psychology: Research and Practice*, 39(4), 381.
- Winnicott, D. W. (1965). *The maturational process and the facilitating environment*. Madison, CT: International Universities Press.

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