

Group Crisis Intervention¹

Stephen E. Brock, Ph.D.
California State University, Sacramento

At approximately 11:40 AM on January 17, 1989, a heavily armed lone gunman walked onto the crowded primary playground of Cleveland Elementary School in Stockton, California. After setting his car on fire, the gunman began shooting. The 105 AK-47 assault rifle rounds fired in less than two minutes tore holes through concrete walls and penetrated metal playground equipment. The damage it did to almost three dozen young bodies was unspeakable. Before committing suicide, the gunman had killed five children and wounded 29 others and one teacher (Cox & Grieve, 1989).

The Stockton, California, schoolyard shooting was one of the most violent acts ever to have been committed on school grounds. Thus, it is not surprising that its impact on the entire school was immense. Virtually every Cleveland Elementary School student was in need of support and/or guidance. Although approximately 50 mental health professionals responded almost immediately to this disaster, there were many more students in need than could be assisted by one-on-one crisis intervention. Thus, as the first day after this tragedy dawned, my colleagues and I found ourselves assigned to provide support to entire classrooms.

Background and Development of Classroom Crisis Intervention

From my experiences following the Stockton schoolyard shooting, I developed an approach to working with large groups of students traumatized by a common crisis. Subsequently, as my crisis intervention training, research, experiences, and thinking evolved, I began to more formally conceptualize the group crisis intervention process that we first employed with the students of one intermediate-grade classroom at Cleveland Elementary School.

Initially identified as Classroom Crisis Counseling (Brock, 1996; Brock, Sandoval, & Lewis, 1996), this model's early development was influenced by Terr's (1992) dis-

discussion of mini-marathon groups. Subsequently, my training in Disaster Mental Health Services (American Red Cross, 1994), Critical Incident Stress Management (Mitchell & Everly, 1996a, 1996b), and participation in the National Community Crisis Response Team Regional Training Institute (Young, 1998) led to several significant modifications that are included in the current discussion.

The most obvious change was re-labeling the model as Group Crisis Intervention (GCI). This was done to help clarify that a team composed entirely of crisis counselors is not required to implement this type of intervention (Galante & Foa, 1986). Although mental health professionals will play a leadership role in GCI, it is not psychotherapy. GCI is best thought of as a form of psychological first aid.

As coordinator of a school crisis intervention team for the past 12 years, I have had numerous opportunities to use this model. Although it was designed for use following traumatic events (e.g., a school shooting, the witnessing of fatal traffic accidents, etc.), GCI has also been adapted for use in the management of normal grief reactions. While my experiences have suggested GCI to be effective, I hope the present discussion will stimulate empirical study. Future research suggestions are offered later in this chapter.

General GCI Issues and Procedures

Who should participate in GCI? Any group of students having experienced a common trauma can be brought together in a GCI. As a rule, GCI groupings are relatively homogeneous (Mitchell & Everly, 1996a; Weinberg, 1990; Wollman, 1993). Groups can be identified according to several logical categories, including classroom membership, age, grade, familiarity with victims, and/or degree of traumatic event exposure (Pitcher & Poland, 1992). However, following major schoolwide disasters GCI is perhaps best employed with naturally occurring classroom groupings of vicarious trauma victims (Everly, Boyle, & Lating, 1999). In my experience the connections already developed by classmates facilitate group sharing and support. It is, however, appropriate to hold separate sessions for those students from different classrooms that were most directly involved with the trauma. In addition, it may be necessary to exclude from GCI students who are displaying acute stress reactions (Johnson, 1993). This approach is not designed for severely disturbed youths, nor should it be considered a substitute for those in need of professional mental health assistance. Severely traumatized students, whose crisis reactions may interfere with GCI, will require individual crisis intervention from a mental health professional. In general, it is recommended that this approach be offered only to vicarious trauma victims, and not to individuals directly involved in or severely traumatized by a crisis. Students who are displaying signs of acute psychological distress and/or have a history of prior unresolved psychic trauma might need to be excluded from the GCI session (Neria & Solomon, 1999).

What is the optimal size of the GCI group? While some have suggested that this type of intervention can be offered to very large groups (Weinberg, 1990; Terr, 1992), I have found GCI to be most effective with classrooms ranging in size from 15 to 30 stu-

dents. Similarly, Young (1998) suggests that 20 to 25 individuals is the ideal size for group crisis intervention. Combining classrooms and creating groups of more than 40 students is not recommended (Bell, 1995; Mitchell & Everly, 1996a). Large groups are likely to limit group sharing and interfere with the expression of feelings (Schonfeld, 1989).

When should GCI be offered? A common belief is that immediacy is important to the success of any crisis intervention. Justification for this belief includes observations that individuals in crisis are suggestible and motivated and that children are susceptible to developing cognitive distortions that may interfere with recovery (Pagliocca, Nickerson, & Williams, 2002). It must be acknowledged, however, that there is virtually no empirical research regarding the timing of group crisis interventions with school-aged youths. Thus, clinical judgment must be used in determining when to offer GCI.

From their observations and experiences working with emergency response personnel, Mitchell and Everly (1996a) recommend not initiating group crisis interventions until trauma survivors are psychologically ready to talk about the crisis. Mitchell and Everly suggest that this typically means waiting at least 24 hours before conducting a debriefing. At the same time, however, they recommend that group crisis intervention be offered no later than 72 hours following the trauma.

From my experience working with school-aged youths, I recommend that GCI be made a priority following traumatic events. If, following a crisis, a teacher begins the school day by following the normal routine (without mentioning the trauma) it suggests to students that the trauma was not a significant event, which may lessen students' willingness to share. Thus, if it is either impossible or inappropriate for GCI to be held right away, teachers or school officials should at least acknowledge the magnitude of the crisis and inform students as to when GCI will be offered. In addition, I recommend that, once GCI is initiated, crisis intervenors should minimize interruptions and breaks (Mitchell & Everly, 1996a; Terr, 1992; Wollman, 1993). Consistent with this recommendation, GCI should not be initiated at the end of a school day. Doing so interferes with the ability to identify and work with overtly upset and anxious students (Schonfeld, 1989).

Given these observations, it is suggested that GCI not be initiated until the start of the first full school day following resolution of the crisis event. This timing will help to ensure that participants are psychologically ready to talk about the crisis event and that there will be enough time to complete the entire process. In addition, it will give the GCI team a chance to prepare, including verifying facts and reviewing the GCI process with the classroom teacher and/or other co-facilitators. Finally, it is important to reiterate that there are no hard and fast rules regarding the optimal timing of crisis intervention and that clinical judgment is necessary.

Where should GCI be offered? Another assumption is that crisis interventions should be provided "close to the scene" of the crisis event. Although limited support for this practice may exist with experience with combat soldiers, generalizing such find-

ings to school children may not be appropriate (Pagliocca, Nickerson, & Williams, 2002). Thus, here again, clinical judgment must be used when determining where to offer GCI. In my experience, providing GCI in the school environment, with its naturally occurring social supports, is optimal. In addition, it is recommended that GCI take place in the students' regular classroom (Schonfeld, 1989), and traditional counseling settings be avoided (Farrington, 1995). This way minimizes unnecessary labeling of students as patients (Klingman, 1987) and reinforces the normality of crisis reactions. This setting also provides structure and routine that is reassuring and facilitates GCI's group processes. Classroom rules will make it easier to progress through GCI steps. In addition, it is suggested that the normal desk arrangement be used. If the classroom is not available, GCI should take place in as accessible, comfortable, normal, and natural an environment as possible. It is important to ensure that tissues are accessible, water is available, and all students know where restroom facilities are located (Young, 1998).

Who are GCI facilitators? Group crisis intervention sessions require a team effort (Farrington, 1995; Mitchell & Everly, 1996a, 1996b; Young, 1998). Thus, it is recommended that two or more staff members facilitate GCI. Larger groups will require more facilitators. A ratio of one facilitator for every 10 students is recommended (Weinberg, 1990). Support for this recommendation is found in research suggesting that, as participant to facilitator ratio increases, participants share less of their feelings and reactions (Armstrong et al., 1998).

Ideally, at least one of the GCI facilitators will be familiar to the students. A team composed entirely of outside crisis intervenors suggests that the trauma was so overwhelming that school staff members are themselves unable to cope, which may unnecessarily increase feelings of hopelessness. In addition, students may be less willing to share reactions and feelings with strangers than with familiar adults. Conversely, the presence of familiar adults who are supportive and nonjudgmental has been reported to contribute to students' willingness to share (Kneisel & Richards, 1988). If familiar adults present themselves as being a part of the solution to trauma problems, they can foster greater optimism and make the situation appear less hopeless. In addition, familiar adults can introduce outsiders and validate that they have special knowledge that will help students (Kneisel & Richards, 1988; Mitchell & Everly, 1996a). Typically, having the classroom teacher be a GCI support-facilitator ensures the presence of a familiar adult. Alternatively, the school counselor or psychologist can fill this role (Weinberg, 1990).

What are GCI facilitator roles? Because GCI is a team effort, it is critical to consider facilitator roles before each session. First, a lead-facilitator needs to be identified. Typically, the leader is a crisis intervention team member who has experience and training working with trauma survivors (Farrington, 1995; Wollman, 1993) and is familiar with GCI. The lead-facilitator is responsible for directing progress through GCI. Another important leader activity is to ensure that the GCI team has accurate and current crisis facts.

Next, support-facilitators need to be identified. Typically, these individuals say little during the GCI session unless called upon by the lead-facilitator (Young, 1998). This is not to say that they are not active in the GCI process. These individuals assist the lead-facilitator in monitoring the group. Especially with large classrooms, it is difficult for one crisis intervenor to facilitate GCI and monitor individual reactions. Support-facilitators help identify students in need of further crisis intervention support and intervene with individuals who are unable to participate in GCI. For example, they can gently remove and talk individually to students who become hysterical. Young (1998) further suggests that additional support-facilitator roles may include providing emotional and practical support to the lead-facilitator, recording group responses on a chalkboard or flip chart, and taking over the group if for some reason the lead-facilitator is unable to continue. Finally, support-facilitators are responsible for following, and ensuring the safety of, students who unexpectedly leave the classroom (Mitchell & Everly, 1996a; Weinberg, 1990; Young, 1998).

What is the role of the teacher? In most situations, crisis teams do not include the teacher(s) of the classroom(s) affected by the trauma. However, intervenors must be sensitive to the needs and desires of the teacher whose classroom they have entered. Doing so helps to ensure that the intervention is well received. As mentioned, insofar as possible, it is recommended that the teacher take an active role in GCI. This recommendation comes from the observation that collaboration is facilitated if crisis intervenors do not act as “the experts” but strive to involve the teacher in planning and implementing the classroom session (Blom, Etkind, & Carr, 1991). Ideally, the teacher will help to facilitate GCI. In some rare instances, the teacher may even lead the session. All lead-facilitators, however, should have training in group counseling (Allan & Nairne, 1984), experience working with psychological trauma victims (Nader, 2002), and be familiar with GCI. Alternatively, when the teacher is having significant difficulty coping with the crisis, outside crisis intervenors will need to take responsibility for GCI (Klingman, 1988). It is important for the crisis team to recognize that crises affect everyone differently and to establish an environment that makes it easy for teachers to acknowledge their limitations and ask for help.

The need for follow-up interventions. It is important to acknowledge that single-session group crisis interventions are likely insufficient for high-risk trauma survivors (e.g., those with poor pretrauma mental health; Larsson, Michel, & Lundin, 2000). Furthermore, among acute trauma victims (e.g., victims of acute burns, accidents requiring hospitalization, violent crime), some research suggests that single-session (or “one-off”) crisis intervention (or debriefing) has limited benefit and may be potentially harmful (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000; Rose, Brewin, Andrews, & Kirk, 1999). Finally, group approaches do not allow for the in-depth individual explorations that individual sessions provide (Nader, in press; Yule, 1998). Thus, it is important to remember that GCI is considered a form of psychological first aid. As such, it should not be viewed as a sufficient intervention for all traumatized students. Just as with medical first aid, more severe injuries will require more involved treatment (i.e., professional mental health intervention). In other

words, for the more severely traumatized student, GCI will only be the first step in a treatment process. In such circumstances, GCI will be an intervention that helps to minimize harm until more sophisticated treatments can be accessed. (This issue is discussed later in this chapter in Post-GCI Activities.) At the same time, it is possible that, for less severe traumatization, GCI alone will be a beneficial intervention (Deahl et al., 2000).

GCI contraindications. In my experience GCI has been effective in a variety of situations. However, Johnson (1993) indicates that group crisis intervention approaches should be avoided under the following circumstances: (a) when the class has a history of being hurtful, divisive, and/or not supportive; (b) when student needs, relative to the trauma, are polarized (e.g., some students are deeply affected while others are untouched or find the crisis beneficial); and (c) when the traumatic event is politicized (e.g., gang membership had a role in the trauma). In addition, Nader (2002) has pointed out that courtroom credibility may be lost because of group influences. Thus, students who are prospective witnesses might need to be excluded from GCI sessions. Finally, it has been suggested that students who were directly exposed to the crisis, who were physically injured, who have preexisting problems, or who lack family support, should be offered individual crisis intervention (Yule, 1998).

The GCI Model

GCI has six steps: (a) introduction, (b) providing facts and dispelling rumors, (c) sharing stories, (d) sharing reactions, (e) empowerment, and (f) closing. Table 1 provides a summary of GCI. This procedure is similar to Allan and Nairne's (1984) Class Discussion Model. It helps students to understand the trauma, express thoughts and feelings, and identify/learn coping behaviors.

As with other forms of group crisis intervention, GCI is ideally completed in one session lasting approximately two to three hours (American Red Cross, 1994; Terr, 1992; Young, 1998). However, the length of GCI must be tailored to the developmental level of the classroom (i.e., older students will be able to participate in sessions for longer uninterrupted periods). For example, Johnson (1993) suggests that elementary-age students can at most be expected to participate in sessions lasting up to one hour. Thus, especially when working with younger children, it will be necessary to take restroom and recess breaks. However, once students have begun to share trauma experiences (sharing stories), breaks should be avoided until after the group has reviewed activities designed to help manage trauma reactions (empowerment; Mitchell & Everly, 1996a). Although it may be difficult to complete GCI in one uninterrupted session, it is recommended that all six steps be completed during the same school day.

Introduction. As with other forms of group crisis intervention, GCI begins with an introduction (American Red Cross, 1994; Mitchell and Everly, 1996a, Young, 1998). This step, which lasts 10 to 15 minutes, identifies GCI support-facilitators and the group leader. As mentioned, it is best if one or more of the GCI facilitators are

Table 1

Group Crisis Intervention (GCI) Summary

GCI Step	Facilitative Statements	Goal(s)	Goal Attainment Signs
Introduction	<i>I'm sorry this happened to your (our) school. When bad things like this happen, it is helpful to talk about it. So, we are going to spend some time today talking. From our discussion we will have a better understanding of what happened, how it has affected us, and what we can do to help each other cope.</i>	<ul style="list-style-type: none"> • Explain GCI purpose. • Identify facilitators. • Review GCI steps. • Review rules. 	<ul style="list-style-type: none"> • Questions about GCI stop.
Providing Facts and Dispelling Rumors	<i>We have experienced an event that was so unusual we might find it hard to understand. I would like to share with you what we know about this tragedy. Feel free to ask questions. It's important that you understand what happened.</i>	<ul style="list-style-type: none"> • Assist students to come to a reality-based understanding of the event. 	<ul style="list-style-type: none"> • Questions about the traumatic event stop.
Sharing Stories	<i>Each person who gets through an event, such as the one we have just experienced, has a story. We are going to tell as many of these stories as we can today. Who wants to start?(Terr, 1992, p. 79).</i>	<ul style="list-style-type: none"> • Get students to talk about their experiences. • Help students feel less alone and more connected to classmates. 	<ul style="list-style-type: none"> • Everyone has had a chance to share crisis stories.
Sharing Reactions	<i>Following a trauma, such as the one we've just experienced, it is not unusual for people to feel and behave differently for a while. Some common reactions are ... These are normal reactions to abnormal circumstances. Who has had some of these reactions?</i>	<ul style="list-style-type: none"> • Get students to talk about trauma reactions. • Help students feel more connected to classmates. • Normalize trauma reactions. 	<ul style="list-style-type: none"> • Everyone has had a chance to share trauma reactions.
Empowerment	<i>Traumatic events can make us feel helpless. I would like to see us take action or make plans to repair trauma related damage or prevent trauma reoccurrence.</i>	<ul style="list-style-type: none"> • Help students regain a sense of control over their lives. 	<ul style="list-style-type: none"> • Concrete action is taken or planned.
Closing	<i>What can we do to begin to place this event behind us and move on with our lives?</i>	<ul style="list-style-type: none"> • Help students begin to think about placing the trauma behind them. 	<ul style="list-style-type: none"> • Completion of activities that enable students to begin the process of saying good-bye to that which was lost.

familiar to the students. A facilitator familiar to the students should introduce unfamiliar facilitators to the class.

After completing introductions and identifying the group leader, the leader explains the purpose of the session. In doing so, it is important to be positive and offer the expectation that GCI is effective. The leader should convey that, with talk and time, most students will cope with the trauma. Although the leader states that students will be working together to understand the trauma, he or she should acknowledge that facilitators have special information to share. Then, the leader briefly describes each GCI step.

Next, the leader should review GCI rules. Students are reminded they are still in school and that regular classroom rules are in effect. Perhaps most importantly, students are told that they are not allowed to leave the room without permission. However, students are told that active participation is voluntary. Additional group process rules may also need to be established. For example, it is essential to discuss the issue of confidentiality. While students should be given permission to discuss whatever they want, it will be important to set limits regarding the fact that verbal and/or physical violence or abuse will not be tolerated (Young, 1998).

I have found it helpful to allow students to assist with setting group rules. Doing so helps to establish an atmosphere in which students are regarded as capable problem solvers. Examples of group process rules include speaking one at a time, encouraging and supporting the efforts of others, and not allowing put-downs. In concluding the introduction, the leader should also mention that facilitators will be available to the class after the GCI session is completed.

Providing facts and dispelling rumors. Unique to the GCI technique is a specific step designed to provide students with facts about the trauma and to dispel rumors. This step lasts approximately 30 minutes. Because students, particularly younger children, have typically had little experience with traumatic events, they will be frightened and confused. In addition, because of their developmental level they may be more susceptible to distortions of the event and its cause. Thus, GCI begins by making certain that students have a fact-based understanding of the trauma.

When providing crisis facts it is important to be sensitive to developmental levels (Lord, 1990; Mitchell & Everly, 1996b). For example, with intermediate-grade students, carefully selected, well-written newspaper articles about the trauma may be helpful to clarify what happened (Klingman, 1987; Terr, 1989). However, with younger students, this would be an inappropriate strategy. Younger students should receive more simplistic descriptions of the event. It is important to remember that the novelty of the situation may make it difficult for students to understand the facts, and facilitators should be prepared to repeat them frequently (Lord, 1990).

It is especially important to dispell rumors because they are typically more frightening than reality (Blom et al., 1991). For example, following the Stockton schoolyard shooting there was a persistent rumor that only one of two gunmen had been identified. This rumor was started because the lone gunman, who had assaulted the playground and then committed suicide, had fired from two separate locations (Armstrong, 1990). The mistaken belief that a gunman was still at large was frightening for students. Such mistaken information can be very distracting and makes coping more difficult. Thus, making sure students have a reality-based understanding of the trauma is important to crisis resolution (Lord, 1990).

Sharing stories. When questions about trauma facts and rumors stop, the classroom is ready to continue. The sharing of student experiences during the event is the next step, which may last from 30 to 60 minutes (American Red Cross, 1994; Galante & Foa, 1986; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998).

While keeping in mind that active participation is voluntary, in smaller classrooms, facilitators will want to move around the GCI group and give each student the opportunity to share. In larger groups (i.e., 30 students) facilitators may not have enough time to do this and may simply ask for volunteers. Specific questions to facilitate this step, suggested by Young (1998), include the following:

- Where were you when it happened?
- Who were you with?
- What did you see, hear, smell, taste, or touch at the time?
- What did you do?
- How did you react?

Facilitators should validate all experiences and reactions and common themes identified (Terr, 1992; Young, 1998). This validation will help students feel more connected to each other and less alone because of their common experiences. It will give students the added strength needed to face and work through the trauma.

Besides asking students to verbalize their experiences, it is also helpful to allow them to recount experiences and reactions in other ways. Art and other creative activities can be a helpful method of expression (Farrell & Joseph, 1991; Johnson, 1993; Klingman, Koenigsfeld, & Markman, 1987; Terr, 1992), especially for younger students who may have difficulty verbalizing what has happened. These activities are also a way to break up a GCI session and may be especially helpful for students who have difficulty sitting still. Johnson (1993), for example, suggests that activities may comprise a majority of the session with elementary-age students. Petersen and Straub (1992) offer an excellent compilation of activities that may prove helpful in a GCI session.

Sharing reactions. Once most, if not all, of the group has had a chance to tell their crisis stories, the next step is to examine crisis reactions. This GCI component is also a part of other group crisis intervention techniques (American Red Cross, 1994; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998). Terr (1992) recommends the following approach to this step: (a) stating common reactions, (b) asking those who have experienced each reaction to raise their hand, (c) asking for individual examples, (d) summarizing comments about reactions experienced, and (e) anticipating reactions that may arise in the future. This step lasts approximately 30 minutes.

Common initial psychological and behavioral symptoms displayed by children following traumatic events include sleep disorders, bad dreams, persistent thoughts of the trauma, belief that another trauma will occur, conduct disturbances, hyper-alertness, avoidance of trauma reminders, and somatic reactions. In younger children, regression to enuresis, thumb-sucking, and more dependent behavior may also be seen (Frederick, 1985). These reactions can be very unsettling, and it is not uncommon for survivors to fear that they are going crazy. Group sharing and facilitator anticipation of trauma reactions help normalize these sometimes frightening symptoms (Armstrong, Lund, McWright & Tichenor, 1995; Mitchell & Everly, 1996a; Terr, 1992).

As students share feelings and reactions, facilitators should not be surprised if some students begin to cry. Students should be told that this reaction is normal and, as long as the classroom is not too distracted by these tears, crying students should remain in the classroom (Lord, 1990). However, students who become hysterical may need to be removed. Their presence can be so distracting that the GCI process will stop (Mitchell & Everly, 1996a).

During this step, GCI facilitators should explicitly state that initial trauma reactions are normal responses to abnormal circumstances (Lord, 1990). Facilitators should also let students know that, with time, for most people, these reactions will go away. However, students should also be informed of what to do if they feel that they are unable to manage crisis reactions. This is a natural time to ensure that students are aware of self-referral procedures for obtaining one-on-one crisis intervention. Facilitators should assure students that, if used early, crisis intervention and therapy can reduce symptoms quickly and with a minimum of pain. “If a traumatic response does not have the chance to become entrenched, it will become only a small scar on a very large life” (Terr, 1992, p. 32).

As this step ends it is appropriate to assist students to predict what they might expect in the future. Specific questions to facilitate such prediction, suggested by Young (1998), include the following:

- What do you think will happen next?
- Will you, your friends, and family continue to be affected?
- What concerns you?

With an understanding of how the crisis event has affected them, and what some potential future concerns might be, students will be ready to engage in a discussion of how to cope with the trauma.

Empowerment. After students have shared trauma experiences and effects, the next step is for students to begin to participate in activities that help them regain a sense of control. Again, aspects of this step can be found in other group crisis intervention strategies (American Red Cross, 1994; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998). During this step students learn that, no matter how impossible circumstances may appear, there are things they can do to improve their situation (Allan & Nairne, 1984). An important goal of this step is the identification of coping strategies (Armstrong et al., 1995). This step may last up to 60 minutes.

A recommended activity for beginning this step is discussion of what students have done in the past to cope with problems (Young, 1998). As these previously developed coping strategies are identified, the facilitator should reinforce those that are adaptive (e.g., “Yes, talking to friends and family is a helpful way to cope with problems”). If maladaptive strategies are proposed, the facilitator will need to offer alternatives (e.g., “No, drinking is not an effective way to deal with a problem, but exercise is a great way to deal with stress”).

Because GCI is a form of crisis intervention, not psychotherapy, facilitators can be very directive during this step. However, students should be as active as possible in identifying coping strategies. Encouraging this independent thinking will reinforce the idea that students are regaining control over what is happening. During this step, it is important that basic stress management techniques be presented, specifically, the importance of getting needed sleep, food, exercise, and talking to friends and family (Mitchell & Everly, 1996a; Weinberg, 1990). Additional options for this step include having students work together on developing strategies to gradually desensitize each other to trauma-related fears (Terr, 1992) and teaching them how to reply to intrusive thoughts and images (Brown, 1996). Through this discussion, students will begin to see a variety of options for coping with trauma and trauma reactions.

Another activity that may be appropriate following certain types of crises is to ask students to brainstorm strategies to prevent reoccurrence of the traumatic event. During this initial brainstorming, student ideas and suggestions are recorded and validated as ways of regaining control over circumstances. Once all ideas have been presented, facilitators can help guide students toward an evaluation of each suggestion. Especially helpful are suggestions that allow for immediate concrete action. For example, following a schoolyard shooting one classroom decided to write letters to government officials regarding the need for gun control. Of course, this approach to empowerment must be used carefully. Caution must be exercised to ensure that the ideas and suggestions generated do not create feelings of guilt. For example, the crisis intervener would want to avoid reinforcing ideas that might lead students to believe they could or should have done something to prevent the trauma (e.g., we could prevent schoolyard

shootings if students agree to attack gunmen). If these beliefs are validated it can foster survivor guilt that makes crisis resolution more difficult.

In closing this step, Terr (1992) suggests that facilitators review tales of heroism and survival. They should praise the courage of students in facing the trauma and looking ahead toward the future.

Closing. The final step in GCI is for students to engage in activities that start to bring a sense of closure to the trauma. This step may last up to 30 minutes. The development of memorials is a natural activity after trauma resulting in death. A variety of creative projects can serve as memorials. Ideally, these will be projects that all students can help to develop. It is important that all memorial projects should be carefully screened before they are delivered to trauma victims and/or their families. Because of their own anxiety and beliefs, students may generate messages that are potentially hurtful. These messages should be screened out (Brock et al., 1996; Lord, 1990). Students who create such messages need to be discretely counseled regarding what makes an appropriate memorial and given another opportunity to participate in the project. In addition, if time is a problem this step may only involve the planning of memorial projects. Completion of these projects can be reserved for another day.

Other closing activity options include preparation for attending or participating in funerals (Lord, 1990; Mitchell & Everly, 1996b) and the writing of get-well cards and letters to victims. If the class has experienced the death of a classmate or teacher, this step should include discussion of what to do with the deceased's desk and belongings (Lord, 1990).

In concluding GCI, facilitators should answer any remaining questions. The GCI is then summarized and closing comments made. If time permits, students may be asked to share what they have learned from the GCI session and what empowerment ideas they are committed to implementing (Allan & Nairne, 1984). In their closing comments facilitators should remind students that they are experiencing normal reactions to abnormal circumstances. Facilitators should acknowledge that, for some students, it might be some time before they are truly able to place the crisis event in their past and move on with their lives, and that, for some students, their lives might never be the same. At the same time, however, facilitators should be positive about the future and remind students that, while memories will remain, with time and talk, the associated pain will lessen and symptoms will typically disappear. Finally, the facilitators should reassure students that additional crisis intervention services are available, if needed, and reiterate self-referral procedures.

Post-GCI Activities

Following the GCI session, students' caregivers need to be informed about the actions they can take to facilitate continued discussion and help students cope. These

recommendations, which should be provided to the families of all GCI participants, include the following:

- Listen to and spend time with your child.
- Offer to talk about the trauma.
- Reassure your child that he or she is safe.
- Offer assistance with everyday tasks and chores.
- Respect your child's privacy.
- Do not take anger or other reactions personally (Mitchell & Everly, 1996b).

After GCI has ended, at least one, but preferably all, of the facilitators should remain with the students (Mitchell & Everly, 1996a). At the very least, a facilitator should be available to students throughout the remainder of the school day, to allow students additional opportunities to seek out support and to have questions answered. It will also give facilitators additional opportunities to assess how individual students are coping.

Finally, as soon as possible after GCI, facilitators should debrief the session. This debriefing typically occurs at the end of the school day and serves two important purposes. First, it allows discussion of student reactions and decisions regarding who will need one-on-one crisis intervention (Neria & Solomon, 1999). Table 2, on page 398, provides a list of indicators suggesting the need for such support.² Second, facilitators should focus on their own reactions and coping. In particular, special attention needs to be directed toward the teacher (Lord, 1990). If needed, crisis intervention services should be made available to the teacher and other GCI team members. Ideally, these services are provided by a crisis team member, trained in psychological debriefing (e.g., Mitchell & Everly, 1996b), who was not a part of the initial crisis intervention response.

Advantages of GCI

Practical advantages. Group approaches to crisis intervention have previously been identified as efficient and cost-effective (Courchaine & Dowd, 1994; Gelsomino & Mackey, 1988). This observation highlights the most obvious advantage of GCI—it allows large numbers of trauma survivors to be seen at one time. Given that situational crises have the potential to affect many more students than most school mental health resources can handle (Weinberg, 1990), this is an especially important issue for school crisis intervention teams.

Table 2

Indicators of the Need for a One-on-One Crisis Intervention Referral

-
1. Suicidal ideation or plans.
 2. Inability to control emotional reactions and arousal level.
 3. Disassociation and/or bizarre behavior.
 4. Excessive self-blame or intropunitive anger.
 5. Absence of emotional reactions in those who were close to trauma victims and/or who witnessed the traumatic event.
 6. Poor pretrauma mental health (i.e., emotionally disturbed).
 7. Physically injured during the crisis event.
-

Note

From Larsson et al. (2000), McFarlane and Yehuda (1996), and Weinberg (1990).

Treatment advantages. GCI also takes advantage of the demonstrated value of posttrauma group treatment models (Chemtob, Thomas, Law, & Cremniter, 1997; Everly et al., 1999). More specifically, it has been suggested that active contact and dialogue among groups of trauma survivors are important to the healing process (Gelsomino & Mackey, 1988). In addition, group interventions have been found to reduce anxiety, improve self-efficacy, enhance group cohesion (Shalev, Peri, Rogel-Fuchs, Ursano, & Marlowe, 1998), and play a role in reducing alcohol misuse (Deahl et al., 2000).

Specific GCI treatment advantages include my observation that it helps students feel less alone and more connected to their classmates because of their common experience. GCI's group processes allow students to observe that they have shared a common experience and are having similar reactions. In addition to building group cohesion (Shalev et al., 1998), this commonality may help to give students the emotional strength needed to face and cope with a trauma. In addition, by promoting the idea that trauma responses are normal, GCI may help students regain a sense of hope and optimism, which in turn helps them to view their reactions as manageable (Gelsomino & Mackey, 1988). The final advantage of GCI is that it is an efficient way to help identify students in need of one-on-one crisis intervention. This is important because it will not always be immediately apparent who is most significantly affected by a trauma. (See Chapter 19 for discussion on identifying psychological trauma victims.)

Research Suggestions

My observations suggest that GCI is effective. However, while previous research has demonstrated the effectiveness of this type of crisis intervention with adults (Mitchell & Everly, 1996a) and multiple-session interventions with children (Galante & Foa, 1986), to my knowledge, no one has conducted a controlled, empirical study of this approach with children. Thus, research in this area is critically needed (Kutash & Rivera, 1996; Rose & Bisson, 1998). Specifically, a methodology should be employed that will help to assess possible relationships between GCI participation and measures of posttraumatic stress and school functioning (e.g., school attendance rates, group achievement test scores, discipline records, etc.). If available, pretrauma baseline data (especially for measures of school functioning) should be considered. Additional assessment should take place immediately before GCI, immediately after GCI, two days after the traumatic event (the duration required for an acute stress disorder diagnosis), one month after the event (the duration required for an acute posttraumatic stress disorder diagnosis), and finally three months after the event (the duration required for a chronic posttraumatic stress disorder diagnosis). Experimental or quasi-experimental research designs should be employed (Kutash & Rivera, 1996). For example, individuals or classrooms could be randomly assigned to a GCI treatment group, a no-treatment group, and/or an alternative crisis intervention treatment group. When comparing treatment conditions, it will be important to control for variables, such as degree of exposure to the traumatic event, and other risk factors, such as familiarity with crisis victims and preexisting psychopathology, that are known to increase vulnerability to a psychological trauma.

References

- Allan, J. A. B., & Nairne, J. (1984). *Class discussions for teachers and counsellors in elementary school*. Toronto, Canada: University of Toronto.
- American Red Cross. (1994). *Disaster Mental Health Services I: Participant's Attachments* (Attachment 12, p. 43). Washington, DC: Author.
- Armstrong, K. R., Lund, P. E., McWright, L. T., & Tichenor, V. (1995). Multiple stress debriefing and the American Red Cross: The East Bay Hills fire experience. *Social Work, 40*, 83-90.
- Armstrong, K. R., Zatzick, D., Metzler, T., Weiss, D. S., Marmar, C. R., Garma, S., Ronfeldt, H., & Roepke, L. (1998). Debriefing of American Red Cross personnel: Pilot study on participants' evaluations and case examples from the 1994 Los Angeles earthquake relief operation. *Social Work in Health Care, 27*, 33-50.
- Armstrong, M. (1990, April). Emotional reactions to Stockton. In F. Busher (Chair), *Tragedy in Stockton school yard*. Symposium conducted at the meeting of the National Association of School Psychologists, San Francisco, CA.
- Bell, J. L. (1995). Traumatic event debriefing: Service delivery designs and the role of social work. *Social Work, 40*, 36-43.
- Bisson, J. I., Jenkins, P. L., Alexander, J., & Bannister, C. (1997). Randomized control trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry, 171*, 78-81.
- Blom, G. E., Etkind, S. L., & Carr, W. J. (1991). Psychological intervention after child and adolescent disasters in the community. *Child Psychiatry and Human Development, 21*, 257-266.
- Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling, 2*, 110-116.
- Brock, S. E. (1996, Summer). Classroom crisis counseling. *NASP Communiqué, 24*(9), 4-6.
- Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building crisis response teams*. Brandon, VT: Clinical Psychology Publishing Company.
- Brown, D. (1996). Counseling the victims of violence who develop posttraumatic stress disorder. *Elementary School Guidance and Counseling, 30*, 218-227.
- Chemtob, C. M., Thomas, S., Law, W., & Cremniter, D. (1997). Postdisaster psychosocial intervention: A field study of the impact of debriefing on psychological distress. *American Journal of Psychiatry, 154*, 415-417.
- Courchaine, K. E., & Dowd, E. T. (1994). Group approaches. In F. M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (pp. 221-237). New York: Guilford Press.
- Cox, J. D., & Grieve, T. (1989, January 19). Schoolyard slaughter—5 killed, 30 injured. Stockton rampage ends with suicide. *Sacramento Bee*, p. 1.
- Deahl, M., Srinivasan, M., Jones, N., Thomas, J., Neblett, D., & Jolly, A. (2000). Preventing psychological trauma in soldiers: The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology, 73*, 77-85.

- Everly, G. S., Boyle, S. H., & Lating, J. M. (1999). The effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine*, 15, 229-233.
- Farrell, J., & Joseph, A. (1991). Expressive therapies in a crisis intervention service. *Arts in Psychotherapy*, 18, 131-137.
- Farrington, A. (1995). Suicide and psychological debriefing. *British Journal of Nursing*, 4, 209-211.
- Frederick, C. J. (1985). Children traumatized by catastrophic situations. In S. Eth and R. S. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 71-100). Washington, DC: American Psychiatric Association Press.
- Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry*, 25, 357-363.
- Gelsomino, J., & Mackey, P. W. (1988). Clinical interventions in emergencies: War-related events. In M. Lystad (Ed.), *Mental health response to mass emergencies: Theory and practice* (pp. 221-238). New York: Brunner/Mazel.
- Johnson, K. (1993). *School crisis management: A hands-on guide to training crisis response teams*. Alameda, CA: Hunter House.
- Kneisel, P. J., & Richards, G. P. (1988). Crisis intervention after the suicide of a teacher. *Professional Psychology: Research and Practice*, 19, 165-169.
- Klingman, A. (1987). A school-based emergency crisis intervention in a mass school disaster. *Professional Psychology: Research and Practice*, 18, 604-612.
- Klingman, A. (1988). School community in disaster: Planning for intervention. *Journal of Community Psychology*, 16, 205-216.
- Klingman, A., Koenigsfeld, A., & Markman, D. (1987). Art activity with children following a disaster: A prevention-oriented crisis intervention modality. *Arts in Psychotherapy*, 14, 153-166.
- Kutash, K., & Rivera, V. R. (1996). *What works in children's mental health services: Uncovering answers to critical questions*. Baltimore: Brooks.
- Larsson, G., Michel, P., & Lundin, T. (2000). Systematic assessment of mental health following various types of posttrauma support. *Military Psychology*, 12, 121-135.
- Lord, J. H. (1990). *Death at school: A guide for teachers, school nurses, counselors, and administrators*. Dallas, TX: Mothers Against Drunk Driving.
- Mayou, R. A., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims: Three-year follow-up of a randomized controlled trial. *British Journal of Psychiatry*, 176, 589-593.
- McFarlane, A. C., & Yehuda, R. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 155-181). New York: Guilford Press.
- Mitchell, J. T., & Everly, G. S. (1996a). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers* (2nd ed., rev.). Ellicott City, MD: Chevron.
- Mitchell, J. T., & Everly, G. S. (1996b). *Critical incident stress management: The basic course workbook*. Ellicott City, MD: International Critical Incident Stress Foundation.

- Nader, K. (2000). Innovative treatment methods for psychological trauma. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson, *Best practices in school crisis prevention and intervention* (pp. 675-704). Bethesda, MD: National Association of School Psychologists.
- Neria, Y., & Solomon, Z. (1999). Prevention of posttraumatic reactions: Debriefing and frontline treatment. In P. A. Saigh & J. D. Bremner (Eds.), *Posttraumatic Stress Disorder: A comprehensive text* (pp. 309-326). Boston: Allyn and Bacon.
- Pagliocca, P., Nickerson, A. B., & Williams, S. H. (2002). Research and evaluation directions in crisis intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson, *Best practices in school crisis prevention and intervention* (pp. 771-790). Bethesda, MD: National Association of School Psychologists.
- Petersen, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques and materials for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.
- Pitcher, G. D., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.
- Rose, S., & Bisson, J. (1998). Brief early psychological interventions following traumas: A systematic review of the literature. *Journal of Traumatic Stress, 11*, 697-710.
- Rose, S., Brewin, C. R., Andrews, B., & Kirk, M. (1999). A randomized controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine, 29*, 793-799.
- Schonfeld, D. J. (1989). Crisis intervention bereavement support: A model of intervention in the children's school. *Clinical Pediatrics, 28*, 27-33.
- Shalev, A. Y., Peri, T., Rogel-Fuchs, Y., Ursano, R. J., & Marlowe, D. (1998). Historical group debriefing after combat exposure. *Military Medicine, 163*, 494-498.
- Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress, 2*, 3-20.
- Terr, L. C. (1992). Mini-marathon groups: Psychological "first aid" following disasters. *Bulletin of the Menniger Clinic, 56*, 76-86.
- Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions. *Professional Psychology Research and Practice, 21*, 271-278.
- Wollman, D. (1993). Critical incident stress debriefing and crisis groups: A review of the literature. *Group, 17*, 70-83.
- Young, M. A. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.
- Yule, W. (1998). Posttraumatic Stress Disorder in children and its treatment. In T. W. Miller (Ed.), *Children of trauma: Stressful life events and their effects on children and adolescents* (pp. 219-244). Madison, CT: International University Press.

Endnotes

¹Adapted from Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling, 2*, 110-116.

²If a student is known to demonstrate the indicators listed in Table 2, on page 398, before a GCI session, he or she should be immediately referred to a mental health professional for individual assistance. It is inappropriate to include these students in GCI.

