

**Group Psychotherapy
for Psychological Trauma**

Robert H. Klein
Victor L. Schermer
Editors

Foreword by K. Roy MacKenzie

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When Trauma Affects a Community: Group Interventions and Support after a Disaster

MARK L. DEMBERT
EDWARD D. SIMMER

A helicopter carrying many senior partners in a law firm crashes during a business trip, and all are killed.

A van with members of a high school band slides off a rain-slick highway and crashes into a tree, killing everyone.

A recently fired executive from a large company returns to the offices with a gun, killing several and wounding others before shooting himself.

A tornado touches down at night in a small town without warning, destroying most of the buildings and homes and killing or injuring most of the town's population.

During a championship middle school soccer game played in front of a large crowd of families from both schools, one of the boys trips and falls directly against the metal goal frame. He collapses, suffers a cardiac arrest, and dies, despite the resuscitative efforts of two doctors attending the game.

SPECIAL POPULATIONS AND TRAUMA GROUPS

Traumatic events like the examples above--by no means an inclusive list--cast a wide net involving families, communities, businesses, and government. Although the medical community's recognition and treatment of individuals suffering the devastating emotional and psychological aftereffects of such events have markedly improved over the last half century, the recognition and treatment of small or large groups of such individuals have only developed over the past two decades (Farberow & Frederick, 1996; Mitchell & Everly, 1996; Peuler, 1988; Young, 1998). These groups fall into two basic categories: acute interventional debriefing groups used immediately after a disaster, and various support groups that provide valuable services for months or even years after a disaster. Neither of these is a psychotherapy group in the sense of fostering intrapsychic change, resolving neurotic conflict, addressing past histories of developmental or early trauma, or changing maladaptive character traits. Members of these groups are generally healthy people who are having normal responses to an abnormal situation. Those who conduct groups for this work thus regard themselves as "group counselors," "facilitators," or "leaders"; these are the terms members use.

How, then, can the traditional group therapist begin to understand the nature of this work and the nature of his or her role in this process? This may initially seem difficult. However, the underlying goal of disaster work is the same as that of traditional group therapy: alleviating suffering and improving function. And although the approaches used in postdisaster groups are somewhat different, many of the techniques used in this work are similar to those used in short-term therapy groups. These concepts become clear in the examples and discussions that follow.

ACUTE INTERVENTIONAL DEBRIEFING GROUPS

In a factory room containing 20 employees, a steam pipe explosion seriously burned two workers and caused lesser burns to others. Those present who provided emergency first aid to their seriously injured colleagues were confronted with the horror of seeing their severe thermal burns and hearing their painful screams. After learning that one of the two severely burned men died after being taken to the hospital, several of the workers later refused to return to work and enter that room. All described themselves as being very emotionally shaken by the event.

A critical incident stress debriefing (CISD; see below) was held 2 days after the incident. The workers in the group were able to discuss what happened, each from his own perspective. By hearing each other's perspectives, they were able to get a better cognitive and emotional understanding of the entire event; even more importantly, they learned about the expectability of their reactions. Information

about possible physical, emotional, and cognitive responses to a traumatic event was presented briefly. Ways to deal with the loss, including memorializing their dead colleague, were then reviewed. After this intervention, all of the employees were able to return to work in this room. Only one required follow-up mental health counseling.

The group therapist who wishes to be involved in disaster mental health work should have training in acute interventional debriefings and should be well versed in issues of stress, posttraumatic stress disorder, psycho-trauma, crisis intervention, the nature and functions of emergency services work, and biopsychosocial aspects of disasters in general (Mitchell & Everly, 1996). Acute interventional debriefing groups can be used both for responding emergency workers and for direct survivors, as well as for indirectly affected victims of disasters.

Critical incident stress management (CISM) programs, which include prevention-oriented stress management strategies of psychoeducation and CISD, developed out of an awareness that disaster workers and emergency personnel can experience a wide array of social, psychological, and physical reactions to stressors inherent in disaster work. These consequences include formal stress disorders, job "burnout" and job loss, family and marital disruption, psychiatric disability and suicide, medical illnesses, and substance abuse. CISD involves a defined and concise local program of contact with individuals assembled in groups within 24-72 hours after they have provided response and rescue services. These group debriefings may last up to 3 hours each and are led by a team of trained peer support and mental health personnel. Each debriefing follows a seven-step process described in more detail elsewhere (Mitchell & Everly, 1996). In brief, the first phase ("introduction") sets the stage for the rest of the debriefing, with guidelines fully explained for the entire process. The second phase ("fact") allows each group member to introduce him- or herself, to describe where he or she was when the disaster occurred, to indicate his or her job or role, and to describe what occurred to the best of that person's knowledge. The third phase ("thought") allows each member to describe the initial thoughts that occurred once the immediate reaction was over; this process provides a transition from the cognitive experience to the emotional experience. The fourth phase ("reaction") allows the members to describe what was emotionally the hardest to experience about the disaster; this usually leads to a wide variety of freely expressed emotions. The fifth phase ("symptoms") provides a transition from the emotional domain back to the cognitive domain, with a focus on members' experiences of stress-related symptoms. The sixth phase ("teaching") is very educative

in approach and allows for much discussion and education about stress survival techniques, including self-care and reintegrating with families, friends, and coworkers. The seventh phase ("reentry") brings closure to the debriefing: final questions are answered, summary statements are made, and the transition to future thinking and a return to daily life routines are facilitated.

Community disaster response teams, another part of CISM, hold postdisaster debriefings for nonemergency worker populations in the community, such as citizen groups, schools, and businesses (Mitchell & Everly, 1996).

Related postdisaster group interventions used as part of CISM include "defusings" and "demobilizations." Defusings are used for selected small groups, perhaps six to eight persons working as a team, who are exposed to severe trauma during the disaster. It is done within hours of their experience. It provides an opportunity for those exposed to a horrible event to talk about the experience before they have time to later rethink the experience and erect cognitive and emotional barriers to processing it appropriately. Demobilizations can be used for larger numbers of persons than can defusings or debriefings (10 to 30 or more). These are done after the end of the first two or three shifts for emergency workers responding to a large-scale disaster or very traumatic event. These are two-part processes: The first part is a brief talk that presents information on understanding and managing expectable reactions to the stress of the work just experienced, and the second is the provision of food and rest at a demarcated place. Demobilizations provide a transition from the traumatic event to the routine within a short period of time. Defusings and demobilizations can also be provided for others who are not emergency workers/disaster responders, including survivors.

The National Organization for Victim Assistance (NOVA), founded in 1975, conceptualized and put into practice in the 1980s the community crisis response team (CCRT) process (Young, 1998). These teams, composed of emergency management peer support members, clergy, other lay personnel, and CCRT-trained mental health care providers, are invited to community-wide crises and provide acute interventions similarly focused on individuals assembled in groups. Like CISD, these interventions are used in an attempt to reduce later morbidity. The process for these debriefings follows a multiphase framework similar to that of the CISD model. CCRT interventions have been used for emergency response and rescue personnel as well as for victims and survivors, involved medical personnel, local government leaders, construction and utilities repair personnel, and members of religious and community service organizations. Involvement with the news media, psychoeducation, and postdisaster planning are among other unique CCRT duties.

SUPPORT GROUPS

In 1996, two major hurricanes struck the coast of North Carolina within a 3-month span. Although few people were injured or killed, extensive damage occurred, and many people lost both their homes and their livelihoods.

Support groups were started 1 to 2 months after the second hurricane. These groups were timed to start after the initial cleanup was mostly complete. These groups were initially led by mental health professionals, but attendance was very poor.

Discussions with trusted leaders in the community indicated that the likely cause was stigma attached to attending a group thought to be for those with mental disorders, because the leaders were mental health care providers. As a solution, interested community leaders were trained to be co-facilitators of these existing groups. As a result, the perceived stigma was replaced with beneficial images, and group attendance greatly increased.

The groups successfully served to allow people to discuss their reactions to the disaster and also to share solutions to many practical problems. Eventually, the mental health professionals were able to phase themselves out of the groups, which then became more like combined support and self-help groups.

Whereas both CISD and CCRT are traditionally used right after a disaster for both emergency response workers and traumatized survivors, support groups are usually begun many days or weeks after a disaster and are primarily organized for traumatized survivors and other members of the affected community. Emergency response workers whose lives outside of the direct practice of their skills have also been affected can participate in such support groups as well.

Support groups constitute one of the mental health interventions of choice for traumatized individuals (Janoff-Bulman, 1985) and the community after a disaster. The beneficial objectives of these support groups are to a great extent concordant with many of the "therapeutic factors" described by Yalom (1995), including instillation of hope, universality, imparting information, altruism, group cohesiveness, and existential factors. Postdisaster support groups also foster a sense of normalization (the reactions members are experiencing are considered to be expectable reactions to an abnormal or unexpected event); a sharing of resources, which promotes cohesiveness; an optimizing of recovery, so that members can approximate their pre-disaster daily functioning; and prevention or amelioration of possible disaster-related psychological morbidity (Bradford, 1994). Wee (1994) provides an excellent comparison of basic types of support groups. The first type consists of the standard support groups, which provide psychological education

with emotional support as the primary function over many weeks or months. The phases of the standard support group, compared to those of CISD, are as follows: "recovery goals," "remembrance," "cognitive mastery," "mourning," "stress management," "teaching/resources," and "follow-up." Groups of the second type are referred to as "topic groups." These are organized around recovery topics (e.g., completion of paperwork for damage and insurance claims; advice on how to pick a building contractor or architect) and may meet once or twice and allow for group interaction, support, and networking. Groups of the third type are called "event groups." These groups bring large groups of disaster survivors together for a single occasion or event to address an entire community's needs (e.g., an anniversary commemorative event).

In addition to the types of support groups that can be developed after a disaster, the mental health provider who plans to work with or begin one or more support groups must take many other issues into consideration (Peuler, 1988; Wee, 1994). The first is evaluating the need for support groups. A broad spectrum of specific populations with unique needs within the community should be considered for separate support groups. These include but are not limited to children, the elderly, ethnic groups, sexual minorities, renters, homeowners, members of various professions and interest groups (e.g., nurses, artists, domestic workers, therapists), those who lost pets, those with physical disabilities, disaster response and recovery workers, those who lost loved ones, and the chronically mentally ill (Speier, Thomas, Carter, DeWolfe, & Rubin, 1996). Also affecting the need for a support group and the type of group chosen are such issues as the overall short-term and long-term impact of the disaster on the specific community, and the extent and magnitude of damage, death, and injury experience among community members (Herman, 1992).

Once the need for support groups has been evaluated, and the types of groups and target populations have been selected, the groups' utility and effectiveness can be maximized through attention to a variety of factors. First, the population of the affected community must be looked upon as a composite of many predominant subgroups stratified by age, socioeconomic status, marital status, religion, ethnicity, race, occupation, health, and geography of residential areas, to name some common ones. An effort must be made to match planned group leaders with salient characteristics of the likely members of these groups. As a corollary, cultural aspects and practices of these subpopulations must be respected when such groups are planned. For instance, food and drink provided at meetings must not conflict with cultural or religious dietary sanctions followed by the members, and group meetings should not conflict with a religious sabbath or church worship schedules, if at all possible.

Second, depending upon the effects of the disaster and the populations it has affected, group leaders may be more concerned (especially at first) with practical matters:

arranging temporary housing, providing basic food for families, immediately starting loan or mortgage applications or insurance assessments of home damage and loss, and/or providing contractor or self-help services for the immediate repairing of homes or of wells or septic systems.

Third, support groups must be held in locations that maximize the transportation assets and abilities of community members. Flooded or damaged highways or local roads, washed-out bridges, debris that block roads, and areas of high damage to homes all influence members' attendance. The emotional attachment to lost or damaged homes may keep many members from making long or arduous trips to a noncentralized group location. If a local building of any type is chosen for group meetings, it should be in a central area. Transportable meeting places, such as trailers or recreation vehicles, may need to be used. Individuals or car dealers who own four-wheel-drive vehicles may be pressed into providing taxi services. Fourth, the group schedule must take into account the other urgent needs that community members have in recovering from the disaster. Immediately after the disaster and for several weeks afterward, damaged homes and injured family members take precedence in the psychological and physical priorities of individuals. A weekly group schedule may be too demanding, but an every-other-week schedule may be feasible. The time and day of the week chosen for group meetings are also important factors, which are influenced by the geography, the weather, the integrity of the roads, the availability of child care, the occupations of the local community members, and so forth. Nighttime meetings may inculcate a sense of fear and resistance to attendance when there are poorly lighted or damaged roads. If individuals in the community are able to go back to work, then a balance has to be struck between weekday work schedules and the need for weekend time to regroup and recover mentally, physically, and emotionally with family members. Fifth, disasters easily conjure up in the minds of the suffering the idea of vulnerability and need for safety. This has to be factored into providing available group locations with nearby parking, as well as very visible protection from crime both outside and inside the meeting area. Such group meetings should be held in areas usually devoid of crime, if at all possible. Sixth, consideration must be given to providing child care services at the site of group meetings, so that adult members can feel free to express their feelings and concerns in the shared privacy with other adults, without being interrupted by children's situational needs. As far as the actual mechanics of setting up groups are concerned, many groups seem to work best as open "groups, with community members being able to participate when possible. This works best with support groups dealing with topics such as home repairs and other self-help issues, local governmental issues, resumption of community and utility services, and so forth. Other support groups fare better as closed groups, whose leaders

may choose to do a pregroup screening for each individual to ensure compliance with basic rules of privacy and confidentiality and participation, as well as to rule out evidence of severe or impairing mental disorders that indicate a need for immediate treatment. These latter groups have been used in the aftermath of disasters involving significant loss of life, especially when such disasters have been caused by an accident (e.g., an airliner crash), intent to harm others, or negligence. In these disasters, examples of which are described below in more detail, the emotional reactions (anger, numbness, shock, etc.) are persistent and at times overwhelming; the call for justice may be overarching; and the intense grieving may endure for months and years. All of these factors necessitate an enclosed, safe, trusting, and containing group environment. The duration of support groups remains flexible in most situations, driven by the unique characteristics and needs of each specific group of individuals; some last a few sessions, some last several months, and some can last years. Last, group rules are usually minimal; however, depending upon the type of disaster, the open or closed nature of initial membership requirements, and the needs of the participating members, additional rules described commonly (Yalom, 1995) may be instituted. Promoting the group requires consideration of (1) developing flyers; (2) contacting key persons and organizations in social networks; (3) seeking publicity through newspapers, radio, and television; and (4) promoting referrals from other disaster survivors as well as health care providers.

Piper, McCallum, and Azim (1992) provide a good theoretical and clinical basis for incorporating loss and mourning into short-term groups. Session-by-session issues in support groups are well described by Paolercio (1993). Basic themes in facilitating support groups are addressed in the case examples below. When and how to refer a seriously disturbed group member for urgent or emergent care needs to be considered, as well as what to do if a group member later dies by suicide, illness, or injury. Anniversary dates are extremely important to acknowledge and plan for in the group (Myers, 1994). The group leader must have an understanding of when documentation and reporting are mandatory for issues brought up in group.

Termination strategies need to be thought out ahead of time. Issues to be considered include (1) preparing the participants; (2) deciding how to continue individual relationships after the group; (3) making referrals to other resources as needed; (4) inducting new support group facilitators; (5) continuing the support group as a self-help group; and (6) providing follow-up to individuals or the group as a whole when funding for the group ceases, such as a federal or local grant for a specific time period of group sessions.

SPECIFIC DISASTER TYPES AND RELEVANT SUPPORT GROUPS

The type of disaster and its inherent themes often shape the nature, content, processes, and schedules of the support group(s) used (Lystad, 1988). In this section, five types of disasters are described: natural disasters; accidental disasters (transportation and technological accidents are common); disasters caused by intent to harm others; business or industry disasters; and disasters that directly or indirectly traumatize children and adolescents. Particular issues in the formation and facilitation of relevant support groups are illustrated in case examples reported by mental health care providers involved in postdisaster groups.

Natural Disasters

Issues to Consider

Even with the inevitable loss of property and possible loss of life, a natural disaster brings up issues of fate and luck. Individuals often turn inward and search their souls for why the disaster happened. Family members often endure the disaster together. There is usually an expectation that all victims' remains will be recovered for burial and emotional closure. Memorial sites may be erected, and these should be readily accessible to community members. Despite the tragic nature of such a disaster, the sense of future is based upon a perspective of relocating (if necessary), rebuilding, and starting a life over.

As noted earlier, logistical factors may complicate conducting support groups after a natural disaster. For instance, many persons may be isolated by floods when roads and bridges are destroyed. Contacting these persons directly, as well as finding ways to enable them to come to a group, can be extremely difficult. Support groups can be started in a shelter even while the natural disaster is ongoing; this allows for very early intervention and paves the way for people to come to more long-term support groups later. Finally, some natural disasters may recur not long after the initial event (e.g., earthquake aftershocks, mudslides, brush fires, floods). This expectably heightens community fears and also requires flexibility in relocating support groups.

In January 1982, a disastrous winter rainstorm hit Santa Cruz County, California. Floods and mudslides took numerous lives and caused extensive property damage. A community support group was formed 3 weeks after the storm in the village of Soquel, and it continued weekly for over 1 year. There was a core group of 10 members; the maximum attendance

was 13; and new members were taken in as the group progressed. Jack Peuler, LCSW, formerly of the Santa Cruz County Department of Mental Health Services and former director of Project COPE (Counseling Ordinary People in Emergency), and a colleague have described this group (Peuler & Ritter-Splain, 1983). The following is taken from that report:

The first four to eight weeks were marked by a sense of the group members being "in shock." Most were emotionally detached and thankful to be alive, while some were euphoric at being alive. These mood states seemed to protect the survivors from the devastating reality of their losses until they were more able to address them.

Group members, without exception, reported poor sleep patterns and nightmares. Many seemed preoccupied and restless. Parent-members were often in denial that their children may have suffered.

In the initial phase, group members most wanted to tell their stories and repeatedly vent their feelings. Many expressed survivor guilt in the form of a magical belief that in some way they had caused the disaster to happen. By the end of the first phase, the members' realization that their losses were even more devastating than they had initially perceived began to set in. There was a sense of a loss of identity, loss of a sense of home and refuge, and loss of a community of neighbors.

The next six to twelve weeks were colored by group members' anger and frustration over the obstacles in receiving assistance from various governmental agencies. Often there was indignation that after paying taxes all their lives, they got so much less than they needed or expected.

Group members reported feeling vulnerable and out of control. There was a great need to have others who were affected less or not at all by the disaster understand how traumatic their own experiences had been.

Four to six months after the disaster, a remedy phase began. Group cohesiveness was very evident. Individuals became actively involved in their own recovery efforts. They exchanged practical information with others inside and outside the group. At the same time, anger over unanswerable demands for accountability surfaced. Bad dreams persisted almost without exception. Often, these nightmares involved being caught or trapped by something or having walls crash down.

Six months after the disaster the group considered disbanding. Members experienced themselves as having survived the crisis and now having a sense of future to embrace. However, they realized they weren't truly ready to stop. They redefined their needs and goals and continued on. Issues of personality changes, spirituality, control and autonomy, and dependence versus independence were discussed. It was also at this point that parents in the group became truly aware that their children had been affected by the disaster and problem solving sessions focused on how to help their children.

During the ninth through twelfth months, new members joined the

group as recurrent storms activated anxiety among original survivors who had not first sought support. The anniversary date brought relief and celebration, with sadness over memories of losses.

Personality traits which are culturally reinforced by sex roles created observable differences in the impact of the disaster on men and women and the types of interventions needed from the facilitators. Women tended to placate, to put others first, and to feel overly responsible for the welfare of others. These served as obstacles to giving themselves permission to grieve their own sorrows, to regain self-trust, and to tend to their own needs. Key interventions included encouragement to set limits on others' demands, to assert their own needs, and to validate their abilities to trust themselves.

Many men found it difficult to acknowledge and express feelings of helplessness and sadness. They described feeling as failures in their roles as family protectors and providers by "allowing" this devastation to strike their families. For some, the threat or actual occurrence of physical injury jeopardized their sense of "manhood." Facilitators encouraged men to accept and express feelings of vulnerability and/or helplessness as human inevitabilities and to make realistic assessments of their own strengths and limitations. (Peuler & Ritter-Splain, 1983, pp. 8-11)

Accidental Disasters

Issues to Consider

In an accidental disaster, such as a transportation disaster or technological disaster, there can be a sudden, devastating loss of life and property. Surviving family members or friends of the victims can experience haunting survivor guilt; in particular, they may blame themselves for making the victims take a certain airplane flight or go to work for a certain shift. An effort to affix blame as to the cause of the accident is also quite common. Any suspicion that the accident was due to terrorism or specific intent to harm others fuels the outrage until such causes are officially investigated and suspicions are laid to rest. When there may have been an error in judgment, negligence, or a design defect that led to the disaster, these possibilities will be heavily scrutinized by families of victims and investigatory agencies. A family's hierarchy can be instantaneously transformed by such a disaster, especially when a spouse or child is the victim, and family cohesiveness, grieving, and problem-solving capacities can be seriously impaired. A large number of victims' remains may not be recoverable if the accident was totally obliterating or if it happened at sea. Especially in a transportation accident, there may not be a community sense of loss from which survivors can derive support, as victims may have been brought together by chance from many parts of the country. There may not be a memorial site to visit later, especially if the disaster occurred at sea or in another country.

On September 8, 1994, USAir Flight 427 crashed near Pittsburgh, Pennsylvania, killing all 132 passengers and crew members. The essential obliteration of the aircraft and bodies created a highly traumatic experience for victims' families, rescue and relief workers, and counselors. Pittsburgh was the termination of this flight from Chicago; thus many of the victims were from the Pittsburgh area and left surviving spouses with children. After CISD was accomplished with emergency response workers and family groups, subsequent support groups focused on families, adults, children, and adolescents. Facilitators from funded public agencies and private practices alike conducted support groups.

Grace M. McGorrian, MD, a psychiatrist in private practice who herself had lost a brother to a commercial airplane disaster overseas many years before, led one such support group for 16 sessions over a 1-year time period (McGorrian, 1995). The following description of her experience is from G. M. McGorrian (personal communication, September 1998) and is modified from her 1995 unpublished document.

Shortly after the CISD interventions and many funerals were held, McGorrian sent out individual letters with personal notes to families in a demarcated area of interlocking neighborhoods, inviting them to attend a support group. She followed up with telephone calls to interested families. These calls served several purposes. First, they provided personal condolences. They also allowed her to describe her reasons for forming the group, its goals, its scheduling, and other information (this group was held at no cost to the members, as she volunteered her time). Furthermore, they allowed her to find out more about the impact of the crash on each family. Finally, they allowed her to do a rough screening for significant depression or anxiety that would indicate a need for additional treatment.

The group started less than 4 weeks after the disaster. The membership was closed at 10 members after the third week; members were informed of the closed nature, in case other survivors approached members later for admission. The group was to run for 8 to 10 sessions, with an option for the group to vote later to extend it.

Since members were from similar neighborhoods, cohesiveness and networking outside of the group began early. Sessions were conducted at a group therapy suite in a physicians' office building (which was centrally located for all members) and were held from 7:00 P.M. to 9:00 P.M. (a convenient time).

McGorrian found it exceedingly helpful to gather as much information on the crash from media sources, and as much information about victims and surviving family members as possible; these details assisted her in the facilitator role. A list of names, addresses, and phone numbers was made for all group members to share. Basic group ground rules were established.

Confidentiality was stressed; and McGorrian's responsibility to decide when a member should be referred for outside mental health evaluation and treatment was stated. McGorrian found it important to uphold boundaries on time, consistent participation, and her personal information, with the exception of anecdotal details of her own prior bereavement process. She did inform group members of her brother's death. They appreciated her disclosure, seeing her as an "insider" who could comprehend what they were facing in their lives. When she encountered a group member in a public setting, the interaction was friendly and supportive.

She encouraged group members to participate in memorial services, to visit the memorial to all crash victims that was constructed at a nearby cemetery, and to visit the gravesites of loved ones interred there. She made herself available to accompany group members, if asked.

During the course of the group, media coverage of other disasters, especially those similar to the group's disaster, brought about expectable transient recurrences of initial symptoms and some forms of individual or group regression.

Members were encouraged as the group progressed to investigate relevant national support groups, such as Compassionate Friends or Parents without Partners, for additional specific networking.

The group was actually conducted for 1 year and was terminated formally after the 1-year anniversary. The first 10 sessions were conducted over 3 months; Sessions 11 and 12 were monthly; Sessions 13, 14, and 15 met every 2 months; and Session 16 met right after the anniversary date. The members and McGorrian maintained telephone contact long after the group's termination.

The following is a summary of relevant themes seen over time:

Sessions 1-3: Members were in a stage of emotional shock and grief over the sudden deaths. There were feelings of deprivation and injustice regarding the perceived preventability of the crash or loss of lives.

Sessions 4-5: These were more emotional, tearful, and outwardly grieving sessions.

Sessions 6-8: The group began to talk of the future and to express hopes of feeling better some day.

Sessions 9-10: These sessions were marked by evidence of members' strengthening important relationships at home and in the community.

Sessions 11-13: In these sessions, legal aspects of the disaster were discussed. Some members had decided to settle out of court, whereas others wanted to proceed with jury trials. Guilt and ambivalence regarding either type of decision were described.

Sessions 14-15: Group members were aware of the impending anniversary date of the crash, as well as the termination of the group. Attempts were made at emotional closure, as well as at realistic coping after the anniversary.

Session 16: This was the final session, held several days after the anniversary. The mood was upbeat and celebratory, born out of the realization of how strong in caring and support the members had been for each other. Individuals expressed optimism for the future and a desire to network among themselves.

Disasters Caused by Intent to Harm Others

Issues to Consider

Violence by one or more human beings against others casts a shadow of incomprehension, rage, insecurity, and distrust across a community--a shadow that can best be likened to a permanent stain in clothing. It really never leaves the collective fabric of the community unconscious or the minds of the individual survivors. Everyone's personal sense of trust and safety in day-to-day society is shaken. There is a fear that a similar incident could happen again in the community, and that it might even be caused by the same perpetrators if they have been released from confinement. A strident demand for justice is common. If the perpetrators are never caught, then for many survivors there is an even greater sense of distrust, loss, and anger that never goes away.

Consideration must be given to starting new support groups months or years after the disaster. It is not uncommon for other community members who were peripherally involved in but nevertheless exposed to the trauma (e.g., witnesses, those who discovered remains or personal effects away from the disaster site, funeral home staff who prepared or embalmed whole bodies or remains) to come forward for emotional support or mental health treatment long after the disaster. This reluctance to participate in support groups can be due to fears of "I will be thought of as crazy if I tell someone how I feel," cultural biases against revealing strong emotions outside of a close-knit community, a need to support loved ones or friends first over time, or fears of losing a job if one is identified as needing emotional support or counseling.

Example: Bombing of the Alfred P. Murrah Federal Building

On April 19, 1995, an intentional bombing of the Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma resulted in the deaths of 168 individuals in the building, including 19 children. Two suspects were subsequently apprehended and found guilty after jury trials. One was initially sentenced to death and one was initially sentenced to life imprisonment, but both sentences were then appealed. At this writing, the appeals are still pending.

Both CISD and CCRT acute interventional practices were immediately utilized

over the next several days after the bombing. After initial American Red Cross response and involvement with disaster workers, survivors, grieving families, and citizens involved as witnesses and rescuers, many types of support and loss groups were quickly formed. Project Heartland was established to coordinate this community-wide counseling response, and it continues to the present.

Edith King, PhD, a clinical and forensic psychologist in Oklahoma City, volunteered her professional time to initiate two support groups for U.S. Department of Housing and Urban Development workers and Social Security Administration workers who survived the blast despite being in the building. These two groups have run continuously since their inception in the late spring of 1995 and are expected to continue for many more years. Information relating to the disaster, and the descriptions of these groups, are presented below from E. King (personal communication, November 1998).

The members of these two groups were terribly affected by the disaster. They were coworkers and close friends of the deceased; a strong sense of family existed in the two organizations before the disaster. Many of the survivors were injured by the blast, and most were haunted by visions of being near coworkers who suddenly disappeared in the explosion. Intense survivor guilt was an immediate consequence that has lasted throughout the groups.

The two groups began within a few weeks of the disaster. Each group had a core number of 7 to 8 routinely attending and participating members. Because membership in the groups was open, the attendance for a single session could attain 15-17. Group sessions were weekly and lasted for 90 minutes. They were conducted at "safe" places far removed from the disaster site, which was an ever-present reminder of loss, anger, and intense grief. Each group could be conceptualized as going through initial, middle, and later phases. During the initial phase, members described being in a state of shock or emotional numbing, along with disbelief or suspended reality. Time sense was lost. Importantly, members described cognitive difficulties: forgetfulness; getting lost while driving; losing items in the home; or even memory gaps for simple information such as addresses, phone numbers, and birth dates. These difficulties continued into subsequent phases.

During the middle phase, intense emotions were characteristic. Tremendous subjective fear generated by a single thought or sensory perception was common, as were marked periods of depression. Rage and demands for justice in the form of execution of the perpetrators surfaced. The loss of friends and coworkers became magnified as group members tried to reassemble their lives as family members and workers: Loss of confidence in abilities as spouses, parents, or family breadwinners was marked. The fears of being out of control, having no control over one's life, and losing one's mind were themes that

required continued processing in the group. Crying, sometimes for days or weeks on end, was observed in many.

The later phase (which is still continuing) has been a refined progression of existential awareness to the realization that a survivor can begin to rebuild a life; that others in the group do have a vested interest in and care about the welfare of each individual; and, most importantly, that a survivor will never become the person he or she used to be before the disaster. There can be no return to life as it was before the disaster; instead, over time, each member has begun aspiring to "reach a new normal" day-to-day life.

As observed in the groups, significant changes in personality, thinking, and private world views developed after this disaster. Members came to accept that others had truly died and would not return. Denial was a particularly adaptive defense mechanism against grief and loss; it allowed members to experience a sense of hope and optimism over small but important events in their lives.

The group counselor has had to be supportive and realistic, to foster cohesiveness, and to convey honest optimism and altruism. She has had to support the quite obvious group needs for reassurance that members could regain a sense of control and mastery in their lives and that they were not "going crazy." Psychological, emotional, and physical strengths and capabilities were (and are) the focus of emphasis at all times. Past traumatic events as they surfaced and were reported in the group have been acknowledged as previously important in the group members' lives, but the focus has always been on the present ("here and now") and the immediate future.

The lengthy trial process and the publicity surrounding it were constant stimuli for group members' anger, as well as for fears that the perpetrators would be found not guilty and released. Despite the guilty verdicts and stringent sentences, the appeals process remains as an ever-present stimulus for these same emotions.

Finally, no real "closure" has been attained by these survivors. The horrific and incomprehensible nature of the perpetrated disaster has irreversibly altered the lives of survivors--probably more so than in any other disaster type.

Business or Industry Disasters

Mental health care involvement and access to businesses and industries whose personnel--corporate executives, employees, and their families--are affected by a disaster can be quite limited, for obvious medical, legal, union, and disability compensation concerns. Issues of causation and liability may remain indeterminate for long periods of time, and investigations into these issues are sensitive corporate matters. Recounting of specific events, catharsis of strong emotional reactions, survivor guilt, and private philosophical views about fate and

responsibility are common themes during acute interventional debriefings, but participating individuals may fear that their job security and pensions, or possible future claims for disability, will be jeopardized by their openness. Provision of any postdisaster mental health services is solely a decision by the company or industry or its insurance company.

The group therapist who wishes to make his or her services available to an industry or corporation for postdisaster work needs to have a well-based connection with the corporate medical department, the human resources department, and the employee assistance program prior to the incident (Myers & Wolfe, 1996; Sperry, 1996). Time spent working with these departments in the areas of mental health prevention and consultation (e.g., psychoeducation, developing written programs, speaking to worker groups, dealing with psychological aspects of downsizing, etc.), as well as developing a private mental health care practice for the referral and treatment of employees, greatly enhances credibility and the likelihood of being contacted for postdisaster services. Concurrently, group therapists may contact and work with the insurance companies underwriting the specific industry, in the areas of mental health prevention, consultation, and treatment; again, this is with the aim of developing credibility and thus availability in time of disaster. Issues of confidentiality and documentation of care, with explicit understanding of to whom the therapist reports, must be agreed upon.

The more flexible the group therapist can be in terms of advertising to a company his or her ability to design the appropriate interventional debriefing or support group in accord with the company's wishes, the better. The processes observed and the themes discussed in any interventional debriefing or followup support group will be influenced by the basic type of disaster (natural, accidental, etc.) that has befallen the company.

Disasters That Traumatize Children and Adolescents

When a population of children and adolescents is especially traumatized in a disaster, they are the primary focus for all of the community, including grieving and surviving adults.

Disasters That Directly Traumatize: Issues to Consider

After an incident that directly kills or injures children or adolescents, consideration in forming debriefing groups and support groups within a school should be given to preexisting bonds between: (1) classmates/close friends of the deceased; (2) children injured in the incident and their classmates/close friends; (3) uninjured children who were involved in the incident; (4) siblings of deceased/injured children and the siblings'

classmates/close friends; and (5) school workers, faculty, and school administrators. Acute interventional debriefings and possible support groups should also be considered for (as examples) a bus driver or bus company, a train crew or airline company, personnel of the construction company that built a school, medical personnel who cared for injured and dying children at the site or at the hospital, and responders who recovered bodies.

Example: Cary-Grove High School Bus-Train Crash

On the morning of October 25, 1995, a commuter train hit a stopped school bus carrying 38 students to Cary-Grove High School in Carr, Illinois. Seven students were killed and 31 students were injured, several critically. After acute interventional debriefings were completed, two types of support groups were initiated. Philip Kirschbaum, MSW, a therapist in private practice, worked closely with students and staff at the high school and cofacilitated both types of groups. Information on the disaster and the groups described below are from P. Kirschbaum (personal communication, August 1998).

The first group type was a set of concurrent 8-week closed-membership support groups that began within 3 weeks of the crash. There were 8 to 10 students in each group, all of whom were closely affected by the crash. Groups included survivors of the crash and friends and siblings of the deceased students. Members were selected for specific groups on the basis of existing bonds to a specific victim or victims, and the groups mixed all four of the grade levels (9-12). Basic assumptions were conveyed to group members that they would be given support and empathy, that they were to continue learning and progress through the school year, and that they would reintegrate with the rest of their classmates psychologically and emotionally over time. Coleaders for groups included one member from the school (psychologist, guidance counselor, nurse, or teacher) and an outside consultant/therapist.

In these support groups, there was an emphasis on two important areas: (1) telling and retelling what was seen or experienced as a survivor, witness, close friend, or sibling; and (2) sharing coping strategies. These strategies were for such common problems as completing school homework and taking tests, resolving conflicts at home with family members, and reducing symptoms of stress (poor sleep, emotional lability, inappropriate anger, and social isolation). Group members kept journals and shared their entries. Difficulties within families were commonly described. For instance, many of the older students were at an age range where independence from families was being negotiated and navigated. Although they needed their families for emotional support and reassurance

of a general world view of safety, at the same time they chafed at parents and family members who hovered overprotectively for their own needs of reassurance and safety. Many parents who knew the deceased or injured were traumatized themselves by the nature of the disaster. Many group members were also outraged at the intense media (especially TV) involvement, and the perceived intrusion into the privacy and grief of so many students and families.

Symptoms of acute stress disorder were reported. Many students experienced poor concentration, inattentiveness, disorganization in their schedules, forgetfulness, impulsiveness, hyperactivity and inability to sit still, difficulty in completing tests and homework, low frustration tolerance, and poor performance on tests. These symptoms were transient, but the school provided tutoring for students who were especially impaired. These groups were held in school and during regular class time. The members were fed bagels and juice during the groups, and the refreshments were well appreciated. Midway through the 8 weeks, group facilitators held a meeting with parents of the group members. They briefed the parents on the basic issues discussed in the groups; at the same time, parents could describe to what degree their children appeared to be coping and significant problems that remained.

Issues of loss and mourning over the victims, as well as the impending termination of the group, were brought back into focus at the seventh and eighth sessions. After the Christmas holiday period passed and the time-limited support groups were completed, some of the members elected to continue in newly formed long-term support groups. These groups had closed membership, with seven to eight students each. These students included (1) ones who needed continued support over unresolved grief and other school or social issues; and (2) ones who had been seriously injured in the crash and thus could not attend the initial 8-week groups because of required medical stabilization and recovery. Special attention was given to selecting seniors, who would be graduating at the end of the school year. The groups have continued, as students who were freshmen at the time of the crash could continue to participate for the duration of their high school years. The groups did not meet over holiday periods and summer vacations.

Family grief support groups were formed not long after the accident. These were cofacilitated by workers from a local hospice as well as school staff members.

Over the many weeks following the crash, expected and unexpected themes emerged in the various groups. Parents of the deceased, as well as survivors of the crash, wondered whether they had caused the crash by some indirect or direct action on their part; conversely, some parents asked over and over what they could have done to prevent the crash or to prevent their children from taking the bus that morning. Survivor guilt was reported by many

crash survivors and classmates. Several survivors later recounted seeing such phenomena as a white haze, angels, or floating figures dressed in white hovering inside the bus in the minutes following the crash and while trapped in the bus. Finally, many cited a sense of spiritual discovery, belief in a personal god, or religion as a component of recovery.

As the first anniversary of the crash approached, members of ongoing groups, as well as students from the previous short-term groups, reported a resurgence of stress disorder symptoms (e.g., high subjective anxiety, startle reactions, hypervigilance, poor concentration, and easily provoked states of apprehension). These symptoms resolved with processing in groups, one-on-one counseling, and the passage of time.

Disasters That Indirectly Traumatize: Issues to Consider

When there is an incident that causes death or injury to family members of a large number of children or adolescents, among the primary considerations are the needs of the grieving children separate from the surviving adults. There may not be preexisting bonds between the children and adolescents, as often the nature of such an incident involves families from many neighborhoods in a large city or from many disparate communities. Acute interventional debriefing groups may be conducted centrally, such as at a transportation hub where families gather, or peripherally at community centers or schools. Subsequent support groups may be conducted peripherally but at locations convenient for a number of communities to use. Group cohesiveness is a special challenge for the facilitator working with children and adolescents in these situations.

Example: USAir Flight 427 Crash (Children's and Adolescents' Support Groups)

A child or adolescent is a traumatized survivor when an accidental disaster takes the lives of one or both parents, one or more siblings, or extended family members. Sue Wesner, MSN, from University of Pittsburgh Medical Center's Services for Teens at Risk (STAR) Program, led support groups for children whose family members were killed in the crash of USAir Flight 427. These groups were based upon the program's work in schools affected by sudden deaths (Kerr, Brent, & McKain, 1997) and are described below (S. Wesner, personal communication, October 1998).

Children aged 4 to 8 years, and those aged 9 to 16 years (predominantly 13 to 16 years), constituted two separate populations from which to draw support groups. Each group was run weekly for a time-limited block of eight sessions, but they were then repeated in subsequent 8-week blocks. The groups for the younger children generally lasted for two to three of these blocks. The group blocks for the older children/adolescents were repeated

over and over for approximately 18 months, as, developmentally, their experiences of loss and mourning required a much longer, more adult-like period of processing.

In all groups, fostering a sense of safety and security was a basis for then encouraging the members to talk about their families, what they themselves were doing at the time of the crash, what happened in their households and their schools after the crash, and how others reacted around them. This allowed for a shift from the facts of loss to feelings of grief and sadness. As the groups progressed, discussion of feelings was supplemented by discussion of worries and concerns. These included fears that a surviving spouse and children would become poor, especially if the deceased parent had provided the main source of income; worries about whether a surviving parent would ever remarry (and, if so, that the surviving parent would forget, in the eyes of a child, the deceased parent); and frustration and anger that everyone expected a child or adolescent to do well in school and in activities as if nothing had happened. As noted earlier, some victims' remains were never identified; thus some children could not visit a specific family gravesite.

The longevity of the groups (repetitive 8-week blocks for 18 months), the ability to recall and rework issues of loss and abandonment, the space and time to process initial feelings, and the need to come over time to accept the actual death(s) of the parent(s) were all allowed to be experienced again and again through the repetition of the groups. This led to a progressive mastery of developmental obstacles and emotional hurdles resulting from the disaster.

Anger at USAir for causing the loss of the children's parents was a very palpable emotion in the groups. One innovative way this was dealt with was in a specific ritual 6 months after the disaster: The members jointly created a large poster of USAir and then threw balled wet paper towels at it in anger. This seemed to aid in creating a sense of power over their grief and anger at the question most angrily asked in these groups: "Why did this happen to my [parent]?"

Suicidal ideation was not common, but did appear at times in a member's wanting to die, so that the deceased parent would not have to be alone any more. Realistic support along with gentle probing of the feelings behind the wish were helpful in ensuring that such ideation did not develop into worrisome proportions.

A sense of sadness was described by many members when they described how a deceased parent's extended family stopped visiting over time. This led to discussions in the groups of a sense of confusion and further loss, especially when there were close attachments to extended family members.

Reappearance of grief and sadness, as well as difficulties in school and learning, were transient but expected at the time of important family holidays and birthdays,

and especially as the 1-year anniversary of the crash approached. At that anniversary, the groups visited the memorial constructed at a large nearby cemetery where many victims were buried. Some children read letters to their deceased parents; some planted small trees in remembrance; and some left important belongings that were felt to provide a special connection and accompaniment for the deceased parents.

Other positive aspects of the support groups were the social connections that they allowed the members to make. Friendships developed over time, and some of the group members kept in touch long after the formal groups had stopped.

THE GROUP THERAPIST IN DISASTER MENTAL HEALTH WORK: LIFE, PRACTICE, AND TRAINING CONSIDERATIONS

A group therapist should be in good physical health, because physical endurance is challenged when many single-session acute interventions are required for potentially long hours at sites of disasters, far from the comforts of an office and in possibly harsh environments. Adaptive aspects of mental and emotional health include a stable personality; the capacity for controlled reactions to stressful life situations in general; a minimum of current life stressors, such as family or professional strife or change; and a past history of personal exposure to traumatic events that has been sufficiently resolved over the passage of time, as well as with personal therapy if needed.

Considerations for professional practice include the type(s) of practice the therapist currently conducts; the flexibility for making sudden changes to practice schedules (salaried vs. private practice); the types of patients seen in the practice, and their general ability to adapt to sudden therapist absences; and the financial needs and goals of the therapist balanced against sudden changes to schedules. A therapist who is more comfortable with a narrow focus of practice and relative control over clinical situations--for instance, analytic groups or long-term psychodynamic groups--may not be well suited for much disaster mental health work. In contrast, a group therapist who remains eclectic and adaptable to conducting different types of groups (both short- and long-term), and can weather unpredictable patients and clinical situations, is likely to be better suited for this work. Other professional considerations include specific skills in disaster mental health work--in particular, past training in conducting acute interventional debriefings and accumulated experiences in previous civilian, government, or military disaster or trauma work with individual patients or groups. Skills in providing organizational leadership, public speaking, and working with the media are important as well.

Also helpful are consultant positions or therapy practice arrangements

with emergency response organizations (police, firefighters, emergency medical technicians); community disaster response organizations such as the American Red Cross; social services or community mental health organizations; school districts; local transportation industries with disaster potential (airports, railroad centers, shipping ports); industrial corporations or factories with disaster potential (e.g., chemical or munitions manufacturing, foundries); nuclear power utilities; and military bases with an emphasis on weapons installations, ships, air transport, and hazardous duty training commands. Geographical or environmental considerations, especially if the therapist lives and/or works in areas and communities vulnerable to extremes in weather or other natural phenomena, can be very important.

Finally, a group therapist who is a survivor of a disaster (e.g., family members are injured or killed, a large number of patients are injured or killed, a home or office is destroyed) should in general shed the therapist role, and instead should participate in acute and subsequent groups as a survivor and allow other therapists to facilitate the groups. In contrast, a group therapist who has not been personally affected by the disaster should be able to function as a group facilitator.

Myers (1994) provides a valuable and comprehensive discussion of the preparation, roles, work, and self-care of mental health workers in a disaster setting. She also addresses the extremely important issue of group leaders /facilitators being debriefed themselves periodically throughout the practice of acute interventional debriefings and support groups. This process of "debriefing the debriefers/facilitators" was utilized in all of the postdisaster group settings described in detail in this chapter.

The field of disaster group mental health work continues to develop. The type of disaster and demographics of those involved will help determine the types of interventions that will be most helpful. In a general sense, however, in virtually every situation, a combination of acute interventional groups followed by support groups will benefit those who are affected by the incident. For the mental health professional with the motivation and temperament for it, disaster group work can be very rewarding and is an excellent way to serve the community.

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RESOURCES

Group therapists interested in acquiring training in acute interventional debriefings should contact either the International Critical Incident Stress Foundation (Unit 201, 10176 Baltimore National Pike, Ellicott City, MD 21402; (410) 750-9600) for CISD qualification (local city, regional, or state disaster management or emergency response services may also sponsor CISD training), or the National Organization for Victim Assistance (1757 Park Road N. W., Washington, DC 20010; (202) 232-6682) for CCRT qualification.

The National Mental Health Services Knowledge Exchange Network (P.O. Box 42490, Washington, DC 20015; (800) 789-2647; ken@mentalhealth.org)--sponsored by the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration--provides numerous free-of-cost, excellent DHHS publications and videotapes on many aspects of disaster mental health services and programs. The Knowledge Exchange Network will send a catalog from which orders can be placed.

All persons listed in the **Acknowledgments** section are willing to be contacted

directly in writing or by telephone for specific information; some have provided telephone numbers above for ease of contact. Some citations in the **References** section are especially noteworthy for their comprehensive discussion of theory and practice in disaster mental health (Lystad, 1988; Myers, 1994), support groups of all types (Wee, 1994), and session-by-session description of the entire life of a support group after a natural disaster (Paolercio, 1993).

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