Crisis Bereavement Group Intervention Guidelines
Protocol for Mental Health Professionals
in a Post-Secondary Educational Setting

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Purpose

The suicidal, homicidal or accidental death of a peer or other critical incident/traumatic event invariably creates a significant stress response among those associated with the deceased. However, Gilbert (2005) wrote that "studies of those who survive major traumas suggest that the vast majority do quite well, and that a significant portion claim that their lives were enhanced by the experience." On the other hand, Brent and colleagues (1996) found that peers peripherally involved–or at least those not thought to be affected by the death–could be deeply affected. It is the view of this writer that maladaptive behavior such as substance abuse, recklessness, excessive anxiety, depression, suicide, and other forms of pathological bereavement may develop or be exacerbated in the absence of adaptive coping skills, positive social support and a desirable resolution about the event. A focused psycho-educational group debriefing, as described in this document, is suggested whenever there are reasonable concerns about the student's social, emotional and/or cognitive adjustment to the death event. The extent to which these outcomes are predicted to occur or not occur is the extent to which this particular clinical intervention is recommended and utilized.

Background

Crisis Bereavement Group Intervention (CBGI) is the name of the suggested clinical intervention. The CBGI model was developed by this writer in 1996. It has undergone many revisions in order to integrate useful concepts that have emerged in the field of counseling individuals after a critical incident or sudden death event. However, there are several aspects of the CBGI model which are similar to the Critical Incident Stress Debriefing (CISD) model developed by Jeffrey T. Mitchell in 1974. First published in 1983, the revised version of the CISD model (Mitchell and Everly, 1996) consists of seven phases: Introduction, Fact, Thoughts, Reactions, Symptoms, Teaching and Re-entry. The CBGI model consists of twelve phases: Initial, Organization, Introduction, Fact, Ventilation, Validation, Prediction, Meaning, Sublimation, Affiliation, Re-entry and Follow up.

Goals

The goals of CISD are to reduce the impact of the traumatic event and to accelerate the normal recovery process. The goal of the CBGI model is to minimize the development of an undesirable resolution about the critical incident and to do so in a way that will support the natural recovery process. CBGI shares similar goals and includes some of the key components of CISD: early intervention, sequential structure**,** group process, ventilation, validation, prediction, education, and social support. Both utilize the stabilization and normalization principles of crisis intervention.

Structure

Although some of the same names have been used to describe the phases of this model of intervention, there are several differences with the CISD model. The CISD model is primarily used to debrief members within a specialized profession such as law enforcement, fire service, emergency medical technicians, military, and other homogenous groups during the period of 24 to 72 hours after their traumatic exposure. The CBGI model is written to provide either delayed (the following day) or immediate assistance to students in a college setting. Immediate assistance (offered within the first few hours after exposure or notification), when effectively provided, may serve to significantly diffuse the harmful effects of the traumatic experience.

There are other aspects of the CBGI model which are also different from CISD. CISD is led primarily by a trained peer associated with the same specialized profession that is receiving the intervention and a mental health professional who takes a rather less active role. The CBGI model is intended to be facilitated solely by school personnel who are also licensed to provide mental health counseling. Both types of the CBGI intervention (defusing or debriefing) are longer and more intense than CISD. Unlike some of the aforementioned groups which may be required to participate in CISD before returning to service, CBGI is not at all imposed upon individuals thought to be affected. It is offered to similarly affected students (not necessarily homogenous in composition) who voluntarily elect to attend. The fact that students agree to attend does not also mean that those same students are expected to actively participate.

CBGI has additional phases and methods of intervention that are not included in the CISD model. The CISD model focuses upon predicting and preparing for stress reactions in adults. The CBGI model focuses on a college student's self-concept and worldview as it relates to the event.

CBGI reinforces and promotes seven of the eight adaptive defense mechanisms identified by the American Psychiatric Association (2000): self-observation, anticipation, self-assertion, sublimation, altruism, affiliation, and the appropriate use of suppression.

These guidelines are written in a sequential format for use by qualified personnel to provide mental health assistance to groups of acutely stressed, traumatized or grief-stricken students. The primary purpose of this intervention is to help students react and recover from extra ordinary stress with a lesser propensity for the development of major depression or a major stress/anxiety disorder. This is accomplished by having students understand what happened, express their emotions, feel understood and validated, and cognitively incorporate the event so that they are able to maintain a positive opinion of themselves and an unimpaired worldview. Students are helped to predict and prepare for their immediate future. Students are also encouraged to link up with friends and family members for additional support. When the event has been positively processed, the students are more able to return to their normal school routine and normal level of academic functioning.

These ideas are written with the assumption that the working conditions are ideal. For example, the traumatic event is over, there are enough adequately trained counselors available, and the ancillary staff are aware of their roles and support the intervention process.

Timing and Efficacy

In situations where the intervention is offered in the immediate aftermath of the event the goal is to defuse those students who come forth, beginning in the Initial phase. In situations where the intervention is delayed by one or more days, this model can be initiated as a debriefing of students, not defused but presumed to be affected, beginning with the Organization phase.

While circumstance may not allow for a choice there are advantages and disadvantages to the timing of either intervention. In a debriefing, time has passed and attitudes have been formed. It is a more intellectual process; however, because of the time delay one's memory of the event is fuzzier. Most who are present are relatively calm and in control of themselves unless negative emotions are triggered and reactivated by a detailed discussion of the event. Those who predict that their attendance and participation in a debriefing will cause them to lose their established sense of complacency may view a debriefing as potentially harmful and may choose to avoid participation. In fact, Mitchell and Everly (1996) specifically do not recommend an intervention during the period of 8 to 24 hours after exposure or notification. They have observed this to be a common period when trauma victims are rigidly defended against suggestion as they attempt to stabilize and reorient themselves. Since this intervention is not imposed upon students at any time, those who attend are present because they feel the need to be present. Therefore, it would seem that the benefit of a debriefing is that it is provides assistance to only those who really want and need to talk. However, the clinician should not assume that a delayed intervention naturally screens for all who still need to talk as it does not account for those who still need to talk but choose not to.

According to Genova (2021): "Nascent [episodic] memories are highly susceptible to influence and creative editing, especially during the period–hours, days and longer–when these memories are being consolidated, before they're committed to long-term memory." She also states that "self-instruction" can derail (unwanted) consolidation before new memories are fully created and that this type activity can activate "neural signaling programs that deliberately erase [newly formed] memories." As such the benefit of defusing is that it may allow skilled counselors to define, shape or influence emotional reactions, and cognitive integrations of the event before they may be negatively defined, encoded and consolidated (in different memory systems) and this could occur with less resistance. However, the facilitator needs to understand that the process of defusing can be quite powerful in a positive or negative way depending on how it is conducted. A discussion that unintentionally includes unwanted details and lurid images must also include a thorough and effective discussion that helps students to appropriately interpret what they saw or experienced and come away from the experience with a view of themselves and the world that is neither maladaptive nor impaired by the event. The following three paragraphs provide an integration of established neuropsychological science with this writer's hypothesis of the benefits of defusing.

It has been said that the human brain has very specific networks for processing and remembering life-threatening events. Genova (2021) states that memory for information and experiences of the day gets locked in during sleep. Ross and colleagues (1994) discussed a

link between the REM (rapid eye movement) phases of deep sleep and PTSD, speculating that “PTSD involves a fundamental REM sleep disturbance.” Strickgold (2008) stated that REM sleep “processes explicit emotional memories” and “these sleep-dependent processes” are both subtle and highly sophisticated. According to van der Helm and colleagues (2011) during REM, emotional memories of the day are re-activated in amygdalar-hippocampal networks which in turn interact with the prefrontal region of the brain. McNamara (2011) in referencing this study reports that the natural or normal course of this re-activation process is that the distressing memories are stripped of their arousing capacities before being stored in long-term memory systems. He further states that this natural process effectively decreases the “overall intensity of negative emotional memories” and that this is “crucial to daytime emotional regulation.” Van der Kolk (2014) stated that “PTSD is notoriously associated with disturbed sleep” and has observed that traumatic memories are activated and processed, primarily during REM sleep. Furthermore, Finkel (2018) wrote, after interviewing Gina Poe a neuroscientist and sleep researcher at UCLA that “it might be best, for example if exhausted soldiers returning from harrowing missions did not go directly to bed. To forestall post-traumatic stress disorder, the soldiers should remain awake for six to eight hours. …that sleeping soon after a major event, before some of the ordeal is mentally resolved, is more likely to turn the experience into [undesirable] long-term memories.” It seems reasonable to apply this same line of thinking and approach to mortally-threatened students in an academic setting. Thus, if a traumatized student (with an unwarranted cognitive appraisal) retires for the evening while (according to Poe, 2019) his or her sympathetic nervous system remains activated they likewise, may be “more at-risk” for developing PTSD.

Persistent and negative alterations in cognitions of self and/or the world are typically associated with PTSD (American Psychiatric Association, 2013). Shapiro (2001) states: “The very existence of negative cognitions is an indication that the traumatic event is a powerfully defining factor in the person’s life, one that has yet been adequately assimilated into an adaptive framework.” Shapiro refers to the same communication framework/network noted by van der Helm and McNamara as the “innate/adaptive information-processing system”. Shapiro asserts that when this system of adaptive (and maladaptive) processing is properly activated by the clinician, the clinician can rapidly and very effectively facilitate the resolution of a persistent and negative view of self and/or the world that has been stored and blocked for months or years. This innate information processing system, albeit maladaptive heretofore in the case of a particular traumatic memory, now becomes an “adaptive” information-processing system for that particular traumatic memory through a successful clinical intervention.

This writer speculates that defusing offers a brief but potentially advantageous opportunity for a skilled clinician to supplant or pair negative cognitions with neutral or positive ones before such undesirable cognitions may actually be installed in the innate information-processing system. In other words, having students explicitly think about and internalize a convincing view of themselves and the world that is adaptive despite the event, and at the earliest possible opportunity, may enhance their chances of a positive or innocuous neuro-integration of the event. Achieving this prior to the student’s first REM period would be ideal as this could proactively provide calming and taming information for the innate information-processing system via its natural and active communication during REM. Furthermore, having a positive or innocuous view that is linked to the event can also provide the student with an explicit and

adaptive counter thought to draw upon, if and when the memory of the event is ever triggered by a reminder. This is a critical task for the clinician to accomplish in the Meaning phase.

In a study of adults, North and her colleagues (1999) observed that symptoms of PTSD most often developed within the first twenty-four hours. Mitchell and Every (1996) state that victims are “very open to help” in the first three hours and there is “some evidence which suggests that an immediate intervention is more beneficial than waiting until the usual twenty-four hours.” One of the most comprehensive analyses to date on the effectiveness of different proactive interventions with adults and PTSD outcomes, including the use of CISD, was conducted by the Agency for Healthcare Research and Quality (ARQH) in 2013. The ARQH analyses reported on one study showing that an “Immediate debriefing (within 10 hours) compared with late debriefing (after 48 hours) led to victims experiencing significantly fewer posttraumatic symptoms.” If given a choice, the findings reported in the ARQH analyses, as well as the observations of Genova, Ross, Mitchell, North, Stickgold, van der Helm, van der Kolk, Poe, and their respective colleagues would implicitly (if not explicitly) suggest that it is more effective and favorable to defuse (in a careful manner) than to debrief. Indeed, the ARQH study (2013) concluded that CISD is not an effective prevention intervention based on studies where the intervention was offered nine or more days after the event. However, CBGI, which differs from CISD in its focus and intensity, should be offered to students as soon as possible after the event.

There have been many criticisms of CISD, ranging from those who believe it is simply ineffective to those who believe CISD can actually be harmful. Well-intended counselors who naively solicit lurid details may incorrectly believe that this activity when conducted within a CISD session is therapeutic in and of itself. Re-experiencing the event through a naïve discussion that neglects to provide for an effective interpretation of the event greatly increases the risk of secondary or vicarious trauma.

To the best of this writer’s knowledge, there is no evidence-based intervention protocol in existence at this time that is recommended for students in the hours or days following a school shooting, student suicide, other sudden death, etc. At the same time clinicians practicing in a school setting are expected to help groups of highly distraught students.

The following quote from William Modzeleski, former Associate Assistant Deputy Secretary at U.S. Department of Education seems to underscore the argument for doing some type of clinical intervention with students. “There really hasn’t been any research in the U.S. that has taken a look at what is the most effective way to respond in the aftermath of a shooting that has occurred in a school... One thing we clearly know from all these disasters is: There are kids that are hurting, there are faculty who are hurting and there are parents who are hurting. Without some help, teaching and learning can’t take place.” Until something else is developed and tested, this writer believes that his untested evidence-informed intervention model seems to be a very worthwhile intervention for groups of highly distraught students.

Implementation Guidelines

In all situations, movement from one phase to the next is a flowing, gradual and non-discrete process. If this is a large group intervention, individual variability in the progression of grief work cannot be as thoroughly attended to as it could on a small group or individual basis.

Therefore, the facilitator will have to determine the general pace of this group progression. Those who appear unable to move at the determined pace may need to be assisted within a smaller group or on an individual basis. Whatever the size, the sequential format should remain the same however, the facilitator should use discretion in deciding which tasks within the following phases are necessary and should be included in the intervention and which tasks are not necessary.

Initial phase of intervention

The duration of this initial phase of this intervention will depend upon the nature of the incident and its impact upon the students. There are two basic types of incidents; high and low impact. High impact incidents involve situations in which the students were closely associated with the death or felt mortally threatened. Low impact incidents are those in which students are notified by an announcement, social media or word of mouth of a death event and feel so distressed by this information that they are unable to maintain an educational focus.

The first priority in a high impact incident is to establish a safe and secure place for the students to gather. Ancillary or crisis intervention staff should limit the extent of the sensorial effects of the incident by quickly removing the students from the scene where there is additional exposure or reminders of the incident. Some students may have neurological or visceral reactions to something they witnessed. For example, they may experience cataplexy, hyperventilation, a sudden change in heart rate, dizziness, lightheadedness, pallor, profuse sweating, nausea, vomiting, etc. Extreme emotional stress or any painful or unpleasant stimuli such as watching someone experience severe pain, the loss of blood or simply seeing a pool of blood can bring about a vasovagal syncope (fainting) response (American Psychiatric Association, 2000). Move less effected students away from those who seem to be having a bodily reaction as witnessing such sights of others is highly disturbing in and of itself. Encourage the physically distraught students to sit down. If these students complain of feeling dizzy, lightheaded, or otherwise report or appear as if they are about to faint quickly have them lie down on their backs and instruct them to elevate their legs or knees above their chin; and to take slow deep breaths. This instruction will help to resume proper blood and oxygen flow to the brain, reduce the potential for actual fainting and preclude any injury from falling down from a standing or sitting position (American Medical Association, 1994).

It may be necessary for available counseling staff to help other excessively anxious students to calm down, especially if a student needs to move away from the scene. Such students may be instructed to try one or more self-calming techniques. For example: grounding; mindful-breathing; progressive muscle relaxation; positive visual imagery; positive self-talk; use of peripheral vision, etc. Reassurance should be offered when practicable. For example, it may be helpful to calmly say: “I’m here for you”, “You’re going to be okay” or “The worst part is over now”.

The decision to have students remain in or near the high impact event will of course depend first and foremost on safety concerns as determined by the police, emergency personnel and school administrators. It is quite likely that in a high impact event many students will have naturally dispersed and gathered with friends and school staff nearby or away from the campus. It is highly unlikely however, that a school-based mental health professional would be asked or expected to provide a formalized clinical intervention at this early stage of a high

impact event. Conversely, clinically diffusing students in the wake of a low impact event is actually rather common. This is especially common with the close friends of a deceased student. If it has been determined that a clinical intervention is warranted with a particular group of students those students may be directed to a support center or drop-in area. Depending on the nature and impact of the event students may either be verbally encouraged or physically escorted to the support area. This area should be a relatively private location and free of any unrelated intrusions.

The atmosphere in the designated support center or drop-in area may become rather chaotic. There may be students entering the room individually or in small groups at different times. Many will be hugging each other and crying, etc. As more individuals enter the room, emotions may be reactivated in those who have settled down.

The leaders must remain calm and encourage the students to stay in the room the crisis team has set aside for the students. After a period of milling about the room the leaders should go to an area within the room where they can remain visible to the students yet have a degree of solitude. If a controlled discussion is planned then this is the time for the leaders to begin to formulate and write down some questions for the students to address. However, such initial questions may be modified if this protocol is followed as a debriefing.

Organization phase

The purpose of the Organization phase is to determine which staff will do what, where, when and with whom. It is recommended that there be two counselors assigned to each group. The counselors should consult over various operational concerns. For example, one counselor will take on the facilitator role while the other counselor will take on the less vocal and subordinate role of the co-facilitator or “scribe” (Young, 1998). Students are more likely to comply with directives and let themselves be helped by a facilitator who seems confident, relaxed, sympathetic, non-judgmental, respectful and capable of taking control of the group. The facilitator determines the pace and intensity of the intervention, asks questions and makes comments to the students. The scribe provides emotional and practical support to the facilitator, records notes on a large writing surface, and contributes in other ways when called upon by the facilitator. The scribe should have a copy of the facilitator guidelines outline. This will help him or her to know when and how to participate in this intervention.

The counselors should also decide whether to divide the group. For example, separating those who felt mortally threatened or witnessed the death from those who did not or those who personally knew the deceased and those who did not, etc. These delineations could allow for a different intensity of intervention and focus of discussion.

The counselors should then decide who will go where, and assess whether pre-established plans for other support staff are ready to be implemented. Chairs should be arranged so that the students can sit in a semi-circle around a flip chart, dry erase board or chalkboard. The facilitator and scribe should sit near each other (and the writing surface) so that they may, in a subtle manner, consult with each other as the intervention process progresses.

When the counselors have determined to move the students from the phase of spontaneous emotional expression to a more controlled discussion, an announcement should be made by the facilitator. Audibly firm yet compassionate verbal instructions are given to the group so

that students “who have questions, are really upset or just want to talk about what happened” can be directed to take a seat or if necessary, referred to an appropriate sub-group and directed to another room.

Additional arrivals to the support center could be greeted by ancillary staff and directed to either group area. However, it is important to establish with ancillary staff a time period when the groups will be temporarily closed to new arrivals. Students arriving after a group has been closed could be assigned to the next available group. Ideally the starting times of additional groups should be offered on a staggered basis to accommodate new arrivals.

If this intervention is a debriefing then the leaders can deliberate over recommendations given in the first three paragraphs in this section; including modifications to any questions or statements that may have been developed during the Initial phase. Students considered to be affected should be contacted and invited to attend and participate in this intervention.

Introduction phase

The counselors should introduce themselves to the students and begin by making some statements about the nature and purpose of the meeting. If students have been victimized by their exposure to the event Young (1998) suggests telling the group: “I am sorry this happened to you.”

For most students, this may be their first psycho-educational type group experience. It can be said that the purpose is for students to listen and learn from each other, and if they choose, to talk about their own thoughts and feelings. State that this is being done in “a group setting with peers” because it has been found to be “the best way to help people who have experienced this; type of loss, crisis, event, etc.”

Describe the agenda or give examples of the questions that may be asked. State that, if they so choose, they can talk about their thoughts and feelings and ask any questions they might have. They should also be told that what they have to say may be helpful to someone else present. State that there may be periods of silence.

Define what the desired outcome is so that students will have a sense of what will be expected of them. This will also help them to know if and when they have been adequately helped. For example, state: “At the end of this time together, you will likely be feeling well enough to go home and relax for the remainder of the day/evening.”

If there has been a delay of one or more days, it would be best to say: “At the end of this time together you will have a better understanding of your thoughts and feelings about the tragedy that took place yesterday.”

Define the roles of the scribe and the facilitator. The scribe “listens and writes things down on the board.” The facilitator “asks the questions and makes comments.” The facilitator should also state some ground rules. For example, state:

> Please be respectful of others in the group; remain attentive and listen, do not interrupt someone who is speaking and wait for your turn to speak. This is a voluntary activity so those of you who do not wish to talk can remain silent or simply say ‘pass’.

If this intervention follows a high impact event a discussion of the event may provoke a high level of anxiety. The facilitator may acknowledge that some in the room may feel anxious about things discussed and then present information on self-calming techniques (as described in the Initial phase) to be used any time they begin to feel excessively anxious.

Be aware that participants who choose to say “pass” may benefit from this group experience just as much as those who speak up. However, it is generally a good idea to draw everyone into the conversation and to do so as quickly as possible. Begin by passing around a clipboard sign-in sheet. At the same time ask everyone to speak up and introduce themselves either randomly or by taking turns within the circle. This could be their name plus another bit of information about themselves. For example, they could be asked to state their relationship to the deceased, how long they knew him or her, etc. If the group is large (20 or more), time may not permit this introduction method. In large groups, initial questions should be directed to anyone in the group who would like to speak up.

Fact phase

The purpose of the Fact phase is to discuss what happened and what the students observed. Even though the event may have a clear onset and course to an outsider there may be a great deal of ambiguity to those who were subjectively involved. According to LeDoux (1996), when there is a critical incident involving a mortal threat many of the exposed students may remember the emotions and physical reactions to the event but not recall important factual information. During moments of fight/flight/freeze the unconscious survival functions of the brain override the executive functions involved in conscious recall (LeDoux, 1996). A discussion about the facts can help the student to make a better cognitive connection to the feelings they have as a result of the event. Some students may have questions about what they have been told. Allow everyone the opportunity to ask for more factual information if they seem confused so that they are clear as they can be about what actually happened.

Students who witnessed the death or were present at the event could be asked to share where they were or what they generally observed (saw or heard). Do not attempt to draw out specific disturbing images or lurid details of the event. The goal later (in the Meaning phase) is to address student interpretations of what (at this juncture) is reported as a general observation or experience. Keeping similarly exposed students together minimizes the chance that the lesser exposed students will become vicariously disturbed by what might be disclosed and described by those who actually witnessed the event. Many who respond to the question: “Where were you when it happened (or, when you heard about it)?” may also talk about what they experienced cognitively and sensorially. It may be helpful for the scribe to diagram the scene and for the facilitator to encourage the students to identify their location within the scene.

In lieu of a diagram, a discussion about the facts and early observations of the incident help to identify the proximity of the students to the incident. This may also show others in the group that they are not alone in the way they perceived the event. It is also possible that this activity may cause some to view the event from a different perspective and consequently have a greater understanding of the event. Gilbert (2005) asserts that information acquired after an event can alter the memory of the event. Listening to others helps students to more accurately fill in details that, for whatever reason, they are not readily able to recall.

According to Gilbert (2005) “Distorted views of reality are made possible by the fact that experiences are ambiguous.” If there is ambiguity about the death event arrange to have an authoritative source enter the room for a few minutes to present factual information. Students should be encouraged to share what they generally observed and what they believe to be a fact not mentioned. Having students report on what they observed gives the authoritative source an opportunity to respond to distortions, exaggerations, rumors and incorrect speculations with the known facts. However, some students who were eyewitnesses may have information that the authoritative source should report to others or verify and return later with an update for the group.

After the facts have been officially established, it is inevitable that such new or restated information may confirm the worst and trigger more of the same or different emotions. Movement forward to the Ventilation phase may occur spontaneously since many may talk about what they experienced in addition to or in place of what they observed. It may be necessary for the facilitator to bring students back and forth between these two phases until all who want to address the questions in the Fact phase have had a chance to speak.

Ventilation phase

The purpose of the Ventilation phase is to discuss what the students experienced physically, behaviorally, emotionally and cognitively. This includes initial reactions and any additional reactions that occurred between the onset of the event and the present moment.

Those who are overtly disturbed should be allowed to speak up first if they show an interest in talking. If a student seems overwhelmed with emotions and unable to speak the facilitator should acknowledge that they seem visibly upset and state: “When you are ready to speak up, we want to hear from you”. If any student is excessively distraught and unable to calm down within a reasonable period of time the scribe (when cued by the facilitator) should escort that student out of the room and link him or her up with a counselor for one-to-one attention.

Other students may spontaneously share what they did (to survive or handle the situation), felt, or thought during and immediately after exposure or notification of the event. The benefit of hearing how others felt and reacted is that it can have a normalizing effect on those who can personally relate to what they hear from their peers. (Emphasis upon this is more formally addressed in the next phase.) As initial actions and feelings are recalled and disclosed the scribe writes down the words and phrases given by the students. Young (1998) recommends that the scribe uses succinct phrases that capture the essence of student’s stated physical, behavioral, emotional and cognitive reactions to the event. Encourage students to put their feelings into words. Allow them to name their own reactions. This activity should be done in full view of the entire group. Student names should not be associated with the statements. With a large group, the facilitator may ask for a show of hands as he or she reviews a list of reactions.

Be aware that every student has a story to tell. It is critical that everyone who would like to speak is given enough time and has the full attention of the group. The scribe and facilitator should listen intently to those who are speaking. When there is a pause acknowledge what was talked about. Although not all who are present will feel comfortable speaking, their story

should to be said to someone–now or later. However, in large groups, time may not allow for disclosures lasting more than a minute or two.

In some groups the majority of students may be quite reticent. Their thoughts and feelings may need to be drawn out. If this appears to be the case ask for a response you would expect. For example, ask: “How many of you felt (or feel) surprised that this happened?” Or: “How many of you feel like you have lost a friend?” Having students raise their hands will show them how prevalent their feelings are among their peers. Observing similar responses from their peers will affirm their feelings and may promote further disclosure. Ask: “What other reactions have you had?” Other common reactions to solicit and have the scribe note may be: fear, confusion, anger, self-blame, or sadness.

If there is a time delay between the event and this intervention students will have had time to reflect upon their own behavior at the time of the event. Consider asking: “How do you feel about the way you acted at the time?”

For many students there is–on a rather philosophical level–an aspect of the event that is most disturbing or confounding. Mitchell and Everly (1996) suggest asking the question: “What bothers (or troubles) you the most about this event?” Answers to this type question should not be a disturbing image or lurid detail. Instead be prepared to look for and/or address issues of loss, disillusionment, a sense of personal inadequacy or other shattered assumptions or beliefs about themselves or the world. According to Peterson and Straub (1992) some specific examples of shattered assumptions are the loss of the following: a sense of immortality, positive self-regard, control over one's life, trust in God, trust in the school, a branch of government, a sense of fairness, a feeling of security or well-being. Shattered assumptions could specifically be evoked by asking: “Has this event caused any of you to think differently about yourself or the world?”

If there has been a time delay between the event and this intervention ask the students to comment on outstanding memories. It would also be helpful to also ask: “Since the time it happened how have you been acting or thinking?”

Students should be encouraged to speak only if and when they want to so. The safer they feel about talking the more natural and free-flowing the discussion may be. Those who have been reluctant to speak up may benefit from your response to the more vocal students with whom they are identifying. Therefore, resist the temptation to draw out the feelings of those choosing to remain silent. If there are periods of silence it is equally important to resist the impulse to immediately fill in the silence with your own comments. Students invariably speak up when the facilitator shows a willingness to remain silent during periods of silence.

When it appears that the expected range of physical, behavioral, emotional and cognitive reactions have been disclosed by all who wish to speak the facilitator should begin the validation process. Although the Ventilation phase is identified as the time to formally address powerful affective and cognitive reactions, such reactions may surface in subsequent phases. With this in mind, the facilitator should be prepared to return to interventions noted in the Ventilation phase whenever students show the need to express themselves. Regression back to previous phases can be minimized by keeping the group closed to new arrivals, thoroughly

assessing whether students are addressing the tasks associated with the phases, and by establishing an appropriate pace.

Validation phase

The purpose of the Validation phase is to affirm student reactions to the incident. Repeat key elements of their stories back to them. Emphasize that most types of reactions are not unusual and that each person's experience is unique. Use their words (particularly those written by the scribe) in your response. Apologize if you use words that a student has indicated are inaccurate for their situation. Encourage a sense of validation from others in the group. Young (1998) states that this can be done by asking: "Did anyone else have a similar experience?"

If this intervention is being offered in the wake of a high impact event, physical and behavioral reactions may have been previously noted by the scribe in the Ventilation phase. Some students may not have had, or recall, a significant physical or behavioral reaction. Low impact events are more likely to be initially experienced in emotional or cognitive ways.

Review and summarize emotional and cognitive reactions and emphasize the similarities between the various student responses. These responses may include those previously listed by the scribe in the Ventilation phase. For example; fear, confusion, anger, self-blame, or sadness.

When the facilitator is ready to discuss these responses, they could be categorized by the scribe as "disorientation/physically frozen/unable to act", "runaway/hide" or "attack/fight." Initial thoughts and emotional reactions could be categorized as "rush of emotions." In doing so the students can see how common and typical their reaction was. Placing blame on the innate actions of the nervous system rather than on the person takes away a sense of personal responsibility and related guilt for inaction or escape behavior; perhaps their only viable option under the circumstances.

If this intervention is being offered in the wake of a high impact event, and there has been a time delay between the event and this intervention, many of those present may have already experienced some additional reactions to the event. These reactions may be early indications of posttraumatic stress disorder. Horowitz and his colleagues (1979) developed the Impact of Event Scale (IES) to assess the impact of a traumatic event. The following questions, appropriate for the facilitator to address in a debriefing, are drawn from the IES:

> A.) Has anyone been having a little trouble falling asleep or staying asleep because pictures or thoughts about it come into your mind? Has anyone been having dreams about what happened? Has anyone been having trouble concentrating? Having waves of strong feelings about it? Have pictures of it pop into your mind? Thought about it when you didn't mean to?
>
> B.) Tried not to think about it? Tried not to talk about it? Tried to remove it from your memory? Stayed away from reminders of it? Felt as if it hadn't happened or it wasn't real? Feeling kind of numb about it?

However, before asking these IES-related questions, students should be told that their responses could be given in the presence of their peers or they could choose to discuss them later and privately with a counselor. Students who publicly reveal such distressing thoughts,

symptoms of increased arousal or avoidance are essentially identifying themselves as needing a boost of social support and maybe some follow up counseling. Although the first six (A.) are distressing, students could be assured that “these are normal and temporary reactions that many people have after a traumatic event.” Discretely note those who acknowledged or reported one or more of the last six (B.) questions.

Prediction phase

The purpose of the Prediction phase is to help students to prepare themselves for thoughts and feelings they may have in the following days and weeks. Certain factors may impact the student’s overall adjustment to a death event. For example: the extent to which students are able and willing to talk about the event; how they have or tend to incorporate traumatic events into their thinking about themselves and/or their world view; and whether they have, or can obtain, adequate social support from friends and family. Orcutt (et. al. 2014) found that a student’s ability to self-monitor their own emotional and mental status also has some predictive value regarding their adjustment. These factors can be described by the facilitator at the onset of this phase. It could be said that “research shows that the following factors help a person to positively adjust to a death event:

- a willingness to talk openly and honestly about the event and their reaction to it
- the person has come to a satisfactory understanding and attitude about their self or the world as a result of the event
- positive social support from friends and family
- the ability to pay attention to their self in the days and weeks going forward and seek additional help or advice whenever that seems necessary.”

Presenting these four factors to students can prompt them to take more personal responsibility for their recovery. Furthermore, knowing that these are key to one’s recovery, participants may share this information with distraught friends who did not participate in this intervention.

Some of what lies ahead may also depend on the circumstances associated with the critical incident. For example, in the wake of a school shooting the proximity of the survivors to the event may have some predictive value on their reaction and course of adjustment. The facilitator could prepare a list of circumstances in relation to the event which may place a person at-risk regardless of his or her style of coping. The facilitator would then read the list out loud and ask students to raise their hand if they “have a friend who is in one or more of these categories.” The student response to this list could identify students who are friends with someone whom they could be told may be more at-risk and in need of social support. This same activity could be used to identify the at-risk status of those who are present. The facilitator could repeat this activity and this time ask “How many of <u>you</u> can personally relate to the following?” The following is an example of such a list, applicable to both groups:

1. “Still feeling really sad, scared or angry (ask this question only if this is a delayed debriefing)?”
2. “Are friends with one of those who were injured?”
3. “Were in the same building earlier in the day?”
4. “Were in the same room earlier in the day?”
5. “Were friends with one of those who died?”
6. “Were friends with two or more of those who died?”

7. “Were friends with one of those who died and had a conversation with him/her within 24 hours of their death?”
8. “Were in the building at the time of the shooting?”
9. “Were in the same room/area at the time of the shooting?”
    a. “Saw the perpetrator fire upon someone?”
    b. “Were injured in the shooting?”

Those who acknowledge these circumstances in a friend may have the added stress of having to help a friend which might include convincing their friend to get professional help. If they have otherwise identified themselves as personally relating to any of the above categories, they are essentially identifying themselves to their peers, the facilitator and scribe as needing a boost of positive social support and maybe some follow up counseling.

Whether or not the aforementioned activity is indicated the facilitator should, in most cases, consider asking the following question suggested by Young (1998): “After all that you have been through, what do you think will happen (to you personally) in the next days and weeks?” In a reassuring tone, predict the course of bereavement in the context of its being a natural and temporary yet unavoidable process. Encourage students to think of the grieving process as something to be experienced rather than something to be overcome. Earl Grollman (2000) states that it is the body’s natural propensity to grieve (to weep when feeling sad) after a significant loss just as much as it is for one to eat when hungry, drink when thirsty or sleep when tired. It is also important for students to be told that grieving should occur, without shame, preferably in the presence of one or more supportive individuals. When done in a somewhat open and outward manner it signals an understandable need for social support.

Grollman (2000) does not believe that people respond to loss in particular stages. He views the process as an unpredictable “roller coaster type pattern” in which waves of intense emotions and thoughts are experienced. He states that a healthy course of recovering from a significant loss includes four basic tasks. To “accept” the loss as a real event, to experience and “express” the emotions and cognitions associated with the loss, to “commemorate” the person who has died and “to go on living.”

The facilitator could identify some of the common emotional, behavioral, cognitive and physical reactions students may experience in the following days or weeks. These can be reactions that were not previously identified (in the Validation phase). For example, the facilitator could discuss feelings of loneliness, a sense of responsibility or regret, reminders and dreams of the deceased, concentration difficulties, preoccupation, unwanted thoughts and unwanted images, sleeping difficulties, somatic complaints, etc.

Someone may ask: “How long will I feel this way?” Students could be assured that they will be feeling better within a short period of time. In fact, most individuals return to their regular routines within one to three days. Yet, a sustained period of bereavement may last four to six weeks (American Psychiatric Association, 1994). An intermittent pattern of bereavement continues as painful thoughts and feelings that often resurface in the future more intensely at birth and death dates, holidays and special events, places or other experiences that are reminders of the deceased. Memories of the deceased may change or diminish over time but the deceased will not be forgotten. Students could also be told that in the future they may look back on this event from a different perspective and with a greater understanding of it.

Some students, because of their close physical or emotional proximity to the death event, may be more prone to develop depression or a stress disorder. These students would benefit from an educational discussion about reactions that are relatively normal and not evidence of impending psychiatric illness versus symptoms that are pathological. The facilitator should consider the need for a discussion about specific examples of uncommon or pathological reactions. For example, drawing the wrong conclusion about the cause of the death or why the death occurred, over-idealization of the person who died, avoidance at all costs from anything that reminds the person of the death, numbing of feelings through the use of drugs or alcohol, a preoccupation or fascination with death, unnecessary risk-taking behaviors, depression or excessive anxiety. Students could also be given information about symptoms of major depression and symptoms of PTSD. They should be warned that certain things or reminders could trigger heightened physical and emotional reactions. This may include sights and sounds, odors, or tastes similar to those experienced by the traumatic event. Although these heightened reactions are distressing, students could be assured that this is “a normal and temporary reaction that many people have after a traumatic event.”

As previously stated, one of the goals of this intervention is to reinforce desirable conclusions about the event. Another is to help avert undesirable or maladaptive conclusions. The human brain’s proclivity is to consolidate and retain the memory of life-threatening events with information useful for one’s physical survival should a similar event occur in the future (Mobbs, et al., 2015). This is one of the reasons victimized individuals have difficulty stopping themselves from unintentionally retrieving and reliving the worst part of memories associated with their victimization or near-death experience (van der Kolk, 2014). In consideration of this proclivity a related task is to encourage affected students (subsequent to this intervention) to avoid future exposure to memory-associated cues and contexts that may trigger the retrieval of unwanted memories. This is especially warranted if the potential for unnecessary and/or debilitating thoughts are anticipated, (for example, as in the case of a student having witnessed a horrific scene). The facilitator should instruct such students to (in the following days and weeks) redirect their unwanted intrusive thoughts and visualizations to something neutral or innocuous and/or to avoid talking about them to others (except for those trained in post trauma counseling); as doing so will activate and reinforce those memories. Genova (2021) states that the more one is able “to leave [the memory] alone the more it will weaken and be forgotten.”

If this intervention is in the wake of a high impact event and there has been a time delay some students may have already acknowledged or reported PTSD symptoms. Such at-risk students should be given special attention after this intervention process.

Meaning phase

The purpose of the Meaning phase is to interpret, define or redefine cognitive views of the event so that a desirable resolution of the event is formed and encoded in the minds of the students. Gilbert (2005) states that “explanations ameliorate the impact of unpleasant events.” He asserts that this is because “explanations allow us to understand how and why an event happened, which immediately allows us to see how and why it might happen again.” Gilbert goes on to state that “unexplained events have a disproportionate emotional impact” because victims of trauma “are especially likely to keep thinking about them… Once we explain an event,” we can file it away in our memory and move on; “but if an event defies

explanation, it becomes a mystery" and it will maintain itself on the forefront of our mind. Gilbert continues on this theme by stating: "Explanation robs events of their emotional impact because it makes them seem likely and allows us to stop thinking about them. Oddly enough, an explanation doesn't actually have to explain anything to have this effect–it merely needs to seem as though it does."

With the aforementioned in mind ask: "Why do you think this happened?" It is critical that the facilitator is able to then carefully place the event in its proper context or perspective. This may be done by providing a credible explanation for the event. Young adults look to other peers and older adults for an interpretation of events and measure the meaning of it, including the degree of danger they are in, by the reaction of others around them. Even though a credible explanation was offered, explore what students believe about how and why the event occurred. This may be a similarly described explanation or it may differ significantly from the explanation offered to the group.

Seligman (2007) described "explanatory styles" for good and bad events. He states that just as individuals have a particular style of dressing, they also have an optimistic or pessimistic bias, or other particular style of thinking about things that happen. He asserts that helping students to make accurate explanations for bad events is critical in preventing a maladaptive response. He states that explanations for bad events should lack permanence and pervasiveness. It is better if the cause, or effect, of the event is judged to be changeable or transient rather than something that will persist. It is also better if the cause of the event is judged to have a limited or specific effect in the larger scheme of life rather than a pervasive or widespread unwanted effect.

If this intervention is conducted in the wake of a suicide there may be issues of confusion, anger, anxiety and distorted self-blame among friends. In addition to friends, others who may be particularly at risk for developing a maladaptive resolution are those who were in conflict with the deceased; those who talked with the deceased within 24 hours of the death; those who felt they could have prevented the suicide; those admired or identified with him or her; or those who suffer from a mental illness such as major depression. According to the Centers for Disease Control (1994) several concerns should be noted. Avoid any discussion detailing the specific method of the suicide. Although suicide is a very rare event, the mental illness evident in the lives of most all that complete suicide is far from rare. Suicide is not the result of any specific stress related event; it is the result of thinking errors and poor coping skills; often associated with major depression. Therefore, avoid focusing upon apparent precipitants to the suicide. This will minimize student conclusions that the act of suicide was a logical, normal or inevitable response to stress events. Focus upon the terrible emotional devastation experienced by the deceased's family and close friends. Acknowledge that the deceased was a "good person" and their positive characteristics, then carefully focus more upon "what," in retrospect; appear to be symptoms of their mental illness. These symptoms could be listed by the scribe. It may also be helpful to carefully talk about other ways the deceased could have coped.

Something may need to be stated to characterize the thinking errors of the perpetrator in the event of a homicide. For example, it might be appropriate to say: "He probably did not think ahead about the terrible consequences of his actions." Or: "Maybe he thought this act would gain himself some level of respect, revenge, or teach someone some type of lesson." It may

be appropriate to say: “He seemed to be mentally ill and probably did not get the help he needed.” Students who may be at risk of developing a maladaptive resolution to this type of event are those who were friends of the perpetrator; those who knew of the homicide plans and under reacted, minimized, ignored, provided aid in a direct or indirect manner, and/or kept them a secret; those who have had homicidal thoughts in the past; those who identified with the perpetrator’s situation; and any student who had reason to feel guilty about things said or done to the perpetrator or victim(s) prior to the incident.

The worldview one has in response to a critical incident may be adaptive. For example, the event may cause the person to feel more informed, be more aware and alert, more capable, empowered, etc. Conversely, others may have a maladaptive response. Their view of the world now causes them to be overly anxious, emotionally paralyzed, hopeless or helpless.

It is important that the leaders guide the group so that students can positively integrate the event into their existing world view. Some students may have identified shattered assumptions about the world in the Ventilation phase. This is a good time to address them. This may require some students to revise their attitudes and belief systems about the world. To address this state:

> Some of you said that in some way, your view of the world is different now. Taking what we live through and using it to our advantage helps us to become stronger, wiser and more mature when we do this. What is it that you realize now that you didn’t realize before?

It is equally important that students are helped to maintain a positive opinion of themselves in spite of the traumatic event. Explore how students have incorporated the event into their thinking about themselves. If this is a debriefing ask: “Since the time it happened have you had any feelings about yourself or the way you have been acting?” The goal here is to reconcile the student’s perception of what happened with what you understand or know happened.

Seligman (2007) asserts that depression is less likely to develop if the explanation for the bad event lacks personalization. For example, about other people or circumstances rather than an explanation whereby the student believes he or she caused the event. If it has been determined that one or more of those present had a more direct or indirect role in the death, careful consideration should be given to the individual’s reported behavior in comparison to his or her level of self-blame about the event. Mitchell and Everly (1996) believe that if a person incorrectly concludes that he is at fault because he should have been able to prevent the suicidal death of his friend, he is likely to develop a serious stress disorder. However, if he is presented with information in the presence of his peers that the death was produced by his friend’s own reckless**,** careless or hopeless attitude “it is far less likely that he will interpret the event in a manner which leads to post-traumatic stress disorder.” Epstein (2004) also suggests that “psychological debriefings” can–in addition to potentially provide individuals to feel validated and empowered–potentially “destigmatize” those whom prior to their group participation felt excessive guilt or remorse.

In any event, discourage the students from assuming an inordinate amount of responsibility for the incident. However, acknowledge, on a private basis, their self-blame for behaviors that were related to the event, are specific, and can be avoided in the future. What is said to, or

about an involved student should not be harmful to that student's sense of self-efficacy. According to Seligman (2007) the corrective focus should always be on the student's particular action or inaction rather than an indictment of the student's character or ability. Affirmation of related actions or inactions (which they know to be true) permits them to recognize their mistake and helps them to move beyond a ruminating cycle of guilt.

According to Shapiro (2001) and Fletcher (1997), some examples of desirable or adaptive self-assessment statements, stated perceptions of others, and stated perceptions of the world following a tragic event are:

> I did the best I could under the circumstances. Bad things can happen (randomly) to good people. There are dangers in life. I learned from it. It's in the past. The chance of this happening here is extremely low. I am safe. I am in control. I can trust myself. I am a good person. For the most part this town is a pretty safe place to live. Since I have lived through this, I have a better idea of what is important to me and what is not. This event has caused me to feel closer to the important people in my life. If I can live through something like that, then I can do a whole lot more than I thought I could.

Ask the students to identify (preferably by a show of hands) the positive self-assessments they are ascribing to themselves.

Other students may disclose undesirable or maladaptive attitude about the event. Undesirable or maladaptive statements would be statements that seem objectively untrue; otherwise described by the American Psychiatric Association (2013) as "distorted self-blame" as well as "exaggerated negative expectations about one's self, others, or the world." Do not actively probe for undesirable or maladaptive statements; however, students who do express these attitudes will require one-to-one follow up. Some examples of undesirable attitudes are:

> I should have known he was going to end his life. It's my fault. He did this because of me. I'm such a coward. I should have acted differently at the time. I cannot go back to that place. I believe this will happen again; to me. It's hard for me to trust anyone anymore. It's hard for me to be sure of anything these days. I think I will be punished because of this. There is something wrong with me. This has mentally damaged me for life. I feel cut off from people these days. I feel like I'm going crazy over this.

The facilitator's goal at this juncture is to find a way to effectively dispute undesirable or maladaptive statements. As a clinician, conducting this intervention with students in an educational setting, the facilitator can blend the role of clinician with that of a teacher. A facilitator can be just as authoritative as a teacher in using the Socratic Method (as described by Shapiro, 2001) to lead and shape a student's thinking processes. By asking a series of easily answered questions in an exploratory vein the student is helped to come to a logical and accurate conclusion. Additional shaping by the facilitator could occur in the form of non-verbal cueing such as a look of incredulity in response to an unwarranted conclusion. Because the subject matter is emotionally charged the facilitator's reactivity and questioning must be gentle, non-threatening, and respectful. Other helpful techniques (often used by cognitive therapists) include; decatastrophizing; asking for evidence; reattribution, and generating more reasonable or accurate alternative explanations.

It may be more powerful and effective to address undesirable attitudes or conclusions by simply drawing out the impressions of respected peers in the group who already have, or, seem capable of role modeling a positive attitude or cognitive integration of the event. The

facilitator should then guide students toward a consensus or group-based belief about themselves, the world, and the event that is adaptive (positive or innocuous). Having a positive or innocuous view that is linked to the event provides the student with an explicit and adaptive counter thought to draw upon, if and when the memory of the event is ever triggered by a reminder. This is really the most critical task of the entire CBGI intervention.

McMillen (1999) writes about the importance of focusing on the "positive by-products" of adverse or traumatic events. Individuals who believe that something was–or could be–gained or learned from a traumatic event feel less victimized or robbed by it. Moreover, McMillen reports that the realization or perception that one has somehow benefited from adversity "may help facilitate" a positive cognitive integration of the traumatic event and may "decrease the odds of having posttraumatic stress disorder." However, McMillen strongly cautions counselors against introducing this concept before the individual is ready to look at the possibility that the adverse or traumatic event may yield benefits. Introducing this concept prematurely might incorrectly suggest to students that they should view the tragic event in some fortuitous way. With this in mind, carefully ask: "Is there any way for you to look at this event and have it help you to be a wiser or stronger person?" The scribe should note any "silver linings" (positive by-products).

Additional questions can be asked to promote a sense of self-efficacy. For example: "Knowing what you know now, how can you avoid this from happening to you?" Or: "How would you act if this ever happened again?" Changed views–that integrate the experience without impairing the self-concept or worldview–and the discovery of any lessons learned may increase their sense of personal control, reduce their sense of helplessness or vulnerability, and perhaps give them a sense of greater maturity and personal growth.

Students may decide that there are changes they would like to make as result of the traumatic event. The scribe should note statements (reinforced by the facilitator) about changes that sound healthy and reasonable.

Sublimation phase

The purpose of the Sublimation phase is to help students to find ways to channel anger and other negative emotions into socially constructive acts or activities appropriate to the cause of death. In the event of a homicide, it is common for the survivors to be filled with anger and thoughts of revenge. While acknowledging their anger and other negative emotions, students should be helped to realize that it is the role of the police and courts to address issues of justice and retribution and that they should confine their energies to socially constructive, non-violent activities. That "compassion" and "respect for one another" makes the world a better place, not hatred and retribution (Kennedy, 1968).

Although reminiscing may occur spontaneously at any point during this intervention process, this is a good time to encourage reminiscing. Stories of the deceased, perpetrators, or victims may yield useful information. Some may feel inspired to form a new student organization or awareness program in the school or community that the deceased would have benefited from, liked or supported. Some may feel a strong desire to design or develop an appropriate memorial.

A discussion about socially constructive activities promotes the adaptive defense mechanisms of sublimation and altruism. If the selected activity seems to have a certain relevancy to the deceased it may give students a greater a sense of meaning to the painful event. Those who have a sense of meaning can more easily develop a positive purpose, resolve or determination to do something constructive. An administrator or counselor within the school should be identified and available as a contact person for students interested in such follow up activities. Small group activities or projects can bring students together at a later date for intermittent discussion of the loss event. This also allows the administrator or counselor to track their adjustment.

Develop a discussion about the visitation and funeral. Funerals allow students the opportunity to confront the reality of the death in the supportive presence of their friends and others. It also is a place to show and provide support and friendship to others who were related or close to the deceased. On-line memorial sites are becoming more prevalent. Students should be cautioned about the public viewing and possible scrutiny of their private thoughts and well-intended words of condolence.

Affiliation phase

The purpose of the Affiliation phase is to establish and encourage social support. Social support provides a number of benefits. It provides opportunities for others to counter negative statements about oneself or, his or her negative view of the world. Social involvement provides companionship and support in helping students to carry out plans for positive changes, to return to normal routines, to observe how well a friend is adjusting, and to intervene with a peer if it is needed at a later time. Ask: “What can you do to help each other during this difficult time?”

Ask: “How are you planning to cope with the thoughts and feelings you have about this event?” If there has been a time delay and this is a debriefing ask: “How have you been coping?” Ask students to talk about how they usually cope when feeling anxious, angry, confused or sad. If not already introduced (in the Introduction phase) students could be taught and encouraged to use self-calming techniques such as: grounding; mindful breathing; positive self-talk; positive visual imagery; progressive muscle relaxation; use of peripheral vision, etc. There is also the potential for some to receive additional social support as a result of meeting others through their group participation. Students who have experienced a prior loss may be a helpful resource to show how one may positively cope with grief. Positive strategies could be summarized by the facilitator and listed by the scribe. Consider the distribution of appropriate and useful materials about coping with loss, school and community resources, etc. These materials could also include information on when and how they should seek further help for themselves.

If there has been a delay of one or more days between the event and this intervention, ask how significant others have responded so far to their reaction to this event. Those who report that their friends, older siblings, parents, or others have shown warmth, acceptance, patience, understanding and other helpful behaviors should be reassured that these persons will be important to them in their adjustment to this event. However, some less fortunate students may disclose non-supportive behaviors or detrimental advice. Counteract detrimental advice with healthful information and encourage these students to continue their help-seeking behavior with supportive adults.

If this is a debriefing some students may be disturbed by rumors that have circulated in the school or inaccurate written information about the deceased. Some of this can be countered or rebutted. Consider giving such students some ideas of what to say to inquisitive or opinionated peers once they are out and about. Help students to understand that most peers make comments or share their personal views with good intentions. It can also be said that some of their peers may actually be trying to help themselves work through the meaning of this event by sounding out their thoughts and gauging the reaction of others.

Re-entry phase

The purpose of the Re-entry phase is to help students to end their participation in this intervention and to return to their normal routine. Generally, within a period of about two hours (following a high impact incident), the atmosphere may become relaxed, serene or even jovial.

When, through private consultation between the leaders, it seems time to end the group intervention, students can be told that it is now time to end the group meeting. Help them to understand that returning to their normal routines will help them to regain a sense of control over their emotions about the loss/event. Ask if anyone is feeling "confused about anything" or is "feeling more upset" now than when the intervention began. The scribe should note those who indicate that they are confused or upset. These students should be encouraged to stay in the room after the first dismissal. Some students, whether or not they have identified themselves as feeing confused and/or highly upset, may choose to leave the session. Whether they choose to stay or not these particular students should also be encouraged to continue talking about this with a trusted friend, family member or other trusted adult.

All of the students should be reminded that the purpose of the meeting was not to completely neutralize their bad feelings, but rather to help them to "have a better understanding of their thoughts and feelings about the tragedy." Therefore, although it is difficult, they must tolerate their discomfort. Remind them of the times they successfully tolerated hunger pangs during class, a headache, a backache, etc. Doing so promotes the adaptive defense mechanism of suppression. Help them to understand that it can be beneficial to mentally set aside disturbing feelings so that they are able to function in their normal daily routine. However, numbing and the avoidance behaviors (associated with PTSD) that impair functioning are not the healthy result of suppression.

Some students may have been drawn to the intervention event for the purpose of reworking a previous loss or trauma. The students themselves may be unaware of this connection. If time permits, encourage a discussion about their loss as well as how their loss relates to the present situation. If time does not permit such a discussion, assure them of your availability and encourage those students to seek you out at a later date.

Thank or praise the group for sharing their personal thoughts and feelings. Tell them that their presence and participation probably helped others in the group. Let them know how they can access support services in the school during the next several weeks and beyond. Ask the students if they have any final questions. When all questions have been addressed consider the distribution and voluntary completion of an exit survey of some type and then dismiss the

students. If time permits allow for students to converse among themselves. The counselors should stay in the room to respond to individual questions or statements.

Those who remain confused or highly upset and those who otherwise indicate that they would like to stay should be required to talk more and ask questions. Their desire to stay suggests they are still overwhelmed with their thoughts or feelings. Perhaps they remain fearful, confused or unconvinced about something.

Consider having some of the more positive and outspoken participants stay after the first dismissal so that they can assist the leaders in getting the more disturbed individuals to a more restored level of functioning. Re-review the facts and then concentrate on issues related to the Meaning phase. Draw out the attributions they are ascribing to the event. If they are unrealistic or maladaptive, encourage the positive and outspoken peers in the group to counter incorrect or unrealistic conclusions about the incident or the person's negative self-appraisal.

Students that do not appear to be responding very well to the aforementioned interventions should be assisted on an individual basis at this point. Students judged to be at-risk should be identified to the appropriate building staff, with a determination of whether they may need special supervision, and/or whether they should receive follow up contact with a mental health professional.

Follow-up phase

Some students–whether or not they participated in this intervention–could be deemed to be at-risk simply due to circumstances beyond their control, or because of their reaction to the death event. For example, students who; were friends of the deceased, witnessed the event firsthand, felt mortally threatened, believe they bear some responsibility for the event, or otherwise feel excessive anxiety, guilt or shame. It is critical for the counseling staff to follow up with at-risk students needing ongoing contact or supervision. This will help them to resolve issues or problems that arose from the traumatic incident. Those who do not show a satisfactory adjustment to the event should receive additional support and/or be referred to an appropriate mental health resource in the community.

The counselor may prefer to provide continued assistance to certain students who seem at-risk and/or the deceased student's inner circle of friends. This contact provides the opportunity to track and guide individuals or a small group toward a therapeutic resolution. The clearest indication that the chosen interventions were sufficient is when the student's overall level of academic functioning returns to the level that existed prior to the traumatic loss or event.

A specific assessment of adjustment could be obtained by having selected students complete a trauma impact scale or other type questionnaire. These assessments could serve as baseline and post-treatment measurements of treatment effectiveness. Those who experienced the event as a major loss could be given a depression inventory along with, or in place of, a trauma impact scale at similar time intervals.

Students could evaluate–for themselves–their emotional and psychological adjustment to this event if they are given an information packet about depression and PTSD. Those who see

symptomatic behaviors in themselves or their peers could be pre-informed about how they could later access support services.

Summary

Students, who were directly or indirectly exposed to a traumatic loss or event need to understand what happened, express their emotions, and feel validated. Students should be helped to predict and prepare for their immediate future. They also need to be able to cognitively process the experience so that they are able to maintain a positive opinion of themselves and an unimpaired worldview. The impact of this intervention process is more powerful and more authentic when it is done at the earliest opportunity and in the presence of encouraging peers. This process also helps to facilitate positive social support or, if necessary, a boost of positive social support. These activities will help affected students to more fully resolve issues or problems that have come up as a result of the incident in a positive manner and promote a timelier return to their regular school routine and pre-existing levels of academic functioning. This should also minimize the development of maladaptive behavior and pathological bereavement.

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End Note

The CBGI model may best be described as “focused psycho-educational group debriefing.” However, it is not, in and of itself, an empirically-based or establish evidence-based intervention. This is because the ability to measure the effectiveness of it is limited to a post-assessment. How can one otherwise conduct a baseline assessment or pretest on exposed subjects and controls when there is no way of predicting when a suicide or homicide may occur? The CBGI model however, could be considered an evidence-informed intervention as the author has used the best available knowledge and research to guide the design and implementation of the model. CBGI integrates some of the key elements of CISD that can be effectively implemented in a school setting, but it departs from CISD in some other ways. CBGI also integrates some elements of crisis intervention, psychological first aid, general grief counseling and cognitive therapy. The extent to which these five treatment modalities are considered effective is the extent to which the CBGI model may also be effective. However, it is an untested model of intervention that carries with it the risk of unintentional psychological harm. This is especially possible if it is conducted by individuals who are not certified or licensed mental health professionals because these clinicians are more likely to have an intuitive sense of whether, when, or when not to proceed with a particular prescribed task in a given situation or context. Nevertheless, clinical observations of student participants by this writer and colleagues within the educational systems in which he served, post-intervention surveys of student participants, and field observations by school personnel all suggest a high degree of satisfaction and approval of this intervention model.