Introduction to and Overview of Group Psychological First Aid

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Psychological first aid (PFA) is emerging as the crisis intervention of choice in the wake of critical incidents such as trauma and mass disaster. Earlier writings have focused on the application of PFA to individuals. This paper takes the next logical step and expands the application of PFA to the small group format. This paper represents an introduction to and overview of group psychological first aid. Rationale and basic procedures are discussed. [Brief Treatment and Crisis Intervention 6:130–136 (2006)]

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Recent research (Center for Disease Control and Prevention [CDC], 2002) provides insight into the potential need for acute psychological care in the wake of disasters. Subsequent to the September 11, 2001, terrorist attacks on the World Trade Center, the CDC Behavioral Risk Factor Surveillance System initiative sampled 3,512 adult residents of Connecticut, New Jersey, and New York via a random digit dialed telephonic survey. The results of the survey suggest a widespread psychological and emotional impact in all segments of the three states’ populations” (CDC, 2002, p. 784). Seventy-five percent of respondents reported having problems attributed to the attacks: 48% of respondents reported that they experienced anger after the attacks, 37.5% reported worry, 23.9% reported nervousness, and 14.2% reported sleep disturbance.

The American Psychiatric Association (APA, 1954) noted that whether a disaster is a function of nature or enemy attack, people will suffer from a level of stress not usually encountered. As such disaster workers must be familiar with common patterns of reaction and understand the basic principles for responding effectively with disturbed people.

In the wake of critical incidents such as violence, fatal accidents, and disasters, there is often a desire to provide some form of psychological support. As Raphael (1986) notes:
In the first hours after a disaster, at least 25% of the population may be stunned and dazed, apathetic and wandering—suffering from the disaster syndrome—especially if impact has been sudden and totally devastating. At this point, psychological first aid and triage are necessary.

More recently, the Institute of Medicine (IOM, 2003) has written:

In the past decade, there has been a growing movement in the world to develop a concept similar to physical first aid for coping with stressful and traumatic events in life. This strategy has been known by a number of names but is most commonly referred to as psychological first aid (PFA). Essentially, PFA provides individuals with skills they can use in responding to psychological consequences of [disasters] in their own lives, as well as in the lives of their family, friends, and neighbors.

Everly and Flynn (2005) have proposed one such model of psychological first aid (PFA) that may be applied to individuals. The National Child Traumatic Stress Network and National Center for PTSD (2005) have collaborated to create a highly useful field manual for mental health personnel in the administration of PFA to individuals. Parker, Everly, Barnett, and Links (in press) have even developed specific “evidence-informed” competencies for training public health personnel in PFA. However, if there is perceived value in individual PFA, what of “group psychological first aid?”

Indeed, Ulman (2004) has noted, “Group interventions offer unique advantages in addressing the areas in which traumatized individuals have been the most affected” (p. 25). Clinically, it may be argued that in situations where groups of individuals were exposed to the same amplitude and chronicity of traumatic exposure, there may be a strong rationale for implementing PFA practices in that natural homogeneous cohort. Furthermore, it may actually be clinically contraindicated to disband that group for the purposes of psychological intervention, except under unique circumstances.

Given that uniformed service personnel (fire-rescue, police, emergency medical services, and military) are both united through a strong sense of group cohesion (which command personnel seek to maintain and promote) and often share similar trauma and loss, utilizing the PFA intervention in a group format may be a particularly useful consideration.

This brief report discusses the nature and practice of group psychological first aid (Group-PFA). The concept of Group-PFA is based on PFA, which is defined according to the IOM (2003) as:

Psychological first aid is a group of skills identified to limit distress and negative health behaviors . . . “PFA generally includes education about normal psychological responses to stressful and traumatic events; skills in active listening; understanding the importance of maintaining physical health and normal sleep, nutrition, and rest; and understanding when to seek help from professional caregivers.” (p. 7)

From a tactical perspective, according to Everly and Flynn (2005), PFA may be intended to achieve any of the following:

- The provision of information/education.
- Provision of comfort and support (intervention based on providing soothing human contact is legitimate and can be universally applied).
- An acceleration of recovery.
- The promotion of mental health.
The facilitation of access to continued or escalated care. Raphael (1986) suggests that PFA consists of numerous processes that may be summarized as follows:

1. Meeting basic physical needs, such as
   a. physical protection,
   b. establishing a sense of security,
   c. provision of physical necessities.
2. Meeting psychological needs, such as
   a. consolation,
   b. provision of emotional support,
   c. provision of behavioral support,
   d. allowing emotional ventilation,
   e. fostering constructive behavior.
3. Fostering social support, such as
   a. reuniting victims with friends or family,
   b. utilization of acute social and community support networks.
4. Fostering ongoing care, such as
   a. triage and referral for those in acute need,
   b. referral to subacute and ongoing support networks.

Rationale for the Group-PFA

As one shifts to a focus on group process and the potential use of the group as a crisis intervention platform, there is a striking parallel, if not synergy, in the use of the group to facilitate the practice of PFA. Yalom (1970) in his seminal text on group psychotherapy enumerated “curative factors” which served to answer the question “How does group therapy help patients?” Said in another manner, “What are the mechanisms of therapeutic action at work within the group process?” Yalom answered this question by enumerating a list of 11 such factors, or mechanisms, derived from queries made to his patients. Among them and most relevant to the process of PFA are

1. Learning about self from other group members (1st)
2. Catharsis (2nd)
3. Increased sense of belonging (group cohesion) (3rd)
4. Universality (learning that one’s reactions were shared by others) (7th)
5. Guidance regarding constructive behavior (11th)

Similar findings were revealed from research conducted by Berzon, Pious, and Parson (1963). They asked group therapy patients to identify critical aspects of the group process that were most personally meaningful. They included

1. Recognizing similarity with others (universality) (2nd)
2. Learning about self from others (4th)
3. Feeling a sense of group cohesion (8th)
4. Ventilating emotions (catharsis) (9th)

With specific regard to intervention with traumatized individuals, Ulman (2004) notes that groups may be uniquely helpful by

1. Providing a structure
2. Fostering symptom management
3. Validating the traumatic experience
4. Providing an opportunity to rebuild trust
5. Decreasing isolation
6. Fostering ventilation and grief in a safe environment
7. Learning about one’s own beliefs and worldviews as they may have been affected by the traumatic experience

In the final analysis, as noted by, and in concert with, Everly and Flynn (2005), within the context of this report, a central tenant of PFA is the provision of as “a supportive and compassionate presence designed to reduce acute psychological distress.” Although generic PFA is
recommended by the World Health Organization (2003) and the National Institute of Mental Health (2002), few practical guidelines exist on how it may be implemented. As noted earlier, Everly and Flynn (2005) have offered guidance on the application of PFA to individuals. This report offers similar guidance on how PFA may be applied in groups (Group-PFA).

The Practice of Group-PFA

Group-PFA can be considered from a phasic perspective. It consists of pregroup activities, six stages of Group-PFA, and postgroup activities. As with most disaster and trauma work, it is advantageous to use coleaders when providing Group-PFA (Klein & Schermer, 2000). It is particularly valuable if one of the leaders is a member of the culture being addressed as in the case of the military or emergency services.

Pregroup Activities

The goal of this phase of Group-PFA is to perform an initial assessment of suitability for group intervention and to meet basic needs that might otherwise interfere with the group process. It is incumbent upon the prospective group leaders to become as informed as possible about the incidents that have confronted the group so as to provide an informational foundation from which to work. With this in mind, the leaders must be assured that the basic personal needs of group participants have been addressed. For example,

- Identify and address medical and physical needs: Any medical needs must be immediately addressed. Appropriate medical referral must occur prior to any group psychological intervention. Basic physical needs (food, water, shelter, provision of time for physical rest) must be met.
- Reduce situational stressors: Acute situational stressors should be reduced; a sense of safety and security should be fostered, if possible.
- Assess homogeneity and functionality: Once these basic needs have been addressed, further and more refined assessment for the appropriateness of group intervention continues—(a) assessment of the degree of exposure homogeneity (similar traumatic exposure), that is, is this a naturally existing group? and (b) the level of functionality, that is, is there evidence of functional impairment, for example, psychic numbing, impaired reality orientation, extreme affective lability, and intragroup aggressiveness. Individuals who are assessed as being too psychologically fragile or potentially disruptive may be considered for exclusion from the group. Beyond addressing homogeneity, medical issues, and meeting basic needs, functionality becomes the key assessment issue to focus on. Beyond its obvious face validity, functional impairment has been shown to be a predictor of PTSD (Norris et al., 2002; North, McCutcheon, Spitznagel, & Smith, 2002) and therefore of prospective concern.

The Six Stages of Group-PFA

The following is a brief description of six general intervention stages that may be used within the context of Group-PFA. This six-stage model is presumed to be applicable within the context of a more formalized group, that is, wherein the group is planned, structured, and authorized, by some convening authority. For example, the staff of a bank or school that has tragically lost fellow employees, a military unit that has been faced with a particularly traumatic incident, a group of parents whose children have been involved
in a traumatic experience, and so on. In the case of impromptu, less structured, less formalized group interventions (such as those that spontaneously arise at disaster venues, firehouses, etc.), the first three stages may be omitted or somewhat altered depending on the needs of the situation.

1. Introduction: As the group convenes it is important to briefly introduce
   - the group leaders
   - the purpose of the group [Note: If the interventionist senses that the recipients are/may be resistant to intervention directed toward them, it may be of value to utilize the concept of “intervention by proxy.” By this we mean that the comments of the interventionist and other group members may be directed toward assisting individuals other than those in the current group. Thus, discussions may focus on recognizing the needs of others and on methods for assisting others who may have difficulty dealing with the aftermath of the current situation. Such “third party” discussions may reduce tension or ambivalence about the group process.]
   - the expected duration
   - any “ground rules”—The establishment of group ground rules so as to reduce anxiety, ambiguity, and clarify expectations. For example, “This is an opportunity to catch your breath in the company of people who have been at your side.” This is not intended to be confrontational and at no time will you be expected to disclose if you choose not to. This is for safety and support.

2. Provide a review, briefing, or short presentation designed to present and acknowledge the facts of the situation, or incident, as you understand them to be. For example, “From what I know about what happened . . . .”

3. Ask for clarification or correction of the facts as presented. Such instruction would allow group members to participate, but only if desired. Participation itself would begin in the cognitive domain as a factual discussion and could remain/return there if affective-oriented discussions are premature and pacing and/or containment is needed. If the leader becomes aware that the group has a misperception of the facts, clarification on all sides is valuable.

4. Teach: Having presented and corrected the mosaic of the “story,” in the case of the formal group process, the leaders teach by offering psychoeducational information that normalizes responses to trauma, reassures, and offers techniques for basic coping and stress management. Engaged with the group, the leaders also point out signs and symptoms that may require further attention.

   In the case of the “informal,” impromptu group process, the leaders would begin by first “listening” to the “story” of the trauma or disaster situation, then “teach” via normalization, reassurance, and information about responses to trauma, basic coping, and stress management. Again, the leaders would point out signs and symptoms that may require further attention.

5. Support the natural cohesion and resiliency of the group. Emphasize the potential role that group members can play in supporting one another. It is a generally accepted notion that it is easier to facilitate the reconstruction of natural support systems rather than attempt to construct new ones. Similarly, great care must be taken not to inadvertently disrupt
such natural support systems when they are in place.

6. Assist in connecting with (a) informal support systems including family, friends, and coworkers or (b) more formalized support systems, including community mental health programs, employee assistance programs, student assistance programs, hospitals, and faith-based resources. In this final stage, PFA means establishing effective human contacts (APA, 1954).

Postgroup Activities

When the group has reached its natural point of termination, follow-up activities remain essential. These include

1. Continued resource: As the group is winding down, the leaders need to establish their availability as a continued resource for group members and identify future needs of higher levels of care. The leaders should be available immediately postgroup.

2. Leaders’ closure: It is important that the leaders structure an opportunity to debrief with each other as well as with a support group, team leader and so on.

3. Countertransference: It is crucial that the leaders recognize and address their personal and professional reactions to all aspects of the trauma and the Group-PFA as trauma inevitably engenders significant countertransference reaction among interventionists (Zieler & McEvoy, 2000).

4. Leader self-care: It is essential that leaders remember the fundamentals of rest, relaxation, and seeking support when necessary.

5. Evaluation: Formal or informal assessment of the effectiveness of the intervention is highly desirable.

Summary

[A] acute distress following exposure to traumatic stressors is best managed following the principles of psychological first aid. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This type of aid can be taught quickly to both volunteers and professionals. (Sphere Project, 2004, p. 293)

From both the acute clinical and public health preparedness perspectives, acute PFA represents a potentially valuable skill set that is easily applied in the wake of mass disasters. Arguably, wherever there is a need for the application of physical first aid, there can be a need for the application of PFA. This report has extended the notion of PFA to include the group format. Although operationally basic compared to the practice of psychotherapy, it is important to recognize that competence in Group-PFA still requires specialized training.

When professionals in the wake of natural or man-made disasters have the privilege and challenge of responding to those in need, it is important for them to recognize that community is a source of safety, support, and recovery. Group-PFA accesses this possibility.

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References


