TRAUMA SCENE: INITIATION OF THE PROCESS OF POSITIVE RESOLUTION OF TRAUMATIC EXPERIENCES IN GROUPS AND INDIVIDUALS

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ABSTRACT

The author presents his experience in assisting traumatized groups and individuals. Within the basic model of traumatic scene the author differentiates four groups of expected victims of psychological consenquences of traumatic event: directly exposed group, indirectly exposed group, wider group indirectly related to the event and the victims' families. Main features and support-providing approach to groups and individuals for the three basic types of trauma scene are presented in the paper.

Psychological impact of traumatic experiences becomes obvious usually during the first phase of war operations - as soon as first casualties come. Exposure to suffering, danger, extreme psychical demands and poor life conditions put whole units under enormous pressure that some individuals cannot cope with. Psychological techniques and procedures, because aiming at maintaining level of quantity and quality of human potentials on the one hand and reducing the stress level and suffering on the other, are appreciated both by commanders and soldiers.

Recently, frequently used various types of debriefing, have given a new, better opportunity for initiating the process of positive resolution of traumatic experiences in individuals and groups exposed. After nine years of working with those who were exposed to the traumatic experiences and five years of using debriefing techniques in Croatian Armed Forces, some new (old) questions have been raised : What kind of experience has stronger psychological effect on individuals?; Who is exposed to traumatic event?;What is relation between traumatic experience and PTSD symptoms? and many more.

Traumatic experience - symptoms relation

Various research done recently showed that relation between traumatic experiences and PTSD symptoms is not so simple as it seemed.

Research by Komar at al. (1998) showed that items of the Traumatic Combat and War Experiences Questionnaire taken as a set of predictors determined 31%. of variance of symptoms measured by CROSS (Croatian Sress Scale). Other research came up with corelation between experiences and symptom scales from 0,30 to 0,51 (Foy at al,1984, Resnick, at al, 1989).

Results of these research revealed many difficulties encountered in classification of various war experiences; specific meaning of particular experience for individuals; unique and bizzare experiences that cannot be classified, but also the same questionnaires measure one experience twice or even more times as they cannot discern the event from a wider context.

The research by this author since 1996. showed more relations between combat eperiences and symptoms of PTSD. Group of 59 diagnosed PTSD soldiers were asked to mark their most difficult experiences during the war (3 of them). Reasonable assumption was that they will mark experiences that are connected with intrusion symptoms, but also other symptoms of PTSD. During the Watson PTSD interview a month later 85% of them confirmed the marked experiences as most difficult (combat experience questionnaire was made in the way that location of particular event commanding officers and other circumstances could be checked).

Table 1. Combat experiences and percentage of those who marked particular as one of the most difficult

War experience	Marked as one of the most difficult
POW	92,3 %
Death of fellow - soldier	79,2 %
Wounded (severe)	54,5 %
Taking care of dead bodies	52,9 %
Withdrawing from enemy surrounding	38,7 %

Results of this research and later interviews suggest that there could be three kinds of exposure to critical incidents:

- "first-hand" experience of those who were directly exposed to traumatic event during the incident

- experience of those who were exposed to the consequences of the incidents (care of the wounded, dead bodies...), but they were not on the scene during the incident
- exposure through psyhological mechanisms - those who were near the place where incident happened or belong to same group as the deceased, wounded or primary exposed

Epidemiological estimates of PTSD suggest that 5% of male population in USA suffer from PTSD, (Kessler,R.C., at al) and in population of combat veterans some 30% suffer from PTSD, (Kulka R.A. at al 1990). This results may suggest that there is some difference between critical incidents during peacetime and critical incidents during the war. Baum, O`Keffe & Davidson (1990) gave the concept of acute and chronic stress and reactions that could explain the difference between prevalence rates of PTSD in general population and combat veterans.

Table 2. Concept of acute and chronic stress and reactions

	Stress	Reactions
Critical incident war	ACUTE CHRONIC	ACUTE CHRONIC
Critical incident peace time	ACUTE	ACUTE CHRONIC

Due to these differences it is possible to differentiate roughly two types of critical incidents:

- critical incidents during the war (on the battlefield)
- critical incidents during peacetime

Of course this distinction is not precise, and variations of both types are possible concerning the possibility of chronic exposure to stress during peace time (polution, flood, earthquakes...).The main difference between war and peace time incidents is that those who participated in war incidents were under pressure of other incidents and constantly exposed to a life treatening situation.

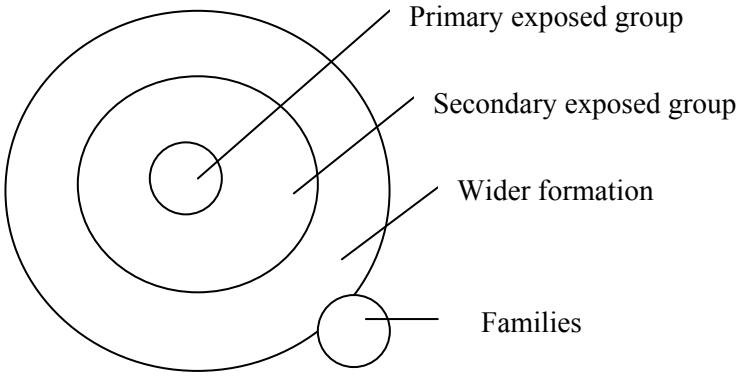
During the war it often happens that whole units are exposed to suffering, danger and witness to deaths of many fellow-soldiers. Such battles occur in every war and are a variation of "critical incident during the war".

Traumatic scene

Different types of critical incident together with types of exposure could be a basis for a traumatic scene concept.

Traumatic scene rises from critical incident and includes individuals and groups related. In every traumatic scene there is a possibility of determining position on acute - chronic axes (war-peace) and groups that are exposed. In some scenes the whole community is involved (major incidents, incidents including moral dilemma...), in others only a small group of people has been exposed. Families of deceased and exposed are also involved and exposed through psyhological mechanisms. Both families and community (public), can sometimes play a key role in resolving traumatic experiences of the exposed, by keeping them in an unsolved situation if they put them under pressure of guilt and responsibility, or initiate positive resolution through social support.

Figure. 1. Traumatic scene



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Through clinical experience and working with groups after critical incidents it became obvious that some individuals on the scene are out of their groups:

- individuals who developed strong acute stress reaction like stiffness, bizzare behaviour, catatonia
- severely wounded individuals are usually evacuated from the scene
- commanders (junior level) very often make part of the primary exposed group but in accordance with their status they usually try to establish control and stay out of the group

PSYCHOLOGICAL HELP

Critical incidents on the battlefield

Psyhological help for groups and individuals after critical incidents was organized according to the concept of traumatic scene.

Follow up meetings should be organized after some time to check reactions after traumatic experience. There is possibility that some soldiers from primary or secondary exposed group have seen another traumatic event, if so, reactions after them should be discussed at the follow-up meeting. The purpose of follow-up meetings is to normalize and discuss reactions from the traumatic event to the present moment. Follow-up meeting discussion gives a lot of information about individuals and points out those who could have serious psyhological problems and will need individual counselling. Critical incident stress debriefing sometimes isn‘t a proper procedure for secondary exposed group. Some modification could be done in phase of symptoms. Either because they usually witness to reactions of those in primary group or they just don`t feel enough involved in the event, they themselves could see their reactions and symptoms not important or developed at the time. Longer focusing on the fact phase and according to development of debriefing, phase of symptoms could be transferred into the phase of education.

Sometimes (usually after several critical incidents in a short period of time) it is recomended to conduct a large group debriefing. During this debriefing officers from operations, or commanders explain what happened at the tactical and the operational level using maps, pictures and statements by those who witnessed key part of the event. The purpose of this procedure is to give a wider context of operations during which critical incidens occured. Some ventilation process could be expected, therefore the size of group and the plan of moderating the process should be prepared carefully.

Social support to large groups could be provided from higher command (military reward system) or media (community). Lack of social support, criticising and underestimating the effort could interfere with positive resolution of traumatic experiences. Families of deceased soldiers could sometimes put the primary exposed group under pressure by holding them exposed through psyhological mechanisms. As the negative impact should be at least assessed, work with families of the deceased should be directed to initiating positive relations towards the unit.

Severely wounded individuals are usually evacuated from the scene within an hour. In view of their psychical shape, debriefing could be done later, but it is recommended that they participate in follow-up meeting, if possibile.

There are several reasons why commanders should be treated separately. The main reason is that their role narrows the area of desirable behavior in the way that they cannot follow the main goals in debriefing phases. Another problem with commanders is that some of them interrupt the process of debriefing by making conclusions and taking the leading role. On the other hand, they could be very useful later because they can evaluate adaptation of soldiers after the critical incident. In the last phase of debriefing commanders were asked to evaluate the impact that critical incident might have the time ahead on the battlefield, and reminded of procedures that could decrease feeling of vulnerability and reactions could indicate serious problems. During a separate follow-up meeting they could give valuable information about adaptation of their soldiers after critical incident.

Table 3. Psyhological help organization after incident on the battlefield

Grouops/individuals	24 hours	24-72 hours	1-2 months	later
PRIMARY EXPOSED	DEFUSING	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	FOLLOW UP MEETING	COUNCELLING INDIVIDUALS
SECONDARY EXPOSED	DEFUSING	DEBRIEFING	FOLLOW UP MEETING	COUNCELLING INDIVIDUALS
WIDER INFORMATION	DEFUSING	DEBRIEFING	SOCIAL SUPPORT	COUNCELLING INDIVIDUALS
FAMILIES	VISITING ORGANIZING	CONDOLENCE	-	-
STRONG ACUTE STRESS REACTION	EVACUATION DEFUSING	DEFUSING/DEBRIEFING	DEBRIEFING FOLLOW-UP MEETING	COUNCELLING
SEVERE WOUNDED	EVACUATION	-	DEBRIEFING FOLLOW-UP MEETING	COUNCELLING
COMMANDERS	DEFUSING	CISD	FOLLOW-UP MEETING	COUNCELLING

Table 4. Critical incidents on the battlefield

	EVENTS	DEBRIEFINGS	SOLDIERS	ASR EVACUATION	PTSD PROBLEMS
PRIMARY EXPOSURE	7	7	34	6	5
SECONDARY EXPOSURE	7	5	25	-	2
TOTAL	7	12	59	6(10%)	7(12%)

Individuals with strong acute stress reaction were only in primary exposed group. Together with those who had significant PTSD problems that could indicate that experience of those soldiers was different from those from secondary exposed group. Some soldiers from the former group suffer from PTSD symptoms, which indicates that they should be treated as well.

In case of a larger-scale battle (with a lot of casualties in a short time period), possible solution is to treat the whole unit as exposed group, divide them into small groups (squads) and imply procedure for primary exposed groups.

Critical incident during peacetime

The procedure for this type of traumatic scenes is more or less the same as for the incidents on the battlefield. The main difference between those procedures is that secondary exposure is not so traumatic, and a larger formation probably won`t need debriefing.

Table 5. Critical incident during peacetime psyhological help organization

Grouops/individuals	24 hours	24-72 hours	1-2 months	later
PRIMARY EXPOSED	DEFUSING	CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	FOLLOW UP MEETING	COUNCELLING INDIVIDUALS
SECONDARY EXPOSED	DEFUSING	DEBRIEFING	FOLLOW UP MEETING	COUNCELLING INDIVIDUALS
WIDER INFORMATION	GIVING CREDIBLE INFORMATION			
ASR	MEDICAL CARE	DEBRIEFING (when possible)	FOLLOW-UP MEETING	INDIVIDUAL COUNCELLING
SEVERE WOUNDED	EVACUATION	DEBRIEFING (when is possible)	FOLLOW-UP MEETING	INDIVIDUAL COUNCELLING
COMMANDERS	DEFUSING	DEBRIEFING (if needed)	FOLLOW-UP MEETING	COUNCELING
FAMILIES	INITIATE POSITIVE RELATION TOWARDS UNIT			

Table 6.Critical incidents during peacetime

	EVENTS	DEBRIEFINGS	SOLDIERS	ASR EVACUATION	PTSD PROBLEMS
PRIMARY EXPOSURE	11	11	44	-	2
SECONDARY EXPOSURE	11	5	30	-	1
TOTAL	11	16	74	-	3(4%)

Closing the traumatic scene

By following these procedures it is possible to make a review of everything that has been done and evaluate the impact of a particular event on groups and individuals.

The traumatic scene concept is a result of clinical orientation towards critical incidents and people involved in them.

Regarding the fact that every critical incident is different, procedures in this paper should be taken in a flexible way, with the possibility of adjusting to cope easier with problems that could rise.

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