Talking as a Primary Method of Peer Defusing for Military Personnel Exposed to Combat Trauma

The barometer of violence, terrorism, and trauma has been of significant focus in the recent media and among citizens around the world. Exposure to traumatic events can engender extreme stress and profoundly affect the life experience of the individuals and families who face such critical circumstances. The odds of similar psychological strains are increased for military personnel taking part in humanitarian relief missions or contentious armed conflicts.

Sanctioned or not, history has shown that war is a part of human life and extends beyond time and civilization. By means of shared public concern, it symbolizes an extreme encounter surrounding the inherent facets of confrontation among social, cultural, and political tenets. To defend an ideology, military personnel are committed to get directly involved in what may result in a physical power struggle.

War is unquestionably stressful and clearly has potential to affect the mental health of soldiers. During active military operations, organized resources to handle such stress may or may not be available for military personnel. In that context, the question arises of how soldiers effectively promote good mental health after being exposed to traumatic events. This article explores the concept of talking as a primary method of peer defusing for military personnel exposed to combat trauma.
BACKGROUND AND SIGNIFICANCE

A review of the literature was completed using databases. The following key words were used to identify relevant literature surrounding the effects of combat situations and active duty during military maneuvers and war:

- Combat stress reaction.
- Critical incident stress.
- Defusing.
- Military stress.
- Talking.
- War stress.

In addition, historical publications, current approaches to critical incident stress management, media portrayals of wartime campaigns, clinical experience, and observations from the warfront were used to supplement the foundation of information. Specifically, the synthesis of the literature revolved around the exploration of how talking as a “first line of defense” for defusing can be used to promote mental health and stress relief during and after traumatic events inherent to military duty.

Many writings address the psychological manifestations of soldiers involved in armed combat. Some authors discuss the phenomenon from a historical perspective (Babington, 1997; Binneweld, 1998; Holden, 1998; Shepard, 2001), whereas others analyze established war principles for treatment in the field (Glass, 1954; Hales & Jones, 1983; Kentsmith, 1986). More recently, research and observation have produced scholarly discussions of the more complex facets of posttraumatic stress disorder (Figley, 1985; Solomon, 1993; van der Kolk, Weisaeth, & van der Hart, 1996).

Despite the extensive literature surrounding the formal process of critical incident stress debriefing (CISD), there is a paucity of literature regarding the use of informal defusing, especially talking, and the subsequent potential benefits of talking for promoting mental health in soldiers. To explore stressful events and strategies for emotional support within a military context, it is helpful to clarify key terms and concepts as they relate to intervention strategies.

TRAUMATIC EVENTS AND STRESS REACTIONS WITHIN A MILITARY CONTEXT

Critical Incident and Traumatic Event

A critical incident is an event that has the potential to overwhelm individuals’ normal coping mechanisms, thereby becoming a source of possible psychological distress and impairment of normal adaptive functioning (Evelyn & Mitchell, 1999). A traumatic event is a psychologically distressing event, outside the range of ordinary human experience that is extremely distressful to anyone (American Psychiatric Association, 1994). Such an event is characterized by extreme and unexpected intensity that may vary in duration from acute to a more chronic course of time. Typically, the event induces strong emotional reactions. It may be encountered alone or in the company of others, potentially affecting a single individual or an entire community (Ursano, Fullerton, & McCaughhey, 1994). The subject of war, presumably the oldest man-made trauma, is clearly a rich source of critical and traumatic events and is likely to generate traumatic responses for those directly and indirectly exposed to it.

Acute and Combat Stress Reaction, and Acute Stress Disorder

An acute stress reaction (ASR) may occur during or immediately after experiencing distressing circumstances. An ASR is not inevitable, but can be typical. The initial psychological response is manifested by intense fear, helplessness, or horror, and commonly includes symptoms of numbing, detachment, or reduction in awareness (APA, 1994) in response to the struggle to recover from an abnormal situation (Shalev, 1996). An ASR in the context of combat or combat stress reaction (CSR) entails more precisely the behavior of soldiers under conditions of military combat. This often is manifested as the conflict arises between the ongoing requirement to be a combatant and the ceasing of functional ability in such a capacity (Solomon, 1993).

The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) (APA, 1994) contains the newly recognized category of acute stress disorder (ASD). The principal diagnostic criteria are that the disturbance lasts for a minimum of 2 days and a maximum of 4 weeks, and occurs within 4 weeks of the traumatic event.

Posttraumatic Stress Disorder

A distinct category initially recognized in the DSM-III (APA, 1980), posttraumatic stress disorder (PTSD) is characterized by recurrent experience of a traumatic event, along with patterns of avoidance and symptoms of increased arousal. The criteria for diagnosis include symptoms lasting for more than 1 month. This condition is not about confronting the events themselves, but about experiencing the prolonged effects of troubling memories caused by past traumatic experiences. Posttraumatic stress disorder is categorized with anxiety disorders, and is presumed to be the highest state of intensity and duration. Subsequently, without integration of the traumatic experience of the battlefield, PTSD potentially can derail future military active duty and service.

MILITARY CONTEXT

The military profession bears innumerable challenges, in peacetime, at home, and in operational settings of unfamiliar surroundings.
A review of the literature and narratives of soldiers' personal experiences confirm the existence of definitive stresses inherent to the military lifestyle.

It has been suggested that responses to the stress of military life, and the subsequent personal adjustments, are essential to prevent psychological, potentially debilitating symptoms (Rosebush, 1998; White & Dela Cruz, 1991). In essence, being a soldier may require facing intrapsychic conflict as early as mandatory basic military training. In addition, inherent to the concept of duty, soldiers may experience a full range of stress levels from daily pressures, to extended periods of tension, to extraordinary and austere situations.

Committed to serve when needed, soldiers are perpetually on call and may be ordered to report to duty at a moment's notice. There is often no choice but to extend service and devotion until the task is completed. The mission becomes a priority and demands a constant effort to compensate and adjust to an unfolding crisis.

The stress faced by soldiers holds varying amplitude during operational missions. Before deployment, there is suddenly a microcosmic, yet multifaceted, aura of excitement, apprehension, and emotional turmoil for the departing soldiers and their families. On the front lines, there is challenging adaptation to unpredictable new elements, including confrontation with a dangerous environment. From the anticipation of hostility and disaster to the normal psychological reactions engendered by humanitarian relief missions or armed conflicts, soldiers may be exposed to disturbing sights and events, any of which could be a possible source of severe traumatization.

Operational stresses may induce a range of reactions and behaviors related to the uncertainty and severity of the activities and experiences in the field.

Based on soldiers' life history and past exposures to trauma, many reactions may emerge, including an inability to perform duty, chaotic interpersonal relationships, depressive states, suicide attempts, PTSD, and other psychosomatic illnesses. These signs and symptoms may reflect exceeding individual limits and the need for accessible stress management interventions to avoid complete personal calamity.

Soldiers are the most precious resource of the armed forces. Each soldier is essential but also is acculturated into a collective group. More specifically, one individual is nothing without the others. Although individual contributions to the team are important, it is the group that is more important than any one person could be. It is this group and not the individual that enables the unit to accomplish the mission with success. To preserve soldiers' mental health and strengthen the group ability, efforts are necessary to provide them with tools for stress awareness and stress management to cope with lived critical experiences (Budd, 1997; Pincus, 1998; Rosebush, 1998; White & Dela Cruz, 1991; Zimmerman & Weber, 2000).

War Stresses

Military life represents a unique culture that can place the soldier in situations beyond everyday human experiences and events. Soldiers' abilities are challenged in chaotic, hostile, and dangerous conditions. A continuum of battle apprehension to the normal psychological reactions facing combat exposes soldiers to a severely disorganizing experience. Difficult living conditions, unremitting pressure, lack of proper rest, unpredictable nutrition patterns, and distance from loved ones contribute to elevated levels of stress. From being bored to being placed on high alert, soldiers almost constantly face the unknown.

While fighting intense anxiety or depressive episodes, tension may build and a fear for safety and security may arise. Soldiers may witness "buckeyes" being injured or killed and must wonder about inevitably killing someone. Throughout that burdensome cultural change, a soldier could be confronted with the reality of life and death during the horrors of war. Being exposed to death, destruction, and violence may engender fear, a sense of vulnerability, powerlessness, and culpability, which may result in psychological disturbance.

Soldiers have no direct control over combat or war, and this situation may become intolerable, with limited or nonexistent opportunities to withdraw. This situation quickly may become physically, emotionally, and spiritually exhausting. In an ultimate effort to effectively adapt or even survive in war, soldiers may exhibit an emotional anesthesia manifested by apathy, numbness, and withdrawal, and incapacitating dissociation (Solomon, 1993). Eventually, such incapacity may require removal from the battlefield, which may represent the "breaking point" and result in the inability to perform duties as assigned.

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Historical Perspectives

Posttraumatic neuroses have been known for many centuries. In
the late 1800s, traumatic symptoms were displayed after individuals were involved in railway accidents. The phenomenon subsequently was termed railroad spines because it was believed to be caused by physiological damage to the spine and the nervous system. It also was assumed a traumatized soldier had an “irritable soldier’s heart,” attributed to pathological foundations (van der Kolk et al., 1996). The concept of nostalgia became popular during the American Civil War, associating traumatic behaviors and presentations to soldiers away from home (Solomon, 1993).

The concept of war neurosis, precipitated by the horror of the lived experience and the reawakening of subconscious conflicts, was later suggested. However, the subsequently defined concepts of combat exhaustion and battle fatigue in World War II supported the short-term response to battlefield conditions, often following prolonged mental strain and bodily fatigue. These symptoms have been observed more recently, including in the Gulf War, armed conflicts in Somalia and Yugoslavia, and in other past and current operations. Solomon (1993) now uses the CSR nomenclature, acknowledging the breakdown is the result of the amount of stress to which soldiers are exposed.

The currently accepted signs and symptoms of CSR may be difficult to recognize. These acute posttraumatic reactions, regardless of whether they are combat related, are labile and may be displayed under various presentations. According to Solomon, Laor, and McFarlane (1996), many signs have been observed, including:

- Intrapsychic and interpersonal distancing, manifested by numbing and avoidance.
- Paralyzing anxiety by thought of fear or fear itself.
- Fatigue and guilt about poor performance and inability to function properly.
- Loneliness from being away from home.
- Apprehension and vague fears about being in a new unit.
- Vulnerability with no apparent means or ability to counter or evade the situation.
- Loss of self-control by weeping, screaming, or any impulsive behavior, and somatic reactions, such as vomiting and incontinence of bowel or bladder.
- Disorientation with difficulty concentrating, focusing on thought, or relieving the sense of confusion and loss.

Shalev (1996) proposes the responses to trauma are complex and may affect victims on every level of functioning, including biological, psychological, social, and spiritual. Shalev (1996) posits reactions may be divided into three main dimensions:

- Observable behaviors or symptoms, such as conversion, agitation, or stupor.
- Emotional or cognitive experiences, such as anxiety, panic, numbing, or confusion.
- Mental process or functions, such as denial or dissociation.

Some of these reactions are expected in war and are likely to occur in any acute stress reactions engendered by the experience of a traumatic event.
The unfolding recognition of such significant mental health dynamics is noteworthy. Combat stress reaction was tenaciously pathologized as an organic physical state and eventually was interpreted as the syndrome of the overwhelmed soldier suffering acute stress reactions. Different words have been used throughout history to attempt to describe this psychological struggle. Current studies again attempt to understand the brain and behavior correlates of trauma and its sequela, but the focus is more multidimensional and holistic to explain and encompass these stress and anxiety-related disorders. The implications of understanding and recognizing CSR or ASR involve the normalization of symptoms and the ongoing development of appropriate interventions and treatments.

CARE AND CRISIS INTERVENTION

Historically, the emotional support and psychological care provided to traumatized soldiers are poorly documented. The years encompassing World War I reflected an era when psychology was controversial and medicine traditionally was focused on explaining the manifestation of psychological symptoms by a strictly organic etiology. Although it was not common to recognize any psychological adaptive disorder, experts believed many soldiers lacked willpower and were cowards or malingerers trying to withdraw from the battle and avoid all combat duty (Bogac, 1989; Cooter, 1998). This misunderstood mental health condition resulted in martial law condemnation of 3,000 soldiers by the British Army during World War I, and 346 officers and men were summarily executed. While the doomed soldiers may have been cowards, as defined by their struggle with an overwhelming war experience, they were treated without any distinction, were sentenced unjustly, and were shot at dawn (Bogac, 1989). Their execution may have been the only, and penultimate, treatment for being unable to cope with their emotions.

When the shell shock phenomenon later was acknowledged to be related to the stress of the battle, soldiers began to benefit from more advanced therapies. On return from the front lines, traumatized soldiers were treated with ample rest, well-balanced nutrition and, at times, unconventional approaches, such as electric current to provoke physiological changes that would promote a return to previously known health status. In addition, Dr. W.H.R. Rivers, an eminent neurologist and Captain in the Royal Army Medical Corps, recorded his experiences while assigned at Craiglockhart War Hospital near Edinburgh, Scotland, and caring for soldiers who had broken down during the fighting on the Western Front (Babington, 1997). His writings revealed early evidences of the psychological component of what was known then as shell shock, the repression of war experience, and the importance of talking about the experienced traumatic event.

The management of acute CSR emerged during World War I and was encountered again throughout World War II. War principles for the treatment of stress reactions were developed and instituted. This approach (PIES) involved the overwhelmed soldier receiving treatment as close as possible to the battle (proximity), as soon as symptoms were observed (immediacy), with an expectation of a prompt return to duty (expectancy) and rudimentary treatments such as rest and food (simplicity) (Glass, 1954; Hales & Jones, 1983; Kentsmith, 1986).

Currently, combat and acute stress reactions are clinically and diagnostically recognized as integral phenomena in contemporary mental health science. To remedy the overwhelming effects of war stresses in the field, an extension and extrapolation of the PIES principles is still in use today. In addition, all soldiers have access to an established panoply of stress-reducing techniques. This includes the gamut from training, psychoeducation, prevention, debriefings, interventions in an operational environment or at-home base, and follow-up examinations (Budd, 1997; Pincus, 1998; Rosebush, 1998; White & Dela Cruz, 1991; Zimmerman & Weber, 2000).

Concept of Debriefing

In the context of historical considerations, it is important to recognize the efforts of General Marshall, chief historian of the United States Army during World War II. He advocated the use of debriefing techniques and sessions on the battlefield. Although the sessions were taking place for the purpose of gathering information about the action of the fighting day, he noted that through this narrative approach, holding debriefing sessions appeared to have beneficial effects on his troops. The effects were spiritually purging and morale-building, and they provided a structured intervention that respected the individuals' experience and expression of emotional responses. He believed in its simplicity and that it could be conducted without specialized training (Bisson, McFarlane, & Rose, 2000).

The model for CISD was based on the same foundational tenets of the familiar PIES approach for trauma treatment (Mitchell & Everly, 1996). Initially described by Mitchell (1983), this psychological debriefing is part of a global approach of critical incident stress management (CISM) (Raphael, Wilson, Meldrum, & McFarlane, 1996). The debriefing is provided after a traumatic event and is a...
structured, group-oriented intervention that promotes emotional processing through ventilation and normalization of reactions. Not intended as psychotherapy, it is a form of crisis intervention (Mitchell & Everly, 1996). In the presence of mental health professionals, elements of the trauma are reviewed by the participants shortly after an event to reduce initial distress, relieve anxiety, and prevent the development of later psychological sequelae (Bisson et al., 2000).

The CISD model suggested by Mitchell (1983) is primarily recognized and accepted worldwide as the standard of care for defusing and debriefing after traumatic events. Subsequently, it is not surprising to find consistent application in contemporary military operations (Rosebush, 1998). Despite Everly and Mitchell’s (1999) position on CISD, controversy regarding the effectiveness of debriefings and speculation about possible associated risks continue.

TALKING AS A METHOD OF INFORMAL DEFUSING

Based on historical and contemporary descriptions of traumatic exposure during military duty, the concept of defusing and talking is of interest as a basic, and potentially effective, means to promote mental health and adaptive coping. Although it is difficult to research the efficiency and efficacy of the debriefing process, it intuitively appeals to therapists or peers who want to help suffering individuals. An opportunity exists for soldiers to explore and report the benefits of talking as a method of defusing in the military environment.

Defusing

Various approaches have the potential to reduce high stress levels experienced by soldiers. The term defusing appears to be a variation of the term diffusing. It is defined as an action to make a situation less dangerous, tense, or hostile, such as a crisis (American Heritage Dictionary, 1992). For Everly and Mitchell (1999), defusing is a small, semi-structured group discussion about a crisis intervention designed to reduce psychological tension and discord.

In contrast, defusing for this article is defined as an informal, unstructured strategy of providing emotional first aid to individuals. Defusing in this context is performed individually, in groups, or in varied social settings. Informal defusing or defusing by talking occurs spontaneously at no specific time or place (Cudmore, 1996). It is neither a psychological debriefing nor a formal defusing session. It is more about the fundamentals of human nature, caring, and early crisis intervention by one’s peers, without the need for formalized intervention or direction by mental health professionals. This is of importance in the active combat situation because these formalized approaches may not be realistic or feasible. More directly, wars do not cease for military personnel to have an organized CISD session with counselors or therapists.

Peers

Peers may be the most readily available resource for defusing and support. In a CISM context, Mitchell and Everly (1996) refer to peer support personnel as individuals from the same trade or professional group, not involved in the stressful event, and drawn to take part, as leaders or team members, in the crisis intervention process.

In a military context, being a peer may suggest a broader interpretation designating any military personnel, such as members of the same unit, mission, trade, or rank. Being a peer implies having something or some experience closely shared. Due to the nature of war and military operations, it is more than likely a peer will have experienced the same or similar events and stressors. Often facing the same distress and disturbing events, going through the same struggle and sharing the same trench, peers form a tight family of support. Peers, often referred to as buddies, eventually may be the actual, and most beneficial, providers of emotional first aid.

Foundations of Talking

One of the basic approaches to relieving emotional stresses and negative feelings is to talk about them. Historically, it has been recorded how effectively talking works to defuse stresses. Discussing in textbooks and clinical manuscripts, talking is practiced in a wide range of settings, from group support participation to psychotherapeutic sessions. Talking occurs all the time and everywhere people converse. Intuitively, people know talking is a beneficial method to ventilate inner thoughts and feelings.
Human Response

Raphael et al. (1996) posited that the psychological first aid provided by helping and caring may be rooted in the initial and basic human responses of comforting and consoling frightened individuals, protecting them from further danger or suffering, and facilitating telling the trauma story and ventilating feelings. Within the nursing discipline, helping distressed individuals is a basic tenet of caring. Caring for traumatized and tormented individuals arises from ethical engagement, moral responsibility, diverse ways of understanding the trauma experience, and acting in partnership with those afflicted (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001).

Pennebaker (1999) stated, “When individuals are given the opportunity to disclose deeply personal aspects of their lives, they readily do so” (p. 13). Subsequently, defusing by talking about traumatic events and the related emotions has the cathartic effect of stress reduction. This can promote normalization of the experience and may result in the reestablishment of the functional social network. This cognitive assimilation can help in regaining a sense of safety and self-worth, and can facilitate the restoration of adaptive functioning.

Effective Stress Reduction

Mitchell and Everly (1996) suggest talking and ventilating emotions are effective methods for reducing overwhelming stress. Allowing the person in crisis to ventilate may be sufficient to stabilize symptoms of distress (Everly & Mitchell, 1999). Pennebaker (1999) also demonstrated that verbally expressing emotions helps to resolve traumas and reduce stress. According to Southwick, Morgan, and Rosenberg (2000), although research data do not support that social sharing and talking to family and friends decrease the likelihood of developing PTSD, the disclosure of emotions appears to be a critical foundation for the psychological recovery from traumatic experience. The same research supports that talking to friends, specifically after the Gulf War experience, resulted in reduced perceptions of inadequacy and other feelings of personal maladaptation. Cudmore (1996) confirmed the same idea, stating nurses in emergency departments have stressful jobs and the value of informal talking is beneficial to staff members’ mental health.

Known Process

It has been known by emergency and rescue team personnel and the military that talking, processing, emotional release, and winding down after a traumatic event are extremely beneficial (Raphael et al., 1996). Therefore, Raphael et al. (1996) added that before the current processes of stress debriefing became popular, formalized, and widely used, informal social processes may have partly fulfilled some of the same functions. Soldiers have been defusing by talking throughout active duty. Psychological debriefing concepts were not developed and professionals were not in close proximity most of the time, but something was being done to alleviate distress.

Peer Defusing

As peers walk, talk, eat, sleep, and spend time together as a close family, the military profession offers intense personal relationships, not leisure, but a bond between soldiers and comrades, and “brothers in arms.” Peers take the time to be present when they can and watch out for each other at all times. Every member of the group is important.

Military peers experience similar difficult challenges and are in a unique position to support each other. They may offer reassurance by a simple gesture, including a tap on the shoulder or a comment such as, “You are going to be alright.” They may be socialized to express themselves with reservation, but may talk if a platform of acceptance and normalcy is set. This may include talk of lost buddies and friends, and the guilt and shame surrounding the events.

Although they have been taught to care for each other in military terms, they come to know and learn so much about each other that a moral obligation to maintain personal safety and the safety of others develops. The context is that to survive, everyone has to care for all others. The individual is not safe and cannot accomplish much alone, but a collective and cohesive group will survive and succeed in its mission. Furthermore, despite directives or dangerous situations, soldiers will still attempt to rescue and help a struggling peer in harm’s way.

Defusing by Talking

It is obvious informal defusing occurs on a regular basis. It has been observed by one of the authors, in his role as a soldier, and discussed among other military personnel. It takes place in the field where soldiers are on duty, in the mess halls, and wherever else they may gather. Between military operations, there is often much idle time to talk. It is easy to imagine an old photograph where military personnel are assembled in the mess tent after a day in the field, having a drink, and possibly a cigarette. They are talking. They ventilate and process the day’s experiences in their own ways, but what matters is they talk about it. They may not openly display emotions, but they will find a method to release their inner pain. They have talked in the past, they talk today, and they will talk in the future.
KEY POINTS

1. Humanitarian relief missions and military operations are unquestionably stressful and clearly have potential to affect the mental health of soldiers.

2. After being exposed to traumatic events, soldiers may develop acute stress reactions, a historically known phenomenon better recognized and understood today.

3. Although organized resources exist, they may not be accessible or appropriate. Soldiers are the most precious asset the military forces have and their peers may be the best and only resource available to them.

4. The need to ventilate and the relief that follows after talking about distressing events are evidence that defusing by talking should be encouraged after exposure to a traumatic event.

BENEFITS OF TALKING

The likelihood of being exposed to traumatic events is greatly increased for individuals in uniform, and more so during operational humanitarian relief or combat missions. Individual limits may be exceeded and soldiers face being overwhelmed by traumatic stresses. Isolated from familiar surroundings and support systems, no resources may be available. If resources exist, soldiers may choose not to use them. In addition, stress management programs exist, but on the front line of battle, they may not be appropriate. It is conceivable that a soldier’s best and possibly only available means is the “buddy,” another member of the military family.

POTENTIAL LIMITATIONS

Potential barriers to defusing exist for soldiers. For example, stigmatization or the apprehension of being labeled negatively, such as “weak,” can prevent an individual from displaying responses to stress or making an effort to talk about it and process with peers. This is related to the old stigma of mental illness and the fear of being excluded and persecuted. Although there still are concerns, recognition of stress reaction syndrome may help to make more sense of the overwhelming experience and the need for defusing.

In a military culture where soldiers have been conditioned to be strong, emotionless models for the purpose of tactical operations, the concern of being perceived as weak may be deeply engraved. This perception could be misconstrued as being a poor leader or an incompetent professional, or as an inability to fulfill the objective of a mission. Avoidance of discussing stresses may be a strategy to prevent professional repercussions or drawbacks for further career advancements.

Rosebush (1998) affirmed soldiers are a difficult group with whom to discuss stress-related issues. Many soldiers may underplay the outcome of stress reactions to protect their status, rank, position, and self-concept. Forcing or threatening these defense mechanisms could be perceived as unproductive or destructive. Rosebush (1998) noted that, in private, soldiers contrastingly discuss with ease the same topic, especially when deployed on missions. As soldiers, they may resist structured group debriefings. Therefore, individual defusings could be much more appropriate and may not represent such a barrier.

Individuals in the special forces, such as soldiers, police, and emergency workers, may have a tendency not to talk and to suppress their painful experiences. Opportunities to join in discussions should be offered, but participation should not be required. Listening and observing in unconditional presence can promote clarification of misconceptions and normalization of the stress reaction to an abnormal situation.

CONCLUSION

Within the established historical evolution and theoretical models surrounding traumatic response patterns, new ideas and concepts, even those not measured by science and empirical evidence, may be useful based on the evidence of “human nature.” Amidst the controversy about such interventions, history has shown that verbal expression and ventilation have been helpful when used by individuals who must return to duty. It is clearly an opportunity to talk with and listen to family, friends, and peers when the presence of a trained specialist or psychotherapeutic approach may be unrealistically unavailable or inappropriate. Based on the actual recognition of acute or combat stress reactions, and the knowledge it is permissible to talk about traumatic experiences, informal defusing appears to provide more good than harm.

The need to ventilate and the relief that follows after talking about distressing events are evidence that defusing by talking should be encouraged for those in need after a traumatic event. The human reaction of talking about events allows for relief of the afflicted individuals. Because the stigma persists, we should reach out and offer help to those who fail to seek a peer with whom to vent and offer him or her the opportunity to talk.
The lack of literature on defusing to reduce the psychological effects on soldiers underlines the need for additional research on the potential benefits of talking as a method of peer defusing. Exposure to future critical incidents of all kinds is likely, and the concept of defusing deserves more exploration.

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