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BEREAVEMENT: INTERVENTION FOLLOWING AN ACCIDENT
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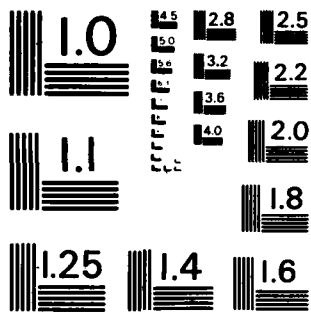
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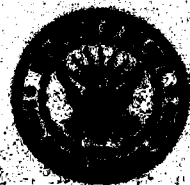
**REAVEMENT INTERVIEW MEMORANDUM
INVOLVING MULTIPLE NAMES AND ALIASES**

B. G. McCAUGHEY

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BEREAVEMENT: INTERVENTION FOLLOWING AN ACCIDENT INVOLVING
MULTIPLE DEATHS AND NO SURVIVORS

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SUMMARY

Problem

Accidents resulting in multiple deaths of service personnel involved in a military mission can cause the personnel of the parent command and their dependents to be stunned and in considerable distress. The bereavement that follows can be so severe that unit readiness is impaired. Mental health clinicians may be called upon to intervene in this situation.

Objective

The objective of this paper was to devise an intervention plan that could be put into effect by clinicians and be comprehensive enough to involve the entire command and its dependents.

Approach

The basic problems that might be generated for a command in this situation were identified and a plan was then formulated to deal with them.

Results

A plan was devised that was divided into two phases: (1) evaluation and preparation, and (2) intervention. It was suggested that the first phase consist of meetings with key command personnel, formulating an understanding of the situation, identifying high-risk personnel and selecting members for a response team. The intervention phase was recommended to consist of structured meetings with one or more of the following groups: (1) the entire command, (2) small groups, (3) high-risk personnel, (4) non-functioning personnel, (5) upper command personnel, and (6) dependents.

Conclusions

Bereavement and other psychological distress affect many members of a command following an accident involving multiple deaths. An organized plan to help resolve this problem has been suggested.

BEREAVEMENT: INTERVENTION FOLLOWING AN ACCIDENT INVOLVING
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INTRODUCTION:

High risk military operations occasionally result in accidents involving multiple deaths with no survivors. As a result the affected command is immediately confronted with a variety of demands and problems. An investigation must be started immediately, and there are a multitude of details regarding the affairs of the deceased. A major problem is the emotional reaction to the accident by members of the command and their dependents. The sudden occurrence of several deaths may generate emotional reactions severe enough to cause prolonged individual adjustment difficulties and impair unit readiness. In this situation a command will attempt to find ways to resolve these problems as rapidly as possible in order to resume normal effectiveness. This paper presents a method of intervention that can be used by mental health professionals to aid the individuals of a command in dealing with bereavement.

BACKGROUND:

The Diagnostic and Statistical Manual of Mental Disorders (DSM III) describes uncomplicated bereavement as a depressive syndrome without gross impairment and a normal reaction to a real life loss.¹ Bereavement is usually self-limiting and can take a year or more to resolve. Because it is considered a normal process, it has been debated whether or not it is appropriate to intervene.^{2,3} Important variables are the command's receptivity to the idea of intervention, its actual form, and the timing of the offer to help. A command in distress due to multiple accidental deaths among its members should be offered assistance. This paper presents an organized plan that is supportive and educative and can be readily utilized in this situation. Two phases are suggested, the evaluation and preparation phase and the intervention phase.

MODEL FOR THE EVALUATION AND PREPARATION PHASE:

In a hypothetical situation, the Executive Officer of a helicopter squadron calls a mental health clinic, stating that one of his helicopters crashed two days

ago, with four deaths and no survivors. He expresses his concern about the effect it has had on the command, explaining that he has noticed alcohol being abused, several of his men coming to work late, and just about everyone looking upset. He then asks for assistance. The following response is suggested.

Arrange for a meeting with an Executive Officer, a senior Medical Department Representative, the Commanding Officer and the Chaplain if one is attached to the command. At the same time notification should be made to your command that you will be involved in this intervention. This is important because of the need for your command to allow you to be away from your normal duties and to provide additional personnel for your intervention. During the meeting of the Executive Officer and others of the distressed command, the goals should be to build trust, propose the intervention, answer questions, demystify yourself as a mental health professional and the bereavement situation, and identify individuals that are having significant difficulties. The command input to the proposed intervention also should be elicited at this time. At the conclusion of this meeting a clear plan should be established. The importance of this meeting should not be underestimated. Without it there is the possibility of confusion and mistrust, which will subvert the intervention. Subsequent to this meeting and during the entire intervention, contact should be maintained with a key individual, usually the Executive Officer.

The next step is to formulate a clear description of the situation. The names of the deceased, their positions, and how they were regarded are important facts. Likewise it should be determined if the mission was necessary and what the circumstances and cause of the accident were. Depending on the cause, assigning blame may or may not be of concern. Commonly related questions are: was the accident due to something the victims did or didn't do; was it caused by someone at the command; was it due to mechanical failure or was it an "act of God?" Finding answers to these questions can be very helpful in resolving many fears and immediate distress for those who must continue the operational functions of the command. To these individuals the most threatening question will be: "Is there something wrong with the equipment, procedures, or is there a problem that I don't even know about that could result in a similar accident and thus my death?"

Identification of high-risk personnel is best accomplished through

discussions with the Executive Officer or the Medical Department Representative. They might include: persons who argued with or traded duty with the deceased just prior to the accident; the person who authorized the mission; persons who worked on the vehicle (in this case a helicopter), and anyone having a close relationship with the deceased.

Selection of the members of your response team depends upon the type and extent of the intervention. The response plan suggested below could involve as many as five mental health professionals. They could be psychiatrists, psychologists, social workers, physicians, corpsmen, or chaplains. Because chaplains are traditionally seen in the role of comforters in this situation, they are especially important members of the response team. In some cases they have been called upon exclusively by commands to manage bereavement.

MODEL FOR THE INTERVENTION PHASE:

The intervention is on six levels: (1) the entire command, (2) small groups, (3) high risk personnel, (4) non-functioning personnel, (5) upper command personnel, and (6) dependents. Each level will be discussed individually. The entire command should be assembled and presented with information about what bereavement is and what feelings commonly occur. It could be stated that this is an unusual situation in their lives and that sometimes it is normal to be abnormal, so that the unhappiness they are feeling can be seen as normal for the situation. Anorexia, insomnia, asking why this had to happen, and feelings of sadness are normal for the situation. It may help to talk about feelings to friends and family but trying to suppress them by using alcohol or drugs will not help. This part of the intervention should be done first and should be done with the entire response team in front of the audience or sitting with them. There should be time at the end of the presentation for questions.

Small groups at high risk include people who worked in the same shop or were especially close to the deceased. Meeting one time, these groups can be used to foster expressions of feelings and to promote group support.

Individual high-risk personnel should be offered an opportunity to meet with a member of the team if there is a significant level of distress and dysfunction. The type of intervention for these individuals depends on the nature and extent of

the distress. Most extreme are those personnel having an emotional reaction to the accident so severe that they are grossly impaired in some major area of functioning, such as work or family life. Short-term individual therapy should be considered. Higher command personnel include the Commanding Officer, Executive Officer, and possibly other senior officers. Their seniority and leadership role dictate that they appear strong to those they lead. The combination of this demand with an increased workload and the isolated nature of their positions may result in difficulties in finding a time or place to express their feelings. An offer to listen to their problems and feelings may be gratefully accepted.

The last group consists of dependents. That dependents' reactions significantly influence the active duty member cannot be denied. Their questions and concerns center on the safety of their mates as well as their empathy and bereavement for the surviving spouses. A group that includes all spouses and two or three members of the intervention team will provide an opportunity for the spouses to express feelings and receive group support.

Spouses of the deceased have not been mentioned. Deciding whether to offer them assistance in the form of traditional management or involving them in the response plan will depend on such variables as their wish to remain alone or be with others and the site and nature of the funeral arrangements. Individual circumstances will need to be assessed to make this decision.

CONCLUSIONS

The intervention as presented above may seem rather time consuming and extensive; however, if organized in an efficient manner, it can be accomplished in the span of a week and using just a portion of that week. The plan as presented above was based on a hypothetical situation. Each command that experiences a major accident has needs that are unique to their situation, so the plan presented in this paper must be modified to fit the particular situation.

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