Emotional First Aid - Critical Incident Stress Management

Dear Editor,

This is in reference to the original article titled *Evolving Strategies for low intensity conflict* MJAFI 2003;59:96-9 and a response to the letter "Our Stress-Proof Jawan" published in MJAFI 2003;60:210. Both make very interesting reading.

I have the following comments/suggestions on the original article:

1. The author has very clearly brought out that we need to "plan for emotional first aid". I would like to draw the attention of the authors to the International Critical Incident Stress Foundation" that has been doing pioneering work in the field of Critical Incident Stress Management (CISM) worldwide, but predominantly within the United States. Their website is www.icisf.org [1]. They run short and advanced courses in providing this emotional/psychological first aid. They have a seven-step model of providing this CISM that has to be applied under different categories of critical stress and at different periods after the stressful event. I have attended the Basic and Advanced Critical Incident Stress Management course run by the organization, and am convinced by the need for such emotional first aid in our set up.
2. The authors do not suggest any model that they would have adopted in providing this emotional first aid, presumably leaving it to the specialized psychiatrist team to develop a model. Similarly, they have targeted the personnel engaged in low intensity conflict operations (LICO). I would like to differ with them on this aspect. Providing emotional first aid is not the prerogative of the psychiatrist or medical officer. Such form of emotional first aid is best accepted when given by peers trained in such therapy. Even the services of the religious priest attached to the unit should be utilized after adequate training in such psychological first aid. Care should be taken that no harm is done (which is quite possible) in providing incomplete or inadequate emotional first aid. Secondly, a model that has proved successful in a particular society / organization may not prove as successful in another society / organization. It is my personal opinion that while the grief process of human beings would generally be the same; the time course of this grief process after a critical incident can very well be modified by the religious ceremonies that ensue after such an event. Differences between our beliefs and customs compared to western customs following bereavement may possibly influence the nature and time course of such psychological first aid that has to be delivered.
3. It has been shown that effective CISM can drastically reduce the incidence of post trauma stress disorder (PTSD). If that were the case, we should not be limiting the concept of emotional first aid only to personnel involved in LICO. If we were to search critical incident stress literature, we will find that there are numerous events in our day to day military life, that qualify for emotional first aid. Let us not deny our personnel the

benefits of this simple yet very effective therapy.

4. My next comment is on the letter titled "Our stress-proof jawan". The author of this letter suggests that PTSD is a rarity in our setting and lauds the hardy Indian soldier. I agree as far as the qualities of the soldier are concerned and will even go further in suggesting that the social support structure in our society including the military units is what probably makes the individual cope up with grief successfully at times of critical stress. There is a remarkable difference between societies on this aspect and this is where our societal support is remarkable. Nonetheless, this is not the only reason that the reported incidence of PTSD is less in our scanty published literature. As a generalization, there is slight reluctance in labeling psychosomatic symptoms to stress or a psychological cause both in the military as well as the civil health care. It would be rather difficult to explain the absence of significant psychological symptoms after a massive earthquake at Bhuj in 2001, when literature suggests that suicide rates can increase as much as 63% in the first year after an earthquake [2]. Moreover, the treating MO would be hesitant to refer an individual to a psychiatrist to rule out PTSD. Add to this, the psychiatrist may insist on a completed AFMSF-10 along with a referral for possible evaluation of a PTSD.
5. My last comment is for the Editorial Board MJAFI. It may be worthwhile to introduce some space for "practitioners papers" in MJAFI. Certain other journals/societies permit such a practice. What it essentially does is that it permits practitioners to write a concept paper that is based on some experience the practitioner may have. Generally, it is the policy of MJAFI to invite papers on contemporary issues from eminent faculty. But junior officers may not be on the radar screen of the journal staff to submit such a practitioner paper, yet they may have a concept based on experience or exposure to certain unique opportunities. I will be willing to send the author of the original article my paper (yet unpublished) titled "Psychological sequelae of trauma: is there a role of critical incident stress management in military medicine?" directly just in case he desires. I am confident that the publication of such practitioner papers may eventually broaden the horizons of our medical fraternity, because such papers may generally have no data to justify their submission as a original article, yet the concept could have significant contemporary relevance.
 1. International Critical Incident Stress Foundation, Inc. at www.icisf.org.
 2. Oster NS, Doyle CJ. Critical Incident Stress. In Disaster Medicine Ed Hogan DE, Burstein JL. Lippincott Williams and Wilkins, Philadelphia PA 2002.

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