

The Effectiveness of Early Group Intervention for Military Reserves Soldiers: The Role of the Repressive Coping Style

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ABSTRACT

This study had two aims: 1. To examine whether soldiers who participated in Early Group Intervention (EGI) would show less distress and better functioning and physical health than soldiers who did not participate in EGI, and 2. To examine the contribution of the intervention to participants with repressive coping style. The sample comprised 166 male reserve soldiers who fought in the Second Lebanon War. The intervention was conducted three months after the traumatic event, was based on military protocol, and took place over the course of one day. Data were collected at two points in time (four months apart). The findings indicated that after EGI, the intervention group experienced less post-traumatic distress than did the control group. In addition, four months after the intervention, the functioning and physical health of the intervention group was significantly better than that of the control group. Notably, the intensity of post-traumatic distress before the intervention was lower among repressors and low-anxious soldiers than among soldiers in the other two groups (high-anxious and defensive). No significant differences were found after the intervention with regard to the various styles of coping with post-traumatic distress. Future clinical implications of the findings are discussed.

Disorder (PTSD). It has been found that, cross-culturally, 13%-20% of soldiers who have fought in wars will develop PTSD during their lifetime (1, 2). PTSD is classified as an anxiety disorder and is typically defined by the coexistence of three clusters of symptoms: namely *re-experiencing* (intrusive thoughts and images), *avoidance* and *hyper-arousal* symptoms. PTSD is frequently accompanied by functional difficulties in various domains such as work/school, intimate relationships, and sexual functioning (3). In addition, veteran soldiers with PTSD have many physical health complaints, make intensive use of health services, and have a high rate of morbidity in comparison to veterans without PTSD (4-7).

In recent years, concerted efforts have been invested in developing psychological interventions to minimize both the risks of long-term psychological morbidity in general and PTSD in particular following exposure to combat. Some interventions have been conducted in the acute phase of combat situations, such as Front Line Treatment (8, 9) or psychological debriefing (10), which is the most commonly used crisis intervention. Debriefing techniques are conducted mostly during the acute phase of combat situations rather than during subsequent phases when these techniques might be more suitable. In fact, therapy conducted during acute phases is controversial. There are those who claim that the mental reaction immediately after exposure to a traumatic event is natural, and that instead of direct intervention, professionals should simply “be with” the victims as soon as the combat situation ends, in order to help them “reconnect” with their natural strengths and regain their mental/emotional balance (11, 12). Raphael (13) suggests performing the intervention only

INTRODUCTION

The most widespread chronic psychiatric illness following soldiers' participation in war is Post-traumatic Stress

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after a certain amount of time has passed, during which time the event can be digested and processed. A similar opinion is expressed by Mitchell (10), who emphasizes the need for psychological readiness for intervention; this readiness is enabled, according to him, only a significant time after the event has happened.

Although the term psychological debriefing has become controversial, researchers who have assessed the efficacy of this technique with military personnel (14) have found it to be effective with intact groups; this effectiveness may be due to the fact that intragroup processes are known to influence individual well-being and because group debriefing is consistent with the military tradition of after-action reviews (15). Other interventions, such as Cognitive Behavioral Therapy (16, 17) and Exposure Therapy (18), have been conducted in the second early phase (i.e., from one to six months following the traumatic event).

It is critical for intervention to be based on the most validated empirical findings. However, to date, no-evidence-based consensus has been reached to support a clear set of recommendations for intervention in the acute and early phases that follow mass trauma (19). Although many studies have found that acute and early intervention following combat are effective, there are only a few studies on the effect of interventions in subsequent phases (from one month to several months after combat) (6, 15). Moreover, critics of early interventions have argued that these interventions cannot be conducted among a wide variety of populations without taking into account the differential effect (20) brought about by interpersonal differences and differences in coping styles among potential participants.

The current study had two aims: The first was to examine the general efficacy of Early Group Intervention (EGI) – an intervention conducted three months after soldiers' participation in a war. We sought to examine whether soldiers who took part in the EGI would show less distress after a traumatic incident, as well as more improvement in functioning and physical health, than the soldiers in the control group, who did not take part in the EGI or in any other intervention. Second, in an attempt to shed light on interpersonal differences, we examined the contribution that EGI made to soldiers, based on their coping styles.

REPRESSIVE COPING STYLE

A repressive coping style has been defined as the distancing of one's self from anxiety-provoking threats through

diverting one's attention away from the threat (21).

Other studies have suggested that the repressive coping style is an unconscious intra-psychic defense (22), and that substantial and persistent use of this defense mechanism turns it into a basic dimension of the personality (23) which is reflected in various cognitive and behavioral processes (24). The most widely used definition was introduced by Weinberger, Schwartz and Davidson (25), who conceptualized repressive coping as a specific combination of anxiety and defensiveness. Postulating four combinations of responses to threat, Weinberger defined repressors as individuals who express low anxiety and high defensiveness.

Recent research has suggested that the repressive coping style can be a pragmatic form of coping that helps people deal effectively with extremely aversive events (26). It has been suggested that in certain circumstances, repressing and avoiding thoughts, memories, and other cues related to the traumatic event may in fact be adaptive (27, 28). Ginzburg et al. (24) found that this coping style might promote both short- and long-term adjustment to traumatic events such as myocardial infarction. Similarly, Palyo and Beck (29) found that after motor vehicle accidents, repressors reported fewer post-traumatic symptoms, anxiety, depression, and health problems than did those who employed other coping styles.

The current study examined whether the efficacy of EGI would differ according to individuals' coping styles. In light of the knowledge we currently have, we hypothesized that soldiers who were characterized by a repressive coping style would have lower levels of distress following participation in combat than would non-repressors. In addition, we hypothesized that EGI would reduce post-traumatic distress among non-repressors, whereas no change or even a worsening of symptoms would be found among repressors. We assumed that EGI, which is based on the principles of debriefing, might expose repressors to threats and elicit a flood of thoughts and unpleasant memories that they would try to divert. Consistent with this view, it has been argued that interventions such as debriefing disrupt the natural process of recovery from trauma, especially for individuals who tend to use coping strategies such as repression and avoidance (30, 31).

THE CURRENT INTERVENTION

The EGI model (32) was formulated after targeting the special needs of the reserve soldiers, and in an attempt to help them process the separation from their fellow unit members and the return to their families and workplaces

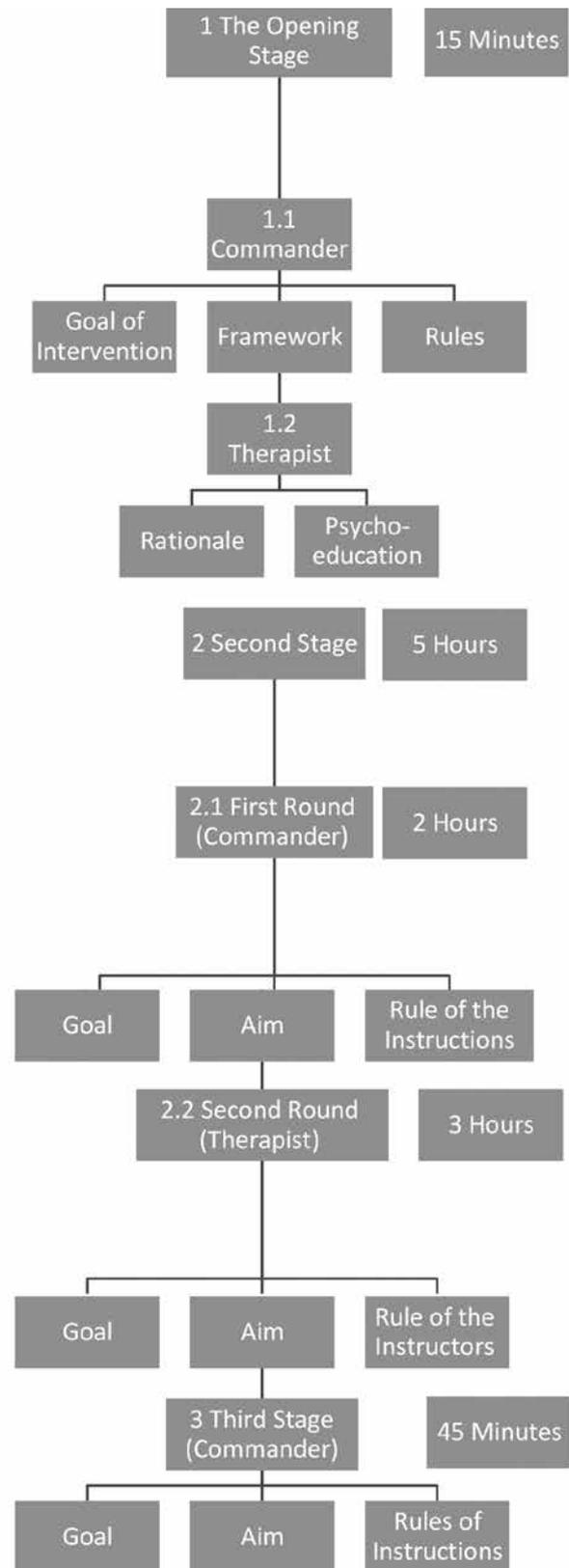
after the war. In addition to providing an outlet for the articulation of thoughts and feelings, and to help foster the development of coping mechanisms, this intervention conveyed the expectation that participants would continue normative functioning in the future. This model could also be used to identify soldiers who need further treatment.

EGI is based on the assumption that the military group provides a significant support network and source of strength, enabling participants to overcome difficult situations. In our case, the existing connection among the soldiers provided social support that was crucial for the success of the intervention (12). The staff of the battalion and the professional workers from the Combat Reaction Unit held a preparatory meeting, which included familiarization with the EGI protocol, getting acquainted with the group mediators (an officer and a professional worker), coordination of the approach to the intervention, and the division of tasks during the intervention. EGI emphasizes the transition from combat to home and recognizes that this transition is a critical social-psychological task.

The intervention was based on a military stress debriefing protocol (33)(see Appendix 1) and was conducted by the Combat Reaction Unit of the Israel Defense Forces among soldiers who fought in the Second Lebanon War. It was held over the course of one day. The intervention consisted of three parts (see Figure 1): In the first part, the soldiers reviewed the sequence of events that occurred from the time of their release from army reserve duty until the present. In the second part, they articulated their thoughts and feelings at the present time (three months after the war). In this way, they were given an opportunity to relate to the losses they had experienced in the war, and they were able to express feelings of guilt and anger. In the third part of the intervention, the soldiers discussed their ability to continue functioning as individuals and as a group (a platoon). The discussion focused on the need to continue living, and the expectation that participation in the group would enable them to resume regular functioning. Common symptoms and difficulties in coping with daily living – e.g., relating to spouses, family members or co-workers – were discussed in the intervention.

Emphasis was placed on the strength of the group and the positive and functional coping mechanisms that the soldiers used. The intervention was conducted by a professional practitioner (mental health officer) and the commander of the relevant military unit.

Figure 1: Flowchart of Intervention



METHOD

PARTICIPANTS AND PROCEDURES

Participants in the study were 166 male reserve soldiers and officers in the Israel Defense Forces, who belonged to a battalion which sustained numerous casualties in the Second Lebanon War (2006). Data was collected in two stages.

Stage 1. The whole battalion was called for a one-day intervention during reserve duty (three months after the war). The intervention followed a structured protocol, and each group comprised an original organic unit. The intervention was facilitated by a professional worker (mental health officer) and a commander of the relevant military unit. Randomization was not feasible due to military constraints. A partial solution to the randomization problem was to form an internal control group consisting of soldiers who did not participate in the intervention for various reasons: (28% were studying, 25% were abroad, 23.5% had work obligations, 16% were unintentionally not invited, and 7.4% had injuries).

The soldiers who participated in the intervention completed the questionnaires before it started. The control group filled out questionnaires at home during the week following the intervention.

Stage 2. Four months after the intervention, the members of the battalion were called again for reserve duty. At that time, the members of the Combat Reaction Unit distributed a second questionnaire to the soldiers. Of those who filled out the questionnaires during this stage, 98 had participated in the intervention, and 68 had not (the control group). No participants in the study had dropped out between the two stages of data collection. No significant differences were found between the participants in the two research groups with regard to combat exposure except for proximity to fire: Both groups of soldiers reported high levels of exposure ($X^2=3.52$, $df=3$, $p=.32$), such as exposure to injury and death ($X^2=0.10$, $df=1$, $p=.75$), evacuation of the wounded or dead ($X^2=0.34$, $df=1$, $p=.56$), proximity to the range of fire (control=91.2%, intervention=98.0%, $X^2=4.03$, $df=1$, $p=.05$), and risk of injury or death ($X^2=1.52$, $df=3$, $p=.68$). In addition, no differences were found in background characteristics: 90% were born in Israel, 70% were single, 64.5% were employed, and 32% were students. Most of the participants were reserve soldiers (86.1% reserve soldiers, and 13.9% officers). A significant difference was found between the groups regarding years of education ($M=14.37$ $SD=2.23$ for the intervention group, and $M=13.70$, $SD=1.77$ for the control group, $t=2.08$, $df=164$, $p=.04$). Differences were also found in

the recent significant event (control=22.1%, intervention=10.2%, $X^2=4.41$, $df=1$, $p=.04$), and these differences were controlled for during the data analysis.

MEASURES

1. Socio-demographic and military information (stages 1+2): This measure included information on the participants' marital status, age, number of children, country of origin, year of immigration, education, occupational status, and military rank.

2. Combat exposure (stage 1): The measure was developed by Schwarzwald, Solomon, Weisenberg and Mikulincer(34) and consisted of six items that examined the soldiers' exposure to combat: complexity of the battle, proximity to the range of fire, exposure to injury and death, evacuation of the wounded and dead, and risk of injury or death. A factor score was derived from a factor analysis ($M=0$, $SD=1$, percent variance explained=.515).

3. PTSD Inventory (stages 1+2): PTSD was measured by the PTSD Inventory, a self-report scale based on the DSM-IV (35). The scale consisted of 17 items that describe intrusive, avoidant and hyper-arousal symptoms. Participants were asked to indicate how often they had experienced each symptom during the previous month on a scale ranging from 1 (*not at all*) to 4 (*very often*). The severity of PTSD was calculated as the mean severity of symptoms. The Cronbach's alpha internal consistency of the questionnaire used in the current study was high (.93), and the scale was found to have high convergent validity compared with diagnoses made by experienced clinicians on the basis of structured clinical interviews (34).

4. Functioning: This dimension was measured on the basis of two questionnaires. **Questionnaire stage 1.** This questionnaire consisted of one item relating to the participant's level of functioning over the previous two weeks. Responses were based on a scale ranging from 0 (*very bad*) to 5 (*very good*). **Questionnaire stage 2.** This questionnaire assessed general psychological functioning over the previous two weeks using the Psychotherapy Outcome Assessment and Monitoring System-Trauma Version (POAMS-TV)(36). Responses were based on a 5-point Likert-type scale ranging from 0 (*extreme distress or dissatisfaction*) to 4 (*optimal functioning or satisfaction*). In this study, one score for functioning (e.g., work/school performance/attendance) was calculated for the mean of the scores on the 10 items. The Cronbach's alpha of the questionnaire used in this study was high (.90).

5. Self-rated health (stages 1+2): Based on a question-

naire developed by Benyamini and Idler (37), participants were asked to assess their current physical health on a scale comprised of three levels (1, 2, 3): bad, moderate, and good.

6. Repressive Coping Scale (stages 1+2): This self-report measure consisted of 58 items, which combined two scales: Manifest Anxiety (Taylor Manifest Anxiety Scale)(38), and Defensiveness (the Marlow-Crowne Social Desirability Scale)(39). Participants were asked to indicate whether or not each item described them, on a dichotomous scale – 0 (*no*) 1 (*yes*). The repressive coping style was determined by the median scores on the two scales. Participants with anxiety scores below the median and defensiveness scores above the median were classified as repressors. In addition, three categories of non-repressors were identified: low-anxious individuals (anxiety and defensiveness scores below the median); high-anxious individuals (anxiety score above the median, and defensiveness score below the median); and defensive individuals (anxiety and defensiveness scores both above the median). The analyses reflected both the dichotomous distinction (repressors vs. non-repressors) and the four-category classification (repressors, low-anxious, high-anxious and defensive). The combination of anxiety and defensiveness as reflecting a repressive coping style has been validated in previous studies (24). The Cronbach’s alpha for the current sample was high, both for the Taylor Manifest Anxiety Scale (.85) and the Marlow-Crowne Social Desirability Scale (.78).

RESULTS

DIFFERENCES IN LEVELS OF PTSD, PHYSICAL HEALTH, AND FUNCTIONING BEFORE AND AFTER THE INTERVENTION

To examine the hypothesis relating to the relationships between participation in the intervention and reduc-

tion of PTSD symptoms, ANCOVAs for PTSD, Physical Health, and Functioning were performed with repeated measures for each stage of data collection, with groups (intervention and control) as the independent variable and education, proximity to combat, and the significant event as covariates. The analysis revealed significant group and interaction effects.

The results of Bonferroni tests presented in Table 1 reveal that participants in the control group reported higher post-traumatic distress symptoms than did participants in the intervention group both before and after intervention. Contrary to the hypothesis, there was no improvement among soldiers in the intervention group. However, while PTSD symptoms remained stable among participants in the intervention group, the symptoms increased among participants in the control group.

Physical Health. Significant differences were found between participants in the two groups with regard to self-assessed health: $F(1, 161)=3.98, p<.05$. Levels of physical health among participants in the control group were lower than among those in the intervention group ($M=2.53$, and $M=2.70$, respectively, with a lower score representing a greater negative change).

Functioning. Due to the use of different measures before and after the intervention, comparisons of the two groups were performed separately at each time point, and no significant change was found. Comparisons of the groups before the intervention revealed no significant differences – $F(1, 161)=0.12, p>.05$ – although the levels of functioning at that time were lower among participants in the intervention group than among participants in the control group ($M=2.54, SD=1.12$; and $M=2.60, SD=.88$, respectively). After the intervention, the levels of functioning among participants in the intervention group were significantly better than among the participants in the control group ($M=3.18, SD=0.53$; and $M=2.94$,

Table 1: Means and Standard Deviations of Outcome Measures, by Group and Timing: controlling for education, proximity to combat, and significant event

Variable		Intervention group (n=98)		Control group (n=68)		F values []2		
		Before	After	Before	After	F(1,161)	F(1,161)	F(1,161)
						Group	Time	Group x Time
Total PTSD	Means	1.52	1.47	1.63	1.77	5.97*	1.08	12.53**
	SD	0.45	0.43	0.65	0.69	.03	.01	.07
Physical Health	Means	2.56	2.85	2.46	2.60	3.98*	0.00	2.27
	SD	0.61	0.42	0.74	0.7	.02	.00	.01

*p<.05. **p<.01.

SD=0.77, respectively: $F(1, 161)=5.52, p<.01$).

THE ASSOCIATION BETWEEN COPING STYLE AND LEVELS OF DISTRESS

First, we examined whether there were differences between the two groups with regard to the distribution of different repressive styles. Table 2 presents the joint distribution of coping style and group. As can be seen in the table, the percentage of soldiers in each coping style category was similar for both groups, and no significant differences between the groups were found: $X^2(3)=.86, p>.05$. In addition, Cohen’s Kappa was calculated to determine style consistency over time, revealing a high level of agreement over time (Kappa=.75, $p<.001$), while no difference in style between groups was observed.

In order to examine the hypothesis that after participation in combat, soldiers who have a repressive coping style will have lower levels of distress than non-repressors, a one-way ANOVA was conducted, with PTSD symptoms as the dependent variable and the four coping styles as the independent variable ($F=18.07, df=3,162, p<.001$). The Bonferroni post-hoc analysis supports this hypothesis: soldiers who were characterized by low anxiety or by being repressors reported lower levels of PTSD symptoms following combat than did soldiers who were characterized by high anxiety or defensiveness (see Table 3).

To examine the hypothesis that levels of PTSD would

decrease among **non-repressive participants** as a result of the intervention, whereas there would be no change or even an increase in the levels of PTSD symptoms among **repressors**, a two-way ANOVA was conducted in regard to change in the level of PTSD symptoms (pre-intervention level minus post-intervention level) x group and coping style. Only the group effect was found to be significant – $F(1, 157)=14.96, p<.001$ – a finding which fails to support this hypothesis, and replicates the first hypothesis. Moreover, there was no change in levels of PTSD among participants in the intervention group, whereas levels of PTSD increased among participants in the control group. Neither coping style nor interaction effects were significant: $F(3, 157)=0.50, p>.05$, and $F(3, 157)=1.88, p>.05$, respectively.

DISCUSSION

The first aim of the research was to examine whether soldiers who had participated in EGI would show less post-traumatic stress than those who had not participated in the intervention. The findings indicated that after EGI participants in the control group experienced more post-traumatic stress than did the participants in the intervention group. However, contrary to the research hypothesis, there was no improvement in PTSD symptoms among the soldiers in the intervention group. Nevertheless, four months after the intervention, the levels of functioning and physical health among the participants in the intervention group were significantly better than among the participants in the control group. And four months after the intervention, the soldiers in the control group assessed their own physical health as worse than it had been a year earlier.

The lack of improvement in PTSD symptoms among participants in the intervention group following EGI does not necessarily indicate that the intervention wasn’t effective. Rather, this lack of improvement might be attributed to the nature of the intervention, which focused on a discussion of responses to trauma. As such, the EGI may have raised the participants’ awareness of their

Table 2: Combined Distribution of Coping Style, by Group

Coping style	Control		Intervention		Total	
	Frequency	%	Frequency	%	Frequency	%
Low-anxious	17	25.0	29	29.6	46	27.7
Repressors	17	25.0	27	27.6	44	26.5
High-anxious	15	22.1	18	18.4	33	19.9
Defensiveness	19	27.9	27	24.5	43	25.9
Total	68	100	98	100	166	100

Table 3: Means, Standard Deviations, and F Values of Stress Indices (Prior to EGI) by Coping Style

		1 Low anxious	2 High anxious	3 Repressor	4 Defensiveness	F=(3,162)	η ²	Source of differences
		N=46	N=33	N=44	N=43			
Total PTSD	M	1.30	1.72	1.34	1.94	18.07***	.25	1,3<2,4
	SD	24.	53.	34.	69.			

***p<.001

symptoms and, paradoxically, inhibited future improvement (40, 41).

The findings also revealed that following the intervention, the participants in the control group experienced more post-traumatic distress than did the participants in the intervention group. They also had poorer functioning and more physical health problems than did the participants in the intervention group. As there was no random allocation, one cannot discount the possibility that there might have been differences between the two groups: for instance, those who did not take part in the intervention might have been more vulnerable to begin with. As suggested previously, it may be that soldiers with PTSD, who have a high awareness of their mental and physical problems, tend to assess their situation as more severe than soldiers without PTSD (42). This explanation is also consistent with the approach of researchers who argue that people who have experienced a traumatic event tend to develop hypochondria, and that somatic problems play a central role in their lives (43).

Two hypotheses regarding the repressive coping style were examined in this research. The research findings support the hypothesis that repressors will show higher levels of adaptation following traumatic events than will non-repressors. The repressors showed a lower intensity of post-traumatic distress, as did the participants in the low-anxious group versus the participants in the other two groups (high-anxious and defensive). These findings are consistent with the results of another study which revealed that among people who had been in a motor vehicle accident, there were no significant differences between repressors and low-anxious individuals with regard to levels of PTSD and depressive symptoms (29).

There are several explanations for the contribution of repressive coping to adaptive behavior: First, repressors are protected by their primary appraisal of stressful events (44), that is, by their perceptions and interpretations of threatening cues. Second, repressors seem to have exceptional control over what they pay attention to in the presence of threat, a process that may foster resilience in the face of trauma (45). They also recall fewer details of stressful experiences (46), and they remember fewer negative events (21). These findings suggest that repressors may be less prone to develop PTSD because they employ selective attention during and after a traumatic event, and thus perceive the event as less threatening than do non-repressors (47). Third, it has been argued that a major motive for repressive coping is maintaining a positive self-image (22). Various findings have indicated

that in comparison with non-repressors, repressors tend to ascribe fewer negative and more positive attributes to themselves (48).

The second hypothesis – i.e., that the intervention would reduce post-traumatic distress among non-repressors whereas post-traumatic symptoms would remain unchanged or even worsen among repressors – was not supported. This hypothesis derived from our assumption that EGI, which is based on the principles of debriefing, would expose repressors to threats that might cause a flood of thoughts and unpleasant memories that they would try to divert. However, no significant differences were found after the intervention with regard to the various styles of coping with post-traumatic distress. Several possible explanations can be offered for this finding. As mentioned, various researchers have indicated that repressors have a more positive self-perception than non-repressors (49), and that they pride themselves on appearing self-controlled and unemotional (22). Consistent with these arguments, it is possible that the EGI allowed the repressors in the present study to maintain their positive self-perception since behaviors that are generally perceived as failures were redefined in the intervention as reactions that are reasonable to expect following the return to civilian life (50).

Furthermore, EGI does not pose a threat to the self-image of repressors. If they describe themselves as possessing effective coping skills, they receive encouragement from the group and from the facilitators. In that context, they are not exposed to threatening feelings from their peers or to feelings of failure and loss of control. Consistent with the findings of Ginzburg et al. (24), in this study the repressive coping style was a protective factor, which contributed more to preventing mental health symptoms than it did to promoting mental health resilience and functioning.

LIMITATIONS OF THE RESEARCH

This study had several methodological limitations, as the intervention was designed to meet military needs (i.e., minimizing risks for long-term psychological problems and assisting soldiers in distress) and was not designed for systematic research. Rather, the research was planned after the intervention took place in order to address the gap between the need for intervention in the military and the lack of studies assessing its effectiveness.

The main limitation was that there was no random allocation to research groups. Moreover, because the EGI was conducted by the military and aimed to mitigate

distress among all soldiers, a random sample could not be attained. Nonetheless, no significant differences were found between the two groups in the main background variables, suggesting that in fact there was a basis for comparing the two groups.

Another limitation of this study was that the control group had significantly higher PTSD symptoms at Time 1 than did the intervention group, a drawback that might be related to the non-random allocation to the research groups.

The second stage of data collection occurred while the soldiers were in reserve duty. Perhaps the renewed contact with the army four months after the war influenced their feelings and reawakened memories and thoughts that biased their responses (i.e., reflecting more symptoms and higher intensity of distress). In addition, some changes were made in the questionnaires between the two stages of data collection due to logistical constraints. Other limitations include the lack of objective measures such as performance on military tasks and other observations.

IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

To better understand the contribution of each component of EGI to preservation or improvement of behaviors among participants in an intervention, there is a need for additional long-term follow-up studies dealing with each of the specific aspects of the intervention method. The clinical advantage of EGI is that it provides a basis for identifying soldiers with PTSD while they are doing reserve duty. Findings have revealed that at a later stage, when the soldiers are at home, they need to take initiative to continue treatment. As a result, those who are not proactive might not receive essential support. Furthermore, if the soldiers at risk are identified immediately following military service, treatment can be provided in closer temporal proximity to the traumatic event. Another significant advantage of the intervention for soldiers who remain in their organic unit relates to the informal interaction among the soldiers and their immediate commanders, who constitute a significant support system and a source of strength that helps them cope with the situation.

The finding that repressors showed a lower intensity of post-traumatic distress indicates that the repressive coping style is a mechanism that can facilitate adaptation after a traumatic event. Therefore, the clinical tendency to encourage all soldiers who have been exposed to a traumatic event to talk about their experience out of a concern that repression of the event might worsen their

condition was not supported in the present study. Finally, little is known about the development of repressive coping and the ability to change that style. Hence, especially in light of its protective function, it would be worthwhile to conduct further research on the role of the repressive style in the process of coping with traumatic events.

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APPENDIX 1 - THE OPENING STAGE

Commander. 1. Goal of the intervention: “We went through harsh events (the commander should direct towards events experienced during the war) during the last reserve service, after which we returned to our life routine. In our session today we will try to clarify what our life routine looks like since we were discharged from reserve duty, with emphasis on the emotional processes that accompanied the process of our return to civilian life. It is important that each of you will express himself. We on our part will enable each of you to do so. In this way we will learn how each person coped and is coping with the return to civilian life on the background of the war events we experienced and how we as a team need to cope in preparation for our next reserve duty.”

2. Framework: “The session is divided into three rounds. In the first round we will describe the sequence of events that each of us experienced since his discharge from reserve duty and will examine, at the facts level, how each of you copes with the routine of his civilian life with emphasis, as mentioned before, on the encounter with “civilianship” after being discharged from reserve duty – after the war. This second part will last about two hours. After a break we will convene for a second round that will last for about three hours, with a break in the middle, in which we will deal with our feelings from a distance of the time that has elapsed since the war events and since our discharge from reserve duty. During the third round we will summarize the discussion for about one hour and will discuss the future and the expected schedules. This entire day will be headed by (indicate name) – a therapist at the Combat Reaction Unit.”

3. Rules: “In order to create an atmosphere that will enable success of this session, I would like to ask you to make sure of the following: do not talk on your mobile phones because succession is important, and for mutual respect, do not enter and leave during the talk, allow each person to finish what he is saying, do not attack, do not criticize (it must be emphasized that this is not an operational debriefing), and finally, it is very important that each of you will speak. If anyone has difficulty with this, he should at least describe his position and role during the event that took place in the war.”

Therapist. 4. Rationale: “The early group intervention’ is intended to prevent the development of effects that belong to what we call the post-traumatic stress disorder, which I will detail right away. This disorder may develop among soldiers who, like you, experienced combat events in which soldiers were killed and injured.

We know from studies and from reports of professionals who experienced such models of talks that the talk within a group of people who know each other well and who experienced the event together is very helpful for emotional alleviation and for preventing post-trauma. This talk is supposed to take place at a distance of about three months from the previous talk you had, the ‘team talk after the event’ during the last two days of your reserve duty, because it is believed that it is possible to prevent the development or exacerbation of effects that belong to the post-traumatic stress disorder during the first three months after exposure to an event. This talk, of ‘early group intervention,’ is actually a continuation of the previous talk in which you participated, and comprises another opportunity for all of you to describe your experiences and emotions and to learn how each of you is coping with civilian life on the background of the event which you experienced during the war. It is also supposed to increase the cohesion, sharing and mutual care among you and will help us, the therapists and the commanders, identify and suggest, to those for whom these talks were not helpful, to receive individual therapy at the Combat Reaction Unit.”

5. Psycho-education: “Chronic post-trauma develops, according to the research literature, over three months and is characterized by three groups of symptoms: ‘avoidance’ of thoughts about the event or contact in reality with things that are reminiscent of the event, for example: contact with the army or watching news that broadcasts pictures from a war, ‘hyperarousal’ which is expressed in alertness on a background of the tension created by the feeling that another harsh event can happen, which sometimes leads to panic from noises reminiscent of the sound of explosives, and ‘intrusiveness,’ which is expressed in nightmares and unceasing dreams and thoughts about the event. All three of these symptoms eventually impair functioning, since if one does not sleep well because of dreams and nightmares one becomes tense during the day, the level of attention decreases and the ability to function well at work, as a parent or as a partner, is impaired. Furthermore, think about the fact that when a person who was exposed to a traumatic event is busy avoiding thinking about the event or coming into contact with things that are taking place in reality that are reminiscent of that event during his waking hours, this increases his difficulty to function even more. We would like to prevent all of this or at least reduce the intensity of the symptoms among those who are already suffering from them, and as I mentioned already, the ‘window of

opportunity' for prevention is within this range of time, i.e., in the early months after exposure.

It is important for me to indicate that even if symptoms characteristic of post-trauma have developed among some of the people sitting here, and even if after the session today some of the symptoms will remain, there are still things that can be done. First of all you must remember that people who experienced such a harsh event react to the event at the emotional level. We know from studies that not less than 80% of the people who are exposed suffer from at least one symptom of a stress reaction, which is the first stage of post-trauma, but the symptoms usually disappear. How? By talking with friends, partners, family, etc. Thus, they recover without any help from a professional by spontaneous talk. What is done here is something more structured, but is based on the idea that one must talk about things, because 'talk' apparently helps. Of course, your belief that it is possible to feel better and that it is possible to again function well as a team is also very important. Finally, it is important to stress that if there is no improvement among someone who already suffers from symptoms, he can come to us at the CRU for individual help. Such help is supposed, in the end, to help reduce the intensity of the symptoms and improve the quality of functioning."

APPENDIX 2 - SECOND STAGE

Second Round

Therapist. Explanation of the different losses (friends, relatives, worldview, self-trust, confidence, trust in commanders, trust in operational ability, loss of motivation)

as a result of exposure to traumatic events.

Commander. "Based on what (should mention the name of the therapist with whom he is working) described, it is important that we talk about each of our losses. What did each of us lose during this event?"

After each participant referred to this question, the therapist should ask: "What are the emotions that accompany the loss?" (The therapist should focus the talk on anger and guilt by reflection, confrontation, leading questions, etc.)

APPENDIX 3 - SECOND STAGE

Third Round

Commander. "Based on the talk today, what things do you think need to be taken from here for the future at the personal level and at the team level?"

Therapist. Stressing the positive forms of coping (for example: reflection of the component of sharing and receiving support from the partner).

Commander. "I would now like to ask each of you to indicate at least one thing that he received from the group today and what his message is to the group." After the discussion the commander summarizes the intervention according to the following points: (1) Summarize the session up to this point (major and positive components that were prominent around the return to functioning after the discharge, prominent feelings and prominent recommendations for future coping). (2) Speak about the moral and ethical (comradeship) commitment "to go on." (3) Speak about the importance of "to go on" for the individual and for the team.

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