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The necessity of the development and preservation of stress-resistance and psychological resilience in the defense sector

PhD dissertation

THESIS BOOKLET

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FORMULATION OF THE SCIENTIFIC PROBLEM

The professional and the contract personnel of the Hungarian Defense Forces, due to their obligations to Hungary, the Constitution and NATO often get into situations when they experience exceptional psychological hardship.

Since 1995 our country has been taking part in missions abroad more and more often. The participation in these missions is a very specific task that differs from those at home. The new threats of the recent times mean new challenges for military operations. The common element of the tasks different from the traditional ones, is that there is no actual enemy to combat. The tasks in missions expect the soldiers to behave, contrary to how they were trained to fight, for example with weapons, to fight not the way they were taught, but to be "diplomats". At the same time, the conditions of warfare are still more those of traditional warfare: enemy forces, guerillas, terror attacks, minefields, etc.) The soldiers when they prepare for a mission are aware of the fact that they can be in danger, they can be seriously injured and can even lose their lives. Peacekeepers getting in combat situations can personally experience life-endangering situations, catastrophes, they may see seriously injured people or even death. These traumatic experiences, the constantly present or unexpected stress weakens the physical activity and the healthy psychological defense mechanisms. For these special services it is absolutely necessary to possess high levels of psychological flexibility, the ability to adapt and being prepared professionally. Thus, with the help of the proper training, it is crucial that stress appearing in dangerous situations would serve as self-protection making it possible for the soldier to concentrate on the given danger with all his might and to prepare to react.

Both in the recent and previous times there were many events in our country and in its neighborhood, as well as in distant operational areas where many went through traumatic experiences. In some professions like those of soldiers, police, firemen, ambulance crews, the danger of traumatization is always present. Following such tragedies, besides normal reaction to stress, there may often develop pathological (abnormal, illnesses) responses and conditions, for example acute stress illness and posttraumatic stress disorder. Which are the cases of stress when we can talk about a psychologic trauma? According to the American Diagnostic Manual, the DSM-IV "it is

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a stressful situation when the life and the bodily integrity of a person is in a direct danger or when the person witnessed another person's suffering or got informed about a relative's unexpected or violent death and the person reacts with the feelings of being threatened or with the feeling of inability to act." There are many and different kinds of events that can cause a trauma and pathologic states: directly lived through events, such as personal participation in combat operations, violence against a person (injury, sexual assault, physical attack, hand to hand combat, torture, etc.), state of being a prisoner, terrorist attacks, robbery, natural disasters, serious traffic accidents, life-threatening diseases. Another cause for trauma is the unexpected bad news, e.g. death, violence, serious accident, etc.

Traumatic events may be specific in cases of professional stress. These are kinds of events that may not happen unexpectedly but as an experience, they may be life endangering. They immediately trigger the body's response to stress. The ability to fight may exceed the person's ability and adaptation capability. The persons I have examined, are specialists who work in the protective sector, e.g. soldiers, policepersons, firemen, armed security guards. These people, due to their work, often face traumatic events. They regularly get into dangerous situations where they face not only other people's injuries and death, but their own integrity can be endangered.

Living through and handling dangerous situations is a psychologically demanding process that can provoke extreme stress or, in some cases, can even lead to a trauma. Extreme stress is an experience when the pulse and the blood pressure are near the border of survival and the cognitive functions of the person become very narrow, as well as the ability of perception and the ability to feel. There may be inadequate behavioral and emotional reactions. There may be inability to act, panic reactions or a catastrophe syndrome. Due to normalization processes the body gets back its balance both somatically and psychologically or if not, pathological processes or conditions may develop. In case of extreme psychological hardship we can speak about all three levels of prevention. In my research there is a special emphasis on the first level of prevention- the description of risk and protection factors, from the behavioral point of view of those who work in the protective sector and face very dangerous situations.

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During their work the stressful processes and psychological events are different, and their forms and patterns are often not the same. It is necessary to take into account the stressful reactions that are provoked by traumatic experiences, the chronic, so-called cumulative stress that may induce other psychopathologic processes, as well as conditions provoked by everyday stress factors.

In case of certain extreme stressful or dangerous situations when the persons experience, witness or get involved in situations including those of being lethally threatened, seriously injured, losing physical and psychological integrity and when the person reacts by intensive fear, anxiety, the feeling of inability, these situations can be described as the cause of a psychological trauma.

Psychological trauma is different in its character and quality depending on everyday stress, and there is a direct danger of physical and psychological disintegration. These are special situations such as: wars, combat events, serious accidents, natural disasters, terror acts, sexual and physical assaults, armed attacks, etc.

With certain professions, such as police, firemen, ambulance workers, the danger of traumatization is manifold. Besides normal reaction to stress, they can often develop pathologic reactions and conditions, such as acute stress-related illnesses and PTSD.

In our days more and more attention is paid to the effective treatment of extreme stress situations both in the civilian and in the defense sector, as well as prevention of appearance pathological conditions and PTSD following a traumatic experience. The main emphasis is on the solution and understanding of those factors that are responsible for the personal vulnerability and resilience. Throwing light on and filtering out the risk factors is constantly present in all levels of prevention. From the point of view of the primary prevention it is very important to measure vulnerability, especially with risk-taking occupations it may indicate aptitude and selection criteria as well.

After the terrorist attacks of 9/11, the facts, data and publications issued by the American Psychology Society (APA), emphasize the necessity for flexible resilience in connection with the traumatic events. They underline that the majority of people have the ability to fight even high levels of stress. According to the APA definition the

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flexible resilience is a process that helps overcome a difficult life situation, a tragedy, a trauma. People are able to fight effectively the distress caused by a trauma.

AIMS OF RESEARCH AND FORMULATION OF HYPOTHESIS

Aims of research

According to the international and domestic special literature and from the results of different researches we can assume that the risk factors causing vulnerability and the partly personal, partly environmental factors characterizing resilience, play a common role in processes following chronic or extreme stress situations, as well as in appearance of pathologic conditions and recovery. There are many research results in connection with those of the risk factors, on the other hand, the examination of protection factors of flexible resiliency is still in its beginning phase. The theoretical background is manifold, contradictory and not enough proved. It is aimed as a primary, quantitative, qualitative in character, cross-sectional, partly exposing, partly reasonable and causative examining empirical research.

With the help of empirical data I want to prove the following:

- The aim of my research is to examine the importance of resilience in adults who faced trauma or extremely stressful situations, especially in the case of professionals who get into dangerous situation during their work (firemen, crime scene investigators in operational tasks, soldiers in missions, armed security guards protecting critical infrastructure).
- My aim is to introduce the occurrence of traumatization, the health/normality and the pathology as well as the prevalence of resilience and other protective factors with the personnel who face heightened risk of danger.
- During my research I want to examine from the point of view of health and pathology if there is a difference in the factors causing pathology with the personnel who get into elevated danger situations. (According to the special literature, when there is elevated resilience present, the probability for the appearance of negative functioning is lessened. Consequently, the possibility of traumatization, following stressful situations is smaller, in other words, the

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possibility for the repair of homeostatic balance or even moving towards posttraumatic development is higher.)

- In the course of my research I want to examine the possible factors responsible for the development of the resilience and their correlation with other protective factors. (These will be proved by the Resilience Scale which has been used by me and which was developed by Friborg and his colleagues, having been validated in many countries). I will prove the validity and complexity of this device as one used as an independent examination tool.
- In my research I want to study different groups within the defense sector and I also want to compare them from the point of view of risk and protective factors and the psychological condition. My aim is to provide a common system of tests which is able to show the psychological condition of all personnel performing the tasks of the defense sector.

Hypothesis

1. ***I want to prove that the health condition, mainly the psychological state of the examined population is explicitly good, the occurrence of risk factors is low.***

Within this:

A/ I assume that the medical condition (somatic and psychological) of the examined personnel is explicitly good, and as a result of proper selection, both their childhood and present conditions are adequate.

B/ I suppose that with the personnel properly trained and selected for their professional area, traumatization and consequently, the presence of risk factors connected to the psychological trauma, are low.

C/ I suppose that, in connection with low traumatization, the prevalence of the PTSD and other pathological conditions, such as anxiety and depression is low, it does not differ from the normal value.

2. ***I want to prove that there is increased presence of protective factors and the resilience within the examined personnel.***

Within this:

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A/ I assume that within the tested personnel the problem-focused coping, the potential that makes up the ability to cope, the dominance of the resilience is high which means that the health standard is above the average or reaches the highest number of points.
B/ I assume that the tested population does not have risk factors that would increase the occurrence of PTSD development.

3. ***I want to prove that when resilience and protective factors are present in a greater extent, there is less chance for the development of PTSD.***

Within this:
A/ I assume that with the problem-focused coping, increased resilience and coping potential, the chance of PTSD is smaller.
B/ I suppose that within the tested personnel the possibility of PTSD is not connected with the appearance of other pathological indications or conditions.

4. ***I want to prove that the Resilience Scale used by me is a proper examination device in itself for measuring the ability of the flexible resilience which is important for the PTSD.***

5. ***I want to prove that in the tested special areas of the defense sector, in other words, in occupational groups there is no difference within the tested personnel in their vulnerability and the protective factors.***

Within this:
A/ I assume that according to the occupational groups (firemen, soldiers, police, ASG), from the point of view of the risk factors and protective factors there is no difference within the examined personnel.

6. ***I want to clarify that there is no difference within the tested personnel from the point of view of age and the occupational time.***

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RESEARCH METHODS

In the beginning of research work I prepared an educational and research plan which was followed step by step and continuous execution.

The data necessary for the formulation of the research aims and the hypothesis was collected by study of special literature and examination of documents.

Different data and its analysis from special libraries as well as the search for the most recent materials with the help of the internet has been planned and constantly performed in the present as well.

In the civilian and the defense sector I have been studying domestic and foreign PhD degrees, researches and articles, studies and papers connected to my topic.

Experience gained during my clinical and research work as well as systematization of the background information was documented, published and introduced at domestic scientific forums many times

With the method of synthesis and analysis I analyzed background literature.

For the empiric research I collected data with the help of questionnaires.

I evaluated and analyzed the results with the method of mathematical statistics, using an SPSS program, both quantitatively and qualitatively. I used the method of abstraction and generalization for the validation of the results and for drawing consequences.

Having processed theoretical and clinical material necessary for the reaching of the established research aims, I concluded the systematization of the results and prepared my thesis

THE BRIEF DESCRIPTION OF THE PERFORMED TESTS BY CHAPTERS

In the introduction of my thesis I formulated the scientific problem in connection with my research, and I also explained my choice of the topic, on the basis of its timeliness and actuality. I introduced the aims of my research, my hypothesis, and showed the applied methods of research.

In the first chapter I tried to summarize our knowledge in connection with the posttraumatic illnesses, without the need for completeness. So, having looked through the history of PTSD briefly, I summarized the notion of the psychological trauma, its

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symptoms, the clinical picture of psychiatric conditions, the criteria of diagnosis. Through the introduction of the epidemiologic research I detailed the data connected to the prevalence of the PTSD, both within the general population and with those having risk factors. As a next step I introduced the biological and psychological processes connected to the development of PTSD. Then I dealt with the question of comorbidity: why it is important to filter out and treat this illness. I summarized the research in connection with the risk factors important for the point of view of vulnerability. At the end I mentioned the interventions with the help of which it is possible to prevent or treat posttraumatic illnesses.

In the chapter dealing with resilience I introduced the results connected with constructum, which was done through the introduction of the relevant special literature. As an introduction I looked through other protective factors of the resilience, such as strategies to overcome and the majority of the protective personal factors. The explanation of the notion of resilience was followed by the description of the research of the psychology development, then the resilience connected with adult psychological and the resilience connected with extreme stress situations. Within this I mentioned the factors responsible for the development of resilience as well as the models showing resilience. I also did research of resilience in the military. In a brief chapter I summarized the Hungarian research. It does not deal much with resilience connected with adult traumatization. Even though the psychological resilience is in the center of attention, but I could not leave out the biological processes of the background. I finished the chapter with the introduction of resilience development program in the US military.

In the third chapter I made a special summary of the characteristics of the personnel examined by me. They work in the defense sector, and consequently, they are especially open to traumatization and posttraumatic distress. I examined police persons, firemen (especially those who perform special tasks or those working at crime scenes), soldiers who are in missions and armed security guards responsible for the protection of critical infrastructures. I introduced the sources of stress and psychological traumas these people may face. In each case I showed the criteria of psychological aptitude and the possibilities of examination.

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In the fourth chapter the empiric research is introduced which I have chosen according to the hypothesis established after having studied domestic and foreign special literature and according to my aims of the research. The main prerequisite of choosing the examined personnel is that they face extremely stressful situations in their work and they have a role in the protection of critically important infrastructures. Accordingly, the examined personnel are the firemen who work in the catastrophe protection, also policepersons who deal with special tasks and participate in crime scene investigation and soldiers who take part in missions abroad. The number of personnel was altogether 137 people.

During the research for data collection I used questionnaires. The following questionnaires were applied:

- Anamnesis sheet for measuring risk and preventive factors in the family history
- A scale measuring the occurrence of traumas: list of life event symptoms
- Davidson PSTD self-evaluation scale for measuring common symptoms of posttraumatic illness
- Derogative symptom evaluation scale (SCL-90-R) for providing information about mental state
- Beck depression questionnaire for measuring the severity of depression
- Spielberger scale questionnaire for measuring momentary state of anxiety (STAI)
- Resilience scale developed by Friborg and colleagues for the measurement of resilience
- Psychological Immune Competence questionnaire which measures the protective personal factors that influence the ability to cope, or in other words, it measures the psychological immune system (PIK or PISI)
- Coping methods questionnaire which measures the ability to cope with stressful situations

Data collection took place in several phases. The introduction of instructions besides the attached sheet of instructions for the set of tests, was done in person.

The examination was performed impersonally, I used codes for the identification of people. Data collection was followed by the evaluation of the questionnaires and the summarization of the data. In the course of my research I examined the aims according

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to the hypothesis. With the help of the descriptive statistics and the SPSS statistical program I worked on the data with one-pattern t-trial, two-pattern t-trial variant analysis, correlation analysis, Fisher-probe and the Khi-square trial.

In the last chapter I summarize the new scientific results I have established and their importance for the defense sector. I also formulate professional offers.

SUMMARIZED CONCLUSIONS

In the chapter dealing with the empiric research, I tested aims connected with the hypothesis. I received the following results:

1st hypothesis: I wanted to prove that while the medical and psychological condition of the tested personnel is outstanding, the occurrence of the risk factors is low.

A/ My assumption that the medical condition (both somatic and psychological) of the examined personnel is very good, and as a result of the proper choice of this personnel, their childhood and present time social conditions and their relationships are proper, was proved only partially.

B/ My assumption that with the well-qualified personnel properly chosen from their area of specialization, the traumatization and consequently, the presence of risk factors connected to a psycho logic trauma is low, was not proved.

C/ My assumption that the PTSD and other pathologic conditions, such as that the prevalence of anxiety and depression is low, was proved only partially.

Conclusion: The 1st hypothesis was not proved. In spite of the fact that the somatic and psychological condition of the examined population was good, the childhood family conditions were appropriate, but the actual number of single or childless persons is high, 78.8% is the number of traumatic events, 27.9% of the traumatized persons and the prevalence of PTSD is 24.2% which is considered high.

2nd hypothesis: I want to prove that within the examined personnel the presence of protective factors and the resilience is increased.

A/ I assume that within the examined populace the problem- focused coping, the personal characteristics that make up the ability to cope and the dominance of the

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resilience is high, in other words the healthy standard is above the average or it reaches the highest number of points, was proved only partially.

B/ My assumption that within the examined personnel there are no such risk factors that would increase the development of the PTSD, was not proved.

Conclusion: My 2nd hypothesis was also not absolutely proved. The dominance of the problem-focused coping, the strategy of help request and the stronger prevalence of personal characteristics that make up the coping potential- compared to standard values that is characteristic for the personnel, the amount of the resilience could be considered more of medium sized. Within this the level of the social support system is considered the lowest. Less time spent with work and the help received in a traumatic situation can also be factors that increase the PTSD.

3rd hypothesis: I wanted to prove that in the case of the examined personnel the stronger presence of resilience and the protection factors can help to reduce the development of the PTSD.

A/ My assumption that in the case of the problem-focused coping, the stronger resilience and the coping potential the development of the PTSD is low, was proved only partially.

B/ The assumption that the development of the PTSD does not correlate with other psychopathological symptoms or conditions, was not proved.

Conclusion: My hypothesis was proved only partially. The presence of resilience and protective personal characteristics can significantly diminish the development of the PTSD, but the problem-focused coping is not connected to this. In the case of the PTSD group the lower resilience and lower resilience and coping potential numbers and the lower numbers of withdrawal strategy are characteristic. The development of the PTSD goes together with higher level of distress, somatization, anxiety and the appearance of symptoms of depression.

4th hypothesis: I wanted to prove that the Resilience Scale applied by me is a proper examination device for the measurement of flexibility of resilience which is important for the PTSD.

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The resilience measured with the Resilience scale is in positive correlation with the problem-focused coping, with the strategy of requirement for help, with the protective characteristics making up the coping potential of the examined population. Consequently, as a more complex measurement device, it can be applied independently with the risk population for aptitude tests, check-ups, measurement of traumatization and for measuring the probability of PTSD development.

Conclusion: My 4th hypothesis was proved. The Resilience Scale applied by me proved to be a proper and independent measuring device for the measurement of the PTSD and the appearance of other the correlating other psychological group of symptoms, the measurement of the flexible resilience preventing their appearance.

5th hypothesis: I wanted to prove that within the personnel of the examined special areas of the defense sector, in other words, the specialization groups, there is no difference from the point of view of vulnerability and the psychological condition.

A/ My assumption that there is no difference within the professional groupings considering the risk factors and the protective factors, was not proved.

Policepersons are less resilient, the problem-focused coping and help requirement is less characteristic in their case, however, their withdrawal strategy is stronger and their coping potential is weaker than that of other groups. It is not significant from the point of view of resilience but it was the firemen who had the highest number of points. The soldiers got the highest number in the case of help invoke for coping strategy, in the coping potential and the problem-focused coping strategy. It needs to be taken into consideration that during the examination of soldiers who deal with special tasks there is a strong emphasis on the measurement of the latter factors and the selection based on this.

B/ My assumption that there is no difference between the occupational groups from the point of view of psychological condition, was not proved.

In the case of the “psychopathologic state”, according to the significant and tendency level research, we can say that it was the policepersons who had the highest score, in

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other words, they are the ones who are in the "worst" psychologic condition considering the posttraumatic symptoms, depression and anxiety.

Conclusion: The 5th hypothesis was not proved. Within the examined areas of the defense sector, or within the occupational groups there is a difference in the vulnerability, protective factors and psychological state.

6th hypothesis: I wanted to prove that there is no difference within the examined personnel concerning the age and the time spent with the occupation.

A/ My assumption that there is no difference between the age groups from the point of view of protective factors and the possibility of psychopathologic state development, was not proved.

B/ My assumption that the time spent in the occupation does not influence the development of the protective factors, the PTSD and the occurrence of other pathological conditions within the examined population, was proved only partially.

Conclusion: My 6th hypothesis was not proved. Age does not influence resilience, but within the coping strategies the emotion-centered coping, the requirement of help and within the protective personal factors the social mobility are the ones that depend on the age. Time spent in the occupation may be relevant in the development of the PTSA.

NEW SCIENTIFIC RESULTS

1. I was the first in Hungary who dealt with the overviewing and summarizing the international research results of psychological resilience which is considered a protective factor in the development of the PTSD.

2. I n the case of professional personnel who face stressful situations and the possibility of traumatization, with the help of empiric methods I proved the importance of resilience and other protective factors (problem- focused coping, personal factors in the ability to cope).

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3. In the case of different professional personnel groups who face dangerous situations (catastrophe protection, the military, armed security personnel) I established the following:

- The prevalence of traumatization and PTSD.
- In connection with the PTSD the prevalence of certain risk factors of vulnerability development.
- The prevalence of possible protective factors, such as the coping strategies, resilience, and protective personal factors which are all important from the point of view of PTSD development.

4. According to my examination experiences I compiled a set of tests that may be applied for the examination of resilience which is important in the development of traumatization and the PTSD in case of occupational groups who face dangerous situations. There is a special importance of the Resilience Scale developed by Friborg and his colleagues which can be used as an independent device for the measurement for the presence of the resilience.

THE APPLICATION OF THE RESEARCH RESULTS AND RECOMMENDATIONS

The aptitude examinations within the military, law enforcement, catastrophe protection and also with the armed security forces use well-established and workable examination methods and procedures. However, in case of psychological traumatization or in the development of PTSD the applied sets of tests are of no help. In the course of my research I proved that there is one complex approach to this is the examination of the resilience which is not equal to the protective personal factors, the strategy of coping or the mental stamina (which are mainly associated with automatic thinking patterns in dangerous situations).

1. I would recommend in Hungary, especially for the defense sector, to initiate the Adult Resilience Scale developed by Friborg and his colleagues, which is one of the most complex resilience measuring device.

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2. It would be extremely useful to pay attention to the symptoms of posttraumatic disease and to detect them during check-ups. The diagnosis of the PTSD cannot be established in every case but if there are certain (but not all) groups of symptoms are present, it can be significant.

3. The development of resilience can be one of the most important aims of preparation and training programs. Preparation for traumatic situations can be specific which are established by the type of the trauma and the aim population (especially the endangered persons, from the occupational point of view). It is also non-specific, in other words, it is applicable for everybody for developing resilience.

4. In the case of some professions, for example with the soldiers, policepersons or with the catastrophe protection personnel or the firemen, it is especially important to have proper preparation, by lifelike exercises but with the application of problem solving and stress handling techniques, (for example, relaxation). The effective training with lifelike exercises helps to build self-assurance, the development of automatic positive reactions and this way, in case of stress, the level of the emotional overstrain may reduce. The training aimed at problem-focused approach helps in combating stress effectively, while by learning the techniques of how to cope with stress, the proper treatment of the already present and intensive fear, anxiety and the control of the emotions becomes possible. Complex training programs can be especially effective with the integration of the following aims and factors:

- Lifelike training with simulation techniques
- Strengthening and development of coping ability
- Establishment of the proper social net at workplaces (group cohesion or the development of group unity)
- Development of positive beliefs and expectations
- Building workplace and occupation specific stress coping programs

5. In my examinations we could see that the help invoke, the development of the family cohesion, the building and use of the social net (though it exists but if it is not used properly, it is of no avail) can play a serious role in the development of resilience. I would recommend these to be taken into consideration for the training and the preventive and intervention activities.

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6. In the area of the secondary prevention we need to deal with the importance of the resilience again, especially in case of living through a psychological trauma and in the development of PTSD. In the case of psychological trauma, as we could see from the examination results, the process of traumatization does not develop in every case. We have to take into consideration, especially in case of well- checked personnel, the possibility of the normalization processes. From the point of view of resilience strengthening there is a need for support in almost all cases. The earliest intervention that develops resilience in case of psychological trauma is the Psychological First Aid-PFA. PFA is a structured intervention that was developed in the recent years for the treatment of distress following serious traumas. PFA makes it possible to provide the traumatized, surviving people as well as victims with the necessary and flexible help.

With all levels of prevention the workers of the defense sector (the Hungarian Defense Forces, the police, the catastrophe protection, firemen the armed security personnel) who face the possibility of traumatization, it is important to introduce the examination procedure for the diagnosis of the posttraumatic stress illness. Taking into consideration resilience in all areas of prevention, consequently, in cases of aptitude check-ups, the use of a proper examination device for measuring resilience and also its development during training (there are several models and programs for these, especially in the US military) and in the area of the secondary prevention during secondary intervention, it is critical to emphasize the resilience strengthening.

- In the prevention of the PTSD development, besides strengthening the problem-focused coping and the resilience-connected personal protective factors, the development of help invoke strategy is, as well as the ability to accept help is important. The background family cohesion and the development of the social aid network, the help needs to be able to be used.
- From the point of view of traumatization, it is especially important to pay attention to those who have no steady relationship and no children or those who just started working and have no experience.

Recommendations for further research:

- The comparison of the occupational groups in case of the entire personnel

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- The process of validation and standardization of the Resilience Questionnaire according to the occupational field
- The extension of the examination for all areas of the military, law enforcement and catastrophe protection where there is operational involvement
- For the reason of forming a more valid picture concerning the psychological state, traumatization, the development of the protective factors and the resilience, there is a need for the involvement of a control group, I recommend to perform a similar examination, with other occupational groups dealing with public service.

In my dissertation I tried to show the process of my scientific work connected with the reaching of the set aims. With my research and with the related further questions, thoughts I want to contribute to the those people who work in the defense sector, whose work is full of responsibility, and who risk their lives, to have excellent mental and somatic health, to their well-being contributing to their ability to work with high motivation and result. And I also wish to get all the possibilities from the organizations to provide proper conditions and background for performing their tasks.

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13. Urbán Nóra: *A pszichológiai reziliencia jelentősége a vészhelyzetek következtében kialakuló lehetséges traumatizálódás vonatkozásában.* In. Kritikus infrastruktúra védelmi kutatások. Viselkedés vészhelyzetben kiemelt kutatási terület. Viselkedés vészhelyzetben konferenciakiadvány. Budapest, NKE, 2013. pp. 52 - 63.
14. Urbán Nóra: *Pszichológiai elsősegély alkalmazása katasztrófahelyzetekben.* In. Önkéntesek a katasztrófavédelemben. Konferenciakötet. Budapest, NKE szolgáltató Kft. 2014. pp. 141 - 158.

PRESENTATIONS

1. 2002. Pszichológiai elsősegély / Pszichiátriai Kongresszus
2. 2003. Pszichológiai intervenciók a stressz kezelésében / A segítő kapcsolatok szerepe testületek szervezeteiben c. konferencia
3. 2003. A pszichoterápiák hatékonysága / MH KHK főszakorvosi összevonás
4. 2005. A szorongás, szorongásos betegségek és a PTSD kölcsönhatása / „A poszttraumás stresszbetegség felismerése a gyakorlatban” c. továbbképző tanfolyam, SE-HKOT
5. 2005. A trauma korai és késői pszichés hatásainak csökkentése pszichoterápiás intervenciókkal / „Sürgősség a pszichiátriában és a neurológiában” főszakorvosi összevonás, SE-HKOT
6. 2006. Gyermekkori trauma, felnőttkori PTSD / „A poszttraumás stresszbetegség társadalmi vonatkozásai” c. továbbképző tanfolyam, SE-HKOT
7. 2006. Pszichológiai folyamatok, pszichológiai intervenciók / „A poszttraumás stresszbetegség felismerésének és kezelésének alapjai” c. továbbképző tanfolyam, SE-HKOT
8. 2006. Természeti katasztrófák / Katasztrófa Kongresszus, szatellita szimpózium

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9. 2008. Pszichoterápiás lehetőségek a depresszió kezelésében / Depresszió c. továbbképző tanfolyam, SE-HKOT
10. 2009. Pszichológus szerepe a klinikai gyakorlatban / Főszakorvosi Összevonás, Budapest, HM ÁEK
11. 2010. A klinikai pszichológus szerepe az egészségügyi ellátásban / Főpszichológusi Összevonás, Balatonkenese, MH HEK Preventív Igazgatóság
12. 2011. Szorongásos betegségek pszichológiai megközelítése, Főszakorvosi Összevonás
13. 2011. Pszichológiai elsősegély Főpszichológusi Összevonás, Mályi
14. 2011. Szenvedélybetegségek pszichológiai vonatkozásai. Főszakorvosi Összevonás
15. 2012. A szemmozgás deszenzitizáció és újrafeldolgozás (EMDR) pszichoterápiás módszer jelentősége a PTSD kezekésében. Katasztrófa Kongresszus, Budapest
16. 2012. Agresszió kiélése a védelmi szektorban. Főszakorvosi Összevonás
17. 2013 Kiégés okai. Burn-out konferencia, Honvédkórház
18. 2013. A pszichológus szerepe a klinikai gyakorlatban. Főszakorvosi Összevonás
19. 2013. A kezeléssel történő együttműködés javításának pszichológiai lehetőségei. Főszakorvosi Összevonás
20. 2013. A pszichológiai reziliencia jelentősége a vészhelyzetek következtében kialakuló lehetséges traumatizálódás vonatkozásában. Kritikus infrastruktúra védelmi kutatások. Viselkedés vészhelyzetben kiemelt kutatási terület. Konferencia, NKE
21. 2014. Az agresszió megnyilvánulási formái a pszichiátriai betegek körében. Mosonmagyaróvár
22. 2014. Adekvát kommunikáció. Aktualitások a boncmesteri gyakorlatban. Továbbképzés.
23. 2014. Főszakorvosi összevonás
24. 2014. Pszichológiai elsősegély alkalmazása katasztrófahelyzetekben. Önkéntesek a katasztrófavédelemben. Konferencia.

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25. 2015. Adekvát kommunikáció. Aktualitások a boncmesteri gyakorlatban. Továbbképzés.

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RESUME

PERSONAL INFORMATION

Name: Nóra Urbán

Date of birth: 03. 20. 1975

PROFESSIONAL EXPERIENCE

2014 - **Lead Psychologist**
Medical Center of the HDF, Service of Clinical Psychologist

2001-2014. **Clinical psychologist**
Military Hospital of the HDF / Rado Gyorgy Military Hospital / State Medical Center/ Medical Center of the HDF, Psychiatry Department

1998-2001. **Psychologist**
Military Hospital of the HDF, Menthal Health Department

EDUCATION

2000-2004. **Clinical and menthal health psychologist**
Semmelweis University of Medicine, Faculty of General Medicine, Clinical Psychology Department

1993-1998. **Psychologist (MA) and psychologist teacher**
Eotvos Lorand University, Faculty of Psychology

1989-1993. Kanizsai Dorottya Secondary School in Szombathely

LANGUAGE KNOWLEDGE

2000. **English:** NATO STANAG 6001 3. 3. 3. 3. (advanced level, professional)

1993. **English:** Intermediate level ’C’ type exam

1992. **German:** Intermediate level ’A’ and ’B’ type exam

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SCIENTIFIC EDUCATION

2012- **PhD candidate** at National University of Public Service, Doctoral School of Military Sciences (Expected PhD Thesis defence: 2015.)

2009-2012. **PhD student** at Zrinyi Miklos National Defense University, Doctoral School of Military Sciences

EXTERNAL LECTURER

National University of Public Service

University of Debrecen, Faculty of Public Health – Training of clinical psychology

OTHER PROFESSIONAL AND PSYCHOTHERAPIST EDUCATION

2013. **EMDR** Level I.

2001- **Psychoanalyzis and psychoanalytic oriented psychotherapist training** (own experience and method specific phase)

1999-2002. **Psychotherapist training** at Tündérhegy (propaedeutic and clinical phase)

1999. **Autogenic training and relaxation therapist** at the Hungarian Association of Relaxation and Symboltherapy

1997. **10 profiled Szondi course** at Dr. Szondi Lipot Memorial Foundation

1995-1998. **Psychodrama** – 274 hours own experienece

MILITARY CAREER

2014- Lieutenant Colonel

2007. Major

2002. Captain

1998. First Lieutenant

1996-1998. Senior Warrant Officer - basic training at Bolyai Janos Military Technical College

1993-1996. FOTAG scholarship at Bolyai Janos Military Technical College