Monday morning after a public drunkenness charge against him was dismissed and headed for California. He got as far as Central Avenue.

Kilgore, no doubt, thought March 12 was his lucky day when Judge Bill Cox, unaware of felonious assault and armed robbery charges pending against Kilgore, dismissed a public drunkenness charge against the 26-year-old Pierce Avenue man and set him free.

"For some unknown reason," said ... together this morning ... Normally all the warrants are kept together. If they had been together he would have been taken back and locked up" after disposition of the public drunk charge.

Sgt. John Meeks said he was just arriving at city court when a man asked him whether Kilgore had been released. The man told Meeks that he was to have testified against Kilgore and that the defendant had threatened to kill him. He also told Meeks he had seen Kilgore ... court officials aware of Kilgore's absence and Meeks put his description out on the police radio. Within 30 minutes he was apprehended at Fifth Street and Central Avenue.

Meeks said Kilgore told him he had been heading to California.

Hearings on the felonious assault and armed robbery charges were passed, and Kilgore was placed under a total bond of $11,000 on the two charges. He remained in custody at the county jail in lieu of making bond.

Metro News March 13, 1979 Chattanooga Times

Care of Young Male Trauma Patients Seen Directly Involved With Families

By EMILY McDONALD

The majority of trauma patients are young males in their very productive years (16 to 35), and the sudden separation from their normal role as provider, father, lover, etc., results in crisis for their families, too, Marge Epperson-SeBour, told a Trauma Seminar on Monday.

"It is my belief that we need to treat the family as well as the patient" in a life-threatening situation, continued Ms. Epperson-SeBour.

Ms. Epperson-SeBour was one of several speakers at the three-day seminar being presented by the Maryland Shock and Trauma Institute and sponsored by the Erlanger Medical Center.

She is a social worker at the institute.

Other faculty members include Carole Katsaros and Judith K. Bobb, nurse coordinators for the Maryland Institute for Emergency Services; Peggy Trimble, nurse coordinator, Divison of Emergency Medical Services, State of Maryland, and Dr. Douglas Bechard, chief of infectious disease at the Erlanger Medical Center.

Must Be Returned

If the patients survives the trauma, he must be returned to his environment. "We do him a disservice to return him physically functioning but emotionally cripple" because his family can't handle his altered condition.

Helping the family deal with crisis should begin as soon as the patient reaches the hospital, and, in Ms. Epperson-SeBour's view, the task should be undertaken by the emergency room or critical care nurse. The main criteria, however, is that the person believes treating the family is a priority item, has compassion and has a little bit of intelligence about what to do and not to do.

Old therapeutic models are not applicable to families in these situations because they are experiencing "sudden, severe stress." The model used today was developed through studying the families of survivors of the Coconut Grove fire, Ms. Epperson-Se Bour said.

Four elements are characteristic of

— George Baker/The Times

Ms. Trimble, Ms. Katsaros, Ms. Bobb, Bechard, Ms. Epperson-SeBour

treating families in crisis. It is a brief treatment modality, lasting a few hours to no more than five to six weeks, rather than a long-term, psychological treatment model. Dealing with the currect crisis is the only purpose of treatment as opposed to therapeutic models that deal with many life elements.

Third, Ms. Epperson-SeBour continued, the goal is to re-establish what was disrupted by the crisis, not improve pre-crisis events. And the helping person must be "readily available for consultation and support while the current crisis exists."

Families must develop "coping mechanisms outside the realm of their previous life experience," and research has shown that they go through six distinct phases before regaining their pre-crisis state.

The crisis itself is a catastrophic event, and a period of confusion immediately follows. The mother may come to the hospital with her hair in rollers; the father is so upset he can't remember where he works. This leads to the first phase, anxiety, which is followed by denial, anger, remorse, grief and reconciliation.

Ms. Epperson-SeBour pointed out that "we all face crisis in our own way, and families don't always experience the phases in the order given. However, her research on 250 families showed that all experienced the six phases at some point. The speaker pointed out ways the nurse could assist family members during each phase.

The seminar continues thorugh Wednesday at the Sheraton Downtown. Nurse, physical therapists, respiratory therapists and emergency room personnel from throughout the Southeast are attending.

Medical Beat

News American 2/16/75

By JOANN RODGERS

Treating the Families of Accident Victims

Two cars collide. A helicopter evacuates the mangled body of a 21-year-old male whose leg was ripped off and whose other injuries have put him in shock and near death. In minutes he is inside the one-of-its kind shock-trauma facility at the University of Maryland Institute of Emergency Medicine (MIEM), where a team of surgeons goes to work on the limp body.

For eight days the young accident victim will remain in the critical care ward, where no one but his doctors and nurses may see him. He receives science's best effort. And he survives.

But go back if you will to the moment of the accident and its aftermath. What about the man's family? What happened during all this to his wife, children, parents?

According to results of a research program at MIEM, they are victims of that collision just as surely as the patient admitted to the shock-trauma unit.

Explains Margaret Epperson, the social worker in charge of the research: "The patients we get are not the usual accident room cases. They aren't brought in here for cut fingers or asthma attacks. When people are admitted here, the families know the worst has happened.

"Patients are in shock here, but so are families," she says, and the usual practice of putting relatives in the waiting room or asking them about their medical insurance and their business phone is, under these circumstances, not only cruel, but destructive.

Intensive study of 230 families seen at the shock trauma unit, says Epperson, suggests that when severe damage occurs, they are propelled into an acute crisis that can leave family stability and relationships in shambles—sometimes permanently.

"We suspect that divorce, insanity and suicide are relatively prevalent among these families. They need professional help from the moment they learn of a accident and possibly for a long time after patient discharge or death."

Designing that help is Epperson's goal and the first step was the identification of a series of "stages" that most trauma families must face:

- High anxiety. Since most severe injuries occur among young men and with young families, their disabilities mean new, possibly unimagined roles for the wife, such as that of primary wage earner. Often, she has no nearby relatives, and income is cut off. Bureaucratic red tape frustrates efforts to obtain help from public agencies. The family system disintegrates, unable, literally, to pull itself together.
- Denial. As a self-defense mechanism, families let themselves doubt that the damage to their loved one has really occurred, or that it is "that bad." This is exacerbated by the inability of relatives to see the patient because of risk of infection and sometimes because the sight of the injuries can be upsetting.
- Anger. At everyone. At state police pilots who acted "too slowly." At passengers for "enticing" the patient to speed. At the hospital rules. At doctors. Mostly, they are angry at the patient for causing all the anxiety and problems that now exist.

Our society thinks badly of people who get angry at sick people, so they get angry at others. Unless this anger is worked out, says Epperson, it may be taken out on the patient during rehabilitation, leading to more problems.

- Remorse and guilt. A child may feel responsible for the accident. "If I hadn't called Daddy 'dumb' this morning, he wouldn't have been mad and driven too fast."

Much of the guilt is not true guilt, but the "if-only" variety. "If only I hadn't nagged him to hurry home." In very few cases are families truly to blame, but they must see this for themselves.

- Grief. Only 62 per cent of the families in the study managed to get through this stage, to the point where they could openly grieve for the patient—and themselves.
- Reconciliation. Here the family members begin to realize the long-term implications of the injury and to reconcile themselves to the differences these will make in their lives.

Says Epperson: "In order for them to regain control of their lives, they must pass successfully through these stages.

"If they don't, we believe they may become crisis prone families. Because they have not learned to cope with this thing, they are highly vulnerable to all other stresses that come along in any family's history—even relatively minor ones."

Her advice: All hospitals should be prepared to "treat" the families of very sick or badly injured patients. And all families should recognize the need for professional help at times of severe stress.