

Chapter 11

DEBRIEFING FOLLOWING COMBAT

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Burdell Moody

Killed in Action

1968

Burdell Moody, with U.S. Army Artist Team #4, starkly portrays a squad returning to base camp in Vietnam, carrying the body of one of their soldiers. Perhaps the most stressful aspect of combat for a soldier, other than pondering his own death, is the death of another, especially a member of his own unit. Witnessing death is a critical event in the life of any soldier and his unit, one warranting immediate debriefing to lessen the likelihood of developing post-traumatic symptoms in the future.

Art: Courtesy of US Center of Military History, Washington, DC.

INTRODUCTION

Emergence of post-traumatic stress disorder (PTSD) as a clinical condition presupposes the experience of an overwhelming trauma and consequent biopsychosocial adaptation. By the criteria of the Diagnostic and Statistical Manual, 4th ed.¹ (DSM-IV), the individual must reexperience the event, perhaps through intrusive recollections, distressing dreams, and avoidance of stimuli associated with the event, and may have persistent symptoms of increased arousal manifesting as hyperalertness, vigilance, and irritable behavior. The symptoms must last for at least 1 month. The stress of combat does not inevitably result in PTSD; debriefing following combat is an intervention that appears to interrupt the causal connection.

Often, at some later point in life, the person exposed to trauma, be it a natural disaster, terrorism, war, or other highly emotionally charged lethal or life-threatening events, will reexperience feelings associated with the original trauma because of an environmental or emotional trigger. In the case of war, PTSD can occur in as many as 15% of those individuals exposed to combat.² In natural disasters, terrorists attacks, and devastating industrial accidents (the so-called civilian critical incidents—CCI), PTSD rates are more variable, depending on the meaning attributed to the stressor and the possibility of legal damages.

Trauma, however severe, is likely to be an organizing factor in a person's life, defining for the individual adaptation that can be both attributed to and dated by the event. Perhaps the most useful intervention is the help provided by families, friends, church groups, military units, and others in stabi-

lizing the individual in the community, allowing for the ventilation of feelings, and validating the role of the individual in the communities to which he or she belongs.³

Psychological trauma following civilian critical incidents has been similarly studied. Erikson⁴ documented the importance of tending to basic needs of survivors when the dam on Buffalo Creek broke and devastated a whole Appalachian community. Long-term distress was exacerbated when families were separated, homes relocated, and roads were built without direct community involvement. As a result, rescue workers learned the importance of enlisting survivors in their own recovery process, a principle that has been utilized in CCI training and actual experience.

For combat, various models have been proposed and studied to reduce the incidence of PTSD and other acute psychiatric reactions. Most models rely on the assumption that unit cohesion, training, and leadership are important in helping soldiers adapt to traumatic or adverse conditions. The decreased incidence was striking in subsequent psychiatric casualties experienced by an elite paratrooper unit when compared to ordinary combat units in the Israeli Army during the 1973 Yom Kippur War.⁵ Significant differences in the units highlight the role of trust toward the immediate commanders, unit identity, and professional soldiering knowledge.^{2,5} Moreover, the community support and effective integration of soldiers returning from battle into their units or homes appears to have the greatest influence on the development of long-term psychiatric sequelae.⁶⁻⁹

THE HISTORY OF POST-TRAUMA DEBRIEFING

One process by which individuals can reduce untoward effects of trauma (eg, natural disasters, war, civil unrest) is called debriefing.¹⁰ Simply put, the individual or group meet at the request of a larger supervisory body to begin a process of integrating the trauma into their individual and group experiences. Debriefing is a process that has been described by mental health workers attendant to natural disasters,¹⁰ terrorism,¹¹ combat,¹² and military accidents.^{13,14} It involves a structured meeting designed to allow for ventilation of feelings, fears,

and the telling of stories of the traumatic event. It is not the end, but rather the beginning, of the healing process during which the reentry of individuals into the community at large is facilitated.

The concept of group debriefing grew out of the work of S.L.A. Marshall¹⁵ during World War II when he attempted to record accounts of small unit military operations for historical purposes. Marshall noted that when a person could describe what happened to him during a harrowing experience this served not only an abreactive purpose but allowed

colleagues to correct misperceptions and render social support. This appeared to decrease the development of combat stress reactions. Marshall observed that these historical debriefings or “reconstructions” restored unit cohesion and readiness to return to combat. He considered this one of his most important contributions to the U.S. Army. Marshall continued to conduct official historical debriefings for highly selected units throughout the Korean and Vietnam conflicts. To the knowledge of the authors, the technique was not used at that time by clinical mental health personnel.

In 1978, the debriefing process was incorporated by Navy psychiatrists in developing the Special Psychiatric Rapid Intervention Teams (SPRINT), which have been discussed in Chapter 9, U.S. Naval Psychiatry). In the 1980s, the U.S. Army’s 7th Medical Command in Heidelberg, Germany used debriefing techniques on their Stress Management Team deployments in response to a number of terrorist attacks. A joint U.S. Navy-U.S. Army team deployed to the Persian Gulf to assist the U.S. Navy frigate *Stark* after it was damaged by an Iraqi Exocet missile.¹² The air show disaster at Ramstein Air Force Base in Germany also required extensive debriefing of survivors, witnesses, and caregivers.

Critical incident stress debriefing (CISD) has also been utilized in the civilian world.¹⁶ Some volunteer CISD teams are now active in most of the United States and in other countries including Canada, Great Britain, the Netherlands, Norway, and Australia. These teams respond to critical inci-

dents involving police, fire, and emergency medical departments. Some governmental and nongovernmental agencies have their own debriefing teams and policies.

During and after the U.S. invasion of Panama and the Persian Gulf War, U.S. Army mental health teams conducted a number of unit debriefings, although there was no formal doctrinal mandate or training program. With the deployment to Somalia in January 1994 of U.S. Army division mental health and combat stress control detachment teams, critical event debriefings became common practice. They were conducted following deaths in a unit from enemy action, accident or suicide, or after other distressing events involving deaths of civilians or mass casualties of multinational force allies at U.S. medical facilities.

U.S. Army critical incident debriefings have been conducted following training deaths at the National Training Center (NTC) in California and the Joint Readiness Training Center (JRTC) in Louisiana; the Green Ramp disaster at Pope Air Force Base in North Carolina; the mass murder followed by a B-52 bomber crash at Fairchild Air Force Base in Washington state; and many other traumatic incidents. The U.S. Navy’s SPRINT teams continue to deploy on call, as have U.S. Air Force teams. U.S. Army doctrine^{17,18} establishes critical event debriefings as doctrinally appropriate after especially traumatic events. Allied countries have also accumulated extensive experience with military debriefings following critical incidents and difficult tours of duty.

TYPES OF DEBRIEFING

A number of models or types of debriefings have evolved from this extensive experience. These include (but are not limited to) the types summarized below:

- After-Action Review (AAR)
- After-Action Debriefing (AAD)
- Historical Group Debriefing (also called Historical Event Reconstruction Debriefing—HERD)
- Civilian Critical Incident Stress Debriefing (CISD)
- Critical Event Debriefing (CED)
- Psychiatric Debriefing
- Large Group Debriefings
- End-of-Tour Debriefings

After-Action Review

After-action review (AAR) is the standing operating procedure for all U.S. Army teams and small units following any training exercise. The training cadre bring the team together immediately after each training event and have them talk through what happened. The cadre share their own observations. The product is positive lessons learned, not blame. Further, AARs may bring together the leaders of all the participating small groups to give the wider perspective and derive lessons learned on command control, communication and coordination. All U.S. Army leaders are expected to conduct their own AARs routinely, without cadre, when conducting their own training exercises. They are

encouraged to continue this practice in real world missions, including combat.

The AAR is designed for nonlethal training, and focuses cognitively on the operational lessons learned. It does not explicitly encourage emotional ventilation or sharing of feelings and reactions. However, effective leaders and supportive cohesive teams do recognize, and work through, the sometimes intense feelings that arise. Mental health personnel are not normally present at AARs, except in their own training. However, it is valuable for the mental health personnel supporting combat units in field exercises to be transported to the AARs of units that have experienced simulated critical incidents, to hear what the combat units do, be seen, and exercise the ability of command to get them to units to assist after real traumatic events.

After-Action Debriefing

After-action debriefing (AAD), in U.S. Army doctrine, is an extension of the routine AAR.

The after-action debriefing process shares the after-action review's concerns with details of what happened. It goes further by actively encouraging the team members to share and even talk out their emotional responses to the event. After-action debriefings should also be routine during training, operations other than war, war, and following any difficult or unpleasant event. Doing after-action

debriefing routinely will make them second nature following any especially traumatic event. The objective of after-action debriefings following traumatic incidents is to promote "healing" by opening up, "cleaning and draining" any unpleasant or painful memories.^{17(pp6-6,6-7)}

Exhibit 11-1 lists the key steps of the after-action debriefing process. More detailed guidance on how to lead an AAD is also available.^{17(Appendix A)} The critical components for leader actions are shown in Exhibit 11-2. The AAD is led by the small unit's own leader(s). Mental health personnel, chaplains, and other trusted outsiders who were not participants in the event would attend only by invitation, and purely as observers. Furthermore,

Combat stress control/mental health personnel should always be notified whenever serious psychological trauma has occurred in a unit. They can assist command in assuring that the after-action debriefing process is done correctly.^{17(p6-7)}

The mental health personnel might intervene subtly during the processes only if they saw that the AAD was ending without having reached a generally positive outcome on issues of guilt, blame, anger, or other disruptive emotions. More often, they would be available to the team members afterwards, who would know that they now shared comprehensive knowledge of the event.

EXHIBIT 11-1

KEY STEPS IN AN AFTER-ACTION DEBRIEFING

- Explain the purpose and ground rules to be used during the debriefing at the outset.
- Involve everyone in verbally reconstructing the event in precise detail.
- Achieve a group consensus, resolving individual misperceptions and misunderstandings and restoring perspective about true responsibility.
- Encourage expression (ventilation) of thoughts and feelings about the event.
- Validate feelings about the event as normal and work towards how they can be accepted, lived with, atoned.
- Prevent scapegoating and verbal abuse.
- Talk about the normal (but unpleasant) stress symptoms unit members experience and which may recur for a while, so they, too, can be accepted without surprise or fear of permanence.
- Summarize the lessons learned and any positive aspects of the experience.

Reprinted from US Department of the Army. *Leaders' Manual for Combat Stress Control*. Washington, DC: DA; September 1994. Field Manual 22-51: 6-7.

EXHIBIT 11-2

LEADER ACTIONS TO OFFSET BATTLE FATIGUE RISK FACTORS

Leader Actions

Conduct small team after-action debriefings after every difficult action (in training and in combat). An after-action debriefing is an extension of after-action reviews which are routine in training. Reconstruct what really happened so that the team benefits from the lessons learned. At the same time, this releases bottled-up emotions and inner conflict that can lead to decreased unit cohesion, battle fatigue, and perhaps even to PTSD. This is the purpose of the after-action debriefing. Feelings of anger and mistrust may go away on their own once the soldier sees how things looked to the others. At least the feelings are out in the open and can be dealt with honestly. Soldiers' natural emotions of loss and grief come out, too, when buddies are wounded or killed in combat. Guilt or shame may come out when soldiers make mistakes. Such soldiers can be comforted and helped to put things into perspective by the rest of the team. The mistakes can be acknowledged and forgiven or atoned for. When conducting the after-action debriefing, the leader must

1. Select a location that is relatively safe from enemy attack.
2. Set the ground rules.
3. Reconstruct the action from everyone's memories.
4. Share thoughts and reactions to the action.
5. Encourage talk about any physical or mental signs of battle fatigue anyone may be having if the action was a high stress event.
6. Bring the focus back to the mission after the feelings have been recognized and ventilated.
7. Use after-action debriefings to orient new unit members. These debriefings familiarize them with the unit's most recent history, introduce them to the veterans' roles and personalities, and acquaint them with the unit's Tactical Standing Operating Procedure (TSOP). It also helps when merging survivors of two units into one, with or without other new replacements.

Adapted from US Department of the Army. *Leaders' Manual for Combat Stress Control*. Washington, DC: DA; September 1994. Field Manual 22-51: A-7-A-9.

Historical Group Debriefing

Historical group debriefing (also called, historical event reconstruction debriefing—HERD), patterned after the work of S.L.A. Marshall, involves all participants of a preexisting unit in processing a brief (up to several days) chronological reconstruction of a significant event. That event may, but need not, involve traumatic events. Shalev,¹⁹ in Israel, has revised the original S.L.A. Marshall protocol and demonstrated its therapeutic effectiveness in traumatic military unit settings where more “clinical” approaches often encounter resistance. This technique may be less suited for ad hoc groups, such as random survivors of an accident, because it concentrates on filling out a timeline of fact that random “victims” might not care about and does not explicitly work through thoughts and reactions that strangers might be unwilling to share. Exhibit 11-3 (adapted from Shalev's work) summarizes the historical reconstruction technique.

Civilian Critical Incident Stress Debriefing

Civilian critical incident stress debriefing (CISD) is the debriefing format developed by Mitchell and used and taught by the Critical Incident Stress Foundation. Its key points and the seven phases of the debriefing are summarized in Exhibit 11-4. The CISD was designed for brief, traumatic incidents involving preexisting civilian teams, but is also usually applicable to ad hoc groups. The debriefer does elicit thoughts, reactions, and symptoms after a relatively brief survey of each participant's perspective on the “facts” of the event. The debriefer also provides some education at the end. The CISD format has been learned and used by military debriefers in military contexts.

Critical Event Debriefing

For the Somalia deployment, a prototype pocket card was developed and fielded to facilitate train-

EXHIBIT 11-3**HISTORICAL EVENT RECONSTRUCTION DEBRIEFING: SUMMARY OF S.L.A. MARSHALL'S DEBRIEFING TECHNIQUE**

1. Debriefings are conducted as soon as possible after the action.
2. Prior to the debriefing session, the debriefer collects information about the unit's background, structure and role in the battle, and the outcome of the action.
3. The participants are told that the debriefing consists of a chronological reconstruction of the event in its most minute details (to understand and learn from the action, not as fault-finding).
4. All those who took part in the action participate in the session. No others are allowed to participate (although new replacements to the unit can be allowed to listen if the veterans agree).
5. The debriefer emphasizes that all ranks are put aside during the session and all participants have equal status as witnesses.
6. After initial "modeling" by the historical debriefer, the debriefing is led by the unit's own commander.
7. The entire group takes part in the reconstruction of the action in all its details. Each soldier is encouraged (but not forced) to add his own version to the other soldiers' accounts.
8. All the information and all points of view on each stage of the action are collected from the participants.
9. Ambiguous information and contradictory statements are recorded by the interviewer as illustrating the complexity of human interactions during an event.
10. Criticism and attempts to teach are discouraged. No open disbelief in any witness's testimony is expressed by the interviewer.
11. No attempt is made to reach agreement among participants. Premature conclusions and closure are avoided.
12. The debriefer creates and maintains a congenial atmosphere and facilitates communication and openness throughout the session.
13. Emotional reactions are recognized and validated, but are *not* emphasized. No deliberate psychological intervention (eg, clarification, interpretation) is attempted by the debriefer.
14. The session is not limited in time, and continues for as long as it takes to reach the comprehensive description of the event. It may adjourn temporarily for breaks, and resume after food and sleep.

Adapted from Shalev A. *Historical Group Debriefing Following Combat: A Study of SLA Marshall's Debriefing Techniques. Final Report.* [Coordinated by Department of Military Psychiatry, Walter Reed Army Institute of Research and Department of Mental Health, Medical Corps, Israeli Defence Forces.] Jerusalem, Israel: Department of Psychiatry, Center for Traumatic Stress, Hadassah University Hospital; 1992.

ing in debriefing techniques. The card drew extensively on the CISD 7-phase model, differing primarily in greater emphasis on filling in an unbroken timeline in the Fact Phase. While calling for an agreement on confidentiality (as in CISD), it also reminds everyone of their obligations to the Uniform Code of Military Justice if material on violations of that code are raised in the debriefing. By agreement with Mitchell, this military modification of CISD is being referred to as critical event debriefing to avoid confusion over the

necessary differences in applying the CISD format in the context of ongoing U.S. Army field operations and organizations. According to U.S. Army doctrine,

When indicated, the unit should arrange for combat stress control/mental health personnel to conduct a critical event debriefing. Critical event debriefings are similar to after-action debriefings but differ in the following ways: The critical event debriefing is led by a trained debriefer who is not a member of the unit being

EXHIBIT 11-4

CRITICAL INCIDENT STRESS DEBRIEFING: KEY POINTS AND PHASES

Points

- The CISD should be conducted after an *exceptionally* distressing event.
- The CISD is conducted by a specially trained team.
- The participants are normal persons who have survived an abnormal, severe stressor.
- Stress debriefing is *not* therapy or counseling. It is basic wise *preventive maintenance* for the human mind.

Phases

1. Introductory Phase: to introduce the team and explain the process.
2. Fact Phase: to reconstruct the event in detail, in chronologic order, as an unbroken "historical time-line," viewed from all sides and perspectives.
3. Thought Phase: to personalize the event and shift focus; to transition from factual to emotional focus. Participants are asked to share what "thoughts" they had at key times.
4. Reaction Phase: to identify and ventilate feelings (emotions) raised by the event.
5. Symptom Phase: to normalize personal physical stress responses. The leader guides transition back from emotional to factual focus, legitimizing participant's physical symptoms and behavioral reactions.
6. Teaching Phase: to reassure by educating that the feelings and stress symptoms are normal reactions to abnormal conditions; they may last a while, but can be expected to resolve normally.
7. Reentry Phase: to complete and close the debriefing.

It is important to ensure that participants have follow-up options as individuals or as a group.

Adapted from US Department of the Army. *Debriefing's Guide to Critical Event Debriefing*. Fort Sam Houston, Tex: Combat Stress Actions Office, Department of Preventive Health Services, Army Medical Department Center and School; 1993: 1-4.

debriefed; the after-action debriefing is led by the small unit's own leader.

The critical event debriefer explicitly defers issues of operational lessons learned in order to focus on the stress aspects and stress responses; the after-action debriefer does seek to capture relevant operational lessons learned in positive terms.^{17(pp6-7,6-8)}

U.S. Army doctrine¹⁷ also cautions leaders regarding preventive intervention after traumatic stress.

- (1) The analogy between PTSD preventive interventions and traumatic wound surgery suggests a cautionary warning. If the surgery is not done skillfully, it can cause more harm than good, leaving dead tissue and bacteria in the wound. It may cut away tissue that did not need to be sacrificed, or realign the broken bones incorrectly. The same is potentially true for poorly executed after-action debriefings or critical event debriefings.
- (2) The problem for early prevention efforts is to forewarn of possible post-traumatic stress symptoms without glamorizing them or ad-

vertising them as a reimbursable long-term disability. To do the latter invites malingering. It also subtly encourages those who do have real but not disabling post-traumatic symptoms to magnify them. This will be especially likely if they have other psychological issues or grievances which the symptoms also address, such as feeling unappreciated for the sacrifices suffered or guilt at having left their buddies.

- (3) As with the treatment of acute battle fatigue, it is essential that all persons involved in preventive or treatment interventions for PTSD express positive expectation of normal recovery. At the same time, they must indicate that continuing or recurring symptoms can and should be treated, still with positive expectation of rapid improvement. They should advise that post-traumatic stress symptoms may recur in the future at times of new stress. Successful treatment after future episodes should deal with the ongoing, new stressors as much as with the past trauma.^{17(p 6-8)}

Case Study 1: The Medic and the Resuscitation

In the evening of 28 February 1991 (the cease fire ending the Persian Gulf War had gone into effect at 0800 hours that morning), as two cavalry units were moving into captured territory, the headquarters troop was establishing camp for the night. They had moved their vehicles into a coil, which is a circular defensive arrangement with tanks and fighting vehicles facing outward. The men were digging foxholes in front of their vehicles. One young soldier, a member of a fighting vehicle crew, was digging his foxhole when his vehicle commander called him back to his vehicle. The soldier turned, shouldered his shovel, and stepped on an unexploded Dual Purpose Improved Conventional Munition (DPICM), which exploded. The soldier was carrying rifle grenades in a bandoleer across his chest. These exploded as well. The soldier was in all probability killed outright.

Two young medics (both inexperienced and just out of school), who had only a few months earlier joined the unit, and only a few weeks before joined this particular troop, tried to resuscitate the soldier. The resuscitation was gruesome. As they tried to ventilate the soldier, air escaped from his cheek, so someone put a hand there. Then air escaped from his chest, then his abdomen, and finally even from one eye socket. The medics continued their efforts for approximately 20 minutes at which time a physician from the medical troop arrived, assessed the situation as hopeless, and called off the resuscitation.

Two days later a combat stress control (CSC) team was asked to see one of the medics because he was clearly troubled by what had happened. The team members responded that they would see him, but that if he was obviously distressed there was probably significant distress in others who had been involved in the resuscitation, as well as the soldier's comrades, and his immediate chain of command. The team proposed assembling all involved to do a debriefing and reconstruction of the accident and resuscitation, along with relevant events before and after. The chain of command agreed.

The group was assembled in the open air and arranged cots in a circle for everyone to sit on. The briefing was begun with the suggestion that for the purpose of reconstructing events, ranks be set aside and that all participants be accorded the status of equal witnesses.

In the course of the debriefing, the details of the resuscitation were presented. The medic the team had been asked to see twice got up and stood in the center of the group, with his eyes focused far away from the group, and described what he had seen and done during the resuscitation. The other medic contributed details as well. The soldier's vehicle commander described the events leading up to the accident. The soldier's friends initially expressed reservations about the competency of the medics and whether all that could have been done had in fact been done. At that point the distressed medic stood back up in front of the group and provided graphic details of the resuscitation. It was then obvious to the dead soldier's friends who had not seen the accident and the resuscitation efforts that the medics had done all that

could be done. The medics had done more than the soldier's friends could imagine themselves doing. As he recounted the resuscitation, the medic became less distressed and gained confidence and self-assurance. Concerns of the soldier's friends over the quality of the resuscitation quickly receded.

The dead soldier's chain of command raised another issue before the group. By regulation, the soldier could have been granted emergency leave to go home to visit his wife and new baby just before the ground war had begun, but he had decided to stay with the unit and go to war with his friends. After some discussion, the group consensus was that he had made the correct decision to stay with his group even though they were all sorry that he was dead.

One other issue was raised by the group. The soldier had been wearing a rifle grenade bandoleer when he stepped on the DPICM. The explosion of those grenades probably contributed to his injuries. The fact that he was carrying these grenades at all had been a concern to some of his friends and to his chain of command. He had no compelling reason to be carrying them once the cease fire went into effect, but no one had pushed him to give up wearing the grenades. In retrospect, the participants wished they had taken a firmer stance with respect to the grenades.

By the end of the debriefing the participants had a clearer view of the accident, its antecedents, and the resuscitation. For the distressed medic, the debriefing was clearly a turning point in terms of how he viewed himself and how his comrades viewed him. By the end of the debriefing he was clearly free of distress and his comrades viewed him with new respect.²⁰

Comment: This case report demonstrates the value of group debriefing after an especially traumatic and gruesome event. It was clear from the participants that most members of the unit, not just the distressed medic, had been affected by the accident and subsequent death. Clarifying the sequence of events and responses to them allowed the unit to put the event into perspective, thus facilitating the reintegration of the medic into the unit.

Psychiatric Debriefing

Psychiatric debriefing (as presented further in this chapter) begins the debriefing process with an education briefing about normal stress and the prevention of PTSD. This may be delivered to large audiences. Groups of participants are then led by psychiatrically trained debriefers in an active process of ventilation (abreaction), sharing, and normalizing of stress reactions. This includes further interpretation and education about psychological defenses (the adaptive and the maladaptive ones). While participants are told that they are not "patients," this technique comes close to being psychotherapy. It may be the most expedient method for assisting a large, ad hoc group that will disperse after

the debriefing and not have the protective benefits of continuing in a cohesive, working organization.

Large Group Debriefing

Large group debriefing¹⁷ is an umbrella term for expedient debriefings involving large numbers of people (100 to 500 or more) where it is impossible to actively involve everyone. The organizational leaders of the sub-elements of the group (for example the platoon leaders, company commanders, first sergeants) perhaps supplemented by natural leaders or “key players” from the enlisted ranks, review and reconstruct the facts of the critical event or longer operation while the remainder watch and listen. Large group debriefings are of limited use for critical traumatic events, except for further integrative processing after the most traumatized elements have been debriefed in their own smaller groups. They can be very effective as end-of-tour debriefings.

Case Study 2: Troop by Troop

An armored cavalry regiment fought effectively in the ground offensive of the Persian Gulf War, but suffered losses from friendly fire and from unexploded ordnance. During and immediately after the battle it had the benefit of an expert combat stress control (CSC) team that had been requested by the regimental commander from the corps. That team conducted several small group debriefings during and after the campaign. On returning to home base, one of the squadron commanders followed the advice of the CSC team and conducted debriefings with the entire squadron, a troop at a time. The squadron commander, assisted by each troop’s commander, conducted debriefing reconstructions of the entire battle with the assembled troops. Concerns that the process might scapegoat or place guilt and blame on only a few individuals were unfounded. It was clear to all that the confusion and fatigue of a rapid advance through desert winter weather and the snowballing consequences of many small glitches in communication, coordination, and alertness spread the blame. Further, it was clear that when things went well, it wasn’t just one person doing the right thing, but a whole series of correct and timely actions that led to a good outcome.

Comment: Postcombat reconstructive debriefings are something that not only mental health personnel but every commander should have in his hip pocket and be ready to use after any significant action.

End-of-Tour Debriefing

End-of-tour (or demobilization) debriefings summarize all the significant events in an entire, pro-

longed operation. It begins by soliciting memories (good and bad), thoughts, and reactions during initial alert and mobilization. When everyone has had their say on that, discussion proceeds step by step through the good and bad memories and lessons learned of the actual deployment, the first days, middle and final phases of the operation, up to the present. The operation may or may not have involved traumatic events, but is likely to have caused many frustrations and perhaps resentments that can be ventilated and not carried home. The process should end with a positive sense of closure.

These debriefing categories are not rigidly fixed, and can merge into each other. The debriefing team must choose the appropriate type and format for the specific traumatic incident. For example, natural disasters may require different debriefing styles than do combat or human-caused incidents. Debriefings of impersonal, mass-casualty disasters should differ from those for small but highly personalized or traumatic incidents. The characteristics of the participants should influence the choice of format. Even in the same traumatic event, debriefings conducted with surviving victims must differ substantially from debriefings of the immediate response rescuers, or of the second-echelon caregivers. Debriefings of senior leaders and their staffs will differ from the debriefings of the junior leaders and the troops. Debriefings of elite, cohesive, and “macho” units must differ from debriefings of ad hoc assemblages of victims, rescuers, or survivors. End-of-tour debriefings (EOTD) that do not involve traumatic events must differ from those that do.

Available resources will often limit (but should not dictate) the type of debriefings that can be accomplished. Some of the factors that influence the choice of debriefing format are the number of experienced and partially trained debriefing personnel, access to safe and reasonably comfortable facilities, the total number and internal organization of the population to be debriefed, the other conflicting mission or treatment demands, and, especially, time.

The remainder of this chapter presents the first and second authors’ experience in conducting psychiatric debriefings and end-of-tour debriefings during and after the U.S. invasion of Panama and the Persian Gulf War. Other information on debriefings is provided in Chapter 9, U.S. Naval Combat Psychiatry, and Chapter 12, Postcombat Reentry.

PSYCHIATRIC DEBRIEFING TASKS

Predebriefing

A model of community consultation which had been developed in the wake of the Korean conflict is useful in setting the stage for the psychiatric debriefing.²¹ Because the debriefing is intended to initiate the reintegration process, the mental health personnel must make contact with the command structure of the unit being debriefed.

If possible, a working relationship with the command structure should be developed prior to any trauma. The contact is intended to educate the leaders of the group about the importance of psychological debriefing in the prevention of PTSD and other sequelae of mobilization and reentry. The process of command contact has been described in Chapter 9, Command Consultation, in *Military Psychiatry: Preparing in Peace for War*,²² a companion to this volume. This process applies whether the mental health team is organic to the higher headquarters of the supported unit (for example, the mental health section in a division) or is providing area support (for example, the mental health section of an Area Support Medical Battalion or U.S. Army CSC Detachment in the field or the Community Mental Health Service or Departments of Psychiatry, Psychology or Social Work of a post's Medical Activity in garrison). The same skills have been practiced by U.S. Army psychiatrists working in civilian homeless shelters. In this instance psychiatrists prepared the shelter staff for the introduction of direct delivery of psychiatric services^{23,24} by building relationships with the shelter leadership over a 3- to 4-month period. The objective of this approach is for the commanders to give permission to soldiers (or civilian workers, family members, and others) to voice their concerns without fear of repercussions. Their experience is validated as a necessary part of their job during difficult circumstances.

Thus, predebriefing tasks are

- Preparing commanders.
- Conducting higher command or installation briefing.
- Maintaining liaison with chaplains and other medical and mental health support agencies.
- Conducting mental health activity training.

Military authorities higher than the unit command structure or installation directly involved may have to be briefed concerning the necessity for

psychiatric debriefing of soldiers. This is because soldiers can be negative about the command structure during the debriefing itself, and the work of the mental health team may be seen as divisive and undermining. A simple explanation of the facts concerning the prevention of PTSD and the helpfulness in maintaining unit cohesion in the face of trauma is usually all that is necessary.

Chaplains, mental health and social support services, emergency, and other medical personnel will become involved in the debriefing process or its follow-up, and it is necessary to educate and coordinate activities with them. When services are not coordinated, other workers may label individual soldiers as patients and thereby increase their psychiatric morbidity. This phenomenon was seen most strikingly during World War II, when soldiers were evacuated to the rear and developed prolonged emotional symptoms.^{25,26} This has been called the "evacuation syndrome."

Training of mental health staff is especially important during this phase prior to the debriefing. Mock debriefings may be helpful in providing staff an opportunity to practice interventions that encourage the expression of feelings and discourage the tendency to overemphasize the reaction to the trauma. In the experience of the authors, staff training is ongoing and involves mock debriefings, follow-up information, and dissemination of data on the efficacy of psychiatric debriefings. Work of this nature is likely to decrease the incidence of worker burnout as well as provide for more effective delivery of care.²⁷ Ideally, members of a debriefing team should first observe a real debriefing led by an experienced debriefer; second, lead a debriefing while being observed and mentored by an experienced debriefer; and, finally, observe and mentor a new debriefer. This is the "see one, do one, teach one" method. However, this ideal requires a steady succession of local traumatic events which will not always be available for training.

Debriefing

When the debriefing begins, it is essential that commanders provide an introduction to lend credibility to the event. A model that has proven beneficial includes the large group setting initially for relaying information about the risk factors for the development of PTSD and potential problems asso-

ciated with reunions with families and communities. Of special importance is the message that the feelings and symptoms, which can be emotional or physical, are normal responses to an abnormal situation. Often this is enough to relieve the anxiety of the soldiers affected.

If time permits, small groups of 8 to 10 participants can then be formed with one or two workers from the mental health staff, who facilitate a discussion of events encountered by the soldiers.

The tasks of the debriefing are

1. Utilizing large-group setting for information sharing and discussion of normal reactions to trauma.
2. Utilizing small groups (8–10 participants, 2–3 facilitators) for exploration of issues (if sufficient staff is available).
3. Maintaining confidentiality.

Confidentiality appears to be a major theme in these discussions. During the small group sessions soldiers may be reticent to describe their experiences because of possible repercussions. They have to be assured that the purpose of the debriefing is not to point out blame or to solve administrative problems. Therefore, they can be encouraged to share their feelings with impunity. Also, silence, sometimes encouraged in therapy, is not helpful in these groups. The facilitators have to be aggressive and ask the soldiers to recall stories and hear about their concerns. The time limit for the entire debriefing can vary from 90 to 120 minutes.

Common defenses during this phase may be denial, anger, and guilt, which have been described elsewhere.^{28,29} As in the experience of any traumatic event, the psychological mechanisms which mollify the experience come into play almost immediately. The debriefer must be aware that supporting these defenses, by allowing for ventilation at an early

stage, can make the use of these defenses less important as time goes by.

Postdebriefing

It must be remembered that debriefing is the beginning of a process of reintegration for soldiers involved in combat or other trauma. Therefore, the debriefers must set the stage for further supportive work if needed, without predicting negative reactions or fostering dependency. This includes identifying and contacting individuals who show signs of needing psychiatric referrals, without stigmatizing them. It includes continued consultation to commanders who may require guidance in matters such as giving passes, leaves, and reassignments.

It is also crucial that the administrative/clinical head of the debriefing process debrief his or her own staff. Feelings of anger, denial, and guilt present in the soldiers can also be overwhelming for the debriefers. Because war can be horrifying, involving the death and mutilation of friends, comrades, and even family members, it is important to take care of the workers involved in helping the soldiers integrate the experience.

After-action reports also serve to organize one's thoughts, and serve as a "clinical" record of the proceedings of the debriefing. They are extremely useful in understanding some of the basic themes experienced by soldiers and the data from after-action reports can guide remarks in the opening moments of the debriefing.

Thus, the postdebriefing tasks are

- Conducting follow-up and referrals as needed.
- Conducting command/community consultations.
- Debriefing staff.
- Completing after-action reports.

ISSUES AND PITFALLS OF DEBRIEFING

There are several issues and pitfalls in debriefing. First is a lack of support on the part of the command or leadership structure of the unit. This is often due to misunderstanding of the value of the debriefing to future readiness. The command may view the debriefer as creating problems rather than preventing them or even of being divisive and subversive. Because so many feelings are part of the experience of trauma, and there

is a tendency to project blame onto leadership, commanders can feel that their authority is being undermined. Contact with commanders early on alleviates the responsibility of blame from them. When presented with the historical data suggesting increased unit cohesion, and a decrease in psychiatric symptomatology following debriefing, commanders are ready to utilize debriefing services.

Debriefers may find that there is a tendency to provide easy solutions and to assign blame for the problems of the unit. It is easy enough to agree with soldiers or victims that their commander's lack of leadership abilities was responsible for their waiting in the desert for 2 weeks without an assignment. In fact, the assignment may have been beyond the commander's ability to influence, but angry feelings are nevertheless present. An exploration of these feelings is the proper intervention, rather than blaming the commander or encouraging that the unit initiate an investigation into his ability to lead.

The timing of the debriefing is of vital importance. While certain groups may be too emotionally and cognitively exhausted to process information, immediacy is a factor in the theory and practice of debriefing. Often, groups have already begun to process the traumatic event in a destructive manner, and the large groups involved (eg, U.S. Army, civilian communities) may act pro forma and without regard to long-term consequences by dispersing groups exposed to trauma in a rushed fashion. Reflexive defenses start to work almost immediately as the individuals begin to deny and project anger, so many groups can and should be debriefed as soon as possible. The clinician has to assess if they are able to do so at the time.

However, when debriefing is done too close to the traumatic event, victims may feel further traumatized and vulnerable. A period of rest and regrouping is preferable (but in the "real world," sometimes not possible) prior to debriefing. Some researchers feel that when a person is in a state of physiological arousal (1–5 d) after the trauma, debriefing may be harmful.³⁰ Others cite the tendency of individuals and groups to form a "trauma membrane" (a mental scab) after about 3 days; prior to then they may be eager and even driven to talk of the event. After then they may avoid and resist being reminded. In this formulation, 1 to 2 days after the event is optimal for debriefing. This area is controversial and will require further study. The following case example shows how debriefing a combat unit too soon might have caused an increasing psychiatric pathology. The case is disguised to protect the anonymity of the unit.

Case Study 3: The Helicopter Crash

Company A, deployed to Saudi Arabia prior to the start of Operation Desert Shield in 1990, suffered the loss of 15 of its 60 members during a helicopter crash. While on nighttime maneuvers, part of the unit being transported by helicopter crashed into the desert sands. All members on

board the aircraft were killed by the impact and badly burned in the ensuing fire.

When the unit commander learned of the crash, he informed his superiors and subordinates in the chain of command. On orders from the senior commander, a psychiatrist and social workers were sent within 4 hours to gather the remaining soldiers in the unit and begin a debriefing. During this period, the psychiatrist provided information about stress-related psychiatric disability and predicted the possibility of intrusive nightmares, thoughts, and angry feelings. Soldiers at the meeting, which lasted about 2 hours, were generally quiet, and appeared dazed and startled. Others looked angry, while still others were sad, immobile, and worried.

After the mental health personnel left, the soldiers met independently in their barracks and discussed how angry they felt towards the psychiatrist and social worker because of the invasion of privacy they felt. "They don't even know what we do, who we are, or how we feel," some members of the unit stated.

A follow-up on this unit revealed an increased incidence (compared with other units) of disciplinary actions, and alcohol-related incidents 4 months after returning to the United States.

Comment: In effect, this intervention was a stress briefing, not a debriefing. It may have inadvertently "pathologized" rather than "normalized" the predictable stress symptoms. Also, it lasted too long. The Critical Incident Stress Foundation¹⁶ recommends brief (10–15 min) "defusings" immediately after the critical event to normalize the immediate reactions and set the stage for a debriefing in 1 to 3 days. A debriefing might have been more effective if it had asked unit members to describe how they were involved or heard about the crash and encouraged them to share their feelings rather than listening to theories about stress.

Mental health staff can become overwhelmed by the debriefing process. War, because of its intensity and disregard for human life, may bring forth a variety of feelings from those individuals who work with combat veterans. The staff must have a period of decompression themselves in order to put the experience into perspective. Most individuals in the helping professions would rather take care of a problem when it arises; during the debriefing process, taking care of the problem involves a reticent, supportive, and encouraging stance.

Thus, the issues and pitfalls of the debriefing process are

- Lack of command understanding and support of the debriefing process.
- Tendency to assign blame.
- Tendency to provide "easy" solutions.
- Inappropriate timing.
- Failure to debrief mental health staff.

IMPLEMENTATION OF PSYCHIATRIC DEBRIEFING

The following case studies are provided for illustration of key concepts in the process of psychiatric debriefing. In Case Study 4, attention is paid to the psychiatrist's efforts at following the correct debriefing process. Although no relationship was built with the affected unit prior to the trauma, the psychiatrist used the medical facility as a familiar site and medical demobilization as a familiar process to aid in developing rapport with the soldiers. In Case Study 5, a disguised case example, the importance of eliciting feelings is demonstrated. Both examples are taken from military experience, but may be adapted easily to the management of civilian critical incidents. Case study 4, drawn from the authors' experience, is of a delayed post-trauma and end-of-tour debriefing.

Case Study 4: Explosion in the Desert

Company B is a reserve unit of about 70 members who were called to active duty in preparation for an overseas military mission. Prior to deployment, the commander of the unit assisted soldiers in developing family care plans, organized spouse groups, and rallied community support. Most soldiers were new to the unit and in their 20s.

When the unit arrived at the deployment site, the commander suffered an exacerbation of physical complaints that had been long-standing. He required hospitalization, evaluation, and eventually was given a medical profile that restricted him from deploying with the unit. The executive officer of the unit assumed command. The first sergeant arrived late because of family problems and was unable to assist in the reorganization and stabilization of the unit. Additionally, the unit, which was originally scheduled to deploy within 3 days of arrival at the mobilization site, was delayed for departure by 2 weeks.

During this time, the chaplain assigned to the unit noted high levels of stress and uncertainty about the details of deployment in the unit. He reported high levels of anxiety and apathy as calls to family members exacerbated unit members' sense of helplessness in dealing with family issues back home.

When the unit finally deployed, family members arrived at the deployment site to wish the unit well. Although there was a ceremony with speeches from political as well as military officials, unit members reported feeling scared and overwhelmingly sad about leaving.

Upon arriving in the war zone, the unit was housed in temporary quarters awaiting its mission in the war effort. Soldiers reported feeling useless and anxious about the uncertainty of their jobs in the overall mission.

Two weeks after arriving, a fuel tank exploded and nearly one half of the soldiers were killed and most of the others were wounded. Most of the living and wounded

soldiers suffered ruptured eardrums and acute anxiety reactions.

After the explosion, the soldiers were evacuated to a safe area, given clothing (as some were in night clothes and most uniforms had been destroyed), and were given permanent housing. The surviving soldiers met briefly with a "stress team" consisting of a chaplain, psychologist, and psychiatrist, who described some of the after-effects to be expected from this tragedy and attempted to elicit feelings and fears.

The Persian Gulf War ended so soon after the explosion that the surviving unit was redeployed to the continental United States without ever having been reconstituted to perform their mission. The psychiatrist at the deployment site explained to the medical command the need for debriefing and began training the mental health staff in preparation for this task. Initially, there was not much support for debriefing the soldiers because the process was seen as another time commitment with logistical problems for the hospital staff. As a compromise, the debriefing was streamlined and "married" to the out-processing medical examination.

When the hospital command learned of the return of Company B, there was already pressure from political and installation officials to rapidly process the remaining soldiers for return to home in civilian life. A parade was planned as was a reception by the post commanding general.

The soldiers were met at the airport by high-ranking military officers and the chaplain originally assigned to the unit. The soldiers were to be examined that evening and returned home in the morning. However, because the medical staff reemphasized the importance of rest and debriefing, examinations were rescheduled for the following morning.

The debriefing almost did not occur. The debriefers planned to meet the group after the medical examinations for 15 to 30 minutes and break into smaller groups for 1 hour. Some officials said that the debriefing already occurred in Saudi Arabia. In fact, the hospital commander was told by a representative from the installation that the examinations were taking too long, the doctors were not working fast enough, and that "all these soldiers need is a hug from their families ... so hurry up."

The authors, as the debriefers, however, insisted upon conducting the debriefing but were given only 30 minutes. The meeting opened with introductory remarks describing the usefulness of debriefing as well as the difficulties that soldiers might face upon reentry into their communities. One soldier said, "We don't need this, we are all friends and don't want to talk." Most were able to talk about their feelings, however, which centered around anger and helplessness. There were attempts to place blame on the unit's leaders as well as on those not injured in the attack, or were absent at the time of the bombing. Soldiers described various somatic complaints: hearing problems, gastritis, muscle aches, and headaches. They said that communication was poor in the war zone, they did not

know who had been killed, where the unit members were, or who was in charge. A second lieutenant was given command in the war zone and despite his eagerness and enthusiasm, he was the object of some ridicule for not being able to solve problems such as clothing and shelter.

They described especially their reaction to the stress team. Many soldiers felt that the team was intrusive, invasive, and offered solutions to problems too prematurely. They experienced the stress team as chiding them for poor behavior in the face of a crisis.

After the debriefing, the staff met to talk about the experience. Most had never participated in a debriefing of this type. The overall sense was one of helplessness and a need to place blame and find solutions. The installation commander was blamed for hustling these troops, the hospital commander for lack of support, the soldiers for being inarticulate and childlike, and the staff blamed itself for opening up emotional wounds. The need for blame was again interpreted and at that time, the process of debriefing was better understood.

One week later, an after-action report was forwarded to the hospital commander and the Office of the Surgeon General recommending training in debriefing and greater support of this endeavor. After the soldiers of Company B returned home, several of the soldiers made an official protest regarding the rushed treatment they received during the demobilization process. Many wanted to spend time as soldiers in a nonthreatening environment after combat, but were quickly returned to civilian life. As a result, some actually had to be brought back onto active duty to continue with psychiatric treatment and other debriefing activities.

Comment: This case study highlights the importance of communication with the command structure and the role of debriefing soldiers who have been involved in combat. Several pitfalls were avoided when the psychiatrist enlisted the support of the medical and administrative staff of the hospital to authorize the debriefing. The debriefing of the mental health staff was essential in their understanding the whole process of debriefing as well as to clear any possible feelings of guilt and responsibility in the endeavor.

The following case example, also drawn from the authors' experience, describes the importance of team work in debriefing and demonstrates the effectiveness of debriefing in eliciting feelings and emotions related to the combat situation. It involves a delayed post-trauma debriefing and end-of-tour debriefing.

Case Study 5: After the Battle

When Company C returned from Saudi Arabia, one of us (RK) was asked to debrief this reserve combat unit. The debriefing was conducted 4 months after return from the Persian Gulf. The unit was from the area adjacent to the mobilization post, so the preparations for deployment were familiar. The unit had begun preparations about 1

month prior to the start of the ground war by combat training in the United States. Three weeks prior to the ground war, the unit arrived in Saudi Arabia. They continued their combat training and suffered some psychological hardship of having no mail and no phones available for approximately the first 2 months.

Company C participated in the beginning of the ground operation and actually preceded the infantry into Kuwait. One service member was injured in his face by fragments but suffered minimal long-term effects. A second service member was killed while he was attempting to clear bunkers and apparently stepped on explosives. He lost a limb immediately and then died two days later in the hospital.

When the participants of the debriefing were allowed to comment freely, the following is a sampling of what they said:

"After we got back home, it was hard to get back into the flow of things. We had a terrifying experience for a short period of time, but now we feel like we want to use our time wisely."

"The period after the war was perhaps more psychologically disturbing than the war itself, since we had so much time on our hands and nothing really to do. We played volleyball, ate beans and rice and were really lonely. Phones were then available for the first time but they were expensive to use and there were long lines."

"We had trouble getting back into the flow, especially changing from military to civilian life. We didn't have any drills for the first 2 months after we got home."

"We tried to eat all the good food we had missed and drink all the good alcohol we had missed for 6 months."

"Although this unit returned to this country in May 1991, this debriefing (September 1991) is only the third Reserve meeting we have held."

"Routine matters like paying bills do not seem to matter much."

Comment: As the soldiers spoke, it was clear they were describing the frustrations of reentry into usual military life or civilian life. It was tempting for the team members to help them with suggestions, but the team members resisted and allowed the soldiers to tell their stories.

"We were promised that we would have a job waiting for us when we got back but some of us really had slots waiting and not regular jobs, and some of us had to move to another state."

"The main problem was that for 4 to 5 months we had one purpose and one purpose alone, then we came back to civilian life and we had absolutely nothing to do. We asked what is the meaning of life."

"Many of us were angry, especially for the first 2 weeks."

"After we were angry, nothing phased us. Overdue bills would bring this kind of reaction—Gee, this is all they've got to do?"

"There was poor attendance at Reserve drills for the first drill or two in contrast to before combat where drill attendance had been 95%."

"Much of the equipment has not arrived back to the unit even as of yet."

"The morale was good up to the cease fire."

"The service member killed in combat was 21 or 22 years old. He was a college student who was going to be a unit leader. He was a member of the company for about a year. He was well-known and well-liked."

"One of our members died in a street accident. It was a case of 'mistaken identity,' although drugs may have been involved."

"Being without money was not a big deal because it was expensive and there were long lines to buy things. Being without mail for 2 months was very upsetting, we could see no reason for having our mail come to us late. We were simply told that there were not enough people to sort the mail."

"There were many problems with pay, both active duty and reservists. The active duty had one pay system and the reservists had another. Some of us got no pay at all, some got double pay, and some of us had much more taken out later than we had imagined."

"Some of us felt, and still feel annoyed when people walk up to us in shopping centers and ask if we killed anybody. The support is strong but sometimes results in constant nagging and asking questions that upset us."

"Why did it take them so long to get us home? We waited for 35 days to have our chance to get onto an airplane and come home. One of our senators came to visit us but he did not know where we had been or what we had done."

"When we arrived in the desert, which took us only a day to get there, we were treated warmly by the active duty units, but when they left, they left us taking our equipment and leaving us with no feeling that we had been appreciated because they left us there alone."

"The activation process took too long. It created a great deal of stress. We were within several hours of home but we could not go there for more than a month. We said good-bye to our families and then went just several hours away and stayed there for a month, creating a lot of stress that we could not deal with. We feel that we should have had some psychological debriefing at that point."

Comment: Many soldiers were angry concerning their service in the Persian Gulf War. They spoke about the inefficiencies they encountered and when returning did not feel they were treated "special" for their efforts.

"One of our greatest stressors was not knowing one day to the next what is going on. This was not due to our leadership. The officers were also uninformed. We were not informed. A major problem was communication. We especially needed to improve communication between active duty and reserve units."

"The active duty often put us down, even though we were in front of them in the battle."

"Another major problem was false information."

One service member said PTSD stands for "pissed, tired, and sick of drills" without knowing he was very close to the actual meaning of the symptoms of PTSD, and that his anger, difficulty sleeping, and substance abuse were early stages.

"The government got us geared up for high expectations for combat. We were not let down because we were not in combat much and yet we had a great deal of energy created within us and it had no where to go. We have not

yet found a way to release this energy. The energy is stopped up inside of us. Working out or exercise helps a little bit. We really don't know what to do with the extra energy."

"Back home after combat, everything seems trivial. Dealing with others is very difficult now."

"Some people seem to hold it against us for going to war, especially if we try to say anything about it. We don't want to hurt the feeling of those who didn't go, yet some of us are very mad at those 18 members of our unit who lied about reasons for not being sent to war."

"We are sick and tired of being compared to Vietnam."

"Some people who watched the war on TV said 'You didn't really fight a war, you just sat around in the sand.'"

"I am involved at home with my wife and child, I have calmed down only a little bit."

"I was just married and sent overseas 6 months after I was married. It has been hard to get back into the relationship since I got back, it just doesn't seem right any more. I have to get out of the house and I usually go somewhere and drink."

"People ask stupid questions like, 'Did you kill anybody, or who was the first person you killed?'"

"We did our job, we are back in the real world, and it is hard to get back into the flow of things."

"Jobs and things that used to worry us, don't really seem that important any more."

"Money is a problem. The military didn't pay us as much as we made on the outside. Some of us didn't pick up any help either."

"Our unit still feels a little bit disorganized. We are getting things done, but we don't seem like we were before we went to war."

"We feel the reserve unit should stay together longer to support each other." (The group was encouraged to exchange phone numbers and stay in close contact with each other.)

"What pissed me off the most was getting ready to go over there and then getting over there and feeling like we didn't get the job done completely and the fear we may have to go back."

"We need psychological debriefing before deployment."

Comment: These sentiments are fairly typical of the several dozen debriefings the authors conducted during the demobilization phase of Operation Desert Shield/Storm. The debriefing demonstrated that many personnel in a unit can experience significant and persistent distress from the circumstances of the deployment and return home, unrelated to any specific critical (life-threatening) event. Many of the problems discussed and the persistent bad feelings they engendered could have been prevented had the unit been encouraged and mentored to conduct routine after-action reviews and after-action debriefings throughout the entire deployment.

There is an interesting follow-up regarding Company C. Approximately 9 months following the debriefing where the above comments were made, two soldiers were killed in automobile accidents that involved alcohol. Several others had not yet procured jobs, while others had been referred for alcohol and drug treatment. Another debrief-

ing of the reserve unit was requested. Comments from this debriefing centered around the sense of helplessness and abandonment by families, friends, and the community. A commitment was made to continue work with this reserve unit, who found it helpful to have the opportunity to express feelings and frustrations regarding the effects of deployment on their lives.

Finally, the process of developing a multidisciplinary team prior to combat or trauma is described in the following case, which involved a critical incident psychiatric model debriefing.

Case Study 6: Death in the Jungle

Prior to any battle during Operation Just Cause, the Chief of Psychiatry at the U.S. Army Hospital in Panama assembled a crisis intervention team. The purpose of this team was to provide immediate mental health intervention during and after disasters related to combat. The team consisted of a team chief who was a military psychiatrist trained in crisis intervention and debriefing. Virtually all other military mental health providers in Panama were included on the team (psychiatrists, psychologists, social workers, nurses, and enlisted mental health specialists). This all-inclusive concept was considered critical to ensure that enough trained personnel were available when needed.

The second key element in staffing was to utilize U.S. Army, U.S. Navy, and U.S. Air Force personnel. Training accidents and natural disasters could affect any of the three service populations. A team member from that service could act as a valuable liaison, especially in the initial phase of trust-building between the affected personnel and the crisis team members.

Finally, it was important to utilize enlisted personnel in these interventions in order to promote the building of rapport. Many affected enlisted individuals might have difficulty relating to officers during a time of crisis.

Training in mental health interventions in combat and natural disasters was conducted on an ongoing basis. Discussions were held on the main tenets of crisis intervention therapy, victimology, and command consultation. Specific topics at such meetings included: the unique psychodynamics of individuals who have had to face life-threatening situations themselves, or who lost a friend to sudden, violent death. Additionally, any actual disaster interventions were reviewed with special attention to lessons learned.

Command sponsorship was especially important. Because the team was organized prior to any actual combat, enough time was available to brief commanders about the importance of mental health intervention during combat or disasters. The previous state of haphazard referral promoted anxiety among commanders about the consequences of allowing mental health personnel into a disaster scene, and kept troops in need of help out of reach. In order to ensure that command sponsorship became a reality in Panama, a detailed proposal was forwarded to the military command in Panama explaining the need for

the team and the critical importance of the command's formally incorporating the mental health mission.

During the early morning hours of 22 February 1990 (approximately 6 to 7 weeks after Operation Just Cause), two helicopters flying a night training mission were lost in a northern province of Panama. The night was moonless and severe weather added to the difficult flying conditions. Once the aircraft were reported missing, an intensive search was begun. The search parties included personnel from the same unit that had suffered the losses. Due to the triple canopy jungle, poor weather, and wide search area, the downed aircraft were not found for nearly 36 hours.

The searchers located the two helicopters destroyed in the separate accidents that had caused the immediate deaths of 11 U.S. Army soldiers. There were no survivors. The affected units included aviators (the air crew) and infantrymen (the passengers). Due to the unexpected and massive nature of the tragedy, there was considerable emotional fallout in the community. Notably, the disasters took place during a period of high morale in the local population. The long-anticipated invasion of Panama 2 months earlier had inspired a feeling of a "job well done." The community was much better prepared for the potential loss of life during combat than at the time of the above-described accidents.

As the situation developed over the 36 hours after the accidents, it became clear that an aggressive mental health intervention was needed. Local mental health providers became aware of the tragedy later that day and began immediate efforts to contact the commanders involved. This effort was hindered by the fact that many of the affected individuals were involved in the search and were unavailable and the commander of the infantrymen involved had been killed in the crash. Nonetheless, by the second day, the mental health team chief accompanied those personnel tasked with identification of the dead. In addition, team members, including a psychologist and five enlisted behavioral science specialists, were on standby status. Aggressive negotiations with commanders resulted in the team arriving at the unit barracks on Sunday morning, 25 February 1990. After initial briefing interviews with the command, the team then held two group sessions of approximately 90 minutes each with all available members of the affected units. The following sections describe the specifics of that intervention in these areas: education, identification, process, and follow-up.

Education. The education process was begun with a brief overview of the history of combat psychiatry. The emphasis here, and throughout the intervention, was on the normal responses to psychic trauma. The team explained the evolution of thought in this area (eg, how in previous conflicts soldiers suffering psychological symptoms in the face of trauma were sometimes evacuated and treated like mentally ill patients). Team members explained that modern day mental health providers think of psychologic symptoms as a normal response to trauma, and expect that most soldiers will recover fully. They were pointedly told, "You are not patients."

In addition, an explanation of the psychology of victims was presented. Victimology classifies various levels of

individuals affected by a disaster primarily by psychologic proximity to the event. This concept was very useful in helping soldiers understand their affective responses, even though many were not directly involved in the accident.

Team members also discussed the classic acute responses to trauma: anxiety, sleep disturbances, irritability, increased alcohol use, and somatic complaints.

This initial portion of the session (approximately 20 min) provided a cognitive framework for the soldiers to begin thinking about their varied and intensely emotional responses.

Identification. From the outset of the intervention, the group was told that some people may need or want individual attention. The soldiers and commanders were given the location and phone numbers of the two military mental health clinics several times throughout the day.

Additionally, the debriefing team members were instructed to watch for individuals who seemed especially affected. During breaks, providers approached smaller groups of soldiers and individuals with this idea in mind. A small number of people were identified in this fashion and later seen on an outpatient basis.

Process. Those affected individually were encouraged, at times, and even called on, to discuss the events of the previous 2 days. Predictably, many of the group members were feeling angry, guilty, or were in a state of denial of symptoms. Team members were instructed to allow discussion and be able to tolerate silences. Appropriate interpretations were made, especially in the areas of displacement, regression, and denial.

The almost universal incidence of some degree of guilt and denial warrants further description. A phenomenon observed numerous times involved individuals inappropriately accepting responsibility for elements of the tragedy. This was consistent with Schwartz's³¹ observation, "The patient becomes unable to discern where his will ends and fate begins." While this construct allowed them the solace of not having to face their powerlessness, the accompanying guilt for action not taken was in some cases overwhelming.

The presence of "survivor guilt" during acute crisis reactions was evident in this group. Members showed almost no denial of the actual events, but many initially denied emotional symptoms, so called "inhibited grief." According to Raphael,³ inhibited grief is a common syndrome and "usually combines psychological numbing, over control, and containment of all feelings related to the death and the disaster." This syndrome is generally considered to be maladaptive and likely to be associated with future impairment. Therefore, efforts were made to gently confront and interpret this defense.

Follow-Up. One message that the crisis team emphasized was the availability of follow-up. Recognizing that individuals integrate psychologic input at different rates, the team members informed the soldiers that some might have symptoms during the days and weeks after the event. A mental health technician was placed at the local troop medical clinic on a daily basis during the week following the incident. The mental health clinic phone numbers were posted in conspicuous places in the unit work and living areas. A small number of individuals were identified and followed up via input from these two sources.

An unexpected outcome in the area of follow-up occurred several weeks later when another unit experienced a similar, but smaller scale event. The commander of this second unit was referred to the crisis team by command elements in the units involved in the incidents described above. This can be taken as indirect evidence of positive reaction to the first debriefing. Follow-up efforts were limited by troop movement, denial within the system, and by the inability of the providers to arrange on-site follow-up treatment groups over the days and weeks that followed.

Comment: The psychiatric debriefing format illustrated here begins with a general information and education briefing for all participants. As this must establish the debriefer's credibility, and rapport for the subsequent debriefing, the material must be properly focused for the specific participants. It must not use technical jargon which will turn them off. It is especially important that it not pathologize the process or the participants, even by inference. The identification of participants who may need individual therapy must be done in low-keyed fashion, without creating an expectation that many will need such care, without turning people who could manage on their own into patients, and without spotlighting and stigmatizing those who do seek further mental health assistance. The ideal of stress debriefing is not to generate referrals or follow-up cases, but rather to make them unnecessary. However, a temporary increase of patients who thereby gain mastery over acute stress symptoms is clearly preferable to a delayed stream of chronic, difficult-to-treat PTSD cases. The process phase of psychiatric debriefing (unlike S.L.A. Marshall's HERD or CED/CISD) is less concerned with eliciting facts and more active in eliciting participation in abreaction. It actively interprets the psychological processes involved—here, too, the vocabulary used must be carefully calibrated for the participants and not alienate them with psychiatric jargon. Follow-up must not be so aggressive as to create negative expectations of successful self and buddy care.

SUMMARY AND CONCLUSION

Debriefing in one of its several forms is an important part of demobilization from any combat situation or stressful operation other than war (OOTW). Debriefing is crucial to quickly restoring

unit effectiveness and preventing post-traumatic stress problems following critical (traumatic) events. Research from management of mental health issues in natural and manmade disasters, personal

trauma, and war indicate that when a group is allowed to ventilate fears, frustrations, and feelings about the event, and its individuals receive the support of their comrades, the likelihood of PTSD is decreased. The lessons learned from various armed

conflicts and disaster management are preparing mental health practitioners to exercise preventive care for potentially large numbers of combat veterans before they develop psychiatric symptomatology.

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