Psychiatric Debriefing Following Operation Desert Shield/Storm

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The authors describe the process of psychiatric debriefing followed at a major mobilization post following Operation Desert Shield/Storm. Specific guidelines for the debriefing process are given as well as case examples from the debriefings. Additionally, survey data from Army psychiatrists indicate that training in psychiatric debriefing is inadequate and that there is no standard procedure for the debriefing. The authors conclude that although psychiatric debriefing has been shown to be effective in decreasing long-term psychiatric morbidity in units and individual soldiers, the practice of debriefing could be standardized in doctrine and in teaching.

During the later part of World War II, Marshall, an Army historian, found a lower incidence of morale and disciplinary problems at units when soldiers recounted their experiences in war. This recounting of war stories and experiences served to (1) validate the role of the individual soldiers in his unit, (2) validate the mission of the unit, (3) provide for ventilation of feelings, fears, and frustrations about military service, and (4) encourage verbalization of conflict rather than acting-out behaviors such as fighting, excessive drinking, and social withdrawal.[1,2]

Over the years, this procedure, though never fully implemented in the US military, became a technique employed standardly by civilian mental health workers following natural or man-made disasters, terrorism, or severe civil unrest such as riots or murders; the so-called civilian critical incidents (CCI).[3,4]

The incidence of post-traumatic stress disorder (PTSD) is found to be high in unpopular conflicts, and with individuals in units with poor social and family support, low-morale, ineffective leadership, and unclear missions.[5-8] PTSD is a psychiatric condition which can follow an overwhelming traumatic event. Specific symptoms include: intrusive recollections of the event, distressing dreams, avoidance of stimuli associated with the event, and persistent symptoms of increased arousal manifesting as hyperalertness, vigilance, and irritable behavior. The symptoms must last for at least one month.[9]

Research by Israeli Defense Force psychiatrists reveal that preparing troops for the stress of battle and following-up with mental health interventions, including debriefing after battle, lowered the incidence of long-term psychiatric pathology such as PTSD and alcoholism.[10] In this country, some attention has been given in the various military services to forming teams of mental health workers who interact with units before, during and after mobilizations, disaster, or battle. The experience of US Army psychiatrists in debriefing survivors and families of the Gander air crash, veterans of the Grenada invasion, and Operation Just Cause emphasize the need for Command sponsorship and integration of the mental health team into the daily operations of the unit.[11-14]

Debriefing

The process of debriefing begins before the disaster, battle, or mobilization. The mental health team, which may consist of a psychiatrist, psychologist, social worker, and psychiatric technicians, must recognize the importance of the debriefing and identify the possible units which might be mobilized to a conflict area and to battle.

Adequate contact has to be made with commanders to educate them as to the necessity of debriefing following deployment or battle. Many commanders will not understand the need for debriefing, therefore, the mental health team must provide research evidence to commanders in a fashion that highlights the possibility of a successful command relationship.

A table indicating some of the tasks which are of importance during the pre-debriefing process is provided (Table I). The importance of developing a trusting relationship with commanders must be noted.

The debriefing itself (Table II) is divided into two sections: information giving and story-telling. The mental health worker usually introduces the group stating that the soldiers are not considered patients and that the group meeting which should last 1 to 1½ hours is standard practice following many of the mobilization or combat experiences. The worker should describe the possibility that some of the experiences soldiers have had during their tour will be upsetting and could cause bad dreams, increased use of alcohol, problems in personal relationships, irritability, a sense of entitle-

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ment, and a change in job performance. This is to be expected because of the violent, impersonal, and fast-paced characteristics of war.

Information should also be given to the soldiers on how additional help — individual, marital, and unit counseling — can be obtained. With that provided, the mental health worker opens the floor up for the telling of stories. These often involve the expression of feelings, fears, and frustrations. Initial regression should be limited, as soldiers may feel further traumatized by the standard psychiatric techniques which encourage regression in order to explore emotions and feelings.[15]

Table I. Pre-Debriefing Tasks.

1. Medical Activity support.
2. Installation briefing.
3. Mental health activity training.
4. Liaison with Social Work Service/ Chaplains.
5. Preparing Commanders.

Table II. Debriefing Tasks.

1. Large group setting for information sharing and discussion of normal reactions to trauma.
2. Small groups (8 to 10 participants, 2 to 3 facilitators) for exploration of issues (may not be possible).
3. Confidentiality.

Table III. Post-Debriefing Tasks.

1. Debrief staff.
2. After-action reports.
3. Referrals as needed.
4. Command/community consultations.

Table IV. Issues and Pitfalls.

1. Lack of medical/psychiatric justification for debriefings.
2. Tendency to assign blame.
3. Tendency to provide "easy" solutions.
4. Failure to debrief mental health staff.
5. Failure to follow-up on debriefing process for medical/installation commanders.
6. Inappropriate guilt, displacement of anger, denial.

A great deal of blame is often placed on commanders, and other leadership personnel. The debriefer should listen but neither condone, nor explain away this anger or blame. To do so would encourage soldiers to harbor angry feelings and to "close-up" conversation. Those in leadership positions may feel defensive and try to explain their actions; the psychiatrist should gently redirect these comments towards an expression of their own concerns.

This latter point raises an important question of whether commanders should be present during the debriefing of soldiers. Generally, our advise is no. The commander can be part of a debriefing group with his or her own peers, but should not be present with the rest of the unit, except to introduce the debriefer and lend his support and authority to the event.

After the debriefing (Table III), it is necessary to inform the commander of any problems encountered and if the need exists for follow-up. For instance, with a unit which had lost some of its soldiers in combat, several follow-up visits should be scheduled in addition to notifying the commander that there exists a high risk for psychopathology in that particular unit.

Good record keeping necessitates the generation of afteraction reports which can be forwarded to the medical command or the consultant's division of the Office of the Surgeon General. In this way, medical command personnel and subspecialty consultants are kept aware of the need for additional psychiatric support on certain posts or in certain Commands.

Perhaps the most important part of the post-debriefing is the work done with mental health providers. Since they were not part of the battle experience, workers may feel cheated out of a combat experience. The usual line given by soldiers: "You don't understand, you weren't there," can weigh heavily upon a worker's mind inducing feelings of guilt and incompetence. Workers must be made aware that they have not caused the problems and frustrations which the soldiers describe. Often workers will feel that they have opened up wounds which should be closed, and that this could be causing more harm than good. This latter point deserves some attention, as it raises questions concerning the time in which debriefing should be conducted. It appears to be true that, when psychiatric debriefing is conducted during a state of physiologic arousal, such as hyperalertness, anxiety, hunger, and exposure, the individual is likely to experience the debriefing as traumatic. It is important to wait a few days, if necessary, before the debriefing process begins; enough time to provide the individual members of the unit with sleep, food, and shelter. Even though doctrine prescribes that debriefing is most effective when conducted immediately after the traumatic event, this area is still under study. One practitioner believes that the time course and duration of treatment may be more important than the timing of the initial debriefing.[16] Another believes that debriefing should occur immediately because individuals can become separated from their units and acting out behaviors can become fixed.[17] Our experience with soldiers returning from the Persian Gulf War revealed that those who were psychiatrically debriefed immediately, while still in Saudi Arabia, expressed much anger toward the debriefing teams and described them as "intruders." The soldiers whose first debriefing experience was upon arrival to CONUS had difficulty focusing on the actual "war experience." They were overwhelmed with the anticipation of returning to their loved ones. Their areas of difficulty centered around leadership, logistical support and the administrative aspects of mobilization and demobilization. We found that the unit most receptive to the debriefing process was an artillery unit that was debriefing a couple of months after

their return to CONUS. They were able to describe in detail their war experience and their difficulties in dealing with the loss of two of their members. Command was receptive to the feedback provided and had maintained good rapport with our Department.

Several problems may arise during debriefing (Table IV). One area that bears mentioning is the tendency for workers to look for "easy" solutions. Because the trauma of combat and mobilization and its ensuing disruption and personal tragedies can be so intense, many workers will want to "smooth over" the difficulties by assigning blame to commanders, individual soldiers, or government leaders. This should be avoided because the mental health providers will be seen as undermining the authority of the command.

Other areas that may cause problems for debriefers include the lack of adequate preparation of the Command in the debriefing process. Commanders must be made aware that debriefing is part of any demobilization process, just as the physical examination is. Keeping in touch with the medical chain of command and the installation and/or unit commanders, will reassure these individuals about the health and strength of their soldiers.

Desert Shield/Storm Debriefings

Several units were debriefed at our facility. The format for the debriefings followed that which has been described above. Both of us had the opportunity to follow a number of units over a six- to eight-month time period after the initial debriefing. The following example has been disguised to protect the anonymity of the unit and soldiers but generally describes the difficulties experienced by many of the units who had been deployed to Saudi Arabia.

Company C, a reserve unit, began preparations about one month prior to the start of the ground war by training for combat while still in the United States. Three weeks prior to the ground war, the unit arrived in Saudi Arabia. They continued their combat training and suffered the psychological hardship of having no mail and no phones available for approximately the first two months.

Company C participated in the beginning of the ground operation and actually preceded the infantry into Kuwait. One servicemember was injured in his face by shrapnel but suffered minimal long-term effects. A second servicemember 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 Company C returned from Saudi Arabia, we were asked to debrief this reserve combat unit. The debriefing lasted approximately two hours and comments by the soldiers addressed their feelings of not being able to control their lives throughout the mobilization. Many felt that the waiting and gaps in communication was demoralizing and led them to question the competence of their leaders. Many related that the experience was not only demoralizing, but also frightening because of the unpredictability of the war situation.

Contact with the unit commander had been maintained and he requested us to provide a debriefing for the active duty staff of this reserve unit approximately six months following demobilization. An initial meeting with the commander revealed that two weeks earlier a soldier was killed in a car accident. While two of five soldiers sent to help another soldier with a disabled vehicle, a truck apparently lost control and ran off the road hitting one of the soldiers, throwing him against another and then onto one of the stopped vehicles. Of the three who were standing, one sustained no physical injuries but went into emotional shock for awhile, another suffered minor injuries, and the other died on the scene of the accident. Two of the soldiers tried to help with CPR but were unsuccessful due to the degree of damage caused by the impact. They saw a severely mangled body. The brains of the casualty came out of his ears everytime they attempted to breathe into his mouth while attempting CPR. His limbs were shattered and blood was splattered over the vehicles and on the ground.

The commander reported that the two soldiers seemed to be doing much better than they appeared initially. He requested the debriefing for the entire group because they all had been talking about it and they were a "very tight outfit." Sixteen soldiers plus the commander were present for the debriefing.

One of the soldiers involved was very verbal and described in detail his account of the experience to include his feelings during and after. He reported sleeping difficulties with vivid dreams that woke him up at night but said he was able to bring himself "back to reality." He also said he became nervous when driving on the highway, especially at the sight of trucks similar to the one involved in the accident. His tendency was to move away and for a while he was avoiding driving on the highway.

The senior soldier was quiet during the group session and declined the opportunity to talk with the debriefer individually. The commander said that he had spoken with this soldier but his concerns had dealt mostly with the administrative aspects of the incident, ie, the investigation. He had also expressed concerns about AIDS since he swallowed some blood in his attempt to give CPR. A test has revealed the casualty tested negative for the HIV virus.

The group was very responsive when the debriefer spoke about reactions to traumatic events. The group expressed much support for their fellow soldiers who were actually involved in the experience and several of them talked about some of their own experiences during Vietnam and Desert Storm.

The junior soldier involved in the

incident agreed to meet with the debriefer individually after the group debriefing. He talked more about the experience and said that in addition to the death of his friend, he was having to deal with other significant losses. He requested individual follow-up treatment as an outpatient through the CMHS. The rapport with this commander continued to be positive as evidenced by several appropriate referrals he made.

Survey Results

In an attempt to determine how widespread debriefing of returning soldiers from Operation Desert Shield/Storm was, we sent a survey to the psychiatrists at all US Army posts. The survey was designed to determine how the debriefings were conducted, the level of preparation of those conducting the debriefings, and if there was support for the debriefings from both line and medical commands.

Of the 58 surveys sent to various division, department, and community mental health service chiefs, 19 were returned (32.8%). Seventy-four percent of those who returned the survey stated that they were involved in psychiatric debriefing of soldiers from Operation Desert Shield/Storm. The usual amount of soldiers debriefed was 150 with a range of 15 to 15,000 debriefed soldiers. Most respondents were responsible for debriefing one to three individual units or battalions.

When questioned about support for the psychiatric debriefing process, respondents felt that there was equal amount of support from the medical command and the "line." On a scale of zero to five ("five" representing "lots of support"), respondents rated, on an average, support from the medical command and "line" as 2.7, and 2.8 respectively.

Eighty-three percent of those responding stated that there was no standard operating procedure (S.O.P.) for psychiatric debriefing at their facility. Few (1.4 from a scale of zero (never) to five (always)) filed after-action reports following debriefing.

With regard to the timing of psychiatric debriefing, most felt that it should occur during the first two weeks of the demobilization, trauma, or battle experience (1.3 weeks).

There was a mix of responses concerning training for psychiatric debriefing. Although the average response was 2.3 on a scale of zero ("not trained") to five ("very well trained"), actual responses revealed a divergence. Many practitioners felt very well trained while there were those who felt poorly trained. This was emphasized by their comments.

Discussion

We have attempted to review the development of the debriefing process and to provide specific guidelines for the conduct of psychiatric debriefing sessions. In the course of this exposition, it became clear that many of our colleagues were involved in varying degrees with psychiatric debriefings. Realizing the individualized needs of different posts and units, we conducted a survey to assess the key features of the debriefing process. We concluded that specific doctrine, education, and organizational support for psychiatric debriefing was lacking. Comments from several respondents indicated unit-specific support for a process which the literature has shown to greatly reduce psychiatric morbidity in individuals exposed to trauma and battle.

Training Recommendations

Given the historical importance of psychiatric debriefing and the results of this recent survey, some recommendations in the training of military psychiatrists, psychiatry residents, and other mental health professionals are apparent. Firstly, the acquired knowledge of PTSD from various countries and various conflicts could be taught as part of the professional training for psychiatrists, psychologists and social workers. Research into the extent of PTSD following mobilization, or other war/training-related disasters must be done to validate models of interventions which have here-to-fore been theoretical.

Military psychiatry, psychology, and social work conferences could address a portion of their agenda towards the importance of command consultation and psychiatric debriefing. Mental health workers could work with commanders, both medical and line, when they come to a new duty assignment in order to put in place a plan for management of disasters and combat-related psychiatric morbidity.

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