Chapter 12

POSTCOMBAT REENTRY

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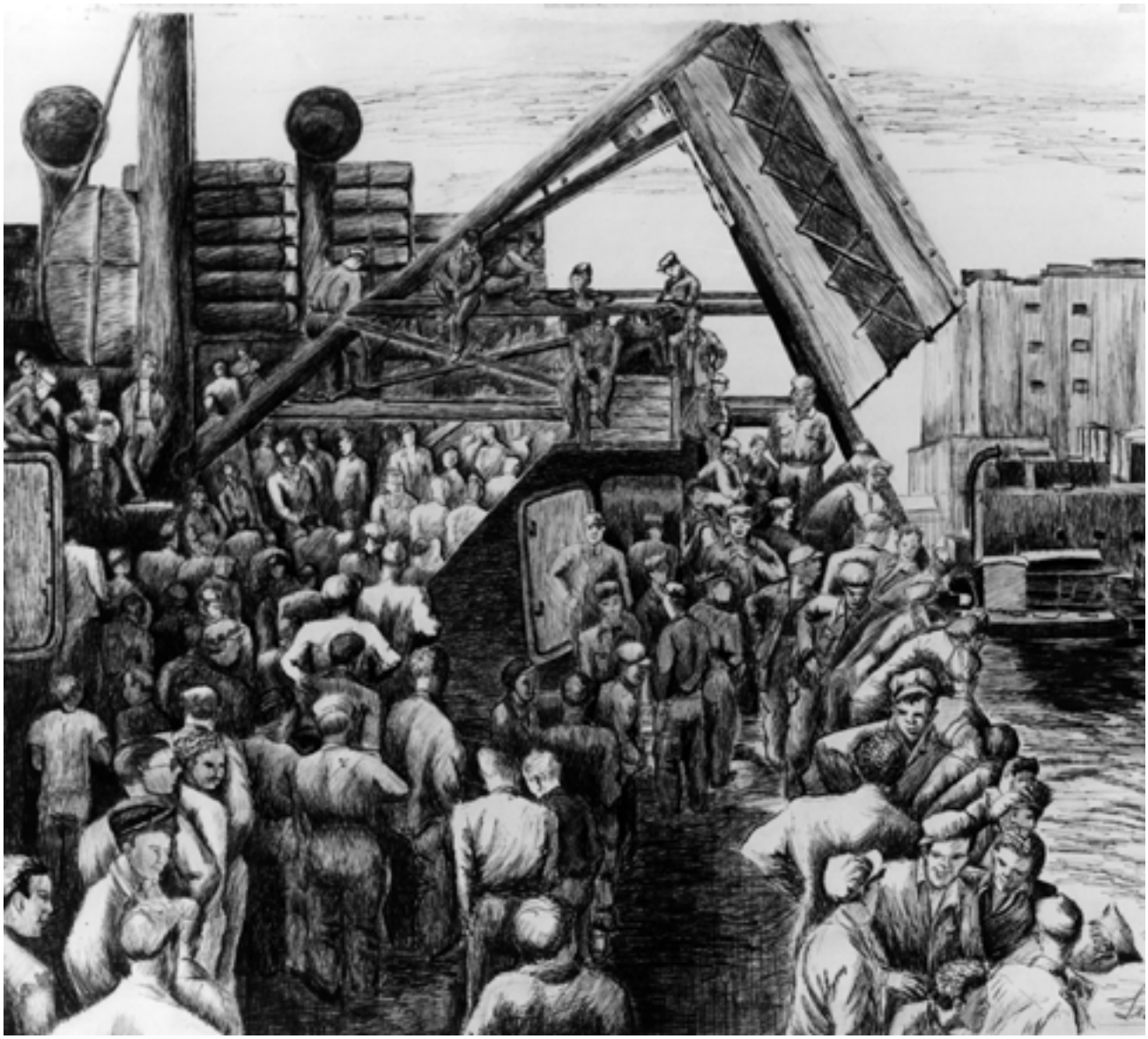

Leslie Anderson *Troops Boarding Homebound Ship* 1947

Captain Leslie Anderson, who joined the U.S. Army Combat Art Section toward the end of World War II, depicts troops boarding a ship to head for home. The return home is a greatly anticipated event for all soldiers, sailors, and airmen, especially after combat. With the increased range of air transports in the 1960s, these trips were shifted from ships to planes, resulting in less time to decompress from battle and prepare oneself mentally for return to civilian life.

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

INTRODUCTION

Major wars in the 20th century have usually comprised indoctrination of populations with the grievances against potential adversaries, a period of mounting tension vis-à-vis a particular adversary, years of combat, and involvement of the populace in enduring hardships and contributing to the war effort. Throughout this process individuals who are members, or who are likely to become members, of the armed services have time to get used to the psychological roles they will be playing as delegates of the population. They learn that they will be called upon to take great risks as champions of their people in a generally agreed-upon cause,[1] (eg, David representing the Israelites against the Philistine Goliath[2]). Civilians and military personnel alike have time to cultivate a set of perceptions that the enemy is an evil pseudospecies whose people may be killed and whose property may be destroyed without inhibition.[3,4] The development of wartime mind-sets helps military personnel not only to carry out their combat duties but also to manage the attendant trauma and guilt so they can reenter the peacetime world when the war ends.

The attitudinal adjustments necessary to define a group as enemy are easy to learn, but they require time, social support, and certain sociocultural prerequisites.[5,6] Similarly, the transition back to peace—relating to families, friends, and coworkers; dealing with social and material situations from a civilian rather than a military perspective; and perceiving the former enemy as neutral or even friendly—requires time and social support.[7–9] Among the strongest social supports that can help the individual soldier make the transition from war to peace is a national consensus about the war that legitimates his behavior in combat and validates the suffering, deprivation, guilt, and fear that he experienced. Not all service members have been able to manage to put their wars behind them and get on with their lives. In many cases lack of a positive consensus has played a role in these failures[10–12] Further discussion of this may be found in Chapter 16, Chronic Post-Traumatic Stress Disorder; Chapter 17, The Prisoner of War; and Chapter 18, Follow-up Studies of Veterans, in this volume.

Some campaigns required only fractional commitment of national resources and did not put national survival in jeopardy (Boer War 1899–1902,[13] French Indo-China War 1945–1954,[14] Korean conflict 1950–1953,[15] French Algerian War 1954–1962,[16] Vietnam conflict 1963–1973,[17] Soviet intervention in Afghanistan 1980–1990). These wars were conducted in a different psycho-political climate from that obtaining in major wars, and produced different reentry issues. Governmental assertions about the national interests that were at stake were not particularly credible, and the longer the wars went on the more threadbare became public support. Civilian inconvenience and involvement were modest, and because casualties were few and affected but few families, there was little pressure in the society as a whole for validation of the war effort to reduce dissonance arising from public distress (Table 12-1).

Soldiers participating in these limited wars had time prior to induction, during training, and during deployment voyages to adjust to the prospect of combat, but reentry presented a number of problems. The most serious of these was that the absence of a national consensus in support of the war made legitimation of the soldiers' actions and validation of their suffering problematic. Moreover, return from the two limited wars waged by the United States was on an individual basis. The returnees were not able to process their experiences with the comrades with whom they had trained and fought. Various kinds of acting out by veterans resulted. The effects of post-traumatic stress disorder on vet-

TABLE 12-1

CASUALTIES AMONG GREAT POWERS IN LIMITED WARS

War	Dates	Deaths
Boer War	1899–1902	21,942 British
French Indo-China War	1945–1954	29,685 French
Korean Conflict	1950–1953	33,629 U. S.
French Algerian War	1954–1962	12,000 French
Vietnam Conflict	1963–1973	56,737 U. S.

Data sources: [Boer War] Amery LS, ed. *The Times History of the War in South Africa,* Vol. 7. London: Sampson Low, Marston; 1909: 24–25. [French Indo-China War] O'Ballance E. *The Indo-China War: 1945-54, A Study in Guerrilla Warfare*. London: Faber & Faber; 1964: 249. [Korean Conflict] Blair C. *The Forgotten War*. New York: Times Books; 1987: ix. [French Algerian War] O'Ballance E. *The Algerian Insurrection: 1954-1962*. Hamden, CT: Archon Books; 1967: 201. [Vietnam Conflict] Westmoreland WC. *A Soldier Reports*. Garden City, NY: Doubleday; 1976: 299.

erans of the American troops who fought in Vietnam are discussed extensively in this volume (Chapter 3, Disorders of Frustration and Loneliness, and Chapter 16, Chronic Post-Traumatic Stress Disorder). The lack of consensus in France about the wars in Indo-China and Algeria led to military challenges to the regime in 1958 and 1961.[18,19] The stress imposed on the weakening fabric of the Soviet Union by the intervention in Afghanistan was one of the factors in the collapse of the communist union. Regimental officers were sufficiently alienated from the national leadership that they would not order their troops to fire on demonstrators opposing a military coup to restore the regime.

A third kind of conflict has emerged during the Cold War era—rapid deployment, short duration interventions such as the British reconquest of the Falkland Islands (1982), the U.S. invasion of Grenada (1983) and Panama (1989), and the Persian Gulf War (1990–1991). The psychological sequelae of such conflicts differ from those encountered in longer wars, especially wars in which there was time to prepare psychologically in advance. One might expect that a soldier who is involved in a short period of fighting would experience less psychic distress than one who endured prolonged combat, and that has proved to be the case, as discussed in Chapter 1, Psychiatric Lessons of War.

Several other factors warrant consideration. The most important of these is that when a state is defended by a small, long-service professional armed force, the same personnel are likely to be involved in several armed interventions. The soldiers are not, as was the case with the majority of soldiers in wars fought by mass conscript armies, discharged to the civil sector for management of their reentry problems; they stay in the service. It is essential that reentry issues be understood so that steps can be taken to capitalize on those aspects of combat experience that strengthen a service member's competence and confidence, and to mitigate traumatic or depressing aspects.

A second factor that merits consideration is that rapid deployment to combat can deprive service members of opportunities to develop clearly defined attitudes about the virtues of the American cause, the evil nature of the adversary, and the importance of the campaign to values that are important to them. As a consequence, military personnel participating in rapid deployment operations may have but little psychological armor to help them manage the experience of killing, the loss of comrades, or the pain and shock of wounds to themselves. A psychologically informed effort must be made before combat to prepare personnel for these experiences. Similarly, postbattle action is necessary to facilitate recovery from these traumata both to alleviate suffering and to preserve the combat potential of units.

The purpose of this chapter is, first, to review the experiences of participants in rapid deployment campaigns, and second, to describe the action by command and by mental health professionals that supported reentry processes and strengthened the psychological integrity of individuals and units. The first section will be a historical summary with a view to identifying policies and behavior relevant to reentry from rapid deployment campaigns. The second section is a catalogue of issues that have emerged from research on such campaigns. The third section is a discussion of the roles of mental health professionals, operating in support of, and in collaboration with, command in managing the reentry process.

HISTORICAL REVIEW

Between 1775 and 1992 the armed forces of the United States have waged seven major wars—six against foreign powers and one nationwide civil war. They have conducted more than 30 limited wars or armed interventions that entailed the use of substantial forces, and carried out hundreds of military operations that included combat or the threat of combat. Following each campaign there have been reentry processes. Of interest to the mental health community are those that provide guidance for policy and conduct in the future. This historical review will focus on reentry processes that affected the postwar active army. It has three parts: (1) major wars, (2) limited wars, and (3) rapid deployment wars.

Major Wars

The American solution to reentry following its seven major wars has been demobilization. After the Revolutionary War the army was reduced to 718 men. Following the War of 1812, 71% of the army was demobilized; after the Mexican War, 77%; the Civil War, 94%; the Spanish-American War, 62%; World War I, 94%; World War II, 93%.[20] Demobilization made reentry a societal, not a military prob-

lem. The former soldiers went home to the approbation and welcome of their friends and families; the Regular Army went into hibernation. Many potential problems were solved by units staying together during long trips home by sea, foot, and horse-drawn vehicle from Vera Cruz (1849), from the Philippines (1902), and from France (1918–1919). Soldiers and leaders could process their experiences together, reassure each other, agree on acceptable myths that validated their behavior and feelings. World War I was the last—until the invasion of Panama (1989–1990) from which units made the journey home as units.

World War II was totally different from the standpoint of reentry. Though units to a large extent trained, deployed and fought with the same men—less casualties and plus replacements, when it was time to go home it was every man for himself. In spite of the national consensus that World War II was a "good" war,[8] there were numerous manifestations of hostility and episodes of indiscipline in connection with the processes of returning home, demobilizing, and reentry into civilian life. A system was devised by which each soldier could earn points for time in the service, time overseas, time in combat, wounds, and decorations. Those with the most points were to be sent home first. The design of the point system was based on research among military personnel.[21]

An unforeseen consequence of the point system was that it transformed the serviceman from a member of a social unit to an isolated individual. He no longer had the support of the comrades and leaders with whom he had trained and fought, and who had given his deeds and discomforts meaning. Because there was a finite number of ships and aircraft with which to bring personnel home, many of them were frustrated by having to wait. In 1946 there were reports that the Pentagon intended to slow the demobilization process. Servicemen "took to the streets and demonstrated in more than a dozen countries."[22] In some embarkation camps soldiers left without authorization, did not report for guard duty, and misbehaved in local civilian communities.[23,24] In the camps, the soldiers were a mob of angry individuals deprived of the fabric of trusted comrades, leaders whom they knew, and the networks of missions, trust, and mutual obligations that had given psychological substance to the authoritarian structure of the armed services. That fabric was necessary to sustain, orient, and support soldiers' self-control. Without it, they acted out their feelings of helplessness and frustration.

The effects of the predischarge period of alienation were to focus and solidify the feelings of discontent that had accumulated during the soldier's service, attenuate the memories of effectiveness and comradeship, and send many home from the service with a bitter sense of denigration and impotence. The veterans of World War II, though they participated in a much longer struggle and won a more comprehensive victory than did their forbears from World War I (1917–1918), were not the committed and cohesive advocates for the armed services that the older veterans were.

Another consequence of the bitterness engendered by the individualized return and demobilization process was a series of complaints about the behavior of officers. The criticism provoked an investigation by a commission chaired by Lieutenant General James Doolittle. The commission found that many officers had behaved inappropriately, and proposed sweeping reforms.[25] The reforms, oriented toward removing arbitrary distinctions in dress and privileges between officers and enlisted personnel, did not address the fundamental issue—which was how to build mutual respect up and down the hierarchy. The reforms proved to be a source of confusion and alienation that complicated relationships between officers and enlisted personnel for more than 30 years.

Postcombat alienation, acting out, and hostility to the armed forces differed from symptoms of combat stress disorders or nostalgia, but they were still part of the psychological aftereffects of a mid-intensity traditional war. By comparing the reentry policies employed after World War II and their consequences with the policies and consequences following other conflicts it is possible to identify actions that are most adaptive.

Limited Wars

Between 1783 and 1940, the United States engaged in 14 limited war campaigns—an average of one every 11 years, as shown in Table 12-2. The guerrilla wars, like the major wars, were fought mainly with volunteers. When the job was done, the volunteer regiments went back to the United States and were disbanded. Return from the combat zone was by ship or on foot, and provided plenty of time for soldiers to talk through their experiences with each other. The regular officers and noncommissioned officers (NCOs) had to look for places in regular units, usually several ranks lower than those they had held in the regiments of volunteers.[26]

TABLE 12-2

LIMITED WARS 1783-1940

War	Dates	Type
Quasi-war with France	1798–1800	Naval
Barbary Coast wars	1801–1805	Naval
Seminole War	1817–1818	Guerrilla
Second Seminole War	1835–1842	Guerrilla
Philippine Insurrection	1899–1903, 1910–1913	Pacification
China Relief Expedition	1900–1901	Pacification
Cuban Pacification	1906–1909	Pacification
Nicaraguan Pacification	1912, 1926–1933	Pacification
Haitian Expedition	1915, 1919–1920	Pacification
Santo Domingo	1916	Pacification
Mexican Border Campaign	1911–1919	Pacification

Most of the pacification operations were carried out by Regular Army or U.S. Marine Corps regiments that remained intact after the operation. Though deployment and return were slowed by the transportation technology available, combat was often intense and brief. These operations were small-scale forerunners of rapid deployment campaigns such as the U.S. invasions of Grenada and Panama and the Persian Gulf War. Unfortunately they took place before the era of interest in the psychological dimensions of warfare, and little has been written that is helpful in understanding the dynamics of the reentry process.

Between 1945 and 1992 the United States intervened more than 15 times in other countries with substantial forces: Korea (1950–1953), Lebanon (1958), Quemoy and Matsu (1958–1963), Cuba (1962–1963), the Congo (1964), the Dominican Republic (1965–1966), Vietnam (1963–1973), twice in Cambodia (an evacuation in April 1975 and the *Mayaguez* battle in May 1975), Vietnam evacuation (1975), Lebanon again (1982–1983), Grenada (1983), Honduras (1988), Panama (1989), the Persian Gulf region (1990–1991), Somalia (1992), and Haiti (1994). None of these operations involved the survival of the United States, and the levels of popular support varied from almost total approval (Persian Gulf, Grenada) to high levels of disapproval (Vietnam after 1968). The forces varied in size from less than a division of ground troops to the bulk of American combat strength. Most involved land, sea, and air forces. Those before 1973 were supported by conscription. Those after 1980 resemble expected future operations most closely in being carried out by professional forces, in the rapidity with which forces were projected and the brief time deployed, and in their frequency—an average of one major operation every 2 years.

Reentry following the two largest limited conflicts—Korea and Vietnam—resembled that following World War II in that service members left the combat zone as individuals. Because most of them were discharged shortly after completing their obligated tours, reentry was a matter for the civil sector to handle. But the conflicts in Korea and Vietnam were not supported by a solid national consensus. The country was apathetic about the Korean conflict, especially after the first year when armistice negotiations began and progress at the bargaining table attracted more attention than combat operations. Casualty rates were high during the first year, but total casualties were so low that too few families were affected for them to become a matter of widespread concern. Three years of combat in Korea killed only about one tenth as many Americans as 4 years of World War II. Returning soldiers were ignored by the populace, but often received a hostile reception from their own service.[27]

Service members returning from the conflict in Vietnam were for the most part met with indifference until 1968.[28] From 1969 on they stood a good chance of encountering savage abuse.[11,28,29] The widespread post-traumatic stress disorders (PTSD) reported among veterans of the conflict in Vietnam have been partially attributed to absence of validation and legitimation from the civilian population. Another factor, one that is rarely cited, was the absence of support and validation from comrades and leaders—who either came home before or were still in Vietnam. The veteran of Vietnam went from the battle zone to the United States in 48 hours. He did not have time to think and talk through what he had seen and done, and in any event he went back with strangers, not the men he had served with. He had to confront reentry to the civilian world completely alone, and often it was a hostile world.

The record of reentry following World War I, World War II, the Philippine Insurrection, the Korean conflict and the Vietnam conflict are of limited relevance for the future. Either the units demobilized, or they stayed in the field and men rotated through them. The units never reentered until the war was over; the individuals left the service at the end of their obligated service. The problem for the future is reentry in which a unit deploys, fights, and

returns—as a unit. The unit and its members will continue to stay together, and must remain ready for the next deployment. Only the most recent history is directly relevant—the history of rapid deployment wars with short periods of combat.

Rapid Deployment Operations

In 1982, 13,000 Argentinean troops seized and garrisoned the British Falkland Islands. In 7 weeks a British multi-service task force assembled and moved 8,000 miles to put ashore a force of 10,000 men to recapture the islands. In 24 days of bitter land, sea and air fighting 252 British soldiers were killed, 6 ships were sunk, and approximately 1 dozen aircraft were destroyed.[30] The reentry processes for the British units are useful for this study because the British attack resembled the type the United States has used since and probably will continue to use, and because the British used regular units, not conscripts.

The British units stayed together after the battle, preparing for the next one. Reentry problems rarely emerged for two reasons. The more important reason is the supportive nature of the British regimental system. It assures the soldier that he will always be with the same unit, the same comrades and leaders, and the same traditions. He partakes of, contributes to, and derives significance as a person from the regiment.[31,32] The honor of the regiment requires him to behave in certain ways. He follows the traditions, feels proud of living up to them, and is cloaked with their dignity. He never experiences reentry alone.[33,34]

The second reason that reentry problems rarely emerge is the British tradition of undemonstrativeness and reluctance to express emotions. These cultural behavioral characteristics limit the range of communications and can mask psychological distress. Ritualized manifestations of loyalty to the regiment distract men from their fears and help them through difficult moments, but they also make it hard for leaders to detect incipient problems in time to take action to alleviate them. Probably some leaders are only too glad that discipline, honor, and the stiff upper lip protect them from having to become aware of, and deal with, psychological pain in subordinates that they are working hard to deny in themselves. Often the first hint of combat stress reaction is serious acting out or decompensation.

The United States conducted rapid deployment operations involving combat in Grenada in 1983, Panama in 1989, Saudi Arabia in 1990, and Somalia in 1992. Many units train continuously for the rapid deployment mission. They know they could go into combat any day on short notice. They know that the mission is real, because their units have gone into combat on 24-hours notice.

The classic rapid deployment operation was Operation Just Cause (OJC)—the invasion of Panama in December 1989. A force of about 4,000 combat troops was on the ground in Panama. An additional 16,000 were air-dropped and airlanded over a 24-hour period, and within 48 hours the entire Panamanian military structure was destroyed. Rules of engagement were strict: U.S. soldiers could fire only at enemy personnel who could be seen firing at them. No suppressive fire was permitted, and no indirect fire by artillery or mortars was used. Only two aerial bombs were dropped, and they were in remote locations. As a result, the action by U.S. forces caused few civilian casualties and minimal collateral damage. Unfortunately, a much larger number of civilians were killed and one barrio destroyed by fire as a result of action by Noriega's Dignity Battalions and of personal vendettas carried out during the collapse of the Panamanian government.

The Department of Military Psychiatry of the Walter Reed Army Institute of Research (WRAIR) conducted extensive research into the human dimensions of OJC. The WRAIR team interviewed more than 800 soldiers of all ranks from ten infantry battalions and two military police companies. The research caught the units in the midst of the reentry process just after they returned to their home stations in the United States, or in Panama in the case of units permanently stationed there. The findings from that study have provided much of the empirical data on which the analyses that follow are based.[35]

The data from the study done by WRAIR indicated that few soldiers suffered from traditional combat stress reactions or disorders of loneliness or frustration (nostalgia), but that rapid deployment, short-duration campaigns provoked specific types of stress reactions in some soldiers, and most units reported some difficulties in coming down from combat to the mundane routines of training. It is these kinds of issues that commanders and mental health professionals need to understand. Properly managed, they can preserve the psychological readiness of units that have taken part in a rapid deployment combat mission. If they are treated with benign neglect because no one knows how to handle them, or because other matters appear to be more important, morale and cohesion can languish and the unit can lapse into a degraded state of psychological readiness.

REENTRY ISSUES

The 10 infantry battalions studied by the team from WRAIR were cohesive and competent. Three had been in Panama for several months before Operation Just Cause was launched. Members of the battalions lived and trained together 24-hours-a-day, week in and week out. They patrolled constantly and provocatively, and had frequent hostile encounters, with loaded weapons, with members of General Noriega's Panamanian Defense Force (PDF). These battalions became cohesive in conditions that were not far removed from combat. Two others were elite Ranger battalions in which cohesion was developed by continuous high-intensity training, free from distractions not related to the mission. Five battalions, including one of those already in Panama, were COHORT (cohesion, operational readiness, training) units. Their first-term soldiers had gone through initial entry training together and stayed together for 3-year tours in their battalions. The last battalion, though neither Ranger nor COHORT, was a part of the division that has been on the highest alert status in the army for decades.

Several of the battalions that were not in Panama when OJC was initiated were on relaxed alert status. Two had sent most of their personnel on Christmas leave. Nonetheless they assembled, packed their equipment and were airborne en route to combat in about 24 hours. Three parachuted into combat; four were airlanded. Official after-action reports and the findings from the WRAIR study indicate that all of the battalions performed their missions effectively. Most of the action was at squad or platoon level, though some company commanders were able to control all of their platoons some of the time.

Six of the battalions studied engaged in severe combat. Between them they suffered 10 killed and 116 wounded in action. In addition there were 6 men killed in accidents. Only one of the 10 battalions studied had no fatalities. OJC is an appropriate case study because it is a prototype of future military operations, and because it was an unqualified success with minimal friendly casualties. As a consequence, the reentry problems that emerged were few in number and easy to recognize and study. From the 10 battalions studied it is possible to describe the range of problems that may arise and the techniques used by commanders and mental health professionals that were most effective in dealing with them. The issues fell into three categories: (1) acute reactions to combat, (2) postcombat validation, and (3) reintegration into the postwar world.

Acute Reactions to Combat

Veterans of OJC reported three kinds of emotional reactions to combat: (1) distress over killing PDF soldiers; (2) a complex mix of grief, guilt, and rage over losing comrades; and (3) generalized patterns of anxiety, irritability, and nightmares.

Distress over Killing

Casualties that the soldier inflicted himself on enemy soldiers were usually described as the most stressful events. A first sergeant described the reactions of soldiers who had killed PDF in close combat: "They don't feel good having a confirmed kill." A company commander said: "Shooting people has been harder for most soldiers to come to grips with than the death of a friend." A squad leader said of one of his men: "He killed two. That night he was punching the wall and crying. He has a bad feeling." His comrades described a soldier who had killed a PDF in a fire fight: "Joe was wound up, talked a mile a minute. He kept asking us what we thought. We told him he had done a good job. He was a pain in the ass, wouldn't shut up. Finally they sent him to the rear to decompress. We never heard from him again." The platoon sergeant of a platoon that had riddled a bus full of fleeing PDF officers said: "There was blood running out the door. People were screaming and bleeding to death. I'll never forget that sight."

Evidence was more often indirect than direct; many of those who had killed were reticent about it, and their distress sometimes took the form of withdrawal or denial: "He was dazed after shooting a PDF soldier three times in the neck—a perfect shot. But he didn't want to talk about it." The squad mates of a one soldier said: "After he killed two guys hand-to-hand he got real quiet. He has since gotten out. He should have gotten counseling." One squad leader described one of his men who had killed two PDF at close range: "He was the most upset guy. He got very quiet." A company commander reported that he had hoped to make a soldier who had two confirmed kills an institutional hero: "He kept to himself. He got out. He said he never wanted to be in a situation where he would have to do that again."

Confronting feelings proved to alleviate stress to some extent. A platoon sergeant said: "Then there's the burden of killing people. I can't reconcile it, I just carry it." A private reported: "I hit an adult and a child. That bothered me." A group of squad leaders distressed by the fact that they and their men had killed a number of PDF said: "We consoled each other." A sergeant major encountered a group of soldiers who had been in a fire fight: "They had killed some people and wanted to talk. It was an impromptu session with 14 guys."

Compassion for the PDF was an issue. One soldier said: "When we saw how terrified they were, we felt sorry for them." Another noted when describing dead PDF: "They were just soldiers, doing their job." A Spanish-speaking soldier told his squad mates that their prisoner had said, "He doesn't like Noriega, but he has five kids and needed a job."

Some soldiers had no apparent negative reaction to killing. After a car full of civilians had failed to stop at a road block and one of the occupants was killed a soldier said, "Better one of them than one of us." A private described the mood of himself and his comrades: "We were very excited. We had been in the country 2 days, killed people, and had no casualties. We were hyped up, felt invincible." When a soldier was killed accidentally, his comrades said of their killing some PDF: "It was gratifying to get some kills. It made us feel better." One soldier who killed a PDF said: "It was like a video game. He was shooting at me." A squad leader who had encountered a PDF ambush said: "It didn't mean anything to me. I shot one, the team leader got the other." A spokesman for a squad that had killed two and wounded two PDF said: "It was a relief. We didn't know how we would react, and we had done okay."

There were three factors that made it difficult for the soldiers who fought in OJC to manage the psychological aftereffects of killing PDF soldiers. The first and most obvious is the aversion most mammals have to killing conspecifics (members of their own species).[36,37] This aversion does not preclude killing in all cases, but it does constitute a threshold the strength of which varies with species and among individuals within a species.[38–40] Pseudospeciation, the ability of humans and some other primates to classify certain members of their own species as "other," can neutralize the threshold of inhibition so they can kill conspecifics.[41–43] While pseudospeciation makes it possible to kill, it does not include processes to neutralize the affect associated with an action against which there are phylogenetically strong inhibitions. The soldier who kills is left with his psychological afterburn.

The second factor was ambivalence. The soldiers who fought in OJC had had opportunities to adjust their perceptions to classify the Panamanian dictator Noriega and his henchmen in the PDF as "bad," as inhuman enough to kill. But the pseudospeciation process was partially vitiated as a psychological support by the identification U.S. soldiers had with PDF personnel as soldiers, and as frightened human beings.

The third factor was isolation. The afterburn U.S. soldiers experienced was exacerbated by the fact that comparatively few U.S. soldiers killed anybody. Those who did were alone with the conflict between having done something inherently aversive, and having done a praiseworthy deed in the context of their social group. Their ability to communicate with and derive support from their group was apparently inhibited to some extent by this conflict. Because the combat phase was brief, there was not enough time for killing to become routine, for it to become an experience most of the soldiers shared. Those who had killed were likely to remain a breed apart.

Reactions to Casualties Among Comrades

Soldiers and leaders reacted to casualties among their own comrades in patterns that were fairly constant irrespective of whether the casualties were caused by enemy fire, friendly fire, or accident. The intensity of their reactions was a function primarily of how well they knew the victims. There were six emotional themes evident within these response patterns: (1) anger, (2) grief, (3) horror, (4) guilt, (5) bonding, and (6) dependency on the mission.

Soldiers expressed anger toward the PDF even if they had nothing to do with causing the casualties. The following are responses by soldiers whose comrades were killed by friendly fire support systems: "We were more aggressive toward the enemy." "It helped to return fire." "If we hadn't been able to shoot at the PDF we'd have fallen apart." Their reactions were about the same when the PDF killed an American. When one soldier was killed, his platoon sergeant said: "People got mad. They wanted revenge." A squad leader observed: "It was hard to enforce the rules of engagement after Joe was killed. The guys did what I told them, but I sensed that they were close to getting out of control." Another squad leader said: "They were eager to kill someone. One guy was especially eager to kill. I said, 'Let's get it under control, get Panama

squared away.'" The essence of the emotional state of the comrades of dead Americans is evident in a description of a junior NCO whose best friend was killed in action: "He was freaked out, angry and frustrated." Their complete helplessness in the presence of the totality of death was extremely difficult for these young soldiers. They were in the early years of their manhood, they had chosen the U.S. Army as a means to achieve a sense of potency, of instant adulthood, and instead they were faced with a loss about which they could do nothing.

The second theme, grief, took two forms: (1) immediate shock, and (2) a deeper feeling that men experienced later. The immediate response was a compound of refusal to believe and a wish to undo the death. A company commander who had just lost a man said: "I wanted to be alone with him for a while. I closed his eyes. Then the medics pushed me away, and I lost it." Another officer expressed a similar feeling: "He's yours and he's lost and there's a family." Describing a death that was reported over the company command radio net, a soldier said, "The platoon went batsh__ over the radio." A soldier who observed a platoon in which two soldiers were killed and two others wounded said: "The squad froze when the squad leader was hit. The platoon leader got them going again with words and by touching them. He said to the team leader, 'You're one-one [the radio call sign of the fallen squad leader] now,' and the team leader took charge." Several soldiers expressed a sense of time rushing by: "It all happened so fast. We couldn't stop." "If you stop to mourn, you make mistakes." "There was so much going on. We really didn't have time to be sad then." "It happened so fast. It was deeply sad, but it went through so fast we didn't have time to grieve then." One soldier recalled a succession of thoughts flashing through his mind: "His wife is pregnant. Am I going to get home? I was nervous. Oh my God."

The longer-lasting grief responses were often delayed. A private who had lost a comrade experienced his grief most acutely at a memorial service in the continental United States (CONUS): "It hit me when I saw his family and I realized how much he had lost." A platoon leader described his men's grief: "You could see in their eyes that they were missing something." A soldier who saw another killed beside him reported, "I still see it in my mind and think about it every day." A squad leader described the members of his squad after a man had been killed: "They were sad. I was sad. His best friend was real quiet." A commander who met another who had lost men said, "I'm sorry about your guys." The other replied, "Yeah, it's rough." Expression of grief was sometimes possible, sometimes not. In some companies soldiers reported that during memorial services: "There wasn't a dry eye in the place." "The company commander spoke, and he broke down. That helped." But in another unit a soldier said: "I'm sure people were sad, but we all felt it would be a sign of weakness to cry." A company commander reported, "I was really sad, but I didn't think it would be right for the men to know it."

Though OJC was limited in time and scope, some soldiers experienced or witnessed a full measure of horror. A soldier who looked into a comrade's face just after he had been mortally wounded in the head said, "I'll never forget his look of terror; he was still alive." The members of a mechanized infantry squad told how their machine gunner had been hit: "When daylight came we saw the track and the gun were covered with his blood. It stank." A platoon sergeant said that casualties affected the least experienced soldiers most: "The newbies were overwhelmed." A soldier described what happened when a rocket hit a soldier from behind: "It set off an explosion in his ruck. There were parts of him all over Bill." A soldier who witnessed the wounding of his comrades said: "I couldn't forget about the wounds, how bad they were. It could have been me. I felt weird, wanted to be alone." The best friend of a man who was accidentally killed by a gunshot in the head was angry and tearful as he described cleaning up the mess.

Guilt was a particular burden of leaders and medical aidmen—those who saw keeping others alive to be their responsibility. A company commander who lost a man in a well-planned and executed operation said: "I was so stunned I couldn't believe it. Could anything have been done better?" A squad leader who had lost men insisted, "I would rather it had been me than them." In another unit a squad leader felt responsible for casualties, but his platoon leader reported, "The squad helped the squad leader to stop blaming himself." A team leader who had been near his squad leader when he was mortally wounded kept saying, "He took my bullet." One medic who tried to treat a man whose arms had been blown off was distressed to admit, "I felt a moment's hesitation about touching him." Another medic was dropped by parachute at a considerable distance from where men were hit: "I wasn't where I should have been." There were also a few who expressed survivor guilt: "Why was it him and not me?"

When a unit suffered casualties, soldiers tended to cling to each other emotionally. One squad

leader expressed a feeling shared by others: "There was tighter bonding. We tried to give more as squad leaders." A seriously wounded platoon sergeant ignored his own injuries in his anxiety about his men: "All my soldiers are still out there. You've got to get to them." After casualties were evacuated a survivor said, "The squad huddled together all night." A medic reported that in the aid station: "The wounded guys kept asking each other, 'Are you all right?'" The friend of a man who was hit said, "After he was wounded he wanted to stay with the unit but it was better that he was evacuated." A platoon sergeant had a man hit near the end of an operation: "I hugged him after he was hit, and told him to squeeze my hand if the pain got too bad."

After sustaining casualties, most units persevered in the mission, but with heightened care and caution. A squad leader spoke for many, saying: "Everyone acted different. Functioned better. They worried about each other. They paid attention to detail. They kept going; no one gave up." A soldier whose friend had been killed said, "We were prepared for this; we expected casualties and we had a job to do." Another soldier who had lost a squad mate said, "We were nervous, alert to each other; we still had a mission to do." A platoon sergeant described his men as: "Looking for reassurance in their tactics. They knew it could be them next." One company commander who was grief-stricken by a death described his soldiers: "They put their loss behind them. They haven't forgotten but they continue to perform." A soldier who had had a comrade killed beside him said, "We didn't want to go on, but we did."

Anxiety, Irritability, and Nightmares

Witnessing the death or maiming of a comrade heightened the survivors' awareness of their own vulnerability. In these cohesive units they looked to each other for reassurance and for a restored sense of strength. They also used the mission to distract them from becoming fully aware of their feelings at the time of the event. These responses were adaptive both for the accomplishment of the mission and for the mental well-being of the soldiers. They provided both time and opportunities to talk through, or share silently, the losses they had suffered, the horrors they had seen, and the fears they had experienced.

But neither time nor comrades erased the memories of killing, losing friends, guilt, shock, and fear. Several soldiers reported post-traumatic stress symptoms. Flashbacks and nightmares were a problem for some: "I had insomnia, and I was irritable." "I was angry at battalion, I jumped a lot, had nightmares, and I kept a weapon within reach." "I keep dreaming that I see him explode." "Several times I have woken up and found myself low-crawling on the floor." "I keep getting pictures in my head; I wonder what could I have done to keep from getting wounded." Almost all of the soldiers who described stress symptoms said they kept them to themselves: "We never mention nightmares or none of that stuff. It could hurt your career." "In this outfit they think you're pussy if you have psych stuff." "My wife listens, but she doesn't have any idea what I'm talking about."

Chaplains and commanders reported that there were increases in both maturity and acting out. There was a rash of marriages and of conception of children in some units after return. In other units there was increased drinking and fighting. Soldiers had not only to manage their acute reactions to their experiences, they had to readjust to peacetime training and routines, and the married ones had to readjust to living with their families.

Reintegration to Peacetime Garrison and Family Life

Historically many men who went through combat have found that there were aftereffects that complicated their return to peacetime pursuits. Research conducted on veterans of World War I found that even those who had the best postwar outcomes—those who were in good health, self-supporting, and happy—reported they were irritable, quick to anger, excitable, nervous, forgetful, restless, and plagued by headaches and dizziness.[44]

Reintegration processes for veterans of short wars, who stay in the armed services and have to prepare for the next intervention, have three characteristics that distinguish them from the processes associated with long wars. First, the intense emotional experience of combat has not been blunted by time and the erection of defenses. This makes the letdown from war to peace more intense.

Second, service members who remain on active duty after combat lose the sense of personal significance and potency associated with a "real world mission" and do not have it replaced by a qualitative change in identity from soldier to civilian. They are still in the service, but instead of being on the cutting edge of national policy they are involved in simulation, make-believe, and bureaucratic procedures. Several soldiers made comments such as, "Down there we were men; back here they treat us like children."

A third factor is that there is no perception that the job is done, the misery is over, and there is an end to terror. Professional military personnel know that there is a high probability that they will be called into combat again, probably soon. These factors did not affect many servicemen at the ends of the big wars or those who finished tours of duty in Korea or Vietnam. The research team from Walter Reed found several clusters of long-term issues associated with reentry. They can be grouped under five rubrics: (1) horizontal cohesion, (2) vertical cohesion, (3) command behavior, (4) persistent stress reactions, and (5) relationships with families.

Horizontal Cohesion

Military personnel who fought together were tightly bonded with each other. They trusted one another and felt safe with each other after having survived dangerous situations together. One commander described his men: "They're closer after the stress plus 50 days of propinquity plus the satisfactions of participating successfully in an important event. People feel better about working together." A senior NCO noted:

"Now we are real relaxed. The men talk about their experiences and joke. The mood is lighter, there is less bickering, and they tolerate each other better. They know the other guy will watch their back. They don't hold grudges. Everybody is a little bit closer after 74 days of hell."

From privates' perspectives: "We pull for each other, we check one another. It's live or die." "The squad is tight, real tight. We were close before we went, but it is really a different kind of closeness now. We know we can depend on each other."

Soldiers varied in their responses to returning to combat from, "I never want to go through anything like that again" to "I'd go back in a heartbeat." But they were almost unanimous in saying, "If I have to go back, I want to be with these guys." This medley of feelings led to a congeries of psychosocial issues as replacements came in and veterans either left the service or were transferred. The salient themes were: "I trust the guys I went to combat with, but not the new guys" on the one hand and, "We train with the new guys and help them; everyone has a battle buddy; we need them and want them, so we do for them" on the other. In some squads there was a feeling of loss and despair as trusted comrades transferred out and clumsy rookies took their places: "They came from no-stress basic training. They're weak and don't want to learn." "It's too bad we can't stay together. We could mature together but instead each guy who leaves takes some experience with him."

The receptions for new men were generally positive: "Peers help the newcomers out a lot." "Nobody is lording it over the new guys." "Most of us don't even wear our CIBs [Combat Infantryman Badges], except on our Hollywood uniforms." "Oh, there was a little hazing, but it was good-natured. The new guys are okay." "The squad hasn't changed. We still bullsh__ around. The new guys are fitting right in." The new men saw things differently: "It was awesome joining a squad where everybody had been in combat." "This COHORT unit was harder to break into than either of the other two units I have been in. The major reason was that I had not been to Panama with them." "They let me in, but I really had to show them that I would put out."

Because of the life-or-death nature of combat, men who did not do well found themselves extruded. Squads bonded tightly with all of the members keeping the one perceived to be a slacker on the outside. "There were some guys who didn't do their share. They're isolated by the rest of the unit." "When we attacked, he hid under a boat. Nobody talks to him anymore." A platoon leader said, "I had some guys who failed in combat. It was their big chance, and they blew it. What do I do with them?"

Vertical Cohesion

Postcombat turnover among junior leaders had the heaviest impact on vertical cohesion. A battalion commander reported, "We had 8 new NCOs waiting for us when we got back, and we're turning over 40 more in the next couple of months. The new ones may have trouble getting accepted. It will work out if they can do their jobs. I worry more about the NCO turnover than anything else."

From the privates' viewpoint the worries were justified: "We have had four squad leaders in 4 months." "The sergeant who replaced our squad leader who was killed is too familiar; he is trying to fit in too fast." "Since all the NCOs were wounded, we have all new squad leaders." "A sergeant came in from another division that had also been in Panama. We advised him to take off his combat patch from that division." These problems could involve many NCOs in the same unit.

> Sergeant X isn't here half the time, he's at school. Sergeant Y was our best team leader and now he's

> a squad leader in another platoon. He takes time to talk about our problems, he shows us how things work. Instead of writing you up, he squares you away. Sergeant Z knew his sh__, how to navigate, what needed to be done, how to take care of soldiers. He was busted and transferred. Sergeant Q, who cracked in Panama, is still a sergeant.

New officers joining a unit that had been in combat had problems, but they were less severe. One lieutenant said:

> I told them I was depending on the veterans to train the new guys. That was all it took. I guess they were pleased that their experience was being recognized. Of course, I was one of the new guys. They trained me but nobody said that in so many words.

Command Behavior

It is difficult to separate vertical cohesion from command behavior because the former is a product of the latter. The essential distinction in this argument is that under the section on vertical cohesion new leaders' problems of being accepted were discussed, whereas in this section the behavior of leaders, whether new or veteran, is the topic. The most critical issue facing commanders upon reentry is engaging the veterans' interest and effort for training after they have done the job in combat. A company commander complained: "I'm having a hard time playing the game. I'm tired of retreading the same territory." A lieutenant said: "It is like starting spring training after you have been to the Super Bowl."

Soldier after soldier echoed these sentiments, but with more pungency: "Why are they putting us through this Mickey Mouse bullsh__ when we've shown we can do it?" "The highers are actually serious about training for NTC [National Training Center]. Can you believe it? As if it was something real." "The training is bad. We go charging off 100 miles per hour in the wrong direction. It's more like being disciplined." "Battle drill may be needed, but they're going about it wrong. Instead of building on Panama they are like saying, 'Forget Panama.'" "It's the same old horsesh__. Ever since we got back we've had people on our backs about barracks arrangement, micromanaging, telling us things we want are impossible when we know perfectly well they are possible." "This so-called training is nothing but repetition of things we already know. No one is reenlisting." "We don't feel we're doing any useful mission here. We felt fulfilled in Panama, but not here." "Training doesn't have the same seriousness or level of importance it did before."

Not all units had problems getting troops interested in training. A lieutenant said: "Things can't just stop. You owe it to the soldiers to train them to be as proficient as possible. But you have to be sensitive about Panama, too." Privates in another battalion reported: "Panama was the highest gear we had been in. We went home, showed off, and came back ready to get back to training, get ready for the SQT." "I have a different attitude toward training. We got back because we knew our sh__." "I'm more serious. I train harder now." "There's no pressure in this battalion for unrealistic standards. You try to beat your own standard." Squad leaders in the same battalion added: "We've had no problem converting back to training because we need to work on our weak points. We have a meeting at 1600 each day on what we'll do tomorrow. I stay a little while with the troops to see if they have any problems." "After Panama there was a different attitude toward training; it had been hard, but it registered on them that if you got it right, your chances of coming back are better."

Another issue was the question of time off for decompression. There was general agreement that there should be time off, that the soldiers should go on leave, and that the pace of training should be less intense. But there was wide variation in how much was enough. Commanders expressed satisfaction; a typical comment was: "The battalion went on block leave as soon as we had recovered our equipment. When we came back I declared a number of 4-day weekends, and we held to those rigorously." The rank and file had different perceptions: "Other battalions got 10 days administrative leave; we had to use our own leave time." "Ten lousy days is all we got. We had missed Thanksgiving and Christmas and New Years." "Who the hell wants block leave in February?" "We had been down there 4 months and been on duty 7 days a week and all we got was 14 days leave." A thoughtful officer described the dynamic in his platoon:

> There should be a policy that after combat or a prolonged, stressful deployment soldiers get time off. They need to dream, filter away the combat. They should maybe be allowed to take more leave if they need it. It takes a couple of months. When we got back we got one day off and then back to work. Is training that critical? Stuff builds up—administration, housework, kids. They need to feel the establishment is behind us.

Persistent Stress Reactions

The flashbacks and nightmares described under acute reactions to combat were a continuing problem for some soldiers. NCOs were most articulate in describing their own symptoms. They tried to deal with them by keeping busy—for distraction and so they could sleep at night. When asked about increased irritability, they reported being angry but not at any specific persons or situations. They were mad at "leaders," mostly at battalion level, for "dog and pony" shows and having to "buy new fatigues to look nice." Paratrooper sergeants reported fears of jumping, especially at night.

Comparatively few privates reported having symptoms. Some of their NCOs said they were concerned about them. Most said they had not had time to ask their soldiers how they're doing. They agreed that the "quiet ones" seem to have more problems. They think that many soldiers on their return from Panama had problems with what they had seen and done. No one had debriefed them or provided them information about combat reactions. (For a further discussion of debriefings, see Chapter 11, Debriefing Following Combat.) They think this would have been helpful and a good idea. They would have heard that others shared their feelings and experiences. A platoon sergeant described a soldier who had intrusive memories and who thought he was crazy. Another told of a soldier who had nightmares about having a dead soldier's blood all over him. No one had told them that nightmares and flashbacks are normal.

There was evidence of a need for mental health services in theater in connection with the operation and its aftermath. A psychiatrist reported, "We had two combat stress casualties." A first sergeant said, "Three of our guys had symptoms—nightmares and such. They had all been hurt and evacuated away from the unit." Another told the team, "One soldier cared for a dying comrade for several hours; he went to the psych unit after his friend died."

But most soldiers and leaders in line units shunned mental health services after their return to home base. There were several apparent reasons; fear of the unknown realm of psychological functioning was one. One company commander said, "Psychologists don't go over well in my unit. They're too 'touchy-feely.'" Another officer noted, "In the religious community, Freud equals evil." A perceptive sergeant major observed, "People fear mental health workers. They might make them look at themselves."

Another reason was anxiety about having their thoughts probed by a staff officer from higher headquarters. A platoon sergeant told the team, "The psychiatrist offered to come to the unit, but command dragged its feet." Another reported, "A mental health team came to the unit. Someone told them to give the information to the chaplain. They didn't want a stranger in the unit."

There were also practical issues such as worry about the impact of a psychiatric report on a service record, and concern about possible psychological malingering. To even mention a psychological problem was seen as a potential black mark. Several NCOs said they thought their men would not go to the troop medical clinics for fear of being labeled "a psychiatric case." With respect to malingering, one platoon sergeant noted that there had been an article in the post newspaper from the division psychologists about availability of assistance for those with Post-Panama Stress Syndrome: "I didn't approve; I thought it would just put thoughts into guys' minds." In one unit a thoughtful group of NCOs expressed a worry that talking with the team from Walter Reed would "Just bring it all back."

Relationships with Families

The deployment and combat put severe strains on wives and children. When the soldiers returned, the role adjustments the wives had made while their husbands were away had to be renegotiated. These strains were exacerbated by the irritability and tension the men brought back with them and, in some units, by their disillusionment with the return to military garrison routine and an uninspired training regimen. The results were an increase in the incidence of divorce, the return of some wives to their parents, and a few cases of spouse abuse. The principal buffers that facilitated soldiers' reintegration with their families were family support groups, a period of uninterrupted leave together, and, in a few units, more predictable on-duty and off-duty schedules.

Family support groups provided information, practical assistance with the tasks of living and raising families, and social support. The more effective family support groups were successful in strengthening wives' morale and mitigating their hostility toward the U.S. Army and their husbands while they were away and upon their return. These factors were important determinants of the ability of the soldier and his family to reintegrate. The effectiveness of family support groups was in turn a function of the degree to which they were demo-

cratically organized, open in communications, and focused on the wives' needs rather than on matters of interest to the U.S. Army.[45,46]

There was a positive side to the experience of combat with respect to soldiers' ability to reintegrate with their families. Several soldiers reported to the research team or to their chaplains or comrades that their feelings about fundamental issues had undergone changes that put higher values on their families. One sergeant major said: "A lot of these kids grew up. They don't sit around and drink and waste time anymore. They don't want to embarrass the unit or themselves." Several chaplains reported a sudden upsurge in marriages, and there was more subtle evidence in the form of an increase in the numbers of children conceived. One chaplain said: "They went through a life and death experience; now some of them are making decisions for life." The accuracy of his analysis was born out by the statements of several privates: "I see life as more special, valuable. We should spend time doing what matters." "I have, like, a reverence for life." "I've changed emotionally; my buddy died." "When I came, I questioned things. Now I'm more pliable, serious. I dig in." "I learned a lot about myself."

There were other behavioral changes—besides marrying and conceiving children—to implement the changes in values. Several soldiers opted to leave the service to, as one new father put it, "Not put myself and my family in jeopardy." A group of platoon sergeants described their struggles with whether or not to stay in the military after encountering the "life and death moral dilemmas that have to be addressed in combat." A substantial proportion of the soldiers interviewed gave evidence of moral growth during the brief period of the invasion of Panama. In some cases they outgrew their need for the U.S. Army; in others that portion of the U.S. Army with which they were associated matured along with them to meet their new patterns of needs. One of those needs was validation—which is the topic of the next subsection. On a broader level, the process by which military mental health professionals can contribute to the institutional maturation of the U.S. Army will be the subject of the concluding section of this chapter.

Validation

Soldiers in combat experience a plethora of unpleasant emotions that can cause post-traumatic stress disorders unless they are managed intelligently. Validation of their experiences, behavior, and feelings is an essential part of the management process. Comrades, leaders, subordinates, friends, families, the public, and members of the mental health/spiritual health community play roles in validation.

The painful emotions that follow combat include reactions to physical distress—hunger, fatigue, cold, heat, prolonged exertion, heavy burdens, wounds, and injuries. They include psychological distress—fear, loss, shame, and guilt. Fear takes more forms than can be counted: fear of death or injury, fear of making a mistake, fear of abandonment, fear of leaving loved ones in the lurch, fear of cowardice, fear of being afraid and showing it—each soldier has his personal closet of terrors. Losses include friends, one's own innocence and idealism, one's fantasies about oneself. Shame is more often for feelings than behavior; most soldiers perform well, but remember how much they wished they could escape from having to perform. Guilt has many facets—what they did, who they hurt, and hurts that befell others but not them.

No one can escape these feelings; repressed they can fester and give rise to future psychopathology. Validation makes it easier to bring them out and confront them, and can detoxify some of them. The veterans of Panama reported three categories of validation that were useful when they were available, and that they longed for when they were absent. The first is symbolic validation—gestures by people or institutions that defined the soldier's miseries and actions as virtuous. The second is validation of losses by expiating guilt and reconciling the loss. The third is substantive validation—interactions that integrate the individual soldier's sufferings into a stronger unit or army.

Symbolic Validation

Approval expressed by a remote, depersonalized entity such as the U.S. Army, the media, or the public is an important source of validation because it is perceived as absolute, as independent of human judgment or prejudice. Herein lies the power of medals, television coverage, and welcome-home banners. Soldiers dealing with the shock and horror of what they have seen and what they have done or failed to do feel better if an "Olympian" voice proclaims their deeds meritorious and their cause worthy. Infantrymen often feel that the hardships of their branch set them apart, and that no one has the right to pass judgment on what they do. Sometimes they turn up their noses at awards. But a medal is a statement by the U.S. Army that what the

soldier did was good, and to that extent it helps in the reentry process.

Many soldiers who had fought in Panama felt that they and their comrades were denied medals because there had been a furor after the invasion of Grenada in 1983 because the press reported that more medals were awarded than there were people participating in the operation: "We got short-changed on awards because the [U.S.] Army was embarrassed over Grenada." Though the cultural ethic is that "medals don't mean sh__," there was bitterness in most units over the paucity of awards: "The only guys who got awards were the ones who got hit." "PFC W spoke Spanish, so he was out in front on every patrol. He never knew where the bullet would come from, but he knew it would be aimed at him. But he kept going out because we needed him. He got zip." "The first sergeant was the most important person in the success of our company. He was put in for a bronze star, but got nothing." "I was given a quota of four awards for the company." "I put in 47 guys for awards. We got six. The colonel said the descriptions showed that my people deserved the medals I had recommended, but there was a quota." "The medals bit was all politics. We didn't have a general to fight for us so we got very few." Awards are the most effective symbolic aid to validation the military has at its disposal. Overdoing is a mistake, so is underdoing. Because awards support successful reentry, a liberal policy is less likely to do harm than a restrictive policy.

The services have less control over the validation provided by the media than they do over their own system of recognition. A certain division may get a disproportionate share of media coverage for any number of reasons, including the influence the reporter covering it has with his superiors or the interest his editors have in military affairs. Soldiers in most of the units in Panama perceived that battalions from only one division got television coverage, and that the others "might as well not have been there." Service members in Panama and the Persian Gulf watched television and knew which units were covered and which were not. Many soldiers expressed the feeling that because the activities of their units were not reported in the visual or the print media, their efforts had no significance. This perception was not trivial; not to be covered was not to exist. The impact of television as a source of validation in American culture needs to be taken into consideration.

Public opinion is a force yet less under the control of the armed forces than are the media, but it is the third "Olympian" source of validation. The high incidence of successful postwar adjustments following World War I and World War II was probably a result of the intense national support for the wars and the men who fought them. The prevalence of post-traumatic stress disorders following the Vietnam conflict is most often said to be a result of negative attitudes among the public toward returning veterans. It is interesting to note that the single most pervasive and gratifying source of validation involved in Operation Just Cause was neither the American people, nor television, nor the Army; it was the grateful and admiring behavior of the Panamanians.

Validating Losses

The most difficult psychological problem veterans have to cope with is the death or maiming of comrades, especially close friends. There is the helpless feeling of loss: "I was looking at him and it kept going through me, 'He's *dead*!" "I was giving him CPR, and the medics were saying, 'He's gone.' 'You can stop now.' They tried to pull me away but I shook them off. I couldn't let him go." Equally difficult is survivor guilt: "He took my bullet." Leaders and medics had a particular kind of guilt about not having done their utmost: "I keep going over it in my mind, what could I have done differently so it wouldn't have happened."

Of particular importance from the reentry standpoint is that the dead should not have died in vain, and that they not be forgotten. These are difficult issues, because a death in battle is obscenely and obviously a waste. Soldiers realize that it is all too easy to forget those who are gone. They are horrified at the prospect that they, too, could die in vain and be forgotten. Soldiers in Panama found memorial services and physical memorials to be important to them: "We had a memorial service the next week. The guys in the squad organized it with the chaplain and the first sergeant. It helped us to realize that we didn't have him anymore." "We had a last role call and taps. There wasn't a dry eye in the company. We had to go through it, and it helped." "His best friend and his squad leader spoke. There wasn't no brass in it. It was our service." Most units that lost members put together monuments or trophy cases in the company to commemorate their fallen comrades. "Each time we go in the dayroom we'll think of him. It's sort of like he's still in the company." "We're going to have a plaque on a rock in front of the barracks. It'll look real sharp."

Senior commanders had different perspectives about memorial services compared to enlisted men and officers in companies. Junior personnel opined, "The company service in Panama was healing. But then we had another back here, and another for his folks. What is all this?" "The colonel wanted another memorial service back in the States. He said it was for his friends back here to say good-bye to him, but it looks like a photo opportunity. All the senior brass came, and the press." "The battalion commander didn't come to the memorial service in Panama, he said his feet hurt. Then he made us turn out for a formal service back here with photographers and all. The general came. Bunch of PR bullcrap."

The fates of wounded soldiers were a matter of concern that had an impact on reentry. Soldiers who were wounded but conscious often did not want to leave the unit, and their comrades did not want them to leave. Good sense always prevailed and those whose injuries were serious were evacuated. But their comrades worried about them and were persistent in their efforts to find out what had become of them. Finding out was difficult because they were evacuated by air to Texas, and there was no direct way of getting word about them: "He was evacuated and that was it. No one knew where he was or how he was. It really bugged us." Their absence and condition remained an open point of anxiety for the men in their units, and those who returned were welcomed back.

Many soldiers who were too seriously injured to stay in the service visited their units, or came back to outprocess: "He came back. He was in a wheelchair. Christ, that was hard to take. He loved the [U.S.] Army. But at least we could say good-bye." These reunions were important. The best situation was when recuperating soldiers were on the same post as their units, and they could visit each other. One lieutenant said, "They're going to be medically discharged, but they're still my men. I visit them whenever I can, and they come do things with the platoon when they're able."

Substantive Validation

Substantive validation not only helps the soldier to manage his feelings and reenter the peacetime world with minimal psychological distress, but also strengthens the unit by reinforcing cohesion and exchanging information gained through combat experience. The primary process of substantive validation is talk—talk among peers, between leader and subordinate, and among the members of a squad or platoon. The talk can be formal or informal, it can be about military matters or about feelings. For it to be effective it has to be forthright and honest. It can only take place in a climate of trust.

The most important sources of substantive validation for a soldier are the men who shared the battle with him. Foremost are his comrades in his primary group; if his squad mates approve of his behavior most soldiers can survive psychologically, though they may be embittered that the approval is not more general. There was a case in Panama in which a soldier accidentally killed one of this friends. He was devastated by the loss and horrified that he was the agent of his friend's death. In addition, he was placed under arrest, interrogated by the criminal investigation authorities, and faced a court-martial. There were no sources of support from outside his squad. But his squad mates, though they had liked the dead man, still stuck up for him, insisted that it was an accident, and maintained their bonds with him. This support facilitates the psychological process described as "concurrence," which helps the soldier see that he and his squad mates are alike and that he is not an isolate. Concurrence is essential to psychological survival.[47–50] It illustrates the power of the primary group bond. If his squad mates reject him, a soldier is in a psychologically vulnerable situation. External sources of validation can provide some support, and it is essential that they be mobilized fully and quickly.

Leaders who participated in the battle are usually the second most important source of substantive validation. Their effectiveness in the validation process is a function of the esteem in which they are held and the degree to which they shared their subordinates' danger and privation. Leaders who are perceived as trustworthy and genuinely interested in their subordinates are credible sources of validation. Together with primary group members, they can alleviate much of the guilt and shame soldiers bring with them out of combat. The mechanisms are listening, talking the battle through, sharing feelings: "We sat around with Sergeant P and went over what we did. He'd say things like 'That must have scared you,' and I'd think, 'Yeah,' and somebody else would say he felt scared and then it would seem okay, I wasn't any more yellow than anyone else." "We had a secret place for the platoon and we fixed it up. We'd go there at night and talk it through. The lieutenant always came. Little by little I got less uptight."

The system of after-action reviews (AARs), that is standard procedure after any operation to bring

out the military lessons to be learned, is also an important validation mechanism. Intended to enhance performance by a frank, mutual review of what everyone did, AARs serve to get the sources of guilt and shame out in the open. One soldier said: "I thought I had really blown it when Smitty got hit, but we went over it in the AAR and everybody said they would have done the same thing I did." The AAR, conducted routinely by the team leader, will be discussed later in this chapter.

Mental health professionals and chaplains can provide substantive validation by helping veterans to interpret their experiences in psychological or spiritual terms through debriefings or religious observances. In a way, these validations partake of the symbolic in that the chaplains invoke the blessing of the deity and the mental health professionals invoke psychological processes, all of which are remote from the day-to-day world of the soldier.

THE ROLES OF MENTAL HEALTH PROFESSIONALS

Successful reentry following the invasion of Panama was the result of teamwork between line leaders and members of the helping professions. Because the concept of reentry is new, few members of either community had worked out comprehensive plans for it. Inevitably, successes were episodic, but lessons can be derived from failures as well as successes. This section is a compilation of the positive and negative lessons that may lead to a provisional program of mutually supportive action by command and the helping professions.

Because of the paucity of mental health professionals in the armed forces, they are limited in the number of soldiers they can help with reentry through individual or group therapy or counseling. Their effectiveness can be multiplied by sensitizing chaplains, commanders, and unit medical personnel to reentry issues and their management. It is of the utmost importance that the mental health staff of a division or comparable headquarters respect the battalion, squadron, or ship's surgeon. The unit medical staff shares danger and discomfort with the combatants, and enjoys their trust. There is no quicker way for a mental health team from a higher headquarters to lose all influence than by treating the unit medical staff—which is often headed by a physician's assistant or by a lieutenant or sergeant without professional medical education—as inconsequential. On the other hand, if the mental health team earns the respect and endorsement of the unit medics, its acceptance by the combatants is much more likely.

During peacetime training there are opportunities for the command mental health staff, unit medical officers, and NCOs to get to know each other through case referrals and ongoing education programs. It is important for the mental health professional to be active and supportive in these interactions. Whenever possible, the division mental health and supporting corps-level combat stress control (CSC) unit teams should deploy to the field with the line units. For on-post exercises this could be as simple as an overnight, 2-day visit. Even better are scheduled deployments to the combat training centers (National Training Center [NTC], Joint Readiness Training Center [JRTC], and the Combat Maneuver Training Center [CMTC]) during which the mental health teams provide active mobile consultation. The mental health personnel in the Medical Department activities (MEDDACs)—the Community Mental Health Services (CMHS) and the Departments of Psychiatry, Psychology, and Social Work may not be able to deploy to the field, but can conduct education and consultation activities in the supported units' work areas in garrison.

The program laid out here is designed to maximize the ability of military psychiatry to exert a positive influence on successful reentry through a combination of command consultation, participation in unit reentry programs, and direct psychiatric treatment.

Consultation on Command Action

Most of the work leading to successful reentry is done by leaders from senior command (division, corps, theater/fleet/air command) down through squad and work group supervisors. Further, most of the work that leads to successful reentry is part of the normal routine of leadership and command. The role of mental health professionals is to advise commanders and to monitor those aspects of leadership behavior that are conducive to successful reentry to see that they are not neglected or off-track due to the leaders' own stress or personal issues. In the process of advising, military psychiatrists and mental health workers can make themselves part of commanders' teams at every level and work toward undermining the antipsychiatry bias they are likely to find in most military units. There are four spheres

of command activity on which the psychiatrist and his staff should focus: (1) debriefings (called after-action reviews [AARs] in the U.S. Army), (2) dissemination of lessons learned, (3) memorial services for deceased members, and (4) decompression leave. (See Chapter 11, Debriefing Following Combat.)

After-action reviews are prescribed techniques in the U.S. Army for learning from mistakes and successes. In training exercises, an AAR is to be conducted following each phase of activity. In combat, it should be conducted as soon as it is safe for the leader to bring the team together. The AAR is informal, solicits input from all participants, and is nonpunitive. It has as its immediate purpose finding out what worked, what needs to be improved, and how to improve it. A broader purpose is to so improve the fighting capacity of units that they can accomplish missions with minimal loss. Along the way several intermediate purposes are achieved such as strengthening cohesion, cementing trust, and opening communications. Members of units in which AARs are a normal part of life are accustomed to admitting when they were confused, uncertain, or frightened, having their human weaknesses accepted, and getting help from comrades and leaders on how to manage, overcome, or compensate for them. AARs following combat provide superb forums for reliving and getting support for the inevitable fears, failures, and guilt with the people whose acceptance and approval are most important. They provide firm foundations for successful reentry. Prior to combat, military psychiatrists and technicians should support commanders in requiring open, honest, fear-free, professional AARs. They can train the leaders to expand the routine AAR into a team after-action debriefing (AAD) which deliberately works through the emotional as well as operational issues, as discussed in Chapter 11, Debriefing Following Combat.

The process of disseminating lessons learned by combat veterans to new members of the unit or to other units provides a means for validation as well as enriching the combat know-how of those who were not participants in the action. The combatant's perception that what he did is sufficiently important that it merits the attention of the service as a whole goes a long way toward alleviating aversive emotions attendant on combat. Because the future of military operations is likely to include fairly frequent short-duration, force-projection operations, only parts of the armed services will be involved in each of them. Those not involved will be eager to learn what went on and what worked so that they will be better prepared when their turns come. Again the role of the military psychiatrist and mental health worker is to support commanders in their resolve to use veterans in cross-pollinating other units. It is good for the service, and it helps resolve reentry problems for the veteran.

Memorial services are helpful for veterans in coming to terms with losses. As noted above, they can backfire if they are perceived as opportunities for senior commanders to be photographed expressing their grief. Memorial services that were perceived by the rank and file as public relations events drove deep wedges between commanders and subordinates, including subordinate commanders. They were perceived as obscene exploitation of subordinates' deeply felt losses. Memorial services must be for the service members who knew and loved the deceased. Memorial services offer opportunities for the mental health workers and chaplains to cooperate in a sphere in which their interests are congruent. Their combined influence can support commanders in using memorial services to solidify vertical cohesion and facilitate the management of grief.

In this connection it is worth mentioning that chaplains outnumber psychiatrists in a division by a ratio of about 20:1, and the entire division mental health team by 2:1. The chaplains are likely to have much higher credibility in companies and battalions. The battalion chaplain is there for the soldier in emotional and spiritual distress. He is part of the unit, not some staff officer from division. Most of them have won some measure of trust and acceptance in their units. They help soldiers' families, show up in the field, and are the channel for action and solace when family tragedies strike. The folklore about chaplains includes heroism on the battlefield rescuing the wounded and comforting the dying. Complimentary comments about chaplains in Panama ranked just behind the almost worshipful love for company combat medics: "The chaplain must have balls of solid brass to parachute into combat without a weapon."

On the other hand, no one had ever heard of a "shrink" on the battlefield. A visit to the psychiatrist was usually perceived as a way station en route to chapter action. When psychiatrists compete head to head with chaplains for influence in military units, the psychiatrists lose. On the other hand, an alliance between the two enhances the effectiveness of both. They can catch a commander who tends toward being indifferent to his subordinates' needs between two fires. Chaplains are usually easier to get time with than commanders, and can provide access to commanders through the

chaplains' already established channels. Memorial services are only one of many ways in which chaplains and psychiatrists can help commanders bring their units through reentry stronger than they were before.

The mental health team has an important role in supporting the chaplains, who are themselves subjected to extreme stress by the nature of their pastoral duties, especially in combat. The mental health professionals can mentor and train the chaplains to recognize serious psychiatric disturbance and know when to refer soldiers for medical/mental health evaluation. The mental health personnel and chaplains can debrief each other, to share the emotional burden.

Decompression is the process by which soldiers separate themselves progressively from the tension, fear, and horror of the battlefield. It includes AARs, talking about combat experiences with comrades and with others who were not there, dreaming, and doing things totally different from combat. After Panama there was a great deal of urgency on the part of several commanders to get back into training. (As the researchers talked to veterans of Panama they recalled the British Regular Army major who on 11 November 1918, was quoted [in reference to the end of World War I]: "Well, at last that's over. Now we can get back to some real soldiering.") The longest leave identified in any battalion was 14 days. A number of senior NCOs and junior commanders were of the opinion that a longer period would have brought the unit back together with more zest for the next phase of training. One platoon leader said:

> The battalion should have shut down for a month, and part of the leave time should have been non-chargeable administrative leave—a kind of "thank you" from a grateful nation. Personnel who felt unready to return after a month should have had the option of taking additional leave.

The short decompression leaves after Panama left a number of soldiers feeling badly used. Further, they were still so keyed up from combat that they saw the training as boring and beneath them as veterans of real combat. Chaplains, company medics, junior officers, and senior NCOs are in the best position to judge the burned out state of their people and how much leave they should have for the unit to return most quickly to peak psychological readiness. The role of the mental health technicians and psychiatrist is to support commanders in getting the leaves authorized using psychological arguments.

Participation in Unit Recovery Processes

Mental health professionals can assist in the reentry process directly by limited participation in some of the programs undertaken by units to facilitate the management of postcombat emotions. The small number of mental health professionals available makes it impossible for them to participate regularly in most of the programs, but they can provide some direct support according to the guidelines in this chapter. There are three functions that are within the capability of the mental health staff: (1) short-term concentration on small units, (2) initiation of some group processes, and (3) occasional participation in after-action reviews, end-of-tour debriefings and prehomecoming information briefings. Their effectiveness in all of these functions will be enhanced in scope and in duration to the extent that they can sensitize and train the battalion medical staff in psychologically supportive processes.

End-of-tour debriefings (EOTD) should be conducted by all small units before deploying home. The unit leaders lead a discussion which reviews all phases of the operation—notification or alert, mobilization, deployment, and the significant actions up to the present. All participants are encouraged to talk about what went well and what did not, the good times and bad, noting lessons learned and working through unresolved, painful, or controversial issues. Like the AAR, this must be well-led to assure a positive sense of completion or closure at the end. Trusted chaplains and mental health personnel can facilitate the process.

Prior to redeployment from the theater, all units and soldiers should receive a prehomecoming briefing. This reviews what changes and expectations are commonly encountered when soldiers, spouses, and children are reunited after a prolonged separation. It provides tips on how to deal with these predictable stresses. The families at home should receive their version of the same briefing. Pocket cards summarizing the briefing have proved useful for both the service members and the families. Sample cards are provided in Exhibits 12-1 and 12-2. These briefings are often conducted by the unit chaplains in the theater, and by the unit support groups at home base, with input and attendance by mental health personnel.

When units return from combat one at a time, the mental health professionals should focus on them for a week or at least a few days. Mental health technicians should be informally available for soldiers to talk to. They should hang out in the mess

EXHIBIT 12-1

HOMECOMING AFTER DEPLOYMENT DEALING WITH CHANGES AND EXPECTATIONS

With deployments come change. Knowing what to expect and how to deal with changes can make reunion more enjoyable and less stressful. Below are some hints you might find helpful.

Expectations for soldiers

- You may want to talk about what you saw and did. Others may seem not to want to listen. Or you may not want to talk about it when others keep asking.
- You may miss the excitement of the deployment for a while.
- Some things may have changed while you were gone.
- Roles may have changed to manage basic household chores.
- Face to face communication may be hard at first.
- Sexual closeness may also be awkward at first.
- Children have grown and may be different in many ways.
- Spouses may have become more independent and learned new coping skills.
- Spouses may have new friends and support systems.
- You may have changed in your outlook and priorities in life.

Expectation for spouses

- Soldiers may have changed.
- Soldiers, used to the open spaces of the field, may feel closed in.
- Soldiers also may be overwhelmed by noise and confusion of home life.
- Soldiers may be on a different schedule of sleeping and eating (jet lag).
- Soldiers may wonder if they still fit into the family.
- Soldiers may want to take back all the responsibilities they had before they left.
- Soldiers may feel hurt when young children are slow to hug them.

What children may feel

- Babies less than 1 year old may not know you and may cry when held.
- Toddlers (1–3 years) may hide from you and be slow to come to you.
- Preschoolers (3–5 years) may feel guilty over the separation and be scared.
- School age (6–12 years) may want a lot of your time and attention.
- Teenagers (13–18 years) may be moody and may appear not to care.
- Any age may feel guilty about not living up to your standards.
- Some may fear your return ("Wait until mommy/daddy gets home!").
- Some may feel torn by loyalties to the spouse who remained.

Source: US Department of the Army. Homecoming after Deployment: Dealing with Changes and Expectations. US Army Medical Department Center and School, Combat Stress Actions Office, Fort Sam Houston, San Antonio, Texas. Modification of materials prepared by 101st Airborne Division Mental Health Section for the Persian Gulf War (1991).

hall, day room, and barracks, for example, and initiate conversations. Their purpose should be to validate feelings and experiences. When opportunities present, these informal conversations could expand into group discussions with the mental health worker as facilitator. The psychiatrist should dedicate his time to the battalion for the week, and should focus on sensitizing leaders and working with those individuals and primary groups that experienced the most severe traumata.

When the simultaneous return of several units precludes concentration on a single battalion, the mental health staff should focus all its assets on initiating group processes in squads and other primary groups in several battalions simultaneously. The ease with which this can be done will be a

EXHIBIT 12-2

HOMECOMING AFTER DEPLOYMENT TIPS FOR REUNION

Reunion is part of the deployment cycle and is filled with joy and stress. The following tips can help you have the best possible reunion.

Tips for soldiers

- Support good things your family has done.
- Take time to talk with your spouse and children.
- Make individual time for each child and your spouse.
- Go slowly when reestablishing your place in the family.
- Be prepared to make some adjustments.
- Romantic conversation can lead to more enjoyable sex.
- Make your savings last longer.
- Take time to listen and to talk with loved ones.
- Go easy on partying.

Tips for spouses for reunion

- Avoid scheduling too many things.
- Go slowly in making adjustments.
- You and your soldier may need time for yourself.
- Remind soldier he is still needed in the family.
- Discuss splitting up family chores.
- Stick to your budget until you've had time to talk it through.
- Along with time for the family, make individual time to talk.
- Be patient with yourself and your partner.

Tips for reunion with children

- Go slowly. Adapt to the rules and routines already in place.
- Learn from how your spouse managed the children.
- Be available to your child, both with time and with your emotions.
- Let the child set the pace for getting to know you again.
- Delay making changes in rules and routines for a few weeks.
- Expect the family will not be the same as before you left; everyone has changed.
- Focus on successes with your children; limit your criticisms.
- Encourage children to tell you about what happened during the separation.
- Make individual time for each child and your spouse.

Source: US Department of the Army. Homecoming after Deployment: Tips for Reunion. US Army Medical Department Center and School, Combat Stress Actions Office, Fort Sam Houston, San Antonio, Texas. Modification of materials prepared by 101st Airborne Division Mental Health Section for the Persian Gulf War (1991).

function of the level of trust and openness already developed in the various units, in the degree of hostility toward mental health professionals preexisting in the unit, and in the quality of the relationships between members of the division mental health staff and the battalion medical platoon. The objective of the mental health staff is to get the groups up and talking, and then turn them over to their own leadership. With more than 30 primary groups in each battalion it is imperative for the mental health workers to move on as quickly as possible. In battalions with strong traditions of AARs conducted throughout the deployment, there may be little for the mental health staff to do—members of those battalions will already be working through their feelings. In battalions with weak traditions of AAR and unit medics who are not psychologically oriented, the mental health people will have to come back to the same squads repeatedly. The psychiatrist will have to divide his time among all the battalions to keep up to date on problems identified by the chain of command and to maintain access for his teams.

Mental health workers can assist units conducting AARs or end-of-tour debriefings to expand their scope to include feelings as well as behavior, making them after-action debriefings. The psychiatrist will usually have to solicit invitations to AADs or EOTDs by explaining to commanders the importance of the emotional dimensions for the

successful reentry of the unit. The role of the mental health worker at an AAR is to listen to the process, and when given an opportunity, assist members who appear to be repressing strong emotions to express them. He can explain the potential of AADs to help individuals manage their feelings and to help units achieve a higher state of psychological readiness. The presence of mental health personnel can be explained as an opportunity for the latter to learn what real combat involves so that they can be helpful to other combat soldiers in the future. By emphasizing the readiness component it is sometimes possible to convert the perception of emotional expression from the realm of unmanly and unmilitary "touchy-feely" to the realm of military competence. If after AARs, AADs, and EOTDs, it is clear to the unit leaders that there are still unresolved issues and bad feelings, those leaders can be encouraged to schedule a critical event debriefing (CED), to be led by mental health personnel trained in debriefing. While such debriefings are best conducted within days of the critical event, even weeks later may be better than not at all. The acceptability of CEDs, like that of the critical incident stress debriefing (CISD) which are now widespread among civilian police, fire, and other emergency response agencies, has improved as they have become common practice and proved their worth. If at all possible, the CED should be conducted while the unit is still in the theater, even if the mental health team needs to be flown in for it. Such activities are unlikely to be well received if they must compete with reunions with families at the home station.

Psychiatric Treatment

Though the emphasis so far has been on assisting the relatively stable members of units to avoid serious psychiatric distress by seeding primary groups with knowledge of how to conduct their own group therapy, there will be individuals and units that require concentrated support, or long-term support, or both from mental health professionals. The reasons are legion: particularly horrifying experiences, heavy casualties, inept leadership, poor precombat intragroup trust or communications, or preexisting psychiatric vulnerabilities. The reason does not matter. The goals are to restore the unit to a state of psychological readiness, and in the process to relieve psychic suffering. The methods are standard group therapy and individual therapy.

The critical issue is creating a climate of readiness to look to psychiatric staff for help. Sometimes the distress is masked by various forms of denial or acting out. The tasks of the psychiatrist are to alert commanders to be on the lookout for aberrant conduct in individuals or primary groups, and to develop in commanders a readiness to support psychiatric intervention. In many cases it may be advisable to seek the participation of all of the members of a squad if one of them is in particular distress. The individual may be the "designated sickie" for the squad, or he may simply be the one who was most affected. The task of the mental health worker will be facilitated, and probably shortened, if he can engage the squad in the recovery of one of its members.

SUMMARY AND CONCLUSIONS

The most common missions of the armed forces of the United States have been and are likely to continue to be rapid force projection operations of short duration. Because history indicates that the frequency of these operations is likely to increase, the Army Medical Service must anticipate repeated commitment of the same units and personnel to combat.

Generally speaking, combat veterans function more effectively and suffer fewer casualties than green personnel, so repetitive commitment is not fundamentally a problem. However, rapid deployment operations entail rapid transitions from peace to war and back to peace, and these transitions have been found to cause stress reactions that vary with the individual and with the nature of his experiences. It is the task of military mental health professionals to take the lead in managing the emotional aspects of short wars in ways that preserve and strengthen the psychological readiness of units so that they can perform with peak efficiency in the next encounter.

Successful reentry following force-projection operations has been the product of a partnership between commanders, chaplains, the unit medical staff, and mental health professionals. The psychiatrist and his staff are likely to understand the dynamics of reentry most clearly, but they are few in number and they do not always enjoy acceptance among military personnel. To gain acceptance, mental health professionals should endeavor to work with commanders, battalion surgeons/phy-

sician's assistants, and units before combat. Alliances with the chaplains and the battalion medical staff are effective ways to gain entry, and are essential if the mental health staff is to win the trust of the combatants. But some chaplains will perceive the mental health staff as competitors for the souls of the members of the unit, and some unit medical personnel will have negative attitudes toward psychiatry and all its works. If this cannot be overcome by positive education and commitment, the mental health staff may do better to devote its limited resources to other units and let word-of-mouth testimonials from those who have been helped by the mental health team's good work convince the suspicious.

To compensate for their small numbers, the members of the mental health staff can transfer some of their skills and understanding to chaplains, commanders, junior leaders, and unit medics. The best time to do this is before combat during training and practice deployments. Assisting commanders in developing mutual trust and confidence across ranks, in including emotional material in after-action reviews, and in restoring troubled soldiers to productivity can create a climate of readiness to confront mental health issues honestly and without fear. When such a climate exists in a unit, or in some of its subelements, many leaders and medical aidmen will be able to acquire quickly many of the supportive skills of mental health professionals.

A second way to make the most of limited resources is to dedicate all of the mental health staff to one unit for a restricted period of time—primarily to transfer skills to leaders, but secondarily to alleviate anguish among members of units that have been severely traumatized. This approach is feasible in peacetime, following a war in which only a portion of the units in a command were committed, or when committed units return on a staggered schedule.

The psychiatrist and the other mental health professionals can be most effective when they operate concurrently on three levels—staff, unit, and individual. On the staff level the psychiatrist supports senior commanders (flag and general officers) in policies that facilitate the management of reentry processes: (*a*) decompression leave, (*b*) cross-pollination of lessons learned, and (*c*) validation through awards, media coverage, and public information programs. Advocacy of constructive reentry policies is likely to entail conflict with other staff officers with equally compelling agendas. The psychiatrist must be prepared to demonstrate that his colleagues' objectives are more likely to be achieved if reentry is managed effectively.

On the unit level the mental health staff supports intermediate commanders (brigade, group, battalion, squadron, and ship) by advising them on how to develop trust and cohesion before commitment to combat, and helping them work constructively with postcombat reactions. These reactions are often contradictory: heightened anxiety in some, new levels of confidence in others; indifference to training, or total commitment to training; abuse of spouse and children, or decisions to marry and conceive; reluctance to ever be in combat again, or insatiable zest for combat. Different types of behavior are required of commanders, chaplains, junior leaders, and members of primary groups to ameliorate the dysphoric reactions and foster the positive reactions.

The mental health staff can be most effective in helping members of units sort out their postcombat emotions if they have helped the unit in peacetime to develop habits of open communications and readiness to deal with feelings during their AARs. After combat, the mental health staff can support commanders in keeping primary groups intact, validating combat behavior, conducting memorial services that promote rather than undermine cohesion, and organizing training that manifests respect for the combat achievements of the veterans.

On the individual level the psychiatrist and the mental health staff assist individuals and groups that have responded in dysfunctional ways to the experience of combat with individual therapy, group therapy, and unit therapy. Some of these interventions may be prolonged; others may lead to medical separation. Their objective is to restore the psychological readiness of the individual and the unit for combat. This does not mean brainwashing personnel to get them back into action at whatever cost to their mental health. It does, however, add some dimensions to classic psychotherapy. In the first place, the therapist has allies not usually present in a therapeutic setting—the service member's comrades and leaders. In most cases these people will have both a practical and an emotional interest in restoring the patient's effectiveness and balance. If they are not interested in him, it is unlikely that he will ever be able to function satisfactorily in the service, and discharge is indicated. Another dimension is that military life is a rough business. Each individual has his limit, and some reach it early. The psychiatrist does neither the individual nor the service any good if he returns to duty a service member who is likely to decompensate in the presence of further stress.

One final word about unit therapy. Whenever possible it is helpful to treat a soldier who is distressed in the context of his primary group. The methodology partakes of family therapy, and appropriately so; a small military unit functions emotionally as a family—and the unit medic is usually a member of that family. However therapeutic the goal of the intervention, the mental health practitioner must avoid the use of the term. Military personnel do not take kindly to being labeled sick—especially sick in the head. Euphemisms such as "debriefings" or "development workshops" might be seen through, but they are better than "group therapy." The approaches that have been most successful emphasized strengthening combat readiness and psychological preparation of the group for combat. Before battle, a soldier who describes himself, or who is defined before the group, as psychologically weak, will be extruded. His comrades would feel that they could not depend on him; they could not predict his behavior. After combat, manifestations of combat stress are accepted and the group will participate in "helping Joe." But the other members of the group will not accept being classified at the outset as having psychological problems—even when most of them do.

Mental health professionals have a decisive role to play in managing reentry in ways that preserve the emotional integrity of military units. Their success will be a function of their sensitivity to fighting men's fears of emotional vulnerability, and of their ability to help combat soldiers accept themselves and their vulnerabilities. It is a particularly challenging facet of mental health work; it is one that will pay immediate dividends in trust and intimacy within units, and in lives saved.

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