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Traumatic Event Management in Afghanistan: A Field Report on Combat Applications in Regional Command-South

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ABSTRACT This article provides information on the use of Traumatic Event Management (TEM) strategies to debrief combat arms personnel whose units sustained traumatic losses in Afghanistan. The specific focus is on the application of Event-Driven Battlemind Psychological Debriefings to combat units. This article offers the first published account of TEM services employed in southern Afghanistan during intensive surge operations in 2009–2010. This article unfolds in three parts: (1) background to the region in which the debriefings occurred; (2) three case examples with a data summary of types of incidents observed; and (3) discussion of observations, lessons learned, and recommendations for training future clinicians to provide effective debriefings to combat arms personnel.

INTRODUCTION

Traumatic Event Management (TEM) is an umbrella term for a flexible set of interventions aimed at supporting troops who experience potentially traumatizing incidents during combat, peacekeeping, garrison, or humanitarian operations.[1] Such incidents might include continuous combat operations, deaths of unit members, accidents, environmental catastrophes, and operations resulting in the death of civilians or combatants. TEM is a component of Combat Operational Stress Control (COSC) doctrine and emphasizes stress management for affected individuals and units.[2] Among those activities that form the core of TEM are unit needs assessments, command consultation and education, triage, stabilization and restoration procedures, individual and supportive counseling, psychological first aid, and psychological debriefings. The intent of TEM is to encourage post-traumatic growth, an adaptive process whereby individuals exposed to potentially traumatizing events can experience improved relationships, an enhanced sense of hope and appreciation of life, and a deepened sense of personal strength and spiritual development. The most well known of COSC services are psychological debriefings, an intervention in which members of units affected by traumatic events are brought together to discuss an event, become educated on individual and group responses to trauma, and have the opportunity for individual or group follow-up.[3]

Given past concerns regarding efficacy and even potential harm with debriefing techniques such as critical incident stress debriefs,[3,4] the U.S. Army currently advocates the Battlemind Psychological Debriefing model in training COSC personnel. According to Adler et al,[5] the Battlemind Debriefing Model was designed for use in three different contexts: (1) in-theater event-driven situations where the interventions follow potentially traumatizing events during deployment, (2) in-theater time-driven debriefings that occur at specified times during the deployment as a means to address the cumulative effects of stress over the course of deployment, and (3) immediate postdeployment debriefings to facilitate transition from combat to home.

Briefly, the components or phases of the Battlemind Debriefing model are: Introduction, Events, Reaction, Self and Buddy Aid, and Battlemind Focus. The order of the phases is sequential, with latitude given to the facilitator in providing either more or less time to a given phase, depending upon the specific needs of the unit exposed to traumatic event(s). Typically, an Event-Driven Battlemind Psychological Debriefing (EDBPD) (related to #1 in the previous paragraph) is held with a group of 10 to 15 individuals varying anywhere from 45 minutes to 3 hours, contingent upon actual numbers of personnel in attendance and the magnitude of the potentially traumatic event. The intent is to intervene early on with a unit, usually within 48 to 72 hours of an incident to help mitigate the development of serious emotional problems and deal with issues that might affect the group cohesion

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during future missions. Another important consideration is the need to facilitate mission capability and focus following traumatic incidents, as well as to foster unit reintegration for the members of squads, platoons, and/or companies. The overarching intent of COSC operations is to preserve the fighting force.

It is our contention that the EDBPD model provides an effective tool for supporting troops following traumatic events. Accordingly, this article focuses on the application of EDBPDs to combat areas in southern, central, and western Afghanistan during intensive surge operations in 2009–2010. Previous literature on Battlemind debriefings has focused on Time-Driven and Post-Deployment Battlemind Psychological Debriefings versus EDBPDs for returning Soldiers from Iraq.[4,6] As noted in these studies, much of the information regarding debriefings is anecdotal. The Adler et al team[6] did employ a randomized procedure where some Soldiers were assigned to a postdeployment debriefing process and others to postdeployment stress education. The postdeployment debriefing yielded positive mental health outcomes on 4-month follow-up for those troops who reported a high number of combat-related experiences in Iraq. This article provides the first published information on how EDBPDs were used in highly kinetic combat environments in Afghanistan, where affected units had no assigned or limited organic behavioral health and combat stress personnel available to them. The authors were Army and Navy Clinical Psychologists who worked in collaboration with each other as part of three separate units (i.e., the Role 3 NATO Hospital, 4th Brigade Combat Team of the 82nd Airborne Division, and the 467th Medical Detachment, Combat Stress Control). What follows is a discussion in three parts: (1) background to the region in which the debriefings occurred; (2) three case examples with a data summary table of types of incidents seen; and (3) a concluding section on observations, lessons learned, and recommendations for training future clinicians to provide effective debriefings to combat arms personnel.

BACKGROUND TO REGION

Kandahar, Afghanistan, is the spiritual center of the country and a key economic area with ancient trade routes to Pakistan and Iran.[7] The center for coalition operations in southern Afghanistan is Regional Command-South, located on Kandahar Airfield (KAF), a sprawling multinational airbase with representatives from over 15 countries and a population of over 20,000 troops and civilian support personnel at the time this article was written. In November 2009, an additional 30,000 troops were deployed to Afghanistan to support a counterinsurgency strategy and to wrest control of the south and west from Taliban forces, particularly in the economic regions of Kandahar Province and Helmand River Valley in southwestern Afghanistan. For U.S. military personnel, conditions were extremely austere with limited logistical support, especially in the many remote Forward Operating Bases (FOBs) and Combat Outposts (COPs).

THREE EXAMPLES OF EDBPDs

The three event-driven debriefing examples were chosen from our respective deployment experiences to illustrate different contexts in which debriefings occurred, as well as varying degrees of complexity in managing the debriefing sessions themselves. The examples include a relatively straightforward debriefing session, a session where a participant left during the debriefing process, and a session where the clinician drew upon clinical experiences and resources outside the standard EDBPD model.

Example 1: FOB (A) OCTOBER 2009—A Straightforward Debriefing

Although this example is described here as a "straightforward" or typical example of a debriefing session in theater, it must be remembered that the traumatic incident itself represented a horrific situation for the troops involved, which was outside the range of almost everyone's experience. A motorized (Stryker) battalion suffered the deaths of seven unit members and one Afghan interpreter during an improvised explosive device (IED) and complex ambush attack. Given the number of fatalities, the battalion requested that the KAF Role 3 Mental Health and Combat Stress Control (CSC) Team augment the Behavioral Health Team organic to the unit. The CSC team was flown to the FOB the next day.

Once on the ground, the CSC Team met with the Battalion Surgeon and the unit's Behavioral Health (BH) Officer, who were already on site. Further communication with the unit revealed that members of the affected unit did not return to the FOB until the previous night, after being at the blast site for 12 hours. Rather than attempt to immediately schedule any meetings, it was recommended that the unit rest for a day before engagement. The CSC team subsequently met with nine members of the platoon during the scheduled session the following evening. The unit's BH Officer served as the primary facilitator. Attendance was voluntary by unit members. The standard EDBPD protocol was followed beginning with a description of the event from each member's perspective, discussion of their reactions to the incident and loss of their fellow Soldiers, an outline of self and buddy care, and options for further support. One striking perceptual phenomenon noted by almost all members was that, regardless of their vehicle's position in the convoy, the sound of the explosion made them think the blast was smaller than it turned out to be. Consequently, as the smoke and dust cleared, team members were unprepared for the level of carnage and vehicle destruction caused by the blast. At the close of the 75-minute session, two unit members stayed behind requesting additional support. The BH Technicians met individually with these Soldiers for an additional 20 to 30 minutes. CSC team members reviewed their observations from the debriefing session, identifying Soldiers needing further follow-up. Overall, the unit members engaged in the EDBPD process and felt it increased their unit cohesion by hearing

others' perspectives and discussing their experiences. The individual follow-up sessions also appeared to be beneficial as the Soldiers involved returned to full duty. Results of session and subsequent follow-ups were briefed to the battalion commander the next day.

Example 2: FOB (B) JANUARY 2010—A Session Where a Distraught Participant Leaves the Debriefing

While conducting a dismounted patrol through the Arghandab River Valley en route to inspect an abandoned school believed to be a weapons cache, several Soldiers were struck by a remote-controlled detonated daisy chain of seven IEDs alongside a mud wall. The Company Commander and Explosive Ordnance Disposal (EOD) Technician were killed, while the platoon leader sustained a traumatic above-the-knee amputation and the medic, a mild concussion. Two days later, a request was placed and the BH Team flew out to the company COP. Those in the company who were not present at the time of the Commander's death were provided individual support and follow-up over 3 consecutive days leading up to their team members' memorial service. For the attached squad that was on-site of the IED, a 1-hour EDBPD was provided by the BH Officer and Technician. Twelve people originally presented for the group and were informed of the nature and intent of the session. Six of those who presented were subsequently excused as only those at the actual event were invited to remain. The standard EDBPD model was followed. Partway through the debriefing, one Solider became visibly distraught and left the session. That Soldier was provided individual follow-up immediately after the group. He indicated that he could not tolerate the visual images that the group discussion generated as he apparently felt responsible for the passing of the Company Commander whom he had attempted to treat. This encounter proved to be highly beneficial, as it not only allowed the BH Officer to note the status of the Soldier for further monitoring, but also laid the groundwork for a working relationship, as this particular Soldier later required individual behavioral health services before redeployment for an unrelated event.

The remaining Soldiers were effective in factually describing the event and then transitioning to the emotional impact they experienced in treating the extensive injuries of their Platoon Leader, the EOD Technician, and the Company Commander. Several Soldiers used the opportunity to voice frustrations with their felt helplessness, guilt for not being able to do more, and even offered some humor when recounting comical statements made by their Platoon Leader at the time of his injury. During the concluding psychoeducational piece, the Soldiers inquired into the status of those surviving and asked questions about expected outcomes and advice on how to approach and interact with their comrades upon eventual redeployment. The participants were then invited to return to the COP for the memorial service and follow-up with the chaplain for spiritual support or follow-up during the BH Team's routine battlespace circulation a few weeks later.

Example 3: FOB (C) APRIL 2010—A Challenging Session Requiring a Change in Protocol

The FOB CSC Team was mobilized to support a unit that had lost three members in a complex IED and ambush attack. The affected battalion was within 2 months of the end of their year-long deployment and had already sustained the highest number of deaths and wounded in action within their brigade. Although the CSC Team received a positive response from the unit regarding an offer of support, the debriefing itself followed a problematic course from the outset. The first problem occurred with miscommunication within the unit regarding those who should be invited to the debriefing session. The initial plan discussed by the CSC Team with the Commander was to have only the five Soldiers who were on-site at the time of the incident appear for the debriefing session. When word was passed to the platoon, the message was received that all 26 members of the platoon were "required" to attend. A second problem arose in that the venue location was changed without notice to the relevant leadership. As a result, a number of Soldiers were angry and displeased that attendance had been deemed mandatory. Seating was arranged in rows and did not accommodate all in attendance.

The level of discomfort and dissatisfaction by the troops was palpable at the start of the session. During the Event Phase, only two Soldiers were willing to reconstruct events. Almost all Soldiers responded "I was pulling security" or "I'm good" (meaning, "I don't wish to speak"). Pursuing any questions regarding event reconstruction proved of little value. Sensing the need to respond to the current situation, the CSC Team Leader shifted to the Kuhlmann Debriefing Protocol.[8] The Kuhlmann Model calls for the group to offer specific means to memorialize or pay tribute to those who have died, as well as a very brief mention of their personal and varied responses to grief. This modality change opened the discussion to a striking and memorable set of recollections and began a shift to a level of lightheartedness as Soldiers reminisced about their fallen comrades. The final stages of the debriefing involving self and buddy aid appeared to engage few members. The CSC team remained on scene for 10 to 15 minutes to offer support, but participants declined follow-up at that time. Interestingly, some of the most hostile and resistant participants sought individual support from the CSC Team in the weeks that followed. These Soldiers remained engaged in individual psychotherapeutic interactions for the duration of their respective Operation Enduring Freedom deployments.

DATA SUMMARY OF INCIDENTS SEEN

The information that follows is based on EDBPDs that occurred between August 2009 and March 2010 in southern and western Afghanistan during a time of surge operations.

Collectively, the authors participated in approximately 50% of all the EDBPDs conducted in the region during that time frame. The lead author, as Behavioral Health Consultant to Regional Command-South, participated in coordinating an additional 30 to 40% of the psychological debriefings in the region. We believe that our experience draws from a representative sample of debriefings within the region (Table I).

As is evident from the summary table, requests for debriefing support originated from FOBs throughout the region. Units requested TEM services in the aftermath of numerous catastrophic incidents, including IED and rocket attacks, vehicle accidents, drowning, and, in one case, suicide. The largest number of requests for services resulted after specific events, rather than from requests for support at periodic times during deployments. Given the frequency of combat-related events and the need to attend to day-to-day care of the troops, there was little time to deliver debriefings at specified intervals during the deployment such as Month 4 or Month 8, as per Time-Driven Psychological Debriefing guidance. Specific outcome data from these interventions are not available as the nature of these debriefings and the context in which they were performed was not conducive to that level of evaluation and research. However, several conclusions can be drawn from these experiences as discussed later.

OBSERVATIONS, LESSONS LEARNED, AND RECOMMENDATIONS

Normal Reactions to Abnormal Events

For the most part, units affected by potentially traumatic events appeared to be relatively cohesive and engaged in steps to return to the mission. Even in cases where there was significant anger directed at Command and leadership for perceived failings, the affected units generally expressed a willingness to "stay in the fight." One author (Patricia Hammond), however, found one company that had sustained substantial losses during the course of their combat tour to have recurrent problems with two Soldiers who repeatedly refused to patrol during the last 2 months of the unit's deployment. This subsequently generated conflict within the unit as they prepared to redeploy. The range and intensity of views and emotions expressed within the EDBPDs were otherwise viewed by the facilitators as within expected and "normal" bounds, given the extraordinary circumstances surrounding these combat debriefings. For several Soldiers observed throughout the deployment cycle, this normalization of combat experiences in theater proved crucial as the mentality was then applied to preparation for redeployment and helping Soldiers reintegrate with their families upon return stateside.

The Need for a Flexible Approach

A "cookie-cutter approach" does not work in a dynamic and ever-changing battlespace. Just as no two traumatic events were alike, no two debriefings were prepared or delivered in the same manner. Rather, all debriefings required an individualized approach based on the requests and needs of the Command, Soldiers, unit atmosphere, timing, location, transportation, combat event, etc. The need for this targeted approach became increasingly evident for one BH Officer as over a half-dozen EDBPDs were conducted with two different companies because of the significant number of casualties and losses sustained. Additionally, psychological debriefing facilitators need a solid grasp of the debriefing process and a wide range of clinical experience to manage their own feelings during the debriefing sessions, especially considering the inherent nature of dual relationships in military and deployed settings. Similarly, an ability to tolerate a high degree of affect, particularly anger, is critical to making the process work. Military medical doctrine, although helpful in trying to standardize a systematic overall approach to CSC and psychological debriefings, does not fully consider and address the more existential and humanistic aspects related to combat exposure. The clinician's ability to individually relate to and interact with the unit on a personal level can exponentially increase (or can deter from) the efficacy of psychological debriefings and TEM overall. Incorporating familiarity with the Soldiers, or even "paying tribute" as described earlier in the Kuhlmann Debriefing Protocol, can make a significant difference.

Helping Soldiers Deal With a Sense of Helplessness

Learned helplessness appeared to be a common theme—in terms of the certainty of constant deployments, limited ability to manage home-front stressors, inherent inequalities with the rank structure, frustration with the mission and rules of engagement, and even the number and nature of current insurgency tactics. This tendency was especially apparent in companies that had experienced a high degree of combat exposure in a relatively brief time. By fall 2009, a common perception held by the population that the authors served was that the enemy possessed the psychological momentum and unit members had a decreasing chance of returning home safely. As losses continued into the following spring, despite strategic efforts in neighboring regions, such as Helmand Province, unit morale was degraded by a sense of helplessness in confronting the enemy. Emotions related to this perception and external "locus of control" were evident throughout the debriefings conducted through summer 2010. Frustration and anger were frequently voiced in response to the Soldiers' seeming inability to engage the enemy following IEDs and perceived duplicity of local nationals who were thought to know the location of these IEDs. In other instances, Soldiers described a sense of mistrust of leaders in guarding the safety of unit members on missions. As casualty rates rose, some Soldiers expressed their perception that their higher leadership was more concerned about the safety of local nationals over that of their own Soldiers. Although specific acts of misconduct or intent to commit

TABLE I. Summary of TEM Incidents August 2009–March 2010

Month	FOB/ Area[a]	Type of Unit	Type of Incident	No. of Casualties	No. of Participants[b]	Setting of Debriefing[c]	No. of Follow-ups	Mode of Transport	Transit Time	Willingness to Participate[d]	Type of Intervention[e]	Days Postincident[f]	Notable Themes[g]
Aug	1	Trans	Occupational Accident	1 KIA	20	Chapel	15	N/A	N/A	4	EB	2	Grief
October	2	Infantry	OPTEMPO Increase	N/A		Motor pool	3	Convoy	1 Hour	4	TB	N/A	Lack of Support, Anger Toward Command
October	3	MP	Ambush	1 KIA 1WIA	15	Chapel	3	Convoy	45 Minutes	4	EB	3	Anger Toward Afghans
October	4	Stryker	IED	7 KIA	15	Chapel	3	Helo	25 Minutes	4	EB	2	Anger Toward Afghans
October	5	Infantry	Ambush	1 KIA 1WIA	21	DFAC	6	Helo	25 Minutes	4	EB	5	Anger Toward leaders
October	6	Infantry	Drowning	2 KIA		Aid Station	2	Helo	2 Hours	4	EB	5	Grief, Guilt
November	2	Infantry	Extended Firefight	None	20	Motor Pool	5	Helo	25 Minutes	4	TB	60	Fear; Unsure of Safe Return
November	7	Infantry	SVBIED	2 KIA 2 WIA	23	DFAC	4	Convoy	4 Hours	5	EB	3	Fear, Anger Toward Command
November	2	Infantry	IED	2 KIA 3 WIA	6	Tent	4	Helo	25 Minutes	4	EB	4	Anger Toward Command
November	8	Infantry	IED	2 WIA		Chapel	1	Convoy	45 Minutes	3	EB	7	Grief, Fear
November	2	Infantry	Rocket attack	1 KIA 3 WIA		Tent	4	Helo	25 Minutes	4	EB	4	Grief
December	9	Infantry	IED	1 KIA 1WIA		Tent	4	Helo	15 Minutes	4	EB	3	Grief
December	8	Infantry	IED	1 KIA 2 WIA		Aid Station	6	Convoy	45 Minutes	4	EB	7	Helplessness, Anger Toward Command
January	10	Infantry	IED	2 KIA 3 WIA	6	Mortar Pit	1	Helo	15 Minutes	5	EB	3	Grief, Shock, Guilt
February	11	Infantry	IED	2 KIA 3WIA		Rooftop	7	Helo	1 Hour	4	EB	12	Grief, Guilt, General Frustration
February	12	MP	Suicide	1		Office	6	Convoy	45 Minutes	4	EB	3	Grief, Guilt
March	13	Infantry	SVBIED	1 KIA 18 WIA	20	DFAC	5	NTV	5 Minutes	4	EB	2	Anger Toward Afghans

KIA, Killed in Action; N/A, Non-Applicable; NTV, Non-Tactical Vehicle; SVBIED, Suicide Vehicle-Borne Improvised Explosive Device; WIA, Wounded in Action. [a]FOBs/Areas noted by number to distinguish various locations, but not to identity specific FOBs for security reasons. [b]Number of participants in debriefing. [c]Type of setting/area where the debriefing was conducted: DFAC, Dining Facility. [d]Perceived willingness of participants to participate/self-disclose: 1 = Minimal/Low to 5 = Highly Engaged. [e]Type of intervention: Time-based, TB; Event-based, EB. [f]Number of days postincident that the debriefing occurred. [g]Typical content themes emerging from the debriefing and/or subsequent follow-ups.

such acts were not identified in the sessions, the conditions to potentiate such offenses do exist, especially among troops with histories of poor coping skills. Per standard procedures, if a Soldier voiced homicidal ideation with a specific intent to harm others, that Soldier would be taken off mission and scheduled for further evaluation.

The Need to Engage Units Outside the TEM Experience

Based on the authors' experiences downrange, it appears crucial for CSC and BH Teams to interact with units outside of potentially traumatic events. This means that CSC and BH assets must remain mobile and become acquainted with Commands and Soldiers alike. Without the buy in of both, clinicians not only lose credibility, but also run the risk of combat stress and behavioral health personnel being identified as "the people who only show up when something bad happens." Such a perception can undermine the utility of any interventions the CSC and BH Teams might provide. Although outcome research with TEM and psychological debriefings is lacking, it is unlikely that a single debrief will necessarily prevent the development of post-traumatic stress disorder (PTSD) or other psychiatric illnesses. This is especially true considering that history of childhood trauma is a better predictor of combat-related PTSD rather than the combat itself.[9] Combat stress doctrine holds that unit cohesion is one of the best predictors of resiliency to combat stress.[10] It seems that clinician time is most valuable and best spent ensuring that interventions and interactions throughout the TEM process are specifically geared toward building and strengthening those bonds.

The Need to Revise Doctrine in Light of Multiple Events

Current COSC doctrine is limited in providing guidance to team members in supporting units that experience multiple catastrophic incidents within a short time frame. Most combat stress debriefing training focuses on discrete incidents, not the cumulative effect of multiple incidents that may occur even within the same week. Although we found the EDBPD process to be a useful tool for many units, COSC personnel need to understand the limitations of what can be accomplished through the use of these procedures. In several cases, facilitators were asked by Command to gauge the ability of units to go "back on mission," based on the TEM process. In those situations, Commands were informed that the TEM process was not a method for determining the fighting spirit or capability of a unit but could help the Command identify individuals who might require further monitoring or follow-up. COSC personnel need to understand their professional limitations in assessing the capacity of units versus individuals to return to the fight following traumatic incidents, especially considering the brief nature and group setting of EDBPDs.

Adequately Preparing Units for the TEM Experience

As clearly identified in military doctrine,[2,10] affected units need food and rest in the immediate hours after a potentially traumatic event. Scheduled EDBPDs were often delayed to allow the unit leadership time to evaluate the Soldiers' more critical and basic needs. Such leader engagement helped to facilitate the debriefings. One particular Platoon Sergeant set aside a table for unit members to sit together for a meal the day after an incident to facilitate the re-establishment of camaraderie and esprit de corps. Similarly, the ability to change into clean, dry uniforms may also help meet recovery needs so Soldiers are not recalling the incident wearing blood-stained uniforms and equipment.

The Value of TEM Services

By observing troops who have faced extreme conditions and potentially traumatic events in a debriefing format, clinicians are afforded a unique window of opportunity for perceiving and listening to how troops talk about their experiences. Such experiences assist clinicians in gauging what is normal and expected under various conditions, particularly as it relates to traumatic events and the rigors of combat. Providing a forum for Soldiers to openly talk about their anger, pain, and fear with the support of both clinicians and Command is essential. Debriefings gave clinicians an inside look at Soldiers' abilities to cope and manage stress. The debriefings allowed us to track trends and inform Brigade Surgeons and Command on the status and general well-being of troops. Debriefings also facilitated follow-up with troops in the ensuing days and months on through redeployment. As such, EDBPDs play a vital role in-theater in the care of our combat troops.

More work must be undertaken to refine the content and structure of the debriefing process to ensure quality care experiences for our troops. As to empirically validated benefits of and potential for Battlemind Debriefings to help prevent the development of PTSD, we are awaiting more data from large-scale research trials. In the absence of any other standardized alternatives to EDBPDs, continued research and the ongoing option to employ such procedures in the field is critical. Initial data could potentially be collected at the unit level by organic BH Teams in tracking Soldiers at the time of debrief and upon postdeployment health assessment, as compared to others in the unit who reported combat exposure, but declined or who were not available to participate in an EDBPD. On a larger scale, self-reported outcome data could be obtained via focus groups and surveys as part of the biennial Mental Health Advisory Team visits. Subsequent research will hopefully evaluate and enhance the effectiveness of this tool with evidence-based lessons disseminated and implemented across the enterprise.

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