

# In Defense of After Action Reviews: THE ART AND SCIENCE OF SMALL UNIT COPING

Major Ronald J. Whalen, U.S. Army



*Now none of this calls for an expert trained at length in such briefing, or for special training in conducting such interviews. Any company officer who has the respect of his men and a reasonable amount of horse sense can do it. If he is fitted to lead them in battle, he is fitted to lead them in re-living the battle experience.*

—S.L.A. Marshall<sup>1</sup>

**E**XPOSURE TO COMBAT-RELATED trauma represents a significant challenge to individual and unit-level coping. The Army has developed two distinct interventions to foster unit-level coping among Soldiers exposed to combat trauma—the “after action review” (AAR) and the psychological debriefing. In their conceptually pure forms, the AAR constitutes a problem-focused intervention, while the psychological debriefing comprises an emotion-focused intervention. Both strategies trace their origins to a common source—the historical debriefing methods used by S.L.A. Marshall during World War II.

In the following pages I argue that this dichotomous approach to unit-level coping is both false and counterproductive, especially when the trauma is a result of enemy actions. To the extent that small-unit leaders insist that AARs be devoid of emotion-focused coping, emotional ventilation, or expressions of disruptive emotions like anger, guilt, or shame, to that extent they limit the AAR’s potential contributions to enhanced unit coping, performance, and cohesion. Conversely, to the extent that psychological debriefings stifle all discussion about operational-lessons learned and thoughts that improved emotional coping may be logically linked to improved tactics, techniques, and procedures, to that extent they can undermine the full learning potential of this post-trauma intervention.

Finally, while present-day Soldiers may have volunteered to join the Army, they are not free to quit should they doubt their coping abilities. Neither are they free to refuse the orders of unit leaders and medical providers to receive psychological debriefings following exposure to combat trauma. Proponents of psychological debriefings argue that, given known risks for mental health problems among Soldiers exposed to combat (depression and post-traumatic stress disorder [PTSD]), it is only right and natural to require their attendance at unit-level psychological debriefings. I argue that psychological

*Major Ronald J. Whalen is a Ph.D. candidate at the University of South Carolina. Before that, he served two tours in Iraq as a brigade behavioral health officer. Major Whalen received his B.A. from Central Michigan University, and his MSW from The University of Michigan.*

PHOTO: U.S. Army PFC Brialynn Lanteigne provides security for a traffic control point in the Sabari District of Afghanistan, 20 January 2010. (U.S. Army, SGT Jeffrey Alexander)

interventions with, at best, ambiguous benefits like those associated with debriefings should always be voluntary. However, small-unit leaders should conduct AARs regularly, but especially after enemy contact and exposure to combat-related trauma, to improve tactics, techniques, and procedures; promote coping; and when necessary, provide reasonable outlets for emotional ventilation, even when unit leaders are the target of such ventilation. By cordoning off emotion-focused coping from problem-focused coping, or worse yet, by stifling any discussion of what happened, why it happened, and how to sustain strengths and improve weaknesses by refusing to conduct an AAR altogether, unit leaders and psychologists are short-circuiting necessary feedback loops between Soldiers and their leaders, and promoting a false dichotomy in coping.

## Organizational Learning the Army Way

The U.S. Army has a rich tradition of extracting battlefield lessons to improve current combat operations.<sup>2</sup> The Center for Army Lessons Learned (CALL) now serves as the Army's primary distiller of operational best practices, with the intent of disseminating these lessons Army-wide in near real-time to save lives and accomplish the mission.<sup>3</sup>

Since the 1970s, the AAR has been the centerpiece of organizational learning throughout the Army and serves as a template for more formal reports submitted to CALL for publication.<sup>4</sup> Unit leaders use the AAR to identify training- and combat-related lessons learned to improve unit performance and survivability on the battlefield.<sup>5</sup>

Ongoing combat operations in Iraq and Afghanistan are producing a wealth of organizational experience and "best practice" recommendations. Among the practices being validated by CALL and social scientists alike is leadership commitment to organizational learning.<sup>6</sup> Indeed, Smith and Hagman found that unit leader effectiveness and learning environment were the best predictors of cohesion. Unit cohesion, in turn, is thought to play a critical role in promoting adaptation to combat stress.<sup>7</sup>

Similarly, combat operations in Iraq and Afghanistan have afforded Army Medical Department (AMEDD) researchers an opportunity to extend previous research on the use of psychological

debriefings, only this time under combat conditions.<sup>8</sup> Like AARs, psychological debriefings typically ask unit members to reconstruct what happened to—

- Promote ventilation of trauma-related emotions.
  - Encourage disclosure of personal examples of physical, emotional, and/or cognitive reactions to trauma.
  - "Normalize" Soldier reactions by educating them about common trauma responses.
  - Instruct Soldiers on self- and buddy-aid strategies to promote individual coping.
  - Advise Soldiers on when and where to seek additional help should clinical services be required.
- By demonstrating individual and group-level benefits from psychological debriefings (fewer Soldiers screening positive for post traumatic stress disorder, or increased cohesion among unit members who received debriefings), AMEDD researchers hope to both validate this intervention in a combat environment and put to rest any ethical questions surrounding the mandatory exposure of potentially traumatized Soldiers to psychological debriefings.<sup>9</sup>

## After Action Review and Small Unit Coping

*We should have known all along that this was the case—that the truth of battle had never been known in full before. Soldiers have never in the past sat down and straightforwardly rebuilt the various parts of their collective experience, even after they have been in sudden death action as members of the same squad of no more than ten or twelve men. Inertia, and often reluctance, stop them from any private inquiry and they are not under any military requirement to do it. Thus the most valuable part of the lessons which can only be learned in bloodshed becomes lost to an army. Each personal experience is sharply etched against a vague and faulty concept of how things went with the group as a whole. The fighting men do not know the nature of the mistakes which they made together. And not knowing, they are deprived of the surest safeguard against making the same mistakes next time they are in battle.*

—S.L.A. Marshall<sup>10</sup>

The AAR is an organizational learning tool intended to help Soldiers and small units evaluate and improve their task performance. By guiding unit members in a professional discussion of what

happened, why it happened, and how to sustain strengths and improve weaknesses, the review allows unit members to discover critical learning objectives.<sup>11</sup> To the extent that such a guided discovery process can help unit members identify with and commit to these learning objectives, AARs have been shown to enhance unit cohesion.<sup>12</sup>

Unit leaders typically conduct AARs in the presence of cadre who evaluate the unit's performance relative to Army training standards. At platoon level and below, reviews are more often informal in the sense that they require little prior planning and are not likely to be recorded in any systematic way. For echelons above platoon level, reviews are a more formal affair requiring greater degrees of planning and preparation and are typically recorded for historical organizational reference.

Systematic use of AARs has historically been confined to major training events such as brigade-level training at the National Training Center, Fort Irwin, California. However, its usefulness is not restricted to a formal training environment. Indeed, Training Circular 25-20, *A Leader's Guide to After-Action Reviews*, encourages their use in combat as well:

The AAR is one of the most effective techniques to use in a combat environment. An effective AAR takes little time, and leaders can conduct them almost anywhere consistent

**...AARs have been shown to enhance unit cohesion.**

with unit security requirements. Conducting an AAR helps overcome the steep learning curve that exists in a unit exposed to combat and helps the unit ensure that it does not repeat mistakes. It also helps them sustain strengths. By integrating training into combat operations and using tools such as AARs, leaders can dramatically increase their unit's chances for success on the battlefield.<sup>13</sup>

More recently, the Army has directed brigade-size elements and larger to submit a compilation of lessons learned throughout a given deployment to CALL for analysis, dissemination, and integration into CALL products.<sup>14</sup> In addition, as part of an institutional effort to foster a culture of learning and to share critical lessons, the Army has stipulated that all of its members, including Soldiers, Department of the Army civilians, and Army contractors, will collect and submit relevant observations, insights, and lessons learned during military operations, either indirectly through organizational AARs or directly to CALL. The Army Lessons Learned Program identifies and addresses systematic problems within the Army and, using analytical products and information from current operations, training exercises, and combat developmental and experimental programs, helps commanders train their units for full spectrum operations.<sup>15</sup> Despite CALL's recent recommendation that unit leaders conduct reviews after every combat mission, there is no requirement that they do so.<sup>16</sup> In the event of a serious incident like the loss of a U.S. Soldier to an improvised explosive device or the fatal shooting of an Iraqi citizen, U.S. military key leaders are required to submit a report that accurately describes what happened. However, generating a serious incident report may or may not involve using a review among all unit members to arrive at a shared understanding as to what happened. Key military leaders frequently generate this report on their own to spare Soldiers the pain of rehashing traumatic events.



U.S. Air Force, Senior Airman Chad Trujillo

U.S. Army SFC Gregory Cook, with the 4th Brigade Combat Team (Airborne), 25th Infantry Division, conducts an after action review after participating in an urban live fire exercise at the National Training Center at Fort Irwin, CA, 13 November 2008.

No doubt, within an organization as big as the U.S. Army, there will be considerable variance in the use of AARs. Captain Morris K. Estep offers a powerful example of how AARs can be used to improve both battlefield performance and psychological coping:

Upon return to the FOB [forward operating base], we always conducted an after action review to review the enemy's methods and develop a learning environment within the platoon. Each soldier in the platoon reviewed how we defeated the enemy's tactics and what worked well and what did not work well for us. Each soldier in the platoon talked about his experiences and perspectives during the ambush. This not only relieved the anxiety and apprehension of being shot at, but it also revealed key details of the fight that could be determining factors in the platoon's success. The platoon AARs allowed us to adapt our strategy to the constantly changing battlefield. In short, the speed and violent execution of our counterattack battle drills were worthless, if we did not adapt quickly to the enemy methods.<sup>17</sup>

The benefits of integrating both emotion-focused and problem-focused coping are intuitively appealing and merit further study. Given such testimony, it is tempting to insist that all unit leaders conduct reviews after every combat mission. Leaders are required to do so after conducting significant training events at the National Training Center in California and the Joint Readiness Training Center in Louisiana. However, mandating a review after every mission risks sabotaging Soldier commitment to learning.

### **Strange Bedfellows: AARs and Post-Trauma Debriefings**

Both AARs and post-trauma debriefings trace their origins to the historical debriefing methods developed by Marshall. All surviving unit members of a recent battle were gathered together and guided through an oral reconstruction of battlefield events for the purposes of generating an accurate historical record. While it was never Marshall's stated purpose to identify key elements of unit performance, his description of the role unit cohesion plays in sustaining combat motivation among U.S. Soldiers

as a result of his debriefing method remains among the more lasting contributions of his work. As Marshall wrote:

I hold it to be one of the simplest truths of war that the thing which enables an infantry soldier to keep going with his weapons is the near presence or presumed presence of a comrade. Men fight because they belong to a group that fights. They fight for their friends, their "buddies." They fight because they have been trained to fight and because failure to do so endangers not just their own lives, but also those of the people immediately around them with whom they have formed powerful social bonds.<sup>18</sup>

Like Marshall's historical debriefing, AARs and psychological debriefings begin by reconstructing what happened.<sup>19</sup> All unit members involved with the mission are to be present and all are encouraged to share their recollection of what happened, individually. By doing so, leaders and debriefers alike strive for a shared or collective appreciation of what happened and what every unit member was doing while events unfolded.

From a tactical standpoint, such a dissection of events will often identify misperceptions about what happened, what others were doing as events unfolded (e.g., higher headquarters initially tried to scramble ground evacuation assets before calling in an air evacuation of wounded), and distortions of personal responsibility (e.g., "If only I had . . . , SGT Jones might still be alive today!"). From a psychological standpoint, such a shared reconstruction of events can short-circuit negative outcomes (e.g., survivor guilt) in a way that years of therapy may never be able to accomplish. Unit medics, for example, are especially vulnerable to distortions of personal responsibility. For example, it may help when a unit medic can hear salutations of his heroic efforts from the very infantry Soldiers he supported, despite his unsuccessful and ill-fated attempts to revive their

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comrade. Such testimonials are more likely to have an immediate and persuasive effect on the medic than any impartial therapist's unconditional reassurance or Socratic challenge. Conversely, ignoring flawed medical evacuation procedures is unlikely to inspire confidence in unit leaders or reduce soldier anxiety, no matter how proficient their use of emotion-focused coping techniques (e.g., diaphragmatic breathing).

However, after reconstructing what happened, reviews and psychological debriefings diverge rapidly. Unit leaders facilitating an AAR are primarily interested in tactical lessons learned to sustain or improve performance (i.e., problem-focused coping), while psychological debriefing facilitators (typically mental health providers) are not likely to have the technical expertise to pursue operational lessons, even if they wanted to. Instead, psychological debriefing facilitators encourage unit members to disclose personal examples of their reactions to trauma in order to help personalize teachings about the common or "normal" features of such reactions (i.e., emotion-focused coping). By doing so, debriefing facilitators are hoping that accurate information and recommended coping techniques can prevent or moderate negative mental health outcomes caused by inaccurate information and a reluctance among unit members to discuss their emotional reactions to trauma (e.g., "I seem to be the only one still grieving SGT Jones' death. I must be weak."). Barring the prevention of aberrant trauma reactions, debriefing facilitators offer guidance on where Soldiers can find counseling services, should additional coping assistance be required.

Psychological debriefing proponents fail to elaborate on why any discussion of operational lessons learned is forbidden, though lack of operational subject-matter expertise among debriefing facilitators would be a good reason to avoid this topic. Similarly, certain assumptions about the degree to which units make use of AARs and related problem-focused coping seems implicit in the argument for psychological debriefings as a separate and distinct intervention.

One such assumption might be that despite the regular use of problem-focused coping strategies (e.g., AARs) by small units, Soldiers continue to report post-trauma mental health problems that could benefit from a unit-level intervention targeting emotion-focused coping. However, because there is no requirement for unit-level AARs, such assumptions are tenuous at best.

## Key Points

In their conceptually pure forms, AARs and psychological debriefings are distinct approaches to improve coping with unit combat stress; AARs promote coping with unit-level stress by identifying tactics, techniques, and procedures to sustain or improve (problem-focused), while psychological debriefings educate Soldiers about common reactions to trauma and offer self- and buddy-aid tips in the hopes of preventing debilitating combat stress reactions (emotion-focused). Either intervention may cross conceptual lines to include aspects of both problem- and emotion-focused coping, but psychological debriefings avoid this as much as possible. Indeed, their ground rules explicitly state that any discussion of operational lessons learned is forbidden. Instead, debriefings facilitators exclusively target emotion-focused coping given their theoretical assumptions that the failure to express or vent such emotions contributes to trauma-related mental health problems.

However, the evidence in favor of psychological debriefings is far from clear. Again, while such interventions may offer important information on emotion-focused coping or improve Soldier perceptions of organizational support, my argument is that integration of problem- and emotion-focused coping is the more meaningful alternative to psychological debriefings.

## Perseverance Despite Evidence

*While we recognize that there are work systems and organizations whose culture makes mandatory participation in some form of early intervention acceptable (e.g.,*

***Soldiers continue to report post-trauma mental health problems that could benefit from a unit-level intervention targeting emotion-focused coping.***

*the military), and that this can improve morale and well-being in the work-place after exposure to trauma, it appears that the costs of mandatory attendance outweigh the benefits for the individual.*

—Clinical Psychology: Science and Practice<sup>20</sup>

*Our results are consistent with prior RCTs [Randomized Control Trials] of debriefings in that there were no clear effects associated with CISD [Critical Incident Stress Debriefing], relative to no intervention; however, there were not strong negative effects either. The CISD was not more distressing or arousing than an intervention designed to teach individuals about how to manage stress.*

—Journal of Traumatic Stress<sup>21</sup>

Despite growing opposition to the use of psychological debriefings within the academic community, the Army continues to insist on their usefulness. Indeed, even a jointly drafted post traumatic stress disorder clinical practice guideline developed by the U.S. Department of Veterans Affairs and the DOD recommended against the use of psychological debriefings “as a viable means of reducing acute post traumatic distress . . . or progression to post traumatic stress disorder,” and warned that “Compulsory repetition of traumatic experiences in a group may be counterproductive.”<sup>22</sup>

In a commentary on why it might be that the mandatory use of psychological debriefings in the military has persisted despite calls for alternative interventions (e.g., “psychological first aid”), clinical psychologist Brett T. Litz offers the following:

It is instructive to ponder why it is difficult to convince care providers who feel strongly about the usefulness of CISD to consider the consensus of the academic community. To gain traction as a set of strategies that can be applied outside of disaster contexts (e.g., in the military), especially in contexts where care providers are scarce, proponents of PFA [physical fitness assessment] will need to win over various helper communities (e.g., clergy, social workers, nurses, etc.). Critical incident stress debriefing is appealing because it is

cogent and uncomplicated (e.g., the strategies are intuitive, logical, relatively easy to learn, and easily communicated), and the organization is egalitarian (disciplines without much formal mental health training can be certified, e.g., clergy). The model respects and honors work cultures (e.g., peers’ co-lead groups), it is well-integrated into work cultures (e.g., the model and the language system is inculcated into policy and procedures), and it instills confidence in management (e.g., the model underscores the normality of distress and the expectation of returning to duty after debriefing, employees who attend the groups appreciate them).<sup>23</sup>

Having secured an institutional beachhead in advance of sound science, proponents of mandatory psychological debriefings within the military have come to depend on the very organizational support they helped create by overselling the benefits of psychological debriefings to unit commanders in the 1990s.<sup>24</sup> In the absence of evidence that psychological debriefings prevent mental health problems like PTSD, military researchers point instead to gains in unit cohesion, morale, and perceptions of organizational support secondary to this intervention.



U.S. Air Force, Senior Airman Andria J. Allmond

**A captain briefs a group of Airmen prior to conducting a combat-stress therapy scenario, Joint Base Balad, 20 August 2009. The expeditionary security forces conduct operations outside the wire, and the briefings are an effort to improve mental resiliency to combat-related stressors.**

For example, a trial published in the *Journal of Traumatic Stress* compared the most prevalent form of psychological debriefing—critical incident stress debriefing—to either a stress management class or no intervention at all by randomly assigning platoons performing six-month peacekeeping duties in Kosovo to one of the three treatment conditions.<sup>25</sup> While perceptions of organizational support (“My organization really cares about my well-being.”) were highest among Soldiers who had received CISD eight or nine months after their deployment, they were not significantly higher than the other two treatment conditions (i.e., a stress management class or no intervention). Similarly, there were no significant improvements in mental health outcomes (PTSD, aggression, depression) among CISD participants relative to the other two treatment conditions. Notable, however, was the lack of evidence suggesting CISD was counterproductive; that is, Soldiers who were required to relive a traumatic event as part of the CISD intervention did not demonstrate a significant worsening of symptoms relative to the other two treatment conditions.

Based on their findings that (1) CISD was well received by Soldiers; (2) perceptions of organizational support, while not significantly different, were nonetheless greater among CISD participants; and (3) mandatory use of CISDs failed to demonstrate harmful effects, Adler and colleagues have called for further research on the use of psychological debriefings with Soldiers serving in Iraq or Afghanistan. However, as previously discussed, the research paradigm used by Adler and colleagues compared two forms of emotion-focused coping interventions (CISD vs. stress management) to no intervention at all among platoons with low levels of potentially traumatic exposure rates relative to those seen among Soldiers serving in Iraq or Afghanistan.

An organizationally more meaningful comparison would be between problem-focused versus emotion-focused coping (e.g., AARs vs. CISDs). Better yet, compare a combined problem- and emotion-focused intervention (e.g., the “after action debriefing” [AAD] where operational and emotional lessons learned are sought with equal rigor by unit leaders) to any gains seen among Soldiers receiving psychological debriefings led by mental health officers.

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In-theater equivalents to the event-driven (e.g., loss of comrades during a combat operation) and time-driven (e.g., mid-tour) psychological debriefings are easily accommodated by the AAR format.<sup>26</sup> Just as psychological debriefings hope to increase knowledge of combat stress reactions and impart ways of improving self- and buddy-aid based on exposure to a particularly traumatic event and total time in theater, the routine use of AARs (or AADs) could similarly adopt event- and time-driven triggers for execution. By having unit leaders (versus mental health officers) impart self- and buddy-aid coping strategies as well as describing where additional counseling services can be found, use of such coping strategies and counseling services may increase as a result of such an endorsement. Conversely, reductions in unit-level stigma concerning the use of mental health treatment services is reasonably implied by having unit leaders play a more central role in helping Soldiers cope with both the operational and psychological aspects of potentially traumatic events.

A potential confound factor in the research design proposed above would include the Hawthorne effect, whereby recipients of psychological debriefings may report higher levels of perceived organizational support as a result of outside subject-matter experts (e.g., the brigade behavioral health officer) being called in to render services above and beyond those offered by leaders organic to the unit. Such confounding effects would likely disappear should these same outside experts be invited to attend AARs conducted by small-unit leaders following a potentially traumatic event. Koshes, Young, and Stokes offer reasonable guidance on the role that mental health personnel might play in support of unit-level AARs (or AADs):

Mental health personnel, chaplains, and other trusted outsiders who were not participants in the event would attend only by invitation,

and purely as observers. Furthermore, combat stress control/mental health personnel should always be notified whenever serious psychological trauma has occurred in a unit. They can assist command in assuring that the after-action debriefing process is done correctly. The mental health personnel might intervene subtly during the processes only if they saw that the AAD was ending without having reached a generally positive outcome on issues of guilt, blame, anger, or other disruptive emotions. More often, they would be available to the team members afterwards, who would know that they now shared comprehensive knowledge of the event.<sup>27</sup>

Note that the role for mental health personnel is greatly diminished in unit-led AARs or AADs relative to the psychological debriefings they facilitate. Mental health personnel who might feel diminished as a result should consider the potential benefits from having unit leaders conduct AARs that include both problem- and emotion-focused coping (elsewhere called AADs). One such benefit would have to include greater self-sufficiency and operational flexibility should, for example, continuous offensive operations delay the timely application of psychological debriefings and generate resentment over unfulfilled “treatment” expectations among Soldiers exposed to potentially traumatic events.

Finally, if the history of combat psychiatry teaches us anything, it is that combat stress treatment principles are frequently forgotten in times of peace and slowly revived in times of war.<sup>28</sup> The years following World War II saw an increased emphasis on doctrine and the institutionalization of lessons learned across every military discipline, and Army psychiatry was no exception.<sup>29</sup> The early adoption and present-day popularity of psychological debriefing methods owes its continued use to the critical role doctrine plays in shaping a professional Army. Similarly, methods of developing problem- and emotion-focused coping at the small-unit level need to be more consistently anticipated and rehearsed as part

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of leader development curriculum if we are sincere about changing cultural attitudes concerning combat-related mental health problems and their treatment.<sup>30</sup>

An “all-volunteer” Army deserves reexamination of the psychiatric treatment principles first developed in the total wars of World War I and World War II, when unprecedented numbers of draftees were required and different norms applied (given a draftee’s motivation to serve and the appropriate levels of coercion required to induce this service). Post-trauma interventions like mandatory psychological debriefings, while lacking evidence of an aggregate negative effect, do a certain injustice to the all-volunteer spirit.

Military leaders and mental health providers can ill-afford to do nothing in the wake of combat-related trauma. The field of trauma research has progressed sufficiently to make the mandatory application of psychological debriefings appear anachronistic, heavy-handed, and paternalistic. The organizational research surrounding the use of AARs to help foster a culture of learning requires that unit leaders guide their Soldiers through a reliving of battlefield events to improve task performance and survivability. The need for leaders to do so is unquestioned, and the literature describing the potential performance and psychological gains for having done so is compelling.<sup>31</sup> By helping small-unit leaders become more proficient in facilitating a professional discussion of what happened, why it happened, and how to sustain strengths and improve weaknesses, Army mental health providers can help mainstream trauma reaction knowledge and effective coping strategies that respect both operational and emotional lessons learned. **MR**



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