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13th International Military Mental Health Conference

Dr. Marten Meijer | Dr. Natasja Rietveld

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Military Leaders Facing Problematic Decision Making

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Edited by
Marten Meijer & Natasja Rietveld

Netherlands Defence Academy
Faculty of Military Sciences

Opening Speech to the 13th International Military Mental Health Conference

Ladies and Gentlemen, as you may have heard, I took over command of the Netherlands Defence Academy only last Friday, so for me it is my first working day in my new position. For many of you it may be your first time in the Event Centre of the Amsterdam Naval Barracks and I wish to thank captain Nieland for his hospitality and warm words of welcome. Saying this, I realise that what we have in common is the excitement of a new environment, the challenge of new tasks to fulfil and the eagerness to cooperate with new colleagues or old friends. For you as participants of the 2010 International Military Mental Health Conference, for me as commandant of the Netherlands Defence Academy. In 2005, this Academy was formed in an amalgamation of the Royal Netherlands Naval College, the Royal Netherlands Military Academy, the Netherlands Defence College, the Faculty of Military Sciences and the Institutes for Military History and Human Resources Management. About 2,000 midshipmen, cadets and officers, also from other countries, are trained and educated by a staff of more than 600 officers and civilians. The training includes military skills, but also development of personality, character building and social skills. The education focuses on(imparting academic knowledge to our students, and, perhaps more importantly, instilling an academic attitude, and I am delighted to say that shortly, for the first time in our almost two-century-old Dutch officer education, our midshipmen and cadets will graduate with a Bachelor's degree. Our ambition is to have more and more officer students graduate with a Master's degree as well in the years to come. In order to keep up with the growing need for international cooperation, some of our midshipmen and cadets follow their education at military academies in other countries, such as Australia, the United Kingdom or the United States. In this respect I would like to welcome all participants from abroad to this conference, as, by their presence alone, they contribute to that fascinating international exchange of ideas and experiences that forms the very essence of the academic community.

Photo 1

Major General Royal Netherlands Army R.G. Tieskens, Commandant Netherlands Defence Academy.

From my professional background in engineering and logistics, the world of military mental health is somewhat unfamiliar to me, although I dare say I learned a lot from a military psychologist who commuted with me some years ago. In the many trips by train we made, he told me a lot about new interesting developments in military mental health care, especially about the group wise third-location decompression in the Isle of Crete after deployments to Iraq or Afghanistan. In this conference this will be a special issue in track 5 on best practices in military mental health care and General Van Ede will also address this topic in his contribution to the military leaders panel of this afternoon.

The theme of this year's conference, military leaders facing problematic decision making in an operational context, is a focal point of the Faculty of Military Sciences as it involves aspects of war studies, military law, ethics and social sciences. I am very glad that general Cammaert, who is a fellow of the Faculty of Military Sciences, will elaborate on some of his problematic decisions from his very broad operational experience. I am also glad that three professors of our Academy will share their scientific views on this type of decision making. Looking back only on the last twenty years, it seems that many decisions of military leaders in the operational context are no longer either right or wrong by

definition. The distinction between friend or foe is blurred and yesterday's friends can easily turn into tomorrow's enemies when we fail to win the hearts and minds of the populations with whom we are working. There is no doubt in my mind that this uncertainty will affect the process of decision making, but also shape the psychological impact of decisions about life and death on the mental health status of the military leader and his or her unit. Keeping this status as good as can be is a challenge that we all have in common, military leaders, scientists and mental health practitioners alike. In that respect, I would like to congratulate the steering committee of this year's conference on their choice of this very significant theme.

Please, allow me to end with a quote from professor dr. Theodore Von Karman, the founding father of the NATO Research and Technology Organisation: 'Scientists cannot support military leaders without a proper understanding of military operations. Military leaders cannot gain from scientific outcomes without a proper understanding of scientific work'. May this 13th International Military Mental Health Conference help to bridge the gaps between military leaders, scientists and mental health practitioners.

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Major General R.G. Tieskens, MSc
Commander of the Netherlands Defence Academy
Amsterdam, 6 September 2010

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Acknowledgements and Disclaimer

We want to thank the Faculty of Military Sciences of the Netherlands Defence Academy for the opportunity to select and edit the papers we have received in Spring 2010 during the preparation of the 13th International Military Mental Health Conference, held in Amsterdam, 6-8 September 2010. Without the wonderful work of the authors of those papers these conference proceedings would have not been published. Therefore, our gratitude goes out to the authors of the papers, but also to the military and civilian professionals who formed the attentive audience of the conference. The papers form the chapters of this book. The knowledge provided in the different chapters is of great value to the military world. It contributes to the successful, careful and morally responsible execution of the military profession in nowadays military operations and to the civil functions of mental health care within the armed forces.

The views and findings in this book are the responsibilities of the authors. They do not necessarily reflect the official position or policy of the Netherlands Ministry of Defence or the Netherlands Defence Academy.

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Marten Meijer
Natasja Rietveld
Breda, March 2011

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Introduction

The 13th International Military Mental Health Conference brought together a variety of military and civilian professionals, who travelled to Amsterdam from different countries, like Estonia, Norway, Ireland, United Kingdom, Belgium France, Italy, Austria, Canada, the United States of America, and the Netherlands, to share relevant experiences and topics related to mental health care in the armed forces and to the military profession.

Photo 2
Participants of the 13th International Military Mental Health Conference.

Discussed topics were: questions about good leadership, prevention of misconduct during deployments, pre-deployment selection, pre- and post-deployment psychological and psychiatric screening, moral dilemmas in modern military operations, and best practices of military mental health care. These topics all form a part of the 'deployment cycle', i.e., topics that play a role before, during and after the deployment of a military unit and the individual service members.

This book includes a selection of the papers about the studies that were presented on the conference. Chapter I contains a summary of the keynote speeches of senior military leaders, who shared their personal experiences from modern military operations at the first day of the conference. The importance of the interrelationship between Leadership and Ethics is clearly shown in Chapter

II. Professor Verweij explains that paying attention to Ethics in leadership, and in particular to Care Ethics, is crucial for the success in military operations. Remarkably enough the ethical perspective of leadership is not taken into account in many studies on leadership. In particular when it comes to leadership within the armed forces, we need knowledge about the ethical aspects in leadership. After all, 'many of the problematic decisions that military leaders face in an operational context can be defined as moral questions and dilemma's'. Professor Verweij teaches us about how a leader can become a 'good' leader in the moral and ethical sense.

The relevance of paying attention to the ethical perspective in leadership will be shown again in Chapter III, where we find a social-psychological analysis of the question why instances of aggressive misconduct occur by peace-enforcing or peacekeeping units. The main hypothesis is that frustration and other negative emotions of the perpetrators themselves, but also of their leaders, are the root cause of many incidents of aggressive misconduct of soldiers of Western armed forces. Professor Vogelaar shows us how this misconduct is facilitated by a number of factors, such as group dynamics, laissez-faire leadership, and a negative image of the population.

Chapter IV is about how to find leaders that will be able to face and solve problematic decisions in an operational context. Dr. Boe shows us an example of the use of requirement, assessment and selection programs in the Norwegian Special Forces.

Professor Irvine discuss in chapter V the question about to screen or not to screen, prior to and on return from deployment in war theatres. He studied the need and adequacy of psychological and psychiatric screening procedures for military personnel.

Chapter VI is about assessing morale during a deployment and the use of the Dutch Morale Questionnaire within a Belgium Detachment in Kosovo. The aim of this test-case was to assess the matching between field observation and the results of the survey. Captain Lo Bue shows us a convergence between the two sources of information.

In Chapter VII Dr. Lahutte offers us, based on a French military engagement in Afghanistan, a pragmatic illustration of how military engagements confront leaders and medical practitioners with difficulties regarding balance between

collective and individual concerns. High intensity combat, where terrorist risk prevails, stresses what may appear as potential disagreements. This study intends to glance through different situations and analyzes command responses, such as in sequences of traumatic encounters, mourns and collective panic reactions in their "shaded" manifestations: mutiny, risk taking and overconfident behaviors.

In Chaper VIII the effects of combat exposure on army snipers is discussed by former lieutenant-colonel Dr. Bradley. His paper is about an interview-based study of 19 Canadian army snipers who had served in Afghanistan between 2002 and 2008. The study is conducted in 2009.

In Chapter IX a case analysis of moral dilemmas in an UN operation of a service member of the Belgian Armed Forces is presented by commander Deheeger and in Chapter X former Staff Sergeant Coops and commander Meijer present a case-study about tragic dilemmas in lethal accidents in the Dutch armed forces. The experiences and difficulties of the actor, the victim, the family of the victim and the social workers are described, as well as questions about how to support the actors adequately and successfully.

Deployment-related guilt and shame are issues that often are a result of experienced moral dilemmas during deployments. In Chapter XI Dr. Rietveld presents her study regarding deployment-related guilt and shame among Dutch veterans of peacekeeping and peace-enforcing missions. As we find in the attribution theory, guilt and shame fulfil an important function in processing intensive events. The moral questions behind both emotions contribute to finding explanations for experiences and help us to clarify the actual extent of own responsibility in the course of situations. If feelings of guilt and shame are not recognised and discussed, they can be at the expense of the mental health.

In Chapter XII Heulot makes us aware of the function of language in coping with trauma. She explains how, with some therapeutic assistance, a person who was exposed to a traumatic event, can take another perspective on the experienced situations, and discover the opportunity to have a choice in life when he/she writes and rewrites his/her own history. Heulot tells us that within the knowledge and acceptance of not having control in life, the possibility lies to embrace certain situations and rewrite them into a full grown experience which enriches life.

Last but not least, another important theme related to processing deployment-related experiences is discussed by Dr. Moelker and Schut in Chapter XIII. This chapter focuses on veterans and their need for motorcycling. Some veterans do not adapt well to civilian life, after homecoming from the military mission. They suffer from Post Traumatic Stress Disorder, guilt and depression. But many of the veterans cope well, and quite a few of them cope very well by riding a motorcycle and joining a motorcycle group which helps them come thru a transition from being deployed to being an integrated citizen. The *communitas* of veteran bikers provides social support and mutually understanding. Moelker and Schut also confirm the healing power of writing narratives.

At the end of this book you will find a comprehensive list of literature in which the references, used by all authors are included. You will find the used credentials of the individual authors in the footnotes of their chapter. Short biographies of all the authors conclude this book.

Chapter I

Moral Dilemmas for Military Leaders

CDR Marten Meijer, PhD[1]

Introduction

This chapter captures the keynote speeches of senior military leaders, who addressed the Military Mental Health Conference at the Naval Barracks Amsterdam in September 2010. The Faculty of Military Sciences of the Netherlands Defence Academy organised this conference in cooperation with the Military Mental Health Centre in Utrecht and the Veterans Institute in Doorn. About forty participants from seven different countries attended plenary sessions and workshops. 'Military leaders facing problematic decision making' was the main theme of the conference. The workshops focussed on moral dilemmas of military leaders, pre-deployment selection, 'blue-flight' for misconduct during deployments, commander's intent versus blind obedience and good practices in military mental health care. These themes are focus areas of military mental health care and have shown strong developments over the past decade of military engagements in asymmetrical armed conflicts[2]. Although these themes are still pressing, they are not new to the field of military mental health care. In 1938 the Austrian psychiatrist Sigmund Freud wrote letters to Albert Einstein, in which they discussed the dilemma of revealing the real character of armed conflict. They realised that as long as this character was carefully hidden by only testimonies of bravery, depicted in great detail in history books, people would keep on waging war[3]. In 1943 the American Army general George Patton slapped a private in the face, who was a patient in a field hospital. The general accused this patient of cowardice. Later on it appeared that these were false accusations and the general had to apologise by order of his superior, general

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[1] Head Expertise Management Branch, NATO Centre of Excellence for Command and Control, Utrecht, m.meijer@c2coe.org.
[2] Van Baarda & Verweij, 2009.
[3] Asimov, 1972.

Eisenhower. In 1947 the American Army psychiatrist David Schneider concluded that the dominant military culture of masculinity does not tolerate any weakness[4], although military personnel is in need of all kinds of care, like all other human beings. The conference poster presents icons of these themes and dilemmas (see photo 3).

Photo 3
The poster of the 13th International Military Mental Health Conference with icons of problematic decision making.

Moral dilemmas in United Nations operations in Africa

Retired major-general Royal Netherlands Marine Corps Patrick C. Cammaert (see Photo 4) discussed the moral dilemmas he had faced in his deployments in United Nations missions to Hong Kong, Cambodia, Bosnia, Ethiopia and Eritrea and the Democratic Republic of the Congo. Nowadays he is a senior military consultant for the United Nations in New York and a fellow of the Faculty of Military Sciences of the Netherlands Defence Academy.

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[4] Schneider, 1947*.*

Photo 4

Major General Royal Netherlands Marine Corps (ret) P.C. Cammaert.

Both positions allow him the opportunity to share his views with large audiences. General Cammaert started his presentation with a moment of contemplation, in which the song Crazy[5] sounded. This song was his favourite song in his mission in Bosnia in 1995. In a 1996 documentary on the hidden feelings of deployed military personnel by Heddy Honigman, he admitted that the bloodshed he witnessed on a marketplace in Sarajevo, in which more than thirty people were killed by a mortar grenade, almost made him crazy. The documentary shows how deployed military personnel connect to their feelings of their deployments by remembering and listening to their favourite songs of those days. Some soldiers, who drove convoys through the Bosnian mountains and were repeatedly attacked by snipers, listened to 'Knocking on Heavens Door' of the pop group Guns 'N Roses. The loud sound of this song fully covered the noise of the shootings by snipers and also covered the fear that their lives could end immediately, when the snipers were effective. General Cammaert phrased his main moral dilemma as the obligation to bear a lot of responsibilities, without sufficient means and time to act appropriately. He used the image of holding as much as possible sand in your hands by keeping the hands open. Trying to hold the sand by a firm grip of the fingers makes the sand slip through your fingers, which it did many times during his deployments. During his most recent

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[5] Crazy, name of the song of the pop group Guns 'N Roses and title of the documentary of Heddy Honigman, available from http://www.heddy-honigmann.nl/hhonigmann/films/crazy/index.php

deployments in the Democratic Republic of the Congo he was struck by these feelings of powerlessness again when he had to witness the atrocities of sexual violence, committed by rebellions. Women and girls were mass raped and captured in some wooden houses which were set on fire. Although he was in charge of a huge brigade of military peacekeepers of the United Nations, he was unable to protect these women and girls. This feeling of powerlessness urged him to choose in the tragic dilemma to carry on or withdraw. Carrying on was hardly possible because sufficient means for effective protection were lacking. Withdrawal was hardly possibly as it would give the victims and their families a feeling that the world turned a blind eye on them. His choice to carry on made him suffer from even stronger feelings of powerlessness, shame and guilt, especially when rumours were spread that Congolese armed forces were perpetrating these crimes in the same way as the rebellion forces, without appropriate interventions from the United Nations peacekeepers. These rumours reinforced the tragic dilemma of the choice between carrying on or withdrawing, as the rumours also affected the reputation of the United Nations who are present in that area. General Cammaert identified another tragic dilemma, that raises from the choice how and when to confront the troops with the intensity of these atrocities. This confrontation, for instance by showing pictures of victims or listening to the horrifying stories of victims, can be part of the pre-deployment training. In doing so, the initial reaction of fright or flight will be coped with before the deployment, which might lead to a better performance during the actual deployment. However, it can also terrify the troops and reinforce an avoidance reaction, which might lead to a worse performance during the actual deployment. According to general Cammaert the troops have to be confronted with the atrocities, in spite of their aversive and avoidance reactions.

Military Leaders Panel

Three senior military leaders reflected on the conference theme of problematic decision making in their past deployments in modern military operations (see photo 5).

Photo 5

The military leaders panel. From left to right: Major-general Royal Netherlands Marince Corps A.G. Van Ede, Major General Royal Netherlands Army M.C. De Kruif and Air-commodore Royal Netherlands Air force T.H.W Ten Haaf.

The deputy commander of the Royal Netherlands Navy, major-general Royal Netherlands Marine Corps Ton G. van Ede, explained how the Netherlands Armed Forces learned important lessons from their deployments over the past two decades. These lessons were used to develop a robust system of mental health care for deploying military personnel. In the pre-deployment training, good leadership and buddy-buddy care contributes to the resilience and cohesion of the unit, which decrease risks for post traumatic stress disorder[6]. During deployments, the model of 'stepped care' is used. This model starts with social leadership and buddy-buddy care, adds professional mental health care by social workers, psychologists or psychiatrists and ends with a flight home, when this care appears to be not sufficient in the deployment area. At the end of a deployment, a third location decompression is part of the transit home. This decompression consists of good food and shelter, group discussions on the ups and downs of the deployment and a preparation of the homecoming-stage. These discussions are lead by a couple of a mental health professional and a military colleague, who learned his own lessons in a previous deployment. From

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[6] Shay, 1994.

evaluations of these group discussions it appears that a vast majority of the deployed personnel is satisfied or very satisfied with this kind of care for personnel[7]. Six weeks after deployment a social worker checks how the process of homecoming develops.

The deputy commander of the Royal Netherlands Army, major general Mart C. De Kruif reflected on the intensity of the processes of loss and mourning in his deployment in the International Assistance Force Afghanistan in 2007 and 2008. In this period he was the Regional Commander South and he commanded over 40.000 troops, of which over 600 lost their lives in actions or accidents. Too many times he had to participate in so called ramp ceremonies, in which the remains of the deceased were taken into an airplane to fly back to a proud and grateful country. In a documentary of the Dutch television he showed the last farewell to an American marine, who was killed in action. In a ceremony at the compound of his unit the name of this marine was called out loud. When no answer followed, he was reported killed in action and the troops paid a tribute to his rifle, helmet and boots, which were displayed in front of all the troops. During his command, general De Kruif had to cope with a deeply tragic dilemma, when Dutch Forces were in charge of clearing areas on Improvised Explosive Devices. Although the area was thoroughly inspected, an American soldier was blown up and killed in this area by such an Improvised Explosive Device. This dilemma originates from the responsibility for too large areas to clear in combination with lack of time and manpower for perfect clearing. Agreeing on the responsibility for only smaller areas decreases the impact of the operation, but larger areas increase the risks on such casualties. This type of dilemma seems to be similar to dilemma of general Cammaert in Africa, where protection of the local population against sexual violence was not possible because of lack of troops.

General De Kruif, who had to make a choice in this tragic dilemmas could decrease the psychological burden of his tragic choice by making a difference

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[7] Meijer, M., De Vries, R. Good Practices of End of Deployment Debriefing in the Royal Netherlands Navy. In *Human Dimensions in Military Operations – Military Leaders' Strategies for Addressing Stress and Psychological Support* (pp. 46-1 – 46-6). Meeting Proceedings RTO-MP-HFM-134, Paper 46. Neuilly-sur-Seine, France: RTO. Available from: www.rto.nato.int/abstracts.asp.

between being responsible and being guilty. In the specific situations he claimed to be responsible, but not guilty, as there was no blood on his hands.

Air-commodore Theo W. Ten Haaf commanded the Dutch air power component in the NATO International Security Assistance Force in Afghanistan in 2007. During his command he was confronted with a problematic decision, when he grounded the Dutch F-16 fleet because of an unknown technical problem with one of the airplanes. Almost immediately allied force commanders put pressure on him to fly and deploy air power again, but he refused to do so for the sake of the safety of his pilots and airplanes. Within twenty four hours his technical crew discovered the human error, which caused the technical failure. A mechanic had erroneously used lubricant oil instead of hydraulic oil in the maintenance of the hydraulic systems of the airplane. Once this error was detected, all the other airplanes were inspected on this failure and ready to fly their missions again. In the aftermath of this error, another dilemma appeared. Air-commodore Ten Haaf could send the mechanic who had made this error back to the Netherlands on a blue flight, but he could also keep him in his unit for completion of his deployment, knowing for sure that he would not make the same mistake. As a matter of fact he was kept in the deployment, after all mechanics were informed of the risks and consequences of his mistake. This choice gave the mechanic a very intense lesson identified and an opportunity for full rehabilitation. Lack of rehabilitation and the subsequent lack of self-esteem of military personnel who were sent out of their deployment on a blue flight home increase the risks of mental health problems like depression or even suicide[8]. A Dutch marine, who was severely wounded and almost lost one of his legs in the middle of his deployment, was repatriated for medical care in the Netherlands. When he was sufficiently recovered he insisted on his participation in the third location decompression of his unit. This participation enabled him to reunite with his buddies and to regain his self-esteem in the group discussions. Last but not least commodore Ten Haaf showed video footage of actions of Apache air assault helicopters. From this footage it appeared that Dutch flying crews were carefully checking if their targets were really opposing forces. In some cases they were not, so violent interventions were not necessary. In other cases it appeared that the opposing forces were wearing female clothing for cover. Once detected as

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[8] Thoresen, 2006, p. 63.

foe, they were effectively killed by heavy machine gun fire from the helicopter. The identification between friend or foe was not always so clear. In situations of doubt, the protection of friendly forces who were under attack prevailed and asked for immediate action, in spite of the risk for collateral damage.

'As I left my father's house'

During the conference, a group of African artists performed a play called 'As I left my father's house'[9]. The artists asked the participants of the conference to sit together in circles, one of the powerful community traditions of African tribes. While sitting in these circles, the participants could listen to three narratives on the consequences of violence in different communities. These narratives were given from the perspective of a Jew, a Muslim and an African man. The Jewish narrative revealed the psychological burden of the conspiracy of silence on the holocaust. By this conspiracy the real character of the murder of millions of Jewish people was hidden by phrases like 'they left and never came back' or 'no one heard of them again'. The Muslim perspective showed that the terror of suicide attacks and improvised explosive devices tears apart the ties between groups within the Muslim world and with outside groups. The peace of mind in every day life is shattered by this ongoing violence, which costs human lives every day. The African perspective focussed on the violence of rebels, who take hostages, rape and kill people for satisfaction of their own lusts and needs. It also showed the tendency to hide the psychological burden of this violence and the need to share this burden with the healing capabilities of a tribal community. The African narrator phrased this as bringing the light of other people into the dark room in his heart, for which he was afraid to enter.

Some observations on problematic decision making in modern military operations

The problematic decisions in modern military operations, which were discussed at the start of the conference by senior military leaders and scientists, varied a lot in character and intensity. Some of the decisions initially seemed to be

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[9] www.asIleftmyfathershouse.nl

difficult, but appeared to be well taken when their consequences unfolded over time. Other decisions turned out to be tragic, especially when the time after the decision showed the terrible consequences of this decision, often on the edge of life and death. As the psychological burden of these decisions continues to weigh heavily on the shoulder of the military and their commanders, only the future will show their real impact in lifelong consequences. It can be clearly observed that at the time of the decision, not all consequences could be known. Judgements on the quality of these decisions should therefore be made with great reluctance and compassion. From the keynote speeches of the military leaders it can be concluded that most of them had to deal with problematic decision making during their deployments in modern military operations. Both general Cammaert and general De Kruif had to deal with huge responsibilities and limited capabilities, which presented intense and tragic dilemmas. Air commodore Ten Haaf had to make a problematic decision, when one of his mechanics made a mistake which jeopardized flight safety for his entire F-16 fleet. However, by his decision to keep this mechanic at work in his deployment, he opened the possibility to learn from this mistake by all his mechanical personnel. The specific mechanic got a full opportunity for rehabilitation and for learning a very important lesson. The flying crews of commodore Ten Haaf, especially from the helicopter squadrons, appear to be most susceptible for the long lasting consequences of their decisions on life and death. What they have witnessed in the heat of the fight will be in their memories for a long time. Therefore they deserve the life long attention of the entire community of mental health professionals.

From the African theatre group it appeared that this attention should be given from the society as a whole as well. Military personnel stem from a parent society, deploy in the society of operations, but have to regain their place in their parent society after deployment. Mental health interventions should reinforce their social connection with their parent society, instead of isolating them in hospitals or treatment units. Mental health professional have to span the boundaries between those worlds.

Chapter II

Do you care? Leadership and Care Ethics

Prof. Dr. Desirée Verweij[10]

Abstract

The systematic focus on the ethical dimension is absent in most research on leadership. However, many of the problematic decisions that military leaders face in an operational context can be defined as moral questions and dilemmas. Paying attention to the ethical perspective and so to the values and normative presuppositions in leadership research and practice is crucial. In this article the importance of the interrelation of leadership and ethics, and in particular Care Ethics, will be discussed.

Introduction

Many of the problematic decisions that military leaders face in an operational context can be defined as moral questions and dilemmas. They underline the importance of the theme 'ethics and leadership' and the interrelation of the two core elements of this theme. Yet, this interrelation is not always acknowledged.

What is acknowledged however, especially nowadays, is the fact that leaders often fail, either in politics or in business or in banking. In these contexts we seem to have many failing leaders. Business ethicist Ciulla starts the chapter 'Leadership Ethics' in her book *Ethics the heart of leadership* with the statement: "We live in a world where leaders are often morally disappointing". Ciulla points out that not only leaders are disappointing; the research on leadership is disappointing as well. She maintains that research on leadership seems to be based on the question "What is leadership". However, it should be based on the question; "What is good leadership"? 'Good' implies 'morally good' and

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[10] Military Behavioral Sciences and Philosophy, Netherlands Defence Academy, P.O. Box 90002, 4800 PA Breda, The Netherlands, dem.verweij.01@nlda.nl.

'technically good and effective'. With reference to several philosophers Ciulla illustrates that the statement "he or she is a good leader" can only be true if the person in question is also ethically responsible. 'Good' can only be good when the ethical perspective is also taken into account. This seems convincing, notably, 'good' is a value judgement and values form the foundation of ethics. Ciulla shows that the problem with a lot of research on leadership is that the ethical perspective is not taken into account. Moreover, the systematic focus on the ethical dimension is absent in most research on leadership. This implies that important aspects of leadership are not taken into account. What is absent in most research is the description of the underlying commitments in the leader-follower relationship. It does not matter how much empirical data are collected with regard to leadership if no attention is paid to the ethical implications of these empirical data. Paying attention to the ethical perspective and thus paying attention to the values and normative presuppositions in leadership research is crucial, but, as indicated before, is unfortunately something that is not done. This is also indicated by Kalshoven (2010) in her book *Ethical Leadership. Through the eyes of employees.* To compensate for the absence of the ethical dimension Ciulla introduces the concept of 'leadership ethics' as a form of applied ethics that can contribute -in a substantial way- to the phenomenon of leadership.

The concept of 'leadership ethics' as introduced by Ciulla, can, in my opinion benefit from ideas developed in care ethics, as I will hope to show in this article.

Care Ethics

Care Ethics, one of the ethics theories and as such the youngest theory and the little brother -or sister if you like- of Utilitarianism, Duty ethics and Virtue ethics, can be of relevance with regard to leadership. In Care Ethics the relationship with the other (in non-philosophical jargon: the other person) forms the point of departure. This implies that Care Ethics does not start from an atomic concept of man, but focuses on the individual as embedded in a web of relations. This implies that it is thus a form of situated thinking and situated ethics and that it is concerned with values such as solidarity and empathy. Every individual is

vulnerable and dependant and thus, in his or her existence, in need of attention and care. The principle of care is a *conditio sine qua non* in that sense. It forms the basis for moral and political judgement. 'Care' can be seen as a social practice. This focus on social practice is not always present in the traditional ethics theories, in which 'the other' is always 'a generalized other'. In Care Ethics the concern is about the concrete other, the actual other person.

As indicated before, Care Ethics places a relational concept of man opposite the atomic concept of man. A human being is embedded in concrete relations with others and this implies that care is closely connected to responsibility and the ability to assess what is necessary is a particular situation. The willingness to take care of the other is crucial is this respect. Tronto, one of the leading philosophers with regard to Care Ethics, maintains that the values 'attention and consideration', 'responsibility', 'responsiveness' and 'durability' form the nucleus of Care Ethics. Tronto has made a distinction between four aspects, or rather four parts, of care: The first part is 'caring about' which implies seeing and acknowledging the need for care. It implies knowing what is needed in a particular situation. I would like to add that this implies awareness, as will be shown later on. The second part of care is 'caring for'. This implies taking responsibility for the start of the actual process of caring. It requires more specific knowledge of the situation and it also requires empathy. For only on the basis of the ability to identify with a person (or persons) in a particular situation can care be granted. The third part of care is 'taking care of'. This implies the act of caring. Tronto also calls this 'repairing' and 'maintenance'. The fourth part of care is 'care receiving'. This fourth part, or form of care, is about the reactions of those who are the subject of care; those who receive the care that is given to them. These reactions are important with regard to the quality of care. Is the care that is needed and asked for, the care that is actually given? Or, is a different way of caring, or a different form of care, needed?

Tronto defines care in the following way: "On the most general level we suggest that caring be viewed as an activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of

which we seek to interweave in a complex, life-sustaining web". 'Caring' and 'taking care' thus imply the ability and the willingness to see and hear what is needed. It thus implies the ability and willingness to take responsibility.

Moral and emotional impact of military operations

The caring leader, who cares and takes care in the four-layered perspective on care, can be considered a 'good' leader in the moral/ethical sense. Against the background of Toronto's description of care we can state that 'good' -in the sense of caring- leaders are necessary, especially given the complexity of military operations, and given the moral and emotional impact of these complex operations. This moral and emotional impact is enormous. "There never was a war that was not inward" is the motto of Nancy Sherman's book *The Untold War. Inside the hearts, minds and souls of our soldiers*. Sherman, professor at Georgetown University and at the Naval Academy and trained as both a philosopher and a psychoanalyst, lectures on resilience, trauma and military ethics. Sherman's book focuses on the inner battles soldiers wage and on the moral weight of war. As Sherman puts it: "Most soldiers, at least the honest among them, fight inner wars as well. They wrestle with the guilt of luck and accident and the uneasy burden of killing and leaving the killing behind"[11]. Yet, the moral and emotional impact of military operations on individual soldiers is not always acknowledged, neither by military organisations, nor by military personnel. The reigning digital mental model of idealized macho toughness in opposition to contemptible pusillanimity results in preference for a hard robust 'Stoic' attitude. However, this attitude shows a dangerous similarity with the strategy of ostriches, who, in an attempt not to look at the approaching danger burry their heads in the sand. Suppressing emotions and rejecting the learning process of creating an equilibrium with regard to the moral and emotional impact of war and the moral and emotional buoyancy to counter this impact, will eventually lead to psychological and social problems. I will come back to the concept of buoyancy at the end of this article.

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[11] Sherman, 2010, p. 1.

The moral and emotional impact of war is indicated in an alarming article in the English paper The Guardian in September 2009, entitled 'The Hidden Army in UK Prisons'. It is written by Alan Travis, home affairs editor of the Guardian. Travis states that according to a new survey, the number of former servicemen in prison or on probation or parole is now more than double the total British deployment in Afghanistan. An estimated 20,000 veterans are in the criminal justice system, with 8,500 behind bars, almost one in 10 of the prison population. The proportion of those in prison who are veterans has risen by more than 30% in the last five years. The study by the probation officers' union Napo uncovers the hidden cost of recent conflicts. The snapshot survey of 90 probation case histories of convicted veterans shows a majority with chronic alcohol or drug problems, and nearly half suffering from post-traumatic stress disorder or depression as a result of their wartime experiences on active service. Those involved had served in Northern Ireland, Bosnia, Iraq and Afghanistan. They are most likely to have been convicted of a violent offence, particularly domestic violence. The study provides the strongest evidence yet of a direct link between the mental health of those returning from combat zones, chronic alcohol and drug abuse and domestic violence. In many cases the symptoms of depression or stress did not become apparent for many years and included persistent flashbacks and nightmares. Professor Tim Robbins, consultant clinical psychologist and former head of traumatic stress services at St George's hospital, London, states: "If we are asking people to do appalling things, to take part in regular fire fights and hand-to-hand combat, you get to the stage where it de-sensitises them to violence. It is not just these specific things, but also [for soldiers] there is the constant rising and falling of the level of tension. In combat, they are constantly on edge and after a while they become constantly on edge." Harry Fletcher, Napo's assistant general secretary, states that the high numbers of former soldiers in prison was unacceptable: "There is overwhelming evidence that support is not available of sufficient calibre when soldiers leave the service. The preponderance of post-traumatic stress disorder and depression is also alarming." Probation staff in 62 offices across England and Wales say the vast majority of former soldiers referred by the courts for criminal justice supervision did not receive adequate support or counselling on leaving the armed forces. Napo also maintains their military experience and

background is not being routinely identified when they are arrested or convicted in the courts. It wants a specific duty to be placed on criminal justice agencies to refer service personnel for appropriate help and counselling. Probation officers point out that the military also urgently needs to provide programmes to tackle chronic alcohol abuse and domestic violence committed by those in their ranks and on discharge. The probation union's estimate of 20,000 veterans in the criminal justice system breaks down into 12,000 veterans on probation or parole, and a further 8,500 in custody. These figures represent 8.5% of the total UK prison population, and 6% of all those on probation or parole.

Obviously this is not just a problem in Great Britain, as is becoming more and more clear, given the reports on psychological problems of veterans in several countries. It seems dangerous to turn a blind eye on the consequences of the moral and emotional impact of military operations.

Moral professionalization

The danger of turning a blind eye on the consequences of the moral and emotional impact of military operations is underlined in Sherman's book. She points out that psychological anguish in war is also moral anguish, which is a fact that is too often ignored. There are always moral and emotional tensions involved. With regard to these tensions Sherman refers to "the inner war and its subtle moral contours"[12] and the "healthy struggle in the best soldier"[13]. The story soldiers tell over and over again is about the battle to reclaim personal accountability and sometimes they don't succeed. Sherman tells us the story about Ted, a top-ranked West-point graduate and elite Army ranger, whom she interviewed for her book. Sherman writes: "I was stunned when I heard on the news in the summer of 2005 that he (Ted) had taken his life in Iraq with his own service weapon. (..) his moral idealism collided with the reality of the war in Iraq and the corruption of contractors whom it was his job to oversee. He went to war seeking adventure and proof of his warrior virtue. In the end he was sullied, morally undone, morally stripped. (…) Ted was the best of the best, but

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[12] Sherman, 2010, p. 2.
[13] Sherman, 2010, p. 2.

somehow war was able to undo him"[14]. There are more examples like Ted in Sherman's book. With regard to these soldiers Sherman states: "Though they do no wrong by war's best standards, they often feel wracked by guilt, betrayal, and a need to make reparations"[15]. And she continues: "I urge that soldiers should not bear the moral burdens of war on their own (...) we need to understand the moral psyche of the soldiers far better than we do".

'We' is the public in Sherman's text. I would like to broaden to 'we' to military leaders, military educators and (maybe most important) politicians. Understanding the moral psyche (as we should do as Sherman points out) implies insight in ethics and psychology. In this article I will focus on military ethics, which I think, can play an important role, especially for the caring leader. As I stated before, it is dangerous to turn a blind eye on the moral and emotional impact of military operations, since moral questions and dilemmas - especially tragic moral questions and dilemmas - can have a detrimental effect on mental health, as Sherman shows in her book. And it is of course not just Sherman who provides us with this information. More and more reports on this subject are being issued.

The question that needs to be addressed is the question how military ethics can be of help in this context. My answer is simple, however, putting this answer into practice takes time and effort. So how can military ethics help? It can help by providing insight in the moral dimension of military practice and by creating and stimulating moral professionalization. In order to explain the meaning and implications of the core concepts in this statement I first have to define ethics and military ethics. Ethics can be defined as critical reflection on values, norms and related interests. Given this definition of ethics, military ethics can be defined as a form of applied ethics, which, like other forms of applied ethics such as medical ethics and business ethics, implies critical reflection on the values, norms and related interests in military practice. I want to underline the meaning of critical in this context. I use 'critical' in the sense of the Greek word 'krinein' which means 'to distinguish' or 'to judge'. This meaning of 'critical', used by

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[14] Sherman, 2010, p. 3.
[15] Sherman, 2010, p. 3.

many philosophers, refers to the ability to judge. This first of all implies awareness of the signification and impact of values and possibly virtues that play a role in military practice. For instance the value of humanity and the virtue of integrity. Do the people involved in the practices in which values and virtues like these play a role, really care about these values and virtues or are they merely window-dressing or being politically correct? 'Care' implies, as is outlined above, that there can be no such thing as political correctness and window-dressing. What is the meaning of humanity and integrity, or, of traditional military virtues like courage, obedience and comradeship? Is the focus of these values and virtues inward or outward? For instance, are soldiers concerned about the civilians in their area of operation or only about themselves and their buddies? In philosophical terms: is the focus on the 'self' or the 'other'? Or is it on the 'self' and on 'the other'? And how can people learn to deal with the moral questions and dilemmas that result from this dual focus that is expected of military personnel? It seems obvious that military ethics and thus critical reflection is needed because of the complexity of military practice. This complexity is related to the monopoly of violence that is given to the military by the state in order to protect the values that the states wishes to hold on to (peace, security, humanity). However, military ethics is not an end in itself; the goal of military ethics is the development and stimulation of moral professionalization, which consists of six aspects. It firstly implies awareness of the moral dimension. This means that one knows and sees that there is a moral/ ethical question or dilemma at stake and that one can identify its underlying values, its rules and interests. Knowing and identifying, however, are not enough. For knowing that there is a moral dilemma does not necessary imply that one is also capable of making an adequate evaluation of the different alternatives. One therefore, in addition (and thus secondly) needs judgement and (thirdly) the ability to communicate. The latter means that someone is able to discuss possible solutions, but also knows how to explain the moral dimension to others who may not have the same awareness. Subsequently, (fourthly) one must be able and willing to act, if that is what is called for. And do so in a responsible way. It is most important, however, that one must be ready to be held accountable (fifthly) for one's actions and decisions. This will be less of a problem, of course, if prudent reflection has accompanied the whole process.

Last but not least, the sixth aspect of moral professionalization: moral buoyancy. This concept is related to the impact of the confrontation with moral/ethical questions and dilemmas. This impact can be severe as Sherman shows us in her book, and as the many reports on veterans indicate. Even if one is able to act in a responsible way when confronted with a moral/ ethical question or dilemma, and thus demonstrates the before mentioned aspects of moral professionalization, one's peace of mind can still be disrupted by the tragic choices one had to make. What is also required then is a good measure of buoyancy or resilience in order to deal with the impact of tragic choices. Moral buoyancy implies a humane attitude, moreover, it implies the ability to cope in a constructive way with tension, duality, multiplicity, doubt and conflicting emotions, all of which are part of military practice in complex circumstances. Soldiers are no robots and cannot become robots, for that would imply moral blindness and moral blindness easily leads to immoral and illegal behaviour. With reference to Shannon French, who maintains that the purpose of a code for warriors is to restrain warriors for their own good as much as for the good of others, I would like to end by stating that moral professionalism not only guarantees moral responsible behaviour it can also safeguard the person in question from the detrimental effects of the moral and emotional impact of war. Moral professionalization thus seems an important goal for caring leaders.

Chapter III

A Social-Psychological Explanation of Misconduct During Deployment

Prof. dr. Ad Vogelaar[16]

Abstract

In many military missions, also during peacekeeping missions, aggressive instances of misconduct by soldiers against the local population have been reported. During military missions the line between functional and legal behaviour and dysfunctional and illegal behaviour is very thin, and the perpetrators of incidents of misconduct mostly are normal soldiers who have no violent disposition. In this paper it will be analysed, from a social-psychological perspective, why instances of aggressive misconduct occur by peace-enforcing or peacekeeping units. I try to explain how normal persons in a regular military organisation come to act in an intolerable way. At the end of the paper I describe some measures the military organisation or commanders may take, to prevent aggressive misconduct.

Introduction

In many military missions aggressive – sometimes even deadly - instances of misconduct by soldiers against the local population have been reported. During military missions the line between functional and legal behaviour, on the one hand, and dysfunctional and illegal behaviour, on the other, is very thin. Soldiers must make a clear distinction between the enemy and civilians who are supporting the enemy. They must try to eliminate the enemy without casualties among own troops and at the same time take care that civilians are spared as

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much as possible. Therefore, incidents may happen that will be qualified as misbehaviour or sometimes even crimes that are conducted by soldiers who are trying to stabilise the country. Incidents may vary from beating up local inhabitants, torturing suspects, killing innocent people, etc.

In many cases, the perpetrators of these incidents are normal soldiers who have no violent disposition. They have been well-trained and well-prepared for their mission and before the mission did not have the intention to commit aggressive misconduct. In many cases they did not even perceive their behaviour as inappropriate and sometimes they were even proud about what they did. In some cases they even took pictures, showing that they thought that their behaviour was somewhat exceptional, but not illegal.

Because these soldiers have a role as a neutral party or aid provider, it is for the public all the more disturbing when atrocities are committed by these soldiers. Therefore, aggressive incidents conducted by these soldiers cast a dark shadow on the otherwise good work that the soldiers are doing. Therefore, these incidents should be prevented as much as possible.

In this paper it will be analysed why instances of aggressive misconduct occur by peace-enforcing or peacekeeping units. The analysis will be conducted from a social-psychological perspective, i.e., explain how *normal* persons in a regular military organisation come to act in an intolerable way, sometimes without even being fully aware of the consequences of their behaviour. The main hypothesis is that frustration either or not in combination with negative emotions (of the perpetrators themselves or of their leaders) are the root cause of many incidents of aggressive misconduct that occur by soldiers of Western armies. The aggression can be facilitated by a number of factors, such as group dynamics, laissez-faire leadership, and a negative image of the population. In this paper the main hypothesis and the facilitators that contribute to the aggression will be unfolded and applied to five cases that will be introduced first. At the end of the paper, some measures are described which the military organisation or commanders may take to prevent aggressive misconduct.

Cases of misconduct

The cases that are analysed have in common that innocent people either have been killed or severely tortured or humiliated by soldiers of an occupying or stabilising force. In all cases soldiers should have been aware that what they did was wrong. Still, in some way or another, they have conducted the atrocities and in some cases they were been proud of what did. The cases differ by background, i.e., by kind of mission, decade, and country or region where the incidents took place. The specific incidents that are chosen have been studied and described by many sources.

Celebes, 1946
Dutch special forces got the assignment to 'clear' the South of Celebes from insurgents. The actions which lasted three months were led by Captain Westerling. More than 4000 inhabitants had been executed on the spot. A number of villages had been burnt down. After that, rest had been restored.[17]

My Lai, 1968
An American company killed hundreds of women, children, and people of age in the Vietnamese village of My Lai. During this operation that took four hours they did not receive any hostile fire. They did not only kill the civilians, but raped and mutilated a number of them.[18]

Somalia, 1993
Soldiers of the Canadian Airborne Regiment have killed the Somalian teenager Shidane Arone. He was captured when he entered the Canadian camp, trying to steal things. After he was beaten up for several hours in the middle of the camp, he died as a consequence of his wounds. There is no doubt that many soldiers have witnessed the maltreatment and that Canadian leadership also knew what had been going on.[19]

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[17] Terror on Celebes, Andere Tijden, VPRO Television, 11/18 January 2007.
[18] 4 Hours in My Lay, Yorkshire Television, 1988.
[19] Winslow, 1997.

Abu Ghraib, 2003

In the Abu Ghraib prison in Iraq, American soldiers have systematically humiliated and maltreated prisoners. They took pictures of these activities and they seemed to be proud of what they were doing. The purpose of these offences was to prepare the prisoners for interrogation by the military intelligence service. The prisoners were mostly persons who had been picked up at checkpoints or search operations. However, for most of these prisoners there was no evidence that they had committed crimes.[20]

Haditha, 2005

On 19 November 2005 at the village of Haditha an American Humvee was destroyed by an Improvised Explosive Device. In the attack the driver was killed and two marines were wounded. According to the American soldiers 15 Iraqi civilians were killed by the explosion and following that the convoy was attacked. The Americans returned fire and killed nine Iraqis. An independent investigation committee of the Americans reported that all 24 Iraqi victims had been killed by bullet wounds and that many of them had been found in nightclothes. A video that was made by a student showed bullet holes and blood stains inside the houses, and not outside the houses.[21]

These five cases will be elaborated in relation to the theory that is described below.

Frustration as an important cause of aggression

Aggression can be defined as the intentional injury of another[22]. In general, there are two types of aggression.[23] *Instrumental aggression* occurs when aggression is used as a means to an end. People see an opportunity for gain by being aggressive. Gang members may earn status from the violence they use, criminals may get money by threatening people, terrorists create fear by their attacks on innocent targets, etc. They may refrain from violence when the costs

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[20] The New Yorker, May 10th, 2004.
[21] Time Magazine, September 4th, 2006.
[22] Berkowitz, 1975, p. 215.
[23] Smith & Mackie, 1995.

are too high. The other type is *emotional aggression*. Unlike instrumental aggression, emotional aggression is not motivated by the calculus of gain and loss. The main motivator of emotional aggression is the sheer desire to hurt the other person. Emotional aggression can be caused by perceptions of provocation and aversive conditions, such as pain and heat.

One of the most studied aversive conditions in relation to aggression is frustration. Frustration is defined as "the blocking of an ongoing, goal-directed activity"[24]. An influential early theory of aggression, the frustration-aggression hypothesis, held that any frustration inevitably triggers aggression.[25] For instance, soldiers who expect to restore peace in an area, but who see the situation worsen despite their efforts, will feel that they lose control over the situation. The resulting frustration is driven by expectations that are not met. Although the original frustration-aggression hypothesis has been contested at several aspects – not all frustration leads to aggression and aggression can also be triggered by other factors than frustration - frustration is still an important factor causing aggression.[26] It is important to make a distinction between loss of control and lack of control. Loss of control leads to frustration whereas lack of control does not necessarily have to if soldiers are well-prepared for it.[27]

Frustration may lead to both emotional and instrumental aggression. Firstly, the frustration-aggression hypothesis suggests that frustrated people are inclined to behave aggressively to relieve some of their negative emotions. The negative emotion is directed first towards the people who cause the frustration. However, when the person or persons who are responsible for the frustrations are too strong or cannot be found, it is possible that the aggression will be directed at other persons who are in some way or another associated with the offenders.[28] These may be innocent passers-by. Secondly, frustration can also lead to instrumental aggression. Not reaching a goal by means of legal ways may force people to think about other, sometimes illegal ways that are more successful. E.g., getting information from a person by means of torture.

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[24] Berkowitz, 1986, p. 310.
[25] Dollard, Miller, Doob, Mowrer, & Sears, 1939.
[26] Berkowitz, 1986.
[27] Leman, 1998.
[28] Berkowitz, 1986.

In most of the incidents that have been described above, frustration played an important part. In Haditha, American soldiers lost one of their comrades by an Improvised Explosive Device that in their eyes must have been put there and exploded by one of the villagers. They wanted to punish the guilty. In My Lai, soldiers have been frustrated by the fact that, before they were ordered to enter My Lai, four of their fellow-soldiers had been killed by booby-traps and snipers and 38 of them had been wounded. They had not even seen the enemy. My Lai would be their first chance to fight the enemy. The Canadian soldiers in Somalia were frustrated by the fact that they, as elite-soldiers, were robbed by little boys. They felt helpless to stop them and saw only one way out: punish them.

The other two cases (Abu Ghraib and Celebes) can be seen as incidences of planned or instrumental aggression, but also as a consequence of frustration. In 2003 in Iraq the American army was frustrated by the fact that whereas they had just won the war, they could not end the insurgency. They had not expected that situation and desperately tried to find the insurgents. They caught a lot of people whom they thought were guilty or had information that could help them find the guilty. These people had to provide information. The guards in Abu Ghraib had to prepare the prisoners to give the information that the Americans wanted. Finally, in Celebes the insurgency could not be stopped and therefore it was decided that a unit of Special Forces under Westerling's command should end it.

The role of the leaders

Commanders have the task to control the behaviour of their soldiers. However, also leaders can be frustrated by the events in a certain mission. In some cases their frustration result in giving explicit or implicit orders to their soldiers to commit crimes.

Explicit orders
A leader giving direct orders to engage in misbehaviour is a very powerful factor, despite the fact that soldiers have learned they should not obey illegal orders. The problem is that soldiers are not alert that orders can be illegal.

Regarding the Canadian Battalion in Somalia, Green[29] described that some soldiers maltreated Somali children entering their camp because one of their superiors had ordered them to teach the next one a lesson. In My Lai the order was given that everyone in the village should be killed. The assumption was that the villagers would be at the market at that time and that the people in the village would be Vietcong. In Abu Ghraib personnel got the order to treat prisoners as dogs and to torture them in order to help the interrogators get their information more easily. It seems that in all these cases both the leaders as well as the perpetrators of the misconduct were not sensitive to the consequences of the orders.

Implicit orders

There is also another, more hidden, process by which commanders are responsible for the misconduct committed by their soldiers. They may give implicit orders in such a way that subordinates have the impression that their commanders would approve of abuse in reaching their goals. They think they are acting according to the commander's intent. E.g., when a commander communicates that he or she cannot afford prisoners of war because of the speed of the operation, the commander may discover afterwards that his or her soldiers have been killing prisoners of war. Or, when the Canadian commander said that he intends to be "the toughest warlord on the hill", this may have invoked soldiers to deal in a tough way with the frustration they encountered[30]. Captain Westerling got the "impossible" assignment to suppress the rebellion on Celebes within a few months.

Factors facilitating aggression

Research has shown that groups are generally more aggressive than individuals.[31] This difference between groups and individuals may be explained by the group dynamics that take place in groups. In the following subsections some of these group factors will be discussed as facilitators of aggression. Also, laissez-faire leadership and a negative image of the local population may

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[29] Green, 1997, p. 62.
[30] Winslow, 1997, p. 244.
[31] Rabbie, 1989.

facilitate the relation between frustration and aggression. In the following subsections these facilitating factors will be discussed.

It should be kept in mind that these factors have stronger effects when groups are relatively isolated, which may be the case with groups of soldiers during missions. This isolation makes it easier for group behaviour to deviate from societal or organisational norms.

Social definition of reality

Situations are multi-interpretable. It is often hard for people to determine exactly what is going on and, as a consequence, how to behave appropriately. Many social psychological studies have shown that people cope with this uncertainty by social comparison: they check if their initial reaction corresponds with the reactions of other persons, and consider that what they are doing is right when other people behave the same way. Or they rely on people surrounding them, who tell or show them how to behave. These people may be superiors, fellow soldiers, or local people whom they trust. This social definition of reality has an enormous impact on the behaviour of people in situations with which they have no experience at all. A soldier may learn from others that it is best to beat a local child when it becomes too pushy. Or he or she may be told that in this country people cannot be trusted and should be treated as such.

The soldiers of Charley-company were brought to My Lai in order to clear the village from Vietcong fighters. They had not expected any other people in the village, so their definition of the situation was that they should kill everyone in the village. When they finally found out that there was no Vietcong, but only women, children, and elderly people there was no mechanism to stop the killing. In Abu Ghraib the guards did not know how to treat the prisoners so that they would be more willing to talk. They got some hints from interrogation experts that it would be best to humiliate them by letting them be naked in the presence of others. In Somalia the soldiers must have wondered what to do with the children that tried to steal their things, until one of their leaders suggested them it would be acceptable to abuse them[32]. In Celebes, after some discussion, soldiers concluded that the executions were the only solution to the problem.

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[32] Shorey, 2000-2001.

Polarisation

Many studies of group decision-making have shown that "the average post-group response will tend to be more extreme in the same direction as the average of the pre-group responses"[33], i.e., that a group, for instance, takes riskier decisions or shows riskier behaviour than all of the composing individuals would have shown on their own. This happens only if the individuals are already somewhat inclined to take risks. However, if the group members are inclined towards cautious behaviour, then the group's decisions or behaviour will be even more cautious. This polarisation effect may account for the fact that groups change their behaviour gradually and many times even without noticing the change. In this way, they may "explore" and cross the boundaries of tolerable behaviour. For the group, however, this cross-border behaviour may become "normal" when they get used to it.

This polarisation may also account for aggressive tendencies in military groups. When many frustrations are experienced, it may be accepted that some aggressive behaviour is shown towards those people who are, in one way or the other, regarded as the cause of these frustrations. It may begin with some shouting and yelling at them, or some mild punishments such as a few slaps, and when that seems to be approved by everyone, some group members may experiment with heavier punishments. In this way it may gradually become normal that stealing locals are beaten up. The expression of aggression may become more and more severe, in some cases even leading to the death of some of the victims (e.g., in Somalia). As was subsequently said in defence of the offenders in Somalia: "Serious incidents did not come out of the blue, but were somehow provoked because of the permissive atmosphere"[34]. In Abu Ghraib, the guards experimented with all kinds of humiliations executed to the prisoners. In Celebes, soldiers reported afterwards that they got used to the executions[35]. All these examples can be seen as instances of polarisation.

Pressures towards conformity

Groups of soldiers isolated from the rest of their unit and working in an unfriendly environment may become highly cohesive. Members of cohesive

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[33] Myers & Lamm, 1976, p. 603.
[34] Winslow, 1997, p. 243.
[35] Terror on Celebes, Andere Tijden, 11/18 January 2007.

groups are usually inclined to believe that their shared perception is right. Furthermore, if they do have some doubts, they may be reluctant to voice them openly for fear of being disapproved of by the other group members. This can be seen as pressure towards conformity. Cohesive groups may also collectively block out criticisms from outside the group and develop feelings of invulnerability.[36] When they hear that outsiders criticise their – sometimes unacceptable - behaviour, they may dismiss these criticisms by saying that others do not know what it is like to operate under these circumstances and that these critics are not in a position to judge. It stands to reason that such rationalisations do not lead to self-corrective behaviour.

Pressure towards conformity is functional when it smoothens the functioning of the group in a difficult situation. As mentioned above, it may become dysfunctional when the necessary self-corrective actions do not take place. It may also keep serious misconduct from being reported. Serious incidents of misbehaviour often come out a long time afterwards, mostly as a result of a group member who feels regrets or someone who boasts about the group behaviour. What had happened in My Lai became known a year after the incidents had happened. It came forward by a person who had heard from it by a friend who had been in Vietnam. They were telling each other war stories. It took two months before the events in Haditha came out and the perpetrators were prosecuted. Also, what happened in Celebes had long been kept secret by the persons who committed the crimes. Van Doorn and Hendrix[37] described it as follows: "Every unit had its history. There were platoon secrets that were not meant for outsiders, not even to detached personnel. In the end, everyone had to cover himself. If something bad had happened, that something became a given. People did not want to discuss it with outsiders".

Deindividuation
Norm violations will easily lead to excesses when no one feels personally accountable for what happens in the group. Under some conditions group members may act as if they are submerged in the group and it may seem as if they have lost their capacity for self-regulation. All group members can be

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[36] Janis, 1989.
[37] Van Doorn & Hendrix, 1970, pp. 218-219.

committing acts that they would not have committed if they had felt personally responsible. Some factors have been singled out that stimulate the process of deindividuation.[38] Deindividuation occurs more frequently when group members feel anonymous, for instance when they are disguised, masked, or dressed in uniforms. Another aspect is the group members' feelings that the group is not responsible for the consequences of the group's actions. That is, the group members feel that it is somehow allowed to act in an illegal way.

Some soldiers in My Lai drove people together and put their weapons on automatic and mowed them down. They would not have done that, if they felt personally responsible. As has been stated before, the soldiers in Somalia worked in an atmosphere that seemed to allow violence against little thieves entering their camp. In Abu Ghraib guards did not feel personally responsible because they thought they were covered by the persons who gave them orders to treat the prisoners as dogs. The pictures showed that the guards thought it was good what they were doing.

Bystander-effect

When groups of soldiers are committing acts which are unacceptable, the problem then becomes who should intervene. Firstly, it is the commander's responsibility to intervene, but he or she may not always be around or, and that is even worse, he or she may be participating in what is taking place. Secondly, one of the group members could stop the behaviour, especially when that behaviour may have serious consequences, such as when the group is molesting someone. But, as will be clear from the aforementioned group dynamic factors, the stopping of this behaviour will be very difficult. One of the biggest problems is that all group members have come to consider the counter-normative behaviour as normal. They may think that this is the way to deal with the specific situation. They may interpret their behaviour as justified because most group members seem to agree. Another problem is that people are less likely to help when others are present. It is more probable that this person will withdraw from the situation. For instance, some of the members of the unit in My Lai simply stopped shooting when they saw that what they were doing was wrong. They certainly did not feel in a position to stop the killings. The beating of

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[38] Forsyth, 1983.

Shidane Arone in Somalia took a long time until he finally died. Many people must have heard what was happening, but no one intervened.[39]

Laissez-faire leadership

As has been stated before, leadership can be the cause of misconduct, either by means of explicit or implicit orders. Leadership can also facilitate misconduct, when leadership is absent where incidents lie in wait. Laissez-faire leadership means that a leader avoids to be involved in difficult matters that his or her personnel have to deal with. Research shows that laissez-faire leadership is very ineffective.[40] In Somalia gave orders to capture the infiltrators and suggested they should be taught a lesson. They should have kept an eye on what was actually happening as a consequence of this order. General Karpinsky, the commander of the personnel in Abu Ghraib did not know what happened in Abu Ghraib because she did not take the time to learn that. In Celebes some commanders higher up in the hierarchy should have followed what Captain Westerling was doing.

Negative image of the local population

Soldiers are sent to places where they have never been and to cultures that may be totally incomprehensible to them. Because of the differences between the soldiers' own culture and the culture of the local population, the soldiers have to find rules for making sense of the local people's behaviour as well as for managing their contacts with the population. Most of these rules will be based on stereotypes. Stereotypes have at least two problems. First, stereotyping means that people base their judgement of and their behaviour to other people (the outgroup) on only a few characteristics.[41] Therefore, stereotypes suggest that people who belong to a certain group are all the same. Second, stereotypes are mostly negative. This is because people have the need for a positive self-image. One gets a positive self-image when one perceives one's own group as better than other groups.

Research shows that aggression towards an outgroup is more probable when that outgroup seems to frustrate the ingroup's progress in a deliberate and

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[39] Shorey, 2000-2001.
[40] Bass, 1996.
[41] Van den Bos, 2008.

illegal way, when the ingroup understands little of the outgroup, and, finally, when the outgroup's image is negative.[42] In extreme cases, this negative image may be developed in such a way that people from the outgroup are dehumanised, i.e., "The idea that people are sometimes denied their proper humanness"[43]. In such a situation of cultural and moral superiority the ingroup feels an emotional distance that makes it easier to commit all kinds of misconduct towards representatives from that "inferior" outgroup.

In all of the cases that are analysed here, dehumanisation played a role. E.g., in the Abu Ghraib prison, dehumanisation took place as part of the humiliations that took place. By letting them make all kinds of figures with their naked bodies and take pictures of them, the prisoners were dehumanised.

Prevention of misconduct

All the causal and facilitating factors that were described before, played a role that was more or less clear in all the incidents that were described. In the following some measures to prevent the misconduct will be described. Both the organisation and the leaders can take measures to prevent misconduct and, when it has happened, react to it.

The organisation
Military organisations can take a number of preventive measures to inoculate soldiers against exhibiting misbehaviour in general and unacceptable aggressive behaviour in particular. One of the first measures to be taken to prevent aggression entails that the organisation formulates a policy that aggression towards the local population is unacceptable. This policy should then be communicated explicitly, in words and in deeds. A code of conduct can help in this respect. An additional measure is that the organisation should be able to detect incidents quickly and be prepared to take immediate action when necessary. When incidents are brought out in the open and it is clear that the perpetrators will be prosecuted, it may prevent others from committing these same acts. Soldiers and commanders should not have the idea they will get

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[42] Rabbie, 1989.
[43] Heslan, Loughnan, Reynolds, & Wilson, 2007.

away with misconduct. And there is also a public relations aspect to this: it is better to have a brief period of negative reporting by the press than to have the press constantly on the look-out for presumed cover-ups.

A second measure may be that soldiers and especially officers and NCOs are made aware of the creeping dynamics according to which moral principles may decay without notice. This may be accomplished by studying cases in which soldiers went too far and by pointing out the underlying processes. As has been shown with the presented cases, most of these incidents showed a combination of factors.

A third measure is that soldiers are realistically informed about the mission, the area of operations, the warring parties in that area, and about the culture of the local population. These briefings should have the ultimate goal that the soldiers have realistic expectations about what they can achieve and that they understand the local population. Ideally, they should understand the position and the needs of the local population in the conflict and have some sympathy for them.

Fourthly, soldiers should be trained to handle difficult situations professionally. They should be determined but not aggressive towards the local population. They should not bother them unnecessarily, even when the soldiers are provoked by them. The soldiers should be prepared to cope with these kinds of frustration and consider them as a kind of professional hazard.

The last measure, but most certainly not the least important one, is that the mandate, the means, the weapons, and the quality and quantity of military personnel are adequate to cope with the mission.

Leaders

Commanders should care to stay in close contact with their men. In stabilisation operations small groups of soldiers will be operating at a distance from their commanders. In such a situation, commanders who do not have good contact with their soldiers may hear nothing about what is really happening. The commanders should be committed with their soldiers when they are experiencing problems. They should also show a readiness to solve the problems with which the groups are confronted, e.g., thefts committed by the local population. Commanders who do not show up when their soldiers have a hard

time, or who seem not to be interested in their problems may hear nothing from them.

Secondly, commanders should identify and recognise symptoms of stress and frustration and take them seriously. Validation of negative emotions[44] is very important. Validation means that commanders show that they know what their soldiers experience or have experienced. Soldiers should be given some recuperation time when they have experienced too much stress and frustration. This may be a very effective way to prevent that people break down. To accomplish this, commanders should have an open communication line with chaplains or psychologists in their units.

Thirdly, commanders should realise that they have the duty to know what happens in their units.[45] When commanders suspect that something illegal actually happens or could take place in the unit, they have to investigate the situation. Commanders cannot defend themselves by saying that they did not have any clue about what was going to happen if they somehow could have known it. When commanders establish any signs of misconduct, they should intervene immediately and do not accept it (zero tolerance). If commanders do not intervene, soldiers may think that their behaviour has been accepted and even may have been approved. An intervention does not necessarily mean punishment. A minor norm violation can also be used as a case to be discussed within the unit in order to prevent more severe problems.

A final aspect is that commanders themselves behave irreproachably. Commanders at every hierarchical level are role models and should not give in to their norms and values. Commanders have to take care not to give orders that can be multi-interpretable and that can be explained as approval of violence.

Conclusion

It is often tempting to treat the perpetrators of incidents as "bad apples" in a good working system and blame them for what happened. This is called the

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[44] Kirkland, Halverson, & Bliese, 1996.
[45] Dixon, 1998.

"person approach"[46]. This approach suggests that the perpetrators have bad characters, are badly trained, or are badly motivated. According to this approach the incidents in e.g. My Lai could be ascribed to Lieutenant Calley and the killings in Haditha to a few derailed marines. It should be clear that this study had a different approach: a system approach. What happened in these cases could have happened in many places where the circumstances are frustrating, where leadership is suggesting to conduct misbehaviour, where group dynamics are supporting this tendency, and where the image of the local population is negative. Military organisations should focus on these circumstances.

It should be stressed that there are no easy measures which may prevent all problems. The solution should be sought in the implementation of a combination of measures.

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[46] E.g., Reason, 2000.

Chapter IV

How to find leaders that will be able to face and solve problematic decisions in an operational context?

An example of the use of requirement, assessment and selection programs in the Norwegian Special Forces.

Ole Boe, PhD[47]

Abstract

Norwegian Special Forces have to fulfill very challenging military tasks like surveillance in enemy territory and surviving in adverse environments for a long time, without any support. Selection and training of these forces has to meet high standard. Recruitment and assessment are critical functions, which have to be developed to state of the art insights in selection psychology. Based on a face value evaluation of standard Norwegian test practices it is recommended to include judgments of Special Forces officers with a lot of operational experience into the selection procedure of Norwegian Special Forces.

Introduction

The Special Forces team in the big MH-47D Chinook helicopter had prepared themselves well for the upcoming mission. The team's mission was to hunt down and kill members of the Taliban in a remote area of Afghanistan. The low level flight towards their destined drop-off point was far from easy for the team and their leader. The chopper bounced up and down, and from side to side in a continuous motion in order to avoid possible enemy attacks with rockets, machine guns and small arms. The loadmaster gave the first signal to drop-off, it was 10 minutes left. The team leader turned on his GPS and memorized the infiltration route one more time. The team then made the necessary last minutes

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checks. As the loadmaster gave the 1 minute to drop-off signal, the pilots decreased the speed of the helicopter. The team grabbed their backpacks in their carrying handles so that they were ready to start dragging them towards the ramp of the helicopter. When the Chinook was hovering over the drop-off point, the loadmaster got down on his knee, turned around and commanded "Go go go". The team dragged their heavy backpacks towards the ramp and got off the ramp. They threw themselves to the ground in an inferno off dust and small rocks that the choppers rotor blades had whipped up. The Chinook lifted off and then disappeared quickly in the darkness. The team got their weapons up and secured the 360 degrees around themselves. The silence they experienced was incredible. The team leader knew that they were on their own now, surrounded by enemies that wanted nothing else to capture, torture and kill them. The team leader focused on the job they had to do, and the team soon started moving. The hunt had begun.

Experiences like this places a heavy mental and physical burden on the personnel that serve in these areas of operations, and even more of those who have to lead others. They serve in one of the world's most extreme environments. Those who lead others during times of imminent physical dangers have been referred to as in extremis leaders.[48] Being able to lead is however not the only challenging task. It takes a special kind of people to cope with and to excel under the constant threat of death or the loss of a team member. Research has shown that Special Forces soldiers produce more of a small molecule in the blood known as neuropeptid Y. This molecule helps to calm down the brain in stressful situations. At present, one does not know whether this is genetic or something acquired to training.[49]

The Norwegian Special Forces, internationally known as NORSOF, consists of two units. One unit belongs to the Army and the other one to the Navy.[50]

    The Army unit FSK/HJK has seen active duty since its conception in 1962.[51] The Navy unit is the equivalent to Navy Seals and is known as MJK. FSK/HJKs

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[48] Kolditz, 2007.
[49] Nilsen & Løset, 2008.
[50] NORSOF is an abbreviation for Norwegian Special Operation Forces.

and MJKs roles are related to Special Reconnaissance (SR), Direct Action (DA), Military Assistance (MA). In addition, FSK/HJK also conducts Combat Search and Rescue (CSAR) operations. The size of both units is classified. During the cold war the HJK as it was known then was traditionally placed on alert in order to solve missions deep into Soviet-union territory in case of an invasion[52]. Both units have been engaged in the Bosnian war and in the Kosovo war. During 2001 and 2002 the units took part in Operation Enduring Freedom (OEF), Task Force K-Bar and Operation Anaconda in Afghanistan. Operators from the NORSOF have been decorated with United States Navy Presidential Unit Citation for their contributions in Afghanistan from December 2001 to April 2002[53].

Recruitment

Where do we find these people? Usually they are young men. In NORSOF they are still all men do to the demanding physical requirements during selection the process. A second question is; are they outstanding in some respects before they are admitted into the unit or do they become transformed into outstanding persons during their time in the unit?[54] Training soldiers to cope with the extra load and weight has been shown to be a decisive factor for success in operations in Afghanistan[55]. What kind of person is able to cope with this type of training?

The NORSOF operators come from all classes of the society. A majority comes from working – or middleclass family background, but some tend to come from upper class family backgrounds[56].

The road to becoming a NORSOF operator is often a long one. For many it starts at the age of 17 when they receive a letter from the Norwegian National Service Administration. In the letter they are requested to fill out a personal statement of health. The Norwegian Government has just decided that all young women also are liable for military service, so at present both the young men and women who receive the letter are requested by law to answer it before a specific

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[51] From 1962 until 1972 HJK is was known as HFJS, and from 1971 until 1997 it was known as HJS. Its current name FSK/HJK was given to the unit in 1997.
[52] Lysgård, 2005.
[53] Web1, 2009.
[54] Women are allowed to apply for selection to the two SF units, but as to the present date no women has managed to get through the selection process.
[55] Knapik, 2004.
[56] Bakkeli, 2007.

deadline. The next step is known as the examination of men and women liable for military service. The Norwegian National Service Administration decides who will be called to this second part of the process. The decision will be based upon the personal statement of health provided earlier by the young men and women over the Internet. Those who are found qualified are called to a liable for military service centre close to where they live. There they go through a series of physical and mental tests. However, serving in the military is still voluntary for young women. Based upon the results from the different psychological and physical test, results from an interview, and the requests from the individual, The Norwegian National Service Administration then tries to match each individual's and the Armed Forces needs. Applying to the Special Forces is popular. The FSK/HJK has put out information on the Army's website in addition to having brochures. There they specify the minimum requirements that a potential candidate must be able to perform. These requirements are within reach of almost everyone, but they are only minimum requirements. Showing up on selection being able to perform only the minimum requirements is a definite and well-known road to failure. The drop out rate may be as high as 90 %, and there are not many that make it through the selection period and then continue on to become a SF operator. The basic education as a SF operator includes a broad tactical education, in addition to a basic officer course that qualifies the individual to operational service in one of the units. This basic education open up for further education up to a Masters level in special operations (Norwegian Armed Forces, 2009).

Because of the transformation of the Norwegian Armed Forces from a typical large invasion defense force to a small and professional expeditionary force, the basis for recruitment has been cut a lot. During the cold war, Norway could mobilize up to 300 000 men with weapons if being attacked by an enemy. In 2009 about 5000 men (and some women) completed their basic military training in the Army.[57] This reduction in size has large consequences for the recruitment to the SF units, as less and less conscripts complete their basic military training every year. Applicants to FSK/HJK may come from all different units of the Norwegian Armed Forces, but a lot of the candidates to FSK/HJK usually come from the personnel who serve as airborne rangers for one year during their

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[57] The Norwegian Army currently consists of about 8400 people, including conscripts.

compulsory military service. FSK/HJK has had a basic training school for individuals that apply to become airborne rangers since 2000. However, only between 4-5 % make it through the selection period to become an airborne ranger in the first place[58]. This means that there are not many possible candidates left to go on to apply for SF education. However, those who are left after a year as airborne rangers usually are very good candidates for entering SF education.

So, what do FSK/HJK look for in prospective candidates? Different personalities will fit into the unit. Candidates may differ as to whether they are extremely structured and likes to plan everything, or whether they prefer to wait until the last moment with everything. The FSK/HJK looks for a special type of people. They want people who like to push their own limits, but at the same time know how to follow rules and regulations. A successful candidate will be a person who can think and operate on his own, but at the same time he has the willingness to obey an order and to commit themselves to the team. A successful candidate will have to learn fast, and be a "doer". This means that a successful candidate has to take what he has learned and quickly put it into action.

What do MJK look for in a prospective candidate? The ideal candidate for SF training with the MJK is an individual that has above average emotional control and a high tolerance for stress. In addition, he has a solid reality testing, he manages stress and ambiguity successfully, he has stamina, and he is able to cope well with people. He also demonstrates a goal-directed behavior which is based upon making detached and realistic judgments and a coherent cognition. This means that general intelligence, an accurate reality testing, psychomotor skills, and personality resources of a superior quality are required in order to become an SF operator in the MJK[59].

Assessment

The most important skills for a Norwegian SF operator are flexibility and a good basic education as a soldier. When the basic education is completed, the

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[58] Nilsen & Løset, 2008.
[59] Kristensen & Sunde, 1998.

operator simply needs only small adjustments in order to change focus from winter warfare in Norway to operations in Afghanistan or other places in the world. Common knowledge is another important factor that must be taken into consideration. Understanding other people's culture, how they live, and their norms can contribute to staying calm in an escalating and otherwise threatening situation. If one adds occupational proficiency, language skills, and the will to improvise, one may start understanding some of the most important factors that contribute to the success of the NORSOF operators in Afghanistan. Most of these skills are developed over the years. A result of this is the fact that the average age of NORSOF operators participating in OEF was much higher than the average age of other Norwegian conventional forces participating in Afghanistan[60].

Trust and integrity are also very important aspects for any SF operator. From the beginning the NORSOF operators are taught to work in pairs. Being able to trust the other person is extremely vital. The operators may go to the commander and say that they can't work with so and so. This means that there exists an extreme form of self justice in the unit. It might seem brutal but it has to be like this. When your life is on the line in some ugly corner of the world, the last thing you want is to be doubtful of your partner or one of the other team members. Trust also reveals itself in the fact that there is a very high degree of openness among team members. After conducting missions, being present at debrief is mandatory for the operators, as well as talking to the unit's psychologist[61].

At present, there is a discussion in the Norwegian Armed Forces as to whether a soldier or a SF operator should need to carry a lot and to able to conduct long marches. The argument against this is that we are now more mechanized than before and therefore the ability to conduct long marches and carrying heavy backpacks and equipment is an outdated skill. The argument for that they still need to be able to do this is that the environment in for instance Afghanistan is extremely demanding. For instance, Danish SF operators have been known to use intravenous extra fluids in order to cope with the extreme physical fatigue that comes from hard infiltration done at high altitudes in the

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[60] Lysgård, 2005.
[61] Lysgård, 2005.

mountains of Afghanistan[62]. So, marching and carrying heavy loads are still vital skills for an SF operator. NORSOF operators will sometimes have to carry up to twice their weight during operations. In addition, the temperature changes are extreme in Afghanistan, and both humidity and temperature may change quickly depending upon terrain and time of day or night[63].

Selection

NORSOF operators are specially chosen, selected personnel, trained to the highest level in all disciplines of soldiering. Selection is an extensive process, based upon the experiences, practices, and knowledge that NORSOF operators, officers and psychologists have built up during the years. It has been stated from the Norwegian SF community: We look for people that view difficult things as okay and the impossible as a challenge[64].

Previous research on paratrooper aspirants[65] and on military divers[66] has revealed that these individuals are very gifted people. Research on people working in high latitudes[67] and on bomb disposal experts[68] reveals the same pattern. So there is something special about these people. But what is? Their giftedness stems part from that they all tend to good cognitive abilities and personality traits. But what does it mean to have good cognitive abilities and personality traits?

A SF operator needs to be an individualist and a good team player at the same time. During selection one aim is to expose fully a candidates own limitations and to get the candidate to acquire a realistic self image regarding what he is capable of achieving. An important aspect during the selection process is that as a candidate you will not know what the next day will bring. This is a way of making sure that one selects individuals that show the ability to cope with the unknown and uncertainty during a long period of time. Having the

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[62] Rathsack, 2009.
[63] Bakkeli, 2007.
[64] Bakkeli, 2007.
[65] Baade, Ellertsen, Johnson, & Ursin, 1978.
[66] Biersner & Larocco, 1983.
[67] Steel, Suedfeld, Peri, & Palinkas, 1997.
[68] Cooper, 1982.

belief that you will succeed is decisive for accomplishing the mission[69]. So therefore, believing in yourself that you will be able to solve what is in front of you is a strong advantage when applying to a SF unit.

Selection involves completing long marches and carrying a heavy backpack. The Danish have experienced a high percentage of knee and back injuries among their soldiers over time in Afghanistan, so testing future SF operator on their capacity for marching and carrying heavy loads for some time is a good starting point[70].

During the many years of selection to the NORSOF it has been revealed that the pest predictor of which candidate that will make it through the selection is giving a potential candidate physical loads over time. Few psychological tests will be able to predict with the same degree of certainty which individual will make it through selection or not.

Psychological test are rather used as a supplement to the long and often costly selection process. FSK/HJK is modeled after the British SAS. Like SAS most of the selection process in FSK/HJK is done by experienced SF officers that knows what they are looking for[71]. The psychological tests are then more used to weed out those who should not be in the Special Forces even though they have made it through the physical tests. Psychological test are also used in order to sort out those who might be in a danger zone for getting delayed psychological injuries from serving in the unit.

FSK/HJK does only accept applicants that have been in the military for at least one year. In addition, they demand the potential candidates should have soldiering basic skills. The reason for this is that a candidate will have to learn a lot during the first year. The main reason for this is that a successful candidate will enter as a part of an operative squadron after his training period. So in this sense it is important for a candidate to already from the start to have good basic military skills, in order to cope with the upcoming training period.

The main criteria in order to be taken into consideration as a possible candidate are will power and attitudes. Having what is known as a healthy

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[69] Siddle, 1995.
[70] Sørensen, 2009.
[71] Reichelt, 2009.

"Norwegian horse sense" is a highly priced commodity in a candidate.[72] In a normal society it will not be more than about 2% that will be able to cope with all the different requirements.

The selection of personnel selection to MJK is conducted in several stages. Applicants can be conscripts, officer cadets, or officers in the Norwegian Armed Forces. They have to fulfil the standard military criteria for physical health, technical knowledge, and general intelligence before they are allowed to take part in the first step of the selection process.

These individuals are normally then subjected to a general medical examination, various cognitive and ability tests, and given an individual interview. The interview is conducted by a board of officers in charge of MJK training together with psychologists from the psychological services of the Norwegian Armed Forces. At this point, no personality tests are normally included in the test battery. Approximately 30% of the candidates will pass this stage and they are then sent on to a rigorous training program. This training program is continuation of the selection process and in accordance with NATO standards[73]. It lasts for 4 weeks, and surprisingly few candidates are ordered to leave because of lack of fitness, although many of the candidates voluntarily decide to quit the program. This indicates that the selection of candidates is typically based upon a combination of several factors. These include self-selection, physical examination, results on ability tests, individual interviews, stamina, and impressions formed during the training. Only about 10% of the candidates tested during the selection period are eventually admitted as MJK aspirants and is allowed to continue to become SF operators[74].

The test battery included in the selection procedure to MJK consists of seven tests. These are Raven's Advanced Progressive Matrices[75], the vocabulary subscale of Wechsler Adult Intelligence Scale[76], Mechanical Principles, Reversal Test, Block Counting, Time Estimation, and Numbers. Six of these tests have been developed by Norwegian Armed Forces psychologists and are included in a

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[72] Basically this means that a person has a realistic perspective on life, and a healthy approach to challenges.
[73] McDonald, Northon, & Hodgdon, 1990; Rahe, McHugh, Kaplan, Rimon, & Arthur, 1972.
[74] Hartmann, Sunde, Kristensen, & Martinussen, 2003.
[75] Raven, 1986: Raven, Court, & Raven, 1992.
[76] Engvik, Hjerkinn, & Seim, 1978.

more comprehensive test battery used for pilot selection[77]. In 2000 the test battery was then supplemented with two personality tests, a Norwegian version of the Big Five[78] and the Rorschach Inkblot Method[79]. The Rorschach test was the only test that could predict whether a candidate would pass or fail during selection. At the same time it was decided that the Rorschach was a too time-consuming method, and therefore it was suggested that it would be better to give it only to those who pass selection[80].

So it seems that using psychological tests may not be the answer. This is in line with Reichelts comments that experienced SF officers know what they are looking for in a candidate. Therefore additional psychological tests may not add much to the selection process in the SF units. A solution could simply be to rely on the psychological and physical tests that all potential soldiers are given when they show up at the Norwegian National Service Administration.

Conclusion

Norwegian Special Forces as well as other Special Forces around the world face dangerous and unknown situations. Both leaders and their teams will have to cope with a lot of uncertainty and they have to be able to make quick and correct decisions. Members of these units are normally above average intelligent, and they have the will power to continue the extra mile. The recruitment process is critical; otherwise one may simply experience a lack of candidates applying to the special units. Therefore a formal recruitment system is required. This should be made available for all people in and out of the respective organization in order to give as many as possible the opportunity to apply. Whether potential candidates make it or not, is another matter. A rigorous recruitment program including internet and promotional videos will do the trick. Using experienced officers during selection or mentors during the assessment period will be extremely helpful.

Putting the candidates through one or several well prepared interviews will reveal a lot about a potential candidate. Trying to find the inner motivation for

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[77] Martinussen & Torjussen, 1998.
[78] Engvik, 1997; Engvik, Hjerkinn, & Torjussen, 1994.
[79] Exner, 1993; Rorschach, 1942.
[80] Hartmann, Sunde, Kristensen, & Martinussen, 2003.

joining is important. Selecting people with a strong inner motivation and drive is important as long as this inner motivation is combined with correct attitudes. Successful candidates will also reveal the ability to learn fast and to put this fast into action when needed.

Several tests should be conducted in order to find out whether a candidate can withstand both physical and mental stress. The traits that one would look for are intelligence, commitment, and character, together high a high level of stress tolerance. Testing people on how well they will function under physical stress will definitely reveal a lot about their personality and will power, as well as how they mange to cooperate with others in stressful situations. A candidate's ability to bounce back and to accept the situation needs to be tested. Peer evaluations are critical and will function as an honest feedback to a potential candidate. Looking for candidates that are truthful and have integrity are important points in an assessment process. Using psychological tests from entering the Norwegian military system may provide enough information about a later potential SF candidate. These tests can then be supplemented with more psychological tests after a potential SF candidate has made it through the selection process. Still, little seems to beat the knowledge of experienced SF officers when predicting which candidates will fail or pass the selection process. Psychological tests may add to the overall picture of a candidate but at present they simply are not good enough to predict the outcome of a candidate during selection. The exception was found to be the Rorschach test[81].

Finally, an important aspect of the recruitment, assessment, and selection process is that developing individuals that will fit into SF units takes time. In addition, they cannot be mass produced, their quality is more important than their quantity, and the individual person is more important than hardware.

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[81] Hartmann, Sunde, Kristensen, & Martinussen, 2003.

Chapter V

To Screen or Not to Screen: That is the Question

Prof. Dr. Sidney H. Irvine, FBPsS[82]

Abstract

The aims were to study the need and adequacy of psychological and psychiatric screening procedures for NATO personnel prior to and on return from deployment in war theatres. Methods included a brief review of published sources showing the extent and nature of disagreements. Results show what field commanders can be rely upon to assist decisions about potential dysfunction on recruitment, deployment abroad and at home on return. In conclusion, some potential tools are reviewed, illustrated and evaluated.

Introduction

Screening is itself an important issue in medicine. A useful summary of the criteria to be satisfied when screens are introduced is to be found in www.scotland.gov.uk/Topics/Health/health/screening/criteria.

The necessary safeguards for defining and using the condition itself, the tests and subsequent treatment are well understood and have been established for almost half a century[83]. Given these criteria, how well do present attempts to screen for temperaments that are unsuitable for military service bear scrutiny?

Screening has been attempted and/or proposed at here three critical career thresholds for military personnel:

- Recruitment,

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[83] Wilson & Jungner, 1968.

- Deployment on active service,
- Repatriation from deployment.

The crossing of each one of those thresholds requires a lifestyle modification. During the time spent in any one of the three career phases, different demands are made on physical and mental health: and with these demands, there are changes in health-related quality of life.

Moreover, there are casualties at every stage; attrition during recruitment training; deaths and wounds on deployment; post-traumatic disorders, alcoholism and domestic violence on repatriation. What might be done to ensure that the correct decisions are made by commanders about what is best for personnel at their disposal is by no means certain. But decisions are more likely to have positive outcomes if fully informed. This is an attempt to show what information could be used in the national interest.

Recruitment Screening

Invariably, recruits are required to complete a number of cognitive tests of training capability. Medical examinations are routinely carried out. Searches for antisocial behavior and criminal records may be undertaken during security checks. The degree and extensiveness of the system is a matter for each nation to decide. Seldom, however, does screening extend to determining emotional stability and temperamental suitability[84] for military employment.

The Costs of Recruit Attrition

How efficient have conventional practices of recruit screening been without assessing temperamental suitability? Perhaps the only measure that commanders might point to as significant for them is an index of attrition during and immediately following basic training where a period of grace is afforded the applicant. The loss of potential service personnel is a perennial complaint.

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[84] Deu, Srinivasan, & Srinivasan, 2004.

The failure of many countries with volunteer services to reduce wastage from attestation to the end of recruit training, believed in the United Kingdom to approach 40%, is not due to any one cause. Overall, the British Army is reported to be short of 4,000 soldiers; but it is the infantry, which should be composed of 25,000 soldiers, where the crisis is hitting hardest. Almost every one of the infantry 36 battalions is under strength. To maintain the infantry - who have been most involved since the invasion of Iraq in 2003, and who are deployed in southern Afghanistan, at least 5,000 new men a year, are needed. Recruiting agencies have not been able to meet the demands of field commanders. The problems of supply and demand have been further exacerbated by the fact that of the 98,000 soldiers in the Army, 7,000 are unfit for duty[85].

Official details on attrition during recruitment among soldiers most likely to be deployed, are available, nevertheless. The following table[86] sets out the numbers of infantry recruits who commenced their basic training at the United Kingdom Infantry Training Centre at Catterick (ITC(C)) and who failed to complete their training.

Table 1

Infantry Attrition During Recruitment.

		Number of recruits who fail to complete their training (as a percentage of those starting)	
Financial year	Number of recruits commencing their training at ITC (C)	Number	Percentage
2009-10	2,969	910	30.7
2008-09	3,828	1,141	29.8
2007-08	3,458	1,180	34.1
2006-07	3,398	1,037	30.5
2005-06	2,517	892	35.4
2004-05	2,420	837	34.6
Totals	**18,590**	**5997**	**32.3**

Note: Figures for 2009-10 are as at 20 November 2009.

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[85] Figures quoted in this paragraph from an article in The Daily Telegraph 24 February 2008.
[86] Table 1, official figures supplied by a UK government minister in response to a question in the United Kingdom parliament.

One third of all those assessed by BARB *(The British Army Recruit Battery)* of cognitive tests[87] and completing other medical and security checks fail to complete the initial training course. The UK Army website estimates the overall average cost of recruiting and training is £19,000 per person. From this, the total cost of infantry training attrition alone from 2004 to 2009 can be estimated at £113.9 million. The loss in other branches can be no less and is probably much greater. The financial costs are great, but the implications for commanders are, or ought to be, serious enough to raise questions if not of training competence, then of selection efficacy.

If further proof of the almost universal attrition rate during recruitment were required, there are similar outcomes reported in the United States Congress. Gebicke (1997) in published testimony to a United States Congressional Sub-Committee gives a detailed accounting of the high costs of attrition. The drop-out rates of US military recruits during basic training for 2002 showed the Army and Navy lost 14% of recruits, the Marine Corps 12% and the Air Force 7%. In every situation, recruits drop out for physical reasons, including injuries: but many have previously undisclosed physical or mental ailments, as well as performance-related difficulties. In the USA, where figures are available, the cost of recruiting new service members exceeds $10,000 per person, while the cost of initial entry training is $35,000 on average. These costs are similar to those quoted for the UK.

Gebicke (1997) begins with a summary statement outlining the reasons for failure to survive basic training losses.

> "The main reasons for the high attrition rate during the first 6 months are that (1) the services' screening of applicants for disqualifying medical conditions or pre-service drug use is inadequate and (2) recruits fail to perform adequately because they are in poor physical condition for basic training or lack motivation. Although the services are greatly concerned about attrition, their goals for reducing attrition are based on inconsistent, incomplete data and are unrealistic."

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[87] Irvine, Dann, & Anderson, 1990.

He concludes his statement with this verdict:

"Currently, DOD[88] defines a "quality" recruit as one who has a high school degree and has scored in the upper mental categories on the Armed Forces Qualification Test. Despite historically meeting DOD's benchmarks for quality, all of the services continue to experience early attrition, thus suggesting that certain elements that make a quality recruit are not captured in the current standards."

Basic Training Index Needed

Websites offering advice[89] to recruits prior to induction provide a key to understanding why so much importance is attached to behaving in new and perhaps unaccustomed styles. The prescriptions for appropriate behaviour during training are undoubtedly accurate: and they are (Chart 1) overwhelmingly *procedural.* They prescribe know-how and are very limited in recounting facts to be remembered.

Chart 1

Know-How, Facts and Physical Tasks Before Basic Training.

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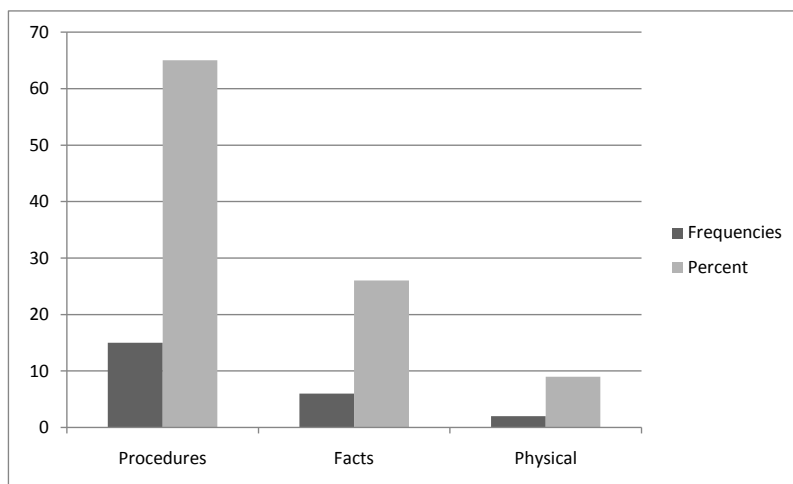
[88] Department of Defense.
[89] See Annex: A for a list from a website in the United States.

Ability Necessary But Not Sufficient

On further scrutiny, the advice given on websites to recruits shows an overwhelming emphasis on *self-esteem preservation procedures* to be followed. Knowledge acquired in high school is deemed largely irrelevant in initial training because of the following fundamental elements of recruit training cultures.

- Basic training constitutes a unique and universal military acculturation experience, closed to outsiders.
- Basic training is a rite of initiation conferring status in a 24/7 command environment.
- Achieved and ascribed group status both determine levels of self-esteem in recruits.
- Personal self-esteem is a critical determinant of individual training survival.
- Self-esteem can be assessed using direct and opaque psychometric methods.

Self esteem arising from group status in basic training is a powerful intervening variable in recruit retention. Without self esteem derived from accomplishments during training, life becomes progressively harder for recruits everywhere. For more than 50 years, it has been well known that in social contexts of 24/7 training with no counter-control on the behaviour of instructors, many recruits are destabilized when unable to cope with adverse physical and degrading social experiences[90]. Finally, performance models in military contexts are not one-dimensional[91], nor are they justified by the academic prerequisites required of recruits[92]. Key historical and current resources underpin this conclusion[93].

If one were a training battalion commander, what knowledge of recruits most likely to be at risk from loss of self-esteem would be of most worth? Clearly, complete breakdown would manifest itself and the recruit would leave. However, encouragement for those with acquired self-doubt and loss of esteem would be beneficial in reducing attrition.

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[90] Schneider, 1947.
[91] Campbell, McCloy, Oppler, & Sager, 1992.
[92] Trent & Laurence, 1993.
[93] Merton, 1940; Schneider, 1947; Vernon & Parry, 1949; Trent & Laurence, 1993; Irvine, 1995; Irvine, Kyllonen, & Roberts, 2000.

The Missing Link: Recruit Mental Health

What evidence is there that attrition is a function of inappropriate personal profiles and military temperament deficits not covered by cognitive benchmarks?

First, a comprehensive 254 page American report[94] states that the lifetime prevalence of mental disorders among US Service personnel is projected at 37.5 percent for any disorder, *the most notable being anxiety, antisocial and depressive conditions*. In coming to terms with this reality, the committee's recommendations leave no doubt about the proven research use of, and hence the need for, a comprehensive medical history itemising mental illness occurrences and symptoms during adolescence. In their judgement, this examination should be supplemented by *"a short set of questions regarding current symptoms and a brief standardised mental status examination that addresses mood, anxiety, psychotic symptoms, and suicide"[95]*.

Underutilised Psychometric Evidence

There are several published psychological sources providing detailed empirical findings that identify non-cognitive positive and negative psychological factors for those who wish to work in military organisations. A benchmark UK report[96] was able to reveal validity and 90 percent accuracy when vocational interest and personality measures in the job classification of United Kingdom Royal Navy personnel were added to standard cognitive measures. This has provided a protocol for work in Britain and elsewhere.

An important review of empirical studies of structural, environmental and personal factors influencing military turnover can be seen in Sümer (2004). For specific conclusions, the following sources are indicated.

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[94] Sackett & Mavor, 2006: Assessing Fitness for Military Enlistment: Physical, Medical, and Mental Health Standards (2006). Board on Behavioral, Cognitive, and Sensory Sciences and Education, National Academies Press.
[95] loc.cit p.190.
[96] Beard & Collis, 1991.

Talcott, Haddock, Klesges, Lando, & Fiedler (1999) found that of the four most common reasons for failure to complete training a critical risk factor was *instability*. Other well-identified personal dispositions portending early attrition included *a lack of maturity and motivation*[97], *emotional instability*[98], *overdependence*[99], and, most frequent of all, *depression*[100]. Positive training outcomes were marked by *optimism*[101], and *self-confidence*[102]. Additionally, there have been studies of self-reports compared with peer evaluations[103].

Among the most authoritative and technically complete publications, however, is Holden's study of the effectiveness of a short personality inventory in predicting attrition in the Canadian forces[104]. Using a sample of 423 non-commissioned recruits in a 10-week Canadian Forces basic military training course, Holden reports that *recruits differed significantly from civilians in terms of psychological adjustment.* Recruits who failed to complete training were more similar to civilians than those who were successful; and *the inventory Depression scale significantly predicted recruit training course release.*

Equally notable among recently completed studies is the work of Cigrang, Carbone, Todd, & Fiedler (1999) on mental health attrition from Air Force basic military training. Recruits recommended for discharge often had a history of depression*, expressed a lack of motivation to continue in the military*, were reporting suicidal ideation, and typically had withheld information on their mental health history during their Military Entrance Processing Station interviews[105]. For research into adaptation to life in the USAF, the recent study by Baumgarten (2004) on job characteristics and mental health is important.

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[97] Jensen, 1961.
[98] Plag, 1962.
[99] Quick, Joplin, Nelson, Mangelsdorff, & Fiedler, 1996.
[100] Carbone, Cigrang, Todd, & Fiedler, 1999; Cigrang, Carbone, Todd, & Fiedler, 1998; Lubin, Fiedler, & Whitlock, 1996, 1999.
[101] Carbone, Cigrang, Todd, & Fiedler, 1999.
[102] Turner, Dixon, Caulfield, & Wolfe, 1999.
[103] Fiedler, Oltmanns, & Turkheimer, 2004.
[104] Holden & Scholtz, 2002; Magruder et al., 2002.
[105] This enquiry is reported in Sackett and Mavor (2006) as being a single question about having a history of mental illness; and they recommend a comprehensive questionnaire (p.190).

Complementary mental health studies are evident in Hoge, Lesiger et al., (2002, 2005); Creamer, Carboon, et al. (2003); Barrett, Boehmer et al. (2005). These severally address the aetiology of psychiatric disorder in military contexts and include attention to measures of health-related quality of life [HRQOL][106] with recommendations that HRQOL surveys should be periodic for military personnel. Finally, for those who may entertain doubts about the need to assess the veracity of military self-report data, close attention should be given to Irvine, (2006), Kyllonen (2006) and Roberts, Schulze and Kyllonen, (2006).

In short, there is a comprehensive body of evidence for using personality test results as part of the medical history of recruits to all military branches. Rarely, if ever, do reviews in medical journals make reference to these. In compiling a recruit dossier, what can commanders use from non-medical sources?

Wellbeing Checklists

One would need to be able to review and understand the results of screening on attestation. However, during training, a recruit wellbeing checklist introduced periodically could prove to be of some considerable use, *provided a climate of trust and concern were assured prior to its use.* For a full description of origins and extensive validation among USAF recruits consult Irvine (2004a). By isolating items that loaded on all three factors of the *Armed Services HRQOL Inventory*, a short, reliable and valid *Basic Training Coping Skills Scale* was produced. This is included as Table 2.

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[106] Voelker et al., 2002; Booth-Kewley et al., 2003.

Table 2

Short Recruit General Coping Skills Scale.[107]

        Felt confident, sure of yourself?
        Been accepted by others in the flight/platoon/section?
        Increased your self-respect?
        Remained in good spirits (active, outgoing, upbeat)?
        Physically felt strong?
        Coped with new people easily?
        Felt happy?
        Done parade ground drills correctly?
        Coped with service demands?
        Been able to keep pace with the workload?

Mean 47.2
N= 1512.0
Std. Dev. 7.0
Cronbachs Alpha .803

This scale, standardized on 1500 recruits, has good reliability, and a usable range of scores. It has shown strong valid relationships with personality measures of degrees of nervous disposition, low coping scores being accompanied by (a) nervous disposition, and (b) with limited military vocational interest.

In addition, a short HRQOL Risk Inventory was found to correlate well with nervousness and anxiety among recruits and also with a desire to leave the service.

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[107] The scale is a Likert self-report scored scale using the quantifiers Always, Usually, Often, Sometimes, Rarely, Never, scored 6, 5, 4, 3, 2, 1 respectively. It could be adapted for interviewers quite simply.

Table 3

22 Item QOL "At Risk" Scale.

Worried about things that might happen?
Felt tense?
Worried about your ability to succeed?
Had panicky feelings?
Worried more than most people?
Felt confident sure of yourself[7]
Worried about personal finances?

Been unable to think straight?
Not been able to remember things?

Felt discouraged or downhearted?
Taken less interest in people and events than before?

Had difficult day-to-day relationships in the flight?
Felt threatened (picked on) by people in the flight?
Been made fun of by people in the flight?
Lost your temper?

Coped with Service demands[108]
Complained to your family about what was happening to you?
Had to take a make-up test or assignment?
Found the noise in the dorm hard to put up with?
Wanted privacy, but couldn't have any?
Had problems walking 300 yards quickly?

Wanted to quit because life was not what you expected?

Before and After Deployment: Evaluating The Wessely Doctrine

While the material on recruitment screening is cogent and relatively straightforward, the literature on the effects of deployment on mental health is vast and complex. Green et al. (2008) and Fear et al. (2010) each list more than 50 sources in recent reviews of the effects on health of deployment. Whereas there can be little doubt about the *effects* of deployment on individuals, family and medical services, considerable confusion exists about the *identification of pre-deployment risk factors*.

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[108] Scored Negatively.

Perhaps the essentials of *the current climate of doing nothing* to assess temperamental suitability of personnel for warfare in countries where the indigenous population offers little or no support to those deployed, is contained in the Liddell-Hart Lecture of 2004 (Wessely, 2004)

In summary form, the Wessely doctrine is simple.

- Once a psychiatric disorder is found, by all means treat it.
- But neither screening beforehand nor debriefing on return can be justified, because there is no evidence that there are predispositions to breakdown.
- There are only a number of known risk factors whose prevalence might emerge only after a non-estimable period of time has elapsed.
- Additionally, all interventions before actual proof of disorder are likely to produce a climate of uncertainty and fear of risk itself, which is unpatriotic.

Oft-quoted historical overviews and anecdotes of past failures to identify psychological risk factors[109] follow this doctrine. They have produced a climate of *ad hominem* argument against the use of motivational profiles as a template for exclusion. The conclusion from these sources is all-embracing and simple. Psychological risk factors are not proven, nor are they readily diagnosable from self-report data. Hence, the use of psychological profiles to exclude those who are likely to be seriously at risk by the emotional, and for many, traumatic, demands of initial deployment and subsequent service, denies the birthright of every citizen to serve one's country for no credible scientific reason.

A Question of Doubt

However, there are many who would point to good reasons for doubting the all-embracing nature of these opinions. One may be forgiven, but there is no official guarantee, for harbouring doubts about any review that appears to omit much that is relevant. An analysis of the references in the keystone Jones, Hyams and Wessely (2000) publication about the history of screening military personnel reveals that 84 percent of the references were published before 1990*; and not*

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[109] Jones, Hyams, & Wessely, 2003; French, Rona, Jones, & Wessely, 2004; Rona, Hooper, Jones, French, & Wessely 2004; Wessely, 2004.

one reference is made to a psychology journal. Perhaps reviews that do not refer to the psychological evidence currently available may be psychiatrically diagnosed by those qualified to do so as a defence mechanism (if one will pardon the expression in this context). It takes the form of denial that a complete psychological profile has any relevance and predictive power in identifying the temperamentally unsuitable soldier[110].

More importantly, there is little or no evidence from a number of medical studies that popular civilian inventories have been subjected to re-standardisation on military personnel. The need for such precautions is cited in an important and virtually ignored discussion on what constitutes temperamental unsuitability provided by MOD psychiatrists themselves, Deu, Srinivasan and Srinivasan (2004). Against the popular tide, they stress the need for instruments to help with diagnoses; and a clear understanding of differentiating factors in temperamental unsuitability for military service.

There is a lack of information on the relevance of currently available standardised personality assessment measures to the military and moreover, British military population. The use of commonly used measures in the Armed forces in the absence of appropriate military norms would be questionable, since they are not a representative cross section of society and therefore cannot be readily compared to normative student, psychiatric or general populations typically used as standardisation samples. Indeed, where measures are available, these tend to have been validated on non-British populations rendering direct comparisons difficult. The military rationale for a comprehensive research and development strategy in the area of temperament and suitability would appear necessary. The cross-cultural differences in military selection, training and roles would indicate a clear need for a British contribution to the development of appropriate assessment tools, norms and evidence-based practice.

This opinion is well supported by a study of the various surveys purporting to investigate the use of self-report questionnaires administered to service

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[110] Rona, Hooper et al., 2006.

personnel. For example, in the watershed article by Rona, Hooper et al. (2006), and its successor, Fear et al. (2010). Show that various health functions in military personnel were assessed by the following medical questionnaires:

- The questions about health consisted of a checklist of previous or current health problems,
- Self-rated health from the 36-item Short Form Health Survey. Symptoms of common mental disorder were measured with the *12-item General Health Questionnaire (GHQ-12)*
- Probable post-traumatic stress disorder with the *17-item National Centre for PTSD Checklist (PCL-C)*
- Alcohol use with the *10-item WHO Alcohol Use Disorders Identification Test (AUDIT)*

Binary outcomes of interest for these analyses were cursorily defined without showing distributions, with the following cut offs:

- 50 or more for the PCL (which we have termed probable post-traumatic stress disorder),
- 4 or more for the GHQ-12 (which we have termed symptoms of common mental disorder),
- and 16 or more for the AUDIT (usually defined as hazardous use that it is also harmful to health, which we have termed alcohol misuse).

These would normally be introduced after careful psychometric checks and balances on reliability and validity. There is no such evidence.[111]

One can take as an example of the problems with using civilian medical checklists the short PCL checklist so often quoted in the landmark studies referenced above. What are its psychometric origins? Do these inspire confidence in its unqualified use in military contexts? Should commanders trust its results?

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[111] Rona et al., 2006, Fear et al., 2010.

Table 4

Symptom-Severity Instruments for PTSD.

Scale	No. Items	References
PTSD Checklist	**17**	**Blanchard et al. 1996**
Mississippi Scale for Combat-Related PTSD	35	Keane et al. 1988; McFall et al. 1990
Impact of Event Scale-Revised	22	Horowitz et al. 1979
MMPI-PK	49	Keane et al. 1984
Self-Rating Inventory for PTSD	22	Hovens et al. 2002
Posttraumatic Diagnostic Scale	49	Foa et al. 1997
Davidson Trauma Scale	17	Davidson et al. 1997
War-Zone Related PTSD subscale of the Symptom Checklist 90-Revised	25	Derogatis and Cleary 1977
Los Angeles Symptom Checklist	43	King et al. 1995b

The commonly quoted PTSD checklist[112] was produced as a core contribution to the medically recommended scales in Table 4. This inclusion seems impressive until the following quotation from the original publication is read.

> "The psychometric properties of the PTSD Checklist (PCL), a new, brief, self-report instrument, were determined on a population of 40 motor vehicle accident victims and sexual assault victims using diagnoses and scores from the CAPS (Clinician Administered PTSD Scale) as the criteria."[113]

There are similar reservations about the use of HRQOL instruments without first producing evidence of their effectiveness with military personnel. Much of what is represented here can be applied to medically-based inventory research carried out in military contexts. To use civilian inventories without offering proof of suitability in a specific military context seems hardly credible. These strictures could, nevertheless, be regarded as lay concerns of no apparent face validity. However, identical reservations are voiced by the accredited medical researchers themselves. Here are cautions against questionnaire use because of climates of distrust among military personnel who are asked to complete them.

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[112] Blanchard, Jones-Alexander, Buckley, & Formeris, 1996.
[113] Blanchard et al., 1996.

> "The main barriers to health screening were lack of trust, perceived low quality of healthcare, and perceived lack of concern within the institution about work environments and home life.....Screening was considered worthwhile, but many confided that they would not honestly answer some items in the questionnaire."[114]

In psychometric terms, this means assessment of social desirability response profiles[115] and guardedness in military personnel, of which there are no examples in any of the British work quoted here.

> "Briefly, in countless epidemiological studies of military personnel, originating in medical journals, there has been no indication of the reliability, validity, and perhaps critically, liability to known response style distortion and distrust by military personnel of conventional civilian inventories."

Residual Technical Doubts

In the technical construction of epidemiological questionnaires[116], there appears to be much room for clarification.

Vocabulary Levels and Category Width
No evidence in is offered for control for vocabulary level and category width[117] in questions of health and other concepts administered to a population said to have an average reading age of 11 years *(for example compare the width of categories 'stressful experience' and 'emotionally numb' with that of 'double vision' HWB2 pp. 20-23[118])*. Throughout the survey document, there are examples too numerous to recount.

Quantifiers
Moreover, there is great variation in the scales used for response frequencies to the items themselves. In HWB2 there are at least 12 different ways of responding to questions calling for a frequency. They vary from ticking a box, to

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[114] French, Rona, Jones, & Wessely, 2004, p. 153.
[115] cf. Bochner & Van Zyl, 1986.
[116] cf. (HWB2: Health and Well-being survey of serving and ex-serving members of the UK Armed Forces: Phase 2 used by Fear et al. 2010).
[117] Hampson, John, & Goldberg, 1986; Hampson, Goldberg, & John, 1987.
[118] This is only one example of countless observations that could be made.

simple yes/no through to always-never on a five point Likert scale. Research on the variability and misleading nature of these has been available for many years[119], but shows no sign of being incorporated in these and other medical surveys.

Response Characteristics
Finally, the reported characteristics of those who respond to the questionnaires invariably do not correspond to those of the original sample. Such response rate characteristics by no means guarantee the random sample that is a prerequisite for statistical inference.[120] In short, the proportions of personnel reportedly at risk may not be accurate.

Given extensive technical doubts about the administration and construction of so-called standard medical questionnaires, what alternative procedures may be of most worth to decision-makers?

The Contexts of Personal Assessment

There are three basic assessment contexts, bureaucratic, social, and interview. Very little is known about assessment by selection and review boards. What there is suggests that rank and prestige of board members have considerable influence in their decisions, which are, nevertheless, not always bad.[121]

A 'Cultural' Sanction?

Social network screening is seldom made public. Yet commanders undoubtedly pay great attention to informal reports of role unsuitability. If these reports from section leaders are field-based there is every reason to pay attention because lives are at risk. One study in the second world war in the US Navy[122] gives an account of a seven-day screening process during which a questionnaire about

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[119] Newstead & Collis, 1987; Newstead, Pollard, & Riezebos, 1987.
[120] Fear, 2010, p. 1790.
[121] Vernon & Parry, 1949 Ch. 9; Jones, 1984.
[122] Garstle, Wagner, & Lodge, 1943.

the acceptability of conscripts was completed. Personnel identified as being of doubtful status by this method were subjected to further screening.

It is reproduced here as an example, without comment. With simple modification for different functions, it is perhaps worth consideration as a within-culture pre-deployment early warning screen.

Table 5
The US Navy 10 Questions 'Cultural Sanction' Checklist.

1. Does he like the Navy?
2. Is he quickly obedient?
3. Does he complain a good deal?
4. Is this man fit for sea duty?
5. Is he cheerful and industrious[123]?
6. Does he keep himself neat and clean?
7. Does he have many friends in Coy.
8. Would you like to have him in your division?
9. Does he learn Navy routine as well as most?
10. Does he take part in games and other activities off duty?

Interviews take many forms, not least of which are conducted by Medical Officers. Rona and colleagues have, however, referred to a "Gold Standard" (GS) in assessment of temperamental unsuitability. Psychiatrists' judgements are preferred to all others and have a permanent place in the valuation of other currency. In one study, the poor results of validating inventory classifications with Medical Officers' diagnoses following receipt of self-report inventories is underlined[124]. However, it is hardly surprising that low correspondence is a consequence of first not training the Medical Officers on the use of the inventories (loc.cit). What, then, could one offer commanders given doubt and confusion and disagreement among experts?

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[123] 'Industrious' changed for vocabulary and category width would be 'hard-working'.
[124] French et al., 2004.

Back to Basics

Efforts to uncover temperamental unsuitability during the second world war are much derided by supporters of the Wessely doctrine, Psychiatrists in the USA were ridiculed for wrongly screening volunteers who later served with distinction.[125] However, no mention is made of the success of female Personnel Selection Officers in the British armed services who interviewed conscripts and then referred those believed to be at risk for further psychiatric assessment[126].

Women's Royal Naval Service personnel assistants conducted short structured interviews. In 1943, at the height of the war, they interviewed 80,000 men. Of these 2.69 percent were rated as unstable. When these were referred to psychiatrists, WRNS personnel were declared to be accurate 75% of the time. Referral rates varied from 2.8 to 9.7 percent. Those interviewers found to be most accurate were judged by supervisors to be *careful, steady conscientious, reliable, experienced and teachable.*

Given the face value of a social network screen, and the case for the use of female interviewers of service personnel, a sequential system using these two techniques is worthy of consideration. If proven helpful in the prevention of deployment disorders, it has the ingredients of intuitive acceptance by commanders.

Post Deployment

Undoubtedly, there is growing awareness about the prevalence of poor HRQOL among soldiers who have been deployed. Apart from neuroses of various kinds, reports of alcoholism, and domestic violence are commonplace. The Guardian of July 5 reports that 8,500 of the UK's prison population of about 93,000 have been in the forces. More than 12,500 ex-service personnel are on parole. In one English County 326 were arrested in the last three months.

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[125] Wessely, 2004; Jones et al., 2000; Rona et al., 2006.
[126] Vernon & Parry, 1949, pp. 155-160.

The reasons for criminal behaviour on such a scale are not at all clear. All one knows is that inmates once served their country in the armed services, often with great distinction. Perhaps it may then seem ungrateful to count the cost. In the UK parliament (July, 2010), the official annual cost of keeping a prisoner in jail was announced as £38k. This is a little more than £100 for every day in jail. When there are 85,000 ex-service personnel in jail for one day, the cost is £850k. If these daily numbers remain unchanged for one year, the cost is £31 million. If this amount is added to the annual cost of infantry attrition in training, the cost is £50 million.

Under the Wessely doctrine, could this outcome reasonably be regarded as the cost of 'cure'? No screening before recruitment and discharge, but one simply allows unhappy recruits to leave and maladjusted ex-serviceman to go to jail. One might well ask if £50 million annually could be better spent in the introduction of usable validated inventories, structured interviews and resettlement procedures provided by senior social workers within the service arms.

Given the unknown human and huge fiscal costs of imprisonment and parole supervision, it is only common sense *to conduct periodic random sample health-related quality of life interviews to uncover the prevalence of poor re-adjustment* in any one branch of the service. When a significant rate of poor HRQOL is a cause for concern, then wholesale appraisal in any branch would be the logical consequence. Undoubtedly, a military standardised HRQOL inventory is necessary. One of those already exists[127] and is readily adaptable for interview use.

Conclusions

Under the Wessely doctrine cure is always to be provided: and it is preferable to screening. This review indicates that screening is possible at each of the three critical thresholds of military employment. Temperamental suitability appraisal among recruits is advisable using computer-administered inventories

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[127] Irvine, 2004a.

constructed with social desirability and guardedness checks[128]. Internal pre-deployment social and dispositional checks are cost-effective safeguards against breakdown. Post deployment sampling of HRQOL in the various service arms is also to be commended. Under such circumstances, prevention is both possible and preferable to cure, in all its forms, real and imagined.

Annexe A

Advice to Potential Recruits Do's and Don'ts in Basic Training.

Coping with a 24/7 Command Environment		
Procedures	*Facts*	*Physical*
Boot camp is physically intensive.	Memorize your particular service's rank structure (both officer and enlisted) before you leave.	Start getting into shape before you leave.
If you know someone who's been in the military, ask him/her to teach you some simple marching and facing movements.	Remember, EVERYONE messes up in boot camp, and EVERYONE gets chewed out.	Work especially on running and push ups.
Inform your family and friends that it's very important that they write often. Boot camp can be very lonely.	You're much better off in boot camp if the D.I. hardly remembers your name.	

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[128] Irvine, 2006.

Practice making your bed with "hospital corners".

Those who are "remembered" often get "special attention".

Bring ONLY what is on the list.

Anything not on the list will be confiscated and will give the D.I. an excuse to chew you out.

You don't want the D. I.s to remember you.

The "real military" won't be this way.

Cut your hair short, and wear conservative clothes.

Don't arrive "standing out in the crowd".

Go in with the right attitude.

Never, ever, make excuses.

Do exactly what you're told to do, when you're told to do it, and how you're told to do it.

Don't be inventive.

When speaking to a D. I. , always stand at rigid attention, eyes locked forward.

Don't volunteer.

If you're "on time", then you're late. Always be where you're supposed to be five minutes early.

Chapter VI

Assessing Morale During a Deployment.
Use of the Dutch Morale Questionnaire within a Belgium Detachment in Kosovo

Captain Salvatore Lo Bue, MSc[129]

Abstract

Among the Belgian operational detachments, Mental Readiness Advisors advice Commanders with information derived from two sources: field observation and the use of a survey at mid-deployment. The current perspective of the MRA's is to develop a validated Morale questionnaire. As part of this program, an adapted version of the Dutch Morale questionnaire was administrated to 158 servicemen participating to the operation KFOR Kosovo. The aim of this test-case was to assess the matching between field observation and the results of the survey. This study shows a convergence between the two sources of information.

Introduction

During an operation, Belgian Commanders have a psychologist in their special staff. The role of this psychologist, called Mental Readiness Advisor (MRA), is to give advice to the Commander on leadership, cohesion, job satisfaction and psycho-social support. To fulfill his mission the MRA bases his work on two sources of information (in line with the recommendations described in NATO Task Group HFM 081/RTG, 2007): field observation (informal contacts and discussion with servicemen in operation) and results of a Morale survey at mid-deployment. According to the work of the Task Group HFM 081/RTG, information from field observation have a low objectivity, a low value as an indicator of

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[129] Cp Roi ALBERT Ier, Centre Princesse Mathilde 65, route de Liège, 6900 Marche-en-Famenne Belgium, Salvatore.LoBue2@mil.be.

change, gives information about cause of Morale problems and are easy to obtain but biased by small number of opinions. Information from Morale surveys have a high objectivity, a high value as an indicator of change, may give information about cause of Morale problems and are easy to obtain and requires simple calculation. When crossing these two types of information, the MRA is able to give a quantitative and qualitative insight of the detachment Morale.

Until now, the MRA cell uses a questionnaire which is not scientifically sounded. It is not validated, not standardized and the results obtained do not always give relevant information of the detachment Morale. Moreover, there are no norms to evaluate the results and the open questions in the questionnaire give the same information than field observation (with the same negative effects).

In order to fulfill their mission on a scientific basis, the current perspective of the MRA cell is to adapt and validate the Morale questionnaire developed by the Dutch Armed Forces in order to apply it within Belgian operational detachments. The Dutch questionnaire was originally based on the works of Gal (1986), Gal & Manning (1987) and Mangelsdorff, King & O'Brien (1985). However, these studies were mainly oriented on land combat units.

As the dynamics and complexity of current operations has increased and as it is more and more a matter of *joint* operations with combat, combat support and combat service support units, the questionnaire has been revised by Boxmeer et al. in 2007 in order to increase its ability to assess all type of military unit in all kind of deployments. In this revision, the authors have documented the former questionnaire, reduced the number of items (from 130 to 94) and added the possibility to assess morale directly (and not inferred from predictors anymore). This revised version was tested on detachments from LOTEUFOR (Bosnia), EUFOR-Tchad and ISAF.

For the use within the Belgian Defense, three French-speaking and one Dutch-speaking MRA translated the Dutch version to French. The Dutch-speaking MRA made also some adaptation for the Flemish military. The different translations were then crossed in order to get the most accurate translation. The questionnaire is based on the following definition of morale:

> "Morale is the enthusiasm and persistence with which a member of a group engages in the prescribed activities of that group."[130]

The subsequent model of morale is based on the *Job Demands Resources Model* (JDR-model[131]) presented as follow (Figure 1).

Figure 1

Model of morale, based on the *Job Demands Resources Model* (JDR-model).
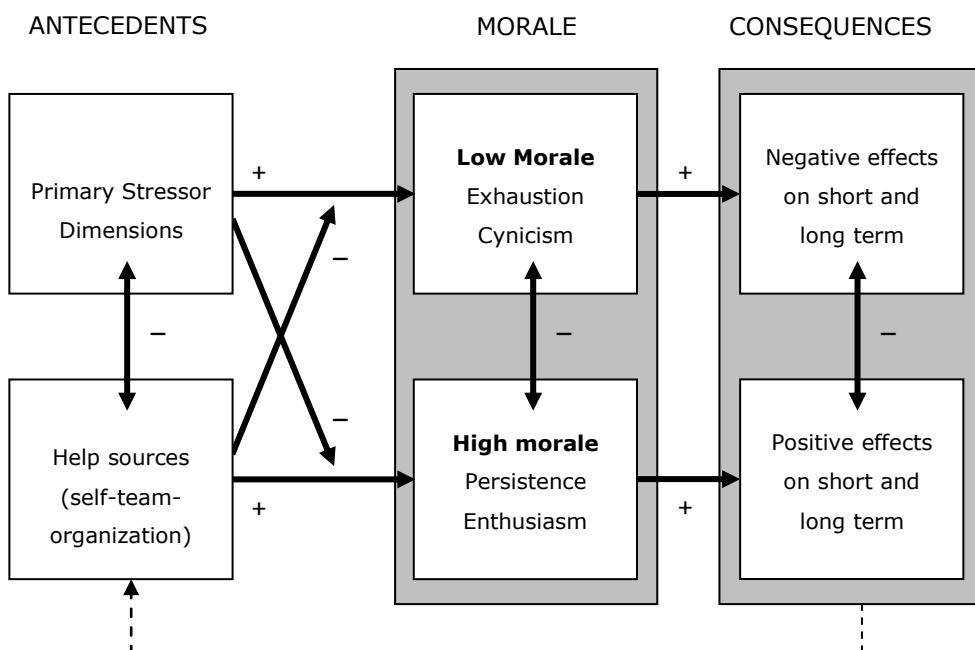
The model presents two types of antecedents which influence Morale. Primary stressors dimensions will have a positive effect on a low Morale and a negative effect on a high Morale. Help sources will instead have a positive effect on a high Morale and a negative effect on a low Morale. Primary stressor dimensions and help sources have a negative interaction. High Morale, per definition, is marked by persistence and enthusiasm. Low Morale is marked by the precise opposite: respectively exhaustion and cynicism.

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[130] Manning, 1991.

[131] Bakker, 2001.

The study presented here is a test-case aiming to evaluate the matching that may exist between field observation and results of the questionnaire. As such a matching is revealed, the MRA is then able to qualify the quantitative results with what he has observed and to quantify the observations he has made with the numerical results. Advice to the Commander can then be more accurate.

Method

Sample

158 servicemen participating to KFOR mission in Kosovo filled in the questionnaire. They were aged on average 34, 95% were male, 5% female.

55% were part of a recon squadron (patrolling the area of responsibility and prepared to control riots), 31% are from the combat service support sub-capacity (logistic, communication and information, military police and medical detachments), 10% of the staff and 4% of a sniper team. 6% were Officers, 27% NCO's and 67% Private. The average amount of operations was 3 with a standard deviation of 2. 12% of the detachment carried out their first mission.

Questionnaire

The questionnaire adapted for the Belgian Defense evaluates the help sources (73 items) and the indicators of high and low Morale (18 items). The help sources are distributed on four clusters: "Self & Task" (17 items), "Group" (16 items), "Leadership" (15 items) and "Defense as a whole" (27 items).

The cluster "Self & Task" assesses one's "confidence in his own capabilities" (CAPA), "self-engagement" (ENGA), "satisfaction with one's function" (STSF) and "support received from home" (SPHO).

The cluster "Group" concerns "identification with the group within one works the most" (IDGP), "cohesion in this group" (COHE), "mutual respect between the members of the group" (RSPC) and "trust in one's colleagues" (COLL).

The cluster "Leadership" evaluates confidence in three levels of command: COC1 (detachment Commander), COC2 (platoon or sub-capacity Commander) and COC3 (team or service Chief).

"Support of Defense" is made of seven help sources: "confidence in weapon and material" (WEMA), "operational support" (SPOP), "satisfaction with living

conditions" (LIFE), "communication facilities with home" (COMM), "knowledge of the operation and the terrain" (KNOW), "perceived support from Defense" (SPDE) and "support that one gives to the aims of Defense" (SPOB).

The indicators of Morale are "Enthusiasm" (ENTH), "Persistence" (PERS), "Cynicism" (CYNI), "Exhaustion" (EXHA), "individual Morale" (MORP) and "perceived Morale of the group" (MORD).

Procedure

The detachment was divided in 8 groups of about 20 persons for a fill-in session which lasted about 30 minutes. An introduction briefing was given by the MRA to explain the aims of the questionnaire, the privacy of their individual responses and the way to answer the questionnaire. Participants were asked to give their agreement on a 5-Likert Scale (7 for the indicators of Morale) to each item. The MRA stayed with the participants during the session in order to answer their questions and avoid any confusion in understanding the items.

Field observations

This operation in Kosovo is a particular one because it is in keeping with the context of the withdrawal of the troops from this region. KFOR is considered as a "third responder" in case of major security crisis (first is local police and second European Police on the theater called EULEX). Therefore, there are not many significant tasks for the recon squadron to fulfill. This lack is perceivable in the informal discussion that the MRA has with the servicemen. They say that they are bored, that there is nothing left to do for them in Kosovo and that the rational of the activities that they are to execute (mainly patrols and observation posts) are invented by the Command to occupy them. This boredom is not observed in the other sub-capacities (staff, combat service support, sniper team). Actually, for the other groups the work remains the same independently of the situation in Kosovo.

Many conflicts are also observed in the recon squadron. Conflicts (and sometime fights) between colleagues of the same platoon, conflicts between platoons, conflicts between groups and their chief. This lack of cohesion seems present in the squadron but not in the other groups.

The detachment Commander seems to have a bad reputation and many servicemen in the recon squadron do not trust him. They say that he lacks of impartiality and strength of character and report that he is more known for his attitude at bars than for his leadership. This reputation is not reported by the other groups as many of the servicemen from these group are not from the unit of origin and do not know his reputation by advance.

Globally, the Morale in the recon squadron seems lower in the recon squadron than in staff, combat service support and sniper team (from now on, these groups will be called "Support group").

Conditions of living seem to be positively evaluated by all the detachment. The camp is equipped with shops, there are two rooms with fitness equipments, a beach volley, a soccer and a basket ball fields, there are also ping-pong tables. Accommodation is quite comfortable with a maximum of two persons per room. At least once a week, visiting activities are organized. The food is excellent at the self-service and there also is a restaurant and three bars. The post is reliable with the possibility to get and send mails or packs at least every two weeks.

The detachment has also at disposal communication facilities (Wi-Fi in the bedrooms, reliable telephone).

A contextual factor is also to be taken into account in the evaluation of Morale. A restructuring of the whole Belgian Defense is affecting hardly every Belgian serviceman. At the time of the operation, there was a lot of questioning about the future and the consequences of this restructuring.

Hypothesis
Based on what the MRA observed on the field, contextual factors and informal discussions with the members of the detachment several hypotheses are formulated:

1. STSF and ENTH are lower and CYNI higher in the recon squadron than in the support group.
2. IDGP and COHE are lower in the recon squadron than in the support group.

3. Confidence in the detachment Commander (COC1) is lower in the recon squadron than in the support group.
4. As a result of these differences, MORP is lower in the squadron than in the support group.
5. LIFE and COMM are positively evaluated by the whole detachment.
6. In the whole detachment, SPDE is low because of the restructuring. As a consequence, SPOB is also low.

Results

Analysis
1. Hypotheses 1 to 4: means of STFS, ENTH, CYNI, IDGP, COHE, COC1 & MORP will be compared with a t-test for independent groups (Squadron vs Support).
2. Hypotheses 5 and 6 will be tested according to the mean result of the variable in an interval of 1 standard deviation. These results will be qualified as follow:
   - .00 to .50 = negative
   - .51 to 1.50 = rather negative
   - 1.51 to 2.50 = average
   - 2.51 to 3.50 = rather positive
   - 3.51 to 4.00 = positive

The results indicate that there is a significant difference between the Squadron and the rest of the detachment (Support) on STFS, ENTH, CYNI, COHE and COC1. The data's failed to reveal a difference between those groups on IDGP and MORP.

According to the criterion selected, LIFE and COMM are positively rated by the participants. The results on SPDE don't allow us to draw a conclusion as the answers of the participants seem to be too scattered. The result on SPOB is opposite to the hypothesis 6, as it was expected to be negative.

The significant differences between the recon squadron and the support group must not obliterate that the results in the squadron are not radically negative. When applying the same criterion as for hypothesis 5 and 6, we can see that STSF is rather negative to rather positive, ENTH rather negative to positive, CYNI very positive to average, IDGP average to positive, COHE average to rather positive, COC1 rather negative to rather positive, MORP average to very positive.

Table 1

Research results hypotheses 1-6.

Hyp	Indep Variable	Group	N	Mean	Std. Deviation	Test	Sig.
1.	STSF	Squad	87	2.38	.88	**t(155) = 4.88**	**.000**
		Support	70	3.00	.69		
	ENTH	Squad	86	3.38	1.26	**t(154) = 6.90**	**.000**
		Support	70	4.60	.97		
	CYNI	Squad	83	1.49	1.13	**t(149) = 4.04**	**.000**
		Support	68	.83	.88		
2.	IDGP	Squad	87	2.98	.82	t(154) = .44	.662
		Support	69	3.03	.64		
	COHE	Squad	87	2.53	.80	**t(154) = 2.59**	**.011**
		Support	69	2.84	.67		
3.	COC1	Squad	87	2.29	.81	**t(153) = 2.59**	**.011**
		Support	68	2.59	.55		
4.	MORP	Squad	85	4.34	1.38	t(154) = 1.05	.295
		Support	71	4.56	1.24		
5.	LIFE		158	2.91	.92	**Average-Positive**	
	COMM		158	3.03	.92	**Average-Positive**	
6.	SPDE		158	2.03	1.49	Rather negative-Positive	
	SPOB		158	2.67	.92	Average-Positive	

Note: The bolded results underline that the hypothesis is corroborated.

Discussion

Globally, this study shows a convergence between information derived from field observation and indexes obtained by the adapted Dutch questionnaire. Actually, the questionnaire was sensitive enough to differentiate two groups that were observed as living differently some aspects of the mission.

Would that mean that only one of these two sources would be enough to advice Commanders? Some differences show that none of these two sources is sufficient to have an accurate insight on unit's Morale. Results from the questionnaire allow to get a more objective picture of the servicemen's state of mind. Every single person is questioned and the results actually give the general opinion of the whole detachment. Consequently, results from the questionnaire compensate the lack of objectivity of the informal discussions with members of the detachment. Moreover, the results of the questionnaire seem to give a picture less pessimistic than field observation based on small number of opinions. In fact, after informal discussion with members of the detachment, we expected that the variable tested with hypothesis 1 to 4 would be negative or at best average in the recon squadron. The people with whom the MRA discussed gave a really negative judgment on these matters. But when we questioned the whole squadron, the results were quite positive. How could we interpret that?

With its role as a psychologist, the MRA will be more in contact with people complaining about what does not work, what is wrong with the mission and with individual problems, than with statements of how the operation is well running. As a result, his analysis of field observation will be biased in a negative way.

Another interesting fact is that servicemen also seem to hear more negative opinions than positive ones. Actually, when looking closer to the results, there is a significant difference between "individual Morale" and "group Morale", with "individual Morale" more positive that "group Morale" (respectively 4.44 ± 1.3 and 3.83 ± 1.35 ; t = 5.198 ; p < .000). In other words, people have the impression that they feel better than the rest of the detachment. However, this way to respond can also be due to a corporate habit in the military not to complaint about one' own situation. Then, answering more negatively on group

Morale can be a way to tell that there is a problem with detachment's Morale without admitting that one has an individual Morale problem.

In brief, if the MRA bases his argument only on field observation, his analysis of the detachment Morale would be negatively biased by two sources: the filter his function operates and the fact that people discuss more about problems and complaints than about what works well.

Those biases can also explain than there is no real difference in "individual Morale" between the squadron and the support group, unlike what was expected. Readers would be certainly aware that this lack of difference can also be due to the size of the sample.

Can we then work only with the results of the questionnaire? First, the figures obtain on each index would have not many sense without the qualitative information of field observation. For example, what would a 60 on "satisfaction with one function" mean if you don't know the context where this opinion is expressed? How could one analyze and interpret such a result.

Moreover, field observation gives us critical information on Morale: the cause why a given pattern is obtained. Information from field observation allows to compensate the lack of information on causes of Morale problem. Without the knowledge of the causes of Morale problems (or positive sides), the MRA is not able to give a useful advice to the Commander. If one knows that the main cause of a negative result on "cohesion" is lack of mutual knowledge between the different sub-detachment, for example, the MRA can then advice the Commander to organize activities that facilitate this mutual knowledge.

These differences between field observation and results of the survey emphasize the importance of these two sources of information. With the quantitative results, the MRA is able to give the Commander an objective picture of his detachment at a particular moment. With field observation, he can find the causes of Morale problems and qualify the results. In this way, the advice that the MRA will give to the Commander will be more accurate.

Chapter VII

From collective manifestations to shared concerns

Dr. Bertrand Lahutte, MD[132]

Abstract

Military engagements confront leaders and medical practitioners with difficulties regarding balance between collective and individual concerns. High intensity combats, where terrorist risk prevails, stress what may appear as potential disagreements. Psychiatric conditions may focus attention and are sometimes unnoticed in their pathologic dimension, at risk of being considered with sole disciplinary "treatment". French military engagement in Afghanistan offer us a pragmatic illustration of these delicates situations. This study intends to glance through different situations and analyze Command responses, such as in sequels of traumatic encounters, mourns and collective panic reactions in their "shaded" manifestations: mutiny, risk taking, overconfident behaviors.

Text

We can postulate that the "panorama" of war has changed across last century. Military involvements in France specially evolved in the last thirty years. This can be linked to the development of multinational cooperation, as well as to the cultural evolution from conscription to professional army. Nonetheless, "OPEX" – that is the French diminutive for operational mission – figure as the main goal of the military career, as well as special times, punctuating the course of this special professional way. Recent clashes such as in Afghanistan remind us the combat dimension of these operations. What was somehow obscured or veiled for some, behind special missions like interposition, humanitarian or peacekeeping, brutally unveils: the crudity of war and violence. French

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psychiatrists are from long engaged in those deployments, with the application of "forward psychiatry". That way, combat stress reactions focus a special interest and are subject to special care, which leads back to WWI, if we consider what Salmon has formalized from his recognitions in psychiatric field units. Our purpose is not to develop the individual clinic of combat stress conditions, but to pinpoint how they are correlated to group or collective aspects.

Give rise to collective aspects

Indeed, acute stress reactions cannot be considered separately from collective aspects. There are aspects of clinical expression as well as of treatment. They are somehow difficult to distinguish one from another, because individual stress expression is tempered or increased by group psychology. Furthermore, group dysfunction can lead to increased individual symptomatic expression, or to massive clinical pathology with tremendous consequences. This is for the clinical perspective; we will step further later. But we think important to consider other than medical vantages. Military operations themselves stress the priority of collective aspects. In this, we do not assign the conduct of military operations (that shows us the difference between a "warrior" and a "soldier"): from this point of view, group is an indubitable necessity, as key to success. We intend to specify what appears to us as a particularity of modern war engagements: the progressive disappearance of boundary between friend and foe, exposing soldiers to a different perspective regarding their subjective position.

Endangered individuality

We are sensible to this dimension, which is frequently mentioned by soldiers. Somehow, a "traditional perspective" would allow us to distinguish and identify the "foe". This is reported from WWI experience. This figure of the "other" is clearly defined and enables to focus aggressiveness. The fellow-human being, the peer, exists. He can be faced or be conducted peace with. Modern engagements tend to dissolve this "clear" situation. Our soldiers clearly express their difficulties to perceive the sense, the goal of their objectives. Balkan operations were the support of a special gap in the personal perception of the

mission. This period was also particularized for French soldiers with other displacements. The first was from the "aggressor" stance to the "peacekeeper" or "interposing"; the second was from "combat" or "offence" to "risk". Indeed, the status change exposes soldiers less to direct aggression than to an omnipresent risk, correlated to the "dilution" of the figure of the enemy. "Face to face attack" should be rarer than "exposure to risk". Snipers, NRBC warfare, mined battlefield especially point out this fact. The Afghan context allows us to further develop this perspective. The vital risk is exacerbated by increased dangerousness, high intensity combats and grieving loss count amongst involved nations. But most of all, soldiers reports stress the difficulty to tell apart insurgents from civilian population. Therefore, danger seems imminent and ubiquitarious. Measures involved (guerilla, IED, terrorist and suicide attacks) contribute to distort perception of any possible single, one-to-one confrontation. The group is convoked. Individuality is endangered in reality, but also in the ability to be efficient. The soldier is pushed to rely on the group.

Are those new concerns?

We can object to this reflection that this point is for a long time taken in account by Command, as collectivity needs organization. Tactic and strategy, such as von Clausewitz develops, implicate coherency and homogeneity in group function. We also long-past know the role of group functioning in stress (precisely anxiety) regulation. The fact we propose to discussion is the following: due to these particularities, actual missions expose soldiers, partially dispossessed of their sole abilities to confront operational situations, to the necessity to rely on the group. The result is effacement: it is not the kind of the removal of responsibility being entrusted to the figure of the Chief, but transfer to an evanescent positioning toward the group. This exposes the group to an increased risk of disintegration or malfunctioning. Our proposal is underlain by the report of decline of "Fatherly function". The role of symbolic fatherly function, sustaining the figure of the leader seems less consistent, and groups of young engages are often organized by "peer regulation", that is structuring relying rather on the buddy than on the Ideal. If this report is to be nuanced, we see it is tempered by training and assimilation of esprit de corps; integration in

the environment allows to take place in the hierarchized and structured organization. But would the situation come to be troublesome or more dangerous, would the guaranties – of safety for example – appear to be weaker – we assist to a regressive stance, from a structured group to a community assembly, where brotherhood takes the place of fatherhood. The role of the fellow-creature appears more active nowadays in the constitution of groups, even military units. Therefore, our experience of military involvements make us notice that stress expressions in group orient them rather to rely on technology, on proximity of others, than on confidence and on trusting the figures of authority of Command. We can speculate that group or collective expression of psychic conditions should be on top concerns for times to come.

If collective psychiatric manifestations are to increase in the future, we should call into question if they are correlated to specificities of engagements, mutations in war itself, or if they are linked to changes in the modern "Master Discourse" (in its psychoanalytical acceptation).

Impact on the ethic of practitioners

Following this point, we must specify what is defined by "collective manifestations". In the Command perspective, they should be related to any malfunctioning interfering with the optimal course of martial operations. This is the discourse of authority, and its counterpart is disciplinary response. It would be excessive to radicalize the perspective to a sole binary obedience-disobedience with sanction as adjustment. Indeed, instructions for leaders regarding stress control are long developed. But this reduction exposes what could be medical presupposition regarding Command in situations of incomprehension or "deaf communication".

Besides, radical medical perspective could tend to separate clinical individual psychiatric conditions from collective disorders such as panic. Psychiatrists are often criticized this way, and so relegated to possible imposture or impotence: one the one hand, they are looked upon suspiciously, being dubious of victimization, stigmatization, worse of being willing to evacuate patients and so, spoil the efficiency of constituted unit; on the other hand, they are helpless whether assailed to interrupt panic reactions and therefore useless. It would be

severely misreading the position of the "forward psychiatrist" to consider him so, but again, we must point out the recurrence of those prejudices in critical situations. We can assume that – at least – they constitute defensive movements against the "psychic fact".

This expeditious shortcut may tend toward caricature. We accept this risk by pointing that war involvements are "non-conventional" situations and open the way to irrational conducts, especially in decision-taking, should it be Medical or Command decision-taking. Moreover, the action of psychiatrists is strictly correlated to doctrine, which is in relation with care practice (such as the Salmon principles), but also with health services organization. Practices regarding medical evacuations, suicidal risk, hospitalizations, let us consider different perspectives amongst nations, sometimes very divergent.

In order to present the French situation, let's develop that if leaders undoubtedly accept to take in consideration psychic manifestations and psychiatric conditions, they are somehow prone to focus on "psychic casualties" with its potential risk of attrition. They are also aware during their instruction of "psychically wounded soldiers" and so may tend to misread situations that are not directly connected to combats.

These divergences are necessary to consider. On the one hand, they participate to the general misunderstanding – which must be pointed out to notice the stalemates of comprehension and communication – whereas on the other hand, they allow us to design the reaches of any potential intervention: confront patients with the effects of segregation, or leave the medical position and expose psychiatric intervention to be an "instrument" of Command. In a way, these notes remind us of works such as those of Michel Foucault: he observed a reaction qualified of "conformist" emanating from the society, with consequences of banishment to its fringes of the dropouts, mad persons included.

It is the responsibility of each medical practitioner to consider whether his intervention is a product of a societal drive or arise from the necessities or contingencies of each singular clinical situation. Psychiatric intervention in operational situations give rise to this disjunction. It appears to be potentially

problematic, being at the conjunction of individual concerns, group equilibrium and operational command issues.

How could we approach such a sensitive subject, focusing so many diverging stakes or desires. We postulate that even if doctrinal or deontological data are available and constitute a precious knowledge or experience, in definitive, the position of the psychiatrist in an operational context relies on his sole responsibility: it has to be permanently reinvented and cannot recommend itself of qualifications or presumed competence, at the risk of being ineffective. In a way, it has to be actively quested, searched, but also found, seizing the opportunity or being opened to surprise. This is what opposes a naïve positivist perspective ("know to plan, plan to act") of the necessity to take in consideration contingency and unpredictability. Maybe the psychiatrist guideline should be the word of Picasso: "I don't search, I find."

Military collective aspects cannot be reduced to panic and disaster reactions

The immediate reaction to exceptional situations or disasters is supposed to be that of "stress" in its life-saving aim: focusing attention, mobilizing the capacities and prompting to action. Individual "inadequate" reactions are usually categorized in four modalities: stuporous inhibition, uncontrolled agitation, individual panic flight, and automatic behavior (reflex or blind imitation).

We also have at our disposition the classical description of collective disorganization. These collective behaviors are different from the arithmetic sum of their individual corollaries even if they are constitutive of them. The sum of each part may be more than the whole.

Maladjusted behaviors are reported from history: collective stupor (loss of initiative, incapacity to evacuate the place or slow centrifugal stuporous exodus), but especially collective panic. It consists in distracted flight, pitilessly overthrowing and trampling all that obstructs it. This state explodes brutally after a phase of insidious preparation charged with rumors or dissensions. Its sequels are marked by a progressive resolution, with discharges of violence,

identification and designation of scapegoats, and regressive desire of being perpetually assisted.

Collective panic situations appear to be a major concern for Command, because of difficulties to deal with. Their consequences require something such as public order measures taken by the authorities, and involve drastic measures very difficult to carry out in operational context. They rely on the fact that those pathologic collective reactions are induced by the dislocation of group structure, and the disappearance of leadership.

We must immediately temper this catastrophic perspective, rather to stress the fact that the knowledge of mass panic mechanics may act like a specter, and so tend to be mistaken about other group reactions.

The first argument is the fact that literature indicates that expressions of mutual aid are common and often predominate. Collective flight may be delayed at risk of threatening survival. Typical response to threats is not to flee but often to seek the proximity of familiar persons or places. We also know that separation from attachment figures acts like a stressor, sometimes greater than physical danger. This refers us to the phenomenological observation of the gregarious nature of human beings and of the primacy of attachments.

The second argument is that these rare occurrences crystallize attention and tend to distract watchfulness from other group behaviors, more frequent and often related to misconducts in "mental hygiene". We could take as illustration the report – from colleagues or from small news items – of trespassing conducts, in Iraq for example.

Is the sole framework of mass panic pertinent?

While mass panic and self-preservation are often assumed to be the "natural" response to physical danger and perceived entrapment, we can develop other perspectives far less intuitive. That is what we defined as minor or rather "shaded" manifestations of panic. Two different categories can be distinguished: on the one hand we assist to the exacerbation of anxiety, in situations in which the structuring of the unit is maintained (it leads to overaggressive manifestations, such as friendly shots or "fire panic", or otherwise to somehow stuporous states, with notable diminution of fighting capacities); on the other

hand, anxiety may seem absent with rather overconfident behaviors. The last ones are characterized by risk taking acts, hasty or inconsiderate comportments. They can be for long mistaken or get away for bravery. When noticed, they are most likely to be treated in a disciplinary way.

Even in a "comprehensive" perspective, those collective manifestations are often qualified by the loosening of "moral censure" or ethics "deviance". This descriptive perspective is of little help in dealing with situations, but indicates us the aim of reprobation or negative judgment that comes with these behaviors.

Operational illustration

A recent experience in Afghanistan provides us with illustrations of this topic. It refers to a specific period, when French army servicemen were severely attacked by insurgents. A small unit (less than ten militaries) was concerned. Two persons were killed on the instant, in particular the leading officer. The suddenness of the attack was specially disruptive and echoed like a shock through the rest of the unit (about fifty servicemen scattered in small formations). The use of precision rifles was noticed by all and drastically increased the sentiment of insecurity. A demand for psychiatric intervention was formulated at this moment. In the same time, a logistic convoy coming toward this place was blasted on a IED. One more person was killed.

The first encounter was the one of the logistic convoy. After the blast, before the intervention of QRF and EOD – contrary to drills and recommendations –, first cares were conducted by a physician present in another armored vehicle. This medical intervention was specially dramatic because injured personals were part of the medical team. On the afterward, the physician relates the risks he incurred, running from a vehicle to another. After medical evacuation of the wounded, he observed, with dread, the EOD intervention blow up a non triggered charge precisely located on the spot of his medical intervention.

We propose to develop three specific aspects related to these circumstances.

Different aspects or risk-taking

At first, we can pinpoint the disorganization induced by the first explosion, and the affective implication that lead to this imprudent behavior. This experience was marked by haste, blind involvement, with exacerbation of the sense of the (medical) mission. It was for all of them an experience of severe anxiety, darkening and obsessing concern.

This scene could be opposed with another dramatic circumstance, couple of months before. We were not present and so can only speculate on the reports coming from the operational theatre. Several French militaries were killed in an ambush. Some elements tend to denounce improper preparation of the mission, or suggest that overconfidence has participated to this dramatic end. Excess in risk-taking was speculated in the way of not taking in considerations data given by local population.

In the case of the rescue team intervention, the fact that colleagues were involved precipitated personals in excessive risk-taking behaviors. The lack of security was firmly reproached and despite their endeavors, one of the injured deceased in the further cares. Technical debriefing pointed out the disorganization in the leading of the intervention, whereas the team was solidly coordinated and trained from months to this type of proceedings. The physician was specially aware of the risks taken by his whole team, every serviceman reporting the atmosphere of extreme loneliness and helplessness that came along with their desperate efforts to pull the bodies out from armored vehicles or bring – unnecessary – material to the medic.

This small situation illustrates retrospectively a minor panic reaction, with automatic acting, sterile behaviors, behind an overall coherent course of care management. The panic expression appeared at first to be strictly located to the technical organization of cares. Indeed, the comments of the physician were punctuated with reproaches related to the quality of first-aid treatments he gave, but in fact this insufficiency experience was related to the stigma of traumatic encounter. The real dysfunction was for some time put to silence: it was the secondary blast risk. This one was put to mind when pictures taken by the EOD show the disintegration of the part of the road where were conducted first-aid treatments.

Increased aggressiveness

At the same time, another unit was subject to severe malfunctioning, in a rather torpid way. The situation seemed to last for long and impacted several small units dispatched through a sensible area. The physician, to whom they had to refer, had noticed indirect signs of group dysfunction. This report was at the origin of the demand for psychiatric intervention (before events precipitate). This situation specially illustrates how indirect signs may indicate further complications in the group dynamic. Indeed, the general practitioner noticed the multiplication of complaints, consultations with the medical assistant, insistent demand for attention, underlain by fears related to communications, supplies or security. Dissensions went growing up, with controversy expressing different ways: in an unit, singular expression became impossible as the group went rigid (any deviation was suspected to be disobedience, and the ideal of mission was given rise to); in another unit, contestation led to disputation, with expression of crude aggressiveness. The preceding case draw the attention, as the situation revealed to be very complex. Communication became impossible between several members of the unit, the medical assistant was subject to brutal aggression and put aside from the rest of the group. Brawls were quickly stopped but showed the potential denouement of this group condition.

We can take this situation as exemplary of minor panic reactions in small isolated units, very dependent from others for security and circumscribed in their ability of response in case of offensive. The insidious development of this collective dysfunction may not attire attention, with summary reorganization, putting at stake rigid ideals or right of might. Maltreatment, physical abuse, tyrannical behaviors, scapegoats designation, may testimony of overtaken circumstances.

Rebellion and disobedience

The deterioration of circumstances went to a critical end when the two militaries were shot. Command intervention was needed and advocated. Isolated units seemed to be in the urge of immediate expression of their grief and recrudescence of violence was observed. At the climax of general dissensions, one of the present officers took an incongruous initiative and called for

destitution of the officer in command, arguing decisions taken, appealing for retaliation. A message was sent to the whole unit, through the communications system. The officer in command was first serviced with this information and immediately took the necessary measures to muffle the mutiny. This was perceived as a gruesome comportment, an offense to authority and undermined trust in the whole unit. Retrospectively, we could perceive recrudescence from despair and frustration amongst mourning servicemen, having been in contact with the ambushed unit by sole means of vocal transmission, and assisting helpless to the fatal end of their fellows, confronted to combined forces of insurgents. The action was quick and harsh and the loss occurred at the earlier or the fight. No decision could have stopped the surprise attack from its consequences, but recrimination especially focused on what was supposed to be a "guilty silence" of leaders and transmitters.

How does this interfere with clinical practice of psychiatrists?

Undoubtedly, the report of this operational situation stresses upon the modesty of any possible medical intervention, regarding the major consequences striking the whole group. Singular face to face clinical sessions are common for psychiatrists, concerning care management. Group interventions are not rare, especially in traumatic circumstances. But resolutely, collective dysfunctions may figure the limit of possible medical intervention. They are interlinked with the efficiency of Command, and stress the disorganization that may extend to the whole unit. Indeed, these embarrassing events are mutual concerns for physicians and leaders. They affect the functionality of the unit, expose to greater risks or dangers, and are associated with increased psychiatric sequels or comorbidity.

Practitioners should not flee from their responsibility and face the necessity to advise Command. French military health services are clearly separate from relevant command authorities, separation that allows medical practitioners technical autonomy. Command advise and counseling is nonetheless a full-fledged allocation of military physicians, within the limits of confidentiality. This note must be stressed upon, so confidentiality may be a precarious notion in operational context. Quality of relationship between physician and leaders,

integration enculturation and knowledge of the milieu become relevant tools for the practice of military medicine. Technically, precursor signs can be identified, as we pointed out. Group malfunction indicators exist and must be actively looked for. They are well known of general practitioners, but may go unnoticed due to their unspecific features. Therefore we must consider that these clinical signs assume their specific or predictive reach, only when correlated with contextual data. In the French operational plan, the role of psychiatrists also relies upon interactions with general practitioners. This is rendered feasible by an active process to establish contact with one another and stay tuned. These shared interests place psychiatrists as technical advisors – sometimes supervisors – for general practitioners on concern of mental health or psychopathological conditions. There is a small gap between this position and that of consultant. Indeed, French medical organization insists on the central or key position of general practitioners in the dispositive. Psychiatrists, even if not confined to sole hospital practice, even if frequently involved in "forward" operations or factual interventions, cannot rely on their sole clinical practice or specialized knowledge to be efficient. Screening is up to general practitioners, who can address their patients or require local intervention, extemporaneous or structured. But the classic schema of care management stands far away from what could be needed in situations of collective disorders.

Our experience leads us to pinpoint the necessary adjustments of clinical practice for the psychiatrist engaged in operational contexts. First of all, even if strongly requested, his stance cannot sustain on his sole recommendation or qualification. He has to "invent" his stance in the eyes of the context and of the units engaged. Interactions between general practitioners, integrated in field units, ready for first-line intervention, prone to screen and detect minor signs of malfunctioning, and psychiatrist, are most capable to assure efficient caretaking of individual and collective psychic disorders. Regarding collective manifestations, target interventions would consist in preventive approach (screening, "welfare" management and also individual cares), Command advice (especially in critical situations) and last but not least assistance concerning sequels of panic reactions whatever their level of intensity. Regarding the latter point, could be considered in the French plan, the possible intervention of

Command psychologists – who are not connected to medical health services –; they could have a specific approach of possible redevelopments or adjustments that could be pertinent. The brief operational illustration mentioned above illustrates the stakes of these unsteady situations. Even if implicated in acute conjunctures, if involved in the quickening of operational context, in the urge of instantaneous action, the action of the psychiatrist must be considered with its temporality. A major part of his intervention comes after the event. The perspective must shift, in order to include comrades, groups, units and their interrelations. The purpose not to lose is that in crisis situation, crisis resolution should certainly not promote a return to previous conjuncture, but tend to obtain a new equilibrium. This dynamic perspective involves temporality parameters as well as lateral collaborations with physicians mixed in the situation. It is a specific practice.

Our summary would consist in this assertion: not alone, measuring the necessary course of time and ready to organize practice between Command and fellow physicians. This implies tactic and strategy and invite us to meditate the words of Sun Tzu:

"Strategy without tactics is the slowest route to victory. Tactics without strategy is the noise before defeat."

"All men can see these tactics whereby I conquer, but what none can see is the strategy out of which victory is evolved."

Chapter VIII

Effects of Combat Exposure on Army Snipers

LtCol (ret.) Peter Bradley, PhD[133]

Abstract

In 2009 an interview-based study of 19 Canadian army snipers who had served in Afghanistan between 2002 and 2008 showed that the snipers had elevated scores on a generalized measure of psychological stress, but their scores were still lower than non-sniper veterans, suggesting that the snipers were coping better than regular soldiers. When asked about specific combat experiences, however, the snipers expressed more concern than non-snipers. Follow-on research with a larger sample of snipers is currently collecting data on a broader range of variables including PTSD, depression, anger, high-risk drinking, encounters with the law, utilization of mental health resources, barriers to care, posttraumatic growth, and others.

Introduction

Many books and articles have been written about snipers[134]. Most of the sniper literature focuses primarily on sniper technology (weapons and equipment) and the types of operations snipers engage in. The present study focuses on the personal impact of sniper employment, in particular the social-emotional outcomes affecting the sniper as a result of his or her work.[135]

By most accounts killing is a squalid business, so an important question is: *What impact does this work have on those who do the killing?* Some research-

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[133] Military Psychology and Leadership Department, Royal Military College of Canada, P.O. Box 17000, Station Forces, Kingston, Ontario, Canada K7K 7B4, bradley-p@rmc.ca.

[134] Coughlin, Kuklman, & Davis, 2005; Culbertson, 2003; Henderson, 2005, 2000; Pegler, 2004; Sasser & Roberts, 1990.

[135] Most snipers are men, but there have been female snipers. For example, the Russian army employed many female snipers during the Second World War.

based works by Dyer (2005), Bourke (1999), Grossman (1995, 2004), McNair (2005) and others suggest that many people who have killed in combat experience some level of remorse. Whether this remorse necessarily leads to post-traumatic stress disorder (PTSD) or other serious mental health issues is not certain however, because research has shown that not everyone who has killed in combat will suffer social-emotional consequences[136].

Based largely on interviews with US veterans of the Vietnam War and historical accounts from British scholars, Grossman's book examines the killing experiences of combat veterans in general, so there are only a few references to sniper experiences in this work. Grossman (1995) contends that many soldiers who have killed in combat go through up to three stages of reaction. First, there is a sense of satisfaction or euphoria much like that experienced by hunters. Some individuals bypass euphoria and go directly to remorse, the second stage in Grossman's model, and the one that can sometimes lead to mental health problems. Third is the stage of rationalization, in which the soldier tries to make sense of the killing. In some cases this stage can occupy much of the soldier's remaining life. Grossman contends that not everyone goes through all stages and that some individuals can become immobilized in a particular stage.

Rachel McNair (2005) examined data collected from 1638 participants of the National Vietnam Veterans Readjustment Study (NVVRS), a government-sponsored survey of Vietnam veterans conducted in the 1980s, to see how veterans who had killed in combat differed from those who had not. She found significant differences on PTSD, as measured by the Mississippi Scale for combat related PTSD[137]. The average PTSD score for the 621 veterans who reported that they had killed, or thought they had killed someone in Vietnam, was 93.4, as compared to 71.9 for the 932 veterans who reported that they had not killed in combat. Scores were even higher for those who had killed civilians. The average PTSD score for the 272 veterans who reported that they were involved in killing civilians was 105.6, as compared to 79.4 for the 157 veterans who reported that they had only seen killings of civilians. The results seem clear: those who killed had higher PTSD scores than those who hadn't killed.

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[136] Grossman, 1995.
[137] Keane, Caddell, & Taylor, 1988.

While most of the published research on snipers is historical[138], anecdotal[139], or based on archival data[140], there is one published account of an interview-based study of Israeli snipers. Bar and Ben-Ari (2005) interviewed 31 snipers, who had served in the Al-Aqsa Intifada, and found that many of the snipers felt regret at having killed enemy combatants. But they also felt justified, particularly in those cases where their target was engaged in hostile action against Israeli forces. The authors noted that the snipers held conflicting attitudes vis-à-vis their enemy, dehumanizing them somewhat, while simultaneously recognizing their humanity.

Canadian Sniper Selection Research

Several years ago Scholtz and Girard (2004) developed a personality-based system for selecting Canadian Forces (CF) snipers. They determined that successful snipers had the following personality profile: (a) low scores on Neuroticism (or strong scores in measures of Emotional Stability, the trait at the opposite end of the Neuroticism factor), (b) strong scores on Conscientiousness, and (c) lower scores on Tender Mindedness, a facet within the Agreeableness trait. In a subsequent study, Girard and Scholtz (no date given) tracked the performance of 29 sniper applicants and found that their performance on basic sniper training was indeed correlated with their scores on the above-mentioned personality traits.

Focus of the Present Study

The aim of this study was to conduct a preliminary investigation into the impact that serving as a sniper has on soldiers working in this role.

Method
Subjects. All 19 subjects had served as snipers in Afghanistan in the previous three years, with their deployments lasting between 4 to 8 months (*M*=6.6). The

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[138] Bourke, 1999.
[139] Grossman, 1995.
[140] McNair, 2005.

snipers ranged in rank from private to sergeant, and had been snipers for anywhere from 3 to 10 years.

Measures. The subjects completed two measures, the Kessler Psychological Distress Scale[141] and the Stress on Operations scale from the Human Dimension in Operations Survey[142], a survey used to measure aspects of combat performance in the Canadian Forces. Many of the items on this scale are adapted from U.S. measures[143].

Referred to as the K10, the Kessler Psychological Distress Scale is a measure of generalized psychological stress that has been used to screen Canadian soldiers serving in operations. The scale consists of 10 items that ask respondents to rate, on a 5-point response format, the extent to which they have experienced anxiety and depressive symptoms in the past month. The scale has been used in Australian population health surveys and categories of potential risk for developing a stress injury have been derived (e.g., low to no risk, medium risk, high risk) from the Australian norms[144]. The scale has also been used in several CF studies[145].

Items on the Stress on Operations scale ask respondents to rate stressful events they experienced on their most recent deployment using a five-point response format (1=never, 2=one time, 3=two to four times, 4=five to nine times, 5=ten or more times). Respondents are also asked to report how much concern each of these stressful situations has caused them on a five-point scale (1=no trouble or concern, 2=little trouble or concern, 3=some trouble or concern, 4= much trouble or concern, 5=very much trouble or concern).

Interviews. The interviews were semi-structured and lasted approximately 90 minutes.

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[141] Kessler, Andrews, Colpe, Hiripi, Mroczek, Normand, Waltersm, & Zaslavsky, 2002.
[142] Garabedian & Blanc, 2008.
[143] Hoge, Castro, Messer, McGurk, Cotting, Koffman, 2004.
[144] Australia, 2002, Available at: www.health.sa.gov.au/pros/portals/0/BR%202002-14%20Kessler%2010.pdf
[145] Garabedian & Blanc, 2008; McCreary & Thompson, 2005.

Results and Discussion

K10. The K10 scores, depicted in Figure 1, show that 6 of the 19 snipers, 30% of the sample, fell in the moderate and high risk categories for having a mental disorder. Four snipers (20%) scored in the medium risk category and two of the snipers (10%) were at the low end of the high risk category. Comparative data in Table 2 show that the sniper sample had fewer respondents in the moderate and high risk categories than a sample of 667 soldiers from Task Forces Afghanistan (TFA) 2007 and a sample of Canadian garrison soldiers (Army norm). These differences may be due to the effectiveness of the sniper selection system.

Combat stressors. Table 1 shows how often the snipers in this study experienced stressful combat situations during their most recent deployment to Afghanistan. Table 1 also contains data from TFA 2007, thus permitting some comparisons. The results show that the snipers in the present study had more exposure to combat stressors than the TFA sample. For example all of the snipers (100%) reported working in areas that were mined or contained improvised explosive devices compared to 51% of the TFA sample.

Impact of combat stressors. Table 2 lists the combat experiences that snipers found most troubling and shows that the sniper sample generally found their combat experiences more troubling than TFA soldiers, perhaps because they experienced more of these stressors, as shown in Table 1, than the task force sample.

Interview Results

Adjustments on returning to Canada from most recent deployment. Two-thirds of the sample reported experiencing a period of adjustment with family and friends when they returned home from their most recent deployment to Afghanistan. Three snipers reported increases in alcohol intake when they returned home, but most said that their drinking patterns were unchanged from their drinking habits before the deployment.

Seeking professional help for stress. About a third of the sample stated that they would likely seek help if they had a stress injury. Another third said they would first approach their sniper peers for advice. Three snipers stated that they had already sought professional help. When asked about the attitudes of their sniper peers on seeking professional help, slightly less than a third said their peers would likely seek help, and two subjects suggested that most snipers would seek advice from their peers first. Half the sample said it was unlikely that their sniper peers would seek professional help if they had a stress injury. About two-thirds of those with an opinion on the matter stated they would prefer to see CF mental health professionals over civilian professionals.

Attitudes towards the enemy. When asked how they felt about the enemy, about one-third of the snipers expressed hatred or contempt for the enemy. Another third stated that they respected the enemy and believed them to be "smart". The remainder were indifferent or stated they did not think about the enemy. From these answers, it appears that there was some dehumanization of the enemy, but not a large amount.

Reactions to killing. One question of interest is the extent to which the snipers experienced Grossman's (1995) three stages of reaction to killing in combat: initial euphoria, remorse, and then rationalization. In the current sample of snipers, several reported feeling an adrenalin rush and one said it was a validating experience, but no one expressed any regrets about the killings they had participated in. A third of the sample stated that they had no feelings about the killing; they said it was just a job. Everyone stated that they felt justified in killing the enemy because of the threat the enemy posed to Canadian troops and Afghan civilians.

Career satisfaction. Most of the sample expressed high levels of satisfaction with their military career and stated that they would remain in the CF. Three of the subjects were dissatisfied and reported that they would be leaving the CF soon.

Family support. The subjects in this study felt that their families supported their military career. Most reported that their wives were proud of their military career and almost everyone stated that their parents were proud of them.

Overall impact of being a sniper. Most of the sample felt that being a sniper had been a positive influence on their life.

Conclusion

This study suggests that the present sample of Canadian army snipers are coping well in comparison to other combat veterans in the army, even though the snipers experienced more combat stressors. This favorable comparison may be due to the sniper selection system introduced in recent years. A limiting factor of this study is the small sample of snipers and the reliance on general measures of stress.

Ongoing Research

The next phase of this research, currently underway, consists of administering a comprehensive survey to a larger sample of snipers. The following measures are included in this survey:

Combat exposure and concern. The Stress in Operations Scale, has been used extensively with Canadian Forces (CF) members who are about to deploy, are on deployment, or returning from deployment[146]. The scale measures combat exposure and level of concern as a result of this exposure. The latest version of this scale is included in the survey along with one item (Did you ever experience an injury that required hospitalization while deployed?) from Schell and Marshall (2008). Also included is the Major Stressors Inventory – Revised (MSI-R), a 22-item measure of non-traumatic stressors used in the Australian Defence Forces, that has been shown to correlate with work team morale and mental health[147].

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[146] Garabedian & Blanc, 2008.
[147] Deans & Byrne, 2009.

Non-operational stress. Two instruments have been included to gather data on non-operational stressors. The first consists of 78 items from the Canadian Forces Occupational Stress Questionnaire, a measure of occupational, but non-operational stressors developed by Kelloway and Barling (1994) that correlates with general mental health and employee turnover. The second measure consists of four items from the Operational Mental Health Assessment (OMHA), an instrument recently developed by researchers from the medical and human resource communities of the CF/DND to measure mental health symptoms and needs. The OMHA includes the Posttraumatic Symptom Checklist and the Patient Health Questionnaire-9 described below.

Post-traumatic stress. Post-traumatic stress is measured with the 17-item Posttraumatic Symptom Checklist (PCL) plus two items to gather additional information. A recent examination of the PCL which included an overview of 19 studies showed that this instrument is psychometrically robust[148]. The PCL measures symptoms experienced in the last 30 days. There are two versions of the PCL, a military version[149] and a civilian version[150]. The civilian version (PCL-C) is used in this study because it is broader in scope than the military version and therefore better able to tap into PTSD symptoms beyond those directly attributable to military experiences, and because it is currently used in CF post-deployment screening[151].

Depression. Depression is the most common mental health affliction[152]. The Patient Health Questionnaire-9 (PHQ-9) is a nine-item measure of depression[153] that has been used in post-deployment screening of CF personnel[154]. Four items have been added from the OMHA because of the additional information they capture.

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[148] Keen, Kutter, Niles, & Krinsley, 2008.
[149] Weathers, Huska, & Keane, 1991.
[150] Weathers, Litz, Herman, Huska, & Keane, 1993.
[151] Zamorski, 2008.
[152] Tolman, 2005.
[153] Kroenke, Spitzer, & Williams, 2001.
[154] Zamorski, 2008.

Present health. Four items have been included in the survey from the OMHA to measure current health.

Generalized stress. The Kessler Psychological Distress Scale is a measure of nonspecific (i.e., generalized) psychological stress developed for use as a screening tool[155]. The 10-item version of this instrument has been used in CF research[156].

Utilization of mental health resources. A 10-item scale was developed to measure the extent to which individuals have experienced any mental health issues, have accessed mental health resources, and their satisfaction with these resources. These items have been adapted from a number of sources[157].

High risk drinking. Given the association of mental health problems and high risk drinking, the 10-item World Health Organization measure, the Alcohol Use Disorders Identification Test, also known as the AUDIT[158] has been included along with two items from Hoge et al. (2004).

Anger. Anger reactions are assessed in the survey by the short form Dimensions of Anger Scale (S-DAR)[159]. Items on the S-DAR address various aspects of anger including anger frequency, duration, intensity, and expression. The S-DAR was shown to be a reliable and sensitive instrument of anger in a series of studies conducted among Australian Vietnam veterans with combat-related PTSD[160].

Encounters with the law. Recently, there have been a number of newspaper articles[161] reporting that veterans of the Afghan war are showing up in Canadian courtrooms and jails. This phenomenon is not extensively researched and is therefore included in this study. A scale has been developed to gather further information on this issue.

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[155] Kessler, Andrews, Colpe, Hiripi, Mroczek, Normand, Walters, & Zaslavsky, 2002.
[156] Garabedian & Blanc, 2008.
[157] Schell & Marshall, 2008; Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; OMHA.
[158] Babor, Higgins-Biddle, Saunders, & Monteiro, 2001.
[159] Forbes, Hawthorne, Elliott et al., 2004.
[160] Hawthorne, Mouthaan, Forbes, & Novaco, 2006.
[161] Bruser, 2009.

Barriers to care. While social stigma is recognized as a barrier to accessing mental health care in the military[162], there are also other barriers to seeking care. Drawing on the work of Schell and Marshall (2008), Hoge et al. (2004), Wong, Marshall, Schell, Elliott, Hambarsoomians, Chun and Berthold (2006), and the OMHA, a scale was developed to measure barriers to care in this study.

Post-traumatic growth. The relationship between exposure to trauma and mental health problems is well recognized, but there is also a growing body of research[163] showing that individuals can grow from their traumatic experiences. One of the more prominent measures in this field is the Posttraumatic Growth Inventory (PGTI) by Tedeschi and Calhoun (1996) which is included in the survey.

Self-efficacy. Research has shown that higher levels of perceived self-efficacy are associated with stronger performance in a variety of areas, thus self-efficacy may have a mitigating effect on stress. Two aspects of self-efficacy are important in this study: individual sniper self-efficacy and collective (i.e., sniper section) self-efficacy. Drawing on the advice of Bandura (2006), a measure of sniper self-efficacy was developed for this study.

Attitudes toward the mission. Research has shown that the morale of soldiers can be affected by their attitudes about the cause they are fighting for[164]. There is also a potential link between such attitudes and mental health outcomes as suggested in the study of US peacekeepers by Gray, Bolton, and Litz (2004). Thus, it is possible that the perceptions of Canadian snipers about their missions may be associated with the onset of PTSD or other mental health problems on post-deployment. Attitudes toward the mission are measured by a mix of items adapted from the CF's Unit Climate Profile scale and newly written items.

Cohesion. It is well known that cohesion is related to combat effectiveness[165], psychological well-being[166] and a range of other military outcomes[167], but it is

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[162] Britt, 2000.
[163] Linley & Joseph, 2004.
[164] Manning, 1991.
[165] Shils & Janowitz, 1948; Kellett, 1982; Henderson, 1985.

the impact of cohesion on psychological well-being that is relevant to the present study. Given the many ways that cohesion has been defined it is clear that cohesion is a multidimensional construct that cannot be measured by a single scale, so three approaches have been included in this research: (a) the CF's Unit Morale Profile questionnaire, (b) the perceived cohesion scale, and (c) social identity theory.

Unit Morale Profile (UMP). The UMP is derived from the Group Environment Questionnaire[168], a prominent cohesion measure. The UMP has been used extensively in CF research and has been modified for use with snipers. Given the emphasis of parties and social activities in some of the UMP's items, it is prudent to take a broader measure of social cohesion, so the Perceived Cohesion Scale and a social identity scale are also included in this study.

Perceived Cohesion Scale (PCS). The PCS is a 6-item measure, based on a definition of cohesion as "an individual's sense of belonging to a particular group and his or her feelings of morale associated with membership in the group[169]." The PCS has been adapted for measuring sniper cohesion.

Social identity theory. Research in the field of social identity also holds promise for measuring cohesion. A central part of social identity theory is that individuals form part of their self-concept on the basis of the groups they belong to, and the values and emotional significance they attach to such group membership. Along this vein, an indicator of sniper cohesion would be the extent to which individual snipers view themselves as belonging to the sniper community and deriving value from being a sniper. Cameron (2004) presented a three-factor model of social identity which has been adapted for this research. The first factor, centrality, refers to the amount of time

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[166] Shils, 1950; Bliese & Halverson, 1996; Hoyle & Crawford, 1994; Oliver, Harmon, Hoover, Hayes, & Pandhi, 1999; Ahronson & Cameron, 2007; Griffith & Vaitkus, 1999.
[167] Oliver et al., 1999.
[168] Ahronson & Cameron, 2007; Tremblay, 2009.
[169] Bollen & Hoyle, 1990, p. 482.

individuals spend thinking about being a sniper. The second factor, ingroup affect, reflects the positivity of feelings associated with being a sniper. The third factor, ingroup ties, represents the perceptions of similarity, bond, and belongingness with other snipers. Based on Cameron's model, a scale has been developed for use with snipers.

Reaction to killing in combat. There is little research on the psychology of killing beyond that provided by Grossman (1995), and scepticism of some of his assertions. One of his claims is relevant to the proposed research, specifically his suggestion that many soldiers who have killed in combat go through up to three stages of reaction beginning with a sense of intense satisfaction or euphoria, followed by remorse or regret, which is then followed by what can be a lengthy period of rationalization in which soldiers try to make sense of the killing. Grossman's theory has not been empirically validated, so a scale was developed for this project.

Demographic variables. Demographic information on variables such as rank, age, education, and tenure will be collected using questions similar to those found on many CF surveys.

Figures and Tables

Figure 1

K10 scores of Snipers, Task Force Afghanistan and Army Garrison.
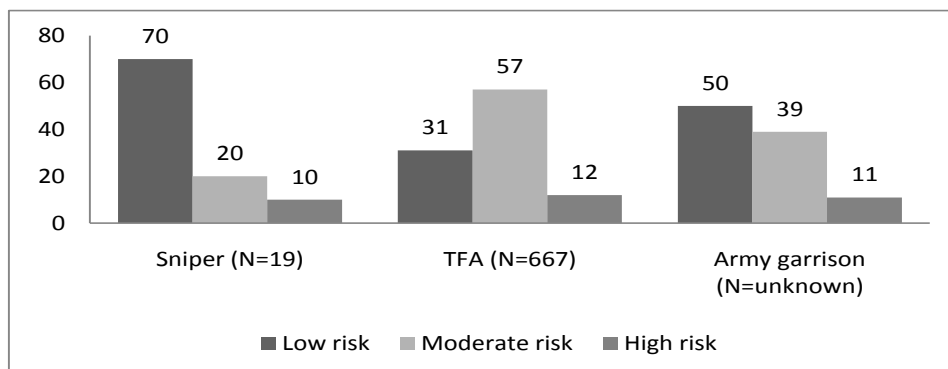
Note: Low risk = K10 scores from 10 to 15; Moderate risk = 16 to 29; High risk = 30 to 50.

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Table 1

Combat Stressors – Sniper Experiences Compared with Experiences of Task Force Afghanistan 2007.

Experience	Sniper	TFA
Working in areas that were mined or had IEDs	100 %	51 %
Receiving incoming artillery, rocket or mortar fire	95 %	71 %
Seeing destroyed homes and villages	90 %	62 %
Receiving small arms fire	84 %	
Knowing someone who had been seriously injured/killed	84 %	73 %
Clearing or searching homes or buildings	100 %	
Being attacked or ambushed	79 %	52%
Shooting or directing fire at the enemy	95 %	
Seeing dead bodies or human remains	74 %	
Being directly responsible for the death of an enemy	85 %	
Having a member of your own unit become a casualty	84 %	

Note: IED = improvised explosive device; TFA = Task Force Afghanistan 2007[170]. Sample sizes: sniper N=19, TFA N=667.

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[170] Garabedian & Blanc, 2008.

Table 2

Most troubling combat stressors of snipers (N=19) and TFA (N=667).

How much trouble or concern has this caused you?		Little or no trouble	Some trouble	Very troubling
Knowing someone seriously injured or killed	Sniper	47%	32%	21%
	TFA	63%	25%	12%
Having a member of your own unit become a casualty	Sniper	63%	21%	16%
	TFA	74%	17%	9%
Receiving incoming artillery, rocket or mortar fire	Sniper	64%	26%	10%
	TFA	78%	15%	7%
Seeing dead or seriously wounded Canadians	Sniper	69%	26%	5%
	TFA	80%	12%	8%
Being attacked or ambushed	Sniper	79%	16%	5%
	TFA	84%	11%	5%
Improvised IED or booby trap exploded near you	Sniper	63%	37%	0
	TFA*			
Being in threatening situations when you were unable to respond because of ROES	Sniper	69%	21%	10%
	TFA*			
Seeing ill or injured people you were unable to Help	Sniper	68%	32%	0
	TFA*			

Note: *No Data Available

Chapter IX

'Continuing darkness'. A case analysis of moral dilemmas in modern military operations

CDT John Deheegher, MSc[171]

Abstract

A case analysis of moral dilemmas in Belgian military operations in Africa shows that these dilemmas can have a heavy impact on the mental health of Belgian military personnel. Outbursts of anger, constant nervousness and aggression reach levels which are hard to stand and detriment daily live to an extent that presents un urgent need for systematic and systemic psychotherapy. The moral dilemmas originate from transgressions of military norms and values, from the hostility of the local population and from a lack of effectiveness of military interventions. The case analysis concludes with lessons learned for the management of these dilemmas, which can be applied to other operations and organizations as well.

Introduction

In recent years, service members of the Belgian Armed Forces have been confronted with tragic situations during military operations abroad. During these missions, Belgian troops inevitably faced situations of moral dilemmas.

As a clinical psychologist in the Military Centre for Mental Health and Crisis Psychology in the Military Hospital in Brussels, my colleagues and I regularly

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listen to the narratives of service members about dilemma situations, their consequent suffering and emotional scars[172].

This paper puts forward a case report describing the mental health problems of a Belgian paratrooper, renamed as 'Andy' in this paper. He participated in several military operations in Africa. During these African operations Andy experienced various situations of moral dilemmas. This chapter contains a case report of his mental health status, the therapeutic process and the description of the dilemma situations. Some conclusions are drawn on the risk factors contributing to the moral disengagement and diminishing moral competences of Andy and his colleagues.

Case report on the Belgian paratrooper 'Andy'

This case report is based on information obtained from himself, his wife and by telephone from Andy's unit commander. Andy's wife accompanied him during several psychotherapeutic sessions. She also provided important information.

Andy was 40 years old at the time of the first consultation. He is married and is father of three children: a boy of 16 years old, a girl of 7 years old and also a boy of 5 years old. Andy is a Senior Corporal who was a member of the Paratrooper Regiment for 20 years. After having served in this Regiment for 20 years he asked to be rotated to an Anti-Aircraft Unit, stationed near his home.

Main complaints and history of the present illness

Andy's Battery Commander had observed manifest changes in Andy's behaviour and urged him to come to the Military Centre for Mental Health to ask for help. Also Andy's wife observed gradual changes in his behaviour at home since Andy's participation in the mission in Somalia in 1993. They described how Andy was silent, isolated himself from others and avoided social contact. He visited his local café more frequently although there were no obvious signs of alcohol dependency.

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[172] Meijer, 2009.

Andy described how he felt alienated from others, how he felt irritated and how he needed to be alone. When he left home, he kept an eye on everything, ready to react in case of a sudden threat. He moreover felt burdened by constant ruminations. He frequently suffered from images from past missions which forced themselves on him. The intrusive memories often had to do with moral dilemma situations. They involved the emotions of shame and guilt. He described how he avoided emotions, felt irritated and was afraid of bursting out in anger at others, at his family. Andy suffered from a constant nervousness which he tried to suppress.

The intake session took place in the year 1996, so these complaints already existed for three years since his mission in Somalia in 1993. During those three years, Andy avoided seeking help. He thought that he would eventually recover without help from others. However, the tense social situation at home could no longer exists, Andy could no longer deny the mental health problems. Andy's medical records indicated he was a healthy paratrooper until the Somalia mission in 1993. He returned from Africa with Malaria. Medical records showed no earlier psychiatric history.

Family history, present state and outcome of therapeutic process

Andy had a troubled relationship with his mother. He tells that as a child he often was beaten by his mother. She saw him as weak and treated him as the lesser of her three sons. His father deceased after being invalidated for many years in a motorcycle accident. Andy's mother blamed Andy for the accident and the years of hospitalisation. As a result Andy got the feeling that he always needed to prove himself. This was also the reason why he has always suppressed emotions of irritation, anger or aggression.

According to the Diagnostical and Statistical Manual for Mental Disease IV, the symptoms of Andy's clinical condition correspond to the criteria of the diagnosis of a prolonged Posttraumatic Stress Disorder. A characteristic co-morbid feature is the inability to cope with emotions. Andy lacks the capacity to identify and to verbalise his emotions. This condition is called Alexithymia, which was probably

pre-existing and could explain the posttraumatic stress disorder. The mental status examination showed no indications for other mental illnesses.

The psychotherapeutic process lasted for 30 sessions in the course of two years. A leadership problem in his unit caused a temporary relapse of the symptoms of irritability and suppressed anger some years later. The focus in the sessions were Andy's thoughts and emotions connected to his experience of the Critical Incidents he had been through. The development of Andy's capacity to cope with intense emotions during the psychotherapy was beneficial. At the closure of the psychotherapy, Andy regained stability in his professional, family and personal life. The recollections of the Critical Incidents did not entirely disappear, but they were no longer intrusive and they did no longer paralyse his emotional life.

Description and analysis of Andy's moral dilemmas

Andy participated in various military operations in Africa, in which he encountered the following three moral dilemmas and their emotional burden.

The moral dilemma of transgression of military norms and values
In 1978 Andy's regiment was put into action in Kolwezi, a city in the Shaba province of Zaïre, now called Congo. Together with the French Foreign Legion the Belgian paratroopers were able to evacuate 2000 Europeans in 'operation Red Bean'. However, one hundred and fifty Europeans were killed in an atrocious way by Katangese guerrillas.

In the course of the psychotherapy Andy spoke about the brutal way in which the French legionnaires proceeded. When entering houses in the city to search for armed rebels, the legionnaires threw hand-grenades into the houses before entering to check if armed rebels were inside. In the atmosphere of urgency and crisis, for the French Légionnaires, a black coloured skin automatically led to the attribution 'hostile'. Andy is convinced that this indiscriminate use of excessive violence took many innocent lives of the local population.

Andy feels ashamed at this transgression of military norms and values. Military norms indeed indicate that violence can only be used discriminately, in

proportion to the hostile threat. They prescribe that killing of innocent civilians should be avoided in every possible way.

The moral dilemma of dealing with aggression by the local population

In 1993 Andy's regiment participated in the armed humanitarian mission 'Restore Hope' in Somalia. When the Belgian paratroopers left home they told their family their mission was to help the local population. They were going to secure the distribution of food to the famine-stricken population. However, when they arrived in Kismayo, a naval port in Somalia, they were disappointed to discover that they were dragged into an endless armed conflict between the two warlords Morgan and Omar-Jess.

The Belgian paratroopers were shocked to discover that their humanitarian efforts were not acknowledged by the population. The soldiers were disillusioned and frustrated by their powerlessness in regard to their efforts to pacify their region. Moreover, the paratroopers were often the victim of stealing and violence by the Somali civilian population. The paratroopers questioned the meaning of their humanitarian efforts and their own identity : "Am I a soldier 'in control' or am I a powerless humanitarian aid worker ?"

The disappointment, frustration and anxiety of the para's brought about a stereotype that saw the Somali males as lazy drug addicts and violent thieves. This negative stereotype of the Somali civilian population[173] seemed to have diminished the moral competence and provoked emotional reactions and misconduct by several Belgian, Canadian and Italian peacekeepers. It also defined the way in which the Belgian peacekeepers approached the local population: suspicious and with an attitude of hostility.

The moral dilemma of violence against children

This example is an illustration how a reduction in moral competence may have far reaching consequences and may affect decisions on life or death.

At night, Andy was on an Observation Post together with a sniper when a Somali male tried to enter the compound, supposedly to steal from the blue helmets. He did not give heed to the repeated warnings of Andy. The sniper aimed and asked Andy when and where he could fire. Andy acknowledged and told him to

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[173] Boniecki & Britt, 2003.

aim for the lower limbs. The Somali was hit in the leg with a 7.62 calibre bullet. When Andy inspected the wounded intruder, he was dismayed when he discovered it was a boy of only about 13 years old. Two days after the shooting, the boy died in hospital of an infection.

Andy feels guilty about his decision in this situation. He doubts if his decision to fire came too quickly, influenced by the stereotype of Somali males as thieves. He feels as if he was the one who pulled the trigger. This feeling of guilt worsened because the Somali victim appeared to be unarmed. The victim reminds him of his own eldest son and of his role as a father. Andy feels ashamed because he was involved in the killing of a child who turned out to be unarmed and chanceless against the precise sniper's fire. Shock, shame and guilt are common psychological scars after the use of lethal firepower in the confrontation with children in the opposing forces in the context of asymmetrical warfare[174].

The decision to open fire came automatically. There was not a single moment of reflection before taking the decision to fire. During psychotherapy, Andy indicates this decreased mental processing was influenced by the negative stereotype of Somali males. The stress of the desert climate and lack of sleep also played their part. The sense of urgency, the stress and the adrenaline flow evoked by the perception of the hostile intruder forced the decision to open fire. Diminished moral competence resulted in neglecting the moral ambiguity of the situation, no reflection or exchange of views about the dilemma and no well-considered decision about the use of weapons. This automatic reaction without considering the consequences for the victim also indicates moral disengagement.

Risk factors for diminishing moral competence and mechanisms of moral disengagement

Andy is a dedicated and long serving member of a military elite unit. He is a loyal husband and father of three children. The case analysis shows no pre-morbid psychopathological disorders. His narrative however shows the

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[174] Pre-released final report of the NATO Research and Technology HFM-159 Task Group on Child Soldiers as the Opposing Force. Paris, France, 2007.

languishing of existing moral standards. During his missions in Africa he witnessed the decline of moral reasoning. This decline in moral competence led to inhumane conduct of several Belgian, Canadian and Italian peacekeepers in Somalia[175]. The Canadian psychologist Bandura[176] describes how moral disengagement can lead to inhuman conduct by intervening troops.

Andy described how he felt ill at ease during the mission 'Red Bean' when he witnessed the indiscriminate use of lethal violence by the French foreign legion troops. In an interview with Time Magazine in 1978[177], an officer of the French foreign legion said "You legionnaires are soldiers in order to die and I am sending you where you can die". A battle-hungry member of the 2nd Foreign Legion Parachute Regiment and veteran of the Kolwezi campaign said: 'one legionnaire is as valuable'. And, 'one legionnaire is as valuable as twenty members of the opposing force'. According to Bandura[178], 'self-censure for cruel conduct can be disengaged by stripping people of human qualities. They are portrayed as mindless "savages", "gooks", and the other despicable wretches. It is easier to brutalize people when they are viewed as inferior, as low animal forms'.

When Andy's Regiment left Belgium for the United Nations mission 'Restore Hope' in Somalia, they were highly motivated. The para's had a clear humanitarian and 'peace enforcing' objective. After they arrived in Kismayo however, their objective gradually vanished into nothing. Their humanitarian efforts were often not effective nor acknowledged by the civil population. Step by step, they were dragged into the foggy conflict between two fighting factions. During the course of these missions, several para's were injured or killed in accidents or victims of the violence which ruled the country. According to Bandura, 'disengagement practices will not instantly transform considerate persons into cruel ones'. The Belgian blue helmets gradually dissociated their feelings of powerlessness, frustration irritation and hate. They ended up acting out these emotional conflicts. The moral disengagement almost went unnoticed.

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[175] Van Baarda, 2004; Bradley, 2010.
[176] Bandura, 1990.
[177] Time Magazine, World, 1978: The Foreign Legion Fights again
<http://www.time.com/time/magazine/article/0,9171,916175-1,00.html>
[178] Bandura, 1990.

Often, an aggressive warrior ethos guided the blue helmets in their approach of the local population. Somali children who tried to steal from the United Nations compound were captured and held above a fire. In the course of various psychotherapeutic sessions several Somalia veterans told me about the thrashing of civilians at roadblocks, careless discharge of weapons, setting huts ablaze when passing by on a truck and treating Somali Muslim women disrespectfully. The inhuman misconduct became the standard for several young conscript para's who often had led an irreproachable life before the mission. Few of the servicemen had been victim of extreme violence like the violence some blue helmets inflicted on the Somali's. The cases of misconduct of several para's lead to some accusations and condemnations in court, although the sentences turned out to be mild[179].

The negative image of the Somali civilians led Andy to acknowledge the sniper's request to open fire. Somali males were seen as drug addicts, as lazy and inferior people and as violent thieves. Different dehumanizing aspects were captured in this negative stereotype. As a consequence, Somali civilians were blamed. They were seen as the cause of chaos and disorder in the country. As a consequence, some blue helmets tend to overlook their own fault in their misconduct towards civilians. On this last risk factor in moral disengagement, Bandura states that in the process of attribution of blame 'people view themselves as faultless victims driven to injurious conduct by forcible provocation'.

Lessons learned

An important lesson can be learned from the analysis of Andy's mental health case and the moral dilemmas he encountered in his missions in Africa. An essential lesson is that these military missions easily and often produce situations which entail moral dilemmas. When a decline in moral competency is present in the military mission, it can easily lead to misconduct and the acting-out of underlying conflicting emotions. An adequate moral management of these dilemma situations entails the competence of the key figures of the unit to

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[179] Van Baarda, 2004.

observe, to identify and to remedy the different mechanisms of moral disengagement. We have also learned that moral disengagement is not a question of merely individual psychopathology. Even decent people can be involved in inhuman conduct when risks factors of moral disengagement are not countered effectively.

Chapter X

Tragic Dilemmas of Social Workers in Lethal Accidents in the Netherlands Armed Forces

CDR Marten Meijer, PhD[180] & Arjen Coops, Ba[181]

Abstract

The case-analyses in this chapter focus on three lethal accidents during modern military operations of the Netherlands Armed Forces. Victims were active duty military personnel, who died by actions in which no enemy or armed opponent was engaged. Social workers appear to be involved in the aftermath of these cases in a variety of activities. Some of these activities present tragic dilemmas to the social workers. Social workers have to cope with tragic dilemmas about informing the next of kin of the victim with all the information they have gathered about the lethal accident. Another dilemma appears when they are asked to testify for juridical investigation teams or to support the other actors in the accident or the unit, also in reunions many years after the accident. In contacts with all the actors in these accidents, feelings of anger, grief, shame and guilt are tangible on the side of the actors, the military unit, the next of kin and the social workers. In the case studies the choices taken in all of these tragic dilemmas are examined. From this analysis it appears that in spite of these tragic dilemmas much can be done in addition to the traditional reaction patterns of social workers to lethal accidents.

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Introduction to activities of social workers in the aftermath of lethal accidents in modern military operations.

As of June 2010 the Netherlands Armed Forces at least have lost eleven military personnel due to lethal accidents in modern military operations over the past thirty years. From a study of the United States Army War College it appears that during modern military operations in the twentieth century, 5-24 percent of all lethal casualties were caused by these accidents. Among the 58.000 American military casualties in the Vietnam war, between five and ten percent were killed by their own side. Of the eight Bradley tanks and tank crews that were lost in the Gulf War, friendly fire destroyed seven[182]. In training for military operations many more military lives were lost. Awkwardly, these lethal accidents are sometimes erroneously called 'friendly fire', but as this fire is deadly, not friendly, this wording will not be used. In the same line of reasoning, the word perpetrator is not appropriate and will be replaced by actor. In all of these lethal accidents lives were lost and the next of kin of the victims had to cope with these losses for the rest of their lives. In some cases it appeared very clearly that actors were haunted by severe feelings of shame and guilt, also for the rest of their lives. Social workers are involved in a variety of activities in modern military operations[183]. As part of the standard operating procedure of the Netherlands Armed Forces, a social worker personally informs the next of kin of a military person when he or she is killed in action, lost in action, kidnapped or severely wounded. This bad news is brought in a personal visit and only after this visit is completed, the Ministry of Defence releases this news to the mass media. In the deployment area a black hole procedure prevents premature sharing of this news, as all electronic communications are blocked until the next of kin are properly informed. Ongoing support for the next of kin is another activity of social workers, especially on the funeral and in the time after that last goodbye. It is also possible that social workers advise commanding officers on how to proceed in the aftermath of the accident, including questions on how to support all the actors involved in the accident. Very often a board of inquiry has to investigate the circumstances in which the accident happened. Testifying to

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[182] Statistics from the United States Army War College Journal.
[183] Thompson & Pasto, 2003.

such a board is of utmost importance, but can be a huge psychological burden to the actors or the witnesses, which presents another need for psycho-social care by social workers. In addition to the work fore the board of inquiry, social workers also participate in Critical Incident Stress Debriefings as chair or facilitator of the group session[184]. Actors in lethal accidents might be in need of special care to cope with their severe feelings of shame and guilt, like perpetrators of atrocities[185]. Both during and after these operations, psychosocial care for military personnel is a rather traditional activity of social workers. In all of these activities, choices have to be made which affect the interests of the organization, e.g. the Ministry of Defence and the interests of military personnel. Most of the time, the interests of both parties can be served, but sometimes a choice has to made which party should be served first. According to the professional code of conduct of social workers, the interests of the client who asked for help should take precedence[186]. In a few cases, the choice of social worker seems to be resulting in a tragic outcome, whatever choice is made. These choices are referred to as tragic dilemmas and are strongly connected to activities of social workers in lethal accidents.

Research question on tragic dilemmas

As explained in the introduction, social work activities can start immediately after the sad event of a lethal accident, for instance in informing the next of kin of the victims. In a life long perspective it can be continued to the last surviving next of kin, actor or the organisation, which may gain from lessons learned of lethal accidents. From a random selection of three cases of lethal accidents in modern military operations the following research questions raises: **what are the tragic dilemmas of social workers in their support of the next of kin of the victims, the actors and the organisation**?

A tragic dilemma is a dilemma, in which the outcomes of all possible choices are tragic, no matter what choices are made. More precisely, a tragic dilemma can

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[184] Ibidem, p. 229.
[185] Litz et al., 2009.
[186] Meijer, 2006.

be defined as a situation, in which an agent has to make a choice in which he overrides moral requirements in any choice he makes[187].

Method of description and analysis of social work in lethal accidents

The cases are selected from the personal professional experience of the authors in the aftermath of lethal accidents and represent recently finished or ongoing cases of social work in the Netherlands Armed Forces. The description of the lethal accidents originates from open sources as much as possible, like books, articles and published reports. However, the privacy of the next of kin of the victims and the actors has to be protected as much as possible, so not all details on every case are presented. A choice in this respect already presents a tragic dilemma, as a guarantee of maximum protection of privacy disables the process of careful analysis and identification of lessons learned. With great respect for the deceased, for their loved ones and for all actors involved in the selected lethal accidents, only these critical details of the accidents are described, which are needed to identify lessons learned. The analyses of the cases were made by the authors and discussed in some detail with psychiatrists, psychologists and social workers in an international conference and at an international workshop with students of social work. Their feedback is highly valued and included in the description and analysis of each case.

Descriptions and analyses of three lethal accidents in modern military operations

The three cases, which will be described and analysed, originate from lethal accidents in modern military operations which took place between twenty and thirty years ago. Although this lapse of time challenges the adverb 'modern', this perspective provides the opportunity to analyse long term effects of these accidents and the interventions of social workers. The first two cases are connected to land operations, the third case is connected to an operation at sea.

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[187] Quinn, 1990.

Box 1

A lethal accident at the end of a patrol.[188]

A sergeant was in command of a road block patrol of four soldiers, which operated from six o'clock in the evening till six o'clock in the morning. After being relieved by the next patrol, the patrol returned to base. At arrival at the gate of the compound, the watch of the compound ordered to unload the weapons, according to standing safety procedures. A private of the patrol tried to unload his weapon, a pistol machine gun, but he had trouble to extract the magazine entirely, due to a mechanical defect, which was reported by him two weeks before. While the private was struggling with the weapon, the sergeant was passing in front of the patrol. At that moment the cocking slipped forward from his grasp and fired off the machine gun. Two rounds were discharged, which struck the sergeant in the head. He fell on the ground and bled heavily. The private tried to stop the bleeding by putting his hands on the wounds and cried out loud for help. Once help was given as first aid, the wounded sergeant was taken to the nearest civil hospital. In the meantime the social worker of the unit accompanied the private, waiting together for further news on the recovery of the sergeant. However, the sergeant died soon after arriving at the hospital. The social worker advised the commanding officer to maintain the private in the unit. Together with the medical doctor of the unit, the social worker accompanied the private in his first confrontation with his colleagues and explained that the accident could have happened to any of the patrol members. A report on the lethal accident was completed ten days after the accident and was sent to the international headquarters in the theatre of operations. At the time that an international military investigation board of these headquarters re-examined the circumstances of the lethal accident in the following months, the whole battalion had redeployed to the Netherlands. The social worker remained in the theatre of operations and testified for this board as a Dutch unit representative, having obtained all his information from the private. The board concluded that the sergeant did not fully comply with the safety orders to supervise the unloading of the weapons by his patrol members. The private did not comply with the safety orders fully either, as he failed to unload his weapon

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[188] Netherlands Military Juridical Journal, 1985, pp. 378-381.

safely, due to mechanical problems. The international investigation board recommended to the Dutch national authorities to determine the degree of negligence of the actor. After return to the Netherlands, representatives of the Ministry of Defence discouraged the private to contact the next of kin of the deceased sergeant. A military court concluded that the private was guilty of negligence, without sentence. In a higher appeal the private was found not guilty. Almost thirty years later the private still suffers from outbursts of anger and severe feelings of shame and guilt. He has changed his name in order to avoid any connection between him and the lethal accident. He is not able to face himself in a mirror, he has lost a variety of jobs, his marriage, contact with his children and behaves in a self destructive way of irregular living, drinking heavily, heavy smoking and frequently using soft and hard drugs. Once in a while he has contact with a social worker of the Dutch Foundation of War and Military Service Victims, who established financial aid from the Ministry of Defence. After the two most recent consultations with social workers, the private intends to close the aftermath of the accident and to start with new hopes and aspirations, like the care of his first grandchild.

From the description of the lethal accident in box 1 it appears that the social worker in theatre accompanied the private, which is a very valuable activity for people who feel left alone with overwhelming feelings of shame and guilt. The social worker testified for the board of inquiry, as all of the patrol members had returned to the Netherlands after completion of their mission. Giving such a testimony presents a tragic moral dilemma. The board can plea guilty by mistake if the social workers testimony is affected by errors of commission or errors of omission. The board can also plea guilty by a lack of such a testimony, so on its own errors of omission. In this case the board recommended a further investigation on the negligence of the private by the Dutch authorities, who concluded guilt of negligence. Only in higher appeal the private was found not guilty. In the presently needed psychosocial care for the private, the social worker has to deal with another tragic dilemma in the choice for establishing contact between the private and the next of kin of the deceased sergeant. In establishing this contact, a lot of horrifying details can be brought to the attention of the next of kin, which will result in reliving the horrors of so many

years ago and a loss of sleep for several nights. The initial discouragement by the representatives of the Ministry of Defence regarding contact between the private and the next of kin of the deceased sergeant also pleas against this contact, but might be seen as an attempt to a fair trial. On the other hand, not establishing this contact will refrain them from a more complete understanding of the events, which lead to the lethal accident. A lot of questions will remain unanswered, probably forever. When no contact is established, the private will not be forgiven by those who miss the deceased sergeant most, so his feelings of shame and guilt will not fade away. As of today, social workers discuss how to deal with this tragic dilemma of the restoration of contacts between the private and the next of kin of the deceased sergeant or his colleagues.

Box 2
A lethal accident on the compound.

During a peace keeping mission, a private was part of a Quick Reaction Force, which operated at night. The next morning the private worked on the maintenance of his personal weapon in his tent on the compound. By accident, the weapon was not properly unloaded and a bullet was still in the chamber. When he cocked his rifle and pulled the trigger for maintenance purposes, the weapon fired the bullet. The bullet went straight from the tent into another tent, where he hit another private in the head. This private immediately received combat casualty care, but died soon afterwards. The next of kin of the deceased private were informed by a social worker of the Ministry of Defence. The other private completed his mission, but was taken to a military court for examination of the accident. As he explained that he was not properly trained for the weapon, which was used in the lethal accident, he was found not guilty. For the remaining part of his contract period, he fulfilled the job of a VIP driver in the armed forces. Almost twenty years after the accident, the next of kin of the deceased travelled to the place of the accident at expenses of the Ministry of Defence. The mother of the deceased private wrote a book about her experiences, which might be published with financial support of the Ministry of Defence. Until now, the actor in the accident never contacted the family of the deceased.

From the description of the lethal accident in box 2 it appears that a social worker was active on informing the next of kin of the deceased private. The actor in the accident was never contacted by a social worker and he never contacted the family of the deceased private. A possible action for social work could be to support this contact. Another possibility would be to contact the private of the lethal accident as described in box 1 to share observations, emotions and strengths to cope with the feelings of shame and guilt.

Box 3

A lethal accident at sea.

During a transit of a frigate in the Atlantic Ocean, a fire broke out in one of the forward boiler rooms. In these rooms, diesel was burnt to heat water to steam, which propelled the turbines for main propulsion of the ship. After it appeared that the immediate fire fighting was not effective, the sergeant in charge of this boiler room ordered to evacuate the room. All evacuees suffered from burn injuries and two sailors of the engine-room crew were reported missing. Subsequent fire fighting from outside the boiler room was not successful either, so boundary cooling was the only option left in waiting for the fire to extinguish by lack of fuel. In this waiting period the captain of the frigate ordered to abandon the ship, except for the crewmembers who were fighting the fire. After the fire was extinguished, the frigate was towed into the nearest harbour by another frigate. The bodies of the two missing sailors were found when the bilge water was pumped out of the boiler room. The ships crew flew back to the Netherlands. In the years after, the sergeant in charge of the boiler room and the damage control officer in charge of the fire fighting were struggling heavily with their feelings of shame and guilt. An investigation board of the navy concluded that a lot of factors contributed to the accident, like the burning of crypto paperwork in the fire in the forward boiler room, failures in the fire fighting equipment and a lack of good leadership of the officers and sergeant in charge of the boiler room. The admiral in charge of the fleet sent a letter to all of his ships, emphasizing the importance of proper fire fighting equipment and good leadership, in which he focused on the lack of leadership by the sergeant. In the years after the accident, the damage control officer kept on practicing fire

fighting drills up to a level that was hard to stand for any ships crew that he was assigned to. During a major international exercise, a physician who was aboard of his ship had to administer him tranquilizers without his consent to get him out of duty. He had to retire early because of progressive psychological complaints. Twenty years after the accident, the officer was found dead in a separation room of a mental asylum at the age of fifty-three. The sergeant was assigned to a variety of jobs, but was never rewarded for his duties as his lack of leadership was depicted as the main cause of the lethal fire. He fought almost twenty-five years for his rehabilitation. He became a member of the Dutch Foundation for War and Service Victims and received full compensation for all his psychotherapy and haptonomy therapy by the Ministry of Defence. At a reunion for the entire crew of the frigate at the Veterans Institute, twenty-two years after the lethal accident, the navy did not allow the organising committee to commemorate the deceased with a moment of silence, although a navy psychiatrist and two social workers had recommended to do so. Neither did the sergeant or the other direct colleagues of the deceased got the opportunity to share their narratives and feelings. The commanding officer was too busy to join the reunion, although he was already retired. Nevertheless, the navy agreed to show video footage during lunchtime on this reunion of the frigate on fire. A maritime patrol aircraft of the navy made this footage, which clearly showed the smoke coming out of the deck openings and the ships starboard side, which burnt black by the high temperatures inside. Immediately after this reunion, one of the social workers sent a letter to the commander in chief of the navy, in which he recommended to never again organize such reunions in such a way. He did not get a reply on his letter, but got an administrative sentence, which was destroyed in higher appeal. Two years after this reunion the sergeant was rehabilitated by a forceful intervention of the Inspector General of the Netherlands Armed Forces. On the recommendations of and in the presence of this inspector and the social worker, the sergeant was given a letter of excuse of the navy and he got twenty five thousand euro's. In spite of this rehabilitation he suffered of multiple cerebral vascular incidents and died only four years later at the age of sixty-eight.

From the description of the lethal accident in box 3 it appears that activities of social workers were only seen at a reunion for the ships crew, more than twenty years after the lethal accident. In that stage of the process, a tragic dilemma for the social workers arose from the question on how to handle the interests of the few people, who really were involved and injured in the accident, like the sergeant in charge of the boiler room. A choice for supporting their interest could present a conflict with the perceived interests of the navy leadership of the reunion, who would not like to focus on the accident. A choice for the interests of the naval leadership of the reunion would leave those who suffered most in the accident unheard and unseen. Initially, the tragic dilemma was resolved in favour of the interests of the navy leadership, as the deceased were not commemorated and the most injured people were not given special attention. The intervention of the social worker after this reunion resolved this tragic dilemma in favour of the military personnel, who were suffering most of the long term effects of the accident, especially in favour of the sergeant, who was rehabilitated and compensated.

Lessons learned from social work in lethal accidents

From the description and analysis of the three cases it can be concluded that the lethal accidents present at least two types of tragic dilemmas for social workers. These dilemmas include choices on how to connect actors in the accident with the next of kin of the victims and include choices on how to support the interests of actors and of the ministry of Defence.

Regarding the first type of tragic dilemma, in all three cases the choice was made not to connect the actors in the accident with the next of kin of the deceased. This choice might have frustrated the need for forgiveness and reconciliation of the actors in the accident. This need is still pressing in some of the actors in these accidents, except for the actors who already died, due to strong feelings of shame and guilt.

Regarding the second type of tragic dilemma whose interests should be served, the case analyses show different options. In the first case the interests of the

actor in the accident were served by the social worker, who gave testimony to the board of inquiry. However, as this board recommended to determine the amount of negligence of the private, it can be argued that his interests were not really served, as the testimony of the social worker was vulnerable for errors of omission and errors of commission. In the second case, social workers did not take action to serve the interests of the actor. Policies of good care for personnel or their next of kin resulted in their travel to the scene of the accident and possibly the publishing of a book. These actions are clearly in favour of the next of kin, at expenses of the Ministry of Defence. In the third case initially most actions were taken to serve the interests of the ministry of Defence. In a latter stage, at the reunion for the entire crew of the ship, a social worker tried to serve the interest of the actors in the accident, but he failed. Only after an intervention by the Inspector General of the Netherlands Armed Forces, the interests of one of the actors were served. He was rehabilitated and compensated by the ministry of Defence.

Last but not least a few lessons can be learned from the analyses of the lethal accidents. The first lesson is that the activities of social work vary a lot in the three cases. Sometimes a social worker is present at the scene of the accident, which gives the opportunity to act immediately. In another case it takes years before the first activities of social work can be identified. When all the possible activities for social workers in the aftermath of a lethal accident would be discussed as a good practice right after every lethal accident, this would be a real lesson learned.

The second lesson for social work in cases of lethal accidents is that this social work raises the question how to cope with tragic dilemmas. By definition, there is not a one best way to cope with such dilemmas, but timely training how to cope with these dilemmas in a consistent way would be another important lesson learned. A final and complete prevention of lethal accidents in any armed force is impossible, so social workers should be prepared to act in the aftermath of these accidents.

Chapter XI

Deployment-Related Guilt and Shame in Dutch Veterans of Peacekeeping and Peace-enforcing Missions

Natasja Rietveld, PhD[189]

Abstract

A recent study regarding Dutch veterans of peacekeeping and peace-enforcing missions[190] shows us that many of the veterans still experience deployment-related feelings of guilt and shame. The study shows us also that both emotions are indirectly associated to inadequate rules of engagement and directly to experienced powerlessness, the 'bystander role' of veterans and the 'unintentional violence' they caused during their military mission. Peacekeepers experienced a greater degree of powerlessness and inadequate ROE than peace-enforcers; however, both groups do not differ in extent of deployment-related guilt and shame. In this paper we present some central research results of the study.

Introduction and research question

Earlier research among veterans shows that many of them experience profound feelings of guilt as a consequence of surviving the war whilst colleagues perished, and that feelings of guilt can be related to painful war memories[191]. Even years after the war many Vietnam veterans appear to be troubled by the feeling that what they have done is unforgiveable[192], and are troubled by feelings of shame[193]. The abovementioned studies concern only American

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[190] Rietveld, 2009.
[191] Lifton, 1973; Glover, 1984; Kubany, 1994; Kubany et al., 1997.
[192] Singer, 2004.
[193] Wong et al., 1992; Leskela et al., 2002; Harrigan, 2007.

researches, whereby war veterans (mostly Vietnam veterans) were always paramount. Furthermore, these studies always concerned the relationship between guilt, shame and psychological complaints, including Post Traumatic Stress Disorder (PTSD). Mostly two types of guilt were prominent, i.e., *survival guilt* and *combat guilt*. The amount and the nature of guilt and shame experienced by Dutch veterans of peace mission have never been investigated.

Since the founding of the United Nations (1945) the Netherlands has supplied military forces for participation in international crisis-management operations. As impartial party, the peacekeeping force is charged with the task of preventing the escalation of conflicts between (ex-) battling parties and must contribute towards a correct enforcement of a peace agreement and a lasting resolution of the conflict, for example through developing and supervision of reconstruction activities. Taking strong action may only be with military force under strict conditions (Rules of Engagement), namely out of lawful self-defence (in the case of a peacekeeping mission) and if violation of human rights take place, and a peace agreement or cease-fire are violated. If needs be, the peace may then be enforced using military force (in the case of a peace-enforcement mission). In any case, the peacekeeping force must ensure that the conflicting parties (continue to) refrain from the use of violence.

In regions of deployment military personnel are witness of the consequences of the war and of the violence which has been, and sometimes is, inflicted upon the civilian population. They are witness of the pitiful conditions under which the refugees must live in the post-war situation, of children dying and other human suffering. The impartiality of the peacekeeping force actually hampers the offering of help and restricts, or sometimes even forbids intervening to stop violence. That makes that participation in a peacekeeping mission can be mentally taxing. Also operations in which the soldier may use military force to stop the violence and to enforce the peace can be mentally taxing. After all, sometimes such operations maim innocent citizens and destroy their houses or infrastructure. After a mission has been completed, military personnel can have doubts about the correctness of certain decisions in the region of deployment, also about the consequences thereof, which cannot always be verified afterwards. In hindsight doubtfulness can occur about the correctness of

choices, behaviour and actions, whereby feelings of guilt and / or shame can play a role.

Guilt and shame are moral[194], self-conscious and social emotions[195] and cognitions[196]. With guilt we condemn our behaviour and with shame our personality[197]. As moral emotions guilt and shame are emotions that are "linked to the interests or welfare of society as a whole or of other people. These emotions originate in social relationships and are built on reciprocal evaluations and judgements of the self and others."[198] Because shame is directly related to one's self, shame is more painful than guilt. Shame and guilt differ in the manner in which people behave when they are ashamed or feel guilt. Shame has a negative impact on interpersonal behaviour. Ashamed people want to hide and feel worthless. A person experiencing guilt wants to undertake actions to make things better. That person is motivated to improve interpersonal relationships. We can explain the *meaning* of guilt and shame of veterans with the attribution theory. This has to do with a social-psychological approach of guilt and shame based upon the want and need of causality which every person experiences in daily life. Everyone has the need to explain that which happens in our lives. It gives a feeling of control over the course of our lives and insight into what we can expect. Witnessing violence and misery and exposure to violence, for example in deployment, means loss of control - leading to fear, insecurity and powerlessness. In such cases we would rather hold ourselves responsible for that which has happened and rather feel unhappy about the self-accusation and shame, than that we must accept that life can apparently be fearful and insecure, namely that we can be at the mercy of arbitrariness[199]. If feelings of guilt and shame are not recognised and discussed, they can be at the expense of the mental health. The veteran attempts to find an explanation for the evil and grief and attribute an explanation to it, by the moral questions about decisions and actions, which lay enclosed in self-accusation. With this, he or she can regain control over the course of their own life. Therefore the research question

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[194] De Hooge, Zeelenberg, & Breugelmans, 2007.
[195] Tangney et al., 2002.
[196] Kubany et al., 2006.
[197] Lewis, 1971.
[198] De Hooge, Zeelenberg, & Breugelmans, 2007, p. 1026.
[199] Herman, 2002.

that is answered in the dissertation is: What is the extent and the nature of the guilt and shame veterans of Peace Operations experience (1) and what personal characteristics (2) and mission related factors (3) are related to guilt and shame?

Method

Participants

In June 2006 around 3,000 Dutch veterans of fourteen peacekeeping and peace-enforcement missions (a stratified random sample including UNPROFOR and IFOR/SFOR, former Yugoslavia; KFOR, Kosovo and SFIR, Iraq) received a questionnaire. All are registered at the veterans registration system of the Veterans Institute. Dutch soldiers become veterans when they were deployed during peace or war mission for at least 30 days. 1,171 (33%) veterans, most male (92%) completed the questionnaire.

The average age of the participants was 43.6 years (SD = 13.5). The youngest respondent was 22 and the oldest 86 years old. 15% of the respondents were aged between 18 and 20 years old when they were deployed.

About the average education level of the veterans: 31% was low, 45% middle and 24% of the veterans was high educated. Half of the respondents had, during deployment a low rank (soldier/corporal), 28% a middle (sergeant/adjutant under officer), 20% a high rank (second lieutenant-lieutenant colonel) and 2% was colonel or general.

Most of the veterans were military personnel by profession and 15% were deployed whilst serving National Service. 58% of the veterans deployed for one time, 24% for two times and 18% for three times or more. In Figure 1 we show the peacekeeping and peace-enforcement missions of the respondents.

Figure 1

Deployments of the respondents (% of n = 1170).
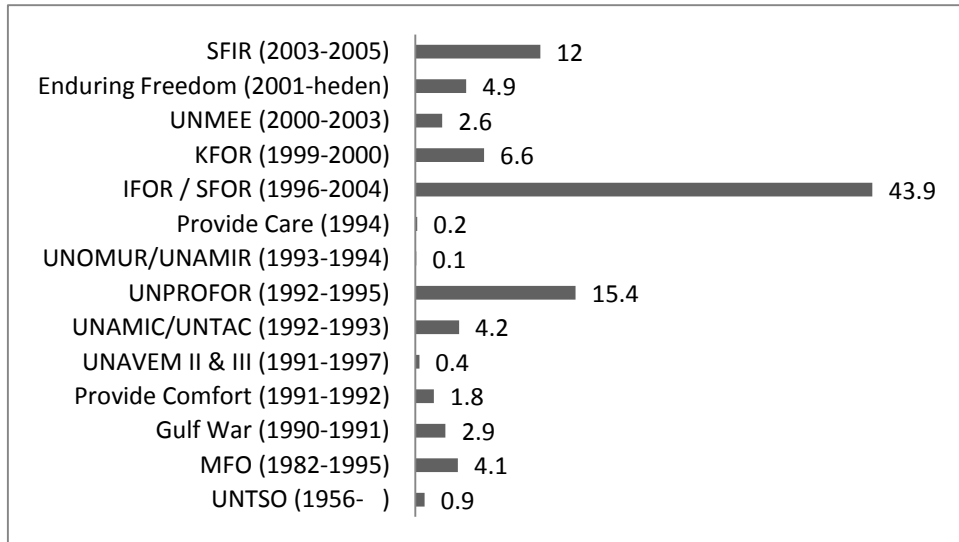
When deployed at least two times the respondents must choose the deployment which had the highest impact on their lives, in order to answer the questions in the questionnaire. Almost 24% of the respondents were deployed between 1991 and 1995, more than 50% between 1996 and 2000 and almost 27% after 2000.

More than 55% of the respondents left the armed forces after 2000. As reason for ending the military career the veterans named pensionable age the most. 2% left the armed forces as a result of sickness, PTSD or injuries sustained during active service.

Measures

Guilt and shame. To investigate the first part of the research question: the extent and the nature of deployment-related guilt and shame we used following measurements. Firstly the respondents had to answer, by using a 5-point rating scale (1 = 'not at all', 5 = 'always') two questions that read: 'To what extent you feel guilty(ashamed) about events or situations that happened during your deployment?". The nature of guilt is measured by a selection of 46 items of the 'Sources of Trauma-Related Guilt Survey War-Zone Version (STRGS-WZ)'

created by Kubany et al.[200] The STRGS-WZ is a list of 120 potential sources of war-related guilt. Respondents rate, on a 5-point scale ('no guilt' = 0, 'extremely guilty'= 4) the degree to which each item reflects a source of their experienced guilt. Based on the mean rating of the respondents and scale analysis, the items were categorized into six types of deployment-related guilt. The reliability of the included categories are: alpha = .86 (9 items) for 'Guilt concerning no acting to stop violence' or 'I should have done more guilt'; alpha = .62 (5 items) for 'Survival guilt'; alpha = .67 (5 items) for 'Guilt after unintentional violence'; alpha = .83 (9 items) for 'Atrocity guilt'; alpha = .83 (15 items) for 'Combat guilt'; and alpha = .63 (3 items) for 'Guilt because of a negative attitude during employment towards civilians'.

Personal characteristics. To investigate the second part of the research question: which personal characteristics are related to the extent of guilt and shame, we incorporates variables know to be associated with guilt and shame, i.e., age, gender, education level, psychoticism and self-esteem.

   Education level is measured by the question: "What is your highest completed education degree?" (for analysis categorized in low, middle, high).

   Self-esteem is measured by the 'Rosenberg Self-Esteem Scale'[201] (RSS). The RSS includes ten items to assess (on a 4-point rating scale, 0 = 'totally disagree', 3 = 'totally agree') general feelings of self-acceptance and self-respect (alpha = .89).

   For measuring *Psychoticism* we used the 'Symptom Checklist (SCL 90)'[202] which evaluates a broad range of physical complaints, psychological problems and symptoms of psychopathology. The veterans were required to respond to the 90 items using a 5-point rating scale (1 = 'not at all', 5 = 'very'). The Symptom Checklist-90 is an important and established instrument. The internal consistency coefficient rating ranged in our study from alpha = .93 for Depression and Sensibility and alpha = .75 for Psychoticism (9 items, e.g., 'Hear voices that other people don't hear').

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[200] Kubany et al., 1997.
[201] Rosenberg, 1965.
[202] Arrindell & Ettema, 2005.

Mission related factors. To investigate the third part of the research question: what mission related factors are associated with the extent of guilt and shame, we also incorporates variables know to be associated with deployment-related guilt and shame, i.e., deployment-related stressors, intensity of stressors and intensity of the mission, and the extent of responsibility during deployment.

Deployment-related stressors are based on the items of the 'combat experiences' list of 'The Risk and Resilience Inventory (DRRI)'[203] and the 'deployment-related stressors' of the 'After Care Questionnaire' created by the Dutch Armed Forces for measuring the mental and physical health of Dutch military after deployment[204]. The respondents had to indicate if they had been confronted with 37 stressors (1 = yes, 0 = no). Based on mean sum scores and scale analyses we distinguished four categories of deployment-related stressors, i.e., "Involvement in war situations and participation in combat" (11 items, e.g., 'killed someone (with a fire weapon)'; alpha = .95), "Exposure to violence and danger" (12 items, e.g., 'directly under fire'; alpha = .92), "Witness of misery and violence" (5 items, e.g., 'Witnessed people were dying and seriously injured'; alpha = .88), and "Not being able to intervene during violent acts" (4 items, e.g., 'insufficient possibility to intervene'; alpha = .88).

Experienced intensity of the stressors and mission: In addition to measuring if the respondents confronted with the 37 stressors we measured to what extent the stressor had been threatening (1 = completely not agree, 5 = completely agree; alpha = .93) and to what extent the respondent had felt powerlessness (1 = completely not agree, 5 = completely agree; alpha = .94). We also asked to what extent (1) the respondent felt powerless during the mission and to what extent the mission in general has been experienced as (2) threatening, and (3) impressive (1 = not at all; 5 = very).

Extent of responsibility: Guilt and responsibility are inextricably linked to each other. After All, without feelings of responsibility we do not feel guilty. The extent of feelings of responsibility was measured by three questions (e.g., to what extent you felt responsible for the well functioning of the unit during deployment, 1 = absolutely not; 10 = very).
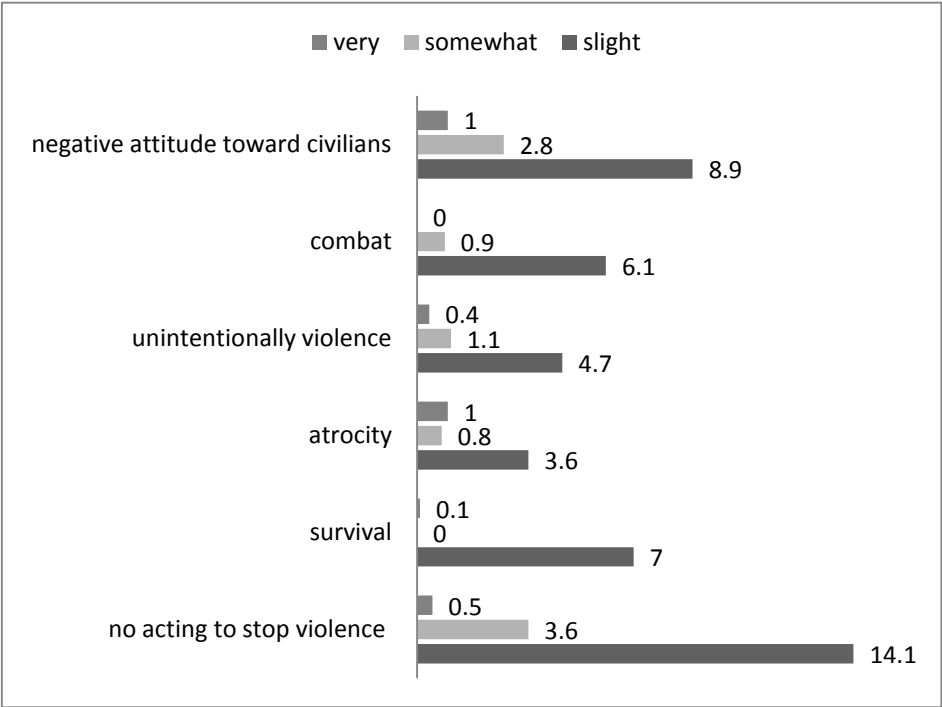
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[203] King, King, & Vogt, 2003; Schok & Kleber, 2004.
[204] Vragenlijst Nazorg-KL, Defensie/CDC/Gedragswetenschappen, 1995-2005.

Results

We found that around 22% of the veterans experience a certain degree of guilt and 25% a certain degree of shame related to the deployment. 4% experience both emotions regularly.

Figure 2
Categories of Deployment-Related Guilt (% of N = 440).

The guilt experience amongst veterans appears to be based upon six categories, situations which arose in deployment regions (Figure 2). Most of the veterans alleged to experience guilt as a result of 'no acting to stop violence' or the 'bystander role' (around 18%, e.g., 'not having protested against brutality or not having tried to prevent brutality'), through 'their negative attitude towards the civilians in the deployment region' (around 13%, e.g., 'no appreciation of the culture or values existing amongst the civilians in the conflict zone') and through 'unintentionally violence' (around 7%, e.g., 'being friendly with a civilian who is

later killed, possibly as a result of your friendship with him or her'). As the most important cause of deployment-related guilt, the veterans themselves name: "The feeling that you have not done your utmost to help civilians. Hiding behind your work, so that you don't have to be with the victims"; "Perhaps the guilt question is that you are so powerless. You really want to help everyone, but that is not possible with a million people. And we really had that task; at least, I thought that…"

Further we observed that the 'combat guilt', including 'survival guilt' and 'atrocity guilt', appeared less frequently than the abovementioned guilt categories.

As most important cause for their deployment-related shame the respondents named relatively often: 'failing', 'being powerless', and 'being deficient'. The veterans were also ashamed of the 'misbehaving of colleagues', 'the respectless attitude towards the civilians in the deployment region', and for example: "(…) shame for one's own luxury in the deployment region, whilst not far from the base people suffered from hunger and had to live under pitiful conditions."

In our research we also see a direct positive relationship between experiences of powerlessness during the mission, feelings of responsibility for the successful accomplishment of the mission and the degree of deployment-related guilt and shame. The powerlessness experienced appeared to worsen when veterans experienced more often inadequate rules of engagement (ROE). Veterans of peacekeeping missions experienced a greater degree of powerlessness and apparent inadequate violence instructions than veterans of peace-enforcement missions.

Table 1

Explanation of the differences in extent of deployment-related guilt and shame.

Independent variables	Dependent variables	
	Extent of guilt	Extent of shame
Stressors		
Witnessing misery and violence	.308** (.205**)	.364** (.238**)
Involved in war situations & combat actions	-	-.248* (-.167*)
Intensity mission		
Impressive	.058** (.107**)	-
Powerlessness	.077** (.170**)	.070** (.152**)
Intensity stressors		
Threatening	.075* (.122*)	-
Responsibility		
Situations and events	.055** (.120**)	.077** (.165**)
Successful course of the mission	.017* (.076*)	-
Functioning of the unit	-	.024* (.092*)
Personal characteristics		
Age 21-30 years (ref. > 60)	.162*	-
Age 31-40 years (ref. > 60)	.154**	.124*
Gender (ref. = Male)	-	-.163*
Education (categories: low, middle, high)	-	-
Psychoticism	.399** (.218**)	.503** (.268**)
Self-esteem	-.157**(-.131*)	-.121** (-.099**)
Adjusted R Square	32%	27%
N	949	949

Note: Unstandardised regression coefficients. Standardised regression coefficients presented between brackets; * p < .05, ** p < .01

We have summarised the direct effects of several factors upon the degree of deployment-related guilt and shame in Table 1. Here we report only the significant effects. As can be seen in Table 1, the differences in the degree of deployment-related guilt and shame in the research group have to do with different factors, besides 'powerlessness' and 'responsibility', i.e., 'deployment-related stressors', the 'intensity of the mission and of deployment-related stressors' and 'personal characteristics' of the respondents.

It can be seen that the youngest veterans experience deployment-related guilt and shame more often compared to their ex-colleagues of 60 years and older. The results show also that, related to the deployment-related experiences, female veterans experience shame less often than their male ex-colleagues. The degree of guilt and shame is also dependent upon the veterans' self-esteem. The lower this is how proportionately more often veterans have deployment-related guilt and shame experiences. Together the different factors account for 32% of the variance in the deployment-related guilt and 27% of the variance in the degree of deployment-related shame experience.

Conclusion and discussion

Around 25% of the veterans – of which 4% regularly – experience guilt and shame after completion of the mission. These feelings are related to the position of the peace soldier: witness as bystander. They also related to the Inadequacy of the Rules of Engagement, by which the veterans were bound; the powerlessness experienced during the mission and a strong sense of responsibility for the progression of the mission and the situations within it. Former peacekeepers and peace-enforcers do not differ in extent of deployment-related guilt and shame. Former peacekeepers and peace-enforcers do differ in nature of deployment-related guilt they experienced. Veterans of peace-enforcing missions experience more survival guilt. Former peacekeepers experienced more exposure to violence and danger, powerlessness during the deployment and Inadequacy of Rules Of Engagement.

From the nature of the guilt experienced by veterans of peace missions and the factors which indirectly (type of mission, violence instructions) and directly (powerlessness, responsibility, deployment-related stressors) influence the degree of deployment-related guilt and shame, we can conclude that the guilt experiences of veterans have mainly to do with strong feelings of responsibility for the welfare of others, together with the feeling of deficiency; to have been with the hands tied. The more often veterans in deployment regions have been witness of misery and violence, the more often they report, after the mission, being troubled by guilt and shame; whilst being involved more often in war situations and combat actions results in veterans being less often ashamed of their deployment experiences. It is clear that deployment-related guilt and shame have to do with loss of control, passivity and powerlessness. This is in common with the experiences of Dutchbat III at and around the fall of the enclave Srebrenica in July 1995, which were characterized by the amount of personal feelings of responsibility, and with this the urge to stop the violent atrocities, to protect the civilian victims and the professional authority which actually forbids the offering of help. From our research it is apparent that, in any case, the Dutch veterans of peace missions are in possession of a sizeable and good-functioning conscience, a morally engaged professional attitude and a capacity for moral evaluation and self-reflection.

The research that we discussed above is about Dutch veterans of several peacekeeping and peace-enforcement missions which took place during the Cold War, and in the last 20 years. Currently the Dutch armed force has supplied around 940 men and women for international military crisis-management operations in various regions in the world[205]. That is less than the last few years where, on average, around 2,000 service members were broadcasted. Till summer of 2010 increasingly around 1,600 service members – 80% of the total deployed Dutch service members – were deployed to Afghanistan. The Dutch military force supplied service members for *The International Security Assistance Force* (ISAF) mission since 2006. Most of them were stationed in Deh Rawod and in Tarin Kowt in the Afghan province of Uruzgan (Southern

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[205] The Netherlands currently participate in missions in Afghanistan, Bosnia-Herzegovina, Somalia, Sudan and Iraq. Date: March 2011. Source: www.defensie.nl.

Afghanistan). ISAF supported the Afghan Government in maintaining security. The soldiers were also involved with various activities and operations in rebuilding the country. The ISAF mission is of a quite different nature to the peacekeeping and peace-enforcement missions we studied in our research. The mandate of ISAF showed more likeness to a combat operation than to a peace-enforcement operation with which we have been familiar (up to 2002). ISAF was a dangerous mission and in May 2010 ISAF claimed the life of the 24th Dutch service member. The number of soldiers that were killed in one mission was never of such an extent since the Dutch involvement in the Korea War (1950-1954). Dutch troops in Afghanistan were involved in combat operations, and are exposed to war violence and threats of violence at the highest level.

Based on the most recent situation, as described above, and knowing the results of our study, several questions arise. What did the ISAF mission mean to the soldiers who participated in it? In what way do they evaluate their deployment-related experiences and, in particular, their own role and responsibility for the progress of certain situations? Do ISAF veterans look back on their mission differently than, e.g., UNPROFOR veterans (Bosnia in former Yugoslavia, 1992-1995); regarding the assessment of their responsibility for the progress and successful course of the mission, and their contribution to improving the situation in the conflict zone? If ISAF veterans, like veterans who participated in our study, experience a certain degree of deployment-related guilt and/or shame, which deployment-related experiences cause the guilt and shame? We suspect the following:

First of all, if ISAF veterans feel guilt or are ashamed, the deployment-related situations that generate guilt and shame are probably of a different nature than the situations that were found in our research. In our study 'bystander-guilt' (not acting to stop the violence) is the most mentioned category of deployment-related guilt. We expect that ISAF veterans in particular mention *survival guilt* ('survive while in the same situation comrades die') and *combat guilt* ('kill or injure someone'). In former research (since 1973) regarding guilt amongst combat veterans, we also found both categories of deployment-related guilt - and both guilt-categories were dominant in those studies. In the first studies of guilt among veterans, mostly Vietnam veterans were study-objects, and the

relationship between guilt, shame and psychological complaints, including Post Traumatic Stress Disorder (PTSD) was always studied.

Secondly, our research (Table 1), shows us that the more often veterans in deployment regions have been witness of misery and violence, the more often they report, being troubled by guilt and shame; whilst being involved more often in war situations and combat actions results in veterans being less often ashamed of their deployment experiences. ISAF veterans will probably not, or at best minimally, be affected by deployment-related shame; many of them having been involved in war situations and combat actions, more often than witness as bystander. This also means that in deployment their traditional military competence and qualities were challenged.

Thirdly, and this is directly linked to the previous presumption, we expect that veterans of the ISAF mission in contrast to veterans of peacekeeping operations (whom in deployment were dominated by passivity, fear and powerlessness) more naturally are proud of their status of veteran and also often consider themselves as veteran. The opposite of shame is pride. This is linked to the studies of Elands et al.[206]: In comparison with 2007 many more ISAF soldiers consider themselves - after deployment - as veterans. This recent study also shows us an increase - in the Dutch newspapers - regarding the image of veterans as heroes and a decrease regarding the image of veterans as victims (in 1980s and 1990s a dominant image of veterans in newspapers). At the same time the danger and violence in Afghanistan has increased.

Recommendations

Before, during and after deployment commanders, and also social workers, psychologists and chaplains must pay attention to the potential sources, including moral dilemmas, of shame and guilt and the difference between shame and guilt in behavioural expressions. They can use the knowledge of this study to support soldiers during their operations and during debriefings and to support soldiers sharing their questions behind the experiences and the possible guilt, shame and confusions. Commanders can use the knowledge during education and when preparing soldiers for participation in peace missions. They can teach

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[206] Elands, Algra, Van Tilburg, Schoeman, & Huls-Van Zijl, 2009.

the soldiers that some emotions, like guilt and shame are really normal, but also important to share. The military itself must also be conscious of their reactions to some difficult deployment related situations, like moral dilemmas, and the function of guilt and shame regarding their contribution to coping ordinary with trauma. Guilt and shame are social and moral emotions and as self-conscious emotions they can generate explanations and meaning after trauma. However, both emotions and the underlying moral and existential questions need adequate attention - and not only in a clinical setting. If feelings of guilt and shame are not recognised and discussed, they can be at the expense of the psychic health. Mental healthcare and moral and emotional support firstly commence prior to a deployment, and must be continued during and after completing a deployment.

Chapter XII

The Process of Repetition, Writing and Rewriting

Anouck Heulot, MSc[207]

Abstract

"…Life is a full catastrophe living…" – Zorba the Greek

Several studies have indicated that a great number of people are confronted with a critical and possibly traumatizing event during their lifetime. Because of the nature of their job, servicemen are confronted regularly with events that could have an enduring impact on their lives. The assimilation can be stuck, despite the support on short and medium term. As a result, the person concerned will get stuck in a process of repetition.

In this paper we will start with the origin and existence of repetition and the "compulsion of repetition". We continue with the speechlessness that comes with this compulsion of repetition, the shortfall in the signification and how we can connect those two through language. Then we examine if the process of repetition and compulsion of repetition can be breached through a literal and symbolic process of writing and rewriting. Final we consider the choices that can originate during this process of writing and rewriting. More specifically the choice to take another point of view on negatively emotionally charged events, through newly acquired insights and any therapeutic support.

"We don't see things as they are, we see things as we are." – Anaïs Nin

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Introduction

In this paper I will, within the context of language, consider trauma and the way in which language can help to assimilate it.

Because of the nature of their job, servicemen are confronted regularly with events that can have an enduring impact on their lives. The assimilation can get stuck, despite short and medium term care. As a result, people confronted with a possibly traumatizing event will get stuck in a process of repetition, in which they tend to relive the event.

First, I'll start with the origin and existence of repetition and the "compulsion of repetition", and how a possibly traumatic event "writes" itself into the body. As a consequence of the shortfall in the signification, the body keeps repeating the event as if it tries to cope with the negative arousal within. This shortfall is characterized by a fundamental lack of words, which finds its origin in primary attachment and development, and starts when the child "asks" his parents to name his arousal and needs. Depending on the style of attachment with the primary caregivers (most likely the parents) the child disposes of a language which gives him the opportunity to control the arousal more or less.

With some therapeutic assistance a person, confronted with a possibly traumatic event might be able to write and rewrite its own history and take another perspective on the things he has experienced. So finally, with this writing and rewriting, one can discover the opportunity to have a choice in life, it's a certain power to change your point of view; within the knowledge/acceptance of not having control on life lies the possibility to embrace certain situations and rewrite them into a full grown experience which enriches life.

Trauma

"One need not be a chamber to be haunted; One need not be a house; The brain has corridors surpassing Material place."[208]

Introduction

Trauma is more than a pathology, a simple "disease" or a wounded mind. It's the story of a wound, that tries to tell us about a truth that isn't available, in any way. This truth is connected to what is known, but also to what stays unknown in our own behaviour and language.

Each form of arousal, manifesting through an uncontrollable amount of stimulants, can be seen as potentially traumatizing. This energetic influx that can't be fully expressed in words, for that matter stays partially uncontrollable and knows his traumatizing effect in its impossibility to work off.[209] As we are confronted with a unexpected radical event, the influx of stimulants from the inside or the outside that partially or completely breaks through our protective shield, surpasses our mind and writes itself into our body.[210]

Despite the fact that a high percentage of people are confronted with a traumatic event, only a small amount of people get stuck in the assimilation and develop a posttraumatic stress disorder[211]. The numbers vary between 1 and 9% and 5 and 12%[212]. One can wonder why one person is capable of assimilation and allocation of the events, and the other isn't. Of course the characteristics of the trauma play an important role, but the questions rather situates on personal level and measures/looks for the characteristics that make the difference in a healthy writing, repeating and rewriting.

In the next part I'll explore in depth the structural trauma that underlies the relation one has with the *Other* and with *language*.

Structural trauma

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[208] Emily Dickinson in The Quotations Page, 1994.
[209] Verhaeghe, 2002.
[210] Freud, 1985.
[211] Harvey & Bryant, 1999.
[212] Verhaeghe, 2002.

Within this discussion it is important to understand the inevitable aspect of structural trauma as it defines the personification. This form of trauma originates from the confrontation between the subject-to-be and the uncontrollable increase of stress, which is caused by the wordless 'Reality' of the own natural drive[213]. The structural trauma is the drive *an sich*, as an intern conflict takes place which is inevitable because it's indissolubly connected to the essential of human-being[214]. He states it as: "The origin of every neurosis is something traumatic, because it is traumatic for the subject. And why is this? Because it concerns something that happens in the developmental stage of acquisition of language, something for which words fail."[215] The physical and emotional needs of a newborn cause a certain arousal that needs to be discharged and answered. Hunger, thirst, need for love or attention manifest through tension building in the body. Since the newborn isn't capable of working of this tension and doesn't have the words to name and thus control the arousal, he appeals to the First Other. Usually this is the mother, who denominates this tension and tries to answer the needs of her child, as well as with concrete actions as with words of comfort and appeasement. So in a secure development, the Other responds to the appeal and offers words that control the tension and simultaneously create the possibility to control the tension personally in a later stage.[216]

Despite the response of the First Others, as we said before, structural trauma is inevitable. After all, each baby pursues immediate and complete appeasement of his needs[217]. No matter how hard the parents try to fulfill the needs of their helpless and wordless child, it is impossible to fully cover the appeal[218]. In the first place, for some natural drives originating from the 'Reality' there are just no words and they keep acting on the body. This is the shortage within the symbolical aspect of language; Secondary, the Other interprets the needs and "there can never be a perfect match between drive and interpretation."[219] Last,

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[213] Verhaeghe, 2002.
[214] Hofmans, 2000.
[215] Hofmans, 2000, p. 20.
[216] Verhaeghe, 2002.
[217] Rigter, 2002.
[218] Verhaeghe, 2002.
[219] Verhaeghe, 2002, p. 137.

but not least, the delay in the appeasement or satisfaction of needs is an essential step in the developmental stage. In function of his development within society where certain rules apply, the child needs to learn to postpone his drive for immediate satisfaction. The possibility to recognize and tolerate the frustration about the delay (simultaneously grows) with the development of a sense of time. In the unpredictable time span between need and satisfaction language and symbolization are born[220]. So we could say that, with the words the parents offers, the child acquires the possibility to control itself. Nevertheless, the arousal of the indefinable and the fear of not being heard which lie at the base of the structural trauma, will always stay present, since it is completely impossible and pathological[221] to offer correct and sufficient response for every feeling and each form of drive through words[222].

From a situation where the Other doesn't respond to the appeal of the child, several problems originate. First of all, the child doesn't get the opportunity to process and later on, name the source of the arousal. This tends to result in a pathology, which is defined by a constant appeal from the 'Reality' and the lack of symbolization to control the tension that arises from the body. We'll call this pathology the 'aktuaalpathologie'[223]. This will be discussed later on. Secondary, the child will develop an unsecure attachment relation with his parents, which is defined by avoidance and distrust[224].

We can conclude that the arousal that arises from 'Reality' causes the process of personification, through the essential appeal to the Other. The Other, most likely the parents, offers the child, together with the symbolic words, his identity. Because of the fact that within the symbolical, there is always a shortage, a part of 'Reality' stay 'unnamed'. And this part keeps appealing, without ever being answered. The degree to where symbolization has been established depends on the response to the appeal of the child, the choice of words and the measure of mirroring offered. Together with that symbolization a certain amount of

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[220] Birksted-Breen, 2003.
[221] In this case, the child would stay converged with the mother in an exclusive, closed and dual mirroring relation. In this relation there is no room for further development of an own identity because of the lack of a shortage.
[222] Verhaeghe, 2002.
[223] Verhaeghe, 2002.
[224] Ainsworth, 1970.

attachment is created which has an important impact on life and the capacity to assimilate traumatic events. This will not be discussed any further because it would bring us too far. However, we will pay some more attention to the 'aktuaalpathologie' and his counterpart on the other side of the continuum, the 'psychopathologie', two structures linked to language and the way we respond to traumatic events.

'Aktuaalpathologie' – Psychopathology

Within personification and the relation the subject and the Other have in this relation, there is a possibility that the subject, in his confrontation with stress/tension/'Reality' appeals to the Other to name this tension and make it controllable. When this processing doesn't succeed, mental elaboration isn't accomplished, so 'Reality' stays focused on the body. So when the individual is confronted with tension, arousal or fear, they can only be expressed through 'phenomenon's', physical symptoms. There are no symptoms due to the lack of symbolization through language. The aktuaalpathological individual lacks the possibility to recognise his internal arousal as feelings or emotions and isn't capable of using words to express this rising of tension and the fear that comes along[225]. Moreover, even if the individual would be capable of expressing himself a bit, he probably wouldn't do so, because he lacks the intention to speak these words to someone. The Other wasn't there when he appealed to him, so why would he trust him? We can conclude that the causal factor for 'aktuaalpathologie' or alexitymia[226] lies in the fact that the internal source of excitation and drive within the subject isn't sufficient or not answered by the Other. The transition from 'Reality' to the symbolical, in which the Other replies, hasn't been carried trough, resulting in initial arousal becoming fear[227]. A 'normal' psychotherapy, as in expressing through words, in not evident. Nevertheless, it is, with this speaking with words and symbols people try to break the lacking of words and tell *their* story.

In a secure development, the Other reacts to the appeal and offers the child the words to control the internal drive. During this 'normal' process of

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[225] Verhaeghe, 2002.
[226] Difficulty in describing or recognizing your own feeling (Coëlho, 2000).
[227] Verhaeghe, 2002.

personification, attachment comes into existence and the child can develop within the psychopathological spectrum. Research about attachment shows that someone with a secure attachment has a firm base to cope with traumatic events and give them a place in their lives[228]. When language and attachment fail, one can suspect that the story can't be told and through repetition keeps appealing to the body in order to be heard anyway[229]. We'll pay some more attention to this repetition in the next chapter.

Process of repetition and compulsion of repetition

> "Who will point at the maids, the young widows, the others, all those women, who eventually knew where he would hide himself and surreptitiously strolled over the grounds, mounted the ladder to the hay loft and only had to see where the blanket of withered grass, under which the boy was concealed, was trembling under the booming that struck his limbs, *the earthquakes with which the war, his war, vainly presented itself to his memory, trying to rid itself of his tissue and vessels, in order to finally be able to be born in language – the flesh that howls and shivers*."[230]

In this chapter I will try to explain the process of repetition and the wordlessness of trauma and how it originates in structural trauma. As we've seen before, repetition within the structural trauma is 'normal' but becomes problematic after a confrontation with a real traumatic event. In an attempt to control this troublesome input the process of compulsion of repetition starts, manifesting through a wide range of phenomenon's. A first question looks for the 'what' in repetition and compulsion of repetition. A second wonders why people get stuck in this wordless, rigid state, why they keep repeating.

Repetition
Repetition originates from structural trauma, where the Other, despite his attempt and a good attachment, can never fully meet the needs. Freud, and as I suppose, many other psychotherapist with him, were confronted with the inability to fully express the traumatic 'Reality'. In this attempt to control it, comes forth a continuous confrontation with 'Reality', which passes imagination,

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[228] Verhaeghe, 2002.
[229] Caruth, 1996.
[230] Mortier, 2009, pp. 180-181.

all words, because some arousal can't be captured with words and thus can't be worked off. Still, the organism keeps searching for other words to capture what is elusive, and in this attempt an associative chain of prescribed words is created. This 'healthy' repetition installs itself within the symbolical-imaginary, through language and distinguishes itself from the compulsion of repetition, because in a 'normal' repetition there is no direct confrontation with arousal, but with the symbolical version of it.

Our own drive is full of desire and traumatic at the same time, because a certain aspect of it, isn't controllable[231]. Still, this drive stays present, not in the verbal memory, but written in the memory of the body[232]. A structural separation between the conscious and unconscious is the result of this dissociation[233].

Compulsion of repetition

"Those who cannot remember the past are condemned to repeat is."[234]

As we saw in the previous chapter, repetition is a rather 'normal' way of the body to cope with the arousal that originates from 'Reality'. Within repetition there is a possibility to vary. In the compulsion of repetition there is no such variation; one is compelled to replay the same trauma over and over again. Since trauma is precisely that thing that can't be captured in symbolization, the compulsion of repetition is "a non-stop attempt of the mind to bind the traumatic element to words"[235].

This compulsion of repetition also occurs after a traumatic event, because of the dissociation between the 'traces' written in the body and the conscious organism who tries to create words to control these traces. The body is reminded of these tracks and wants them to be known. In vain, because the conscious memory won't get a hold on the non-verbal traces, whereby these express themselves in a variety of ways. The experienced 'physical' pain gives notification of the truth or trauma from which the individual itself doesn't have

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[231] Verhaeghe, 2002.
[232] Levine, 2007.
[233] Verhaeghe, 2002.
[234] George Santayana in The Quotations Page, 1994.
[235] Verhaeghe 1997, p. 94, in Hofmans, 2000.

any knowledge[236]. This happens through different form of phenomenon's, like intrusive re-experiencing the trauma, recreating the trauma, recurrent dreams or nightmares and acting-out. Levine (2007) states that without the release and fulfillment of the enormous energetic arousal that emanates from trauma, we are forced to repeat the tragic cycle of re-living through acting-out or imagination. According to Levine the strong attraction to acting out is found within the urge for fulfillment, the 'negotiation' about the trauma. During this negotiation the repeating cycle of re-living is transformed into a healing event, which we can compare to rewriting.

Conclusion

In this chapter we have discussed repetition, and how it originates from the structural trauma as a consequence of personification. During this personification the shortage in our language becomes obvious and we can understand how the symbolical isn't enough to capture the arousal. In the compulsion of repetition, a traumatic event is placed upon the structural trauma, and again we are confronted with the shortfall of the Other and language.

One last question remains; how can we break this compulsion of repetition and rewrite the traumatic or negative event so we can leave it behind us? In the next chapter about writing and rewriting we'll see how people can conquer traumatic events through rewriting. They liberate themselves from a wordless rigidity, awaken their 'frozen mind' and restart life[237].

Writing and rewriting

Writing

I would like to explain the two different aspects of writing, the 'automatic' writing and the 'therapeutic' writing. The automatic writing is, as the structural trauma, connected to the personification and happens naturally. This is clarified by Van der Zwaal (1990) in *The Narrative Paradigm in the psychoanalysis*[238] where he attends us to the narrative structure of men and the linguistic

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[236] Caruth, 1996.
[237] Garland, 1998; Levine, 2007.
[238] Original title: 'Het Narratieve Paradigma in de psychoanalyse'.

structure as a reference to human temporality. A man has to be able to write his own history.

The second form of writing is the therapeutic writing. As Van der Hart (1992) I suppose that this therapeutic writing can be used to capture certain unprocessed events in the 'right' words, write them off and give them a place in the own history. Also Pennebaker & Chung[239] investigated the positive effects of writing in their article. Especially the effect of translating emotions into language, or as they state themselves, "a metaphorical translation of an analog experience into a digital one". Research has shown that keeping a secret can have serious consequences for the health, so the authors started from the opposite reasoning, namely that putting a traumatic event into words can be very good for your health. Research with the Basic Writing Paradigm[240] shows that writing about emotional events can be related to a number of improvements, among which physical improvements[241]. Further research about the precise effects of writing, but the temporarily results are promising.

There are two ways to explain the positive effects of writing. Levine[242] states that the unexpected and unprocessed traumatizing events write themselves into the 'physical memory'. Consequently one might suspect that the connection between body and mind offers the opportunity to arousal and pain to be expressed trough writing. With the symbolization language offers, one can give a verbal expression to physical arousal[243] and in this way break the compulsion of repetition. A second explanation comes from Pennebaker & Chung (in press). Some researches point at the positive effect of taking a new perspective, as in looking for the positive aspects in a negative event, and add those positive aspects to their own history. During this slow process of intense writing, thoughts and feelings that touch the internal being, are looked upon and sorted

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[239] Pennebaker & Chung, in press, p. 4.
[240] This basic laboratorial writing technique requires experimental subjects, designated to two or more random groups. All groups are asked to write about an assigned theme, during one to five consecutive days, for fifteen to thirty minutes a day. This writing usually takes place in a laboratory and no feedback is given (Pennebaker & Chung, in press).
[241] Measured by the amount of doctors visits and the painkillers taken, before and after the writing assignment (Pennebaker & Chung, in press).
[242] Levine, 2007.
[243] Levine, 2007; Van der Hart, 1992.

out in a way they can be controlled[244]. People must be able to tell their story and that story must be correct[245].

Of course, this writing doesn't work for everybody. Some people just don't like to write, and luckily there are plenty of other ways to symbolize the unspoken, but this matter won't be discussed in this paper. The process of writing and the renewed perspective are inextricably bound up with the concept of rewriting, which will be discussed in the next point.

Nachträglichkeit and Rewriting

Nachträglichkeit has an important role in the process of repetition and (re)writing. With this term he referred to the fact that one can interpret some elements from the past from a position in the present. A good example is that of a depressed patient who will especially emphasize all the negative events in his life due to his depressed state[246]. This example attends us to the necessity of a reversed timeline, meaning that the precedent only gets a certain value due to what follows. This indicates that the meaning of precedent is only virtual and thus can be rewritten[247]. This implicates that the past doesn't follow a straight timeline, but can be rewritten in the present. The here-and-now only has a temporal meaning and the past is only the past, as interpreted from the present[248]. The aspect of 'truth' of a traumatic event does not matter. It's about the way someone experienced the event and which place he gave this event in his life[249]. Also the moment when the event took place isn't so important. Your point of view in the present on the event and the possibility you get to cope with it later on, offer more chances to get over it then when one would only try to find 'the truth'[250] and within this acceptation lies the letting go. From this new point of view one can make a choice. With the Nachträglichkeit and under the influence of new experiences, memories can be reshaped and self-knowledge

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[244] Herman, 2002.
[245] Van der Zwaal, 1990.
[246] Verhaeghe, 2002.
[247] Baranger, Baranger, & Mom, 1988; Verhaeghe, 2002.
[248] Birksted-Breen, 2003.
[249] Eickhoff, 2006.
[250] Baranger, Baranger, & Mom, 1988.

improved. With this improved self-knowledge new opportunities for change are created.

I would like to end this discussion with a clear quote from Anaïs Nin:

"We don't see things as they are, we see things as we are."[251]

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[251] The Quotations Page, 1994.

Chapter XIII

Quest for healing, stress and coping

René Moelker, PhD[252] en Michelle Schut, MSc[253]

Abstract

Some veterans returning from war struck regions do not adapt well to civilian life. Some suffer from Post Traumatic Stress Disorder. Unemployment, homelessness and divorce are recurring phenomena. As a result, many veterans are stigmatized as either victims or perpetrators. But many cope well and demonstrate surprising resilience, and some (quite a few actually) cope very well by riding a motorcycle and joining a motorcycle group which helps them come thru a transition from being deployed to being an integrated citizen. Both the military career and motorcycling towards a 'sacred' destination such as Lourdes or 'The Wall' in Washington DC, show aspects of liminality i.e. it being a transitory phase that helps bring about reintegration and adaption into an in society. The communitas of veteran bikers provides social support and understanding to the veteran, whilst the ride, reception and recognition of the audience who welcome the bikers on arrival at their destination feels like coming home, and being accepted and integral part of society. In this paper the healing aspects of liminality will be studied by examining motorcycle groups on their pilgrimage to Lourdes or other road trips, as well as the maladaption and psychological wounds which sometimes haunts veterans who return from a deployment.

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Introduction

Meeting Black Crow at the Mall in Washington DC was an unexpected experience. Riding with Vietnam Vets across the United States of America had been an healthy experience meeting people who coped well with their past experiences and here we met someone who was homeless, confused and begging for a dollar so that he could buy the next beer, in short we met one of those many veterans who did not do well. Black Crow claimed to be a veteran from Somalia who supposedly figured in Marc Bowen's book Blackhawk Down. He looked shabby in an oversized Army unbuttoned uniform that showed a bare belly, bare arms, leaning on a large stick with the national flag loosely attached at the upper end. Cigarette and glass of beer in one hand, whilst saluting us with the other. The contrast with the riders from Vietnam and this dude was stark and made us realize that many of the riders probably also have been down like Black Crow and that one of the reasons why they were riding was exactly to promote their and others health.

> "I ride my bike to stay sane. The last time they let me out of the loony bin, I got this bike. It's just about the only thing that makes sense to me".

Just a quote from an American biker and Vietnam Veteran from the anthropologist Jill Dubisch[254]. Dutch veterans share the same experiences, because riding a motorcycle accommodates thrill seekers with excitement, but also provides the former warriors social support and thus results in an opportunity for catharsis and peer contact. Thirty percent of Harley-Davidsons' customers in the USA have been actively involved in the military and a veteran POW/MIA memorial ride like Rolling Thunder[255]/Run for the Wall in Washington DC attracts 900,000 riders and spectators. In the Netherlands veteran culture is only very young and still developing. That is why cross-cultural comparisons are important and provide practical lessons learned. But in this paper we will mainly focus on Dutch experiences and present results from Dutch participatory observations.

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[254] Dubish, 2005, p. 153.
[255] http://www.rollingthunder1.com/about.html

Method: kinetic ethnography

Studying motorcycle groups requires a special methodology because these groups exist out of certain tensions between themselves, themselves in the past, present and future, and themselves and society and/or the state. On top of this they are characterised by high mobility and transformation, the apotheosis of their existence being the road trip towards some destination, albeit profane or sacred. This mobility, the vulnerability of these groups because of possible past experiences and the common feeling they share of being rejected by wider society as both a veteran and a biker, makes it difficult to win their trust other than by partly participating in their life style and engage in participant observation using ethnographic methods. These two characteristics of the veteran-bikers, the tensions and the mobility of groups that are defined by membership and closure towards 'normal' citizens and the non-veteran-biker community, i.e., those 'who would not understand', requires *kinetic ethnography* as a method[256]. By kinetic ethnography a form of participant observation on the move is suggested that brings to the fore a new research tool; the motorcycle! Besides this participant methodology also *camp fire interviews* were conducted. These were sometimes short, sometimes lengthy interview in odd places like parking lots, restaurants, camp sites, etceteras. In total some thirty interviews, taken during road trips totalling 5,000 kilometres, were noted down.

Liminality, Stress and coping: Wild Hog's narrative

One might state that life itself is a voyage and therefore liminality is a characteristic found in everything. The very concept of *liminality*[257] is inherently charged and motored by the kinetics of the topic and people under study, because it is all about transitory phases and 'spaces in between'. Being born, living and dying, can be described in terms of the phases that Arnold van

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[256] The term is adapted from Edith Turner who coined the concept of *kinetic rituals*, 1978: xiii
[257] Michalowski & Dubich, 2001; Dubich, 2004, 2005; Turner & Turner's
http://www.liminality.org/about/whatisliminality/
http://en.wikipedia.org/wiki/Victor_Turner
http://74.125.77.132/search?q=cache:DPKVe7xWRzcJ:uob-
community.ballarat.edu.au/~dwaldron/documents/lectures/lecture8.doc+turner+liminality&cd=4&hl=e
n&ct=clnk&client=safari
http://www.confest.org/thesis/twopartone.html

Gennep distinguishes in *The Rites of Passage*[258], i.e., separation, liminal (transitional) period, reassimilation. In *Liminality and Communitas* Turner[259] defines liminal individuals or groups as 'neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremony'. The concept is linked to posttraumatic stress because veterans returning home do not close the liminal period by successful reintegration when they feel not welcome upon return. Riding on motorcycles together with other veterans helps the veteran bikers coping with this poor welcome and with past experiences.

Stress and coping in a nutshell means that veteran bikers want to re-live re-experience events that cause the same thrill and stress that they experienced whilst during the mission, in order to deal with it better, and the re-experience must be in a safe and controlled (by them) environment. Whilst riding provides some kind of 'catharsis', the stress-coping mechanism is an additional explanation for veterans wanting to ride motorcycles.

Dahr Jamail presents some shocking statistics for the United States of America that demonstrates the size of the aftermath of military mission regarding mental health and wellbeing:

> "One thousand veterans who are receiving care from the Department of Veterans Affairs (VA) are attempting suicide every single month, and eighteen veterans kill themselves daily … The suicide rate for 2008 was calculated roughly at 20.2 per 100,000 soldiers which for the first time since the Vietnam War is higher than the adjusted civilian rate … As of March 287,790 war veterans from the occupation of Iraq and Afghanistan had filed disability claims with the VA."[260]

But the plight of veterans is heavy in each and every country. In the Netherlands it is difficult to produce reliable data about suicide among veterans. According Jan Schoeman of the Veteran Institute the suicide rate among veterans is over one per month[261]. Annually the number of suicides thus amount to twelve or more. This number probably is an underestimation because often a farewell letter is lacking. Estimations are difficult because the exact number of

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[258] Van Gennep, 1960.
[259] 1969, p. 95.
[260] Jamail, 2009, pp. 28-29; Bilmes, 2007; Jelinek, 2009.
[261] Karskens, 2010, p. 9.

veterans is unknown. Twelve suicides to 125,000 veterans annually amounts to 9.6 per 100,000 veterans. If the total of veterans is estimated 135,000, the ratio is 8.8. According the Central Bureau of Statistics the Netherlands average equals circa nine incidences per 100,000 in 2009 (1,525 suicides divided by 16.6 million inhabitants). If one would calculate the ratio over inhabitants older than fifteen years, the ratio would be higher. In summary, the suicide ration among veterans is probably not significantly higher then the Dutch average. But one must be cautious in interpreting these statistics. Jan Schoeman suggests that 'soldiers are selected out for being stress resilient, meaning that they should in comparison to average citizens be more stress resistant'.[262]

Suicide rates for veterans are to be carefully interpreted. However, other indicators of veteran well-being, like Post Traumatic Stress and mental health are thoroughly studied. In the Netherlands one of the first studies[263] into mental health of veterans revealed 21 per cent to be bothered by either avoidance behaviour, arousal or intrusion and that roughly five per cent, those veterans who scored high on all three indicators (avoidance, arousal and intrusion) suffered from Post Traumatic Stress Disorder. This finding proved relatively stable over time and is also quite comparable to international findings[264].

Measurements differ from study to study, and the historical conditions vary widely. When missions run smoothly and the risk level is low, PTSD-estimates drop to 2 per cent. When missions have a dramatic ending, when they are accompanied by feelings of impotence or guilt, likely to occur in veterans of the UNPROFOR mission by Dutchbat III that ended in the massacre of 8,000 Bosnians in Srebrenica, the estimates for PTSD rises to 10 per cent. Also the mission UNIFIL/Lebanon in the eighties was particularly heavy on the soldiers. 16 per cent of the veterans in 2005 obtained scores that are indicative for PTSD.[265] International estimates vary also on account of measurement instruments and the hardships that servicemen encountered. Presently the literature is averse to the use of the concept of PTSD because one really needs someone from the medical profession to diagnose a patient with PTSD. Formal

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[262] Karskens, 2010, p. 9.
[263] Bramsen et al., 1997.
[264] Moelker & Op den Buijs, 2002, pp. 407-408.
[265] Mouthaan et al., 2005, p. 63.

diagnostics require professional assessment if only because it concerns a complex matter, a traumatic experience has to lie at the root of the affair and the disorder has to effect disfunctioning for a long duration.

The literature in the Netherlands has recently taken an interest in topics like hardiness, resilience, guilt and coping.[266] But not before in the Netherlands, has there been a study into the positive contribution to psychological well being of veterans riding motorcycles in groups that render each other social support. In this study we look into the narratives of these motorcycling veterans. An example is given by the life story of Wild Hog. Wild Hog is a veteran of Lebanon and overcomes his Post Traumatic Stress Disorder by riding a trike in the motor group Blue Helmets.

As only son I was obliged to join the service. During my conscription there was the mission in Lebanon, where I went from the 7th of June in 1979 to the end of March in 1980. On a post, in the middle of no-where. "The end of the world". The normal rotation time at a post like this is a month or two. I was posted for ten months. I was damaged and pushed away my memories of the last months of my stay. It is hard to come back. One moment you take decisions of life and death, and the next moment they complain when some triviality is not delivered on time. You have completely different values and norms to consider, and on top of that there is the lack of adrenaline, camaraderie and hegemony. There you could trust everyone blindly, but here you have to be much more careful. That contrast is very large.

Furthermore it was no media war, like Bosnia or Iraq, where embedded journalist joined on the tank with their camera. In the Netherlands they could only guess about what we did. Of course we came back with a tan and were accused of playing the tourist. Back in the '80s a psychiatrist once said that we suffered from the Vietnam Syndrome. Not embraced by society. Some boys were killed by friendly fire, and the comments were, "Hey, you shoot your own friends" and "nice tan you got". Nobody knew what really happened.

We were under fire every day, but you get used to that. Then you come back and it is very difficult. When I returned, I left the service. You have problems with everyday life; you drink or sport a lot. If you are tired or drunk,

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266 Schok, 2009; Rietveld, 2009; Delahaij, 2009.

you don't have to think. You become workaholic. Almost all stages of addiction you go through, and finally someone says "you could have PTSD". I was diagnosed in 1983. In the beginning, after two years of treatment, you have been diagnosed and send back, with the words "there's nothing more we can do for you". It goes on and on. In 2004 it could no longer continue and an emergency admission followed at Stichting Centrum '45 in Oegstgeest. After two years of illness and an honorable discharge, I was 100% condemned. Obviously future missions have learned much from our experiences. We had to help ourselves. After this I had to be tested and examined for having problems preceding the mission into Lebanon. But if I had psychological problem before mission, why didn't they refuse me earlier? Now I am still in legal battles with the Armed Forces. I'm 51 now, still being treated and treatment will probably continue forever.

My stress relieve from this all is driving my motorcycle. I ride a trike and really enjoy it. If my head is full, I take some coffee and bread for on the road and drive. When I return after a few hours, my head is empty.

In 2004 a friend, who is member of the Blue Helmets Motorcycle Group, asked "why not get a license". It sounded temping, but my therapists thought I was not wise driving on two wheels with medication. I started to think about an alternative, a trike. Through the contact with the BNMO in Doorn I came in contact with the Blue Helmets Motorcycle Group.

We are no macho men, drive neatly in formation. Everything is allowed, there is nothing you have to do, it is all about freedom and happiness. Sometimes we talk about the past and you are then supported by your comrades. Driving with the Blue Helmets is just great, we have a real connection! It is a brothership comparable with the feeling you had with your comrades on mission. The sense of belonging and understanding, that is very important. And mutual respect. There is always someone who wants to listen and understands you.

Safety is very important. That is one of the conditions for me to drive with them. Driving safe, with the aim to have fun and enjoy. You are not looking for any risk. If I find myself searching for adrenaline, it is getting dangerous. If you want an adrenaline rush, you go to the race track. Not in the group. No crazy things.

Often we drive to memorials, ceremonies where veterans are decorated for the wounds they suffered, open days and once in the every two years we make a big journey to another country. The years in between we go on a short trip. Recently we picked up a member who is still active serving and came back from Uruzgan. This was pretty heavy. You see all the banners and people who are in tears, and that brings back memories. To be riding with the Blue Helmets is important to me; you know you are not alone. They give you a hug and ask how you feel. Half a word is enough.

4th of May, memorial of the dead, we go to Loenen and Havelte, to the UNIFIL monument. It is very far away, because you drive around the 400 km with all the emotions you have. But it is very impressive. The most of us wear leather jackets with on the chest our logo. Other insigne's and logo's refer to places you visited or other personal badges. We always appear neatly at the memorials, in our leather suits, with our blue berets and scarves. People do recognize us. We regularly are asked why we look that weird. On the other hand, there are also many positive comments and invitations.

Two years ago, we were invited to join the International Military Pilgrimage to Lourdes. That was a great ride. We, the Blue Helmets Motorcycle Group, were with ten motorbikes and one trike. In total there were 45 motorbikes. We were on the road for four days, with many military related visits for example to Verdun. It was weird, that we suddenly slept in barracks again. In Lourdes, we gathered at the airport and drove with the whole group under police escort into the city. That was very impressive. There were many soldiers from all countries around the world. People were clapping and giving us thumbs up. We all wore our blue berets. With 45 motorcycles we entered Lourdes! What a moment! Old veterans from Korea and India felt crying in our arms, "great that you did this". We came in contact with old and young veterans. It gave a match! So respectful to each other! That was great! Moments you never forget!'

Reconstructing the healing narrative; forget the war, remember the warrior.

Narratives have healing power. That is why the narrative of Wild Hog was presented. In Wild Hog life story he reconstructs his identity as a veteran who

did not get the recognition he needed, and the method in use for reconstructing the narrative is kinetic, it is by driving his trike and constructing the biker identity in which social support is incorporated. In American narratives also a 'welcome home' from the wider society is included.

During and after Vietnam politicians never succeeded at explaining the strategic reason for this war … "the Vietnam War lacked a recognizable narrative structure",[267] and this is the reason why the home front, soldiers and veterans never understood what they were fighting for. After the Vietnam War the veterans were despised and the need for a new narrative grew stronger.

> "The search for a new narrative about the Vietnam War is part of the motivation that leads veterans and others to join the Run for the Wall. Through political action and healing rituals, the Run provides an opportunity for its participants to find answers and to fashion new meanings about the Vietnam War, about the Americans who never returned from Southeast Asia, and about those who returned but never heard someone outside their own families say, 'Welcome Home'."[268]

According to the psychologist Dan McAdams narratives are healing because of their integrative function in constructing an identity. The identity of veterans is in pieces because of diverse traumata, and by telling life stories to others, the veteran creates his own identity and the fractured pieces of live are put into place. McAdams distinguishes in an original 'I' and a constructed me. It is the 'I' that constructs a 'Me' by telling stories that relate to the self. The process of creating and telling these self-stories therefore is coined 'selfing' by McAdams. Selfing is the narrating process to create a modern self.

> "It is mainly through the psychosocial construction of life stories that modern adults create identity in the Me. Life stories may be examined in terms of their structure and content, function, development, individual differences, and relation to mental health and psychosocial adaptation."[269]

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[267] Dubisch, 2005, p. 152.
[268] Dubisch, 2005, p. 139.
[269] McAdams, 1996, p. 295.

Then what the life story really does is that it integrates the narration of self into a coherent whole.

> "By binding together disparate element within the Me into a broader narrative frame, the selfing process can make a patterned identity out of what may appear at first blush to be a random and scattered life."[270]

The integrative function of storytelling, the coherence it offers, is relevant to the construction of an identity, to psychic health, adaptation of veterans to civilian life after being 'out there' and to the political interest of veterans being served by the stories. Therefore more insight and knowledge into the process of narrating enhances our understanding of the expressive side of veterans.

In psychology Sarin[271] suggests that the narrative 'may be a new "root metaphor" for psychology as a whole' and Polkinghorne[272] even places the narrative at the center of understanding human lives

> "Our lives are ceaselessly intertwined with narrative, with the stories we tell and hear told, with the stories that we dream or imagine or would like to tell. All these stories are reworked in the stories of our own live that we narrate to ourselves in an episodic, sometimes semiconscious, virtually uninterrupted monologue. We live immersed in narrative, recounting and reassessing the meanings of our past actions, anticipating the outcomes of our future projects, situating ourselves at the intersection of several stories not yet completed."[273]

In this process of 'selfing', the I narrating experience to create a self whilst the Me is the self that the I narrates, McAddams distinguishes three levels. Level one consist of *traits*, that 'provide a dispositional signature for personality description.'[274] These traits can be similar to what psychologist describe as the Big Five for instance when somebody describes him or herself as introvert, but mostly laymen's traits are used like 'I am a go-getter', or 'I always look on the bright side of life'.

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[270] McAdams, 1996, p. 309.
[271] Sarin, 1986.
[272] Polkinghorne, 1988.
[273] Polkinghorne, 1988, p. 160.
[274] McAdams, 1996, p. 301.

At level two, the personal concerns level, storytelling refers to the Me as "personal strivings, life tasks, defense mechanisms, coping strategies, domain-specific skills and values, and … other motivational, developmental, or strategic constructs that are contextualized in time, place, or role".[275]

At level three "reside the psychosocial constructions that constitute identity. … such constructions assume the form of stories of the self – internalized and evolving life stories that integrate the reconstructed past, perceived present, and anticipated future."[276] These are the psychosocially constructed narratives that make up the Me in a coherently told internalized life story offering the reconstructed past, the perceived present and the anticipated future. [277]

Sometimes a narrative does not work anymore and therefore it needs to be rewritten. A psychologist can assist in reconstructing these life stories. The criterion of truth simply comes down to the narrative being a 'good story' comprising strong characters a good and convincing story line and a plot as an ending. 'At least six standards of good life-story form may be identified: (a) coherence, (b) openness, (c) credibility, (d) differentiation, (e) reconciliation, and (f) generative integration.[278] In generative integration fault lines in the Me are reconciliated and integrated. Differentiation in the stories arise from the main character growing older and acquiring more events.

Rewriting the narrative can also be done by riding a motorcycle. The former soldier reconstructs a dual identity by presenting a life story as a veteran and as a biker. The 'I' generates a 'Me' by experiencing liminality and communitas, by going on a road trip together with other motorcycling veterans. A trip with a goal, and with change in identity and societal recognition as a result.

Healing occurs when participants succeed at reorganizing the old failing narrative and when they can construct a new narrative that tells a coherent and meaningful story, that provides a symbolic order containing the message that the effort of veterans helped protecting homes and fires, that it bettered the world and made it a little bit safer. The 'welcome home' is an essential ritual in the healing process.

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[275] ibid.
[276] ibid.
[277] Ibid, p. 307.
[278] ibid, p. 315.

"On the Run, such 'restructuring' involves, in part the replacing of the veteran's hostile homecoming reception with the positive 'welcome home,' and of shame at having fought in an unpopular war with a sense of pride."[279]

The new narrative that helps making sense of the world is 'forget the war, but remember the warrior'.

"On the Run for the Wall, one way to create an acceptable collective memory of the Vietnam War is, in the words of a T-shirt we saw several times on the Run, to 'forget the war' but 'remember the warrior.'… (this) message demands that the nation accept the full human consequences of sending men and women to fight wars, including those wars that were lost."[280]

Interestingly, leverage in constructing this narrative leading to societal recognition is provided for by a grouping that is stigmatized in the same way as that veterans were stigmatized when they came home from the war. The bikers originally had as bad a reputation as the veterans, but now it is the bikers who are rewriting the narrative "the Run itself represents a liminal and stigmatized social group, that is, 'bikers', and one of its additional goals is to portray bikers in a positive light, as veterans and patriotic Americans."[281]

The Dutch Lebanon veteran Wild Hog found recognition by telling his story as a biker-veteran. In telling this story he created a narrative that works, created an identity and gained social support and partial healing.

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[279] Dubisch, 2005, p. 149.
[280] ibid, p. 139.
[281] Dubish, 2004, p. 118.

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