A 4th Military Information Support Group (MISG) paratrooper reunites with his family during a redeployment ceremony on 8 July 2016. About 60 soldiers assigned to 4th MISG returned from Qatar following a six-month deployment supporting U.S. Central Command missions in the area. PHOTO BY STAFF SGT. KISSTA DIGREGORIO, 4TH MILITARY INFORMATION SUPPORT GROUP (AIRBORNE).

The complexities of transitioning from war to home are myriad, and Jennifer Hazen's monograph *Transitioning from War to Peace: Post-Deployment Support for Special Operations Forces* not only describes many of the complex factors associated with post deployment adjustment of Special Operations Forces (SOF), but elucidates what can be done to improve the ways in which the Services reach SOF Service members and families. For SOF, the complexities associated with reentering civil society following wartime deployments may be exacerbated by the frequency, intensity, and unpredictability of special operations deployments. She observes that many current programs are designed as "one-size-fits-all" interventions and are often of little value to the participants. Consistent with USSOCOM's views on this matter, Hazen suggests that programs need to be tailored to accommodate the unique characteristics of individuals and units.

Joint Special Operations University
7701 Tampa Point Boulevard
MacDill AFB, FL 33621

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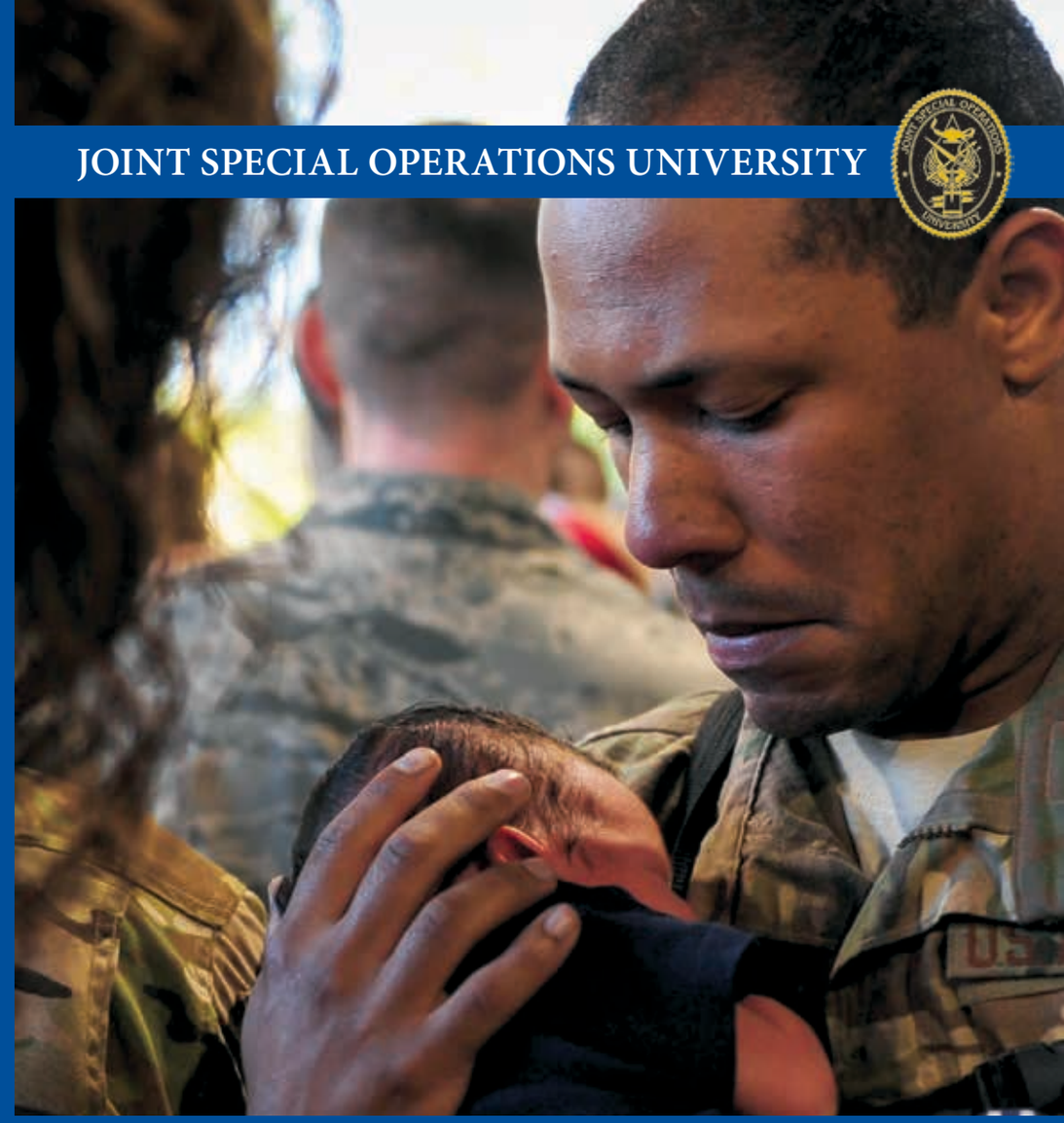
JOINT SPECIAL OPERATIONS JSOU UNIVERSITY PRESS

ISBN 978-1-941715-26-0

JSOU Report 17-8 Transitioning from War to Peace: Post-Deployment Support for SOF Hazen JSOU



JOINT SPECIAL OPERATIONS UNIVERSITY

Transitioning from War to Peace: Post-Deployment Support for Special Operations Forces

Jennifer M. Hazen

Foreword by Donald R. (Rob) Neff, Ph.D.,
USSOCOM Preservation of the Force and Family

JSOU Report 17-8

Joint Special Operations University and the Center for Special Operations Studies and Research

The Joint Special Operations University (JSOU) provides its publications to contribute toward expanding the body of knowledge about joint special operations. JSOU publications advance the insights and recommendations of national security professionals and the Special Operations Forces (SOF) students and leaders for consideration by the SOF community and defense leadership.

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Transitioning from War to Peace: Post-Deployment Support for Special Operations Forces

Jennifer M. Hazen

JSOU Report 17-8
The JSOU Press
MacDill Air Force Base, Florida
2017

Comments about this publication are invited and should be forwarded to the Director of the Center for Special Operations Studies and Research, Joint Special Operations University, 7701 Tampa Point Blvd., MacDill AFB, FL 33621.

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Printed in October 2017.

ISBN 978-1-941715-26-0

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On the cover. A communications navigator craftsman with the 4th Special Operations Squadron, holds his newborn for the first time during Operation Homecoming at Hurlburt Field, Florida, 6 November 2015. U.S. AIR FORCE PHOTO BY SENIOR AIRMAN MEAGAN SCHUTTER.

Back cover. A 4th Military Information Support Group (MISG) paratrooper is reunited with his family during a redeployment ceremony on 8 July 2016. About 60 soldiers assigned to 4th MISG returned from Qatar following a six-month deployment supporting U.S. Central Command missions in the area. PHOTO BY STAFF SGT. KISSTA DIGREGORIO, 4TH MILITARY INFORMATION SUPPORT GROUP (AIRBORNE).

Contents

From the Director

"Train as you fight." In this monograph, Jennifer Hazen extends that proven admonition to the process of reintegration. Given the duration of combat and frequency of stressful deployments, Hazen observes that reintegration is not a single discrete event but a process that must be approached with the same attention and training as other military operations. Hazen also acknowledges that developing the means and processes is insufficient by itself. Overcoming the stigma of seeking assistance, when needed, is an exceptional leadership and cultural challenge in the United States Special Operations Command (USSOCOM) enterprise.

Hazen posits that re-conceptualizing reintegration to the notion of transition permits the planning flexibility to develop options for individuals, units, and families. Additionally, the fundamental observation, that transition affects the individual SOF member as well as spouse and family members, is central to developing effective means to foster resiliency and preserve readiness.

The Center for Special Operations Studies and Research is grateful to USSOCOM's Preservation of the Force and Family for their support and contribution of a foreword by the deputy director, Rob Neff. It is our hope that this monograph, the second JSOU Press title that deals directly with issues related to preservation of the force and families, will be a vehicle to further conversation among SOF leaders.

Francis X. Reidy
Interim Director, Center for Special Operations Studies and Research

Foreword

The complexities of transitioning from war to home are myriad, and Hazen's monograph *Transitioning from War to Peace: Post-Deployment Support for Special Operations Forces* not only describes many of the complex factors associated with post-deployment adjustment of Special Operations Forces (SOF), but elucidates what can be done to improve the ways in which the Services reach SOF Service members and families.

For SOF, the complexities associated with reentering civil society following wartime deployments may be exacerbated by the frequency, intensity, and unpredictability of special operations deployments. Moreover, time spent at home is oftentimes punctuated with intensive training requirements that remove the Service member from the home in preparation for the next mission. In today's complex global security environment, the pace of operations will remain high for SOF. This high operations tempo demands there be concerted efforts to not only address the mission essential training needs of SOF, but the social and psychological needs of SOF and their families as well. In other words, we must ensure that SOF are able to perform on the homefront, as well as on the warfront. The readiness of the SOF operator is inextricably linked to that of their families. To understand the impact that family relationships have on readiness, one may simply look at military suicide data, where the presence of failed intimate relationships is consistently the most common risk factor associated with suicides.

In chapter 3, Hazen posits that the process of deploying and re-deploying should be viewed as transitions rather than reintegration. This is a reconceptualization of how we have traditionally thought of the process of returning to family and civil society after wartime deployments. Hazen's astute observation takes into account that individuals and groups, to include families and communities, are in a constant state of flux and the expectation that one can simply "reintegrate" may be an unrealistic one. Frequent and lengthy separations create situations where changes among individuals and family members occur along different trajectories. The Service member returning from a deployment is a different person in possession of experiences that cannot be understood by those that did not share them. Similarly, the family to whom the Service member returns is different than the one he or she left.

Hazen posits that Service members and their families must be trained and educated to anticipate and adapt to the uncertainties of human development. Much like the training that SOF undergo for their jobs, they and their families must also be highly adaptable when reuniting after combat deployments.

In chapter 7, Hazen provides an informative review of post-deployment family programs done by the Services and the United States Special Operations Command (USSOCOM). She observes that many current programs are designed as "one-size-fits-all" interventions and are often of little value to the participants. Consistent with USSOCOM's views on this matter, Hazen suggests that programs need to be tailored to accommodate the unique characteristics of individuals and units. Given the sociodemographic characteristics of SOF and its unique mission, it is particularly important that pre- and post-deployment programs are attuned to the needs of SOF audiences, and that it imparts useful, practical skills.

Donald R. (Rob) Neff, Ph.D.
Deputy Director, USSOCOM Preservation of the Force and Family

About the Author

Dr. Jennifer M. Hazen currently teaches at the University of North Carolina at Chapel Hill. From 2011-2015, she served as a social scientist at United States Africa Command (USAFRICOM) in Stuttgart, Germany, where she improved senior leadership understanding of Africa through research and strategic advising on areas of subject matter expertise. Prior to joining USAFRICOM, Hazen served as a research fellow at the University of Texas at Austin and at the Center on Conflict, Development and Peacebuilding in Geneva, Switzerland. She also worked as a senior researcher at the Small Arms Survey, a political affairs officer at the United Nations peacekeeping mission in Sierra Leone, an analyst with International Crisis Group, and a research analyst at the U.S. State Department.

She taught at the University of Texas at Austin, Georgetown University, and the United Nations University for Peace and has published several articles and book chapters, as well as a single-authored volume *What Rebels Want: Resources and Supply Networks in Wartime*, and a co-edited volume *Global Gangs*. She has conducted field research in more than a dozen countries with a focus on armed groups, conflict dynamics, transnational threats, peace processes, post-conflict peacebuilding, and security sector reform. She received her bachelor's in political science from the University of Michigan, and her master's and Ph.D. in international relations from Georgetown University.

Hazen's career has straddled the academic policy nexus. She possesses more than a decade of post-doctoral experience conducting policy-relevant studies that inform decision makers. Her approach is based on the belief that detailed research is at the core of successful policy, and that an understanding of real world dynamics is essential to developing effective strategic and programmatic responses to policy challenges.

Acknowledgements

I would like to thank the men and women, Service members, civilians, and contractors of the United States Special Operations Command, Preservation of the Force and Family, United States Army Special Operations Command, Air Force Special Operations Command (AFSOC), Marine Corp Forces Special Operations Command, and Naval Special Warfare Command (NSW), who generously provided their insights, time, and support to this endeavor. I am deeply grateful to those at NSW and AFSOC who welcomed me during my research visits, arranged numerous interviews, and responded to my many follow-up questions.

I would also like to thank the Joint Special Operations University team, the anonymous reviewers who provided critical feedback on the monograph, and, in particular, Paul Lieber and Peter McCabe, who provided essential support and guidance throughout this process.

When we get home,
home is still the same,
but something in our minds has changed,
and that changes everything.[1]

Introduction: Strain on the Force

> Service members experiencing reintegration difficulties may represent the untreated casualties of the longest U.S. war in history.[2]

In the post-9/11 period, the United States utilized its Special Operations Forces (SOF) to carry out numerous missions.[3] After more than 15 years of war, the forces are showing signs of fatigue and strain. As the wars wind down in Iraq and Afghanistan, conventional forces (CF) are able to reduce deployments; the same cannot be said of SOF. Although the majority of the force is faring well, 15 percent of the force reports severe symptoms related to post-traumatic stress (PTS), depression, alcohol-related problems, low resiliency, and low levels of social connection.[4] Beyond these clinical symptoms, Service members face challenges transitioning from deployments to a home environment, and some find it difficult to navigate this transition and reconnect to home life. The stress on the force resulting from multiple deployments raises questions about how to best enable Service members to manage these demands. Currently, transition support is often minimal. Improved transition support, including providing essential information and transition skills to Service members, could enable SOF to more seamlessly transition from war to peace, which in turn would enhance their capacity to train and deploy in the future.

This monograph aims to provide information to SOF leadership and behavioral health providers as they continue efforts to understand the strain on the force and provide programming to moderate that strain. Given the high operational tempo, SOF make numerous transitions as they complete multiple deployments. The pace of operations provides little time for reintegration while home. This suggests the need to focus on these transition periods, and what can be done to support SOF during these transitions. There is no 'one-size-fits-all' approach to ensuring Service members make this transition as smoothly and successfully as possible—and yet, currently, with for a few exceptions, post-deployment programming tends to be standardized and limited. Just as the military provides training to enable Service members in combat, support in the post-deployment period could provide the information and skills needed to adapt and make these transitions more

smoothly. In other words, the military could prepare SOF for coming home as much as it prepares them for going to war.

This introduction provides an overview of the rise in demand for SOF deployments since 2001, and the resulting strain on the force, and therefore the need to develop support programs to moderate the impact of deployments. It then provides an explanation of why transition assistance is needed in particular, and ends with a discussion of the methodology of this study.

Increased Demand for SOF Since 9/11

The demand for SOF and their deployment overseas dramatically increased after the events of 9/11. Military operations in Asia and the Middle East increased in number and frequency of deployments, alongside missions in other areas of operation across the globe.[5] SOF perform a unique mission set. Special operations core activities include: "direct action, special reconnaissance, countering weapons of mass destruction, counterterrorism, unconventional warfare (UW), foreign internal defense, security force assistance, hostage rescue and recovery, counterinsurgency, foreign humanitarian assistance, military information support operations, and civil affairs operations."[6] Given their capabilities and operational demands, SOF have "experienced shorter but more frequent, and often more violent, deployments" than the CF during this time.[7]

The increase in deployments after 2001 generated sustained high deployment levels and an increase in the size of the SOF enterprise.[8] The average number of SOF deployed overseas nearly tripled from 2001-2014.[9] The number of deployed SOF personnel rose from 2,900 per week to 7,200 in 2014.[10] Military personnel increased from 42,800 in FY2001 to 62,800 in FY2014, a 47 percent increase.[11] Civilian personnel increased from 2,800 in FY2001 to 6,500 in FY2014.[12] The Department of Defense (DOD) estimates that personnel levels will remain near this high mark of 63,000 through FY2019 due to existing operational requirements.[13] As a result of the high operational tempo, "at any given time a high proportion of total SOF is either deployed, preparing to deploy, or just returning from deployment."[14]

The demand for SOF capabilities is unlikely to change in the near future. Even as CF are coming home and their pace of deployment is declining, it is unlikely that SOF will see a similar decline in their operational tempo.[15] As a result, the number of deployments is not expected to decline.[16] While

the numbers of SOF deployed on a weekly basis is not expected to decrease in coming years, where these forces will deploy will continue to change as events evolve across the globe.[17] Although operations in Iraq and Afghanistan drove both conventional and SOF deployments in the 2000s, as those operations come to an end, SOF deployments to those areas decline. However, this change did not decrease the overall demand for SOF. Instead, it simply allowed SOF to shift to other areas of the globe where need had either increased or was not being met due to the demands of Afghanistan and Iraq.[18] Requests for SOF already outpace capacity, and such requests are projected to increase in the future.[19] Unlike the CF, the pressure on SOF will continue, including high rates of deployments, highlighting the need to maintain attention to the strain on the force and possible ways to support SOF through deployment transitions.

Continued Strain on the Force

The fast-paced operational tempo increased pressure on SOF to maintain demanding deployment schedules. Due to the nature of their missions, and the knowledge and training required to perform at this demanding level, it takes time to produce SOF. Whereas CF can be quickly recruited and deployed, SOF cannot. SOF are highly-specialized, trained forces that go through lengthy selection and training processes, meaning that they cannot be 'mass produced,' nor can they be created after emergencies occur.[20] Any increase in the number of SOF must be planned and executed ahead of an increased demand for their services. If demand spikes, the response cannot be the immediate recruitment of more SOF for deployment. Instead, higher demand places a heavier burden on existing SOF to conduct repeated high-risk missions.[21]

During the early years of the increase in deployments, U.S. Special Operations Command (USSOCOM) leadership was slow to address how the increased operational tempo negatively affected Service members, and the detrimental impacts of back-to-back deployments on the force.[22] As time passed and the strain increased, USSOCOM leadership focused on trying to find solutions. Former USSOCOM Commander Admiral Eric T. Olson created the Pressure on the Force and Families Task Force in 2011 to understand the challenges SOF faced.[23] The task force identified "perpetual absences" of Service members from families and home as one of the key stressors.[24] By

2011, USSOCOM noted the need to improve the "predictability factor" of deployments so that operators (and their families) would better know when they would be where, and be able to rely on these schedules.[25] USSOCOM also recognized the need to improve education on and understanding of the effects of traumatic brain injury and post-traumatic stress disorder (PTSD).[26] Former USSOCOM Commander Admiral (now retired) William H. McRaven continued this program started by his predecessor. McRaven renamed the task force Preservation of the Force and Family (POTFF) in 2012, and expanded the unit, providing it with additional resources and emphasizing a more proactive approach to treatment. USSOCOM emphasized the need to properly maintain personnel in line with the SOF 'key truth' that "humans are more important than hardware."[27]

Annual assessments indicate the majority of SOF are managing deployments and the stress on the force well; however, scores on a range of self-reported scales indicate some are experiencing challenges. Of most concern are those rating very poorly on these scales: 15 percent of respondents reported moderate to high levels of PTS symptoms, 6 percent indicated major to severe major depression, roughly 10 percent struggled with alcohol-related problems and low resiliency, while more than 20 percent indicated low levels of social connection.[28] While it is not remarkable that some percentage of the force would be facing challenges, what is important to note is that the majority of those scoring the worst on these scales are not seeking support to manage these challenges, and many of them report not seeking assistance because they do not believe they need it.[29]

After more than a decade of war, there is growing recognition of the strain placed on SOF as the signs of 'fraying.'[30] Suicide rates pose great concern, but so do high divorce rates, falling retention rates, and rising frustrations within SOF over salaries, equipment quality, and the utility and efficacy of their efforts.[31] SOF had 10 suicides in 2011,[32] faced a dramatic increase to 23 in 2012, a gradual decline to 18 in 2014,[33] and 12 in 2015.[34] While this downward trend is positive, concerns remain about how best to support the SOF community to continue to bear a heavy deployment burden.

Suicide rates pose great concern, but so do high divorce rates, falling retention rates, and rising frustrations within SOF over salaries, equipment quality, and the utility and efficacy of their efforts.

Why Transition Assistance Is Needed

According to Major General James B. Linder, who assumed command of the U.S. Army Special Operations Center of Excellence in May 2015, SOF "are adaptable enough to shift as the nature of the threat shifts, fighting the kind of asymmetrical warfare that special operators have been fighting since World War II. This is what SOF is trained to do; this is why they built us."[35] A tremendous amount of time is spent on training for deployments; as it should be to ensure SOF are highly-trained and capable of performing their demanding missions. However, the skills and training received to be excellent warriors may not be the same skills needed to be able to operate effectively in a non-deployed setting.

Existing research indicates the majority of those deployed—both SOF and CF—do not exhibit high levels of PTS symptoms when they return home, and most make a smooth transition.[36] The most common finding in many research studies has been resilience, not chronic PTSD.[37] However, many face readjustment challenges after returning home, including: substance abuse, difficulty sleeping, depression, anxiety, and a variety of interpersonal challenges (e.g. difficulty connecting, lost social structure, and lack of camaraderie of the deployment environment).[38] Insufficient data exists to fully explain the nature and extent of these post-deployment challenges, how these may differ across Services, occupational specialties, and individuals, and the relationship between post-deployment challenges and actual deployments.

While the majority of Service members studied have transitioned from deployment to garrison in a relatively seamless manner, many "struggle to find their place in the world they left behind."[39] It is not uncommon to see those who deployed claim to have zero problems when they return home (as reported on their required, standardized, self-reporting post-deployment forms), yet seek support from behavioral health services only a few weeks after returning due to experiencing post-deployment challenges. The Naval Special Warfare Command (NSW) estimates that 11-16 percent of Service members who return from deployments seek additional support in the period following deployment.[40] Other Service components were not able to provide exact percentages, but behavior health providers interviews acknowledged a lag between SOF returning home and seeking behavioral health support.[41] Since symptoms, whether related to combat or the transition, can increase over time, early identification of problems and early interventions are likely

to be most successful.[42] That being said, it remains unclear whether challenges experienced by Service members are purely deployment related or stem from the transition home. The latter could account in part for the delayed onset of difficulties. Anecdotal reports suggest Service members face some combination of challenges stemming from both deployment stressors and stresses from transitioning home.

Interviews with some of those in charge of managing post-deployment care suggest that standardized forms, while perhaps helpful for identifying some individuals with deployment-related concerns, often do not catch everyone experiencing trouble transitioning home; in particular those who experience these difficulties as a result of the transition home, rather than from combat-related experiences. Overall, service providers interviewed felt that some form of transition assistance is needed, but they were not certain what that assistance should be, nor were they confident that what is currently provided is working.[43] One interviewee stated that they know there is a problem, and that Service members tend to not be fully honest on their post-deployment forms so that they can go on leave, but they did not know how to best respond to managing these challenges.[44] Some care providers interviewed indicated they would welcome external advice and guidance on how to handle such challenges.[45] Unfortunately, data is not systematically collected and then collated to determine the primary post-deployment challenges SOF face, the number of Service members affected by them, or when and why Service members seek post-deployment behavioral health assistance. Combined, this makes it difficult to assess the extent of the challenge and the factors that contribute to post-deployment difficulties, and then develop effective support to address these factors.

One interviewee stated that they know there is a problem, and that Service members tend to not be fully honest on their post-deployment forms so that they can go on leave, but they did not know how to best respond to managing these challenges.

Not all Service members will experience post-deployment transition in the same way. Understanding these challenges, and how they may vary, will require more than the standardized post-deployment health assessments (PDHAs). Some Service members will have very little difficulty making the transition, while others might face significant challenges. For some, these challenges will have a quick onset, occurring during deployment or upon the

transition home. Others may experience a delayed onset of challenges, with a three-to-six month delay being quite common.[46] The types of challenges experienced by Service members may vary widely, from difficulty sleeping, to an inability to 'dial down' one's intensity, to anxiety resulting from family relationships and garrison duties. There is no 'one-size-fits-all' approach to ensuring Service members make this transition as smoothly and successfully as possible—and yet, currently, with a few exceptions, interviewees described this as the type of post-deployment programming that exists for many SOF. With some describing the military approach as a 'cookie cutter' one, several service providers emphasized the need for more tailored programming that takes into consideration the varying individual needs of Service members.[47]

A very small percentage of SOF training is spent on transitioning home; for some it is a few days, for many it is even less. Support received, i.e. for Air Force Special Operations Command (AFSOC) enablers and United States Army Special Operations Command (USASOC) forces, is often limited to reporting on standardized forms, where there are perceived incentives for not being entirely honest, and standardized post-deployment briefing, which are repetitive for those with multiple deployments. NSW provides a third location decompression (TLD) for its Service members: a 24-to-72 hour stopover at a site outside of the continental United States. The purpose of this time is to facilitate the Service member's process of transitioning from deployment to home. During this time, NSW SOF receive information on a range of topics related to post-deployment transition, have time to acclimate to a non-kinetic setting, and receive medical and psychological evaluations to assess potential hurdles associated with returning home. Shortly before AFSOC ground forces return home, they receive a forward-based evaluation to assess returning Service members' post-deployment needs. This is not a full TLD, but it does allow for early identification of SOF facing post-deployment challenges.

In theory, training could provide some of the skills needed to enable Service members to make an easier transition.[48] Research indicates higher levels of resilience in those with higher levels of preparedness and training.[49] Given the level of warfare training that SOF receive, this should boost their resilience during deployments, and reduce lasting impacts of combat trauma. However, even the best trained and highly-resilient can be overwhelmed by extremely difficult deployments. And it remains unclear whether resilience training translates into skills needed to navigate transitioning home; resilience skills designed for surviving combat may not translate well into the

demands of home life. SOF may require additional training in transition skills to navigate post-deployment challenges.

Methodology

This monograph marks an initial effort to focus specifically on the post-deployment transition period. This limited study is based on existing literature on post-deployment challenges and reintegration, USSOCOM annual survey data, interviews with more than a dozen SOF behavioral health providers or behavioral health support staff at the SOF Service commands, and a small survey with NSW.

Interviews were semi-structured. Common questions focused on what the interviewee assessed as the most common challenges during transition; whether they had data to confirm those assessments; the type of transition assistance provided; whether they assessed that transition assistance to be effective, and whether data existed to support those assessments. Follow on questions differed across interviewees and focused on the interviewee's experience and knowledge base. Interviewees are not named in this monograph, nor otherwise identified to ensure they remain anonymous and to provide them the freedom to speak unhindered.

A short survey was made available to NSW Service members who returned from deployment in 2015. The survey entailed a handful of questions pertaining to the most common challenges faced upon return, whether respondents felt the transition training they received enabled them to manage those challenges, and what additional transition training and support they would like to receive in the future. The survey was optional and anonymous, and no tracking was done to identify who responded. Additional information on the survey can be found in chapter 6.

This initial research highlights the importance of paying more attention to the transition period and the support provided during this time, and suggests further exploration of the post-deployment transition period would enable improvements to current transition programming. The remainder of this monograph details the challenges of post-deployment transition (chapter 1), the need to focus on transition, rather than reintegration (chapter 2), the current approaches taken (chapter 3), and how these vary across the service components (chapter 4). The monograph also highlights what is working (chapter 5), and provides suggestions for improving transition support (chapter 6).

Chapter 1. Common Transition Challenges

> After nearly 13 years of sustained high operational tempo, our people need help with mending their mind, body, and spirit.[50]

This chapter reviews common transition challenges highlighted in the literature and through interviews. These challenges can make the transition from deployment to home potentially difficult to navigate. There are the normal residual reactions to combat—e.g. difficulty sleeping, hyperarousal, hypervigilance—that can linger for some time, sometimes several months, after returning home. Post-deployment concerns include persistent traumatic stress symptoms, and the possibility of PTSD. In addition, SOF encounter challenges resulting not from combat but from the actual transition process, including difficulties adapting to the changed operating environment, social structure, and required mindset and appropriate behavior when they shift from a deployment setting to being at home. Seeking assistance to manage these transitions may be difficult given expectations of self-regulation that permeate the community, and the negative stigma on seeking help that persists.

Residual Effects of Combat and Returning to Baseline

Returning Service members face the normal neuro-physiological reactions to high stress environments. They are likely to experience common residual effects of the 'fight or flight' response activated during deployment, including: hyperarousal, hypervigilance, irritability, anger, anxiety, and panic. The fight or flight response is a normal and necessary biological response to situations of danger. It is "an adaptive and beneficial response when there is a threat to your personal welfare or that of others, and the persistence of these reactions is the body's effort to ensure that you're immediately ready if the danger occurs again."[51] When confronted with a life-threatening danger, the body responds by releasing a variety of neurotransmitters and neuropeptides (e.g. norepinephrine, serotonin, dopamine), which creates a physical state of arousal—hypervigilance—that facilitates the ability to act to survive.[52] In this

state, the limbic system takes over, relying heavily on reaction and trained response, rather than rational thought, which serves to protect the Service member in combat.[53] Automatic responses to perceived threats are essential in combat, but are unlikely to serve Service members well at home, where such actions are likely to be interpreted as overreactions.

Service members, when returning home, need to give their brains and biological systems time to adapt to the non-threatening environment. SOF will need to manage their elevated senses, enabling them to return to their normal baseline, whatever that might be for the individual. This does not mean turning these senses completely off; instead the focus is on regulating responses. A key component of regulation is regular sleep; yet difficulty sleeping is one of the most common challenges among Service members returning from deployments. Service members often turn to alcohol as a way to relax and go to sleep. While alcohol can induce sleepiness, it also greatly reduces the quality of sleep. This can create a vicious circle of sleep deprivation and alcohol consumption.[54] While sleep aids can assist a Service member in obtaining sleep, the use of prescription medications is only a first step toward getting a Service member rested enough to focus on the factors that are preventing natural sleep.[55]

Recurrent deployments with insufficient time to rest and recover in between deployments allows "biological systems little time to return to baseline."[56] Service members instead remain at heightened stress levels. Over time, without this return to baseline, the constant stress response can lead to biological, physiological, and neuroanatomical abnormalities associated with PTSD, which can result in neuropsychological impairment.[57] To combat these negative outcomes, Service members need to self-regulate, and if this is not possible, seek assistance to regulate stress levels, enabling them to return to their baseline as quickly as possible upon returning home and before the next deployment. This ensures both best performance while in the military and the most stable long-term outcome.

PTSD

Clinical PTSD is a possible outcome for SOF when they return from deployment.[58] However, the vast majority of SOF do not exhibit PTSD symptoms. This suggests caution in using the PTSD label and protecting against it being used "as a catchall [phrase] for the myriad ways that war, peace, genetics, and

institutions all shape the behavior" of Service members.[59] Research indicates at least 50 percent of the U.S. population has experienced a traumatic event, however, only a small minority of those individuals will develop PTSD.[60] The prevalence of PTSD in the U.S. population is 10 percent in men, and 10 percent in women.[61] Military Service members with combat exposure are at higher risk for developing PTSD due to the nature of their service and the higher likelihood of experiencing traumatic events. However, even in the military, the percentages of PTSD remain relatively low. An estimated 14 percent of Operation Iraqi Freedom and Operation Enduring Freedom (Afghanistan) veterans in the CF experience PTSD.[62] The USSOCOM annual needs assessment survey indicates roughly 15 percent of respondents experience moderate-to-high PTS symptoms, however, this is only reported symptoms, not a measure of PTSD rates.[63] A study of USASOC estimated PTSD rates at 16-20 percent;[64] although a review of that study argued those rates were likely overestimated.[65] USSOCOM does not provide publicly available statistics on the rate of PTSD in SOF.[66] It is important for Service members to understand the difference between PTSD and normal transition challenges.

Understanding 'Normal'

A key challenge for supporting returning Service members is to assist them in understanding what is 'normal' upon transitioning home, and what can be expected in terms of common challenges and recognizable behaviors indicating difficulties transitioning. In other words, it may be helpful to convey to Service members that not 'being normal' at the time of return and the period following a deployment is actually a normal response. Perceptions are important: "if you view yourself … as having a disorder according to what a professional (or society) says, rather than someone experiencing expected reactions from combat, it affects how you feel and think about yourself and your loved ones."[67] It often takes time to adjust to the transition; for many this may take three or four months.[68] However, Service members also need the knowledge and skills to identify problematic behavior and recognize when the post-deployment transition is not going smoothly, when symptoms are not abating, or when reactions are so severe

A key challenge for supporting returning Service members is to assist them in understanding what is 'normal' upon transitioning home.

that they impair daily functioning and/or create the potential for harm to oneself or to others.

Changed Environment

Returning from deployment requires adjusting to a new environment. Service members must adapt to garrison and home life. The operating environments—deployment versus garrison—present almost opposite conditions. Most deployment settings are in developing countries, where living conditions are difficult. The deployment setting is dangerous requiring constant vigilance of surroundings and awareness of how people are behaving. The community in which SOF operate is likely hostile to the operators. After deployments, Service members shift from a setting of danger to one of safety. In most instances, this means a transition to a relatively familiar and benign environment, but one that requires civilian modes of operation. Transitioning home requires changing one's behavior to what is appropriate for a civilian setting.

Service members must stow away military behaviors in favor of civilian ways when they return home. Military training creates habits that while effective in combat and in the military world, may not fit the civilian world, including: a focus on safety, trust no one, identify the enemy, mission orientation, decision making, response tactics, predictability and control, emotional control, not talking about the mission, and providing information on a need to know basis.[69] The changed environment imposes a social demand on Service members to alter their behavior; to not respond with intensity, or overreact, to what are perceived by society as normal everyday encounters. The ways of doing things while on deployment do not always work well at home, where these behaviors can alienate friends and family and isolate Service members from their support systems.

It is worth noting the potential 'dangers' that can be perceived at home as well, such as challenges communicating with family, a strained family life, a pending divorce, and other conditions that can act as stressors on returning Service members. Even though challenges at home are not usually dangerous, the stress of the situation can prompt the Service member's system to respond as though it is life threatening.[70] These stressors produce reactions similar to those of combat in that they activate the fight-or-flight reaction,

and this can hinder the individual's ability to decompress from the deployment and adjust to a peacetime environment.

Changed Social Structure

Equally important is the changed social structure. On deployment, SOF operate as a team. The social bonds created in war are often some of the strongest; and Service members, regardless of how positive or negative their home life experience is, may not feel this same level of cohesion, support, and trust at home, as they do when operating with the team on deployment.[71] This can produce a sense of loss of camaraderie and support when returning, which can reinforce the tendency of SOF to gravitate toward their team rather than their family members after deployments, which can contribute to additional tension at home. This can be exacerbated by the demands of home life, whether that is demands on time or additional household responsibilities (e.g. childcare, cleaning, home repairs). Several Service members, in casual conversations, have stated they "just want to be left alone" when they return from deployment. For some, the need to be alone includes distancing oneself from family members. Family members may perceive the need for space as a rejection of the family, rather than the need for solitary time to decompress after deployment. Service members also return to more independent spouses, different parenting styles, and renegotiated household roles, leaving some feeling like guests in their own homes.[72]

Several Service members, in casual conversations, have stated they "just want to be left alone" when they return from deployment.

Changing the Mindset

A changed environment requires an adjustment in mentality and behavior. SOF must change their focus from the mission to training mode; from deployment goals to garrison life, and from the team to the family. On deployment, SOF are focused on the mission and primed to act. They have a mindset for survival that entails hypervigilance, aggressiveness, and often a lack of emotion.[73] At home, numerous demands on the Service member's time and attention preclude a singular focus, and instead demand multitasking. In casual conversations, Service members have often described being on a mission as easier than being home; they are focused on the job, doing what

they have been trained to do, and contributing in a useful fashion. When on a mission, they have a sense of purpose, at home they may question what they did and how useful it was.[74] The pace of action declines precipitously at home from a highly kinetic and 'always on' tempo to a much slower pace of activities, which can lead to boredom and frustration.[75]

Persistent Stigma

Despite actions taken by those in military leadership positions to encourage Service members to take advantage of support mechanisms when they are needed, and to reduce the stigma associated with those having difficulty managing combat stress and deployment transitions, the stigma persists.[76] For some, the stigma is self-imposed and is the desire to not appear weak; for others it is external concerns about being seen as 'crazy' or having careers negatively impacted by seeking help.[77] Those facing challenges do not want to admit to 'having problems' or to 'seeking treatment,' which may inhibit SOF from asking for help or self-identifying when they are having trouble.[78] Some of this is ingrained in the culture of the military, where any sign of weakness is viewed as unacceptable. As one SOF veteran stated: "I can't admit that I have to see a counselor or psychiatrist, that makes me weak."[79] Concerns persist about the impacts of seeking assistance on the Service member's career, including the loss of a security clearance or promotion, as well as reactions of team members or letting the team down, which create perceived barriers to seeking behavioral health care support.[80]

Chapter 2. Re-conceptualizing Reintegration as Transition

> SOF live[s] within a short-term deployment & training cycle that result in little or no reintegration period with families … we are always at war.[81]

Coming home from deployment is widely viewed as a joyous occasion, especially by those at home awaiting the arrival of loved ones. While this may hold true for most, this presumption obscures the various challenges of coming home and the difficulties both Service members and family members may face during this transition period. This is particularly true when there exists a presumption that nothing has changed, except for the individual having been gone, and therefore the task of reintegration is to enable the deployed Service member to return to 'normal' by returning to the life he or she had before deployment. Rarely does this presumption hold true. Numerous changes take place within the Service member and at home while the Service member is deployed. Understanding these changes, and their impact, can be essential for the Service member to successfully navigate the transition process. In addition, given the nature of SOF and the recurrence of deployments, it may be more helpful to frame homecomings as transitions, rather than reintegration. This chapter begins with an overview of reintegration in order to set the stage for reframing the post-deployment dialogue as one about transition.

Reintegration: Managing Coming Home

There is no common, widely accepted, or widely used definition of reintegration. Approaches to reintegration may focus on a specific time period when reintegration is expected to occur, on the activities entailed in reintegration, or on the individual adjustments necessary to transition from one environment to another (e.g. deployment to home). There are pros and cons to each approach. A holistic approach to reintegration would incorporate elements of all three.

One approach to reintegration is associated with events and dates. Post-deployment reintegration is viewed in terms of the 'return home' of the Service member and his/her reunion with family and community.[82] This process of returning home can also be framed as reinsertion of the Service member into his/her previous context. Reintegration is widely considered a long-term process covering various domains of one's life (e.g. personal, family, community). It is unlikely that given current operational demands that periods at home between deployments will provide sufficient time for full reintegration. Thus, this homecoming could also be viewed as a transition period, since many active duty SOF are returning home with the knowledge that they will be deployed in the future. Understanding reintegration in these terms largely focuses attention on the timing of the transition and events associated with reintegration beginning with the reunion and ending with a new deployment.

Another approach to reintegration shifts the focus from a certain time period to the actual activities involved in reintegration. This approach tends to focus on the multiple domains of daily interaction, e.g. home, work, community, and the ways in which reintegration must take place in each domain. Here reintegration entails the individual's reintegration (e.g. 'feeling like oneself again'), reintegration back into family life (e.g. rebuilding spousal and familial relationships), work reintegration (e.g. adjusting back into garrison life, returning to normal duty), and cultural reintegration (e.g. returning from settings of extreme deprivation to a setting of relative abundance).[83] This approach implies that these processes may not fit within a certain period of time or occur at only a particular time in the deployment cycle. The focus is less on when these activities take place, than on what needs to take place for reintegration to occur and be successful.

A third way of considering reintegration is to view it as readjusting to a peacetime environment, wherein the change in setting requires different behaviors and approaches. Interacting in this new environment and managing conflicts that occur will require different skills than those perceived as effective and necessary during deployments. This requires Service members to have the necessary skills to operate in this largely civilian environment, including: communicating effectively, making effective decisions, interacting with civilians (versus solely military), and both setting goals and engaging in civilian-centric activities.[84] The challenge is that while the military provides extensive training for deployments, it provides limited

training for transitioning home; specifically, how to alter behaviors that serve them well on the battlefield, but produce negative responses in a peacetime environment.

Taken together, these various ways of looking at reintegration suggest that post-deployment reintegration should focus on the levels of functioning at home, at work, in relationships, and in the community after deployment.[85] This broadens the focus from the individual, and common concerns about PTS and the physical health of the individual, to understanding how that individual is managing the transition from a deployed setting to home and adapting to all of the demands and challenges of this transition. However, reintegration also implies remaining within the post-deployment setting for an enduring period of time. The operational tempo of SOF usually precludes this from happening. Even if the reintegration process begins, deployment schedules will likely disrupt it. SOF will not be able to fully reintegrate until they stop deploying.

Service Definitions

There is no common definition of reintegration used across all U.S. military Services.[86] The Defense Centers of Excellence defines reintegration as "the process of transitioning back into personal and organizational roles after deployment" that serves to "return service members to their previous levels of function and well-being."[87] While this definition highlights the transition that takes place, its emphasis on returning to a previous state of functioning suggests there is no allowance for change, which can be challenging. It is rare that deployments do not change both the Service member and the Service member's family at home. Creating expectations that there is a 'normal' that must be returned to when coming home fails to recognize changes that likely occurred during the deployment and sets the stage for conflict when 'normal' is difficult, or impossible to achieve.

The conventional Army uses several terms for the process of coming home: redeployment (getting ready to return home), homecoming (physically coming home), post-deployment (the time directly following homecoming), and the reconstitution phase (the period needed to rebuild relationships at home).[88] The Army recognizes the importance of reintegration as part of the overall cycle of deployment, but views it in terms of getting soldiers ready for another deployment. The focus is often on reintegration's role in individual

and unit readiness.[89] The conventional Army defines reintegration as "the reestablishment of Soldier and civilian readiness, including personal readiness, deployment readiness, and family readiness."[90] This definition rightly acknowledges the various spheres of reintegration—personal, work, and family—but the focus on the mission on soldier readiness may distort the focus of the individual away from non-military spheres of life, resulting in only partial reintegration.

The conventional Navy defines reintegration as "the process and establishment of normalcy as a sailor readjusts to family life, returns to work and copes with stress following deployment."[91] The Navy also uses the terms 'reunion' and 're-entry' to characterize the return from deployment.[92] The definition acknowledges the likelihood of post-deployment stress, and normalizing it, which is a positive aspect. However, the focus on normalcy may not serve this population well, as part of navigating the transition home is often a reestablishment of what is normal, creating a 'new' normal, rather than trying to achieve what existed prior to deployment. NSW tends to use the terms post-deployment and resiliency, rather than reintegration or other related terms.[93] NSW SOF operate with the knowledge that the return from one deployment is part of the overall deployment cycle, and that they will be deployed again. A focus on coming home as part of this cycle helps to set the stage for future deployments; indicating an awareness that Service members are unlikely to have sufficient time to fully reintegrate between deployments.

The conventional Air Force defines reintegration as "the process of returning Air Force Service members back into a 'stable and normal environment.'"[94] Again, the use of normal as the standard can set the bar too high for many who will need to define a new normal. The Air Force emphasizes the need to recognize, accept and adapt to change in order to ensure a smooth transition from deployment to garrison.[95] The focus on change as part of the transition is essential, however Service members may find it difficult to navigate these changes without support. The conventional Air Force uses the terms redeployment (which is the physical homecoming) and post-deployment (the period following a return to garrison) as the main terms for the post-deployment period, rather than reintegration.[96] AFSOC tends to use post-deployment and resiliency, rather

The focus on change as part of the transition is essential, however Service members may find it difficult to navigate these changes without support.

than reintegration or other related terms. While some AFSOC behavioral health providers use the term reintegration in discussions, this tended to be a euphemism for homecoming and reinsertion; a few providers were quick to point out that reintegration was a long-term process that could not be addressed in a discrete time frame and "wrapped up like a nice package."[97]

The Marine Corps defines reintegration as "the process of the return home and reunification with family members following a deployment."[98] The main purpose of reintegration is to "significantly improve the return and reunion process, reduce the potential for emotional difficulties and marital strife, and ensure Marines are ready for the next mission."[99] Marine Corps Forces Special Operations Command uses the phrase "Reintegrate, Rest, Refit" to characterize the post-deployment phase. During this phase, Marine SOF complete post-deployment training and after action reviews, and provide feedback that can be incorporated into future training.[100] The emphasis in the post-deployment phase is on mission readiness, ensuring Marines are fit to deploy again.

Although the Services have different post-deployment programs, commonalities exist. There is a focus on mission readiness, and forces being ready to redeploy. There is a strong focus on change and transition, which is essential, but the Services provide limited training for Service members on how to manage the transition and navigate these changes. A broader recognition of the various spheres of life where difficulties could emerge and hamper Service member performance could shift the way the military thinks about the post-deployment period to include both deployment readiness and overall Service member health and mental well-being, and family health and stability. This would entail considering not only what is needed for short-term readiness, but also what is needed for long-term performance and sustainability.

Transition, Not Reintegration

It may be far more useful to speak in terms of transition rather than reintegration due to the reality that SOF experience numerous homecomings and deployments, sometimes with relatively little time in between. This is unique to SOF. While conventional forces usually deploy for longer periods of time, they also experience longer periods at home between missions, which provide time to reintegrate. SOF tend to have shorter deployments, but deploy with

more frequency, and often less reliability in terms of scheduling. Reintegration is not possible under these conditions. While coming home will entail the challenges of adapting to garrison and home life, it is unlikely that SOF will be able to focus on reintegration as long as they have another deployment on the horizon. Under these conditions, setting full reintegration as the goal may create unachievable expectations. Former USSOCOM Commander Admiral William H. McRaven alluded to this challenge when speaking to the House Armed Services Committee in 2012, emphasizing that the revolving cycle of home to deployment is just one of the challenges that comes with the territory of being SOF and current demand levels for SOF deployments.[101] Reintegration is difficult when Service members and their families are also thinking about and preparing for another deployment in the near future.[102] Even with more regular deployment schedules and longer dwell times, the reality is SOF are coming home only to prepare to leave again. Discussion of true reintegration will be hard to achieve until the operational tempo declines; but even then, given the nature of SOF, reintegration may only be possible once an individual is no longer in a position of deploying.

Rather than focusing on reintegration, it may be more useful to use the term transition. Service members are repeatedly transitioning from warzone to peacetime, from deployment to home, and then in reverse, from home to deployment and combat conditions. These transitions entail mental, physical, emotional, and social challenges. Navigating these challenges can prove difficult, especially for those who lack the necessary skills. Just as the military provides training to enable Service members in combat, support in the post-deployment period can provide the skills needed to adapt and make these transitions more smoothly. In other words, the military could prepare SOF for coming home as much as it prepares them for going to war.

Chapter 3. Current Approaches: Overview

> Today we have multiple choice, check-the-block training … we throw some safety surveys at the troop and give him a mandatory suicide brief.[103]

The current approach to maintaining the health of the force relies heavily on two measures: efforts to reduce the frequency of deployments and a series of pre- and post-deployment questionnaires to track strain on the force. Maintaining low deployment-to-dwell ratios is not always possible to achieve, or maintain, due to training and operational demands. While standardized forms offer a simplified means of tracking the health of thousands, and are perhaps a necessary component of managing personnel, they may not be sufficient to ensure the health of the force. Behavioral health care providers interviewed spoke of not having a comprehensive picture of the needs of returning SOF, and how these needs vary across components, deployments, and individuals; they also indicated concern that current approaches may not be effective. This chapter provides an overview of the standard post-deployment efforts and suggests where some possible gaps may exist in current efforts to transition Service members home.

Deployment-to-Dwell Time Ratios

Having sufficient dwell time in between deployments is essential for Service members to have the necessary time to "properly recover physically, socially, mentally and spiritually" from deployment.[104] In 2005, USSOCOM "issued policy requiring active-duty SOF personnel to remain at home for at least an equal amount of time as they were deployed for operations and training."[105] This would equate to a deployment-to-dwell ratio of 1:1. However, it proved difficult to implement this policy across the command. Not all SOF components—Air Force, Army, Marine Corps, Navy—were able to meet this target due to operational needs.[106] In addition, lack of clear implementation guidance led to inconsistent interpretation of the policy across USSOCOM.[107] Component commands (e.g. USASOC, AFSOC, NSW, Marine Corps Forces

Special Operations Command [MARSOC][108]) also lacked reliable data to track deployments.[109] In 2007, USSOCOM clarified the requirements of the deployment-to-dwell policy.[110] In 2008, USSOCOM updated the policy, reiterating the need for a 1:1 ratio, but encouraging component commands to strive for a 1:2 ratio, and stated a long term goal of reaching a 1:3 ratio.[111]

As of 2014, the command was striving for a deployment-to-dwell time ratio of 1:2; equating to being home twice as long as being operationally deployed.[112] The aim of this ratio was to acknowledge emerging requirements and allow forces time to rest in between deployments. USSOCOM relies on component commands to track and report if units are complying with this policy.[113] Component commands track the readiness of their Service members, including tracking the number of days deployed in a year, and rating the health status of individuals. However, deployment demands might still win out over concerns about these numbers and ratings, resulting in individuals who are not completely 'green' (mentally and physically 'ready to go') deploying on missions.[114]

Emerging requirements—more than 100 in FY2014—ensure that not all units can meet the deployment-to-dwell guidelines.[115] USSOCOM and its component commands admit certain units have higher deployment rates than prescribed, e.g. USASOC Civil Affairs, Army Ranger units, and some MARSOC Support Group forces.[116] Others, such as NSW, Air Force Special Tactics Squadrons, and MARSOC teams, are able to structure deployments on a 1:2 ratio, but this does not take into consideration emerging requirements, which could change demands for deployments and increase them beyond this ratio.[117]

Results from Wave IV of the USSOCOM annual needs assessment survey suggests that, on average, the time spent away from home is declining.[118] Service members, on average, are spending 4 months deployed and 5 months on temporary duty (TDY) per 24 months, approaching the 1:2 ratio (9 months away, 15 months at home). While this indicates deployment-to-dwell time ratios are moving in a positive direction, this overall average hides the reality that some units still do not meet these guidelines, and additional effort is needed to address those units still heavily strained by deployments. Despite efforts to

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constrain the amount of time actually deployed, Service members and their significant others continue to express concerns that time at home contains so many demands—including training, TDY, exercises, and office work—that even if dwell times technically fit within Service and command policy, they may not provide sufficient time for Service members to recover from their deployments.[119] Some units, and even some individuals pulled for particular expertise for missions, experience less dwell time, and this is where higher strain on the forces is likely to occur, and therefore where transition support could be most critical.

Standardized Self-Reporting Forms

"In December 1998, the Joint Chiefs of Staff published uniform, standardized procedures for deployment-related health surveillance and readiness which included the requirement to conduct pre-deployment and PDHAs for deploying personnel. These health assessments [are] documented using DD Forms 2795 and 2796 respectively."[120] Those deploying generally are expected to complete the DD 2795 form (a pre-deployment health assessment) and the DD 2796 form (a PDHA). These forms are standardized, self-reporting, and stored in the Service member's permanent medical record. The process evolved since the late 1990s. While additional forms were added to periodically assess the overall health of a Service member on active duty, e.g. the Periodic Health Assessment[121] and the Deployment Mental Health Assessment,[122] post-deployment transitions still rely heavily on these standardized post-deployment assessment forms, or some version of them.

A PDHA is a commonly used tool in many countries to assess soldiers returning from deployments, whether from combat or peacekeeping missions.[123] These assessments "review each deployer's current health, mental health or psychosocial issues commonly associated with deployments, special medications taken during the deployment, possible deployment-related occupational/environmental exposures," and any deployment-related health concerns.[124] The PDHA poses questions about a variety of symptoms related to: depression, traumatic stress, alcohol use, relationship problems, anger, and sleep.[125] The purpose of the assessment is to detect early signs of problems to enable the provision of appropriate treatment as soon as possible; early treatment is more likely to produce a positive outcome. This assessment must be completed in-theater or within 30 days of returning home."[126] In

practice, Service members are often expected to complete these forms within the first two weeks after returning home. Service members are incentivized to complete them in a timely fashion; these need to be completed before the Service member can take leave. The reason for providing the assessment right after deployment return is to address any immediate signs of trouble resulting from the deployment itself,[127] as opposed to problems that may emerge in the months following a return home. The PDHA process has identified a significant number of CF as 'potential candidates' for follow up evaluation and treatment.[128]

In response to negative symptoms and recurring challenges observed in Service members from Operation Iraqi Freedom and Operation Enduring Freedom,[129] the military created an enhanced PDHA. These enhancements, created in 2003, "included modification of DD Form 2796 to more thoroughly document post-deployment health and mental health status, deployment-related occupational and environmental exposures, and appropriate referrals for further evaluation and care."[130] The changes were designed to improve post-deployment health screening for all returning Service members, including a screening tool for mental health concerns, and for other health and behavioral issues. The enhanced PDHA is to be completed within five days of return from deployment, and then filed in the Service member's permanent medical record within 30 days of return.[131] The enhanced PDHA remains a self-reported assessment, however, policy indicates that it should be reviewed during a face-to-face meeting between the Service member and a credentialed health care provider.[132] Interviews at SOF components indicated they require the form to be completed within the first week home, however, there was no mention of a standard face-to-face meeting to review the form with a health care provider.[133] Instead, Service members who screen positive for symptoms of PTS, depression, or alcohol-related problems are referred for follow-up services, and offered options for follow-up care.[134]

In March 2005, the DOD mandated the implementation of a second post-deployment assessment, the Post-Deployment Health Reassessment (PDHRA) (DD Form 2900).[135] The purpose of the PDHRA is "to identify and address health concerns, with specific emphasis on mental health," that might emerge over time following deployment.[136] Service members are required to complete the PDHRA within three to six months of coming home. Research suggests a follow-up assessment is warranted for a number of reasons: the honeymoon period will wear off and symptoms will emerge;

the stresses of reunions and relationships start to manifest; symptoms that are normal at the time of return (e.g. hypervigilance, inability to sleep) may persist; and some who are initially asymptomatic will develop symptoms between their return home and the 120-day mark.[137]

While standard assessments can provide an opportunity to identify those experiencing difficulties when returning home, and research supports the necessity of these multiple assessments,[138] there are also challenges to using the assessments effectively. Conversations with Service members and interviews with behavioral health care providers suggest standard forms may not be the most effective screening tool for a few reasons. The PDHA and PDHRA are not anonymous. As a result, Service members are fearful that being honest on these forms could lead to negative consequences. In the short-term, there is a concern about being held back from going on leave. More broadly, there is a concern that anything perceived as negative, or weak, in their record could affect one's career and promotion possibilities. As a result, there is an incentive to not disclose problems on these forms.[139] Despite efforts to reassure Service members they will not be penalized for seeking help, fear persists that any problems relating to mental health will be used against them, and Service members know what to report on these forms to avoid getting flagged for follow-up services.[140] Even when Service members report significant post-deployment symptoms, research indicates few request services to assist in managing their symptoms.[141]

More broadly, there is a concern that anything perceived as negative, or weak, in their record could affect one's career and promotion possibilities.

Ultimately the questionnaires do little good if they are not completed. A government review of PDHRA completion rates in 2008 found that the DOD did not collect sufficient data to identify completion rates.[142] In February 2008, the Armed Forces Health Surveillance System developed a compliance assessment methodology.[143] A review of NSW compliance rates revealed that less than half of those under study had completed a PDHRA, and less than a third had completed both a PDHR and PDHRA after a deployment.[144] However, when disaggregated by year, completion rates of the PDHRA increased over time from 2006-2010, nearing a 75 percent completion rate.[145] Additional factors may affect PDHA and PDHRA completion rates such as changing units, deployments, and discharges.

Gaps in Current Post-Deployment Approaches

Behavioral health care providers interviewed indicated concerns about being able to effectively address the challenges facing returning SOF, and what type of support would best enable individuals to make the transition home successfully. Several interlocutors anecdotally mentioned existing challenges: they "know" there are problems, but they "don't know what they are" and they "don't know how to fix them;" some are resistant to research on reintegration despite this awareness, while others are looking for information and recommendations on effective methods for supporting the transition process.[146] Some interviewees offered their thoughts on key problems in the community and challenges that seem to arise most often, e.g. hypervigilance, sleep problems, and navigating difficult relationships at home, but they did not have the data to back up their impressions, nor understand why these were the most common challenges.[147] There was an expressed recognition that alcohol is a common coping mechanism. While this is not a desirable or effective coping strategy, it is one that is ingrained in the military culture and difficult to tackle.[148] The concerns raised by those interviewed suggests that additional efforts to understand the needs of Service members, how they vary, and how they evolve over time would provide essential information for targeting support to enable Service members to successfully manage these challenges.

Understanding Changes during Deployments

While some individuals may suffer from trauma related to deployments, research suggests challenges also arise during the transition process that are related to the transition process itself and are not a direct result of trauma from war.[149] A common saying is that Service members change during deployments:

> War changes people. One can argue whether these changes are positive or negative, but the fact that combat deployed soldiers change cannot be argued.[150]

> Each soldier returned a very different person, and had to recognize this, accept this changed reality, and rediscover who they are.[151]

> My soldiers have been fighting now for 12, 13 years in hard combat—hard combat, and anybody that has spent any time in this war has been changed by it. – Navy Admiral (retired) William McRaven[152]

It is not always clear whether these changes are positive or negative. Although they are often presumed to be negative, there is also evidence of positive changes resulting from combat, including greater maturity, self-confidence, and self-reliance; acquiring new skills; greater appreciation for home and family; and, greater dedication to the military mission.[153] Regardless of the nature of these changes, those that take place in the individual during deployment will affect the trajectory of the individual's transition home. The question is whether Service members have the necessary skills to recognize these changes, accept them, and then manage the transition into a home life that likely expects them to be the same person they were when they left for war.

Research has not established what exactly causes changes in individuals during deployments. These could result from combat exposure, traumatic events whether related to combat or not, and from deployment-related stressors. They also likely result simply from being in very different situations, environments, and duties, than is the norm. Some of these factors are modifiable, which could alter the level of impact, while others are not.

Combat exposure is not an easily modifiable factor. It is highly unlikely the military will be able to modify how much combat a particular unit will experience while deployed. However, knowing that combat exposure is an important factor that can influence an individual can help to develop pre- and post-deployment interventions that can assist those who have experienced combat exposure.[154] Combat exposure declined from 2013 to 2014, as reported by active duty Service members in the USSOCOM annual needs survey, but the reported rates of problems increased during this same period.[155] Possible explanations for this rise in reported problems include: different respondents from 2013 to 2014 leading to the variance; active duty Service members now having longer dwell times, which can allow for more time to experience and be forced to manage problems at home; and the response of active duty SOF to not being deployed, and the resulting feelings of boredom or ineffectiveness.

Other factors that affect those on deployments are potentially modifiable. Deployment-related factors include a host of stressors: uncertain

redeployment dates; long deployment length; feeling homesick; lack of privacy or personal space; boredom or monotony; concerns or problems back home; problems with supervisor(s) or chain of command; lack of time off; extremes of heat and/or cold; not having the right equipment or replacement parts; and difficulty communicating with home.[156] One factor that appears to dampen the effects of deployment stressors is unit cohesion.[157] Preparing Service members for the new environments in which they will operate could help reduce the shock of working in a developing and war-torn country; often a context that is foreign for most and overwhelming to many. Increasing access to the right equipment, replacement parts, and hot- and cold-weather gear could also improve morale and performance.[158] Some of these stressors may have easier resolutions than others, or at the very least are factors that can be considered by leadership for action.

One factor that appears to dampen the effects of deployment stressors is unit cohesion.

Lack of Data

Currently, no data has been collected on the most pressing challenges, and effectiveness of existing programs. This is the result of the lack of well-defined policies, procedures, and assessment metrics to design and assess programs that meet the needs of Service members.[159] Data collection initiatives could assist in identifying challenges: understanding existing needs, changes in trends over time, and the evolution of these trends to assess when programs need to be adapted or completely changed. Data collection initiatives could entail monitoring existing programs. This can identify which programs, trainings, and procedures exist for each component, and within the components (e.g. for those components that provide different assistance based on occupational specialty), and assess the impact of these efforts in managing Service members' needs in the post-deployment period. Data initiatives would also maintain records. This includes recording what has been tried, what has worked and what has not, why there were changes to programs, why a certain program was selected to replace a previous one, and the measured impacts of the new program. Such information can prevent efforts to 'reinvent the wheel' with each new program and avoid repeating programming that were not successful in the past.

Creating data intensive initiatives may face resistance. The U.S. military on the whole seems to have a growing aversion to research studies, with a common complaint of being 'over studied' or not seeing the utility of 'academic' studies.[160] More could be done to link academic studies to actionable recommendations, which would make such studies more appealing to the military, and easier to translate into policy and programming. Currently USSOCOM has limited in-house capacity to collect data; this deficiency could be addressed by building in data collection to daily operations in ways that make the collection streamlined and less burdensome. It would also make it internal, which could reduce any concerns about 'internal problems' being publicly exposed. Data collection is the first step; using that data to improve Service member well-being is the second challenge. Wider distribution of study results could reduce resistance to these studies, such that those collecting data do not feel the effort is useless and those providing the data do not see it as "one more study" that they never see. Participation in research could wane if Service members perceive there is no corresponding action to address concerns raised in the research. Although USSOCOM circulates the summary data from the annual needs assessment survey, this tends to go to senior leadership, and it is unclear how much of that information trickles down the chain of command.

Community Engagement

Finally, successful post-deployment transition requires community engagement. Responsibility for supporting the transition of Service members cannot fall on USSOCOM and SOF Service members alone, in large part because the transition from combat to garrison is only one piece of the transition process.[161] A more holistic approach involves the family, the garrison community, and the broader community. However, communities may not be well placed to understand what is needed or how to provide support.[162] Community-based support for transition provides ways for Service members to reconnect to their communities, to share their deployment experiences, and to bring the war home for all.[163] Today's wars take place outside of the U.S. and outside of the everyday experience of the average American. Despite the thousands of Service members who have deployed overseas during the past decade, that still represents a tiny fraction of the American population. The lack of popular knowledge about these wars, about what Service

members are experiencing, can alienate returning Service members from their communities.[164] In part, this results from the defensive response by Service members to shelter family members from the horrors of war and to not talk about their deployments, their experiences.[165] In part, it is the failure of the American public to engage in U.S. foreign policy and bridge the civil-military divide that keeps the military separate from the rest of society.[166] The lack of consensus on the value and morality of recent wars,[167] the statements of "we support our troops" that rarely go beyond bumper stickers and the national mantra,[168] and the lack of validation of Service members' efforts in war[169] contribute to the disconnect felt by many returning Service members. The ability of Service members to successfully transition home after deployment is "closely related to the well-being and successful function of their families and communities;" effective transition programs will recognize and support this varied population.[170]

Chapter 4. Current Approaches: USSOCOM and Service Components

> We obviously have a peer-to-peer stigma, the machismo that 'I can't admit that I have to see a counselor or psychiatrist, that makes me weak and we're at war, and there can't be any chinks in the armor.'[171]

While USSOCOM supports programs operating across the component commands, such as POTFF, Military & Family Life Counseling program (MFLC), and the Families OverComing Under Stress program (FOCUS), actual post-deployment programming decisions rest with the leadership of the respective SOF components. Each component command determines what training and support will be provided, when and by whom, to its respective Service members as part of the transition process. While all components utilize standardized post-deployment forms, each component command takes a different approach to the post-deployment period, based on location, unit, or occupational specialty of the individual returning. Thus, programs and support offered can vary greatly across component commands, as well as within them.

This chapter begins with an overview of the USSOCOM annual survey results that indicate a continuing need for transition support. The chapter concludes with an overview of post-deployment programs by USSOCOM and the component commands, and indicates efforts that could serve as models for other components.

Continuing Challenges in the Force

USSOCOM's POTFF conducts an annual needs assessment survey of the special operations community.[172] While results demonstrate the vast majority of SOF are managing the challenges of Service and deployment without serious debilitating effects, the data indicates some areas of concern where Service members are exhibiting signs of stress and need support. Importantly, the results also demonstrate that those most in need of support are not seeking it. However, the timing and the wording of the survey questions do not distinguish between those who are facing challenges due

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to a deployment and those experiencing difficulties due to the transition. The challenge is understanding why some are experiencing significant challenges, while most are not. The presumption appears too often that deployment is the cause, and that implies a certain treatment plan; but if it is not, if the challenge is the transition home, such responses will be largely ineffective, because they are treating the symptom, not the cause.

The POTFF assessment asks questions about symptoms experienced over the past 12 months on five scales: PTS symptoms,[173] resilience,[174] alcohol abuse and dependence,[175] depression,[176] and social connection.[177] The majority of respondents in Wave III reported none to low levels of most symptoms, with more than 80 percent reporting in the lowest categories except on the social connection scale; but the remainder of the population is experiencing symptoms at a moderate to high level, indicating a need for support.[178] The percentage of the population experiencing moderate to high levels of symptoms on these scales increased in Wave IV of the survey, indicating a negative trend.[179]

The most common symptoms—those identified by at least 30 percent of respondents in Wave III[180]—included: "trouble falling or staying asleep" (39.9 percent), "difficulty concentrating" (32.1 percent), "repeated, disturbing, and unwanted memories of the stressful experience" (30.9 percent), "being 'super alert' or watchful or on guard" (30.8 percent), and "irritable behavior, angry outbursts, or acting aggressively" (30.1 percent).[181] These are normal responses to stressful and threatening situations, as well as to the strains of deployments. These symptoms are part of the body's natural response to danger, and are designed to improve the individual's ability to react and survive.[182] However, they are less useful, and more harmful, in peacetime settings, such as in garrison and home life, where they are perceived negatively. While these are normal responses, and they often subside over time if stressors are absent, if they persist and the individual is unable to successfully manage them without assistance, they can disrupt an individual's ability to function normally. Some individuals can learn to cope with high levels of symptoms, and may even continue to function at normal levels in the short-term, but over time the stress on their system is likely to lead to reduced performance and impairment of normal function.[183]

Although the majority of SOF reported experiencing no symptoms or very mild symptoms across scales measuring PTS, depression, and alcohol abuse, a small percentage did report scores in the high ranges for these scales. The high scores suggest that Service members would be unlikely to manage these symptoms alone, and would likely need external support to successfully manage them and any deleterious effects they have on physical and mental well-being. Yet, the majority of those experiencing high levels of symptoms did not think they needed assistance and therefore were unwilling to seek additional support.[184] Less than 50 percent of Service members scoring in the high range of symptoms—whether PTS, alcohol abuse, resilience, depression, or social isolation—opted to use military-sponsored behavioral health care services in the previous 12-month period, and on some measures the percentage was far lower.[185] The main reasons for not using behavioral health services fell into three main categories: lack of need or interest, concerns about the impact of utilizing behavioral health services, and lack of access. Lack of trust in the provider and a preference for non-military externally-provided care, although indicated less frequently, are additional barriers to those in need seeking care. Given the high score on the measurement scale, choosing not to seek assistance when experiencing problems suggests an inability by these individuals to recognize that they may be having difficulties or choose not to admit that they are having difficulties and need assistance. Although USSOCOM has made efforts to reduce the stigma of seeking help and reassure Service members that seeking help will not automatically result in negative consequences, these results suggest that Service members may not yet be convinced by this message.

Lack of trust in the provider and a preference for non-military externally-provided care, although indicated less frequently, are additional barriers to those in need seeking care.

Clear patterns emerge from the survey data about the characteristics of those experiencing high symptom levels. They are mostly male—not surprising given the composition of SOF. They are primarily enlisted. Differences in age, education levels, and extent of training could explain why enlisted Service members face greater challenges than officers, who are likely to be older, have higher levels of education, and therefore more opportunity to develop cognitive and coping skills.[186] They are at the beginning of their careers, having served less than five years in SOF. Exposure to new experiences and

challenges, and being in the process of developing the necessary skills to perform on deployments and cope with deployment stressors could explain why the group with fewer than five years of SOF service experiences more negative symptoms than those with more time in SOF.[187] Despite the assumption that operators are 'invulnerable' and do not experience difficulties in carrying out their missions or recovering from them, there were no significant differences between responses of operators and support personnel; both populations are at risk of experiencing post-deployment challenges. Likewise, despite the assumption that those who are screened are somehow stronger and less vulnerable than those who are CF direct assigned to SOF for a specified time, there were no significant differences between responses of screened and direct assigned; exposing the misconception that screened 'can't be broken' or are 'immune' to the effects of combat and the difficulties of post-deployment transitions, and that both populations are at risk of experiencing post-deployment challenges.[188] These findings indicate where assistance could be targeted—enlisted and early career—and where certain assumptions of invulnerability should be challenged, highlighting that transition assistance and post-deployment support may be needed by a range of individuals, across rank, Service, occupational specialty, and time served.

Common Post-Deployment Programs[189]

Each component command has a POTFF representative, as well as representatives from a variety of command-common programs aimed at providing support for Service members and their families. The POTFF representatives serve as both liaisons with USSOCOM, as well as advocates of the needs of the specific component command; this sometimes creates tensions between headquarters and the component command, and requires balancing the various interests. POTFF representatives adapt programming efforts to their assessments of the needs of the component command, thus there is no standardization. This flexibility is useful for targeting programs to a component's specific needs. However, one challenge with respect to transition assistance is that POTFF is not always closely involved with the return home of the Service member, but instead provides support after the Service member transitions home. In this instance, programming tends to focus more on the family than the individual Service member. While this support can assist with family-related post-deployment challenges, these programs

are voluntary, not mandatory, which can leave space for struggling Service members unwilling to ask for help to fall through the cracks in the system.

Component commands provide additional support through a variety of programs, including the MFLC and FOCUS. MFLC provides short-term, non-medical counseling for Service members and their families.[190] MFLC provides support in a confidential fashion, meaning that these services are not part of the Service member's official record. However, MFLC is limited to non-medical counseling, such that any problems beyond short-term counseling related to military life challenges would need to be referred elsewhere. Trust is an important precondition for accessing these services, and not easily gained within the SOF population; the routine rotation of MFLC counselors can reintroduce barriers with each rotation, as new counselors will need to reestablish trust with Service members.[191]

FOCUS originally centered on the psychological health of families, including building resilience and reducing stress within families. The program has since extended its services to single Service members. One interviewee indicated the program has had positive impacts including reducing stress and anxiety within families, reducing the number of children experiencing difficulties, and improving the health of marriages and family function.[192] An early study of the program supports these findings.[193] These programs provide voluntary services that can complement transition programming, and are designed to achieve this goal. Still they do not provide a substitute for focused transition programming for returning Service members to prepare and enable them to transition successfully.

NSW

A key component of NSW's post-deployment transition home is the TLD. Deployed Service members spend 24-72 hours in a non-combat location outside of the United States between deployment and coming home. This time provides an opportunity to decompress individually and as a team. This is especially true for those who return to marriages and families; this time can provide the space the individual needs to readjust prior to having to manage relationship and family matters. The TLD enables a transition in stages, slowly readapting to the various challenges of coming off a deployment, adjusting mentally and physically to the change, and then adjusting to home life, instead of facing all of these changes at once. TLD also provides

an opportunity for the psychological staff to have a first look and assessment of Service members. Finally, TLD provides time to hold information sessions on what to expect and how to manage the transition.

After returning home, NSW SOF are required to report for a 'check-up from the neck up' at roughly the three-month post-deployment mark. This is an informal meeting with the force psychologist to discuss the post-deployment transition. The service provider does not take notes and the session is off-the-record. This meeting is required of everyone—no one is singled out—which helps to reduce the stigma of seeing the psychologist. The force psychologist believes having this informal and undocumented meeting helps to reduce the stigma of seeing a mental health provider, and improves the likelihood of Service members sharing honest information about their situation.[194] This 'check-up' provides the psychologist an opportunity to check in with the Service member and to physically see how the person is doing. This also builds rapport between the psychologist and the Service members, which can help to build trust and keep the door open for the Service member to seek future support.

This raises the question of whether the NSW TLD model should be adopted by other SOF components. NSW believes it has developed a good model.[195] MARSOC reportedly modeled its post-deployment transition on the NSW model.[196] AFSOC ground forces have a forward-deployed check of Service members before they return home, which is similar to the TLD model, though not as lengthy or comprehensive.[197] USASOC would likely face difficulties employing the TLD model simply due to the size of the component, and the costs and logistics entailed.[198] A review of TLD indicated it was far less successful when conducted inside the U.S., than when conducted at a third location, raising doubts about trying to adapt the model to the large USASOC population stateside.[199] Potentially some elements of TLD could be adapted to garrison delivery to provide the transition information and psychological support to USASOC, even if the Service members do not benefit from the time for decompression. Ultimately, the question is: Does it work? And, therefore is it worth figuring out how to fund it and how to implement it for all SOF?

There is some proof that TLD works. Several militaries utilize some form of TLD, including Australia, Canada, the United Kingdom, and the Netherlands. NSW requested an independent study of the NSW TLD program to assess the program's effectiveness. This review provided supporting evidence

that the program helps with the transition from deployment to home. Service members were not unanimous in their praise, but the majority found the TLD briefings useful, and believed that the TLD program should be continued.[200] Positive results seemed to depend largely on how the program was run and what was included in the program.[201] The review identified areas for improvement including: choose a good location, increase the number of structured activities provided, streamline travel logistics to avoid delays, increase time spent with psychological professionals, and improve the understanding of TLD among spouses.[202] One change, that appears to have had an impact on both Service members and their loved ones, is to clearly build TLD into the deployment schedule, so that it is seen as part of the deployment, and not extra days tagged on at the end that extend it. While some Service members still view it as deployment extension, building it into the deployment cycle helped increase support and reduce resistance to the program. This was especially true among spouses, who initially viewed the program as a few days on a drinking holiday before coming home.[203] Spouses who were initially skeptical or hostile to the program, anecdotally reported seeing positive differences in their Service members between deployment with TLD and those without, the latter often involving more difficulty in transitioning home.[204]

AFSOC

AFSOC SOF deploy and return home in various ways. Ground forces are more likely to deploy as a small team, whereas support personnel deploy in singles or small numbers, and not necessarily return home at the same time. This variation in deployment cycles and schedules makes it difficult for AFSOC to employ one post-deployment transition strategy. AFSOC behavioral health care and support providers acknowledged they used different approaches to the post-deployment transition, but have yet to develop something that they felt worked well for everyone.[205]

AFSOC ground forces receive a specialized form of post-deployment transition. AFSOC recognized that given the nature of deployments, i.e. the higher likelihood of engagement with the enemy during deployment, these forces needed something more than the standard PDHA form and welcome home talk. Although not a full TLD, service providers are forward deployed at the end of a mission to assess the team and begin the transition

process home. While this can provide a short period of decompression, that is not the main purpose. The focus is on assessing the Service members in a location outside of the United States, i.e. close to the deployment site, to ensure preparations are made at home for the return of those with any identified special needs so that support is immediately available when the Service member arrives to garrison.

AFSOC support forces, in contrast, are required to complete the PDHA self-reporting questionnaire and attend a reintegration talk within the first week of return. There is an awareness in AFSOC that this is not very effective in terms of identifying those experiencing challenges with the transition, or even as a means of providing support. AFSOC Service members expressed frustration with the process: "leave us alone; the program is not useful; I have heard it all before, this is my 12th deployment; no one is honest on forms because they do not want to get stuck in the system if there is a problem, they just want to get home."[206] One much repeated frustration is with the transportation delays returning home. Many spoke of being stranded waiting on 'mil-air' to provide transportation. These long delays could be turned into opportunities if they could be used to provide TLD-type assessments and information sessions. However, the logistics of doing this may make it impossible given the manning of the component; specifically, the limited number of personnel who are qualified for the task of assessment who would be available to forward deploy monthly.[207] Another often repeated frustration is the challenge of returning to fast-paced garrison life at work, where Service members often have more than one job at work. In addition to catching up on what was not done in their billet while they were deployed, they are often given additional tasks to manage for those going out on deployment. This adds strain to coming home, making it difficult to decompress from deployment.[208]

One much repeated frustration is with the transportation delays returning home.

One measure that appears to have a positive impact on the transition process is the presence of a psychologist or licensed social worker within the teams. However, the effectiveness seemed to depend on a mix of personality and trust. One licensed social worker claimed she had been in her post for one month and "the guys were finally talking to her and saying hello."[209] While she had not yet reached the point where they would have more substantial conversations, she felt this was progress. One AFSOC psychologist

conducted short, anonymous surveys of returning airmen to determine what they needed in order to develop effective responses.[210] She found this to be an effective method to providing personalized support, rather than a one-size-fits-all approach. The psychologist underscored the uniqueness of every airman and situation, which is valuable, but this also meant that the emphasis was on difference, and not on assessing commonalities across airmen. The psychologist did not collect anonymized data over time, making it difficult to track common challenges. While this approach seemed to have been effective, it was not the standard across AFSOC.

Interviews suggested two common challenges: the need to develop trust and a rapport with Service members over a long and potentially difficult process; and, second, the rotation of behavioral health staff at periodic intervals, which leads to a disruption in service or changes in how services are provided, and reintroduces the hurdle of building trust. This is especially true if certain personalities match well or bring in more effective approaches than others.[211] Selection of the right people to fit these slots emerges as a crucial consideration, however, the military personnel system is not always suited to this type of selection process.

USASOC[212]

USASOC approaches post-deployment transition in a fashion similar to AFSOC non-ground forces. Returning Service members are required to complete the self-reporting, standardized post-deployment forms (PDHA and PDHRA).[213] Service providers recognized that USASOC did not provide more in terms of training and support specific to the Service member's transition home. They assessed that what they did provide was not sufficient based on the fact that Service members would seek additional behavioral health support in the weeks following homecoming. However, they acknowledged that they did not know how to tackle the problem more effectively.[214] One challenge is certainly the larger size and wider dispersion of the command—a challenge other components do not face. The size of the component could make implementing a TLD-type program difficult, if not impossible, and some USASOC service providers were skeptical about utilizing such a program.[215]

The Army has employed a series of trainings aimed at improving the health of the force. These programs are intended to increase resilience and

optimize performance. This has included Battlemind debriefings and trainings, mandated across the Army in 2007. A review of the Battlemind program indicated participants reported fewer PTS and depression symptoms, and sleep problems, than those in stress education-only programs.[216] The review also noted that participants in Battlemind large group trainings reported fewer symptoms than those in stress education programs regardless of the level of combat exposure.[217] In 2009, the Army shifted to use the Comprehensive Soldier Fitness (CSF) program that incorporates elements of Battlemind and Master Resilience Training. There are conflicting reports about the effectiveness of the CSF program. Those implementing the program report successful outcomes.[218] However, there are also numerous critics of the program who claim limited evidence exists to support its effectiveness,[219] that the program is largely ineffective,[220] that it does not have the necessary metrics to demonstrate effectiveness,[221] and ultimately that it remains unclear whether CSF achieves the goals it sets.[222] The CSF program transitioned into the Comprehensive Solider and Family Fitness (CSF2) program. Soldiers are mandated to complete an annual CSF2 online assessment tool and training.[223] The CSF2 program also incorporates a set of metrics to enable senior leadership to gauge program results.[224]

MARSOC[225]

MARSOC focuses on its Performance and Resiliency (PERRES) program. "MARSOC PERRES incorporates three aspects (mind, body, and spirit) into an overarching, principal-based ethos that is laser-focused at giving the MARSOC community the tools to obtain and maintain overall resilience of the force: the individual and unit's capacity to withstand mental, spiritual, and physical stress and hardship and remain functionally and holistically able to self and group renew."[226] "The purpose of PERRES is to provide the MARSOC community with an integrated and holistic apparatus capable of providing physical, mental, and spiritual optimal performance throughout the individual member and his/her family's tenure with MARSOC and beyond."[227]

MARSOC's approach appears performance based, which could translate into difficulties for Marine Corps Special Operations Forces (MARSOF) to admit when there are problems, which could be viewed as weakness or an inability to perform well. That raises concerns about whether MARSOF

would seek support if encountering challenges during deployment or upon return home. One force psychologist noted that SOF are motivated by the notion of improving performance, and therefore behavioral health support crafted in these terms may be more effective than that couched in terms of mental or spiritual health, which could be seen as admitting weakness.[228]

MARSOC references the "Warrior Transition," which for MARSOC can involve a third location decompression.[229] This TLD is based on the NSW model, but adapted to MARSOF.[230] The TLD is presented as "an interlude between combat and [returning home]," that "can be utilized," but TLD is not stated as a requirement for all forces.[231] The purpose of the TLD is to assess the well-being of Service members. "This event brings together all three PERRES aspects, designed and mentored by both the unit and PERRES personnel, to gauge individual posture for the return home."[232] Importantly, it also includes an element of family support and preparedness. "Concurrently, the family and unit are coached and mentored to anticipate, integrate, and execute the changes and transitional hurdles of the return to [the United States] and family life."[233]

Chapter 5. What Works in Current Approaches

> My personal mental exercise to think 'I will keep the frequency, intensity, and duration—low, mild, and short,' allows me to not strangle the store clerk, run for the hills, withdraw from life, be emotionless, or act or speak in a self-destructive manner.[234]

Service members are seeking support services, as described in chapter 5, whether to manage deployment-related or transition-related challenges, but the USSOCOM annual survey suggests the percentage seeking support remains low. More significantly, the percentage remains low among those who exhibit high levels of symptoms indicating they are experiencing difficulties. Efforts to reach those most in need but most reluctant to utilize services could build upon what some SOF have indicated works: embedded unit-level support and post-deployment trainings aimed at developing transition skills. A survey of returning NSW SOF indicates both an interest and a need for these transition skills.

Behavioral Health Services

A key concern, highlighted in the POTFF survey results, is that Service members experiencing the most challenges are also reporting low rates of seeking support services to manage those challenges. Less than half of those scoring high on the PTS scale sought assistance through behavioral health services in the 12 months prior to the survey.[235] The selection of service provider gives some indication of the type of assistance sought, with the presumption that visits with psychologists and psychiatrists would be oriented toward the individual, and more likely deployment related, while visits with social workers, MFLC, and FOCUS would be oriented toward relationship (couple, family, child) issues.[236] Those who sought assistance reported more visits to individual support services than family-oriented services, but the usage was not dramatically skewed toward individual support. The most commonly sought service provider was the unit psychologist.[237]

Service members who reported utilizing behavioral health services in the USSOCOM annual survey also reported finding them useful. A large percentage of those seeking assistance reported five or more visits with the chosen service provider, indicating some benefit from the service and an interest in continued service.[238] The ratings of satisfaction and usefulness of providers were strong, with unit level providers receiving the highest ratings.[239] However, it is worth noting that not everyone was satisfied, and some service providers received 'very unsatisfied' ratings. One challenge in the military behavioral health system is that Service members do not have a wide selection, and sometimes no choice, in who the mental health provider is, and therefore any lack of trust of or discomfort with an assigned service provider could lead to reluctance by that Service member to utilize existing services.[240] Identifying and addressing the concerns underlying some of the negative ratings could improve both usage and satisfaction rates among Service members.

Given the rising number of active duty SOF respondents reporting challenges on the annual survey, it is significant that the use of behavioral health care increased by 2 percent in the latest survey. According to the data, 21 percent of active duty respondents sought some form of behavioral health support, with embedded behavioral health assets receiving the highest ratings on satisfaction and usefulness by those who utilized these services.[241] This indicates both an increasing willingness to seek support, and a reliance on unit-level support systems. SOF tend to trust those in their unit, more than outsiders, and are more likely to utilize embedded service providers that they know and with whom they have had positive interactions.[242]

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One effort that has taken place across component commands is the embedding of special operations-specific behavioral health professionals at the unit level. In 2013, only 60 behavioral health professionals were embedded at the unit level; in 2015, the number had more than doubled to 131.[243] The embedded location of these behavioral health professionals assists Service members in seeking assistance in three ways: normalizing the presence and use of behavioral health professionals, increasing the trust of these individuals through daily interactions, and making it easier to drop in for a

chat when a Service member wants to discuss an issue. Behavioral health providers interviewed indicated they perceived an improvement in the trust levels and relationships with Service members.[244] These findings suggest ensuring access to unit-level resources could be instrumental in increasing utilization of that support.

Pre- and Post-Deployment Retreats

Overall, in the Wave III assessment, respondents indicated a lack of participation in voluntary pre- and post-deployment retreats. These retreats are voluntary and participation is based on interest (of the Service member), availability (whether and when they are offered), and accessibility (whether the Service member has time to participate). Only 19.2 percent of all survey respondents reported having "attended military-sponsored pre-deployment and/or post-deployment retreats within the past 12 months."[245] Of the group reporting the highest levels of negative symptoms, a slightly larger percentage (24.7 percent) reported attending retreats. The low participation rates raise questions about the role of pre- and post-deployment retreats in providing support to Service members and their families.

In looking at all respondents, various reasons were provided for why they did not participate in pre- and/or post-deployment retreats.[246] More than half of the respondents expressed that they had "no need" or had "no interest" in attending military-sponsored pre-deployment and/or post-deployment retreats.[247] Another important finding is that those who had an interest in attending these retreats were not always able to access them. The reasons for not being able to attend included: being "unaware" of retreats (5.5 percent), "scheduling conflicts" (8.9 percent), insufficient time due to a demanding operational pace (6.1 percent), and retreats not being offered (5.2 percent).[248] The reports of challenges accessing these programs indicates there is interest in this type of programming, but not always the ability to participate, which suggests that increasing access could facilitate higher levels of participation in these programs.

When looking at the entire respondent pool, the results indicate that those who reported having no need for retreats, scored lower on the PTS scale than those who attended retreats (7.91 mean score versus 10.11 mean score).[249] Both scores are well within the low range of PTS scale, but the difference is significant.[250] This suggests those potentially needing support

through retreats were utilizing the retreats, while those who reported having no need, may have indeed had no need. More importantly from the perspective of providing support to those who need it, when looking at those who stated "no need" versus those who stated access problems, those who did not attend retreats because they could not access them demonstrated higher scores on the PTS scale than those who did not attend because they "did not need" the retreat (9.71 mean score versus 6.11 mean score). In addition, those who stated access problems also scored worse on the other four assessment scales.[251] This suggests that improving access to these programs could enable SOF to better utilize this support.

Focusing only on the group of respondents scoring in the high PTS range, 24.7 percent chose to attend pre- or post-deployment retreats.[252] This is not necessarily surprising, as those with high levels of PTS symptoms may not perceive of retreats as the best forum for asking for help, and might prefer more personalized and private care, and might be more likely to seek out psychological support than to attend a retreat. However, of those who chose not to participate, 42.7 percent indicated "no need", "not interested," or "find no benefit in participating," while 42 percent indicated some challenge accessing the retreats in terms of not having the time or retreats not being offered.[253] These results raise concerns about the ability to self-identify when they have difficulties and take advantage of support programing offered. The results suggest, again, that access can pose a significant hurdle to participation, and that ensuring information is available on retreats and enabling Service members to attend retreats, could enable those with the most need to take advantage of these opportunities.

Of those who attended retreats, their responses indicated the usefulness they found in attending these events; more than 70 percent claimed they were satisfied or very satisfied with the retreat, and more than 60 percent found the retreats useful or very useful.[254] These response rates held relatively constant regardless of the type of retreat, including both pre- and post-deployment retreats, and a variety of demographic specific retreats, such as: couples retreats, family retreats, command or unit retreats, and single soldier retreats.[255] For most types of retreats, the level of perceived usefulness was higher for the post-deployment type than the pre-deployment. This could reveal a difference in who attended these retreats. It could also reflect the demands on the Service member prior to the deployment and the focus on preparing for that deployment. However, it could mean that post-deployment

retreats provide certain venues and tools for Service members and their families to manage the challenges of returning home. The results suggest the value of providing post-deployment support.

NSW Survey on Post-Deployment Challenges

A survey of active duty NSW Service members who returned from deployments in 2015, and their spouses/significant others, provides insights into the challenges Service members faced when returning home from deployment, and whether they felt that the training they received from NSW helped them manage these challenges.[256] Spouses/significant others were asked their views on what they saw as the challenges their husbands/significant others faced, and whether they seemed to have the skills to manage those challenges. All respondents were asked what additional training or support they would like to receive to manage post-deployment challenges. The survey included NSW active duty SOF with a wide range of experience, ranging from zero to more than 14 prior deployments.

Active duty NSW SOF respondents were asked what challenges, if any, they faced when returning home. Respondents could provide more than one answer; and were asked to rank those answers. The primary challenges respondents faced (indicated by ranking them first) included: difficulty communicating with significant other (and family), difficulty turning down the dial (reducing intensity), and difficulty sleeping. The most common challenges faced by the small group of active duty respondents included these primary concerns, as well as managing emotions (e.g. anger, irritability), managing lack of emotion, and having difficulty enjoying social situations with civilians (see fig. 1).

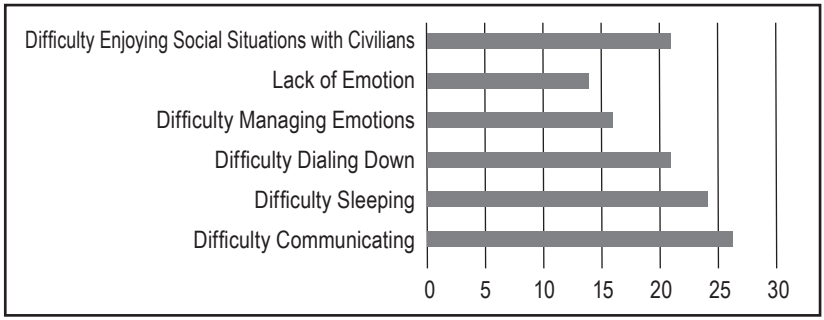

Figure 1. Most Common Post-Deployment Challenges, number of respondents (n=66). NSW survey by author.

Active duty respondents were also asked whether they felt they had the skills and knowledge to manage their challenges, while their significant others were asked whether they felt their active duty partners had those skills (see fig. 2).

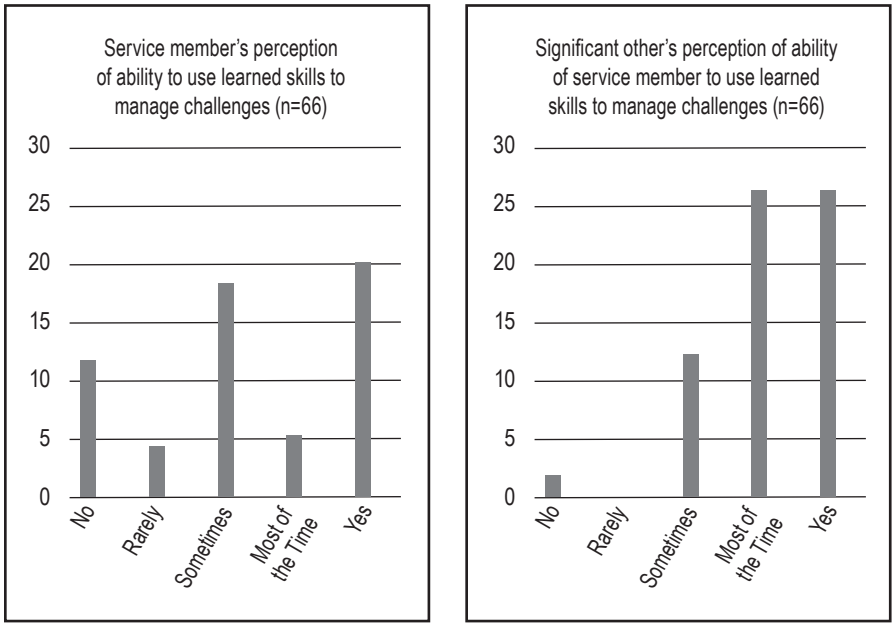

Figure 2. Assessments of Ability to Manage Post-Deployment Challenges, number of respondents. NSW survey by author.

The two response groups offered different assessments; however, this could be the result of the different individuals answering the question. They were not matched pairs, and so the significant others were not speaking directly about those active duty members who answered the question. It could also result from the honesty of Service members on the questionnaire—or those same respondents put on a strong façade at home. The answers of the Service members suggests that active duty NSW SOF are facing transition challenges for which they may not have the necessary skills to manage effectively. This is further supported by the answers of the active duty NSW SOF on what additional post-deployment training they would like to receive (see fig. 3), which largely mirrored the most common challenges reported: improving sleep, communication, and self-regulating.

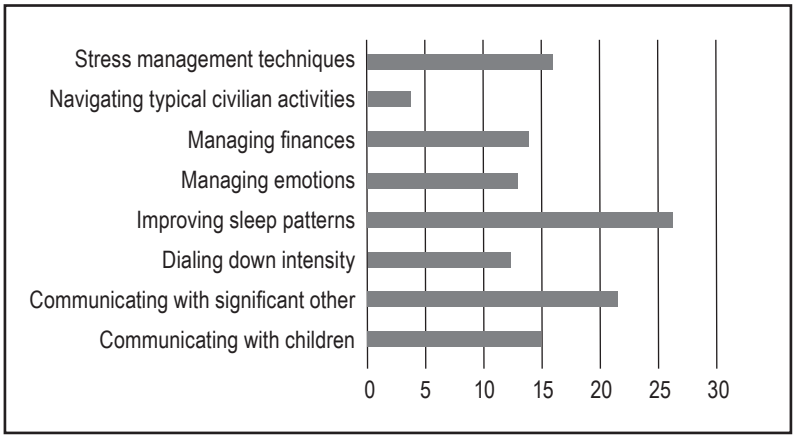

Figure 3. Desired Additional Training, number of respondents (n=66). NSW survey by author.

Respondents were also given the opportunity to provide any additional information about their post-deployment experience that they wanted to share. These responses offer additional insight into the concerns and challenges of active duty NSW SOF, although this sample cannot be generalized to the entire NSW population. Significant others indicated concerns about the lack of post-deployment retreats and workshops, and concern that funding is ending for these programs. Significant others also expressed concern about the high operational tempo, and how this reduced time available for the family even when active duty Service members return home due to training and other operational demands.

Active duty Service members expressed concerns about post-deployment programs either not being available or not being helpful, with one respondent with more than 10 deployments adamant that the post-deployment programs were "a joke." Single active duty Service members noted the lack of support targeted at their demographic, and the discomfort felt when attending retreats designed for couples and families. One Service member lamented the lack of time to recuperate: "Returning from deployment to a non-stop training cycle leaves very little time to even think about unwinding let alone taking courses to help with it." Other respondents reiterated concerns about the limited amount of time at home to transition, due to training, the operational tempo, and other requirements. Several respondents, both active duty SOF and significant others, commented on how being home was more

stressful, or "boring" and "lame," than being deployed. This is a common comment among active duty Service members of all Services.[257] Overall the results indicate the need for support to assist active duty Service members in making the transition from deployment to home, and managing that transition successfully.

Chapter 6. Conclusion: Next Steps for Improving Transition Support

> All [S]ervice members return changed, but most return uninjured physically and without a mental health problem that requires psychotherapy.[258]

A tension exists within SOF between recognizing the struggles and challenges of individuals, and recognizing the overwhelming level of resilience within the force. There are those who lean toward the former, and tend to use the language of 'fraying' and 'broken.' One retired NSW commander noted he had never met a retired Special Operations veteran who was not at least partly disabled: "We physically crush special operators during their careers, and when they retire they are broken. We broke these guys. We need to do our best to send them back into the civilian sector as whole as possible."[259] For some this language rings true, and may reduce the stigma of seeking help. For others, it rankles: "stop assuming everyone is broken," "stop reminding me that the force needs preservation;" instead these SOF want to underscore the high level of resilience within SOF.[260] While the language of 'broken' may fit some experiences, this language lends itself to notions of defeat and helplessness, at least for some, and therefore may not provide the best motivation for admitting a need for help. This language can reinforce a sense of weakness, which is largely abhorred by the culture. The language used is important because how support is presented may determine who ultimately takes advantage of that support.

Research suggests Service members are more likely to respond positively to programs that offer them a competitive advantage, that make performing their jobs easier, that make them better at doing their jobs, rather than a focus on what is broken or bad.[261] How post-deployment training and support are pitched to the SOF population may be just as important as what the training and support entail. This suggests a reorientation of what is considered 'normal' during the transition period

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could encourage Service members to seek support. Mental health education is most effective when it "normalizes mental health fluctuations, creates an expectation of recovery and wellness, and highlights actions that individuals can take to maintain or regain their mental fitness."[262] In other words, shifting away from a laser focus on PTSD concerns and away from the language of 'fraying' and 'broken,' toward an understanding that fluctuation, not stasis, is the norm, and that solutions exist for those facing transition challenges could open lines of communication and create opportunities for Service members to make the transition more smoothly and with the needed support.

It should be expected that SOF will return home wired, agitated, and on edge; it is unrealistic to expect SOF to turn off these trained reflexes like a light switch. Instead, the real questions are: What training can be provided to give SOF the skills to self-regulate, to 'turn the dimmer switch down,' in order to transition more smoothly from deployment to garrison? How can Service members learn to recognize when their systems are overwhelmed and they need additional support to manage the transition process? And, how can the component commands provide support to those who cannot self-regulate and need support in the transition process?

Some Service members have expressed frustration with the post-deployment transition process. There seems to be two competing themes: those who complain they are not getting the support they need, and those who do not feel they need any special support or attention and therefore do not like or are not interested in any post-deployment efforts. At the core of both complaints is the sense that the standardized forms and briefings are not useful and do not provide good venues for accessing support. One particular source of frustration can come from the evaluation process itself, which while scientifically developed, does not "help the warrior understand what's going on," does not explain why one Service member is experiencing post-deployment challenges, while "fellow unit members seemed to be spared; nor does it necessarily help in figuring out the best course of treatment, if treatment is even indicated."[263] Service members would likely see post-deployment transition support more favorably if it were tailored to the needs of the Service member, provided useful skills (not just repeated briefings they have heard several times before), and if there were anonymous venues for reporting transition challenges to reduce the hesitancy of reporting for fear of negative consequences.

Targeted Transition Briefings

The framework for transition could be strengthened by moving beyond filling out the standardized post-deployment form. Additional support could include providing information to returning forces about the transition process, what to expect, what is normal, and when they should seek additional support. Briefings that are informative, simple, and relevant provide one avenue for delivering necessary information. Research indicates that briefings are most effective when they focus on clear requirements and needs; emphasize strengths, skills, and abilities, not 'fraying' or being 'broken;' when possible they should be team (or unit) based, which can build cohesion and a stronger support system.[264] In addition, briefings that focus on the explanatory, answering the question why Service members might be facing challenges, highlighting misunderstood reactions (e.g. 'it is all PTSD,' or someone is 'broken'), and normalizing the common challenges faced when returning home can be most helpful.[265]

Briefings could incorporate real and relevant examples from Service members who have faced transition challenges, e.g. being short-tempered with kids, having difficulty communicating with family, having difficulty sleeping, etc. Returning Service members can find it easier to relate to these real-life examples, and their presentation by active duty Service members can reduce the stigma surrounding talking about these challenges. Research suggests that military audiences are more receptive to trainings from a pair of trainers (one a trained mental health clinician and one a military operator) because these are viewed as more credible, especially when the military speaker is persuasive and has a shared similar operational experience of the target audience.[266] Interviews suggest briefings or discussions with those who have deployed and who talk about their challenges upon returning home are best received because Service members can relate better to this type of storytelling, than to civilians or leadership telling them they might have problems and where to seek help if they experience any problems.[267]

Transition briefings that are adapted to the specific audience and its needs are likely to be more effective. Those with multiple deployments noted the monotony of transition briefings—that they did not offer anything new—and so the Service member barely listened and only went because it was required.[268] Adapting briefings to occupational specialty, particular deployments and anything that may have happened, or simply recognizing the

different needs of those returning home for the first time versus those who are returning home from their twelfth deployment could improve the utility of post-deployment briefings. It is important to understand the specific situations and challenges that each occupational specialty may encounter, and to provide support for those specific circumstances.[269] Particularly traumatic deployments may require additional support. However, each Service member will respond uniquely, and support needs to be adaptable to this variance.

Skills Training

Skills training offers one track for providing support to Service members and enabling them to navigate the transition home. Various options are available, but training needs to be built into the overall deployment cycle and program of training; it will be far less effective if it is provided as one-off programs only during post-deployment transition. Resilience training is one option. The challenge is that it is difficult to teach resilience, and there is limited evidence that teaching resilience skills *en masse* has had a significant impact on improving outcomes.[270] However, having various coping strategies and flexibility to adapt strategies to a context has shown the most positive outcomes.[271] This suggests that teaching strategies, rather than trying to 'build resilience,' might be more effective. This training is most effective when it is "experiential and action focused, providing tangible skills to build flexible and adaptive coping mechanisms, that have real world applications, and can be developed through scenarios and situational training."[272] Training could also be provided to create and enhance specific skills that would assist in managing typical transitional challenges, including skills in: communication, conflict management, and relationship management.

Additional training is often needed because military training does not necessarily translate well to the civilian world. "A warrior's body knows how to respond to threat and danger, and how to handle high anxiety, stress, and fear … to dial up or down their level of alertness, tension, and awareness of potential threats."[273] However, these skills do not always span to civilian situations. One veteran has noted, "attack, retreat, re-group, close ranks," is part of the mantra of survival in the military; on deployment, the options for resolving problems are "shoot it" or "walk away," but this mantra and these options offer limited solutions for navigating typical civilian challenges.[274] However, Service members are rarely "instructed (or even reminded) on how

to let go of our military modus operandi" when they return from deployments.[275] "We are indoctrinated into the violence, the selectivity and the heritage that is Ranger; we are not, however, taught how to turn it off."[276] In some cases, military skills could translate to civilian situations, if Service members learned how to adjust their approach to a civilian setting. One example is patience. "Patience is a crucial skill in combat … However, many warriors completely forget this skill when they come home. They can't tolerate the stupid stuff people do, and instead of remembering to practice this skill (for example, in a supermarket line), they explode at relatively minor things."[277]

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Post-deployment retreats often provide sessions on building communication and conflict management skills, however developing these skills requires repeated practice, and one retreat is unlikely to provide sufficient time to fully develop these skills. The NSW survey, discussed in chapter 6, indicated such skills training are needed and desired by those returning from deployments. FOCUS programs provide another possibility. These teach five primary skills to enhance resilience: emotional regulation, problem solving, communication, managing reminders (of deployment/trauma/loss), and establishing readiness and goal setting.[278] Resilience retreats, for family members and Service members, and educational workshops offer additional opportunities for skills training.

Identifying Programming Needs and What Works

Creating effective programs depends largely on knowing what is needed. Data collection, however, can seem onerous, or even pointless, for many. The requirement of collecting information can be made less daunting by building it into existing data collection efforts, such as the pre- and post-deployment required forms, annual surveys, and other existing efforts.

Anonymous surveys can also be made available through secured component portals. NSW used to maintain an anonymous survey online that provided the opportunity for Service members and their spouses to provide input at any time. This online option was discontinued after USSOCOM began their annual survey, the assumption being that the two tools duplicated

efforts.[279] However, the NSW option had a different purpose. It was always available, which meant it could provide an timely assessment of the environment rather than relying only on annual surveys. Keeping the online version short and simple, and focused on reporting both positives and challenges, could provide ongoing input about the health of the component; complementing, not duplicating, the larger annual effort.

The annual survey is a useful tool to provide a general assessment of the health of the force, including the component level. Currently, it does not provide great insight into the post-deployment transition specifically. Adding questions that focus specifically on the post-deployment period could be one way of gathering additional information. The shortcoming of this approach is that it would make an already lengthy instrument even longer. The annual survey findings could be more useful if the findings were widely shared across SOF; currently a trickle-down approach seems to be the most common, with findings shared with senior leadership, but the information is not necessarily making it down to the unit level.[280] One challenge to expanding dissemination is the manpower needed to analyze the data and put it into an accessible format.

Input at the unit level may be most useful for creating specialized programming that best fits Service members' needs.[281] USSOCOM survey responses indicate a strong level of trust of unit level behavioral health providers among SOF, placing those providers in a unique position to potentially collect sensitive information about transition challenges. Anonymous surveys in the post-deployment period provide an opportunity to identify needs and provide support that targets the requirements of specific units. One challenge to this approach is ensuring there are qualified service providers at this level who can collect this data and utilize it to create effective programming. Resource constraints could make this challenging to implement across components. This approach would also have to guard against any pressure toward standardization; the intent of this approach is to identify specific needs, not to produce generic programming to implement across all units.

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Efforts can build upon existing data collection tools and capitalize on what Service members are willing to admit. For example, most Service

members are willing to discuss sleep-related problems over other problems.[282] Yet sleep problems are often the result of an underlying stressor; one that the Service member may not understand or be willing to acknowledge. Managing the sleep problem provides an entry point for investigating the underlying stressor, and creating a solution that will address the underlying cause of the sleep problem. Another example is communication with spouses and children. This is a common challenge for returning Service members, and one that appears to be easy for Service members to discuss. The source of the problem could be relationship-based, or it could result from the transition home. Tackling the problem as one of communication, rather than any problem with the Service member, could provide an avenue to exploring transition challenges.

Anonymous and undocumented venues for reporting and discussing transition challenges may be an essential element of improved support. Despite efforts to destigmatize seeking help, concerns persist among active duty SOF that seeking mental health support or other counseling can negatively affect their career trajectory. These concerns can be dampened through anonymous surveys, whether at the unit, component, or command level. Anonymous surveys are more likely to obtain honest feedback, and this information can be used to develop targeted programming at the group level. However, this will not enable the identification of individuals who need specialized support. One way to encourage these individuals to seek support is to offer undocumented (off-the-record) meetings with a behavioral health care provider. This is not a replacement for clinical care and on-the-record meetings, but could be used as a confidence building measure to build rapport, as well as to check in on Service members in an informal way that may create better opportunities for honesty and sharing. While some service providers, such as MFLC, can provide undocumented support, not all service providers can, which limits the anonymous options available to Service members. NSW currently requires undocumented check-ins with the force psychologist following return from deployments as a means of opening lines of communication and providing a safe venue for reporting difficulties. This may be a model for other components to follow to create non-threatening opportunities for seeking support. Embedded psychologists may offer the best foundation for developing this model. Their role is not to find the 'broken,' but to provide guidance for improved performance, just as sports teams would use sports psychologists to give players a cognitive

competitive advantage, and make them better thinkers in all settings; this would likely reduce the stigma associated with seeing a psychologist because that person is a part of the team and someone to speak with regularly about optimizing performance.[283]

As programs are continued or new ones are developed, it is essential to assess these programs to understand what works and why. Program evaluations offer opportunities to assess the effectiveness of programs and retreats, to determine what needs to be altered, what is missing from programming, and when programs may need to be replaced. Currently there is limited evaluation of post-deployment programs, support services, and retreats. This makes it nearly impossible to assess whether what is being offered is effective. Anecdotal information suggests, at a minimum, programs need to be adjusted to improve the positive impact they have.

Characteristics of Effective Transition Support

Several themes emerged in interviews and over the course of this research that could bolster transition support. First, the provision of personalized care is essential. Standardized forms are unlikely to be effective in identifying and supporting individuals who need assistance. "Instead of strong leaders, today we have multiple choice, check-the-block training. In the past, a First Sergeant or Platoon Sergeant would have to address a troop who they felt was in some trouble. Maybe buy him a beer and offer to hear him out. Today we throw some safety surveys at the troop and give him a mandatory suicide brief."[284] This example might be the extreme, but for many, standard forms and briefings are the norm for coming home, and there is sufficient feedback that these are not effective and are viewed more as 'check-the-block' requirements than true means of seeking and receiving assistance to question their utility for assessment. The Defense Centers of Excellence suggest using the total force fitness (TFF) concept as the foundation for transition.[285] While the TFF highlights various aspects of life that may need to be considered for transition programs, it is questionable that creating a standardized one-size-fits-all approach would be most helpful. Instead, TFF probably best serves as a reference for remembering the various dimensions of transition and what might be considered for a particular unit, team, or individual. Tailoring assistance to the needs of specific groups within the population will likely be more effective. For example, offering the same retreat for everyone may

be less effective than offering retreats that target certain ranks, relationship status (e.g. single, married, family), or occupational specialty, which would enable a focus on the unique challenges faced by these different groups and provide more tailored assistance.

Second, trust is essential. Service members are unlikely to seek support if they do not trust the service provider. Trust will be easier to build with those who have 'been there' and can talk from experience. Incorporating active duty or recently retired Service members into post-deployment briefings, where they can share their experiences, is one option for creating a more open environment. Trust is also more likely to develop at the unit level where there is already familiarity, knowledge, and frequent interactions among Service members and behavioral health providers. Programs can build upon this existing family setting through programming targeted at the unit level, embedding psychologists and social workers at this level, and considering ways of maintaining these service providers within units for longer periods of time. Local knowledge and daily contact will increase the likelihood that both service providers and Service members will notice when someone is struggling and be able to respond.

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Third, time and timing are essential. Service members need down time when they return from deployment; this requires time to sleep, and time away from stressors. Although there may be no life-or-death situations at home, this does not mean that coming home is free of stress. Difficult relationships, hectic schedules and work demands, trainings, and TDY can all create stress. The body does not distinguish between stressors. Home stressors or combat stressors can produce the same biological response. While the stressors at home may not seem as dangerous, our bodies react to threats (whether from the threat of a shooter or the threat of a failed marriage) in the same way; stressors at home can keep the body at an elevated stress level, resulting in prolonged symptoms of stress. This means that even though the Service member is home, the Service member is not able to decompress from deployment due to the existence of stressors at home; in effect one stressor has been replaced by another. In addition, time to decompress can often be interrupted by training requirements, bureaucratic requirements,

and unexpected deployments. Service members need time to seek assistance if they need it. One of the reported primary reasons Service members who wanted assistance but could not access it, was lack of time to seek help.

Timing of assistance also matters. Some Service members may not develop negative symptoms until several weeks, or months, after returning home from deployment. Service members may not immediately recognize they are having difficulties transitioning. They may not recognize what they are feeling, or not understand what is normal versus what is not. Service members may be so happy to be home that initially symptoms are ignored or overshadowed by positive feelings about being home.[286] Symptoms may not result from deployments, but from the transition, and therefore will only emerge after being home for some time. The variation in the timing of the onset of challenges indicates the importance that opportunities for seeking assistance are available when needed, not just immediately upon return from deployment. Timing also matters for treatment; the sooner an individual seeks support after developing symptoms, the more positive the outcome.

Fourth, skills for coming home are just as important as skills for deployment. The military provides knowledge, skills, and training for deployments. This ensures Service members know what to do in mission-oriented tasks. This gives them control while on deployment, which enhances the likelihood of survival and mission success. The military does not provide equivalent training to enable Service members to operate effectively in the garrison environment after deployments. There is limited training to support Service members making the transition home. This research indicates a gap in support, suggesting the military could do more to provide Service members with the appropriate knowledge and skills to transition home, just as they do to ensure Service members are mission-effective.

Acronym List

AFSOC	Air Force Special Operations Command
CF	conventional forces
CSF	Comprehensive Soldier Fitness
CSF2	Comprehensive Soldier and Family Fitness
DOD	Department of Defense
FOCUS	Families OverComing Under Stress Program
MARSOC	Marine Corps Forces Special Operations Command
MARSOF	Marine Special Operations Forces
MFLC	Military & Family Life Counseling Program
NSW	Naval Special Warfare Command
PDHA	Post-deployment health assessment
PDHRA	Post-Deployment Health Reassessment
PERRES	Performance and Resiliency Program
POTFF	Preservation of the Force and Family
PTS	post-traumatic stress
PTSD	post-traumatic stress disorder
SOF	Special Operations Forces
TDY	temporary duty
TFF	total force fitness
TLD	third location decompression
USSOCOM	United States Special Operations Command
USASOC	United States Army Special Operations Command

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51. Hoge, *Once a Warrior*, 35.
52. Jennifer J. Vasterling et al., "Neuropsychological Correlates of PTSD: A Military Perspective," in *Military Neuropsychology*, ed. Carrie H. Kennedy and Jeffrey L. Moore (New York: Springer Publishing Company, 2010), 338.
53. Hoge, *Once a Warrior*, 54-56. Hoge provides a non-technical and clearly written description of the how the brain reacts to threats.
54. Hoge, *Once a Warrior*, 81. Author interview, 22 June 2016; interviewee commented on seeing this as a frequent problem, and that more needed to be done to manage drinking among Service members and to educate them that alcohol consumption could worsen their sleep difficulties.
55. Author interview 22 June 2016; Hoge, *Once a Warrior*, 75-80. Discussion of sleep and sleep medications.
56. Vasterling et al, 2010, 326.
57. Vasterling et al., "Neuropsychological Correlates of PTSD," 328. Hoge, *Once a Warrior*, 58.
58. PTSD is a clinical diagnosis. It is based on assessing symptoms in four categories: re-experiencing the traumatic event; avoidance of reminders or thoughts of the event and numbing of emotions; hyperarousal; and negative changes in beliefs and feelings. In addition to the presence of symptoms, a person must have experienced a traumatic event, defined as an event in which a person "experienced, witnessed, or was confronted with an event or threat to the physical integrity of self or others" and had a response that entailed "intense fear, helplessness, or horror." In addition, the symptoms must persist "at least one month and cause clinically significant distress or functional impairment." It is at this point that symptoms are assessed as a disorder, and behavioral health intervention is recommended. See Vasterling et al., "Neuropsychological Correlates of PTSD," 321-322; and, U.S. Department of Veterans Affairs, "Symptoms of PTSD."
59. Brian Van Reet, "Troubled veterans may suffer from something other than PTSD," *The Washington Post*, 22 August 2013.
60. Vasterling et al., "Neuropsychological Correlates of PTSD," 322.
61. Ibid.
62. Ibid.
63. Wave III, USSOCOM POTFF.
64. Matthew Hing, Jorge Cabrera, Robert Forsten, and Craig Barstow, "Special Operations Forces and incidence of post-traumatic stress disorder symptoms," *Journal of Special Operations Medicine* 12, no. 3 (2012): 23-35.
65. Daniel J. Neller and Jimmie J. Butcher, "Prevalence of Posttraumatic Stress Disorder in Special Operations Forces," *Journal of Special Operations Medicine* 14, no. 1 (2014): 91-92.
66. Koran, "Special Ops commander tries to lessen stigma." Koran states USSOCOM "does not maintain statistics on post-traumatic stress cases because of privacy prohibitions."

67. Hoge, *Once a Warrior*, 9.
68. Adler, Castro, and McGurk, "Battlemind Briefing," 21.
69. Danish and Antonides, "The Challenges of Reintegration," 552; E. Ann Jeschke, "Postdeployment Reintegration: The Ethics of Embodied Personal Presence and the Formation of Military Meaning," *Annual Review of Nursing Research* 34 (2016):199-226; RealWarriors.Net, 2016.
70. Hoge, *Once a Warrior*, 56.
71. Mike Stajura, "What Ails Vets Today," TIME, 9 November 2013. Mike Stajura is an Army veteran who wrote this piece to describe his experience and that of his friends; Sebastian Junger, "Why veterans miss war." TED talk, January 2014; John R. Christian, James R. Stivers, and Morgan T. Sammons, "Training to the Warrior Ethos: Implications for Clinicians Treating Military Members and Their Families," in *Living and Surviving in Harm's Way: A Psychological Treatment Handbook for Pre- and Post-Deployment of Military Personnel*, ed. Sharon Morgillo Freeman, Bret A. Moore, and Arthur Freeman (New York: Routledge, 2009), 30-3.
72. Steven L. Sayers, "Family Reintegration Difficulties and Couples Therapy for Military Veterans and Their Spouses," *Cognitive and Behavioral Practice* 18 (2011): 109.
73. Danish and Antonides, "The Challenges of Reintegration," 551-552; Sayers, "Family Reintegration Difficulties," 110, 111, 113; RealWarriors.Net, "8 Battlefield Skills that make Reintegration Challenging," 15 August 2016.
74. Danish and Antonides, "The Challenges of Reintegration," 552-553.
75. Ibid., 552.
76. Concerns about the career impacts of seeking assistance are likely also influence by anecdotal stories of discharges and studies, such as the one recently conducted by the U.S. Army, that upheld its standards for discharges, even though many specialists found questionable the discharges of thousands of conventional soldiers; soldiers who they say needed behavioral health assistance, not a discharge. National Public Radio, "Senators, Military Specialists Say Army Report on Dismissed Soldiers Is Troubling," 1 December 2016.
77. Paul N. Pfeiffer, et al, "Peers and Peer-Based Interventions in Supporting Reintegration and Mental Health Among National Guard Soldiers: A Qualitative Study," *Military Medicine* 177, no. 2 (2012): 1471.
78. Acosta, et al, *Mental Health Stigma in the Military*, RAND Corporation: Santa Monica, CA, 2014, 11-12.
79. Shanker and Oppel, "War's Elite Tough Guys."
80. Todd Yosick, et al, *A Review of Post-Deployment Reintegration: Evidence, Challenges, and Strategies for Program Development*, Arlington, VA: Defense Centers of Excellence, 10 February 2012, 61; Thomas W. Britt, et al, "The Stigma of Mental Health Problems in the Military," Military Medicine 172 (2007): 157-161; Charles W. Hoge, et al, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers

to Care," The New England Journal of Medicine 351, no. 1 (2004): 13-22; Author interviews, 6/16/2016, 6/21/2016, 6/22/2016, 7/13/2016, 10/11/2016, 11/10/2016.

81. Votel, "Advance Policy Questions," 26.
82. Michael E. Doyle and Kris A. Peterson, "Re-Entry and Reintegration: Returning Home after Combat," *Psychiatric Quarterly* 76, no. 4 (Winter 2005): 361-370.
83. Ann-Renée Blais, Megan M. Thompson, and Donald R. McCreary, "The Development and Validation of the Army Post-Deployment Reintegration Scale," *Military Psychology* 21, no. 2 (2009): 368.
84. Danish and Antonides, "The Challenges of Reintegration," 550-558.
85. Karen-Inge Karstoft, Cherie Armour, Søren B. Andersen, Mette Bertelsen, and Trine Madsen. "Community integration after deployment to Afghanistan: a longitudinal investigation of Danish soldiers." *Social Psychiatry Psychiatric Epidemiology* 50 (2015): 654.
86. Yosick et al., *A Review of Post-Deployment Reintegration*, 75-76.
87. Ibid, 6-7.
88. Department of the U.S. Army, *U.S. Army Deployment Cycle Readiness: Soldier's and Family Member's Handbook*, 2008.
89. Doyle and Peterson, "Re-Entry and Reintegration," 361-370.
90. Yosick et al., *A Review of Post-Deployment Reintegration*, 75.
91. Ibid, 75.
92. Ibid.
93. Author interviews, 21 June 2016, 22 June 2016.
94. Yosick et al., *A Review of Post-Deployment Reintegration*, 75.
95. Ibid.
96. Air Force Medical Service, "Post-deployment Reintegration," Fact Sheet, 26 April 2013; USAF Services, Combat Support & Community Service, "Redeployment," website.
97. Author interviews, 13 July 2016.
98. Yosick et al., *A Review of Post-Deployment Reintegration*, 76.
99. Ibid.
100. Marine Corps Forces Special Operations Command, *MARSOF*, MARSOC Pub 1, Camp LeJeune, NC, 2011, 5-11.
101. House of Representatives, Subcommittee on Emerging Threats and Capabilities, Committee on Armed Services, *The Future of U.S. Special Operations Forces*, 15.
102. Bowling and Sherman, "Welcoming Them Home," 454, 456.
103. Jack Murphy, "Don't Kill Yourself Briefs: The Army's Cynical Approach to Skyrocketing Suicide Rates," SOFREP, 5 August 2012, Accessed 11/11/2016, https://sofrep.com/10047/armys-cynical-approach-suicide-rates/.
104. Wiggins, 72.

105. GAO, "Special Operations Forces: Opportunities Exist to Improve Transparency of Funding," 26.
106. Ibid.
107. Ibid.
108. For a description of component commands see U.S. Special Operations Command, *USSOCOM Fact Book 2015*.
109. GAO, "Special Operations Forces: Opportunities Exist to Improve Transparency of Funding," 26.
110. Ibid.
111. Ibid.
112. Ibid.
113. Ibid.
114. AFSOC and NSW shared some of their tracking instruments. One such instrument color codes individuals based on their assessed readiness to deploy, resulting in green (ready), yellow (potential problems), and red (should not deploy) stick figures on a chart. Interviewees admitted that the color coding did not always prevent the "yellows" and "reds" from deploying, and that these individuals tended to have the most difficulties when returning from deployment. Author interviews, 21 June 2016, 13 July 2016. The positive side of this is that at least the tracking allows for identifying those at-risk, and could be used to provide additional support to those who are most likely to need it upon return.
115. GAO, "Special Operations Forces: Opportunities Exist to Improve Transparency of Funding," 27.
116. Ibid.
117. Ibid.
118. Neff and Caserta, 2016.
119. Wiggins, 72-73.
120. Department of Defense Deployment Health Clinical Center (hereinafter DOD Deployment Health Clinical Center), "Background on Programs for Identifying Deployment Health Conditions and Concerns."
121. "In accordance with HA Policy 06-006, Periodic Health Assessment Policy for Active Duty and Selected Reserve Members, Feb. 16, 2006 all active-duty Service members and members of the selected reserve (SELRES) are required to receive a Periodic Health Assessment (PHA) annually (DD Form 3024) in order to ensure medical readiness and help improve the health status of military personnel. The PHA includes a current self-reported health status, review of medical records, identification and referral for current health and mental health problems, identification and management of occupational health risks and preventive health needs, and identification and development of a plan to manage health risks." DOD Deployment Health Clinical Center, "Periodic Health Assessment."

122. "For members of the Armed Forces deployed in connection with a contingency operation, a person-to-person Deployment Mental Health Assessment (DMHA) is required before deployment and three times after return as prescribed in DoDI 6490.12, Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation, Feb. 26, 2013. According to DoDI 6490.12, "the purpose of the deployment mental health assessment is to identify mental health conditions including posttraumatic stress disorder (PTSD), suicidal tendencies, and other behavioral health conditions that require referral for additional care and treatment in order to ensure individual and unit readiness." "The required four time frames for DMHA completion are: (a) within 120 days of deployment, (b) between 90 and 180 days after return from deployment, (c) between 181 days and 18 months (545 days), and (d) between 18 months (546 days) and 30 months (910 days) after return from deployment." "The DMHA consists of an online self-report assessment completed by the service member using validated tools to assess alcohol use and symptoms of PTSD and depression. The assessment is followed by a confidential person-to-person interview with a health care provider in order to: assess suicidal ideation and violence risk, address specific mental health concerns, provide brief supportive counseling if necessary, assess the need and make any referrals necessary for further evaluation and follow-up, and complete the provider portion of the form. The DMHA must be conducted in a private setting and include a review of available health records. DD Form 2978, Deployment Mental Health Assessment, February 2014 was created for documenting the DMHA." "To streamline the implementation and tracking process, the DMHA has been integrated into DD Forms 2795, 2900 and 3024 for administration when the timeframes for completing the first two DMHAs overlap with the Pre-DHA and the PDHRA and when the third and fourth DMHAs are administered in conjunction with the ensuing two PHAs." DOD Deployment Health Clinical Center, "Deployment Mental Health Assessment."
123. Bliese et al., "Timing of Postcombat Mental Health Assessments," 141.
124. This form is required if "a DD Form 2795 was required during the pre-deployment phase or per the decision of the combatant command commander, service component commander, or commander exercising operational control if any health threats evolved or exposures (occupational and environmental health (OEH) or chemical, biological, radiological and nuclear (CBRN)) occurred during the deployment that warrant medical assessment or follow-up." DOD Deployment Health Clinical Center, "Post-Deployment Health Assessment."
125. Bliese et al., "Timing of Postcombat Mental Health Assessments," 141.
126. DOD Deployment Health Clinical Center, "Post-Deployment Health Assessment."
127. Bliese et al., "Timing of Postcombat Mental Health Assessments," 141-142.
128. Ibid., 142.
129. Paula K. Underwood, "Pre- and Post-Deployment Health Assessment Process," Department of Defense, Deployment Health Clinical Center.

130. DOD Deployment Health Clinical Center, "Background on Programs for Identifying Deployment Health Conditions and Concerns."
131. Ibid.
132. DOD Deployment Health Clinical Center, "Deployment Health Assessments" states that "Personnel who are deploying or have deployed must electronically complete the deployment health assessment forms within the required timeframes listed in the chart below. Following completion of the form, a health care provider (i.e., physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician, or special forces medical sergeant) must review the form, conduct a confidential face-to-face interview, and complete the provider's section of the form, including indicating the need for further evaluation."
133. Author interviews, 16 June 2016, 21 June 2016, 22 June 2016, 13 July 2016.
134. DOD Deployment Health Clinical Center, "Background on Programs for Identifying Deployment Health Conditions and Concerns."
135. Bliese et al., "Timing of Postcombat Mental Health Assessments," 146.
136. DOD Deployment Health Clinical Center, "Background on Programs for Identifying Deployment Health Conditions and Concerns;" DOD Deployment Health Clinical Center, "Post-Deployment Health Assessment."
137. Bliese et al., "Timing of Postcombat Mental Health Assessments," 146. This study found that 15.4 percent of Service members in the study developed symptoms in the period following the return home; they were initially asymptomatic but developed symptoms between return home and 120 days later (145).
138. Paul D. Bliese, et al, "Validating the Primary Care Posttraumatic Stress Disorder Screen and the Posttraumatic Stress Disorder Checklist with Soldiers Returning from Combat," *Journal of Consulting and Clinical Psychology* 76, no. 2 (2008): 272.
139. Bliese et al., "Validating the Primary Care Posttraumatic Stress Disorder Screen," 272.
140. Bliese et al., "Timing of Postcombat Mental Health Assessments," 141-142; Ibid., 278.
141. Bliese et al., "Timing of Postcombat Mental Health Assessments," 147.
142. GAO, *Defense Health Care: Oversight of Military Services' Post-Deployment Health Reassessment Completion Rates Is Limited*, Report GAO-08-1025R, 4 September 2008, 6, 16.
143. GAO, *Defense Health Care*, 6, 16.
144. Naval Health Research Center, *Program Evaluation of Naval Special Warfare's Third Location Decompression Program*, San Diego, CA, n.d., 51.
145. Ibid., 53.
146. Author interviews, 16 June 2016, 22 June 2016, 13 July 2016.
147. Ibid.
148. Author interviews, 22 June 2016.

149. Danish and Antonides, "The Challenges of Reintegration," 550.
150. Beder, Coe, and Sommer, "Women and Men Who Have Served in Afghanistan/Iraq," 516.
151. Kristal C. Melvin, Jennifer Wenzel, and Bonnie Mowinski Jennings, "Strong Army Couples: A Case Study of Rekindling Marriage After Combat Deployment," *Research in Nursing & Health* 38 (2015): 11-12.
152. Shanker and Oppel, "War's Elite Tough Guys."
153. Danish and Antonides, "The Challenges of Reintegration," 552; Blais, Thompson, and McCreary, 2009, 367; U.S. Department of Veterans Affairs, *Returning from the War Zone: A guide for families of military members*, Washington, D.C., March 2014, 4.
154. Bonanno et al., "Trajectories of trauma symptoms," 321-322.
155. Discussion with USSOCOM POTFF, 14 October 2016.
156. Stephanie Booth-Kewley, et al, "Factors Associated with Antisocial Behavior in Combat Veterans," *Aggressive Behavior* 36 (2010): 336.
157. Kevin Brailey, et al, "PTSD Symptoms, Life Events, and Unit Cohesion in U.S. Soldiers: Baseline Findings from the Neurocognition Deployment Health Study," *Journal of Traumatic Stress* 20, no. 4 (2007): 500-501.
158. This challenge may be less applicable to SOF than to conventional forces, where accessing appropriate and effective equipment appears to be a larger challenge.
159. Yosick et al., *A Review of Post-Deployment Reintegration*, 62.
160. Author discussions, 16 June 2016, 17 June 2016.
161. Shirley M. Glynn, "Family-Centered Care to Promote Successful Community Reintegration After War: It Takes a Nation," *Clinical Child and Family Psychology Review* 16 (2013): 410, 412.
162. Glynn, "Family-Centered Care," 410, 412.
163. Sebastian Junger, "How PTSD Became a Problem Far Beyond the Battlefield," *Vanity Fair*, 7 May 2015.
164. Sebastian Junger, "Our lonely society makes it hard to come home from war." TED Talk, November 2015; Doyle and Peterson, "Re-Entry and Reintegration," 361-370.
165. Leanne K. Knobloch, Aaron T. Ebata, Patricia C. McGlaughlin, and Jennifer A. Theiss, "Generalized Anxiety and Relational Uncertainty as Predictors of Topic Avoidance During Reintegration Following Military Deployment," *Communication Monographs* 80, no. 4 (2013): 453-4; Christina L. Lafferty, Kenneth L. Alford, Mark K. Davis, and Richard O'Connor, "Did You Shoot Anyone? A Practitioner's Guide to Combat Veteran Workplace and Classroom Reintegration," *S.A.M. Advanced Management Journal* 73 (Autumn 2008): 5.
166. Junger, "How PTSD Became a Problem."
167. Doyle and Peterson, "Re-Entry and Reintegration," 361-370.
168. Lafferty, Alford, Davis, and O'Connor, "Did You Shoot Anyone?," 4-11, 18.

169. Doyle and Peterson, "Re-Entry and Reintegration," 361-370; Junger, "How PTSD Became a Problem."

170. Yosick et al., *A Review of Post-Deployment Reintegration*, 61.

171. Beder, Coe, and Sommer, "Women and Men Who Have Served in Afghanistan/Iraq," 516.

172. To date there have been four surveys: Baseline Needs Assessment administered from 30 October 2012 to 3 December 2012, the Wave II Needs Assessment administered from 13 January 2014 to 21 February 2014, the Wave III Needs Assessment administered from 6 January 2015 to 9 February 2015, and, the Wave IV Needs Assessment administered from 29 March 2016 to 9 May 2016. Neff and Caserta, 2016.

173. The PCL-5 is a 20-item self-reporting measure that assesses symptoms of post-traumatic stress disorder (PTSD) to screen individuals for PTSD, make provisional diagnosis, and monitor symptoms for change. Scores range from 0-80. A score between zero and 20 is considered "low PTS" on the scale. Scores ranging 21-30 are considered "moderate PTS," and scores ranging 31-80 are considered "high PTS." U.S. Department of Veterans Affairs, "PTSD Checklist for DSM-5 (PCL-5)."

174. The Brief Resilience Scale (BRS) is a 6-item self-reporting measure that assesses the resilience of an individual. Scores range from 1 (low resilience) to 5 (high resilience). Bruce W. Smith, et al, "The Brief Resilience Scale: Assessing the Ability to Bounce Back," *International Journal of Behavioral Medicine* 15 (2008): 194-200.

175. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item self-reporting measure that assesses hazardous alcohol use, dependence, and harmful alcohol use. Scores range from 0-40. Scores ranging from 0-7 indicate no problems; 8-15 suggest potential problems; 16-19 indicate high level problems; and 20-40 indicate very high level problems. Thomas F. Babor, et al, *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*, Second Edition, Geneva: World Health Organization, 2001, 11, 17.

176. The Patient Health Questionnaire (PHQ-8) is an 8-item self-reporting measure that assesses depression. Scores range from 0-24. Scores ranging from 0-4 indicate no to minimal depression; 5-9 mild depression; 10-14 moderate depression; 15-19 moderately severe depression; and 20-24 severe depression. Kurt Kroenke, et al, "The PHQ-8 as a measure of current depression in the general population," *Journal of Affective Disorders* 114 (2009): 163-173, appendix has full questionnaire.

177. The Friendship Scale is a 6-item self-reporting measure that assesses the degree of social connectedness and social support perceived (or felt) by the individual. Scores range from 0-24, with 0 representing total social isolation and 24 representing social connectedness. Graeme Hawthorne, "Measuring social isolation in older adults: Development and initial validation of the Friendship Scale," *Social Indicators Research* 77, no. 3 (2006): 521-548.

178. Wave III, USSOCOM POTFF.

179. Neff and Caserta, 2016.
180. These respondents reported their level of being affected by the emotion or activity as "a little bit," "moderately," "quite a bit," or "extremely."
181. Wave III, USSOCOM POTFF.
182. Lauren M. Conoscenti, Vera Vine, Anthony Papa, and Brett T. Litz, "Scanning for Danger: Readjustment to the Noncombat Environment," in *Living and Surviving in Harm's Way: A Psychological Treatment handbook for Pre- and Post-Deployment of Military Personnel*, ed. Sharon Morgillo Freeman, Bret A. Moore and Arthur Freeman (New York: Routledge, 2009), 123-145.
183. Hoge, *Once a Warrior*, 11,58.
184. The failure to recognize a need for service is not uncommon. A study of Canadian military Service members found "84-96 percent of those who met criteria for a disorder did not perceive a need for services." Suzanne Bailey, "Road to Mental Readiness: Challenges & Opportunities" (PowerPoint slides), Presented at the seminar on Resilience Research and Training in the U.S. and Canadian Armed Forces, American Psychological Association Convention, Toronto, Canada, 7 August 2015.
185. Wave III, USSOCOM POTFF.
186. These skills, often used in problem-solving approaches, have been found to be effective in assisting individuals in managing stress and conflict. Meredith, et al, 2011, 24.
187. Hoge, *Once a Warrior*, 17.
188. Email discussion with USSOCOM POTFF, 28 October 2016.
189. This section is based on existing studies as well as author-conducted research including visits to NSW (Coronado) and AFSOC (Hurlburt Field). These components generously provided information about their post-deployment programs. USASOC and MARSOC declined to be part of the study. USASOC did provide some information on its post-deployment approach. MARSOC did not respond to repeated requests for information about post-deployment support.
190. MHN Government Services, "Military & Family Life Counseling (MFLC) Program," n.d.
191. Author interview, 13 July 2016.
192. Author discussion, 21 June 2016.
193. Lester, Patricia, et al, "Evaluation of a Family-Centered Prevention Intervention for Military Children and Families Facing Wartime Deployments," *American Journal of Public Health* 102, No. S1 (2012): S48–S54.
194. Author interview, 22 June 2016.
195. Author interviews, 21 June 2016, 22 June 2016.
196. Author interview, 22 June 2016. MARSOC did not reply to requests for information.
197. Author interviews, 13 July 2016.

198. Author interview, 16 June 2016. Interviewee identified TLD as not possible for USASOC given size of USASOC.
199. Naval Health Research Center, n.d.. Components of TLD could be useful in stateside post-deployment transition support.
200. Ibid, 18.
201. Ibid, 16.
202. Ibid, 16.
203. Author interview, 21 June 2016; Naval Health Research Center, n.d., 15.
204. Author interview, 21 June 2016.
205. Author interviews AFSOC, 13 July 2016. The interviewees indicated that the program was not particularly effective in its current configuration, especially for non-ground forces. In addition, interviews revealed that different programs had been tried, however, there has been no documentation of these programs, what worked and what did not, and why certain new alternatives were chosen to replace older programs.
206. Ibid.
207. Ibid.
208. Ibid.
209. Ibid.
210. Ibid.
211. Ibid.
212. USASOC declined to participate in this study. However, the author did speak with POTFF, chaplain, and behavioral health services representatives. The information here is based on that discussion and unclassified USASOC and USASOC-related publications.
213. Author interviews, 16 June 2016, 11 October 2016.
214. Author interviews, 16 June 2016.
215. Ibid.
216. Adler et al., "Battlemind Debriefing and Battlemind training as Early Interventions with Soldiers Returning from Iraq: Randomized by Platoon," *Journal of Consulting and Clinical Psychology* 77, No. 5 (2009): 936.
217. Ibid.
218. Paul B. Lester, et al, *The Comprehensive Soldier Fitness Program Evaluation. Report #3: Longitudinal Analysis of the Impact of Master Resilience Training on Self-Reported Resilience and Psychological Health Data*, Research Facilitation Team, Office of the Deputy Under Secretary of the Army, December 2011; Lester, Paul B. Lester, et al, *The Comprehensive Soldier and Family Fitness Program Evaluation. Report #4: Evaluation of Resilience Training and Mental and Behavioral Health Outcomes*, Research Facilitation Team, Office of the Deputy Under Secretary of the Army, April 2013.

219. Dan Sagalyn and Jason Kane, "Army's Mental Resilience Program: Your Questions Answered," PBS NewsHour, December 23, 2011; Roy Eidelson, "The Army's Flawed Resilience-Training Study: A Call for Retraction," Psychology Today, June 4, 2012; Maria M. Steenkamp, William P. Nash, and Brett T. Litz, "Post-Traumatic Stress Disorder: Review of the Comprehensive Soldier Fitness Program," *American Journal of Preventive Medicine* 44, no. 5 (2013): 507-512.
220. Eidelson, "The Army's Flawed Resilience-Training Survey."
221. Meredith, et al, 59, 2011.
222. Roy Eidelson and Stephen Soldz, *Does Comprehensive Soldier Fitness Work? CSF Research Fails the Test*, Working Paper No. 1, Coalition for an Ethical Psychology, May 2012.
223. U.S. Department of the Army, *Comprehensive Soldier and Family Fitness*. Army Regulation 350-53. Washington, DC, 19 June 2014, 6.
224. U.S. Department of the Army, *Comprehensive Soldier*, 18.
225. MARSOC declined to participate in this study. The author's repeated attempts to obtain basic information on the reintegration program were unsuccessful. The information here is based on unclassified MARSOC publications.
226. MARSOC Pub 1, 7-1.
227. Ibid.
228. Author interview, 22 June 2016.
229. MARSOC Pub 1, 7-4.
230. Author interview, 22 June 2016.
231. MARSOC Pub 1, 7-12.
232. Ibid.
233. Ibid.
234. Hoge, *Once a Warrior*, 115.
235. Wave III, USSOCOM POTFF.
236. A service provider agreed that this was a relatively accurate way of considering service providers and types of services provided. Author interview, 10 November 2016.
237. Wave III, USSOCOM POTFF.
238. Wave III, USSOCOM POTFF. Forty percent or more of the respondents visited the following service providers five or more times: unit psychologist, unit psychiatrist, unit social worker, military treatment facility psychologist, military treatment facility psychiatrist, military treatment facility social worker, and other on-base and off-base counselors. The percentages were slightly lower for MFLC (35 percent with five or more visits) and FOCUS (25 percent with five or more visits, 50 percent with three or more visits).
239. Wave III, USSOCOM POTFF.

240. Trust is an important factor in seeking out mental health care. If that trust does not exist, Service members will not be honest, and are unlikely to seek out services or to continue seeing a provider. Author interviews, 21 June 2016, 22 June 2016, 13 July 2016, 11 October 2016.
241. Neff and Caserta, 2016.
242. Data from the Wave III, Preservation of the Force and Family (POTFF) Needs Assessment 2014-2015 and the Naval Health Research Center study of NSW TLD support this finding. This was also often mentioned in interviews with service providers. Author interviews, 21 June 2016, 22 June 2016, 13 July 2016.
243. Hickey, "High Suicide Rate."
244. Author interviews, 22 June 2016, 13 July 2016.
245. Of valid responses, 80.8 percent replied "no," 19.2 percent replied "yes." Wave III, Preservation of the Force and Family (POTFF) Needs Assessment 2014-2015. Data provided by USSOCOM POTFF.
246. Only 77.1 percent provided a reason. 49.7 percent in the "no need/interest" category, and 22.9 percent in the "access issues" category. 4.3 percent reported "prefer to spend time with family," and 0.2 percent reported "other."
247. Wave III, USSOCOM POTFF.
248. Ibid.
249. Although a relatively small difference in terms of what the score means on the PCL-5 scale, the difference was statistically significant.
250. A score between zero and 20 is considered low on the PTS/PCL-5 sum score. U.S. Department of Veterans Affairs, "PTSD Checklist for DSM-5 (PCL-5)."
251. The differences were relatively small, and both groups remained in the low concern end of the scales, the differences were statistically significant, suggesting a true difference between the groups, and that the group not able to access retreats, but that wanted to, may have needed them more than the group that said they were not needed.
252. The attendance rates were even lower for those scoring high on the other four scales: Alcohol (21.2 percent), Depression (21.4 percent), Social Isolation (19.4 percent), Low Resilience (15.9 percent).
253. Wave III, USSOCOM POTFF.
254. Ibid.
255. The scores on pre-deployment retreats for single soldiers fell slightly below 70 percent. Wave III, Preservation of the Force and Family (POTFF) Needs Assessment 2014-2015. Data provided by USSOCOM POTFF.
256. NSW POTFF agreed to assist in the distribution of a short electronic survey to those who had returned from deployment in 2015 and their significant others. The survey was designed in Qualtrix by the author. NSW POTFF sent the survey link with a request for participation to four SEAL teams who deployed during 2015. This included two teams based on the East Coast and two based on the West

Coast, with deployments lasting six months. Each SEAL team consists of 225-250 individuals, resulting in a respondent pool of 900-1000. However, transfers to other units and departures from service since deployment would reduce this number. Those who were currently in a team, but who had not deployed with that team during that time frame, were asked not to respond to the survey. The number of eligible active duty NSW respondents was 500-600. POTFF also asked married Service members to have their spouses take the survey. An estimated 30% of the force is married, which would result in 150-180 significant others being invited to take the survey. 160 respondents shared their designation: roughly half were AD (79), and half were spouses/significant others (81): SEAL (18, 11.25 percent) SWCC (11, 6.88 percent), Enabler (50, 31.25 percent) and Significant Other (81, 50.63 percent) – of these, only 133 provided answers on most of or all of the questions: Significant Other (68), Active Duty (65). The majority of respondents (103) was stationed on the East Coast.

257. Danish and Antonides, "The Challenges of Reintegration," 552.
258. Ibid, 550.
259. Shanker and Oppel, "War's Elite Tough Guys."
260. Wiggins, 79.
261. Author interview, 22 June 2016; Wiggins, 75.
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