Psychiatrists in Combat

Mental Health Clinicians' Experiences in the War Zone

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Foreword

The small room that had been set aside in the convention center was filled with people, many in uniform. They were telling stories. At the front of the hall, a man in double-breasted blazer and gold buttons of Navy Dress addressed the crowd, and there were tears in his eyes. Flanking him were those in crisp Army Class A's, a smaller number in Air Force Blue.

Those versed in this sort of detail might have noticed that both the speakers and the crowd contained an abnormally high concentration of officers, most with insignia that designated medical backgrounds. Many had ribbons that designated service in Iraq, Afghanistan, or both. It was not entirely a military crowd, however. At the speaker's table was also a young woman in an elegant green dress and a civilian dressed in a brown tweed jacket and bow tie that reflected an academic rather than military fashion. Each patiently awaited their turn, and a few wept along with the Navy Officer.

The leader of this group, the woman directing the discussion, was dressed in civilian clothes. Her bearing, a formality and comfort with command, still said "military" even while dressed in a pants suit. This was Elspeth Ritchie, Cam to most friends now, but still, in perpetuity, Colonel Ritchie to those who knew her story.

Colonel Ritchie had culminated her military career as the specialty leader for Army Psychiatry. Retired from military life, but still caring very much about the mental health of Service Members, Cam organized a series of talks and panels at the conference of the American Psychiatric Association. Most of these concerned the typical topics of post-traumatic stress disorder and preventing military suicide. Others were talks by prominent figures, generals, admirals, and senators. But she had also set aside this room for us to talk to each other, about each other, and about ourselves and what we had seen and learned during the longest war in US history.

Military mental health providers have a terrible privilege. We are told the secrets of the warrior's mind. We hear these stories, these secrets both magnificent and horrific, and we must keep them. The privacy and the trust of our warriors depend on it. But the listeners carry their own loads. We go into the battlefield or wait in the hospital for the wounded to roll in. The stories themselves can weigh upon the mind. There are things that we also have to say, lessons that need to be taught, and experiences that must not be lost in the silence.

"A psychiatrist can only tell his own psychiatrist," is the old cliché. That psychiatrist presumably would tell his own psychiatrist and so on up the pyramid until the person at the top is bursting with the pressure of knowledge.

But the cliché doesn't really work. First of all, it's not just psychiatrists, but a whole cadre of mental health professionals—psychologists, social workers, technicians, occupational therapists, and more—who share these experiences. Many of the storytellers are female, each telling her story to her psychiatrist. The stories are diverse, and we need to share.

We knew that there were ways to tell our stories, to disguise the identity of our patients but still impart what they had taught us. If you hadn't figured it out already, I was the Navy guy at the front at the workshop bawling my eyes out in very unmilitary fashion. I had written a book called *At War With PTSD*, about what I'd learned as a military psychiatrist and researcher.

Others such as Heidi Kraft, who contributes a chapter here, had done so in much more eloquent fashion in her book *Rule Number Two.* Scientists like Carl Castro had gathered up the larger numbers and given us a picture of what the average soldier or Marine had experienced. Cam Ritchie herself had organized numerous case conferences, in which groups of doctors discussed the best possible treatment for a patient, without ever knowing that warrior's identity.

What was missing in our individual stories was the larger narrative that we shared in this room. Here we were not just getting the Army perspective, or the Navy perspective, the experiences of a psychiatrist or psychologist, the tribulations of an Air Force wife whose husband left for Iraq, or a Marine Corp husband whose wife deployed to Afghanistan.

Here we were seeing the big picture. Here was the psychological history of the war on terror, from the attacks on 11 September 2001 to the last American psychiatrist in Afghanistan.

Peter Armanas and Jesse Locke, two of the authors, are about the closest thing we have to telling the final chapter of the history of psychiatrists deployed in the war on terror. There are still almost 10,000 American troops in Afghanistan, about 5000 in Iraq, but these doctors were among those present when, on 28 December 2014, NATO officially ended combat operations in a ceremony held in Kabul. Dr. Armanas was with the US Army in Bagram. Dr. Locke was stationed around the country imbedded with a unit of Marines.

That was one of the things we learned as the war went on, to keep the providers with the troops they serve. Over 13 years since 9/11, and over a decade since Armannas had served as an artilleryman in the invasion of Iraq, Drs. Armanas and Locke were the instrument to apply all we knew and had learned about mental health in the war on terror.

How did we get to them, having these doctors in Afghanistan? Most people remember where we were on September 11, but how about 7 October 2001? That was the day the USA officially launched Operation Enduring Freedom, better known in civilian circles as the war in Afghanistan. At that point, there weren't any psychiatrists at the front lines.

As the USA prepared for the invasion of Iraq, Dr. Kris Peterson already knew that if there was another front of the war, he would be going in with the invasion. That invasion occurred on 20 March 2003, and with that invasion they trucked in psychiatrists like Robert Forsten and Kevin Moore. After all, as Dr. Forsten explains later in this book, this was one of "only two ways to get troops to Baghdad." The other way was by plane, but the shrinks weren't yet considered important enough for air freight.

These mental health providers had to deal with complex issues in war; when to keep a stressed soldier with his unit, when to send a Marine who is suicidal home, etc. Dr. Moore had to be more than a psychiatrist, serving as the doctor in charge of other doctors and being assigned to a team who had to investigate any incident that might be considered a war crime.

In 2004, Dr. Milligan went to Iraq as a general physician just out of internship, trying to keep Marines alive after wounds from "mortars, direct fire, IEDs, and ambushes." He also discovered that being a doctor is no protection from being a target, as did Kenneth Richter, one of our psychiatrists who wears a purple heart on his uniform today.

It is a surreal experience to go from healer to patient. As an occupational therapist for the Army, Shannon Merkle had evaluated countless soldiers with traumatic brain injury, but would suffering such a concussion make her a better provider or only prove the adage that doctors make the worst patients?

War is a fine, if ruthless, teacher. Providers both in the war zone and at home were learning how to better manage casualties, both physical and mental. We were gaining the wisdom to improve ourselves. As Heidi Craft explains of her experiences in Iraq in 2004, we learned to be "more empathic, more flexible—and more thankful." But we also had to learn to deal with our own darkness.

Elspeth Ritchie (Cam) was tasked with investigating the events at the Abu Ghraib prison. Christopher Warner would note that the same police officers he had just trained in lifesaving skills were, in fact, secretly members of Al Qaeda.

The lessons were not all learned on the battlefront. Service members were coming home alive, thanks to improvements both in combat arms and in medical technology. But we were doing things we had never done before. The military was sending people to war, then home again, and then back to war. We were sending sailors to be soldiers and soldiers to be prison guards and using our reserves as frontline forces.

Captain Robert Koffman reviewed the hard numbers and had to tell those at the top that our service members were burning out. Rohul Amin treated these warriors one on one in Walter Reed Hospital as they returned from war. Kaustubh Joshi had to deal with his own frustrations when he was deployed just after his father died. We've always asked who watches the watchmen before, but did we know who would help the helpers?

Not all was bleak. As the war progressed, we learned about post-traumatic growth as well as post-traumatic stress. While deployed, Dr. Vincent Cambell noted: "[I] completed my Lean Six Sigma Greenbelt, and taught introduction to biology course to deployed service members. I also learned how to drive a manual shift." This was in addition to treating 800 patients.

Growth was a common theme among all of the providers. We all learned something. We all had tales to tell.

The room where we were brought together was small. We were, as the Marines would style it, among the few and proud. But we served something larger. By coming together, we educated ourselves about the psychology of war and healing and, perhaps, about our own nature. We learned lessons that were bigger than that room and bigger than ourselves. This book is a way to make that room expand. I am grateful that you, the reader, are taking time to join us now. I hope that it will be helpful.

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Disclaimer

The views expressed herein are those of the authors and do not necessarily reflect the official policy or position of the Department of the Army, Navy, Air Force, Department of Defense, Department of Veterans Affairs, nor the US Government.

Preface

Over the nearly 30 years that passed between the end of the Vietnam War and the initiation of combat operations in Afghanistan and Iraq, significant changes occurred in both the military and in the field of behavioral health. For the military, Vietnam brought the end of a very unpopular war in which returning service members were not viewed as heroes, but rather treated very poorly. Indeed, many service members themselves were ashamed of their service.

The military at that time dominantly consisted of draftees who served 1 year tours in Vietnam and subsequently left the service. Reports throughout the conflict were rampant with allegations of maladaptive behaviors to stress to include drug and alcohol abuse, fratricide, unethical battlefield behaviors, and numerous unprofessional behaviors within the local village communities.

Since that time, the military made significant transitions to an all-volunteer force, which also focused on combating those maladaptive behaviors by instituting ethical principles and values expected of all soldiers. As time progressed though, the perceived need by the American public and Congress for the military declined, especially after rapid and successful military actions such as Grenada, Panama, and the stunning success against the Iraqi Army in Operation Desert Storm/Desert Shield. These swift and decisive victories, coupled with the fall of the Soviet Union and victory in the Cold War, left the USA as the sole super power in the world.

There was a corresponding belief that we no longer required a large standing military force. Over the decade of the 1990s, the military was significantly downsized, as the thinking was that we would no longer engage in a large-scale war but rather smaller regional issues. The USA also thought that with our technological superiority of our equipment, we would not be challenged by large state actors. This led to limited involvement in Somalia, Bosnia, and Kosovo, operations other than war, that never carried a large military footprint.

The military medical system was initially spared from this reduction in force. However, many felt that much of the military healthcare system could be contracted or privatized and/or questioned the need for a uniformed military medical force.

Military psychiatry during this time saw a significant reduction with the closure of teaching programs and hospitals and a reduction in the overall force strength. By the time Operation Enduring Freedom kicked off in 2001, less than 10 % of the military mental health force had any deployment experience.

Meanwhile little changed in the training, preparation for war, and the initial tactics and procedures that deployed mental health providers used in treatment. Despite the fact that the prior twenty years had seen the introduction of much safer medications such as selective serotonin reuptake inhibitors and atypical antipsychotics, the military still focused on treatment principles from World War II.

These principles known as Forward Psychiatry, including Proximity, Immediacy, Expectancy, and Simplicity, taught to generations of psychiatry residents as PIES or BICEPS (when Brevity was added), are focused on returning service members to the battlefield after the acute exposure. However, little consideration was given to how to treat service members returning to combat on multiple tours, treating depression, PTSD or suicidality in a combat environment, or the impact that resiliency and/or stress inoculation might have on stress responses.

In contrast, advances were made in awareness of and screening for behavioral health disorders. After the Gulf War, it was clear that there was not a good system identifying which exposures military service members had suffered. This came to the forefront when veterans began presenting with medically unexplainable illnesses, frequently referred to as the Persian Gulf Syndrome. This led to the Department of Defense initiating post-deployment screening which included environmental exposures, medical symptoms, and mental health screenings including post-traumatic stress disorder, a mental health term that did not exist until after Vietnam. The screenings were adapted over the years to include modifying the questions, screening tools, screening intervals, and timing.

With the initiation of operations in Iraq and Afghanistan, conditions changed significantly. The volunteer soldiers were asked to deploy multiple times back into a combat zone to fight a nonuniformed, faceless, enemy, that frequently hid among civilians and on an asymmetric battlefield. The technological advances were countered with guerilla warfare tactics and roadside bombs which exploited limitations in the vehicles of support and sustainment units. Additionally, unlike Vietnam, service members were not permitted open access to the community but rather lived in small, walled off bases (Forward Operating Bases or FOBs) with strict rules and limitations to both avoid offending the local nationals and to protect the soldiers.

Over the coming years, behavioral health personnel were challenged with how to identify and treat post-traumatic stress disorder in an environment where they were continuously at risk and on edge. They were challenged in helping grow a force in a time when the majority of Americans were not volunteering to serve. It also became evident that their roles as providers were just as busy—or maybe busier—at the home station as they were on deployment.

The major issues of the smaller behavioral health force included: (1) numerous behavioral health personnel deploying multiple times to combat zones, (2) being asked to tackle new issues such as a rising suicide rate, and (3) how to manage deploying service members who were taking psychotropic medications.

As the war progressed, the behavioral health community found itself under fire and criticism with allegations of separating service members administratively to deny their medical benefits, sending unfit service members off to war, and not identifying a terrorist within their own ranks (Major Nidal Hasan).

However, over the course of over 15 years now at war, the longest sustained war in the history of the USA, psychiatrists and other mental health clinicians have contributed to a growing understanding of the needs of service members in combat. New initiatives were developed. Proving once again that war is a genesis for advancement, we have seen more advances made in military behavioral health in the past 15 years than in the prior 100 years.

The intent of this book is to highlight the brave individuals who volunteered for this combat service, to hear their stories of how they went through the crucible of a deployment, came out a more resilient provider, and contributed to an enhanced system of care. This book highlights behavioral health providers from all phases of the war to include those who were there through the initial invasions all the way through the recent retrograde from Iraq and downsizing in Afghanistan. It will display a comparison and contrast of both the growth and transformation of the mental health system of care during this period but also shows a change in expectations and resiliency among the providers.

This volume should serve as a guide to future deploying mental health providers on expectations and challenges. It will also serve a broader audience by giving insight about the experiences of soldiers and other military service members. It should provide leadership lessons on transforming systems in high-intensity environments.

We hope it will give civilian and military providers, veterans, and other citizens an understanding of the unique experiences that this particular group of service members face. We also hope you enjoy reading about it, as we definitely enjoyed (or hated) living it.

Bethesda, MD, USA

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The Road to Iraq

1

Kris Peterson

Between the acting of a dreadful thing and the first motion, all the interim is like a phantasma, or a hideous dream.

William Shakespeare, Julius Caesar, Act 2, Scene 1

1.1 The Beginning

In December 2002, with war looming, I learned I would be called up to the 98th Combat Stress Control (CSC) to deploy to Iraq. Several others had been ahead of me in the Professional Officer Filler System (PROFIS) position slated for deployment. One by one they dropped out. My anxiety increased as I moved up the priority list to become one of the remaining names able to deploy. My supervisor at Madigan Army Medical Center, near Seattle, was looking for another psychiatrist, and with his list growing short he informed me that I would be going.

I was not looking forward to this deployment and leaving family and home but was willing to do my duty. My anxiety was increasing. I was lamenting leaving family and was increasingly scared about going into combat.

I was not alone in terms of working my way up the list to deploy; CPT Mike Cole, a young Army psychiatrist, was moved to the 98th as well. Mike and I headed dutifully off to the 98th and 62nd Medical Detachment Conference in January, 2003.

Our mission was briefed to us: land in Turkey, convoy to a rally point near the port, drive 4 days across country to an assembly area, and then follow the 4th Infantry Division (4ID) across the border into Iraq. Our entry point was to be just east of Syria. We were to follow the 4th Infantry Division across the Euphrates, and

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then move southwest to Tal Afar. That city is just 30–40 km west of Mosul. Here we would be based at a secure airfield doing combat stress operations and other medical support.

We were told to have a duffel bag packed within 24 h. I had little idea about what to pack, but in hindsight did not do too bad a job. Uniforms, wet wipes, medical books, batteries, nets for holding things, a small fan, a head lamp, some snack bars, and pictures of family were packed. All were helpful. Especially the wet wipes.

Days went by. Turkey refused to let our troops into the country. Diplomatically it was a nightmare. Offers of billions of dollars in aid were made but refused. Debates on the TV raged on, with the outcome declared by three votes of the Turkish government. They refused to let the United States and the 4ID go through the country.

The news made us think we might not deploy. Unfortunately instead it resulted in a much more arduous and dangerous journey.

The days wore on, and each weekend was sought after like a life preserver and then held on to with the same fervor. Every Sunday night, putting my one and three year old boys to bed and hearing their prayers was painful. Nights were spent looking out at Mount Rainier in the moonlight. My head did not seem to be on right. I would be wrecked on the occasion of my 3-year-old saying "I don't want you to leave," or "I'll miss you."

In mid March the president gave a speech to the UN. One more time Saddam was given "one last chance." That chance came and went. On March 19, 2003, the B-1 Bombers and Stealth fighters began the attack.

1.2 Hitting the Road

On April 1, the Turkish Parliament again rejected the US request to open its ports to the 4ID and Task Force Iron Horse. This now meant that there would be no northern front. Task Force Iron Horse would be rerouted through Kuwait with the same objectives: Mosul and Northern Iraq. It was a "much longer drive" as it was put by one of the members of the 98th after being briefed.

On April 10 we had definitive word that we would be sent to Kuwait and then be traveling North. Our weekends and time at home came to an end. Our flights were readied at McChord Air Force Base. We made our way to Fort Lewis, with family in tow, our gear dropped off at a collection point, and buses ready to take us away.

However, the vans to collect our gear "could not be moved" because the keys were lost. My family and friends visiting helped reload my gear, rucksacks, and duffels out of the vehicles that were keyless and drove the ¼ mile to the trucks that would take them to the aircraft. I held my boys, my wife, hugged my dad and my uncle, and then got on the big blue bus to McChord.

The bus driver honked as we passed the detachment as a last good by. He had been deployed twice to Vietnam. We drove under a freeway overpass. "We support the troops" signs and US flags were waved. We pulled into McChord AFB and were escorted into a hanger, and sat on benches with way too much gear.

The time there passed very slowly. It was a relief though to be finally underway and to really have said goodbye. No more life preserver weekends or roller coaster emotions -we were now committed. Everyone felt relief to hear the final farewell from General Dunn and then walk out on the tarmac to the plane.

Prior to boarding the plane I had prescribed sleep aids for those who wanted them for the flight. Most of our team did. The team climbed up the steps and made their way on board sitting in the first seats available. The flight attendants wore Uncle Sam hats and indicated that they could not care less if we buckled up or left the seat back up. Most of us made ourselves as comfortable as possible, took a pill and fell asleep.

1.3 Kuwait

In Kuwait we disembarked, walked about a quarter mile, to buses lined up and waiting for us. It seemed a long ride to our first stop, Camp Wolf. We were exhausted even though we had slept on the plane. The emotional toll and intermittent excitement had us all soon laying atop our gear and sleeping on the floor.

We did not exactly know what to expect, what awaited us or exactly where we were going. We received news that the war was going well: moving quickly through to objectives and "clean up operations." After hoping so long that we weren't going to deploy, we now hoped that we would end up staying in Kuwait or being sent home. However the 47th Combat Support Hospital Commander was working to find us a mission, and a place to go.

Our vehicles and equipment had been shipped to the Middle East; first it was headed to Turkey, then rerouted to Kuwait. We headed to a port there to pick up our gear. It took hours to find all of the vehicles and containers (called CONEXs) in the hot Middle Eastern sun.

As we drove I looked at the sun setting; same sun, just a different world, one that was incredibly unknown to me and those around me. Hot, dusty and sandy. Local people looked at us curiously as we traveled. We headed down a dirt road following the vehicles in front of us and turned onto a paved highway.

It was dusk when we were well underway. Visibility was further reduced by the sand being kicked up by the numerous vehicles in front of us. We skirted along the border with Iraq and now moved through open desert in the dark with sand flying.

For minutes we drove blindly, only picking up a taillight at the last second, narrowly avoiding a collision. Hitting the brakes, we froze, fearing being rammed in the rear by the vehicle behind us.

This game of blind mans bluff grew significantly more dangerous minutes later. We were hours into the convoy when we heard the distinct clanking of tracked vehicles nearby. We saw ghostly figures of Abrams tanks from the 4 ID running parallel to us, seemingly only yards away. Minutes later the tanks on our left joined the HEMMITs, long large vehicles hauling ammunition, to our right.

Driving with no visibility, in the desert, in the dust and with tanks driving along side was clear insanity to this psychiatrist.

We were hot, wearing Kevlar flak vests with seatbelts that barely fit around our equipment. The HMMWV (High Mobility Multipurpose Wheeled Vehicle) was crammed with equipment, radio, chemical gear, M16 weapons, ammunition rounds, camel packs, food, MREs, my harmonica, notepads, maps, and water bottles, plus a bottle to piss in for the long ride.

The Humvees we rode in had cloth doors. There were cracks in the plastic windows that barely zipped open and shut. Someone had left my name and rank stenciled in the front window as if we were still in garrison. LTC Peterson. Nice target.

We would radio periodically. "Psycho 6, Psycho Sierra we've lost visibility with Psycho Charlie, over," or "Lost sight of convoy, over." The reply was "If you're in the dust cloud, you're going the right way, keep coming." Or "See those red lights, just follow those." Our response: "If we could see the lights we wouldn't be using the radio right now."

Our convoy slowed, the tanks disappeared and the dust began to settle. We saw signs of an encampment. Concertina wire, cement blocks, and floodlights illuminated a fortress in the desert. We moved forward between sand bunkers and turned into a concrete maze.

Guards were manning .50 CAL machine guns. More soldiers directed the floodlights onto our vehicles, as we were each individually checked and cleared to proceed. With more radio traffic it became clear that we were entering into Camp New York, just miles from the Iraq border.

Giant cranes lifted milvans, moving to and fro. Haze from dust and sand kicked up. Fire from burning trash pits cast a hellish glow behind the floodlights. The floodlights and flames cast a shine on the concertina wire.

We pulled to a stop. CSM Yobut, our senior non commissioned officer, was out of his vehicle checking on the soldiers. "How was that for a combat patch ride?" was his comment through the unzipped windows of the HMMWVs as he walked past. Miraculously no one was hurt or lost.

1.4 Camp New York

Quickly our team settled into Camp New York. The heat was intense with dust and sand everywhere. Tracked vehicles and cranes drove the dust into the air causing clouds within the tents. The camp was desolate and faded into a continuous horizon of dunes. Sand rose up in all directions to touch the sky.

The view was broken only by scattered tents a quarter of a mile away. Helicopters flew by in the distance, sun glinting, off their windows. Convoys miles away put up a rooster tail of dust, marking their passage, as they crossed over into Iraq. Our turn for crossing was approaching in a few short days.

We gradually explored the grounds, the hardened bunker, and the tent areas as we settled into our own tent. It was crowded and uncomfortable, but retrospectively was the most luxurious part of our deployment. Community showers and honey bucket bathrooms that we disdained at the time were later seen as a luxury.

Over the next few days of waiting a "battle rhythm" started to develop for us; waking up early at day break, washing, cleaning, reading, writing, working on our area to make personal improvements and accounting for gear. Walking to the mess hall by lunch time was unbearable in the heat. As we prepared to cross into Iraq we unpacked our MILVAN and repacked our vehicles for our drive North. Rumors came and went about the status of the war and the need for mental health support.

A sand storm came through our camp. It was an experience that would be repeated multiple times over the course of our deployment. Despite the danger and discomfort they presented, the sand storms remain natural events beautiful to behold. We were spell-bound to see the sand front move towards us and also frightened as it enveloped the camp.

1.5 Convoy into Iraq

On Easter morning we loaded our vehicles and lined them up. We cleared our weapons and distributed the ammo. I had opted not for an M16 but a 9 mm pistol. I was in the sixth vehicle in our convoy of roughly 60 vehicles. I was the senior officer in our group as a LTC. I was the oldest as well, at the age of 39. My call sign was "Psycho Doc Pappa." I liked it.

We started out with dust everywhere. Amazing to me was its consistency. It was so fine that it behaved like a fluid, as if waves were rippling in front of a boat. Soon however, the characteristic properties of the dust flying in the air turned to grit in my teeth and made me thirsty for water.

We stopped once before the border. Stepping out, stretching my legs and then taking a pee by the side of the vehicle was the necessary routine at stops. We drove for a while across dessert, then turned on to a hardball road. A few miles down there were two large "berms." The second was the border crossing into Iraq.

The border was guarded by two machine gun nests and a Bradley Fighting vehicle, our vehicles passed through a trough between them. I was not sure what I was expecting, but this wasn't it, I was expecting something more impressive.

Unceremoniously something fell from the back of the HMMWV in front of us. SGT Gonzales and I pulled over out of line to recover whatever it was, thinking it might be important. It was laundry detergent. We piled back in and regained our spot in the convoy with the mission vital "TIDE." Puns lightening the mood were thrown across our vehicle marking our entry into the war zone, "we are sure going to clean this place up," "the Tides going to change now," "hope they don't shoot any SUDS missiles at us."

1.6 Iraq

Within a mile of crossing the border again my expectations were not met. What I saw was a mass of impoverished children, shoeless and in rags standing by the roadside. These younger kids were not the "threats" I thought might meet us.

Tentatively they made their way to the road and at some points slowed and stopped our convoy. As we progressed, these younger children were joined by older people; men of military age gathered as we moved past. Many had blank stares and watched motionless, while the younger ones gave thumbs up, and waved, signaling that they wanted food, MREs, or water.

As we progressed it was clear that the security of our convoy was lousy. If we stopped we were mobbed by the civilians who gathered around and in between the vehicles. Our instructions were to "bumper up" putting our vehicles bumpers touching but this was nearly impossible. Even a little space remained a conduit to the child or adolescent to climb between to get to the drivers side of the vehicle and ask for food or water. We "accordioned" along, with spacing between vehicles way too wide.

My anxiety reflected that of many, but there was a component of the medical reserve group we had joined who seemed oblivious to the danger. Many appeared as if out on a Sunday drive in Topeka, Kansas. Some of the soldiers appeared to encourage the chaos and melee of people by throwing out MREs, water, and exchanging some dollars for worthless Iraqi money.

My heart raced during these moments when we came to a stop. Shortly though, we were back to a steady pace making our way northward, with scattered debris at every overpass, empty TOW missiles along the freeway, and burnt out fox holes.

Observing the scenery along our convoy I noted hutments, crude shelters, and adobe homes. None appeared to have running water or inside toilets as outhouses appeared to be the norm. There were small farms near the houses and herds of animals. Larger groups of men were herding sheep and camels.

One snapshot: along the roadside we saw parents with a baby. It was so hot, so desolate in the sand, and in the wreckage of the vehicles I wondered how they were to survive. It seemed naïve to think that there was help out there at all for them. I hoped that they and the baby would be all right. We drove on.

We pulled around a clover-leaf, the convoy slowed and came to its first refueling point. We took on fuel after waiting for a long time for our turn. The fuel was delivered to us from trucks or large rubber and cloth balloon like things called blivets. The term originally was slang for something ugly and unwieldy "ten pounds of manure in a five pound bag" which seemed apt.

After hours of waiting we were told to rest for the night. We ate MREs and made "cat holes" to go to the bathroom. We ended up spending the night there, opening our cots up by the vehicle with the door open protecting one side with a poncho draped over the top.

The dust remained horrible. Wet wipes would serve as our showers for many days; after that a bag filled with water hanging on a nail would do for months. My eyes were heavy, the adrenaline now ebbed. Feeling as if we were safe for the moment, I slept.

1.7 A Few More Convoy Adventures

We woke up early and loaded our equipment into the vehicle. We waited and waited again some more until finally we rolled out. We got on the highway after a short drive through several towns.

As we drove SGT Gonzales my driver, and I noticed the vehicle would periodically shake, or jerk. We smelled smoke. “Psycho Doc Pappa, you are on fire, pull over now.” We pulled to the side of the road, the convoy pulling over as well. We jumped out with people pulling security alongside their vehicles.

I ran to the side of the vehicle, 9 mm drawn, but was soon occupied less with security, and more with putting out a fire on the trailer tire. The ball bearings had frozen and the rubber wheel was smoking heavily. Pilecki, our mechanic looked at it and deemed it a total loss. We quickly unloaded the vehicle, redistributing what we could into other trucks and HMMWVs. We were on the road again.

This was typical of most of the days we were convoying up north. We stopped along the way outside of cities and towns that would become infamous later, such as Fallujah.

Nearly any long delay near a town or city led to crowds gathering around our vehicles. Directions to the convoy soldiers of “don’t let anyone get near the vehicles,” shout “Imshee,” “get away,” was what we were told to do as a result of threats. We would also have our weapons at the ready just in case. For me this meant typically having my 9 mm pistol drawn and at the side of the cloth door.

One time, there was a vehicle from an earlier convoy destroyed, burning on fire in front of us. We could see the smoke. We waited as crowds gathered around. Most seemed similar to previous groups that had looked to us for food, water and trading things through the windows. The difference this time was the burning vehicle about half a mile up the road.

A number of the individuals walking along the side of the road were young men. One person in particular caught my eye as he walked back and forth along the vehicles looking at the names and ranks in the window. He noted mine, walked along looking in the windows of several others, then came back towards me. He was wearing a white sarong and seemed to pause a moment.

Seemingly making up his mind, he walked rapidly to my window. I was watching him and he had made me nervous. My 9 mm was drawn and to my side. He came up to my door and reached rapidly into his shirt. I quickly raised my 9 mm and pointed it through the window in response. The muzzle was inches away from his face, and he jumped as I shouted “Imshee.” He ran. I shook from fear.

Soon we were back on the road. It was a Shiite holy day. It marked the death of a mullah named Hussen who 400 years ago had died in Karbala. He was taken prisoner by enemies. He called out to the “faithful” to free him but they did not come and he was killed. For centuries ever since, the Islamic people had come to Karbala for a religious pilgrimage, and a form of repentance. For years the Shiites had not been able to make this pilgrimage, for under Saddam Hussein and the Baath party there would be roadblocks and soldiers preventing them from making the trip. At least this was what I came to understand. This was the first time that the Islamic pilgrims had been able to make the trip to Karbala without interference for decades.

The roads as a result had even greater congestion with hundreds of vehicles out filled to over-flowing with people in religious fervor. Open trucks were filled with men, buses were packed with people chanting and beating their chests in rhythm. They drove by mostly ignoring us, as they seemed in a trance, but some would glare and even shake fists at us as they were passed.

During this time security within the convoy became a nightmare. There was a sense of powerlessness. The only combat support or security that we had on occasion was the 101st helicopters that joined us for short periods of time either on their way to someplace else or adding security. I chose to believe the latter just because it made me feel better.

We were now in areas that still had smoking tanks, trucks and artillery. Often we saw these weapons right next to homes. Impressively and typically only the weapon was destroyed (by our side), with little, if any, damage to the houses. A few of our helicopters had been destroyed, lying as wreckage along the road.

Dead animals were also decomposing along the roadside and the smell of rotting decay was ever present. At night we still pulled over, slept in our vehicles or cots outdoors, using the door of the Humvee as part of our bedchamber. We were still peeing in bottles as we drove and throwing them out the door or making cat holes along the way. The women in the convoy had difficulty; peers would hold up a poncho so they could do their business when we did stop.

The heat, dust, and unrelenting stress were taking a toll on morale. We ended up stopping in another forsaken place just west of Baghdad. It was a former Iraqi military base of some sort. We were told we would be just a few days here, and so we kept sleeping on our cots or in our vehicles.

Sand storms hit and the misery index soared. We crouched in the HMMWV in the heat, doors shut, windows zipped shut, wet wipes shoved into the cracks, while jets of dust forced their way into the vehicle. With our eyes and mouths sandpapered with Iraqi landscape, my driver and I sat in silence for hours.

Needing to get water we finally opened the door and trekked to our water buffalo. The visibility was horrible and what portions of our body were not already saturated with sand now became so. It was a necessary task to fill our canteens, but it was nearly futile. It was impossible to fill the water without significant amount of sand getting in. Fortunately there were also some plastic bottles of water nearby as well.

Taking those and what we could from the buffalo we came back to the HMMWV and got in pulling off our goggles and bandanas to readjust and take some sips of the water. SGT Gonzales after a swig looked at me and smiled with raccoon eyes and a white sand covered mouth and said “mmmm good, crunchy” as the sand in the water added texture. We laughed and resumed trying to exist in the heat and sand.

1.8 Latrine Issues

The few days here at this base outside of Baghdad turned into several weeks. I was told it was a military and an industrial complex built by the Russians, but not completed, to produce and store chemicals. Two silos stood next to a group of burn pits that had flames leaping out of them burning garbage.

There was a line formed of about 30 people for the outdoor latrines; people who waited out the sand storm now had to “go.” Patiently they stood in their gear, holding toilet paper that came in MREs, or a roll that they had brought or gotten as they stood in line. The flies around were epidemic.

The latrines were made of a wooden box with an opening and with wood slats to the sides for some modicum of privacy. They were outdoor and exposed to the sky, dust, flies, bugs and passing helicopters. The outdoor "freedom" toilets (so described here as to the liberating experience of having a bowel movement in the broad daylight with just a short piece of plywood on your left and right and nothing to your front) looked through a chain linked fence out to a landing strip. The landing strip was filled with helicopters. These were busy taking off and providing protection to convoys, picking up the injured, and going out on missions constantly.

It was more than a coincidence that when they took off or came back to land they lingered over our latrine. On two occasions as I sat contemplating my position in life, meditating and trying to relax as much as possible, a helicopter took off some distance away. I could feel the picking up of the wind and gradually noticed it increased.

Greater and greater was the wind as the helicopter approached lifting gradually off the ground and then flying straight at me low to the ground. Initially I thought it was cool but then became disturbed by the dust now picking up. In swirls making loops the backwash of the propellers generated a sand storm. In horror I stared as another storm brewed.

Stuck where I was, I watched bits of toilet paper flying out of the other unoccupied toilets joining the sand whirling about me. I looked up and saw that it was just at this moment that the helicopter was hovering just above me at low altitude. I imagined I could hear laughing. I simply endured the crap storm that was flying about me.

Our home for the next couple of weeks was this area, called Camp Dogwood. The airfield stretched out before us and with what looked like a palace nearby in the distance; all was surrounded by a wall that stretched around for miles. We were told we would wait here for "awhile."

Three or four wild dogs prowled within our area. One was a bitch with four or five pups. She was aggressive, howling most of the nights as we slept, quiet for periods of time when hunting to scavenge our food or catch something else. The fire, smoke, and stench that arose from the burn pits cast a ghostly hue to our surroundings. Gradually the smell became less intrusive as we grew used to it.

1.9 Boosting Morale

Since we were the mental health "team" we talked and generated some "morale boosting" plans. In the middle of the vehicles, we put up a tent and unloaded some of the equipment we used for presentations. A movie projector was set up that evening and "Shrek" was showed on the side of the tent. The ground and few chairs were quickly occupied and for over an hour troubles were forgotten. People smiled and laughed and were absorbed in an outdoor movie on a tent.

Towards the end of the show, a wind began to pick up and the tent waved distorting the picture. Sand started to swirl again. Some people made their way back to shelter but most stayed where they were as another storm arose. Keeping the film

running off the generator and sand out of electronics was a concern, but the movie ended, with visibility diminishing by the minute. Quickly equipment was packed up, and people made their way into vehicles. Night came early, the setting sun obscured by sand and darkness.

1.10 Conclusion

This account focuses on leaving my home and family near Ft Lewis, and getting to Iraq, experiencing a toll both emotionally and physically. For many soldiers and other service members, the transport there and the environmental hardships were a significant part of the deployment. Building positive relationships with your fellow soldiers was key in enduring the hardships that the environment produced. Supporting others when they needed support and taking their help when needed, sharing, finding humor and building comraderie was vital in maintaining mental wellbeing.

COL Kris Peterson is a retired Army Psychiatrist. The uncertainty of going to war and his experience of being deployed early into Iraq are related here. The pre-deployment events begin in January 2003.

Farm Boy Turned Military Psychologist: A Summary of War Deployment Experiences, Struggles, and Coping

2

Layne D. Bennion

I froze when I heard the KA-BOOM. This sound was different from the periodic detonation of incoming mortars and rockets. This was during daylight; it was more powerful, somehow deeper. The metal frame building shivered, dust oozed out of the walls. I glanced at my mental health technician through the office doorway. She was staring back at me, not moving. I primed myself to drop out of my chair and roll under the table if anything else happened. We were both motionless, waiting. After a minute, nothing changed. I got up and glanced across the hallway. The logistics sergeant looked out of the supply room. "Whoa" he mouthed silently. Minutes passed. Nothing else happened. Slowly everyone went back to their work routines. I sat back down at the computer, but I couldn't focus on my patient documentation. I shook my head, "What am I doing here in Iraq?" I thought. I smiled at myself and recall that not that many years ago, I had left home and headed off to college. A kid raised outside a small remote town, driving a 25-year-old car with four or five colors of paint, undercoat and rust. I had a big plan; become a civil engineer. I had thought maybe I would work at an engineer firm in the big city two and a half hours from home like my oldest brother did. But, years later, here I am in Iraq, in a war zone, a military clinical psychologist. How life twists and turns.

Approximately 30 min after the big boom, an overhead announcement informed us a massive VBIED (Vehicle Bourne Improvised Explosive Device) had detonated outside a security gate followed by an unsuccessful insurgent attack. Fortunately none of ours were killed in the incident. I happened to hear days later, from a patient,

Note: While I am attempting to convey the stories of the men and women I had the honor of working with and learning from, out of respect for privacy I have changed identifying details.

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the blast was so potent they found not a shred of the driver of the VBIED and only a few parts from the vehicle: the engine block, an axle, and a pretzeled steering wheel.

When 9/11 happened, I had no premonition that what became my 20-year "marathon" as a military psychologist was just past the warm-up stage. I had joined the military, frankly, for financial reasons. I was a young husband and father. We were saddled with student debt from my graduate degree programs. At the time, our immediate financial future seemed to stretch barrenly ahead of us. For my school mates, the most typical path forward would be a 1-year low-pay clinical internship with moves at both ends, and then finding a job after internship. In addition, one would have to find the time and energy to complete a Ph.D. dissertation and then study for and pass the national licensing exam. My decision to join the military meant a relatively high-paying internship, a guaranteed job after internship and family medical coverage. It also meant that I, a farm boy, was launched onto an international pathway.

Over the years, each time the decision surfaced to leave or stay in the military, I found myself thinking about the men and women wearing the uniform and the high percentage of them who dedicated their lives to making the massive bureaucracy function. I also thought how sometimes I was able, in small ways, to help the men and women who smooth that process.

Immediately post-9/11, the military medical system was energized, but chaotic. There had been plans on paper to manage large scale deployments for years. Reality, particularly as the initial surge settled into a long-term process of deployments, was apparently unaware of those carefully laid plans. I came to understand over and over again, it is the smart, dedicated individual service members who make the military work—individuals from "paper-pushers" to "fuel guys/gals" to "wrench turners" to "eye-in-the-sky watchers." The military really does work hard to prepare all levels of medical personnel for work in the field. But, once on the ground, the reality is always different.

Deployed life is distilled down to the basics: work, eat, sleep, pee, poop, and a minimum of personal chores. At some sites, there is even a no-pay laundry service, assuming you don't mind losing a t-shirt or a sock once or twice a month. Some individuals find deployed life disturbing and stress-filled. Deployed life strains every resilience "muscle" they have; every day is a challenge not to fold into oneself and abandon responsibilities. Others thrived in the simplicity of deployed life. Some actually prefer deployed life and are reluctant to return home.

Unexpectedly, a portion of my days were not so different from the work I did every day at stateside assignments. Individual airman, soldiers, sailors and marines come in to share and hopefully shuck some of their burdens: hobbling stressors, too-skinny sleep patterns, or buckets of glitches with spouses or children or friends. Yep, just like my office stateside … if every square inch of horizontal space was spritzed with dust and fine sand 2–3 times per day, the walls were either canvas or cheap plywood, the space was squeezed down to half, furniture was folding tables instead of desks, seating was either plastic shackable lawn chairs or canvas sling chairs or cheap couches covered with burlap-like fabric which wheezed dust every time someone sat down.

The textbook definition of "mental health" doesn't apply during deployment. I was regularly called upon to deal with or advice in situations someone thought was "mental health." There were many examples. Not too many weeks into the deployment, a medical technician started crying and ran out of the ER during an influx of bloodied soldiers. A day-shift leader who wanders through the clinic at odd hours night after night. But when anyone asks him shouldn't he be sleeping, "Oh, no, I'm good … just checking in." The distraught buddies of a soldier who died from huffing compressed air. The angry-beyond-words nurses who were handed an unidentified small bundle from a Special Ops helo and it turned out to be a toddler with a severe head injury. Why didn't they tell us they were flying in a child? The muttering, glaring unit members of a wounded service member who had gathered outside the medical building. They found out the insurgent, who reportedly shot their battle buddy and was currently in trauma surgery, had been shot in the leg, was captured, and was now in the ER receiving care for his own gunshot wound.

To me, above are examples of normal people trying to manage when the craziness of war tromps on their daily life, not the pathology or mental illness popping out. But, all those incidents listed above were "my people" and figuring out a way to help was part of my responsibilities. No textbook held any answers. No classroom or seminar had addressed such problems.

Often I found myself thinking back to various personal and professional mentors who had kindly eased my life. What would they do in this situation? What would they say to console this soldier? Help me think of what to say to a teenager, who just a few hours previously, had witnessed his friend breathe his last after a rocket-propelled grenade detonated against the cab of their truck pulverizing his friend's face and leaving his skull mushy and misshapen? Tell me how to help a young medical tech who had been assigned to monitor and be with a mostly unresponsive patient with a severe head injury. A patient who was going to die in the next few hours because there was no additional medical treatment to give and there wasn't a chopper available to fly him to a major medical facility.

Another new role was dealing with a common concern: "I need to go home, I can't do this anymore." This complaint came in many boot sizes and colors. In most cases, my job was not to send them home, but to find a way to help them find a smidgen of motivation to pick up the pieces of their life and carry on in spite of the danger, fatigue and disillusionment.

Of course, there were ample "no-kidding" mental health problems to manage. Mild depression and anxiety was around every tent corner. Many service members had such garden-variety symptoms from simply managing the task of staying alive in a mostly unpredictable combat zone.

Other situations were more subtle requiring careful building of relationships. For example, a soldier in his mid-20s came in for sleep problems. Reportedly he was accomplishing his job and had a reasonable reputation with the command. According to the mental health technician who initially interviewed him, this soldier was "odd … was off," more than just lack of sleep. A social worker met with the soldier a few times and then asked if I could see him to provide a fresh perspective. We did some psychological testing, but it wasn't particularly helpful in this case.

After a few sessions with this soldier, he began to disclose to me, bits and pieces about the daily voices and moment-by-moment commentaries he heard. Initially, I thought perhaps these "voices" were part of his religious and cultural upbringing, essentially self-talk perceived as the "voices" of spirits or ancestors who he felt guided him. But, over time, the data began to line up that he was psychotic—not flagrantly, but enough that some of his decisions were nudged by the voices. The content of his voices were relatively benign, i.e., at the time weren't telling him to endanger himself or others. But, after consulting with my social work colleague and another psychologist by phone, I contacted the soldier's command and recommended he be medevac'd out of the combat zone for additional inpatient observation and evaluation. Stateside, such a case may not need such urgent intervention. But in a combat zone, this young man carried a loaded weapon every day. No one knew, no one could predict if or when the voices might change.

An airman in her late-20s who initially came in as she perceived she was being treated poorly by others in the work place. She had volunteered for the deployment. She was very invested in the mission, doing her job meant a tremendous amount to her and in her mind working hard off-set some perceived failures in her past. It took me a while to appreciate all the contributors to her situation. It was true she was on the receiving end of insensitive comments. However, it was also true she was rather socially inept and mostly "did not get" subtle feedback. Hence her coworkers had become increasing blunt in their comments to her. One of her supervisors was quite clear in his opinion she needed to be sent home as she was more of a hassle than a help. Over the course of many weeks and more detailed discussion with some of her coworkers and other supervisors (with patient permission), we found ways for her better navigate the interpersonal demands of working with others as well as taking better care of herself. The end result was not exactly work-place harmony, but the balance of hassle vs. help shifted in a positive direction.

The immediate reaction to a suicide attempt with a broken shaving razor by a cook was straight-forward: remove the "sharps," get him to medical care, put the now-patient on suicide watch and set the process in motion for a medevac to get him to a facility with inpatient psychiatric services. The less-than-straight-forward part was his coworkers who came together after the suicide attempt: upset, crying, feeling hopeless. Their supervisor came to me. Several of the patient's coworkers had tried to help this troubled young man and were now feeling horrible and asking "What went wrong?" I talked with the supervisor for a time and together we thought carefully about the coworkers, their values, their personalities and outlined a plan to meet as a group.

Although the exact pathway was unclear, the goal of helping that group of food service workers come together as a team was clear. As most of the coworkers were quite religious and attended church together, I asked one of the chaplains to join us. We found a space to meet and gathered the 10-or-so coworkers. The supervisor started off the meeting introducing everyone, the chaplain offered a prayer, and several of the coworkers offered their own prayers. As a group we talked, shed some tears, shared, prayed some more, sang a few hymns.

Over approximately one and half hours, we nudged the conversation toward what would help the group grow together and what might help the young man (who was

still local awaiting a medevac flight). Several of the group floated ideas how to support each other and manage through the rest of the deployment cycle. One of the workers who was closest to the young man wanted to write him a letter explaining what they hoped for him as he got help. This was well received and ended up being a trove of letters the supervisor and the chaplain delivered to the tearful young man before he was bundled off on a flight for additional care.

Deployed life as a psychologist was not just attempting to help other cope with depression or stress. Being a part of a medical team meant many new roles for a psychologist.

At irregular intervals casualties (wounded) were choppered in or driven in; mostly from two or three Army outposts some miles away. At those times, everyone took on additional tasks and were busy for handfuls of hours. Almost everything else in medical stops when medevac choppers are incoming with two or more patients. If there were multiple wounded coming, a call went out for "All Medical." Within minutes dozens of uniformed hands arrived by foot, by Hummers, fire trucks, and pickups with extra personnel ranging from chaplains to off-duty firefighter teams to Special Forces docs and medics. For myself, these events usually meant donning bug-eyed goggles, ear plugs and gloves as part of a team to crouch-run up to the side of the chopper (don't stand up in case the wind shifts and the rotors dip giving you your last haircut down to your cerebellum). To carefully and non-jarringly, off-load litters overflowing with bloody, bandaged soldiers and weighted down with an additional 50–100 lbs of armor, O_2 bottles, IV bags, and portable vitals machines.

We hustled them into the ER where metal stanchions were slid under the litter, and we eased back through the incoming flock of gowned/bespectacled/gloved/bootie-ed medics who swooped in to do dozens of tasks. Someone cuts off uniforms, while others check various pulses, call out vitals, sponge away bloody grit, examine God-made and bomb-made orifices, assess the mental status and responsiveness of the patient, feel along limbs for bony outcroppings and long bone edges, call out for lab tests and X-rays, weave into the throng with bags of blood and fluids, unwrap hasty field bandages oozing blood, and unpack gore-soaked tampons from gaping shrapnel holes (yes, tampons is what many field medics found work very well to pack the holes blasted into flesh).

On average, somewhere around half of wounded were then prepped and intubated for surgery where the surgical team removed bits of metal or gravel from interior flesh, realigned shattered bones, stitched up perforated internal organs, augured in metal pins to hold broken bones straight, grafted in Erector-Set-looking external fixators which held limbs and joints in correct healing position, tied in shunts to reattached severed ends of arteries to keep blood perfusing severely damaged limbs, and surgically finished partial blast amputations. Lots of hard-to-forget cases of young men and women whose life course was violently altered in milliseconds.

I did have an unusual opportunity for a psychologist—a product of being in the right place at the right time, or the wrong place and time depending upon your perspective. Typically the triage team has a photographer snapping pictures to

document traumas, procedures and types of treatment (*pictures showing the faces of patients are removed or edited later for privacy purposes*). The medical photographer was pulled for another task in the ER. As she headed for her new task, she handed me the camera and pointed at the shutter button. After a few what-am-I-doing moments, I started shooting pictures of the action in the ER trying to get those grim-faced, sweat-dripping-down-foreheads medical action shots. As a patient was being prepped for surgery, the surgeon saw me with the camera, "you're photographing today? Be in the OR in 5 minutes."

Initially I thought I should hand off the camera, but reminded myself where else would I get an opportunity to witness first-hand trauma surgery. Somehow I convinced myself I could do this without passing out or vomiting. Someone helped me find booties, hat, surgical smocks, and gloves and into the OR I went. I was a fly-on-the-wall observing the surgeons, anesthesiologist, OR nurse and surgical tech. This type of surgery is not exactly gentle—it's tense, bloody, pokey, proddy, messy, and gloppy. The surgeons abruptly changed tactics as they began to appreciate the depth the damage, with intense discussions of the dynamics of patient's status all the while continuing to dissect and prune away damaged tissue, pump in fluids, call for lab work and bark medical short-hand and terminology I only vaguely understood. What I clearly understood was the weight of responsibility the team felt, in spite of minor differences of opinion, in keeping this man alive while he see-sawed between medical stability and body systems shutdown. Some 60 min later, they got the patient moderately stabilized and "packaged up" for his medevac flight to a larger facility. I did make it through to the bloody end of the surgery, with the help of some deep breathing and having a job to focus on. I even helped mopping up of the pools of drying blood under the OR table and the bloody boot prints coloring the most frequent pathways through the OR.

We also had the opportunity to attend the too many memorial services for Army troops. Medical is included as we often have had a part in the final moments of the deceased's life. The basic format of Army memorial services is spelled out by tradition. Everyone comes early and sits solemnly while music quietly plays. The DVs (distinguished visitors) (Colonels, sometimes Generals, one or two representatives of local Allied forces) come in last.

Centered in the front on a small platform, is one or two or three pairs empty boots, rifle(s) propped up vertically, muzzle end down, helmet(s) capping the butt end of the weapon and the deceased's dog tags dangling from the trigger guard. The four items which are never far from a soldier. Generally a Chaplain starts the service with a few words of welcome. A fellow soldier reads a brief biography of a brief life. A handful of the deceased's brothers-in-arms read prepared talks generally focused on the deceased's qualities and accomplishments, then a few gently told stories highlighting their humanness, such as the now-dead soldier who several months previously had been bitten by a spider while he was sleeping. It was not medically serious, but did swell some and create a small abscess. His buddy told him that type of spider was very territorial, was aggressive and was obviously living in his CHU (trailer). Reportedly, the soldier spent his entire off-day, moving everything out of his CHU, shaking, inspecting, sweeping, cleaning, painting, and chalking all the seams. The

crowd quietly loves these little stories of jokes successfully played on each other, these macho stories of kinship and band-of-brothers love.

The company commander offers a remembrance and eulogy—once in the form of a letter written to the deceased's 3-year-old son. A now fatherless son who would grow up knowing his father treasured being a dad, all his warrior buddies knew about love for his son and that his father was honored soldier who died doing his job to protect his brothers. Sometimes there is a musical number. Some among these hundreds of grim-faced, burly soldiers had surprisingly beautiful and soulful voices. Then a 21-gun salute and the playing of taps. Then the deceased's 1st Sgt stands and begins roll call: "Alpha company … 2nd platoon … Roll Call." As the last names ring out, a soldier stands and barks back "Here 1st Sgt." When the 1st Sgt reads the deceased's name, there is a long silence. Again the 1st Sgt calls out the missing soldier's rank and name. Again silence. And a final third time, with clear enunciation and in measured tones the decedent's rank and full name rings out. Followed by … a long silence and a trickle of tears.

The ceremony ends with the DVs slowly marching up in rows of three or four, standing for a moment heads bowed, sometimes reaching out to briefly grasp the dead man's dog tags or lay a hand on his helmet. Then they come to attention, offer a slow measured salute, execute a careful right or left face and slowly march away. This process continues for up to an hour in near absolute silence as three or four or five at a time come forward and friends and company mates salute each final sacrifice.

There are also some funny times in the midst of blood and near-death … like the massive soldier who came in with both arms broken/crushed during a vehicle rollover. He was rumbling with pain as the medics poked and prodded to find out where he still had feeling and circulation. When they rolled him on his side to assess his back, his groin cover fell off and the female doc said "Ok, folks, let's keep his dignity covered" and he was able to joke in his deep baritone "It's OK … (groan) … I know it's small … I ain't ashamed." Later 6–7 people tried unsuccessfully to lift him off the litter to get X-ray film sleeves underneath him. He finally said "I can do it … just tell me when" and he did, jack-knifing his mid-section a few inches off the creaking stretcher while the techs levered the film trays underneath him.

Of course, mental health workers are not immune to stressors, or to their own reactions to austere conditions. In fact, mental health folks along with those in other helping professions are vulnerable to "I'm Superman/Superwoman" or work-a-holic attitudes. Then all-too-often the military loses an entirely exhausted provider who exits at next opportunity.

For myself, coping took several forms: an endlessly supportive and independent spouse, a sense of helping others at least some of the time, the semi-meditative process of low-intensity long cardio workouts, alone time or "escape" time (reading, movies and ping-pong even if we played on warped and chipped tables), having a personal project to work on (e.g., professional studies) and relationships.

This latter one is tricky. One needs connection to others, but at the same time, as a mental health worker one has to be aware this-or-that work colleague could be your next patient. Balancing these needs can be done many ways. The first month or so of deployment is filled with subtle jockeying of various group dynamics as the

group settles into a work unit—an ebb-and-flow which would fascinate Yalom [1] and other group process thinkers. To me, those first weeks are a time to maintain a polite friendly distance while social alliances form and settle. Perhaps just my view, but being strongly associated with one or another "clique" can hinder mental health work and being seen as somewhat independent from this or that social group can be helpful.

For myself, I tried to have numerous "having fun" acquaintances, a handful of selected closer relationships, and a few "buddies." The latter were usually one of the chaplains. Chaplains typically outnumber the mental health providers. Amongst that group of men and women was always one whose life perspective, but not necessarily faith and spiritual viewpoint, was comfortably close to my own.

Another relationship theme which some dealt with admirably and others miserably is the aspect of everyone-being-in-everyone's business. Not surprisingly, the intensity of working/sleeping/eating/ joking/showering/ toileting in close quarters for months on end with no means of escaping or relaxing for an evening or weekend results in people talking, wondering and rumor-mongering. In addition, in some ways, work interactions become much more sexualized than in work environments at home stations. I suppose in large part this is because whatever perfectly healthy sexual relationships or other tension-reducers one previously had, those are unavailable while deployed.

This sexualized aspect was variously experienced as ranging from "high school hormones raging all over" to "we're gonna die anyway so let's have a bit of fun" to a true family sense of being "brothers and sisters in arms." Inevitably male–female relationships of any type receive a lot of comment and attention—deserved or not. There were always a small percentage who had difficulties appropriately coping with and managing those drives. Some coped poorly and engaged in outlets which hurt families and loved ones far more than being separated for months. Some coped by becoming the morale "police", with the lofty goal of vigorously stamping out any possible iota of bawdy behavior.

Personal opinions ranged from "even if nothing was going on one should always avoid the appearance of XYZ" to "it doesn't matter whether they were or not, they're adults, it's no one's business." As with many real life situations, in my view, there are no simple answers. Except that mental health care givers need to work extra hard to manage this side of their reactions because the perception of an "infidelity," real or not, deserved or not, spreads like fire in drought and shuts down the motivations of individuals seeking care.

In the end, what did I learn? The primary driver of human beings is relationships. We fight, we love, we work, we sacrifice … mostly because we think, we feel, it will is either our responsibility or will benefit our connection to another human being.

Given a choice would I do it again? I have thought about that question many times since 9/11. Some days I would and along the journey, I would try to worry less and appreciate more. Other days, I think I would go back in time, put more late-night hours into Engineering 101 and make sure I passed the damn course.

Reference

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Dr. Layne D. Bennion is a retired USAF psychology/neuropsychologist. This chapter combines events and experiences from three deployments: Diego Garcia, 2001 into 2002; Iraq, 2003–2004; and again in Iraq, 2006–2007. All deployments were in multiservice settings.

Someone Always Has It Worse: The Convoy to Balad

3

Robert D. Forsten

There is an unwritten rule in the Army: "If you think you have it bad, there is always someone somewhere that has it worse." Usually, that person in the Army has a combat arms background (Infantry, Armor, Special Forces). Most of these volunteers love what they do and would have it no other way. It was and still is an honor to support them medically, and I have the utmost respect for these front-line fighters; they have earned it a hundred times over in the last 15 years. I certainly don't mean to belittle them in the text that follows nor do I wish to make light of those who made the ultimate sacrifice in Iraq or those that came home with physical or mental wounds they will carry for the remainder of their lives. But I tend to see humor as a great defense or coping mechanism when dealing with stress and in doing so, believe it builds resilience.

There is a saying that war is 90 % boredom and 10 % sheer terror. I think those that closely served with me in a Combat Support Hospital during this deployment would agree that our ratio was closer to 70 % boredom, and 30 % humor, even during those brief times of terror secondary to mostly rocket or mortar attacks. Humor helped to cope with the boredom, frustration, and suffering and, in my opinion, was the glue that held us together as a team. This chapter will cover the weeks leading up to deployment into Iraq, from Fort Hood, Texas, to Camp Victory in Kuwait, to the four-day convoy to Balad, Iraq, about 40 miles North of Baghdad.

Looking back, the initial few months of the deployment was tough at times but not too difficult. More tests of hard times were in my future. However, my progression toward enlightenment on the point that "someone always had it worse" started at Darnell Army Community Hospital at Fort Hood, Texas. I was the Chief of

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Outpatient Psychiatry. It was an impressive sounding title, but I was the most junior officer on the department medical staff.

The work was slow, and uninteresting compared to my previous 2 years assigned as the Division Psychiatrist to the first Cavalry Division. Most of the soldiers that came into the outpatient clinic at Darnall during this time were related to morale issues or anxiety to the upcoming deployment.

There were a lot of soldiers transitioning through Fort Hood at the time since it was 2003, and we were going to Iraq. The Department Chief approached me in February 2003 and asked me if I wanted to volunteer to deploy with the 21st Combat Support Hospital (CSH). This unit would be built around a core of locally assigned medical staff, but would pull staff from military hospitals all around the country using the professional filler system, or PROFIS.

My wife was six months pregnant with our third child, which gave me some pause, but I selfishly jumped at the chance to deploy. And I will add that barring capture (death or injury never crossed my mind), I suspected my deployment would be easier for me than her staying home with a newborn and two toddlers ages 1 and 2 (I was right). My major reference point for what this deployment would look like was the short Gulf War in 1991, and I figured it would not be more than 6 months. I had previously completed a training rotation with the unit I was assigned to with the First Cavalry Division at the National Training Center (NTC). NTC is located at Fort Irwin, California, in the middle of the Mojave Desert. It was dry, hot and austere preparation for what we faced in Iraq.

I spent the 90s in a psychiatry internship, residency and fellowship; thus I was not permitted to deploy while in training status. My first assignment out of training was with the First Cavalry Division in 2000, and that unit did not deploy to Afghanistan. I expected Iraq might be my only opportunity to deploy, and I did not want to be that soldier who spent his entire career practicing for the big game but never getting in the game. I firmly believed that the USA would not be involved in either country for too long, and wanted to do my part in service.

The CSH did some training at Fort Hood, familiarizing ourselves with weapons, chemical/biological equipment, etc. I had qualified as an expert shot with the M16 rifle and M9 pistol with previous units, but I wasn't assigned a weapon. At the time, Army policy stated that only 70 % of medical personnel were required to be armed when deployed. I wasn't too upset, if it came down to doctors and nurses needing actually to fire at an enemy combatant, there would be plenty of weapons lying around. Additionally, I thought about accountability for that weapon 24/7. Not having a weapon in combat could end my life, but losing one could end my career. I gambled with the latter and took the same attitude in a future deployment. I would not make the same choice if I ever deploy again, but that decision is based on better training and familiarization I later received while serving in another unit.

We were warned that we would not have cots once we arrived in Kuwait, secondary to a change of plans in the overall unit deployment orders. All our equipment was to be routed through a particular country, and that changed unexpectedly at the last minute. These things happen and it was no fault of the command or supply (it helps to take this attitude, and better to laugh than get angry) so I purchased and duct

taped a cot to the side of my duffle bag. There would be things crawling on the ground in the desert that would be attracted to my body heat.

My cot became an issue of both admiration and contention when we arrived in Kuwait. As advertised, there were no other sleeping options but the ground for the 76 other souls with whom I shared a tent. The extra space my bed occupied was resented by a few, but I'd always been a light sleeper, so I wasn't about to give it up and face the constant barrage of coughing (or feet) in my face all through the night.

The coughing was an epidemic in Kuwait. The ever-present dust from the desert storms blasted into the tent, fouling both lungs and equipment, every time someone was foolish enough to open the door. Viruses also spread rampantly. Outside it was 110 °F, but overly enthusiastic air conditioners kept the temperatures inside at near freezing.

The cold ate at me at night. I had brought only a thin green sleeping bag rather than the winter black shell we were also issued. Back at Fort Hood, the thicker material had seemed an undue burden to carry to the scorching desert. After all, we weren't even supposed to be there for the winter. It was going to be a short war, and my deployment orders ended in 179 days (I learned later that the Army could always change or extend orders). And it was much colder in the winter.

The solution to the frigid tent came in the form of a horse blanket bought from a local Kuwaiti. It smelled like a stable, but at least it was warm. In retrospect, I could have broken out the polypro long underwear that lurked at the bottom of my duffle bag. At the time, apathy was a stronger force than the cold.

My resolve was weakened not only by the sand and the extremes of temperature but also by the acclimatization illness. This came in the form of a cough, sore throat, fever, headache, dizziness, fatigue, joint pain, and diarrhea. The diarrhea was the worst. The constant call of nature meant I had to endure the mental anguish of visiting the "blue room," as we called the portable toilet made of blue plastic. Unless caught immediately after a visit from the SST (Sh-Sucking Truck), the blue room was the nightmare of any obsessive compulsive. Once, on one of my 5–6 daily runs, I entered only to find that someone, presumably with a passive-aggressive personality, had defecated in the urinal. Given the angle of approach required for such a feat, the individual must have been a gymnast or contortionist before joining the military. Anger and frustration can lead to some amazing acts.

Given the level of morale at the base, I did surprisingly little work as a psychiatrist while in Kuwait. This troubled me, as I didn't want to lose my skills. I tried to advertise my presence, and eventually, word got out to units around us that a psychiatrist was available "a few tents over." Soldiers in our unit or others that had trouble adjusting would meet with to me, usually brought by a senior enlisted supervisor who had noticed something was wrong. I would talk with these soldiers sitting in the sand. At the end of our talks, I'd write up a brief note, give it to them, and instruct them to place it in their medical record. Even if they had to wait until they redeployed, I stressed the importance of keeping that note in case there were any problems later during the deployment or after deployment back home.

There were rare occasions when more serious work was necessary. I had several unit commanders approach me to evaluate one of their soldiers who had said

something about killing himself or someone else. Again, the soldier and I would sit in the sand and talk. I ended up sending one man to a larger medical hospital for further evaluation, but all others went back to their units.

Some psychiatrists in this position tended to order a weapon or firing pin be temporarily removed. Others would instruct that a watch be set on the soldier until everyone was sure that the situation had calmed down. My personal and professional belief was that neither the unit nor the soldier needed that burden. It would only make things worse. If something concerned me enough that I didn't entirely feel comfortable sending a soldier back unmonitored, I would talk to the unit chaplain, and ensure they checked in each day. But ultimately I felt that it was my duty to make that decision. I was the expert and had an outstanding military residency training program that prepared me to make that call, in addition to 2 years' experience and training with the First Cavalry Division.

Sometimes schedules were flexible, and I could have the soldier come back and see me for what resembled regular appointments. They were good kids, and I figured I could talk to them about their issues, and help them work on personality traits that didn't adapt so well to the desert. Often these soldiers would suddenly disappear from our impromptu counseling. Sometimes, they lost interest, but more often I found that they had deployed north to Iraq with their unit.

Despite the malaise and lack of purpose, my obsessive compulsive nature was not entirely defeated. To the amusement of my tent mates, every morning I would neatly roll up my sleeping bag, bedroll, and horse blanket. Each night these would be carefully unfolded and arranged on my cot. Most of my friends had forsaken even basic hygiene, and questioned this ritual with a simple "why bother?" But the dust continued to pile in, and I didn't see the ability to do laundry coming anytime soon. A simple fix was to issue a bucket for washing that fit snugly into the bottom of each duffle bag with the huge assumption there would be water in the desert.

Even as I started to recover from my sickness, the hacking of my tent mates continued to keep me up at night. Thus, fatigue was terrible during the day. The camp opened up a dining facility (DFAC) after our second week in Kuwait, but it was a half-mile away. Just to walk 100 yards in the sand was an effort. I ate infrequently. Gym equipment helped quite a bit with morale but we didn't bring enough and the stuff we did have was broken or outdated. Between sickness, fatigue, not eating, and not exercising, I lost close to 20 lbs while waiting in Kuwait.

Small luxuries provided greater motivation and improved morale. We had a small military store, a Post Exchange or PX, open shortly after the DFAC. Our oral surgeon talked me into waiting in line with him to see what could be bought. We shuffled to the end of the line. It had not seemed that long, but after a long wait, we had moved forward only about 10 ft. I asked the guys in front of us how long they were waiting. They said they were where we were an hour ago. I left and went back to our tent.

Returning from the frustration of failed consumerism, I was struck for neither the first nor last time by that Army rule about someone having it worse. Two soldiers from an armored cavalry regiment (ACR) had come into our tent looking for our first sergeant. They had been told he could get them some water. Each of the ACR

soldiers was laden with a large amount of gear and weapons. As they stood in what I thought of as our dismal tent, the look on their faces was one of awe. There was a longing in their eyes, similar to what I felt when I saw Air Force jets flying over returning to Kuwait.

"This must be the easy life," one of them said.
"Air conditioning in the desert," said the other.
"And I think I saw a DFAC out there."
"No sh—. And a PX."

We offered them an air conditioner to go with their supplies as they left. Cold air in the tent was something of which we had an over-abundance. But they had no way to run it. Air conditioners might be plentiful, but the generators to run them were rarer, and harder to transport.

Having failed again to help, the apathy was as contagious as the coughing in our tent. When the power went out one day, everyone assumed that someone else would fix it. When nothing changed by nightfall, instead of any of us taking the initiative to look into the problem, we pulled out flashlights, or just rolled over early to bed. After a short time, the apathy started to weigh on our tent in quite a literal way. The sand had built up during storms, and the side supports were bowed in precariously. One more storm would probably have collapsed our home, but we stubbornly refused to do anything.

We had a good team of surgeons with us, and we all knew that the trauma team would be essential once we started moving across the border. Unfortunately, the necessary surgical equipment that had come to us in MILVANS, the 20 by 40-ft containers the Army uses for transport, hadn't been properly blocked or braced. Operating tables and scalpels were strewn everywhere, as was medical equipment for other specialties. As a psychiatrist, I didn't need much to do my job, but if our mobile hospital was going to treat bullet wounds and bleeding, we needed to get the equipment organized to survive the trip into Iraq.

We sorted and packed equipment, and threw out the trash. It was grueling work in the desert heat, but it felt useful. We started smiling at each other, feeling like a team. Doctors, nurses, physical therapists, and techs, we were all pulling our weight. We were laying the groundwork that would be needed when the invasion began.

I walked back from this work feeling better than I had since arriving when a Humvee started to pass. I flagged it down, and they offered a ride.

"Where are you headed," I asked.
"Arifjan," answered the unit's supply captain, speaking of the base in Kuwait that housed the other U.S. military services, the Marines, Navy, Air Force, and even Coast Guard.

I noticed that there were only two passengers in the vehicle other than myself. It seemed less cramped than the tent to which I would otherwise return.

"Hey captain, you mind if I go with you?" I called out over the rumble of the engine.
"Why?"

"To add a little extra security to your convoy."
"Do you have a weapon?"
"No, but I can get one," I said while thinking, where can I get a weapon?
The driver shrugged. "I don't care, as long as it's all right with the acting commander."
"I'll see," I said.

Our executive officer, or XO, typically second in command, was acting commander at the time. He was also a friend from Fort Hood. I explained the situation and requested to go.

"I don't care, just let the chief doc know," the XO said with the contempt of a man who has to stay behind and run the unit.

One problem down, one more to go. I made a beeline for one of my new friends, a surgeon that I saw with an M9 pistol earlier. I asked him for his weapon.

"Here you go. Have fun," he said, handing over the pistol and a ten round clip without even asking why I needed it. Some would think this unprofessional as a soldier and typical of medical personnel. That is entirely not the case. After closely working and living together for weeks, we trusted each other, knew strengths and weaknesses, and this trust would be extended to most, if not all, of the unit's medical officers at this point and throughout the deployment.

I holstered the weapon and ran back out to the Humvee.
"Ready to go," I said, jumping into the back seat.
The captain looked in the rear view mirror and tapped his head.
"Helmet?" the passenger next to me explained.
"Oh crap, wait up" I exclaimed. I was so excited to finally do something my brain was not working properly (perhaps that's how people get hurt in combat, OCD can be a good thing). I made another dash back for the tent while the entire convoy waited thinking, "Who was this screwed up major?" The captain and I became good friends for the next 11 months.

The moral of this story is one of many throughout my experience and career. Relationships mean everything in the Army and can make or break an individual, unit, or mission. That remains true today at every level from tactical, operational, and even more importantly, strategic. Even though we all went our separate ways after returning, I would make friends in this unit that I am still close with today.

Armed, and my skull protected by Kevlar, we finally moved on. It was my first time leaving the gate of Camp Victory since arriving in Kuwait. We rumbled through the desert toward new adventures.

Our first stop was Port LSA Spearhead. The temperature dropped 10–15 °F, down into the almost bearable 90s as we approach the sea. You could smell the salt in the air. Ships were unloading an incredible volume of military equipment: tanks and Humvees, rifles and bullets, plus the tons upon tons of basic supplies that are necessary to keep an Army marching on its stomach.

The CPT moved toward the vast line of vehicles to try and wrangle some transport options for our unit. I walked around and noticed they had trailer bathrooms

and showers. Porcelain toilets here, the height of luxury, much better than our tents in the sand (I would not see a porcelain toilet for 11 months in Iraq). Outside the bathrooms, I noticed a Navy officer crouching over what looked to be a giant spider, 5 in. long and the color of the sand. It raised its mandibles threateningly.

> "What the heck is that?" I asked.
>
> "Darn if I know," he said picking up the creature with a water bottle cut in half. "It has ten legs. Spiders are only supposed to have eight."

It turned out the officer was an entomologist. Dealing with the local bugs is a surprisingly important part of any invasion plan. He told me this creature was a camel spider, which is more closely related to scorpions than spiders. They aren't poisonous but are vicious hunters. Camel spiders use their four, powerful mandibles to tear apart small prey, and they have a large tail that mimics a real scorpion and can scare off larger creatures. They will also fight to the death if two of them are put together. Or so I was told; never tested that idea.

That night, in the tent with my new bunk mates, I scooped up another of the camel spiders that was looking to join us. I repeated the entomologist's lecture, which made me the celebrity spider-expert of the evening. Several soldiers seemed particularly taken with the idea of camel-spider fights, and went off to look for potential gladiators. I wondered what I might have started. Another rule I learned early on is that soldiers do a lot of stupid stuff to fight boredom. In some cases, this leads to a lot of pain and sometimes, unfortunately, death. My comrades and I were lucky during this deployment.

We drove from the port to finish our journey toward Camp Arifjan. We pulled into a field hospital set up in a warehouse on the center of the base. We dropped off some medical equipment then headed to a huge dining facility. At least 2000 soldiers, sailors, airman, and marines sat down to have dinner. The food was plentiful, and I ate like a prisoner at his last meal.

After dinner, it was time to turn back and convoy through the starry desert to Camp Victory. As we headed out, I again put on my helmet and checked the firearm at my side. I noticed that the troops we have encountered along the way were wearing soft caps rather than helmets. Most of them neglected to even carry their gasmasks. Not that I ever thought I was in any danger, I just tried to follow the rules. If someone in charge said we were allowed to walk around in shorts and flip-flops, I would have complied.

I checked back in at my medical unit when I returned to Camp Victory. The chief hospital physician said things had been slow. He mentioned receiving a call from Kandahar Airfield in Afghanistan asking if any of our medical personnel wanted to relieve the staff there. The response was a simple, "No." They called the following day again, and we answered with added expletives. We still hadn't done anything in this war, had started some bonding in the unit, and didn't want to start all over with another unit in a different country.

Of course, for us, the war hadn't started. All we had been doing was preparing, and waiting. Then the word came down. We were moving north. I packed everything

into one duffle bag (with cot duck taped to it) and rucksack in preparation to leave for Baghdad on Easter Sunday.

The holiday came and went. We packed, and unpacked, and packed again. The mission changed with the baggage. The cycle of waiting and not knowing wore upon morale, but we were excited. We were finally going on the adventure we anticipated when joining the Army.

In 2003, there were only two ways to get troops to Baghdad: aircraft, or riding in the open beds of huge 5-ton military trucks. The Army hadn't yet started to install armor on these vehicles, and mine-resistant transport was still years away. I was displeased the choice turned out to be by truck (better than walking, think of our troops during the civil war). I had already turned my only weapon back over to the surgeon. Our chief nurse spoke for all of us when bringing up the point at headquarters that medical staff in unhardened (no armor) vehicles presented an easy target for Iraqis who wanted to go "hunting for Americans." The response from our higher command did little to improve our anxiety, but looking back, I know our commanders were extremely busy and probably working on 3–4 hours of sleep a night for weeks. But in potential life or death situations, it is better to spend a few minutes to explain what is going on and why; this builds team trust and increases morale. To this day, I don't sweat the small stuff, but I do tend to get a little more vocal where safety is concerned.

We awoke before 4:00 am for our convoy out of Camp Victory. When our tent of 50 men was up and ready to move, we looked out to a strange absence of activity. It turned out that our start time had been changed from 4 to 6.30. Hurry up and wait.

At 10:00 am, we finally rolled out of Camp Victory. Our convoy consisted of one wrecker, one Humvee, and six trucks, each loaded with 17 men. The vehicles were uncovered, so the heat of the sun beat down on us without mercy. To prevent malaria, we were all taking doxycycline tablets, but an unfortunate side effect of this medication is that it increases sensitivity to the sun (leading to sunburn). We had the choice of turning to lobsters or covering head to toe. I wore gloves, masks, and a helmet in 100 °F heat. Dust and diesel fumes added to the discomfort.

We tried to track our progress as we went, but those of us in the back of vehicles lacked an official map or military GPS. (I brought a civilian GPS, which helped us a day later when lost and helped me navigate a convoy from Balad to Kuwait, first becoming lost in Baghdad). I found a copy of Newsweek that had a reasonably detailed map of the major points of interest in Iraq and used this to try and match our position to the border crossing, fueling stops, and other identifiable landmarks on our journey. I'm pretty sure we crossed the Iraq border at Umm Qasr, a port city in southern Iraq that connects to Kuwait by a bridge across a small inlet. The US civilian contractor pumping gas on the boarder before we crossed into Iraq said he was being paid close to a hundred thousand dollars for 6 months. I don't know if that was true, but if it was, he earned every penny. At the time, I thought that must have been the hottest, busiest, and most dangerous place in the world. I couldn't imagine a worse place to be. Of course, we weren't in Iraq yet.

Crossing the border, the first thing I noticed was a large fence with concertina wire and deep pits (I assume were tank traps) that stretched as far as the eye could

see. There was nothing on the Kuwaiti side of the border: no houses, people, or animals, just sand. On the Iraq side, however, just past the tank traps were little farms with a few scraggly animals. People came out of their little mud houses to see us pass.

Stark reality here that someone always has it worse than you. We had complained about being deployed to the armpit of the world, but we drove on. These people stayed. A 2-year-old child stood at the side of the highway looking at us. He was soon joined by other young children, all coming dangerously close to our oversized wheels. No adult seemed to care.

Some of the children were begging for food. We had been warned not to give them anything. It wasn't that we didn't want to, but items thrown from a truck sometimes were sucked back in by the wind. Children paying no heed to anything but their hunger would run directly into the path of the convoy, and the drivers had been told not to stop for anything.

Luckily these orders weren't always obeyed. A veteran of the Gulf War was driving our truck. A child lay down in the road in front of us, clambering for something. A senior enlisted sergeant told him not to stop, and he replied, "F–k that, I'm not running over a kid." Ethical issue solved.

As we progressed deeper into Iraq, the number of children increased. There were hundreds, and they were now joined by adults who were trying not only to get food but also to sell us their Iraqi dinars for a few bills of currency that didn't include the face of the disposed Saddam Husain. It was no wonder that the people had never risen against him. They were struggling too hard just to survive. And I'm not going to go into how Saddam treated the Shia population in Southern Iraq after the first Gulf War, but he killed them by the thousands.

The children continued to approach, barefooted and walking on tar heated to 150 °F. They would offer wads of the worthless Iraqi currency, repeating over and over again "dollars." One private in our unit leaned down and exchanged four dollars for five hundred dinars. He thought he had gotten a good deal until he discovered others that had gotten five to six thousand dinars per dollar. I tried to cheer him up by telling him that it may be worth something if he passed it along to his family for the next 150 years.

The carnival atmosphere of our slow trek toward Baghdad was altered one day when a kid, as innocent looking like all the others, approached and suddenly threw something into the truck. A black cylinder, about 4 in. long, covered in electrical tape, and with what looked like a fuse on one end landed directly between a private first class and me. This might have been a probe to see how we would react.

Our reaction was the private and I exchanging a sudden wide-eyed look, and a "Holy sh–!" but then the apparent dynamite bounced harmlessly out behind us. We waited for an explosion, but it never came. The kid who had thrown it was lost in the mass of children just looking for food.

We tried to be more careful after that. We didn't run over anyone, but we also didn't exchange any more currency. The convoy just rumbled on, as did we. The closer we moved North, the more destruction we encountered. I stopped counting the smoking Iraqi T-72 tanks and armored personnel vehicles; there were so many.

We suffered, and complained, and knew that there were those who had it much, much worse. But when soldiers complained, you knew they were ok; it's when they stopped complaining that you needed to worry about them.

We were lost outside of Nasirayi on the second night of the convoy. Getting lost in a combat zone is never a good thing. Then one of the unit's large trucks got stuck in the sand when we attempted to turn the convoy around. We all dismounted and moved into the surrounding fields to maintain security. About 500 m in front of us there was tracer fire from what were assumed to be AK-47s. We didn't know if it was a battle or celebratory fire but this was the same area where a maintenance unit was ambushed about 3 weeks prior after getting lost. So we are all out in this field, and I noticed the dried hard-packed mud was of the perfect consistency for throwing dirt bombs like we all did as kids. Lying on stomachs, I'm reaching up and chucking dirt bombs at the helmet of an internist doc, and friend, next to me. After the third or fourth of these hitting his helmet with a nice "thwack," he tells me to stop and annoyingly asked me what the hell I was doing. I responded, "I'm zeroing my weapon." This triggered a muffled laugh. For a very brief time, we medical personnel were those that had it worse than most others. We became even closer friends after that, and the two of us would routinely use humor to mold our group of medical professionals to help us survive the rest of the deployment (and to fight boredom, we would usually volunteer for any mission that broke up the routine of the week). We all left that field, attempting to retrace our footsteps after our chief nurse discovered unexploded ordnance in the area in which we were all sitting. But we got the truck unstuck and fortunately found our way back to the right route (our operations officer, or S3, sought me out after learning that I had a GPS).

We always found a way to get "unstuck" from situations, that's what good teams do. We were fortunate in a lot of ways over the next 11 months. I attribute that to leadership and luck. A good military leader will acknowledge the latter after a successful command tour, especially in combat. Some say that units who train harder make their own luck. I agree to an extent. We never lost a soldier, nor could I recall even one serious injury but I tend only to remember the positive aspects. This is what some today call traumatic growth. It was still two more days to get to Balad and what would eventually be our home for the next 11 months. The CSH saved many lives and reduced a lot of suffering during that time. Coming together as a team helped us conduct our mission, and that bond we shared was built with humor, and never taking ourselves too seriously unless it involved life, limb, or eyesight. We knew there were a lot of Soldiers out there in worse places counting on us.

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Psychiatrists in Combat: From the Deckplates to Division

4

Kevin D. Moore

As the First Marine Division (1st MARDIV) approached Baghdad, Iraq, I was assigned to the Reportable Incident Assessment Team (RIAT). This team, prototyped by 1st MARDIV Commanding General (CG), General Mattis, could be task organized to investigate any alleged or potential incidents that may be perceived as a war crime. We had been asked to investigate a reported Red Crescent ambulance that had been shot by US forces. Membership for this assignment included Division Staff representatives from Civil Affairs, Staff Judge Advocate (SJA), and Surgeon.

We entered the city far ahead of the main command headquarters. The scene was complete chaos. Dead, injured, damaged buildings, along with looting and lines of people trying to evacuate were everywhere. There was no means of communication between the two unarmored Humvees transporting us. Armed with several M9 pistols, a few M16s, and a couple of shotguns that had been acquired en route, we used maps to find grid locations. Navigation was not easy, because GPS devices were in limited supply.

Unable to find the location during the day and becoming too dangerous to remain outside unprotected, we pulled into the United Nations compound as night fell. When I sat down to an MRE, I suddenly noticed lights above me. I quickly realized these were actually tracer rounds from incoming gunfire and immediately took cover. A group of Marines came to inform me that someone was down. They needed "the Doc."

I arrived on scene with two Corpsmen beside me. A Marine had been shot. The Corpsmen had done the initial assessment and stopped the bleeding, but the patient needed medical evacuation (MEDEVAC). When the firefight stopped, the patient was sent in a Humvee for pick up by helicopter, but his MEDEVAC flight never arrived. The Marine looked at me when he got back to the compound and said, "Doc, please don't send me out there again. They will kill me this time." We kept

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him until daybreak for MEDEVAC, and the team left the compound to continue our search of the ambulance. Our actions later qualified for the Combat Action Ribbon (CAR).

The Reportable Incident Assessment Team was eventually able to locate the Iraqi vehicle that had been shot. It was not an ambulance after all. While being guarded by armed security, I entered the disabled vehicle to examine the three dead men that had been shot. A review of video footage revealed that they had run up behind an armed convoy and refused to back off. The shooting appeared justified, but it was still a sad, tragic reminder of the victims of war.

4.1 Why Did I Join The Military?

People tend to join the military either because they had a father who was "too good" (or overbearing), and they want to keep one into adulthood, or because they had a father that was "too bad" (or absent), and they hope to find a better one. My dad was both.

I was raised a "military brat," adopted by a US Navy Chief Petty Officer. He retired from active duty when I was in the seventh grade. A decorated combat veteran, who joined the Navy when he was only 17 years old, he had served in World War II and Vietnam. He had lost half of his crew when his carrier, the USS BUNKER HILL, was struck in its main flight deck by two kamikazes in WWII.

Throughout my childhood, my father would deploy for many months at a time. I never understood why he would choose to be away from his family so much for so long. He said that he loved "being underway and part of a team." I think he simply loved being in the Navy. He was proud to serve his country and to wear the uniform. Welcoming back his returning ships and attending award ceremonies as a child, I remember being very proud of him.

Retiring to his home state of Kentucky, my father often seemed frustrated and unhappy after leaving the Navy. He was still a Navy Chief even after he hung up his military uniform. I had missed him while growing up, and I had wanted him to not leave home again, but I had trouble connecting with him.

His salty advice seemed crude. "Opinions are like assholes, everyone has one." "You all are like a bunch of sea gulls. All you do is eat, shit, and squawk." Where did he learn all this? I could not help but wonder, did he ever miss me when he was gone?

One day, at the ripe age of 16, while watching a documentary on television about Vietnam, I proudly announced to my father that I didn't understand why it was such a big deal to be a conscientious objector. I told him that if I didn't believe in a war, I would probably think of doing the same as they had. Why would I go to a war I didn't support? He flatly replied, "Get the hell out of my house!" Even with the hubris of youth, I knew that was not the time to debate.

I became the first in my family to attend college, attending Western Kentucky University (WKU) on a War Orphan's Scholarship. Since my father had received 100 % service connected disability through the Veterans Administration, I qualified.

Not knowing much about majors or degrees, I took courses that interested me. When I ended up at the top of my classes, I was encouraged to consider "premed." I completed my undergrad with two degrees in 4 years, a Bachelor of Arts in Psychology and Biophysics along with Bachelor of Science in Biology and Chemistry.

Although I was accepted early decision to University of Kentucky, I was not sure how I would pay for medical school. I applied and was selected for the Navy Health Professions Scholarship Program (HPSP). If accepted, it would obligate me to 4 years of active duty service after completion of training. Student loans were my other option.

My father had not appeared very supportive of me becoming a doctor. He once asked, "Why would you want to be in school all your life to have a job where your mistakes were dead people?" When I asked my father if I should take the HPSP scholarship, he told me, "The Navy was good to me, son. Now that you are a man, you will have to make that decision for yourself."

I decided to join the Navy. My dad had a hard time concealing his pride when he saw me repeat the oath of a commissioned officer at the Louisville recruiting station.

Never did I plan a career in the Navy. I would do my payback and return to the civilian world. Never did I think of combat deployment. After all, we were not at war in 1982. Nor did I consider deployment with ground forces. I was joining the Navy.

My father told me the best thing about the Navy was, "You have a warm, clean place to sleep every night. If you lose it, you lose everything, not like the poor bastards in the Army or Marines." He spoke from experience at the Deckplates.

4.2 Preparation for Greenside

Dad never mentioned that Navy doctors take care of the Marines. I learned during Officer Indoctrination School (OIS) that the US Marine Corps does not have its own medical officers. They have their own lawyers, but Chaplains and "Docs" are Navy.

During my internship and residency at National Naval Medical Center (NNMC), Bethesda, Maryland, I treated Marines and Sailors, performed disability and limited duty assessments, rotated to The Basic School (TBS), Quantico, Virginia, to gain "Greenside" exposure, and taught at the Uniformed Services University of Health Sciences (USUHS), as a field instructor for the combat stress prevention course.

As chief resident during Desert Storm/Desert Shield (DS/DS) when exposed to all the resulting chaos and emotions exhibited by those chosen and not chosen to deploy, I had started a paper entitled "To Not Be Chosen," exploring parallels with those emotions of not being picked for the first string team on the playground. Those of us left behind could only support those in preparing and returning as well as the others not chosen. The paper was never published.

I saw some staff crying in the hallway when they were notified of impending deployment, upset that they "didn't sign on to go to war." It was now an all-volunteer

force, and many recruiters focused on the low possibility of another conventional war. After all, the Cold War had reinforced the concept of the military being used as a deterrent to a shooting war. If we fired the first shot, we had failed our primary mission. Even though DS/DS would not last long, it marked the return of large-scale deployments and the need to prepare for such.

Most troops had redeployed by the end of my residency. I felt I had missed something. I was looking forward to my first assignment after Graduate Medical Education (GME). I hoped for a clinic in Hawaii, but I was called into the office of my Specialty Leader shortly before the list announcing orders was released. He told me that I was needed as the Division Psychiatrist in Okinawa, Japan. There was not an option to decline.

The Navy and Marine Corps are in the same Department of the Navy. Both are expeditionary, but their cultures, like their uniforms, are profoundly different. Navy personnel have the option of adopting Marine uniform regulations when they are assigned to a Marine unit, but they will never be a Marine, even if the Navy Doc learns to look and talk like one. Translating between Blue and Green can be very difficult.

While the "Division Psych," I provided the clinical services for the Marines and Sailors assigned to the Third Marine Division (3d MARDIV). Since I was the only "operational" psychiatrist for Third Marine Expeditionary Force (III MEF), I became the first choice for the other Marine units in the area. Marines like to take care of their own, but if I could not manage them as outpatients, US Naval Hospital, Okinawa, was available for referral. Pride and pressure resulted in them rarely being used.

After my first year, I complained to my Division Surgeon that I was getting too little operational exposure "baby sitting" the Division in garrison. He was more than happy to accommodate me. Over the next 2 years, I then deployed throughout Asia for battle staff and field exercises. I served as a medical planner on field exercises and performed humanitarian aid on Medical Civic Action/Dental Civic Action (MEDCAP/DENCAP) missions.

I returned for the Military Forensic Psychiatry Fellowship sponsored by Walter Reed Army Medical Center. The first Navy graduate of the program, I was subsequently assigned as the first billeted forensic psychiatrist at NNMC, until I went to the Naval Hospital, Charleston, South Carolina.

When it was time for my next assignment, one of my mentors, who knew I had done well as the Division Psychiatrist, urged me to "put my name in the hat" for the Division Surgeon at 1st MARDIV. I thought it would be a chance to return to the operational arena in a more senior assignment. Besides, I had missed the Marines and their leadership style.

Many criticized my possible return to Division. "Why would you want to go back to the Marines? You are going to be bored. All you're going to do is get ready for exercises. We're not going to do anything. Do you think we are going back to the Middle East? That isn't going to happen. We just got out of there." I applied anyway.

After a series of interviews and waiting several months, I received the congratulatory call from the office of the Medical Officer of the Marine Corps notifying me

of my selection. I asked, "How long do I have to decide if I want to accept?" The voice on the other end went silent. Then I heard, "No one tells the General 'No' after he has made a decision."

I was to detach from Charleston on 11 September 2001. The furniture was gone. Our home of 3 years had been sold. I awoke on an air mattress. Most of the suitcases had been packed into the van for our trip to California. The air mattresses, coffee machine and portable TV were all that remained to be loaded.

Getting up to make one last pot of coffee, I turned on the news to see the planes crashing into the Twin Towers and Pentagon. I knew that the nature of my assignment had instantly changed.

As a result of the attacks on 9/11, all military personnel were frozen in place. Security was increased on all bases. A few days later, as the shock wore off, movement was again authorized. My family and I started our cross-country drive.

I attended Advanced Officer Leadership Training at San Diego, California, prior to reporting to 1st MARDIV in Camp Pendleton, California. Most in the class were headed to new duty stations. All wondered what was next.

4.3 Reporting as Division Surgeon

Division Surgeon is a misnomer. Many assume that this is a surgeon from the operating room, resulting in a quizzical look when a psychiatrist is introduced. Division Surgeon is the senior medical officer for the Ground Combat Element (GCE), the infantry, within a Marine Air Ground Task Force (MAGTF). The Division Surgeon is a special staff officer under the cognizance of the G4, the general staff officer in charge of logistics.

I expected a few comments about being the General's Psychiatrist, but being the Division Surgeon during the preparation for the first invasion of another country in decades would not be an easy role to fill regardless of medical specialty.

The staff of the Division Surgeon was small, in accordance with the expeditionary mission of the Marines. Deploy quickly, stabilize and then go home. Surgeon, Psychiatrist, Medical Administrator, Environmental Health Officer and a few Corpsman were at headquarters, the rest were assigned to battalions and regiments. An Assistant Division Surgeon had been appointed from one of the second year GMOs (General Medical Officers). Like his contemporaries, he had completed his internship and had accepted a tour with the Marines planning to return to his residency program.

4.4 Predeployment

The Russians were "Beaten by the Bugs" in the Middle East (e.g., infectious diseases). We were given Professional Military Education (PME) to review the lessons of their failed occupation. Medical could not let these mistakes be repeated. Preparation would be the key to success.

Pre-deployment focused on readiness, training, and rehearsal. The people and equipment had to be ready. Appropriate training had been given. Everyone had to know what was expected of him or her, and they had to have a chance to rehearse their role. General Staff Planning Conferences developed courses of action from which the CG would build the battle plan. Field exercises would serve as dress rehearsals for the invasion, verifying requirements and identifying necessary changes.

Everyone had to be issued required NBC (Nuclear Biological Chemical) gear. This was a huge logistical exercise. Gas mask, eyeglass inserts, antidotes, and training were only the start. All members required pre-deployment medical and dental screening to make sure they had no limitations.

Drills were modified to deal with anticipated threats. Hikes and runs added Kevlar body armor to gear lists. "Gas Mask Thursdays" forced all members to don their gas masks to understand the claustrophobia and difficulty in performing such mundane tasks as using a phone or talking to an office mate.

Pre-deployment briefs were mandated to familiarize those deploying with what to expect and what was expected. Identified environmental threats were met with preventive measures. Uniforms had to be treated with the insect repellant DEET. The Marines had just adopted the new MARPAT (Marine Pattern) digital camouflage uniform, but if everyone didn't have it, no one could wear it. The result was additional uniforms needing to be treated to repel the bugs.

Medications needed to be obtained and distributed. The choices for malaria prophylaxis were either Tetracycline or Mefloquine. Neither was perfect, but malaria was a worse option. Tetracycline often caused gastrointestinal (GI) symptoms and increased sun sensitivity. Mefloquine was feared by many due to the mental status changes some Marines had during DS/DS. Compliance would be a concern.

Smallpox vaccinations had to be given in response to the renewed biological threat. The vaccination had not been given in decades, so administration was unfamiliar and anxiety provoking. Data of compliance was closely monitored, tracked, reported and reacted to at every level.

OPTs (Operational Planning Teams) and IPTs (Integrated Process Teams) were conducted. Coordination with other MSCs (Major Subordinate Commands) and higher headquarters required extra effort with correspondence, requests, phone calls, and meetings. Unfortunately higher headquarters often had difficulty supporting plans and frequently felt they had better ideas. I couldn't help but reminisce of my father's salty advice about opinions and "assholes." Maybe the military hadn't changed much over the years. Maybe the people weren't that different either. Information systems were not linked, since peacetime security for IT (Information Technology) differs from secure systems. It was busy and pressured.

Flights were assigned. I left early on Valentine's Day, leaving Valentines for my sleeping family. The flight would be long, but most felt relieved to get on the plane bound for Kuwait, where the staging for invasion was being completed. The rehearsal was over—"showtime!"

4.5 Into Theater

Upon arrival, I reported to the Headquarters Battalion (forward). We slept in smaller tents within large Kuwaiti desert tents to keep from waking with sand and dust in our faces. The camp was large and growing. Getting ready to cross into Iraq meant meeting with all the other staffs, coordinating and verifying plans and intentions. It was time to see if everything fit together.

Unfortunately, overlapping USMC/USN and line/staff boundaries left many areas that had to be worked out in the field. A visit to the Group Aid Station set up in Kuwait proved they were not aligned with Division's battle plan. They were convinced they knew better.

The psychiatrists in Group presented a white paper through their chain of command about combat stress support. In it, they insisted that the Proximity in PIES (Proximity Immediacy Expectancy Simplicity) or BICEPS (Brevity Immediacy Centrality Expectancy Proximity Simplicity) was only possible if it was also safe enough for the mental health providers not to get hurt. They were confident that medical evacuation to and from combat operations would allow the mental health assets to remain in the rear. Their assumptions would be proven wrong.

Time Phased Force Deployment Data (TPFDD) was developed, which provided a time frame for all units arriving. If you were not on it, you weren't moving forward until after everyone else. The Group would not be on the TPFDD crossing into Iraq.

The MEF Surgeon told me that I needed to talk to the Group psychiatrists. After all, I was the psychiatry specialty leader. Unfortunately, command in combat zones trumps any specialty leader authority. The Group Medical Battalion had its own Commanding Officer (CO), who in turn had his own staff. The Group CG had his own Surgeon. Despite repeated requests and negotiations trying to solve the problem, Division deployed with no embedded mental health assets except for the Division Psychiatrist.

The GMOs and their Division Corpsman had done well in focusing on predeployment of their battalions and regiments. As feared, despite Medical Battalion promises to the contrary, some Authorized Medical Allowances (AMALs) did not arrive in theater. Battalions were forced to share equipment, since resupply would not occur until after the invasion had begun.

The wait in Kuwait was brief; we received our orders to move into pre-position for invasion. I vividly remember looking out over the desert over the anticipated Line of Departure (LD), wondering what would be the endpoint. We talked about it amongst ourselves. No one knew the answer. It was not our role to even question. We were to be ready to start when told.

4.6 Crossing the Line of Departure

Minutes after the mobilization order was received, I called my wife, Marie, on one of the cheap Kuwaiti cell phones that had been acquired to do business. It wasn't secure, so I couldn't say much. When I said, "I love you … goodbye," I was convinced that I would never hear her voice again. We were at war.

Entering Iraq was eerie. The oil fields were burning. Warned of likely NBC attack, we wore our NBC suits. We learned to appreciate the activated charcoal that absorbed body odor after we had to remain in them for a month. It would be weeks before a chance to take a shower. Baby wipes were the only hygiene option.

We moved at night with the advantage of night vision goggles (NVGs). We learned how hard night ops can be on unfamiliar terrain with limited communications. Driving Humvees at high speeds in total darkness is an accident waiting to happen. Our Humvee ran into the back of another vehicle as we tried not to lose them in the desert darkness. We couldn't risk not keeping up with everyone else. We wouldn't be able to assess the damage until the next morning. There was no stopping.

When we finally paused to make camp, we were in the middle of the red sand storm that looked like something out of a book in the Bible, making all of us wonder if this was Someone telling us to leave. The wind and sand resulted in little to no visibility.

With great effort, we managed to get our three men tents set up to weather out the storm.

One of my Corpsman abruptly announced, "Sorry, I have to take a dump." He quickly disappeared from sight into the sand storm. He was gone for a long time, returning exhausted but reporting satisfaction that he had done his duty far from the tents. He was embarrassingly mistaken. The next morning despite wind, sand and even rain, his feces were in clear view only a few feet away from the tents.

With our shelters in place, I reported to the Command Operations Center (COC). The mood was tense. As we set up the equipment, the G4 came into the tent and tried to ease the situation, "It could always be worse!" As he left, as if by cue, the lightning and rain started. He shortly returned to the COC wet and muddy; he had fallen into a flooded area. He corrected himself, "I guess it can be."

I remember leaving the Command Operations Center later that night to return to my tent after being warned that the perimeter was not secured. I had never truly experienced fear until that night. I held my M9 service pistol in my hand all night and slept little as I watched the door, convinced that an uninvited Iraqi soldier was at my door.

4.7 Improvise, Adapt, Overcome

As promised, conditions were austere. Many things were left behind. In Kuwait, there had been Portajohns. As soon as we crossed into Iraq, those no longer existed. Going to the bathroom in the field required digging "cat holes" and then burying the waste left behind. Maneuvers, like sitting on the side of an entrenchment (E) tool, became advanced skills to master. Ammo boxes became makeshift toilets that were coveted by those who didn't have boxes. With the mass movement of an entire headquarters element, slit latrines had to be implemented. These consisted of a long ditch dug with the intent of straddling it to defecate or urinate, filling in the area with dirt afterward to consolidate and isolate human waste.

One of my Corpsman woke me shortly after we started the invasion, "Doc, you aren't going to believe this." The Corpsman had taped an area where they had dug a slit trench. There were no flashlights, so it would prevent walking into or tripping on human waste. The Marines had apparently decided the tape merely marked a target area. The Corpsman laughed as he showed me the mounds of feces inside the tape but not in the trench. We had missed something in our rehearsal.

The headquarters leapfrogged forward. We were moving quickly into Iraq. Briefings occurred at least twice daily in the COC if we were not moving. During one of these briefs, the CG called for the Surgeon. He said in a firm voice, "Doc, I need to have all the Marines on Cipro by the end of the evening." I stood shocked by his order. I tried to tell him that there was no indication for starting Ciprofloxacin. After all, we hadn't been exposed to Anthrax.

I reminded him that Cipro was the antibiotic used for treatment after exposure and that no cases had been reported. The CG told me that he well understood that Cipro was not for prophylaxis, but he would only consider another action if his first warning sign of an infection was not the death of one of his Marines.

We only had a few doses of Cipro for each Marine. Resupply was not anticipated for weeks if not longer. Before I could say anything else, he told me, "Tonight!" The CG stared at me. General Kelly, the Assistant Division Command (ADC), pulled me aside by the neck and whispered, "This is not the place to argue with the CG. Tell him 'Yes Sir' and let someone else higher in the chain of command tell him no." I complied, "Yes Sir, I'll coordinate with Group and MEF." I knew their answer would be no, but that would come from a more senior warfighter, not a junior staff officer.

General Mattis was a practical man. I was in his office when the Navy Sea Bees started to install screen doors on the building we temporarily inhabited. He said, "Thank you gentlemen, but you see all those other buildings where all the other Marines are living? They need screens first. I'll be happy to have some after they all have them." He then turned to me, "Doc I think we need to spray for mosquitoes."

I started to tell him that we had already sprayed and the life cycle of the mosquito would not be affected by spraying again so soon. Before I could finish a few words, he interrupted me, "Doc, I don't want to hear more about the mating habits of mosquitoes. I'm a simple man. I'm going to go hang outside at night, naked. If I get a bite, we spray. If I don't, we don't." I knew better than to let him conduct his experiment. We sprayed.

I felt the CG trusted me, but I was never sure about the Chief of Staff (C/S). One day the C/S came to my tent and yelled, "Doc Moore, come here!" I had no idea what was happening. I followed him to the COC. I heard him mumble, "one of the regimental commanders has been relieved. As a Marine, I would rather die than be relieved in combat." He gave me no details. His interpersonal skills were worse than usual. "The General wants you to talk to him to make sure he is ok."

I was told little more than get my stuff and get in a Humvee. I was then on a helicopter, flying to one of the Regimental Headquarters. I was informed that the ADC had been at the unit trying to help the Regimental Commander return to the fight after one of his units had been ambushed and sustained casualties. I was told

that the Colonel seemed to be improving but subsequently was found in his rack during combat operations. The efforts had failed, and the CG had no option but to relieve him. The ADC told me, "The Colonel is a good man and the General wanted you to make sure he is ok."

Both generals trusted my opinion. I had offered for the Division Psychiatrist to do the assessment, but was quickly told, "We don't know him, Doc." The psychiatrist had failed in his role of gaining credibility with the line leadership and the role defaulted to the Surgeon, who also happened to be a psychiatrist.

The Colonel made the evaluation easy for me. "Come on in, Doc. I know why you are here. I know the General is worried. There is no need. I always knew that someday the Marine Corps would break my heart. It might be because I didn't make rank or get an assignment. It might be that I wasn't selected Commandant or it might be that it is time to retire. Today is that day for me. Don't worry doc. Tell the General not to worry. I knew this day would come. I have alternative plans."

I briefed the ADC, who then briefed the CG. I heard that the ADC sent a note to the Colonel's wife. It reassured her that this is in no way a reflection of the quality of this man. Rumors of conflict and betrayal later circulated. I only know I saw noble officers dealing with being human in extraordinary circumstances.

4.8 Restoration Operations

Before returning to the main, I was diverted to assist at the Civil Military Operations Center (CMOC). I received a call from higher headquarters that a journalist was sick at the Palestine Hotel. To be honest, I didn't see this was a priority. I remembered how embedded reporters had been thrown out of Division after giving away our location. I sent a Corpsman. Within a day, the Corpsman told me that he thought I should be there. He told me that CMOC was being stood up and reminded me that the goal was now rebuilding the infrastructure of their health system. He felt that he was in over his head.

When I arrived, the Corpsman had already started to recruit volunteers to help restore the Iraqi medical system that had existed prior to the invasion. Brave Iraqi doctors volunteered to help us help their people and patients. Most were medical students or residents that volunteered, since most of the more senior physicians had left. They had only been able to hold senior positions by aligning with the regime in power. They feared invaders would not trust them.

One Iraqi translator reflected on how different his world had become and how nervous he was due to the change. "It is very different now. Before, it was forbidden to identify some bad people. You and your family might disappear if you did. Now, it is difficult to know what to say or what this new freedom will bring."

A young female Iraqi physician, "Dr. Joy," asked me to thank my wife for allowing me to come to Iraq. She wanted me to remind her that there are good people in Iraq that appreciated her sacrifice. In a matter of days, we met with several groups, even visiting the Ministry of Health that had been bombed, to try and figure a plan to get needed supplies to the Iraqis.

Without warning, we were awakened at night and told that we had to move out. We were not given any details. It was an order. Neither the State Department nor the Army ever relieved us. We heard the unit headed to replace us was "shot up" and wouldn't make it. The shame of having to leave without saying goodbye never goes away. I felt that we had betrayed those that had worked so hard with us to restore the Iraqi health system.

The mission was quickly turning into sustainment. As the headquarters settled into a site next to Babylon, I resigned myself to an extended stay in Iraq. To my surprise, I was informed that instead, I would be heading back to Continental United States (CONUS). I didn't argue. I had to get the Division ready to redeploy if it was needed for another mission.

4.9 Leaving Theater

On the banks of the Euphrates, General Mattis asked me to join him for dinner before I left theater. He thanked me for what I had done and told me to be proud of what we accomplished. The CG said, "Marine and logistics should not be used in the same sentence" as we discussed that we never got even one band-aid in resupply during the invasion. "Doc, you did everything I asked. Everything you did was better than I could have imagined. I know you feel that you could have done better, but BUMED failed you. It is not the first time they have failed the Corps."

I asked him if he ever got tired of living in "shit holes," the often used description of austere environments like ours. He told me that he wasn't all that fond of shit holes, but as long as he was the best chance for "these fine young men and women to get home in one piece," he would be with them. Then, the sparkle returned to his eyes. He joked, "Maybe next time, we can invade France. Kill during the day and fornicate with a good wine at night. Doc, that would be great."

He offered me something to consider in the future: "Doc, you are a true gentleman. I've seen that. I just want you to know that sometimes, with a bunch of grunts, that can be mistaken as being weak or timid. I know that is not the case. I have seen you and your work. Just remember that in the future. I'd never tell you to change, but it is something to keep in mind. I'm a little different, when I walk into a room, I'm trying to figure out when I can use my first four letter word." General Mattis always had a way with words.

I was given a ride to an abandoned airport, where I was alone for several hours waiting for others to arrive. We were all meeting a transport plane to go back to Kuwait, where we would turn in our paperwork and then go home.

When I returned to Kuwait, I was anxious to get home. I remember walking into the Dining Facility (DFAC) where I found a table of Marine colonels. One of them told me, "Doc, good to see you. We have been rooting for you to make it home." They knew my wife was pregnant. "Many of us have missed the birth of ours." Every colonel at the table had missed the birth of some if not all of their children. I would be lucky enough to make it home to see the birth of my son.

4.10 Return and Reunion

Those from Division who returned with me did not know what was going to greet us. We boarded a bus and turned in our weapons. We then got back on the bus, unsure where we were going. We were not sure if there was a return ceremony, but we were delighted to find our families and the band.

My wife was in her final trimester when I returned. My 6-year old daughter, Kristabel, was by her side holding a welcome home sign. I was able to return home to attend the birth of my son. A few days off and then back to finish the redeployment process. Paternity leave gave some time, but the mission had to again come first.

At the time, I felt that I had helped the Iraqi people. I felt good when people would thank me for my service. At the same time, it was difficult to turn off the television news. It was tough to adapt to being home. Everything was different after returning from combat. I found myself falling asleep on the couch, watching the news, wondering what was happening to those left behind. This never fully resolved.

I was shocked and grief stricken when I heard that my friend, Margaret Hassan, a nongovernmental organization (NGO) aid worker, who had worked with me at the CMOC, was killed after she had been abducted. She had taken aside a brash young officer and reminded him that the Iraqis had many good people trying to rebuild their country. She was truly a wonderful person, who loved her country. There were many good people left behind in Iraq.

4.11 Clinical Pearls

Medications for front line troops need to be capsules, not pills, and kept in Ziplocs. With all the other gear required, crush proof containers only add unwanted bulk. When Marines go prone, whatever is in the pocket that is crushable is crushed. Medications and medical records don't do well in harsh environments.

Like all medical encounters, it's not over until the paperwork is done. Unfortunately, paper is not as easily accessible, maintained or protected in deployment. In the desert, everything gets wet and dirty if it isn't in a Ziploc bag, including medical records and Post Deployment Health Assessments (PDHAs).

It is impossible to understand how austere it really is during an invasion with the Marine infantry. Discipline is essential to minimize DNBI (Disease and Non Battle Injuries). Compliance with medications and sanitation (e.g., slit latrines) is more than just education. Knowing and doing are two different things. Although dental made sure teeth were in good repair, making sure to brush teeth was a challenge.

There was no routine in combat to facilitate habits. Keeping sleeves down with temperatures over 120 °F is not an easy order to follow, especially with how hard it was to drink warm water. Sleep was poor; fatigue was an unwanted alternative. Stimulants could extend work hours, but too much produced adverse side effects.

Constipation can be a significant problem, particularly for senior male Marines. When women were assigned at headquarters and regiment, male Marines were concerned about the women seeing them use the bathroom. Many utilized NVGs (night

vision goggles) to go at night when no one else could see them. The women had no problems going to the head together, but the men were disturbed by the possibility of sharing. Once when the privacy netting was too high, some men expressed concern that the women could be seen using the head. One outspoken female Marine said, "If someone is sick enough to get excited watching me use the head, that is their problem, not mine."

Humans were never designed for riding in poorly cushioned Humvees on rough terrain or for wearing body armor and equipment weighing more their own body weight. Back problems and hernias were not a surprising result after the deployment.

Deployments are depleting. Exceeding tolerances of the human mind and/or body results in breakage and failure that may not manifest until much later. Endurance is lost without conditioning. Asthma can result from environmental exposure. Orthopedic injuries increase if Vitamin D is low. Despite being in the desert, sun exposure is limited with sleeves down and use of sunscreen.

Managing combat stress is the role of leadership, not just clinicians. I saw this first hand when General Mattis required all units to attend an out brief with him before leaving theater. In it, he told every Marine and Sailor, "You have seen a lot of difficult things. You have done some amazing things. Remember: you are responsible for all those heroic actions. I am the one who ordered you to do some of those difficult things." Ideally, all commanders will be as aware and dedicated to managing combat stress.

Operational psychiatry cannot be delivered from an office based consultation model. The Division Psychiatrist must be out with the war fighters to gain trust and recognition. When a psychiatrist has not established a relationship with combat troops, they are perceived as outsiders.

Culture shock on return is inevitable and difficult to distinguish from trauma. There is thin veneer of civilization. I believe one of the most troublesome existential realities is how things are not fair and how they can fall apart so quickly. In learning about NBC threats, it was pointed out that the initial clinical presentation often gave little clue of a specific agent or infection. Readjustment or redeployment was a lesson on how difficult determining pathology can be.

4.12 Lessons Learned

Admiral Mateczun, one of my long-time mentors, once told me that the job of the military has always been to do the impossible with inadequate resources. Operation Iraqi Freedom (OIF) was no different. We never had the resources we wanted, but we accomplished the mission.

During the invasion, the days were long but the weeks were short. Movement was fast, and the injuries were less than expected. We identified the potential medical threats, took appropriate preventive measures, prepared for potential casualties, and provided the emergency medical support and MEDEVAC that was needed. Casualties during the invasion were low.

The intent of lessons learned is to learn from the experiences of others. The military implemented formal lessons where we learned to avoid being doomed to repeat past. Unfortunately, history is lost due to communication, politics, apathy, and perspective. Lessons not learned end up being little more than lessons observed.

When I reported to 1st MARDIV, I found an old copy of Lessons Learned from Operation DS/DS. The mental health issues anticipated for OIF were identical, but, years later, no action appeared to have been taken to fix any of them. The lessons were in fact "observed" and not "learned."

Unfortunately, no formal debriefing was ever done for me as Division Surgeon. Returning combat veterans were treated like prized cows, introduced and paraded on stage until asked to talk about their experiences. If the feedback did not match the party line of higher headquarters, those with experience were quickly given the hook and exited off the stage. The opportunity to find out what really happened was often missed.

Deployment and in garrison care require overlapping, but not duplicate skills and equipment. Experience and success does not always transfer to the other venue. After DS/DS, members were assigned to the platform so they could train in the event of mobilization, but this did not incorporate a rotation plan for sustained operations. As a result rotation from theater often placed those rotating to a new command at risk for immediate redeployment, and there was no database tracking deployments or experiences of personnel.

A Marine Major summed up his observation about the internal conflict in military medicine. "Navy Medicine has not decided if they are operators or loggies. They want to tell everyone they are ready like operators, but their product requires metrics and deadlines like logistics and supply. They need to figure out which one they want to be."

Personnel and politics were key issues. While implementing the new Command Master Chief program, tension arose as the senior Navy enlisted member forced his move to report directly to the Marine CG vice the Division Surgeon. Since military personnel systems for officers and enlisted are different, assigning the senior sailor disconnected an essential presence in the DSO (Division Surgeon's Office).

Any deployment must deal with personnel issues: pregnancy, conflicting rotation dates, crises at home, and physical limitations or injuries. However, conscientious objectors were unique to a combat deployment. Two medical officers raised the issue. The General warned me that it would break his heart, but he would ruin their careers if they refused to go. Neither was disciplined. One deployed without a weapon. One rescinded his request for consideration.

Those that were heroes were as surprising as those that were failures. Prediction was impossible. Doing well in garrison did not predict someone would do well in the field. Some were overwhelmed. Some refused to participate. You couldn't tell who would do what, especially with little true simulation prior to the actual event.

My Corpsmen always looked out for me. They would check to make sure I was ok. Once, one of my Sailors had acquired a Tactical (TAC) phone. I knew I didn't want to know where or how he got it. I started to remind him that he needed to return it when he handed it to me and said, "I know you haven't talked to your wife in a

long time. I brought this so you could tell her you're ok." Near the end of our time in Iraq, another one of my Sailors told me that he noticed that I was always the first to wake and the last to go to bed. He knew I was looking out for them, and he thanked me for that.

An impromptu support group formed in theater. Its members knew it as "the persona non grata" (The PNGs). It consisted of the Surgeon, Chaplain, Public Affairs Officer (PAO), Staff Judge Advocate (SJA), and Communications Officer. Whenever there was a problem, one of this cast of characters was usually the fault or solution. Our high pressure, high responsibility jobs helped us bond and look out for and after each other.

"Comm sucks" is frequently heard to explain the lack of information available up and down the chain of command. Email, Skype and satellite phones sometimes made managing information flow difficult to impossible. Sharing too much and too soon can result in other communication issues. MEDEVAC needed to work during the invasion. There were problems in identifying units and locations. Communication channels were quickly overwhelmed. The idea had initially been to have higher command report down, but accountability often resulted in information being pushed up. There was not enough bandwidth to accompany both.

Everything becomes routine AFTER a period of adjustment. This is good and bad. Learning to be on guard and hypervigilant intensifies culture shock and disenchantment. Everyone changes and everyone eventually will break.

It was warm and kind when people would thank me for my service, but no chance for catharsis was offered. Some become bored, others overwhelmed by details. It is not much different than being a doctor and describing medical school. It's just a lot scarier.

4.13 Reflections

For me, my first deployment in support of OIF was a once in a lifetime journey into a very unique world, truly a road less traveled. Like any untraveled path, there were many unexpected twists and turns. There was no map or GPS.

I wish I had been able to talk more with my father about his experiences in a combat zone. He died just before my first round of finals in medical school. I often wonder what we might now share, if only we could talk today.

Captain Kevin D. Moore is a retired US Navy psychiatrist. This chapter reflects on events surrounding the invasion of Iraq in 2003 by coalition forces, when he served as Division Surgeon for First Marine Division and Psychiatry Specialty Leader for the Navy Surgeon General.

Occupational Therapists Share Deployment Experiences from Iraq and Afghanistan

5

William Heath Sharp, Matthew G. St. Laurent, Michelle J. Nordstrom, Brian T. Gregg, and Krustin Yu

Arriving in country just past midnight; it had been a hot, sweaty flight on a C-130 from Kuwait. We were bussed to the temporary sleeping arrangements on the Forward Operating Base (FOB). Soon after falling fast asleep a loud overhead speaker announced 'incoming, incoming, incoming!' Jumping out of our beds and seeking cover; we waited in apprehension to hear the explosion … Instead we heard an 'all clear, all clear, all clear.' That night was the first of many uneasy sleeping nights.

Lieutenant Colonel (LTC) Enrique Smith-Forbes, Occupational Therapist, US Army, Active Duty

Some of the unique missions, circumstances, and challenges experienced by occupational therapists during the last decade and a half (2001–2016) in support of OEF and OIF are demonstrated in this chapter by personal, firsthand accounts.

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5.1 What Is Occupational Therapy?

Occupational Therapist (OT) provide rehabilitation for those who experience difficulties performing everyday tasks as a result of physical, neurological, and psychological injuries or illnesses. They evaluate patients' physical and mental functioning and develop treatment plans to improve patient autonomy. Purposeful therapeutic activities are often used to facilitate the rehabilitation process.

The OT's primary objective is to minimize the impact injuries have on function, thereby maximizing independence and quality of life. In a deployed environment the primary goal is to return a Service Member (SM) to full duty, in order to preserve unit strength and maintain mission capabilities.

It is important to note that the term "occupation" encompasses not only a SM's job or mission-related duties, but also basic self-care (sleep, hygiene, nutrition), advanced life roles (SM, leader, spouse, friend, coworker), and leisure pursuits. Thus, if any form of injury or illness prevents SMs from participating in daily occupational performances, it is the OT's responsibility to help them regain or adapt to that function [1].

Deploying as members of the Army's Combat Operational Stress Control (COSC) team, OTs provide evaluations and treatments for SMs whose performance has been impaired as a result of Behavioral Health (BH) injuries or illnesses. Treatment focuses on function and normalizing behaviors in response to abnormal events. For example, a SMs involved in a military vehicle rollover may have difficulty riding in military vehicles due to continued anxiety. This level of anxiety could make them incapable of completing missions and potentially jeopardizing unit effectiveness.

The OT may provide anger management, stress control, and exposure therapy by progressively reintroducing activities involving military vehicles, therefore desensitizing the SM to anxiety-provoking activities. Activities provided by the OT can be graded, by making them easier or more difficult, based on the SM tolerance. By successfully grading a SM's treatment activities, the OT ensures they are providing him or her with the "just right" challenge. This increases confidence and rebuilds skill sets required to return to duty.

5.1.1 Brief History of Occupational Therapy in Military Populations

Adolf Meyer was the first psychiatrist to recognize the importance of the "total person" in his theoretical development of psychobiology. He believed purposeful human action was more than a simple integration of detachable parts. Rather, the total person required "blending in consciousness, integrating our organism into simple or complex adaptive and constructive reactions of overt and implicit behavior" [2].

Meyer's professional contributions to mental health rehabilitation were formative through his assertions of the importance of *ergasias* (a term meaning "to work, to do, and to act"). *Ergasias* was utilized in early mental health therapeutic practice

as the formal description of purpose-driven and goal-directed activity demonstrated by the patient [3]. From under the branches of Meyer's educational tree grew the OT practice in guiding "purposeful activity" for SMs in need of mental health recovery following wartime service. The historical association of OT in the U.S. military was developed during and following World War I with the inception of reconstruction aides [4].

Early OTs assisted injured SMs by promoting meaningful and purposeful activities that developed skills needed for vocations following military service [4]. Traditionally OTs work with those recovering from amputations, burns, orthopedic injuries, and Trauma-related psychological conditions.

The U.S. military later committed to the occupational needs of SMs by incorporating the OT profession into active military service [4]. In 1918, the Division of Physical Reconstruction was created by the U.S. Army and became the first organized OT division in the U.S. military. "The intent was, through use of mental and manual work, to restore maximum function, to any military person disabled in the line of duty." [4].

Since that time, OT expanded to its current role as part of active duty military service. Military OTs identify both behavioral health challenges and physical limitations which require specific interventions to restore work engagement and improve functioning [5–7]. The role of OT for military BH was further developed in response to battle fatigue with the development of combat and operational stress control teams [5, 8–14]. As a result, there has been an increasing awareness of the occupational needs of injured Service Members and veterans reintegrating into service or home environments. These needs include refocusing energies, coping with change in work environments, and reconstructing meaning [15].

Throughout the last 15 years of continuous deployment in Iraq and Afghanistan, OT utilization has been robust and wide-ranged. As many as 62 OTs have deployed as part of over 34 unit deployments in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) [16].

5.1.2 Challenges Facing Deployed Occupational Therapists

Active duty OTs traditionally work in a military hospital or clinic setting within the US, Europe, Asia, and Korea. "Reservist" OTs usually work full-time in civilian hospitals, academic, or administrative positions. They perform their military training as a member of a reserve unit, generally one weekend a month or in a full-time capacity when deployed requiring them to serve stateside similar to an OT on active duty.

Since the beginning of OEF in 2001 and OIF in 2003, both active duty and reserve OTs have deployed numerous times to the battlefield, supporting combatants with rehabilitative services. Their proximity to austere, dynamic, and often violent conditions creates a highly stressful work environment. This stress is compounded with communication challenges, role changes, and limited resources.

In addition to their primary role as clinicians, OTs assume additional roles or responsibilities such as interim Commander, Executive Officer, or team leader. These positions involve unit level decision making, supervision of personnel, and responsibility for acquiring unit resources and equipment maintenance. For example, OTs could also be assigned as legal officers for criminal investigations of personnel or as unit movement leaders for the planning and execution of moving equipment and personnel to different locations. These added responsibilities are critical to the mission and require a significant amount of additional time, which must be balanced with their primary role as therapists.

Returning home and reintegrating back with family and community after a deployment is a challenge that all deployed personnel experience. Coming home to unfamiliar daily routines and changed role expectations can illicit emotional or behavioral responses that overwhelm or negatively affect relationships, roles, and performance of daily activities.

Some of the unique missions, circumstances, and challenges experienced by OTs during the last decade and a half (2001–2016) in support of OEF and OIF are demonstrated below by personal, firsthand accounts.

5.2 Personal Experiences

The following experiences relate specifically to deployments with Combat Operation Stress Control units in Afghanistan and/or Iraq which ranged from 6 to 15 months in length. The intent is to provide the reader with a glimpse of individual experiences OTs encountered while deployed. These accounts do not necessarily reflect the daily routines, activities, or experiences of the majority of deployed OTs.

5.2.1 Leaving for the Warzone

First, rumors are heard followed by general conversation until one day there is a formal announcement that the unit is deploying. Although uneasy for a SM and their family to grasp, it is their reality. Even though Combat Operation Stress Control teams deploy to relatively secure areas (by war zone standards), there is no telling what kind of danger one may encounter.

Upon receipt of official deployment orders, the earnest military training begins. Without proper and thorough preparation, a unit's security and mission success can become vulnerable. Units must simulate performance to certify that they are ready and capable to conduct their mission. Each OT is assigned a personal weapon, either a 9 mm handgun or an M4/M16 semiautomatic rifle. Accountability of a weapon is critical every minute of every day during a deployment. One should never lose sight of their weapon; it remains in arm's length at all times. Due to the terrain and threat of roadside bombs during vehicle convoys it is imperative rollover simulation training is completed as a pre-deployment requirement.

Fig. 5.1 CPT Nordstrom and Major (MAJ) Butch, COSC Therapy Dog, on a Chinook Helicopter en route to a BH Mission, Afghanistan, August 2012 (Courtesy of CPT Nordstrom)

Individual readiness is also a key component that must be accomplished prior to entering the combat zone. Despite all the military training, nothing can prepare a Service Member to leave their family for a 6–15 month deployment (Fig. 5.1).

> It was 2100 and I knew I had to be at formation in preparation for leaving by 0200. There was no way my husband and I were going to sleep and I did not want to disrupt the children (ages 7 and 3), so we said our good-byes early. After spending 3 long months preparing for my deployment, I can still remember in detail, these extremely emotional last few hours with my family.
>
> Everyone deploying with the COSC made it on time and in the correct uniform the morning of our departure. The overall excitement and apprehension took hold as if we were all moving in slow motion. We collectively put one foot in front of the other and boarded the first of three airplanes.
>
> It was not until getting to Kyrgyzstan that the vital role of technology was realized. Stateside, we all had cell phones; if something came up; we could text, call, or email one another to maintain communication. During a 48-hour layover spent in Kyrgyzstan, it was evident that communication outside the United States was going to be complicated.
>
> Within the first 12 hours, unit members were showing up in the wrong uniforms, incorrectly assigned groups, and wrong locations. At some point during our travels, new information was communicated but not fully disseminated to everyone. Failure to accurately provide information in its simplest form to a large group of people, especially in such austere circumstances can cause chaos, confusion, delays, frustration, and anxiety to an already uneasy group.
>
> We were tired, frustrated, and concerned for each other's wellbeing. My deployment in its onset demonstrated the absolute importance of training, knowledge sharing, and maintaining one's physical and psychological wellbeing.
>
> Captain (CPT) Michelle Nordstrom, OT, US Army, Active Duty

5.2.2 Dangers of the Warzone and Its Unique Stressors

All deployed personnel, medical staff included, face physical, psychological and emotional stressors, due to the ever-present dangers of living and working in an active war zone. Physical or psychological harm from the unexpected nature of mortar attacks, Improvised Explosive Devices, or small arms fire are constant threats. The indiscriminant violence wrought in modern warfare is a risk each individual had to consider at all times. These risks are highlighted in the 2008 account of an OT deployed to Iraq.

> Our adjacent FOBs (Forward Operating Bases) were hit 21 times by rocket mortar attacks today, Christmas day. We were expecting to get hit, but what do you do when you're expecting?
>
> The emergency room (ER) doctor, here for seven days, the father of three children, was killed along with many injured by mortar attacks that day. He was on his way back from church.
>
> I spent most of the day at the hard shelled/concrete Combat Support Hospital, which was built to withstand a blast. Due to the number of attacks we were not allowed to remain in our living area, which was a soft-shelled Containerized Housing Unit. Eventually, we were cleared to go to the COSC clinic, which was also concrete. Some people slept in the COSC building that night.
>
> The ER doctor died at around 11 PM, approximately 5 AM eastern time. All I could think about was the casualty officer going to his house on Christmas morning. Christmas for those kids will never be the same."
>
> LTC Arthur Yeager, OT, US Army, Active Duty

This testimony highlights the unpredictable environment of a deployment; physical damage, loss of life, and the extent to which the lives of survivors are forever changed. Such stressors can significantly impact the psyche of a SM; with the effects lasting long after their return home. These persistent psychological effects may manifest as Post-Traumatic Stress Disorder (PTSD) and depression, which are especially prevalent in those returning from war.

A recent study of approximately 289,000 veterans with mental health diagnoses estimated that 21.8 % return from deployment with PTSD and 17.4 % with depression [17]. This is a stark contrast to the national averages; 3.5 % of adults in the United States have PTSD and about 6.7 % suffer from depression [18, 19].

5.2.3 Burnout

A hazard among deployed medical SM's, including OTs, is the potential for burnout. Burnout can manifest in forms of physical and/or psychological fatigue, loss of morale, depression, hostility, or reduced commitment. This is demonstrated by the following account from CPT Francisco Rivera while stationed at a Combat Out Post (COP) in Afghanistan (Fig. 5.2).

> We arrived once again at one of the most dangerous places in Afghanistan. The COP was being manned by a Stryker Brigade Combat Team; one of the Army's most effective fighting forces.

Fig. 5.2 CPT Rivera with SFC Zeke, COSC Therapy Dog, transporting to perform a Combat Stress Prevention Assignment, Afghanistan, September, 2011 (Courtesy of CPT Rivera)

The Commanding Officer, other senior unit leaders and I were tasked to complete Traumatic Event Management debriefings, which were required to assess and manage emotional and physical responses of unit members when experiencing comrades killed in action (KIA).

Alpha Company had 4 KIAs, along with 12 wounded in action who sustained multiple amputations and other life threatening injuries. We conducted 11 debriefings accounting for over 100 Soldiers with a goal to help them process the trauma and constructively manage emotional reactions to these combat experiences.

A number of Soldiers were struggling with and concerned about thoughts of trying to avenge the deaths of their fellow Soldiers while on patrol off the COB. It was very difficult to encourage them to "drive on" and stay focused on their mission. Many had lost the motivation to fight or carry on with their assigned mission. Some struggled to identify with the mission and had difficulty rationalizing the worthiness of it all and risk of more loss of life. Others lacked confidence that higher command was supporting their needs."

CPT Rivera, OT, US Army Reserves

CPT Rivera's narrative attests to the mental and physical exhaustion SMs endure while on deployment. Factors such as suffering from injury, witnessing severe trauma or loss of life amongst friends and fellow SMs can severely disrupt one's emotional state. Additionally, performing military operations without meeting calculable success, perceptions of neglect or lack of support from superiors despite individual efforts, sacrifices, or losses can lead to emotional collapse or burnout. Deployed OTs must be able to recognize burnout in order to rehabilitate, rejuvenate, and return a SM to duty with the capacity to independently and safely perform their mission.

5.2.4 Different Missions/Goals Deployed Occupational Therapists Face

When not in a deployed environment, OTs assist patients in restoring functional skills needed to return to work, daily life, leisure, and social reintegration. When deployed, OT treatment objectives predominantly focus on returning a SM to active duty. The timeline for recovery is much shorter in a war zone. If a SM displays the inability to function safely and productively in a timely manner, a medical evacuation must be considered. OTs must be cognizant of the unique physical and psychological duty requirements of a SM to alter their therapeutic treatment programs accordingly (Fig. 5.3).

> Our COSC unit arrived in Baghdad in support of OIF in 2008. Our mission was to coordinate and deliver Combat Health Support to US forces in the Multi-National-Corps-Iraq sector by conserving the fighting strength, preventing injury, or evacuating COSC casualties to higher levels of medical care (Germany), if a patient's recovery was not in a timely manner or needed more intense medical attention.
>
> In Iraq, I was assigned as the Officer in Charge (OIC) of Restoration (a rehabilitation mission), housed in a facility created by two adjoining trailers, and co-located with the Troop Medical Clinic. My team's mission was to restore a Soldier's physical and mental capacity to return them to the fight.

Fig. 5.3 LTC Enrique Smith-Forbes on a visit to Al-Faw Palace, Iraq, 2008 (Courtesy of LTC Enrique Smith-Forbes)

Lieutenant Colonel (LTC) Enrique Smith-Forbes, OT, US Army, Active Duty

Preparing yourself physically and mentally when deploying to an active combat zone is critical for everyone. Therapists must adapt professionally and train to address injuries not experienced back home in a traditional hospital setting. One must be prepared to treat symptoms such as anxiety, depression, workplace violence, and survivor guilt, among others provoked by events such as combat, indiscriminant blasts, death, severe injury, unresolved problems at home, relationship constraints, or financial crises.

The urgency to return SMs to duty is driven by the need to maximize unit strength to meet the requirements of the mission. Treatment goals and priorities must shift to provide these individuals with the rehabilitation they need within a truncated time frame. This differs significantly from civilian or stateside military hospitals where a longer, more ideal rehabilitation timeline is available to maximize psychological recovery.

5.2.5 Expanded Roles of the Occupational Therapist While Deployed

Deployed OTs must often juggle additional work responsibilities in addition to managing their therapy programs. They must be prepared to assume duties required of a military unit deployed to a combat zone. CPT Bash, provided his account from a deployment to Iraq in 2005 with a Massachusetts Reserve COSC unit. He described some examples of additional roles incumbent of an Army officer while deployed (Fig. 5.4).

Fig. 5.4 CPT Daniel Bash sitting on a berm, Iraq, October 18, 2005 (Courtesy of CPT Daniel Bash)

Following the short time spent at a remote base in Iraq, I was transferred to a large division headquarters base, where I was assigned as the Officer in Charge of a treatment prevention team being relocated from the Baghdad Green Zone. I was given a team of Soldiers in which some had remained from the original prevention team and others were transferred to my team because of behavior issues or incidents with their previous teams.

Essentially, I was tasked to create an effective treatment team with a group of young Soldiers, some experienced, others not. In short order, we had to be a cohesive and well trained treatment team able to effectively manage the COSC mission at hand, which did not occur without challenges.

We quickly evolved having to manage one of the busiest COSC missions our unit had experienced during our yearlong deployment. We were treating a rate of over 100 contacts a week and simultaneously housing as many as eight Service Members in need of longer term restoration at any given time.

No senior enlisted personnel were available to assist at the time. Since my team consisted primarily of young and inexperienced Soldiers, I not only performed as a clinician and senior officer, but also as a surrogate father, role model, disciplinarian, and an educator. I also had to perform as a diplomat in dealings with other base units, facilities, and higher command to advocate for proper staffing and support for my clinic and team. All the while, I was mindful of ensuring best practice treatments were performed and my team remained safe.

CPT Daniel Bash, OT, US Army Reserves

I had the opportunity to perform both my OT BH clinical role as well as additional duties as assigned. Some of those duties included being the OIC of a firing range, a court-martial investigator, unit movement officer, and other pertinent unit level positions.

Lieutenant Colonel (LTC) Enrique Smith-Forbes, Occupational therapist, US Army, Active Duty

It is evident from these accounts that role delineation for an OT is neither finite nor confined to clinical activities. Assigned roles can be fluid throughout a deployment. Success is measured by having the flexibility to assume expanded roles while effectively performing primary responsibilities. Amongst the many roles OTs are assigned, it is critical to maintain professional identity and ensure clinical care is within their scope of practice, and meets the mission of returning Soldiers to duty as quickly and safely as possible.

5.2.6 Reintegration into the Civilian Community

Within stateside MTFs, OTs frequently engage in retraining and teaching Service Members how to reintegrate back into community life. Returning home can be an emotional struggle, especially for those inflicted with BH injuries or illnesses. Transitioning home requires readjusting to daily routines vastly different from those encountered during a deployment.

Once loaded onto a government-contracted civilian flight en route home, it may be as if the deployment mission and responsibilities were suddenly turned off. One's mind is still racing with memories of the past several months, but simultaneously a new mental focus arises in anticipation of returning home.

Returning home can be as challenging as when leaving. The home environment has likely changed; relationships evolve, children grow, role expectations shift, and duties within the community and household are assumed by others. Having expectations of relationships, work responsibilities, and life roles remaining in the state they were left is unrealistic. SM realize upon returning home that the dangers of a combat zone are nullified; life likely progressed without them. However, time and understanding from everyone (SM and family) is required for a realistic and appropriate adjustment of expectations and behaviors to reintegrate to a "new normal." This can be difficult to achieve, but equally challenging is the effort to manage painful and emotional deployment memories while trying to adjust, retrain, and assimilate back home (Fig. 5.5).

> I went from Iraq as part of a Reserve COSC unit to my living room in five days. I had spent the better part of the last year of my life in a war zone and then I got on a plane, flew to Kuwait, Ireland, Wisconsin, then home. That was it. One day a Soldier, the next, a civilian.
>
> It was hard to figure out how to return to my pre-war life. My home was more foreign to me. Life had changed, without my permission. I had spent a great deal of my time briefing outgoing units on how to reintegrate back to a regular "normal" community life back home, and somehow didn't think it applied to me!
>
> I missed Iraq, I had nobody to share war stories with; no more smoking and joking, no more port-a-potties and local nationals; no more casualties to care for, convoys and Blackhawk flights."
>
> MAJ Tammy Phipps, OT, US Army Reserves

Phipps' account highlights common emotions experienced by those returning home from deployment. It is not unusual to "miss" the camaraderie of fellow

Fig. 5.5 MAJ Phipps spending her last few moments at the airport with her children (Madison and Noah) before returning back to Iraq following three weeks of leave, Aberdeen, South Dakota, March 2008 (Courtesy of MAJ Phipps)

Soldiers or previous assigned responsibilities from a deployed military environment. The adjustment of role expectations, home situations, and short transition from Soldier to civilian can induce acute anxiety and a feeling of "What's next?" or "What do I do now?"

5.3 Final Words

Occupational therapy is an essential rehabilitative component of COSC units. Approximately 62 OTs participated in the last 15 years of deployments to Afghanistan and Iraq and faced battlefield challenges while providing rehabilitation services to those struggling with BH injuries and/or illnesses. Understanding the various challenges both OTs and SMs encountered is necessary to improve rehabilitative methods in a deployed setting. Being trained and prepared for these challenges is critical in maximizing therapeutic effects to return individuals back to duty as quickly and functionally whole as possible.

Clinicians must be capable of recognizing burnout in the SMs they treat while remaining vigilant of their own emotional exhaustion. Providers must learn how to balance clinical roles with the extra duties assigned to them as part of a deployed unit. Adaptability, creativity, and resourcefulness will foster mission success.

A clear differentiation exists between clinical practices in a deployed environment versus a stateside hospital, particularly in establishing treatment goals and outcome expectations. While deployed, treatment goals focus on coping strategies to address acute stress resulting from loss of life, survivor guilt, anxiety, burnout, conflict resolution, anger, and much more. Treatment is rapid to restore functional performance and return to duty as quickly as possible. Stateside military rehab facilities focus on return to duty and or community reintegration but with fewer constraints on the treatment duration.

Returning home from a deployment presents its own challenges and stressors. Leaving a warzone may provoke a level of distress. Not only are you leaving behind those who relied on your clinical care, but also fellow "battle buddies", with whom you served and formed lasting relationships and memories. Life at home may have changed, routines overhauled, and expectations altered, but there is nothing more meaningful than returning to loved ones who, because of their love, learn to cope, adjust, and acclimate with you.

Despite the myriad of challenges and hardships addressed in this chapter, the overwhelming majority of Army OTs views their deployment as the highlight of their Army career. The experience of working and living together on a daily basis with fellow Service Members creates a unique and lasting bond that is not replicable stateside. The opportunity and privilege to experience shared sacrifices are primary reasons the majority of Army OTs not only willingly deploy the first time, but eagerly accept the opportunity to deploy again.

War is never a preferred option and the wounds of a war extend beyond the combatants to the fabric of our society and world. The stories and impact of this war will continue to unfold for years to come on many levels. It is our responsibility to shape these stories in a way that heals the individual lives swept up by this conflict and to cultivate a healthy and productive relationship between our society and veterans. It has been, and continues to be, an honor to serve in this capacity and I am forever changed by my experiences. I am humbled by the collective accomplishments of my peers in the Army Medical Specialist Corps, past and present. I am inspired by the stories of the Service Members I have worked with and constantly amazed by the courage contained within the individual human heart.

CPT Jo Ann Zahn, OT, US Army Reserves

CPT Zahn enjoying a visit from General Casey, Afghanistan, December 2010
Photo by: Staff Sergeant Marcello Alejandro

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The Most Efficient Marine

6

Heidi S. Kraft

War changes people, my Marines always said. Having spent much of 2004 in western Iraq—a Navy clinical psychologist with a Marine surgical company—I am living proof. I am changed. A piece of me is injured. But another part is now more patient, more empathic, more flexible—and more thankful. Choosing to focus on growth that emerges out of trauma is therapy in itself.

Twelve years after my war, I've learned that combat shifted my perspective across facets of my life that still affect me today. As a psychologist, I am more tolerant now of silence during a session. I am also more likely now to actually touch a patient if the situation warrants it. As a mother, I am now capable of watching my children's sporting events with gratitude, feeling thankful not just for their success and growth, but also (most of the time) for the little mental errors, missed serves, and strikeouts. I struggle not to judge those parents whose frustration with their children's imperfection is obvious at these games. After all, these people have not lived what I have lived. They have clearly not held the hand of a dying Marine, who used to be a baseball star—and whose mother would give anything to see him strike out, just one more time.

Finally, as a San Diegan, I am infinitely more likely now to laugh at people who think 85 °F is hot. My story picks up there—on a summer day in Iraq, much warmer than 85. The day on which I learned what it means to be a combat psychologist.

The husband of one of our corpsmen sent an old wall thermometer—the kind you see at an outdoor pool. We hung it outside the front hatch at our barracks, for entertainment more than anything. By the middle of August, it had pegged at 132 °F every

Names and identifying details have been changed to protect the identity of my patients and the members of their commands.

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day for weeks. We identified a tiny window of opportunity to meet up in the morning—while the thermostat needle hovered only in the low 100's—and briskly walk that three quarters of a mile to the gym. And it was really early. Depending on who had been on duty the night before, a rotating group of us communicated by flashlight signal across the small field that separated the male and female barracks. That friendly flicker of light indicated that our partners were waiting. Together we would race-walk to that old warehouse, filled with older workout equipment that reeked of sweaty men, where we found the drug to which we had become genuinely addicted during deployment: aerobic exercise. At an intense enough level, it magically numbed our pain, flushed our fear, and uncluttered our minds for the day ahead.

This particular August morning was already stifling when I woke at 0440, laced up running shoes, and navigated the passageway by the blue lens flashlight that hung from my dog tags. I saw the blue flash across the field, and jogged across to meet up with Bill, one of our PAs. The predawn air hung heavy and hot in the aftermath of a sandstorm that had howled and screamed like some sort of rabid animal the night before. Before we left, I allowed myself a brief glance at that wall thermometer—108.

Bill and I focused on the ground in front of our flashlights, carefully avoiding the large potholes that littered the path to the gym, the earth literally ripped apart by incoming rockets and mortars. We had been in Iraq five months. Our small group of cherished friends, which had become my lifeline, counted down the days with big red X's on a wall calendar, and rationed our twice weekly screenings of one episode of THE SOPRANOS. Meticulous planning early on ensured we would watch the season finale the week before we left for home. *Home*. Such a faraway, foreign place now—not just from this endless tan landscape, surreal sandstorms and brutal casualties of war—but from somewhere deep within me as well.

Feeling energized and renewed after working out, I returned to our barracks showers. I stood under the lame, icy trickle to wash my hair, thankful for running water. There was no makeup in Iraq. I looked the same every day. The good news was twofold: no one cared, and my short hair dried instantaneously upon emerging into the blast furnace we called outside. No need for a hair dryer. Not that I had one—nor that there was functioning electricity most of the time to plug one in even if I did.

After morning rounds with the surgical company staff, I met up with Jason, my partner and our psychiatrist. We walked to breakfast as we did every morning. Along our walk, on which no one ever joined us, we provided each other with supervision, consultation, and the chance to move the stories of trauma, fear and loss we heard from our patients all day, out of our own hearts and into the blast furnace between us. We ate powdered eggs and pancakes most days, sitting alone to debrief. Once in a while, fresh eggs would be hard boiled. Sometimes, the shells came off perfectly in one smooth, rolling piece, leaving an unblemished egg white beneath it. Those were *good egg days*. Jason and I still wish each other good egg days, 12 years later.

The shell on my hard-boiled egg that morning shattered under my thumbs into countless tiny pieces that embedded in the egg white itself, impossible to free. The egg became littered with tiny shards of shell. I should have known. I moved on to pancakes.

Clinic that morning was a carbon copy of every day in Iraq. Jason and I returned from breakfast and we were briefed on the schedule by our terrific psych techs, who ran our combat stress platoon with skill and professionalism. My first three patients were follow-ups, which was unusual—and a good sign. With the extraordinary operational tempo experienced by most of the units on the base, very few had the luxury of time for maintenance visits to combat stress. And then, before we would break for a delicious lunch of Meals-Ready-To-Eat, Corporal Miller arrived at my door.

His light brown hair, closely cut in typical Marine fashion, curled ever so slightly along his hairline, giving him a boyish appearance. His light blue eyes, although shockingly bloodshot and encircled with deep shadows, smiled before his mouth did. He extended his hand.

"Nice to meet you, Ma'am." He held a surprisingly firm handshake for longer than expected. An edgy tone laced his words. Something was off for this young man. He struggled to keep his voice under control. We took a seat.

The Marine had a plastic bag with him. He laid it at his feet and propped his rifle against the back of his chair. He glanced my direction and then away, multiple times, tapping his boot on the concrete floor to the beat of a quick, silent song. He leaned forward and rested his elbows on his knees. Lowering his face to his hands, he ran all ten fingers through the short curls in his hair and then jolted straight up in his chair. He exhaled sharply and broke into a brilliant grin, revealing straight white teeth. The tapping continued.

"What can I do for you, Corporal?" I asked pleasantly. The Marine had self-referred.

"Where to start, where to start …" His voice trailed off into an easy whistle—an upbeat, jazzy tune. He looked around the small room again, boot still tapping. Then he burst out in agitated laughter. Assuming he was extraordinarily nervous to be there, I attempted to make him feel comfortable. "Take your time," I said softly.

His bright blue eyes locked with mine. The chaos behind them began to emerge. Words tumbled out of his mouth at a dizzying rate.

"OK, I'll just say it. I can't sleep. I mean, I don't want to, really … so that's why I'm not really sure if I should be here or not. After all, who goes to the Wizard when things are going absolutely great? That would be insane. And I'm pretty sure I'm not insane. Let's face it, no one is talking to me who isn't there and I don't see my grandmother or anything. Not that that would be a bad thing. I loved my grandma. She taught me to draw, a long time ago, but I never really did much with it. But now I've been drawing lately and it's making me remember her. The funny thing is, I really like the drawings …"

"What do you draw?" I interrupted him gently.

He reached into the plastic bag and retrieved a stack of paper. He shuffled through them briskly and selected one, which he handed to me.

I could not take my eyes off the image before me. Two hands, every wrinkle and fold expertly sketched, were folded in prayer, and a Catholic Rosary was wrapped around them. It was exquisite. I looked up.

"It's beautiful. You are very good. I see you have a stack of drawings there. When did you do all of these?"

"Last night, I think. Or the night before. I'm not sure."

"You drew all of these in one night?"

"I got on a roll. Once I started, I just kept going."

"All right," I started, softening and slowing my words, hoping to model a more normal rate of conversation for him, and simultaneously help him feel safe. "Let's talk about that a little. Can you tell me about the last time you slept at all, even a few hours?" He sighed deeply. Once again, the conflict was obvious as he struggled to remember, to find clarity. He scrunched his eyes together and shook his head.

"I don't know. Maybe Thursday night?" (It was Monday.) "All the days feel the same out here." I couldn't argue with that. Ground Hog Day, we often joked.

"Is it possible you have not slept at all in three or four days?" He nodded enthusiastically.

"But here's the thing, Doc. I'm not tired. Not even a little bit! I feel totally amazing. I worked out at about 0230 today. I guess that was about eight hours ago now? I mean, what time is it? Anyway, it was the best workout of my life. I must have done a hundred squats. Never done so many pushups in my life. Every muscle in my body is loving being out here. I mean, the heat is something else again but it's almost like it doesn't bother me the way it does everyone else. My roommate was just telling me the other day that I am like some sort of alien, the heat doesn't affect me at all. I am like the energizer bunny, Doc … going and going, you know?" He paused to wink at me flirtatiously.

"What was I saying? Oh, right … I can work out all hours of the day and I feel fantastic and everyone in my platoon is jealous of me. I'm the perfect person to go on deployment. I might even find out that I have some sort of powers that are making me able to do what no one else can. It's completely awesome …" His words flowed faster with each sentence, and became genuinely difficult to understand.

"Corporal. CORPORAL." It took significant intervention on my part to interrupt. He stopped talking, surprised. "May I have your permission to interrupt you when I have the information I need? I know there is so much you'd like to tell me and much of it is really important, but I also need to gather some specific details to be able to help, if that is all right." He seemed briefly embarrassed. He nodded and lowered his head.

"Yes, Ma'am."

I asked about a history of similar symptoms. Nothing like this had ever happened before. No history of symptoms of depression, either. Or anxiety. Or psychosis. No suicide attempt and no thoughts of it now. I asked about family history, which he said was negative, but then admitted he was adopted and didn't know his birth mother. There was no history of trauma, other than the indirect fire we'd taken there in Iraq, and the loss of a few Marines in his unit. He had never been treated for mental health problems, took no meds, and was healthy. No history of head injury. He denied use of drugs or supplements. He had done well in school, including competing on the swim team, and was on the fast track in the Marines.

"Oh, except that I might be in trouble …" He grinned at me, and started giggling wildly, burying his mouth in his hand like a teenage girl. I waited. But not for long.

"You know the Commandant? Of course you know the Commandant, you are in the Navy and are wearing our uniform. Well, I wrote him an email yesterday. At

least I think it was yesterday. Anyway, I was thinking about you officers, you know? And how it's so ridiculous that we are out here in a combat zone and people are shooting at us – did you know they are actually trying to kill us, Ma'am?" I nodded, but he didn't wait for my response before he went on.

"Anyway, we are trying to be operational out here, you know? The Marines are the greatest fighting force in history and we have these uniforms to BLEND IN with the desert … right? But there our officers are with SUPER SHINY THINGS on their collars. And people like you with SUPER SHINY WINGS on your chest. The rest of us wear dark brown insignia for a reason, right? I mean, do they actually want you to be targets? Cause if I were a bad guy – which I'm not, Ma'am—I would take aim at anything that sparkled, you know? My Major, he's hard core and not nearly as good a communicator as I am – there was one time he literally had us doing the most ridiculous goat rope exercise and no one talked to each other at all, it was a game of telephone. You know that game you played when you were a kid? Not sure if you played it, but we did …"

"Corporal. Let me stop you there. Your email to the Commandant got you in trouble, you said?"

"It's about to." He stopped, and his eyes darted back and forth, avoiding my gaze. Then, without warning, they filled with tears. "I love the Marine Corps, Ma'am. I don't want to get kicked out."

He was still holding the stack of drawings. His hands trembled so wildly that the papers rustled. Both boots were tapping now, uncontrolled and clumsy. Overcome with sorrow for this bright, talented young man who found himself in the throes of his first manic episode, I reached out and placed my hands on both of his. The trembling ceased. He looked at me again, and bit his lip.

"Help." His voice was a whisper now.

"I will."

He did not completely understand. In all my time as a psychologist I had only seen two patients in the midst of acute manic episodes. They never quite understood, either. Mania is too much fun, they explained. Usually we meet them much later in their experience, when their mania gets them in trouble or they get hospitalized for delusional behavior, or a suicide attempt, or both. Thankfully, Corporal Miller came to my door before it got to that point. Somewhere deep inside the chaos, he had enough insight to know that despite how fantastic he felt, something was not right. And somehow he trusted me enough to believe me when I explained we needed to bring him to the hospital to keep him safe. And to protect his fellow Marines.

We walked over together and I admitted him to our one-room ward, sending a radio message to Petty Officer Patacsil and asking him to contact the Marine's unit. It was the worst for my patient when our surgical company Marines came to take his weapon. He panicked, agitated and anxious to let them take it from him. I felt empathy, knowing how vulnerable I felt without my own 9 mm in my shoulder holster. And I don't even like guns.

I ordered the routine MEDEVAC and sat down to write a basic evaluation to send with him. He would go to Baghdad, on to Germany and finally back home, where a

treatment team would be waiting for him. He would be treated for Bipolar Disorder and receive the medication he needed before his medical discharge from the Marine Corps. This was a young man of many talents. Similar to my experience with other manic patients, he was very likable and a delight to interview. He was engaging and entertaining. He had insight and intelligence, and a fabulous smile. He would be okay. He simply could not carry a rifle in a combat zone any longer.

The ink had not dried on my signature when the echo of stomping boots filled the passageway. And a booming voice outgunned all the other sounds of a typical day in a hospital.

"WHERE THE FUCK IS DOCTOR KRAFT?"

I stood up and smoothed my blouse, smiling to myself a little as my gold wings caught the light. He was right, I mused. Why was I wearing gold collar devices and wings? In the next second, my patient's Officer In Charge was in my face.

He was a Major. He was nearly bald, with huge shoulders and an angry snarl on his lips. His hands on his hips, he stood inches away and glared at me. I half expected him to touch his nose to mine, and found myself wondering if he was a Drill Instructor in his former life.

"What can I do for you, Major?" I smiled sweetly at him.

"I just got word that you have ordered the MEDEVAC of Corporal Miller," he barked.

"Yes. He has Bipolar Disorder and has been experiencing an acute manic episode for several days."

"You can't take him."

"Major, it is dangerous for this man to stay in a combat zone. We do not have the capability to care for him appropriately here. He is not fit for duty."

He backed off a few inches and tried a different tactic.

"Doc," he said, his voice much softer. "I know you know what we are up against out here. We are undermanned as it is, with those Marines injured and killed last month."

"I'm so sorry for your loss."

"Thank you." He smiled. "So you can see why I need Miller. He does the work of two men, maybe more. Did he tell you that he single-handedly catalogued an entire warehouse of parts a few nights ago? IN ONE NIGHT? And he wasn't even on duty! Every piece of equipment we need is now organized in a computer system. It's nothing short of mind-blowing. I can't lose him. He is my most efficient Marine."

"Thank you, Major, for illustrating my point. He catalogued an entire warehouse in one night because he is MANIC. It's a serious psychiatric condition and it will get worse without treatment. His life and the life of those around him could be at risk." The Marine officer frowned.

"I want a second opinion."

"Certainly. Let me call my partner, Dr. Bennett." I picked up my radio.

"Forget it," he growled. "Here's the deal, Doc. Line overrules medical. I am overruling your decision. I am taking Miller back with me. Needs of the Marine Corps." He spun on the heel of his boot and started out the door.

"No problem …" I called after him. "I do need you to just sign this first, though, before I can release the patient to you." I picked up a blank sheet of paper and started writing. I read out loud to him while I scribbled.

"I, Major Smith, have been briefed by Lieutenant Commander Kraft regarding the psychiatric diagnosis of Corporal Adam Miller, and understand that my decision to take this patient out of the hospital is being made against medical advice. Thus I understand that I am assuming ALL RESPONSIBILITY for any adverse event that occurs as a result of this diagnosis going untreated …" I handed him the pen.

He looked at me for a long moment, his face a changing landscape of colors—orange, red and purple. He snatched the paper off the table and crunched it into a ball in one hand, then spiked it on the ground.

"SHIT!" He stomped out the door, his profanity-laced rant fading as he disappeared down the passageway.

I waited, frozen, until he was gone. And then my knees buckled beneath me and I plopped backward into a chair at the nurses' station. The urge to burst into tears found itself strangely juxtaposed with a desire to howl with laughter. I did neither.

Symbolic of our entire deployment, which brought the best and worst moments of my life—sometimes at the same time—I often reflect on that hot day in Iraq through the lens of perspective and growth. I learned a few life-changing lessons that day. I will never forget them.

From my patient, I learned how terrifying a first experience with mental illness must be—anywhere, really, but especially in a combat zone. I learned that the courage it took to accept help, and the sorrow he felt in leaving his fellow Marines behind were both exponentially greater than the fear he felt at symptoms he didn't understand. From his OIC I learned about the conflict faced by combat leaders, and about the agonizing choices they have to make every day, between doing what is best for the mission and what is best for their people. He didn't express it very eloquently, but I am certain he felt it. And from somewhere deep within myself, I learned that no matter what obstacles might stand in my way, I can and will summon the strength to stand up for what is right. It will be my job, going forward, to raise children who understand. We defend those who cannot defend themselves. And it is always worth it. It turns out that if this is the definition of a combat psychologist—it is exactly what my Marines have been trying to tell me, all along.

The Purposeful Doctor

7

Mary El Pearce

7.1 Rules of Leadership

I met my husband when we were both working for a military health facility that provides care to soldiers suffering from the effects of traumatic brain injury. I'd been supporting various military missions by the way of public affairs for nearly a decade, but none struck me as more important than this one—treating service members suffering from the invisible wounds of war. Though we worked in different areas, we were mutually drawn to each other. He would describe our meeting as destiny. I tell him now that it was his charm and flashy smile, but the truth is I was both inspired and enchanted by the passion in him to find innovative ways to care for his fellow service members. He brought that passion to every meeting and patient encounter, and his peers lauded him for it on his last day of work after he finished his tour of duty. This passion stretches beyond his personal goals and reaches into the heart of everyone he treats or examines. It's bigger than himself—it's compassion at its finest, the kind that can only exist from having contended with loss, pain, hardship and heartache firsthand, allowing it to penetrate his core but not decimate his soul.

As I got to know this man whom I first revered and then grew to adore, I learned about some of the experiences that shaped him into the purposeful doctor that his patients and colleagues admire, and the caring, confident man I would later marry. During his 24-year Army career, my husband served on three deployments—two to Iraq and one to Afghanistan. Beyond doubt, his tour in Iraq from January 2004 through January 2005 was the most rewarding yet the most gut-wrenching, as the impact it would have on his family would dramatically change his views of the world and himself.

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When combat operations started in Iraq and Afghanistan, most psychiatrists had never deployed due to the period of relative peace since Vietnam, so little institutional experience was available when he received the notification that he would be deploying. The experience was life altering and rewarding, but at the time he had some misgivings as he was asked to substitute for another psychiatrist who was initially assigned to that position. Because my husband was the most junior staff at Walter Reed Army Medical Center, he went in place of the other psychiatrist. Thankfully, he had ample combat care training and knowledge to guide him through this time of uncertainty.

My husband was commissioned as an officer in the U.S. Army in 1992 when he began medical school at the Uniformed Services University of the Health Sciences, or USU, in Bethesda, Maryland, the nation's only military medical school. Besides USU being the best choice among other schools he explored, joining the Army was part of his family's tradition of military service—his father was an Army medic stationed in Korea during Vietnam; his uncle was shot and killed in an ambush serving as an infantryman in Vietnam; and his grandfather was rescued from the shark-infested Pacific Ocean after his ship sank while serving in the Navy during World War II. In addition to standard coursework, he took military-specific courses, like military medical history, tropical medicine, and operational and emergency medicine. During summers he participated in operational rotations including spending time with line units or going on training field exercises. Although he didn't expect to deploy any time soon, on these field exercises he began to learn how to operate in a deployed environment.

Between his first and second year, his classmates and he spent a week in the field learning the basics of military operations. Each of them took turns in leadership roles so they had all served in various capacities inherent to the company element by the end of the week. One night he was acting as squad leader for a nighttime casualty extraction exercise. They rode in troop transport vehicles and used land navigation to find coordinates of the known casualty. He set up a defensive perimeter as a team searched for their casualty in the woods, eventually pulling out the mannequin which represented the patient. They were behind on their timeline, so they mounted up hastily and headed back to camp. Upon their return, they basked in the satisfaction of their completed mission, but back slaps and high fives were soon interrupted by an irritated classmate covered in mud. My husband had sent him out as one of the perimeter security elements, but the classmate was too far away to hear the order to mount up and watched the taillights of their vehicles fade into the night. With no other option, he traversed the road for several miles back to the campsite in the darkness, stumbling through puddles and uneven terrain. He was rightfully angry, and my husband felt tremendous regret for having left a soldier behind. He would never forget the importance of attention to detail and accountability after this incident. Thankfully, it was just a training exercise, and these are exactly the types of lessons young officers are supposed to learn.

The following summer my husband spent six weeks with a line unit performing duties as a Second Lieutenant (his rank). He trained with a medical unit from Fort Bragg bringing heavy equipment, such as tanks, onto a shore without port facilities.

He witnessed field medicine in action and had a very tolerant company commander who gave him plenty of opportunities to excel and make novice mistakes. That summer he learned four key rules he felt were integral to being a good leader: (1) *Command presence is critical*; (2) *Not standing out in incompetence is far more important than standing out in excellence*; (3) *Knowing your limits and listening to your NCOs promotes success*; and (4) *Command strategy may not always be readily apparent to boots-on-the-ground troops*, *and from the ground troop perspective, accepting that rather than becoming disgruntled will save you a lot of energy*.

The final exercise of medical school during their senior year, an intensive field exercise that required them to apply all that they'd learned over the past 4 years, was the first time he felt competent as a physician. They had helicopters and moulage patients (real people with mock injuries), and for 96 hours they provided casualty care in a simulated combat environment. He graduated shortly afterwards, completed a five-year residency, and became board certified in internal medicine and psychiatry. He later did a fellowship in geriatric psychiatry, and because of his specialized training he was stationed at Walter Reed Army Medical Center in Washington, D.C., instead of going to a remote post like many of his peers. When the Pentagon was attacked in 2001, he had the opportunity to go with his mentor and boss, Harold Wain, to Arlington Hospital to see patients who had been brought straight from the building. Although he'd treated combat-wounded from the Bosnian War, the U.S. Embassy bombing in Kenya and the bombing of the *USS Cole*, their experience in taking care of the 9/11 terror attack victims (many who eventually transferred to Walter Reed for definitive care) set his foundation for handling patients with combat stress.

7.2 Deployment: Cold to Hot

My husband deployed with the 785th Combat Stress Company, a reserve unit out of Fort Snelling, Minnesota, two and a half years later when he was a Major. The only combat stress unit in theater at the time, the unit was essential to providing soldiers with proactive, preventive, and restorative care. In addition to the day-to-day hardships of being in a war zone (as he would soon find out), soldiers had to manage household logistical issues, the distress of being away from their loved ones, and sometimes even breakups with their significant others. The 785th comprised the best group of people for the work that needed to be done at that time. They regularly went above and beyond, and everyone worked together in concert to help soldiers return to duty as quickly as possible.

They flew on a commercial aircraft off of an airbase that was near Fort McCoy, Wisconsin. January in Wisconsin is what my husband has described to me as "butt-ass zero below freezing." After one failed attempt to depart due to mechanical issues, they lined up outside the enormous airplane with their rucksacks, duffel bags, and weapons. He was already missing his family (his then wife and two young sons) and didn't want to fly farther from them, but he was bathed in warm relief when they were finally given the order to board. The soldiers lumbered up the stairs

and sat every other seat with their duffels next to them and their rucksacks in their laps, and flight attendants gave them hot towels to wipe their faces. Other than having his gear, my husband felt like he was in first class.

As they flew to Maine to refuel then on to Kuwait, his attitude shifted to a fatalistic point of view. He took stock of his life up to that point and decided most of his decisions had never been ambivalent. Where he did his training, what field of medicine he chose, and even where he was stationed all were clear choices. But being deployed—that wasn't in the plan. The only way he could reconcile it was to see this deployment as his destiny, something that was out of his control. He didn't know it then, but this concept of acceptance and fatalism would be vital in getting him through the deployment.

After a 24-hours trip, he landed in Kuwait, a stark difference from Fort McCoy. It was butt-ass a hundred above boiling (my words—but he assures me it's an accurate description). There were too many people. The portable toilets overflowed all the time. You had to stand in line 45 minutes for chow. And the commanders were making work for the soldiers to do while the unit waited for their vehicles to arrive from Fort McCoy. Another psychiatrist who was senior to my husband got bent out of shape about the experience, feeling the command wasn't informing him adequately of the plans. Cloaked in his new attitude, my husband decided it was nice not to have to make any decisions (well, except for the decision not to make decisions). People told him where to be and what to do all the time, and all he had to worry about was following orders. During this lull he began to develop a relationship with his commander, who increasingly asked him medically relevant tactical questions and about his perspective on personnel management issues that were affected by extreme personalities. He capitalized on my husband's rare experience of direct combat casualty care and made him the medical director of Combat Stress Company, as well as appointing him as the officer in charge of the treatment center in Baghdad. The senior psychiatrist who had been agitated upon arrival was unhappy he had not been named medical director. *Rule No. 4: Command strategy may not always be readily apparent to boots-on-the-ground troops, and from the ground troop perspective, accepting that rather than becoming disgruntled will save you a lot of energy*.

Although his training had paid off and he was energized about the mission, he was devastated four months in when he learned his six-month deployment had been extended to a year. He had grown weary of the constant, around-the-clock combat operations. Time was filled with tense, hot days and restless, anxious nights. Throughout the day he could hear gunfire and explosions in the distance, and at night he'd be woken up by what sounded like thunder on top of him and everything outside shaking. One night their treatment center, a converted Iraqi Republican Guard building, was damaged by a rocket that landed in an alley across the street, which funneled the shrapnel like a gun barrel. The shrapnel blew off their front door and shattered the windows, filling their house with smoke and debris. Everyone was accounted for and miraculously no one was hurt, but they couldn't deny the front lines were becoming blurrier, the combat inching closer to them every day. He knew the longer he stayed the greater his risk of injury. And now he wasn't even halfway through his deployment.

After the attack, and because his unit's location was at an important intersection in Baghdad, they had to develop a defensive plan. If the base was overrun, they were supposed to hold their building for several days while the nearby hospital and government workers could be evacuated to a new rally point. A quick inventory of the one box of ammunition in the whole house made it apparent that they would be poorly prepared and equipped to meet this objective. They requisitioned the brigade for more ammunition, fixed the holes in their walls, and drilled for attacks and evacuation. They asked the nearby combat arms unit to help design their defensive fighting positions and guard towers. Recognizing that NCOs are the backbone of the military and provide invaluable counsel to leaders, my husband relied on them to hold regular drills so everyone could spring into action should things go south. The key for him as medical director was to leverage the skills and expertise in and outside his unit since he wasn't about to pretend to be an expert on combat arms. Leaders make the decisions, but they should solicit counsel from those under their command. *Rule No. 3: Knowing your limits and listening to your NCOs promotes success*.

In the meantime, my husband and his unit were compelled to bring combat stress care concepts to the next level. The doctrine directing care came from years of theory since Vietnam, but (fortunately) military doctors had little opportunity for practice due to long periods of peace between the wars. First, the 785th evolved and improved doctrine based on lessons learned. For example, they expanded their mission focus to include anything behavioral health related, not limiting care just to combat stress patients. Getting patients to come be treated for anything mental health related was already challenging, so expecting patients to figure out which behavioral health provider to see at what center wasn't reasonable. Next, they broke down stigma associated with accessing care. Their patient numbers swelled, averaging 120 contacts a week and made possible by their well-coordinated care team of psychiatric technicians, nurses, social workers, psychologists, and psychiatrists. Third, they removed the physical obstacles between them and patients by bringing the care to the patients. Troops were scattered across Iraq on small bases with few resources, and soldiers with combat stress couldn't go convoying through hostile territory to come seek care for combat stress or another mental health issue. While all three of these actions were radical, this last one affected the most change in their concept of care.

7.3 Meeting the Patients Where They Are at

Despite having satellite phones and Internet—however spotty it may have been—word of mouth proved to be the best method of finding small outposts with soldiers who needed care. The 785th would obtain grid coordinates to the outpost then walk into the supply hub in Baghdad and ask if the guys had ever heard of the place they were trying to get to. If the guys were making a supply run, the 785th soldiers would ride along and show up unannounced. They'd get out of the vehicle, show their identification, and tell the outpost soldiers they were from Combat Stress

Company and came to check in on them. Then they would talk to the chaplain (because everyone who's stressed out goes to the chaplain), then whoever was running the battalion aid station (since they treat the soldiers), then the First Sergeant (who knows his troops best), and finally the commander (to fill him in on the plan). After setting up their operations, they'd see the soldiers who needed to be seen then go off to the next base.

One day they visited a unit that had experienced more than their share of combat. Over half of one of the platoons were reportedly Purple Heart recipients. My husband tried to talk to the soldiers and they told him, "Sir, you don't know what you're talking about. You haven't been out there. You don't know what it's like." Blame it on his fatalism, but he found himself saying, "Show me." The company commander was a Captain, and when my husband asked him if he could go out on a mission with them, the Captain replied, "Well, sir, you're the Major. If you want to do that, fine." My husband should have been scared, but he knew they weren't going to let him go out on a high-risk mission, and just riding along on a routine patrol gave the 785th firsthand experience of what their patients were dealing with.

One of the first missions they went on was in Sadr City. A psychologist and my husband joined a patrol for about six hours during which they got shot at, chased down a guy carrying an AK-47, took badges away from the local militia, and held back an agitated crowd with their weapons. The soldiers they were with were hard core—1st Cav, well trained combat arms guys. The trick for my husband was to not be an idiot (a trait that makes him a superb husband as well). He didn't want to accidentally shoot himself, and he didn't want to shoot one of the soldiers, so he meticulously followed directions from the Lieutenant and tried not to look scared. That's all that was needed. No one was killed, they got through the day, and they got home safe. *Rule No. 2: Not standing out in incompetence is far more important than standing out in excellence.*

After that, many of the staff in the 785th went out on missions to develop a rapport with soldiers. My husband wanted patients to know they were reasonable people and weren't looking to ruin soldiers' careers by saying they were crazy. Most soldiers were having a normal reaction to an abnormal situation, and the 785th could probably make them feel better. Once they saw the Combat Stress soldiers were willing to put themselves beyond the wire to help them, they opened themselves and started talking. Meeting the patients where they were at—that's what it took.

60 Minutes got wind of what Combat Stress Company was doing and embedded with the unit. The crew accompanied them to a base near Sadr City and watched the team in action. CNN's Christiane Amanpour interviewed my husband, who was bald at the time, and the *60 Minutes* crew kept powdering his head until a cameraman told him, "I don't think there's enough powder in Iraq to make that head not shine." (If you watch the episode, you'll notice his forehead is cut off.) Having the media tell their story was exciting, but this was anecdotal at best to the overall experience. The greatest part of the deployment, my husband will tell you, was breaking through all the barriers to care inherent to a combat environment and returning 95 percent of soldiers to their units after treatment.

7.4 Reintegration

While the 785th was making great strides to help their patients in impactful ways and change Army procedure, my husband's family was suffering. His oldest son was five years old and having a tough time without his dad. When my husband could get a satellite phone or Internet messaging to work, his wife would tell him how his son was playing with other kids' fathers at the pool or something else to show the impact the deployment was having. His youngest son started walking and talking about a week after he deployed. When the deployment was extended, she called his supervisor and fought to get him home, which of course was fruitless. As the months went by, her fighting spirit waned until one day she called to let him know she was considering going out with a man she met at the gym. Outfitted in body armor, set to mount up and head into the red zone, my husband helplessly listened to his marriage ending on a phone call. The prospect of losing his family was incomprehensible as he forged ahead to complete his mission.

A few months later he returned stateside and faced the hard reality that besides the familial woes, he had a host of personal issues to work through. Everything was an assault on his senses—color, sights and sounds, carpet, driving—but the worst was being misunderstood. At that point in the war, soldiers with direct combat exposure were a novelty, particularly physicians, and it felt like no one could relate, especially not a young mother who had decided she could keep the home fires burning just fine without her deployed husband in the picture. When he was awarded a Bronze Star by a two-star General a few weeks later, she attended the ceremony and stood by his side onstage, and while the General commended this innovative and courageous mid-grade officer, she leaned in and whispered, "This is bullshit." Not long afterwards, she formally asked for a divorce and he moved into a two-bedroom apartment with no more than a duffel bag filled with clothes. The U.S. Army saw him as a hero; heartbroken, wearied and alone, he could only see himself as a failure.

He tried settling into his new normal, but he couldn't get comfortable. Neither apartment nor single life suited him, and he was having trouble healing from the adjustment and loss. One day driving to work, someone tailgating him honked, and he lost control of himself. He slammed on the brakes, jumped out of the car and, in uniform, beat his hands against his chest, screaming, "You want a piece of me?!" The man in the car looked terrified, threw up his hands in submission, and drove around him. My husband stood in the road, breathing heavily, heart pounding, and realized he was not honoring himself, his children, or the uniform. He'd spent a year helping others, won an award, ended up on TV—and fate had brought him here, standing in the road screaming like a lunatic. *Rule No 1: Command presence is critical.*

7.5 Destiny

Violating his first rule of leadership was the jolt he needed to awaken from his post-deployment and post-divorce haze. Just like during the flight to Iraq, he was forced to reconcile events outside of his control, and eventually he could not imagine an

alternative path. Over the next few months, the jumpiness and irritability faded, as it usually does for most after deployment. While he healed, he focused his energy on morality and justice, and he began to respect and see people for what they believed rather than who they were. By deconstructing himself, fate gave him the opportunity to rebuild and reinvent his life in a much deeper way than was previously possible. Fatalism was the mental construct he needed to take unavoidable bad events and use them as a launching pad for personal growth and development, rather than let them destroy him.

My husband's career and personal life have been filled with fortune since the deployment. He has cultivated his identity and self in a way that brings him much closer to his ideal, and I am not sure he would have achieved that level of personal fulfillment had he not been through the experience. He went on to serve two more deployments, one more to Iraq and another to Afghanistan, and he has held a variety of leadership positions and achieved the rank of Colonel. And of course, he met me, and at the exact right time in each of our lives. Today his teenage sons know him as one who values upstanding character, honor, and doing the right thing. He looks back on this tumultuous time and says fate led him—and saved him—there. I see a man whose selflessness and valor redirected the destiny of hundreds of U.S. soldiers.

Acknowledgement *Disclaimer*: The views expressed in this chapter are those of the author and do not reflect the official policy of the Departments of Army/Navy/Air Force, Department of Defense or U.S. Government. The author declares no financial, commercial, or other conflict of interests.

Mary El Pearce is a military public affairs specialist and the wife of an Army psychiatrist. The chapter focuses on her husband's first deployment to Iraq in 2004 where he served as medical director of Combat Stress Company.

The Iraqi Heart of Darkness: A Visit to Abu Ghraib

8

Elspeth Cameron Ritchie

As Psychiatry Consultant to the Army Surgeon General, I went to Iraqi prisons to assess the mental health needs of soldiers and detainees in October 2004. The "Abu Ghraib" scandal had surfaced in April of that year.

This story was mainly written by the light of the computer, while swapping at mosquitoes. My computer got coated with dust. (Later, back in the States, it crashed.)

The four of us—two other forensic psychiatrists and a senior enlisted mental health technician—gathered for the convoy on the outskirts of BIAP, the Baghdad International Airport. A line of Humvees, armored vehicles, and gunships gathered. The soldiers were smoking and joking, leaning on their vehicles.

We were en route to Abu Ghraib, eight long miles through one of the most dangerous routes in Iraq. The main supply route we were to travel was "green," but we still got the warning about explosive devices, roadside bombs, and instructions to point our weapons out the windows of the vehicle.

I had my photo taken with the young female captain who would be driving, and joked to Todd that this might be the last photo with both my legs (Our Humvee was not armored.).

My silly 9 mm pistol pointed out the window for the eternally long twenty minutes it took us to get there. Silly because it would do no good if we were hit by an

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improvised explosive device (IED) or taken out by snipers. Driving fast, and erratically to avoid the guys who took potshots from bridges, we passed several very large craters, from other bombings.

At last we reached the infamous prison, a large walled compound actually in the suburbs of Baghdad. It had been notorious in Iraq for the torture and execution of numerous Iraqis, under Saddam Hussein. The previous spring, photos of naked prisoners in piles, with female guards holding them on a leash, surfaced.

Since then there had been a change in leadership. The scandals were part of the reason we were there.

The Army correctional personnel who now ran the camp showed us to our sleeping quarters. This was a large empty room with filing cabinets with records of detainee health care. Hooks were screwed into the ceiling.

We set up our cots. It had been ten years, since my Somalia deployment, that I put together a cot, and I, embarrassed, had to ask our NCO to help.

Soldiers were lodged in the prison cells, literally. The cells provided some protection from mortars. These young Soldiers, looking like kids, in gray Army t-shirts, had turned the cells into make shift homes with plywood doors and mink blankets.

The only dress allowed was desert camouflage uniform (DCUs) or Army gym clothes, plus body armor and helmet. Always one had to wear flak jackets and Kevlar helmets when outside the hardened facilities, which were the prison cells.

Weapons and magazines with bullets must always be within easy reach. Two rockets landed not far away that day, and another few the day before.

The proceeding April multiple mortars landed in the tents of the detainees. In one attack, 22 Iraqis were killed and a hundred more wounded. The MPs could not get help to them for a long while, because the detainees were throwing stones at them. The mortar rockets had US on their fins.

The whole place was a trash dump, literally built on a landfill. Perhaps 19,000 people were killed there in the last decade, or only 12,000, or maybe 30,000, or 100,000 depending upon with whom you talk. Occasionally the boots of the Soldiers kicked up human bones.

Hooks were screwed into the ceiling in the cells and in the large common room where we put up cots. Prisoners were strung up there during Saddam's reign. Now the hooks served to string ponchos, separating male and female Soldiers.

"The place is full of evil spirits," said the rational doctor across from me on at the plywood dinner table at chow.

Soldiers and contractors also said that if you take photos in the death chamber, shadowy faces of the dead appeared in the edges of the picture.

A young medic gave me a tour of our living quarters, one of the prison buildings. Standing on the roof, my guide pointed out where they thought insurgents would attempt to breach the walls.

Trash used to be piled up to the roof, a perfect landing platform for attackers. The medics, who lived within the prison for security from the rockets, had made plans to secure the LSA (living space area) in the event that insurgents stormed into their living quarters.

I was not sure that I had confidence in the plan. But I just got here.

That first night, I slept soundly, worn out by the long day. Then I vaguely heard some thuds, then a siren. They called us to put on our flak jackets and Kevlar helmets. We assembled in formation, then returned to our cots. A couple more thuds—mortars or helmets hitting the floor?

Next morning at the staff meeting we learned that five mortars landed within the compound walls. Some damage to the motor pool, no one hurt.

In the morning, I visited the compounds on sick call and did psychiatric rounds "through the wire." With my body armor on, and the 120 °F temperature, I dripped sweat continually. So did the guards, with their heavier guns. I was beat after an hour. The air-conditioned wooden shacks of the guards and chilled water offered some relief.

The detainees lived 200–300 in a compound. Through an interpreter we asked the identified "psych patients" about their symptoms of anxiety and depression. The leaders in the camp told us about the "crazy folks", who cut themselves or talked to the air.

There were so many poignant stories from detainees:

> I did nothing wrong. I love America, I would not harm any Soldiers. My mother died when I was here; I could not go home to bury her.
>
> I worked for the US. I am a geologist, and my sister and uncles are doctors. The Americans treat us well here. I want to work for them again when I am released.
>
> I was with my father and brother and cousins, and they made me come in here (with the other juveniles). Please let me go back to my family. I am more comfortable there.
>
> I want to go back to the hospital. Other Iraqis beat me up. I will swallow some more razor blades (from the concertina wire) if I cannot go back there.

"When am I going to be released?" was the universal question from all the detainees.

Are their stories true? The guards reminded me that they were picked up as insurgents, who have tried to kill my fellow soldiers.

Thirty-six juveniles were imprisoned there, aged 12–18. They were in a separate compound but often said they are older, in order to rejoin their families.

There were also stories from the correctional staff, hard-working soldiers, dressed in flak and Kevlar, plus many guns. It was extremely hot, but they seemed to have adjusted to the desert.

It was other issues that the correctional staff talked about:

> My son was killed right before I came out here. I wanted to come here; otherwise I would have killed the guy who did it. Now I need to go back for his trial.
>
> I don't want to report it … in the convoy, he kept taking my hand and putting it in my crotch … my mother was a Marine for 20 years, she tells me to just hang.
>
> They point their fingers imitating RPGs at me, shout Fallujah, and threaten my family.

But the guards seemed to be doing all right overall. Their main complaints were of the earlier Abu Ghraib prison scandal, and how they were tarred by that brush.

In the evening, bats flitted everywhere in the setting sun, which outlined the watchtower. That was the end of the first full day.

The choppers came and went all night. There were no more mortar attacks. Roadside bombs killed two American soldiers nearby.

The next morning, we went to the "hard site." The infamous photos of the naked human pyramids were taken here. The Iraqis now were in charge, and the cells were used for "criminals."

The cells were very small, narrow, barren and dark. Hands reached out through the bars, as in a hundred bad movies, but here it was for real.

The American contractors who lead us through seemed sincere and motivated, and urged the Iraqi medical staff to attend to their prisoners. The contractors insisted that the prisoners get medical treatment, if needed. Most prisoners seemed grateful for the American presence.

But when the jail door opened, and there was only one Iraqi warden between the detainees with baleful stares and me, I decided to move on.

I was given a souvenir—an orange jump suit with Arabic and English writing on the back, saying Abu Ghraib. Will I wear it on Halloween, if I ever get out of here?

Saddam's death chamber had twin gallows. We viewed cells where prisoners waited to die, names and dates of execution scrawled on the wall in Arabic. The dates are clear.

How many died here? They say that if the guards liked you they fed you to the grinder headfirst, rather than feet first. It is hard for me to comprehend that much cruelty.

Our interpreter was imprisoned there for 3 years. He looked somewhat shell-shocked by being back in the "hard site."

Good care was now delivered to the wounded, the ill, those with gunshot wounds suffered in fights with our troops. Mental health care has just arrived. I have a tour of the new hospital—big, effective and clean.

More sick call in the camps. Detainees were colorfully dressed, praying together on large mats. We watched them pray and play volleyball from the watchtower where the soldiers break up fights with lethal or non-lethal weapons (rubber bullets).

The American combat stress control staff tried to get detainees to take their psychiatric medications, to not threaten to scratch themselves on concertina wire, or eat the sharp blades. Too many have swallowed them.

Coming back at night from the Internet café in my Army shorts and shirt uniform, there was a dog barking balefully. Three soldiers have already been bitten and were given rabies shots. I only have sneakers and bare calves; can I kick him? Or shoot? I wish I had my boots on. My little clip-on penlight does not offer much light.

I watch as two Chinooks speed in, low and fast and with no lights. They land in the dark on the pad, swirling up sand into the lights from the prison. Soldiers have been sitting on the concrete to bring the insurgents into the prison to be interrogated.

Sensory overload:

Sounds: generators, barking feral dogs, military vehicles, air conditioners whining, helicopters beating the sky, but no mortars.

Sights: watchtowers around the prison lit up with lights, choppers flying in low and dark, soldiers on the side of the road, waiting to board, a line of blindfolded men, ready for interrogation.
Feels: hot wind-blowing sand; sweat dripping down my neck, fingers typing on the computer screen.
Smells: porta-potties. No overt smell of death, not bad, unless imagined.
Uncertainty: whether there will be scorpions in the latrine, rapid feral dogs biting me on the ankle, insurgents on the walls, rockets on our sleeping platforms, or if the snores from the NCO will keep me awake.

This is a haunted prison; the whole place is a killing ground.

Two days and three nights after arrival we get up at 5 AM to catch the convoy home. This time the security brief is more serious. Seven Marines were killed 2 days ago slightly west of here, and an IED exploded on this road last night. Weapons should be locked and loaded. "Watch out for friendlies though."

We moved out smartly, speeding down the highway, guns again pointed out the window, past old cars and trucks and a new big pothole from an IED that was not there 2 days ago.

Sheep and villages lie along the side. Then to a more rural road, with tall grass that could easily hide a sniper, and the pace feels way too slow. A beautiful morning, though, especially to be whole and alive. Finally into the checkpoint, we clear our barrels, and we are safe inside the compound.

Back at home in the USA, I show pictures to an Iraqi-American colleague, whose thirteen cousins were executed by Saddam, three of whom were at Abu.

My computer will not turn on, and I blame ghosts or sand from Abu Ghraib—a very evil place.

The orange jumpsuit, with Abu Ghraib written on the back in English and Arabic: I do wear it at Halloween. It is warm and comfortable. But very creepy.

Elspeth Cameron Ritchie Colonel Elspeth Cameron Ritchie is a retired Army Psychiatrist. This chapter focuses on events in Abu Ghraib in October 2004, while she served as Psychiatry Consultant to the Army Surgeon General.

The Two Sides of Modern-Day American Combat: From Camp Austerity to Camp Chocolate Cake

9

Jeffrey Millegan

9.1 Prelude

I graduated from medical school in 2002 and have had my military medical career defined by the September 11 terrorist attacks and the global war on terror that followed. In 2003, I completed my psychiatry internship and was transferred to a Marine infantry unit to serve as the battalion surgeon. A battalion surgeon functions as the unit's physician and is responsible for the health and readiness of over 700 Marines. In combat, he becomes the front-line physician in treating the ill and wounded.

This is an overwhelming position for any young physician new to the military. It becomes more intimidating joining a unit less than 6 months after the invasion of Iraq with a certainty of joining the fight. Psychiatry training at a military hospital, thankfully, is much broader given this possibility and includes a combat medicine course and Advanced Trauma Life Support certification.

Prior to deploying to Iraq, my only hands-on experience with chest wounds and arterial bleeds came from work on goats in the vivarium lab. Needlessly to say, I was not entirely confident my small amount of trauma training on goats and a psychiatry-focused internship would equip me adequately for what was to come.

9.2 Deployment 1: Camp Austerity

In early 2004, I left with my Marine battalion for a 7-month deployment to Iraq. We spent a few weeks preparing in the bleak tundra of Kuwait, before convoying over 30 h by vehicle through Iraq to our area of operation, Camp Austerity. My home for

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Fig. 9.1 Adaptations to the climate in Iraq

the next 7 months was no more than half a square mile in size, had no electricity, running water or walls (yet) between us and the Iraqi town.

On my second day, I was woken by the sound of 25 mortar rounds gradually increasing in volume as they came closer to where I had been sleeping. Although jarring on day two, it was amazing how common place these became as I got used to the surroundings. These became so frequent, that I became more annoyed by the mortar attacks delaying my daily chess game with the Air Officer, than worried for my safety. The vast majority of these attacks resulted in zero casualties and no visible scars to the grounds. It was easy to forget the dangers that they represented.

Once, during a mortar attack, I walked out to the command center wearing only shorts and a t-shirt, until being quickly corrected and sent back outside (during the continued mortar attack) to fetch my helmet and flak jacket. It is a jolting reminder on those few occasions when you leave cover to find a destroyed vehicle or someone else with wounds.

It was interesting how predictable the mortar attacks became. They always occurred 30 min before curfew. If we set the town curfew at 8 PM, the attacks would come at 7:30. If we moved curfew to 6 PM, the mortars would be invariably launched at 5:30. In retrospect, it was kind of funny that the attackers always respected the curfew.

Being the only Navy officer and physician on a small outpost of around 400 Marines can be a lonely place. The sense of being an “other” is strong and takes

significant effort to overcome. The isolation is even stronger since, as the only physician on the base, I was seen as the person to fix others and to be a therapist to my corpsmen and the Marines when needed. Although I was in a new and scary situation with little experience to fall back on, I felt a duty to be seen as a source of stability and strength to others. That can be taxing. I have since developed great empathy for wartime mental health providers and chaplains who often serve throughout the world in solo practice settings.

The other 399 people on that small outpost all had a common identity as either Marines or grunts or corpsman. And then there was me. This isolation was fueled further by my lack of regular communication with the outside world. Camp Austerity was not a developed base with hotel-like amenities. The main vehicle for outside communication was a satellite phone. Since our base had only two of these, my regular call to my anxious wife was not a high priority to the overall mission.

Although I found opportunities to make this call, there were unique challenges for an intimate connection. The line of others waiting to connect with loved ones made any call of over 5 min a difficult task. The combination of operational security and not wanting to overly worry her made those 5 min mainly spent with pleasantries and staying relatively superficial.

On three occasions, my phone calls were abruptly stopped due to an incoming mortar attack. My wife would hear a large explosion, and then me saying, "Gotta go, bye." This may be followed by several days of a ban of outside communication, due to a recent casualty, with my wife left to her imagination on what had become of me.

I connected with the Marines and corpsmen at every opportunity. Besides my daily chess game, I enjoyed talking with the corpsmen about medical cases, playing basketball (when it was safe), and checking regularly with the base leaders. I made many lifelong friendships out there that remain the high point of the whole experience. It is true that we fight more for each other than for any higher cause.

I came to this warzone without deep confidence in my ability to do my job as a battalion surgeon adequately. I feared being discovered as a "fraud" and, much more so, contributing to the unnecessary death of a Marine. I was very lucky that I was surrounded by experienced, combat-hardened corpsmen.

Most of my corpsmen were deploying to Iraq for the second time and had only spent 5 months in the USA prior to their last deployment. They joked about their time at home being their deployment before they returned "home" to Iraq and how they recognized a particular mound of sand and piece of sparse vegetation.

Less than 2 weeks into my deployment, I encountered my first significant casualty. The gunner on the top of a Humvee was severely wounded by shrapnel from an Improvised Explosive Device (IED) (this became a way too common situation during this deployment). He had shrapnel in his arms and head including the eye. I ran to the casualty scared as hell. My fear subsided when I saw my corpsmen spring to action and treat the life threatening injuries with minimal direction from me. Air support was miraculously fast and, within 10 min of coming into contact with the wounded Marine, a helicopter had taken him away to the closest surgical team. A few days later, we heard that the Marine survived and kept vision in one of his eyes. These corpsmen were incredible.

That was a spectacular feeling. It was the first time during the deployment that I felt that I could do this, plus may actually be able to help. Over the next few weeks, I treated many Marines wounded from IED explosions and small-arms fire and was able (with help from the corpsmen) to deliver life-saving care and hand them over to the helicopter for definitive care at a larger base. A few days later, I would hear the good news that they survived and were doing better than expected. Although the war was terrifying, there was a sense of purpose and a rush of adrenaline with each Marine successfully treated.

Then, a Marine died.

Immediately into this deployment, the Marines were engaged in combat and we were regularly under attack from mortars, direct fire, IEDs, and ambushes. It became a daily occurrence to get the call that someone was wounded and I would rush to the unarmored ambulance (this was 2004), with my corpsmen and head out to the site of the casualty.

However, in this case, when the ambulance stopped and we hopped out, there was an unnerving lack of frenzied activity. It was pitch black and all I could see were the corpsmen and the accompanying Marines looking out into the horizon, but not running toward the casualty. I was notified that a suspected mine field was between us and the wounded Marine. The wounded Marine's vehicle had hit a landmine and was in very bad shape.

There was nothing that we could do. Eventually, a safe path was found to the vehicle but it was too late. The Marine was dead. I have never felt so helpless and useless as I did at that point. Any of the adrenaline rush associated with running to a casualty ceased at that point. This was real.

I did not get much time to reflect and grieve, as a few days later the whole town became a battle zone. That morning started with a patrol being ambushed and five of our Marines killed. That was by far the most deaths we had suffered in 1 day.

Before having time to reflect, more battles started. At one point, we were informed that over a thousand insurgents were in a mosque several blocks away preparing an all-out assault on our small base. Marines were firing their M-16s from the guard posts. One of the intel Marines suggested I grab one of the confiscated AK-47s, just in case we were overrun.

The battle lasted over 24 hours until all resistance had been defeated. As everyone returned to the base, an eerie quiet consumed us. We were only 2 months into this deployment, with 5 months to go. Was this the new normal?

Thankfully, that battle was the peak of our combat operations during the deployment. We still were routinely mortared, and there was the occasional ambush or IED attack, but we fell into a regular rhythm.

During this time, I noticed a difference in the morale and psychiatric condition between two of our companies. The small outpost where I spent the bulk of the deployment was primarily run by Bravo company. Bravo company engaged in more combat and loss than the other companies in our battalion. At the other end of the spectrum was Echo company, that was at our large, main base and was involved primarily in base protection. They saw the least amount of combat.

During my time with Bravo, not one Marine was evacuated due to a psychological or behavioral concern. Morale was high, cohesion was tight and the sense of shared duty was palpable. Echo company was a different story. They were plagued

with low morale and disciplinary problems. A number of Marines from Echo were evacuated for mental health reasons.

Unit cohesion and purpose can be incredibly protective and provided an astounding layer of resilience to people facing adversity together. I don't believe there is any therapy as powerful as being in the moment.

On our return to the USA, many of the corpsmen and Marines of Bravo company did eventually suffer from PTSD in the following months and years. But while we were there, they were all fueled by that shared duty and sacrifice.

The two worst parts of the deployment were the first death we suffered, and the final casualty before we went home. That final casualty occurred while we were turning over the base to the incoming battalion. We were less than a week from leaving Camp Austerity when one of our Marines was shot while standing watch on a guard post. The wound was "relatively" minor and he survived, but it hit me hard. Although our unit suffered scores of wounded, the fact that it could still happen so close to homecoming just seemed cosmically wrong.

Every time I have moved, I have felt some pang of nostalgia for the place I was leaving. I never felt any of this for Camp Austerity. Camp Austerity was war.

9.3 An Interlude

Less than a year after my return from Iraq, my wife and I had our first baby and I was back in the warm confines of psychiatry residency with 3 years protected from the war. In 2008, when I graduated from residency, the wars were, sadly, still ongoing and psychiatrists were in high demand in the combat zones. Less than 2 months after completing residency, I set foot in Iraq once again.

9.4 Deployment 2: Camp Chocolate Cake

I returned to Iraq as a psychiatrist and head of a combat stress team based out of Camp Chocolate Cake, a large air base with 14,000 inhabitants. I saw patients in an office embedded in an Army Combat Support Hospital (CSH). Compared to Camp Austerity, Camp Chocolate Cake was Valhalla. This base had three dining facilities run by contractors that served ice cream and cake as part of every lunch and dinner. Camp Chocolate Cake had a downtown. Let me say that again … Camp Chocolate Cake had a DOWNTOWN.

Downtown Camp Chocolate Cake was similar to Downtown Disney, full of fun things and ways to indulge. We had our world class weight room and gym to keep us in shape. The fully stocked general store was next door with food, electronics and other comforts. Across the street, there was a barber shop, beauty salon, Burger King, coffee shop and, eventually, a Cinnabon. When the Cinnabon came in, I was half expecting a Sharper Image to open. The recreation center next door had video games and pool tables and offered such events as salsa dancing and talent shows on the weekends.

The Combat Stress Team all lived together in one of the houses on the base, with each of us having our own large room. We had electricity, air conditioning and internet in each room. Down the hall, there was a hot shower and a washing machine. Every evening, after my day of clinic, I went back to my room and talked to my wife and two daughters through Skype.

Following my conversations of anywhere from 10 min to an hour or more, I would go to the gym and work out in the weight room followed by a shower. All cleaned up, I would walk to one of the three dining facilities (which one had the home-made pizza night again?), for a nice, warm meal and maybe some ice cream for dessert. After watching a movie on my computer and checking my e-mail, I would go to bed in my twin bed and lay my head on my pillow and curl up under the comforter.

In the morning, I would wake up early and walk to the swimming pool for some morning laps while being watched by a civilian life guard. As winter approached and the water got cooler, I purchased a wet suit on Amazon.com that arrived in the mail a week or so later and continued my swimming. All of us on the Combat Stress Team had deployed before to varying levels of austerity and had the same thought. "I can do this time."

Not only was life comfortable but the deployment was devoid of combat and being attacked. 2008 was the heart of the Sunni Awakening and a temporary, relative peace throughout Anbar province. We were never mortared once.

I did not realize just how calm it was until someone died on the base. The person died from cardiac arrest and was dead before arriving at the combat support hospital (CSH) emergency department (ED). After the death, the commanding officer of the CSH requested that I go to the ED to provide mental health support to the staff.

I was confused. During my last deployment, casualties were a constant and so was, regretfully, death. How could this death be so wearing to this combat medical team? I mean, they had been here more than 6 months longer than me. I asked them and they told me that this was the first death they had experienced during their entire deployment. I was shocked.

All of these creature comforts and lack of being shot at did not sit well with some of the Marines. The senior enlisted Marines on base charged with good order and discipline were clearly not pleased with Salsa Night and morning laps in the pool. I could tell this by the constant and seemingly random changes to the rules.

Later, I would refer to this as the Glow Belt Wars. At Camp Austerity, light discipline was critical to not getting shot at and one learned how to get to the urinal tubes by memory. At Camp Chocolate Cake, we wore glow belts. Glow belts were necessary so you were not hit by a passing car on the road. The rules concerning uniforms and glow belts constantly changed.

One week, the rule was to wear the glow belts everywhere, including indoors with our shiny rank devices (easier for a sniper to make out the officers). Then it would be to never wear them indoors and we had to switch to the non-shiny rank devices. I pitied the junior private who faced the full wrath of the enforcers of these rules.

Psychiatry in this environment was surreal. The first thing that stands out is the presence of a gun rack in the waiting room. Our patients would walk in with their

M-16s rifles and place them in the gun rack while we saw them. After we finished the visit, wrote any necessary prescriptions and scheduled follow-up, the patients would retrieve their M-16 and walk out.

Therapeutic rapport is important in any environment but it seemed exceptionally more so in Iraq where you would see your patients wondering the base carrying an assault rifle. I was always very aware of the possibility of a disgruntled Marine opening fire on the base. A few months after I returned home, an Army soldier opened fire on the members of a mental health clinic at another base in Iraq, making this fear, tragically, prophetic.

Besides the creature comforts and the lack of being constantly shot at, what made this deployment much more bearable than my first one was that I had regular work to do. At Camp Austerity, I was either bored out of my mind or completely terrified. At Camp Chocolate Cake, I saw a full panel of patients daily. Patient problems included continued treatment of preexisting conditions, substance-induced psychosis, mood and anxiety problems as well as difficulty coping with deployment, work or family separation.

Family-related problems were interesting. At Camp Chocolate Cake, we all had ample access to means of communicating with home. This was a Godsend for most (me included). Others on the base would clearly have been better off without unlimited access to home. The combination of being intimately aware of all of the home front problems, but being thousands of miles away, led to MANY visits to my office.

The people on longer deployments were given a 2-week period to visit home during their deployment. I saw a ton of people upon their return from these leave periods who were dealing with the sensory overload of returning home, being flooded with home problems, and then being thrust back into the deployed environment. I felt fortunate that, due to the 7-month length of my deployment, I did not have to manage this jarring 2-week return home.

Military psychiatrists become very aware very quickly which units have a morale or leadership problem. We become aware because a disproportionate number of our patients come from a few units. One of these units was an Army company whose job was base maintenance. The problem was that base maintenance was done primarily by contractors making the company's jobs somewhat redundant. The morale problem peaked with a cluster of their soldiers coming to my clinic within a week of each other reporting homicidal thoughts toward their leadership.

Each soldier came in with a more over-the-top plan for how they would kill their leadership and each time I recommended they be sent home. By the seventh soldier, the company commander pushed back at my recommendation for evacuation fearing (appropriately) that eventually all of his soldiers would be sent home. I convinced him that his resistance was not worth the risk and the soldier was sent home. After he left, the homicidal threat cluster stopped and his unit's morale improved.

At the end of my deployment, with my relief on board, I was excited to go home and rejoin my wife and two young daughters. But, as opposed to my unsentimental feeling about Camp Austerity, I did feel that usual wave of nostalgia before leaving Camp Chocolate Cake.

My daily video chats with my family allowed me to remain connected to them and especially to maintain a relationship with my 2-year-old. I don't know how I would have connected with her through only an audio connection. I had regular work that I felt a sense of competence at and was proud of the care I provided to my patients. I was in the best physical shape of my life, from daily morning swims and evening weight training. I was surrounded by behavioral health techs, other mental health professionals and Navy medical/dental officers to connect with and share the experience with.

We all laughed at some of the absurdity at life on a large, quiet base in a combat zone and never felt threatened or experienced the tragedy of combat wounded or deaths. This did not feel like war but more like some bizarre summer camp.

Combat experiences of a psychiatrist are a very broad subject as illustrated by my two experiences above. Although Camp Austerity has clearer evidence of adversity and stress associated with it, it is important that we do not quickly discount experiences from places like Camp Chocolate Cake. Although I found connection and purpose at that base, there are many people who will struggle much more at a place like Camp Chocolate Cake, due to lack of a clear link to the greater war effort, more isolation given the large numbers of people on the base and a harder time finding how their efforts are important. Every deployment to a combat zone has its unique hardships and opportunities. Although for me … I'll take Camp Chocolate Cake every time.

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Zero to Sixty: From Residency to the War Zone

10

Christopher H. Warner

My unanticipated military journey began in 1991. I was a junior in high school who was looking at numerous college opportunities with a plan to do premedical studies and become a physician. At that time, I planned to attend an accelerated medical program and then find a pediatric residency training program near my hometown. I expected that after completing my training, I would return to the area that I grew up in the Ohio River Valley near Pittsburgh, Pennsylvania and become a small town doctor. However, during that year of high school something life changing occurred when Saddam Hussein invaded Kuwait.

Over the majority of that year I watched as our nation forged a massive coalition of military power in the Middle East and pushed one of the largest armies in the world back into Iraq. During the following months, I saw those American military personnel return home as heroes and the nation embrace our modern day war heroes in GEN Schwarzkopf and GEN Powell. I became enamored with the concept of performing honorable service with honorable men and women and found myself more and more drawn to the military. I remained on my career goal of being a physician but now a military physician. I subsequently attended the US Military Academy at West Point and then Uniformed Services University of Health Sciences and found myself loving what I was doing.

While I was attending medical school, I watched as my friends and classmates from West Point participated in a number of operations other than war in locations such as Bosnia, Kosovo, Kuwait, Sinai, and Somalia. They related accounts of their experiences and I knew that I had a strong desire for operational medicine. In some respects, I felt guilty for still being in school while they were out serving our nation. I felt a desire and sense of obligation to be out caring for those amazing men and

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women at or near the front lines. As I began to consider what residency I would select, I found myself very confused. I knew that my childhood view of pediatrics had changed dramatically—after about the second week of my pediatrics rotation. But I remained unsure. I was drawn to the operational medicine opportunities that the primary care fields presented, but also found myself with a love and fascination for the field of psychiatry.

Fortunately, I discovered that the Army had a best of both worlds opportunity with the combined Family Medicine Psychiatry residency training program. I entered this 5-year training program in 2000, naïve of how significantly the world and my life would change during that time.

Fifteen months after starting that residency, I had my second career defining experience with the attacks on the World Trade Center and Pentagon on September 11th. That day would shape the rest of my military career.

We were at Walter Reed Army Medical Center, preparing for the numerous anticipated casualties to come from the Pentagon and watching the varying news reports. I was repeatedly calling my wife who was a physician at Aberdeen Proving Grounds to reassure each other that both we and the children were okay and to share what we knew.

Throughout the morning, I looked out the window and saw the smoke from the fires in the sky. We spent the morning cross training our inpatient psychiatry faculty to be prepared for burn and trauma patients and discussing trauma event management to care for the anticipated casualties, but they never came. Most were dead; the few wounded went to other hospitals.

Over the coming days, I would serve as one of the on-the-ground physicians providing both medical and mental health care to those serving in recovery operations. I was also the physician who would pronounce those who were found as deceased before removing the bodies from the rubble. The sites, smells, and sounds from the event will forever remind me of the vulnerability that we all have. It also hardened my resolve and commitment of service to the nation, the Army, and most importantly the Soldiers that we serve.

By the time I completed my residency training in 2005, we were involved in two major wars in Iraq and Afghanistan. I had been actively involved for over 3 years in caring for the wounded. Whereas my early training was shaped with seeing critical care retiree patients and acute psychosis, my latter was heavily weighted with post-traumatic stress disorder, traumatic brain injury, and amputee management.

As I was discussing initial assignments with my consultant, COL Ritchie, I expressed a desire to deploy and get to the war zone. She reassured me that my time would come but that it would likely be about a year after graduation as I was being sent to Fort Polk to work at the hospital, as that was the only location the Army could provide where there were openings for both myself and my wife, an active duty Army Family Physician.

We were all prepared to go to Fort Polk until about 6 weeks before graduation, when a series of events rapidly changed our future. The psychiatrist deployed with the 3rd Infantry Division was unable to complete the deployment and needed to return to the United States. A replacement would be required.

Shortly thereafter, I got the phone call from COL Ritchie asking if I was still interested and noted that it would result in deploying to Iraq almost immediately after graduating from residency. Additionally, this change would result in my wife and I moving to Fort Stewart in Savannah, Georgia. After a brief discussion with my spouse, I said, "yes."

Over the course of the next 6 weeks, we finished residency, sold our house in Maryland, purchased a home in Georgia, moved our family (including three children, two dogs, and a cat), and took our Family Medicine board exams (it would be nearly four more years before I would complete my psychiatry board exams because of constant rescheduling due to multiple deployments).

Upon arrival to Georgia, I was rapidly prepared for deployment and within less than a month of getting there I was validated on my training, issued a mound of new equipment, and put on a plane headed to Iraq. We still had half of the home unpacked by the time that I departed leaving my pregnant wife and three children behind.

During this time I rapidly looked for any material that would prepare me for what I was to encounter. Sure we had talked with some staff who had deployed and we had received some training on the principles of Combat Operational Stress Control, but all considerations and exercises were notional. As I prepared I read whatever resources I could find including the Army manual on combat and operational stress control, collections of lessons learned from prior wars, and recent accounts from other deployed psychiatrists [1–4].

Still, as I arrived in Kuwait and awaited movement into Iraq I was very green. At that point, several key things hit me: (1) I was in a war zone where there were individuals who wanted me dead, (2) I was about to practice for the first time without the safety net of a staff physician to fall back on, and (3) I was expected to not only provide combat operational stress control but lead a team of providers spread throughout the greater Baghdad region and be a key advisor to senior leaders.

Just one of those could be anxiety provoking but combined they felt daunting. As I moved into Iraq and arrived in the Baghdad area I realized how increasingly complex this mission would be and how legitimate those fears were. I was expected to split my time between two separate locations, one in Baghdad near the airport, and the other at a major base approximately 25 miles north of Baghdad with the latter being my primary location. I would lead a team of more than 25 behavioral health providers who were scattered throughout at 50 mile radius of Baghdad and be responsible for the mental health care and unit consultation for nearly 50,000 Soldiers.

Over the course of this experience, I learned four key lessons.

10.1 Lesson 1: Establish Rapport and Respect by Showing You Are a Soldier and Willing to Accept Risk

To be effective, I knew the first steps we would need to take were to form a tight and cohesive team and to establish my own credibility within the team. I spent a large amount of time in the first few weeks traveling to the numerous locations meeting

with the various behavioral health team members and getting to know them and establishing trust. At the same time, I partnered with key members of the Area Support Medical Company that we were attached with to partner in tasks both on the forward operational base and off, multiple times volunteering to serve with the medics on patrols or as a physician on medical humanitarian outreach missions. This willingness to get engaged and also accept personal risk allowed for the development of cohesive and trusting relationships with both medical and line personnel and earned the respect of the local line leaders.

This trust was put to the test shortly after arrival when the Brigade Commander's convoy was hit with an improvised explosive device, killing and wounding several soldiers including our most senior medic, Master Sergeant Wallsmith. That medic was one of the first individuals to welcome me to Iraq and helped "square me away" on day 1.

His loss personally hit me hard as we talked many times during my first weeks about our families, our desire to serve, and our passion for caring for soldiers. I found myself very afraid and could sense that concern and anxiety almost pulsing throughout the unit as MSG Wallsmith had similar impact on nearly everyone within the battalion. I knew we had to overcome that fear or our unit would be paralyzed.

Shortly after the convoy team returned from their recovery operations I assessed each of the team members and could see the fear and panic on their faces. I met with the Battalion Commander and discussed these observations. We both agreed that we needed to get them back out there as soon as possible.

The decision was made to immediately put the convoy team back on the road and drive the 20 miles north to Ballad, where we could visit with the three members of the team who were wounded but survived and were being stabilized and prepared for evacuation out of Iraq. This would both allow for confidence building and allow the team to see that their wounded teammates were okay.

This plan was met with significant frustration by multiple leaders within the unit. To this day I can recall getting into a shouting match with our battalion executive officer (second in command) about this being the proper course of action. His concern was that the team needed rest and "weren't ready." I grabbed my Kevlar and told him not only was this the right action, but that I was so confident that I would be going with them and joined the convoy. The trip was uneventful, the soldiers greatly enjoyed the opportunity to visit with their wounded team members, and the following day were more cohesive and motivated than ever to continue their mission of daily convoys and protecting the commander.

10.2 Lesson 2: Don't Limit Yourself to A Clinic

In arriving to an established unit, I moved into an existing clinic facility that was already operational and functioning. I was stunned when I was told how we had days off and was in shock when I came upon a combat stress detachment's facility, that had a sign that said it was closed for weekends. This was definitely not what I expected from a war zone and found myself frustrated.

I reached out to two key individuals that would become close friends and great mentors to this day, COL John Lammie and then MAJ Dave Hamilton, both primary care providers in the clinic where we were co-located. As I was venting frustration and discussing expectations COL Lammie looked at me and simply asked "what is your purpose here." The answer was simple, to treat and prevent combat and operational stress conditions.

As far as treatment, we were doing a phenomenal job. Our team including our behavioral health technicians, social workers, and psychologists had established support groups, were providing individual treatments, and were maintaining phenomenal return to duty rates. But the latter, prevention, we were not doing nearly enough. It became clear that if we built a clinic, we could fill it up but we may not be doing the greatest good for our units and our leaders.

In response, we dedicated time to spend out of the clinic and out with the troops. This is sometimes referred to as "therapy by walking around." We spent time talking and visiting with Soldiers in the motor pools, flight lines, gymnasium, and other areas. This was not uncommon, but where we found that we really broke through the stigma barriers was when we began spending more time with the Soldiers on "their turf."

One of the psychologists on my team began flying with the aviation teams on a regular basis, establishing more rapport with this usually tight lipped group. I frequently volunteered for patrols, convoys, and humanitarian missions using my primary care skills to double as a medic. The discussions that soldiers would have with you after walking a mile with them on a patrol could never compare to a conversation in the gym.

Suddenly we found personnel seeking us out for advice and assistance early in situations and leadership requesting input on quality of life and performance improvement. These bonds tore down traditional stigmas and barriers and expanded our influence well beyond the individual care of a clinic. The largest compliment came when one soldier would bring one of his buddies in and tell his friend to talk with us, a recurring line was "they get it and can be trusted."

10.3 Lesson 3: Be Prudent in Your Risk Taking

The problem with lesson #2 is knowing when enough is enough. You gain significant credibility by putting yourself at risk with the soldiers, but at the same time, you are a very limited resource and must ensure that your efforts stay focused on your primary mission. You do not want to avoid the risk out of fear as risk is prevalent everywhere in the war zone. For example, 20 ft from my office was still the hole where a mortar had hit some 6 months prior and wounded a fellow Army psychiatrist and the office still had shrapnel holes in the wall from the blast.

But we do need to be prudent in how we expose ourselves. I learned this lesson with my continued involvement in humanitarian and outreach missions. In conjunction with the Civil Affairs teams I volunteered to be part of a group who trained one of the local Iraqi Police stations on combat lifesaver skills. We were back out at the

police station bringing resupply for the combat lifesaver bags when we learned that the majority of the personnel we had trained were no longer at the station as they were identified as members of Al Qaeda.

I can recall that sudden fear and realization gripping me of knowing that we had spent a full day at a location with our protective gear off, teaching, interacting, and relaxing with these individuals who we later learned were insurgents. This brought images of the video that we all were required to watch prior to deploying, of the beheading of an American contractor by Al Qaeda reminding us of the ever present risk.

At the completion of our time at the police station we were heading to the vehicles when the station was attacked by insurgents. A 20–30 min firefight ensued with small arms, mortar, and rocket propelled grenade fire ongoing until American air support cleared the area and allowed us a safe return.

The event was definitely an adrenaline rush and admittedly did not curb my behavior in the short term. In the months to come when I took some time to reflect back on the experience, I asked myself, if the commander had to write a letter to my wife that day about how I died in combat, what would he say was my purpose that day. Why was I there?

It was not until my second deployment, that I put it into practice, but I was definitely more judicious with my risk taking and exposure. Not afraid or avoidant of the opportunities but ensuring that I had a task and purpose which was relevant to my role.

10.4 Lesson 4: We Must Be Held to a Higher Standard

I always took my role as a military officer very seriously. Those in the Air Force who I trained with frequently wrote in my quarterly counseling statements that I was "too Army." I always took this as a compliment and sought to maintain my foundation in the Army values. Throughout my Army upbringing we frequently heard of the importance of choosing the harder right over the easier wrong, but it was not until I deployed that I realized how important that was and how much of an easier wrong would be present.

We did receive training during our military psychiatry residency to prepare for combat operational stress control, but the majority of that training focused on the battle fatigue that would result from continued offensive operations. Nothing prepared me for how to manage the morale questions that I did not consider I would encounter, such as infidelity.

Within the first few weeks I found myself discussing with my colleagues that it felt like at times that I was running an adultery support group and that a number of individuals were seeking some form of justification or affirmation that their behavior was acceptable. On several occasions I saw infidelity rip apart units, teams, and soldiers, but never considered that it might occur within our own team. However, it did and had lasting ramifications. Within a few weeks of taking over my team I received numerous complaints about one of my providers for poor boundaries including complaints of counseling in inappropriate locations (talking to patients in shower areas, inviting soldiers into her living area, etc.).

My psychologist and I would counsel this provider and discuss the risks of these actions. Each time we were baffled by the rationalization we would receive justifying the actions taken and lack of insight into making the corrections. But none of that prepared us for the day we learned of her pregnancy.

Prior to the deployment the provider was undergoing fertility treatment and even initially requested to not deploy due to the desire for fertility treatment. She was one of the first in the unit to take the two week rest and recuperation visit and she was meeting up with her husband and going to Europe. There was significant discussion throughout the unit that she would seek some fertility treatment in Europe and would become pregnant after return. To our shock, she did return from the break and shortly thereafter made us aware that she was pregnant; however, we rapidly learned that the father of the child was not her husband but one of the brigade chaplains.

This event was devastating to our credibility and effectiveness. Over the coming week's our team had to go before the Commanding General for disciplinary action for this lack of judgment. The action became a rumor, joke, and/or story throughout the base undermining the credibility of the service. Over the coming weeks to months numerous inappropriate comments were made, including soldiers coming to behavioral health bordering on propositioning and harassing our female staff.

It took months of work to repair the damage that this event caused and to repair the team's credibility. The worst part is that who was injured were the soldiers we were not able to help because of the lost trust in the services provided because of an event. The bottom line, deployments are a very lonely place for mental health providers, yet finding sanctuary can be difficult. But I cannot stress enough the importance of maintaining professionalism at all times.

10.5 Conclusion

In the end, my first deployment went faster than I ever could have imagined and was a rich and rewarding experience. I would have never expected that I would jump straight from residency to a war zone, but thanks to mentors who reached out on a frequent basis and provided guidance, the close friends I developed during the deployment, and my family's support as well as the brave men and women who I had the privilege to serve with, I returned home safely. I learned key lessons of both what to and what not to do and remain in awe of the honorable men and women we serve with every day and their willingness to put themselves in harm's way.

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Christopher H. Warner In 2005, Christopher Warner graduated from Psychiatry/Family Practice residency program and shortly thereafter found himself on a plane headed to a combat zone in Iraq. This account highlights key lessons learned during those first crucial months in the war zone.

Research at the Tip of the Spear

11

Carl Andrew Castro

The man is the first weapon of battle. Let us study the soldier, for it is he who brings reality to it.

Ardant du Picq, Battle Studies (1821–1870)

This essay is a personal story that spans a period of approximately 30 years, yet focuses on my time conducting behavioral health research during the war in Iraq. It is based on my memory and view of events that transpired before and during the invasion of Iraq and Afghanistan—conflicts that I like to refer to as the Great Wars on Terror. While I have consulted my diary, that is my "little green" pocket memo books, while composing this essay, it is necessarily biased and prejudiced. I am not pretending, nor particularly interested in giving a balanced view, a politically correct view or a view in which everybody looks good. As a result, I may unintentionally (and in some cases intentionally) insult or anger folks. Furthermore, if the editors allow me to get away with it, I will not provide any references for this personal story. Like all personal stories, I will be the hero of my story.

I joined the military as an infantryman when I was 17 years old. My mother signed the "paperwork" allowing me to join the military in the library of my high school, where she worked as the assistant janitor. Within two weeks of graduating from high school, I left home for the first time to attend basic and advanced combat infantry training at Fort Benning, Georgia. Although I reached the rank of sergeant by the age of 19, I never received a good conduct medal, something I still think about to this day.

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My First Sergeant, Sergeant First Class Steele, put my name forward for the Army's green-to-gold program, in which enlisted soldiers go to the university and upon graduation become officers. Upon my departure, Steele told me, "Never forget where you came from, and what this Army is all about. It is about the Infantryman!" Those words have stayed with me now for over 30 years and they still guide my thinking and research. I quickly obtained my bachelor's degree from Wichita State University in 1984, and 4 years later my master's and Ph.D. in psychology from the University of Colorado.

11.1 The Value of Research in Making Good Policy and Program Decisions

When I was a major I commanded the US Army Medical Research Unit-Europe located in Heidelberg, Germany; the unit has since closed and relocated to Joint Base Lewis-McCord in Washington. While in this position I deployed multiple times to various locations, including Bosnia, Kosovo, and Kuwait to conduct behavioral health care research. Thus, I understood firsthand the ins and outs of conducting field research. Further, I learned how important medical research is to the Army.

The Army is the leader in conducting military medical research. While many of my colleagues from the other services might take objection to this assertion, the facts speak for themselves. The medical research budget for the Army is twice that of all the other services combined. The number of personnel dedicated to conducting medical research in the Army is four times the size of all the other services combined. As a result of the Army's commitment to medical research, the contribution of Army scientists has been tremendous. Nowhere have these contributions been more evident than during the decade and half of wars in Iraq and Afghanistan. However, my goal here is not to be a cheerleader for Army medical research, rather to note the Army's commitment to medical research is the primary reason for the Army's success. I am convinced that if the other services equally supported their services medical research efforts similar accomplishments would also be seen. The fact that the other services do not embrace medical research to the same extent as the Army means that the Army is and will remain a leader in this area.

Most leaders understand the value of good data in making decisions. Surprising to most is the fact that the biggest supporter of psychological health research is the operational leaders. That is the "trigger pullers" support psychological health research much more than does most medical personnel, the exception being those medical personnel who actually served in combat arms units such as the brigade or division surgeons or those who served on brigade or division mental health staffs. Folks like Lieutenant Colonels Nadia West (now a major general), Christopher Warner (now a colonel), among many other division surgeons embraced behavioral health research and did their best to support it.

Over the years, I have experienced far too many times folks from the medical community, with little or no operational experience attempting to block or interfere with psychological health research, possessing the misguided belief that senior

leaders would never support the "touchy, feely" studies that were being proposed or naively believing that research was a waste of effort and time. Obstacles which were easily overcome once the division or corps chief of staff was briefed on the research study.

In all my years of conducting research, I never encountered a chief of staff or general officer from the combat arms who didn't enthusiastically support psychological health research, including Major Generals Casey, Abizaid, Campbell, Bell, and Petreus, all who went on to become four star generals. To be sure, psychological health research has also enjoyed continued and uninterrupted support of the Army Surgeon Generals, including Lieutenant Generals Blanck, Peake, Kiley, Schoomaker, and Horoho, whom I have gotten to know personally throughout my military career.

11.2 Conducting Your Wartime Mission in Peacetime

Army research psychologists have been deploying to conduct behavioral health care research for many years prior to 9/11. Research psychologists have deployed to Somalia, Haiti, Bosnia, Kosovo, and Kuwait, just to name the major ones. In addition, research psychologists have also conducted countless data collections in garrison and during training exercises. Thus, when it came time to conduct data collection missions during combat deployments they were ready. However, conducting data collection missions during peacekeeping or humanitarian deployments is very different than conducting data collection missions in a combat environment.

The data collections in Iraq would be the first ever psychological health research missions conducted during ongoing combat operations, yet built upon the sociological research conducted during World War II. This accomplishment cannot be overstated. It was only because of the field and deployed research experiences involving these other types of military operations that research psychologists were so hugely successful in conducting their research mission during combat operations.

11.3 Dying for a Data Point

Many opponents of conducting research in combat operations have stated that "no data point is so important that it is worth dying for." Yet it is only by conducting such research studies can the health and wellbeing of the service be immediately improved. These critics seem to be saying, "Hey, let's wait until the current conflict is over, and then conduct a series of lessons learned (usually using only anecdotal data) and then from these anecdotes decide how to fight the next war." Thankfully this legacy approach to improving military medicine has been soundly rejected by most senior military leaders.

When it comes to conducting behavioral health research in Iraq and Afghanistan, it is amazing how eager soldiers and Marines were to answering candidly questions

about the behavioral health care they received while being deployed and how that care can be improved. More often than not, the observations and recommendations provided by these soldiers and Marines were the same recommendations being developed and considered by the research team based on quantitative assessments.

Indeed, although I was told that a Marine would never talk to "an Army guy," later I was told by a navy corpsman who attended the interviews that he had never heard Marines talk so openly and candidly before, including to Navy and other Marines. Soldiers and Marines can detect sincerity, and they know when someone doesn't give a shit about them. Unfortunately, many soldiers and Marines often only encounter the latter.

11.4 Courage, Research and Leadership

Elsewhere I have defined courage as the "ability to face unpleasant facts." Often research uncovers facts that might be perceived as unpleasant or things that we wished we didn't know. Good leaders never stand in the way of conducting research that might reveal unpleasant facts, flinch from facing those facts, or interfere with their reporting. Sadly, however, there are a few senior leaders within the military that panic when confronted with unpleasant facts. Rather than displaying the courage required to confront the facts to improve the functioning of the military, they instead use their rank and position to bully or intimidate the "messenger" to change their message or to block others from knowing about the message.

When leaders don't like the findings of a research study they typically do three things, usually in this order. First, these leaders will attack the methodology of the research: the measures, the sampling strategy and/or the data analyses. Next, they will attack the interpretation of the research findings. And finally, when all else fails, the unhappy, and fearful, leader will launch a personal attack on the investigators of the study. As a researcher who has been through this process a few times, you know that when the final event happens that your study is in pretty good shape. The release of the findings from the fourth Mental Health Advisory Team (MHAT) assessment will serve as an example.

I was the Science Officer on the first MHAT under Colonel "Pat" Patterson, who did a brilliant job leading the first team. Later I was selected to lead the fourth MHAT. The fourth MHAT would be different than all of the others. It would be the smallest MHAT, comprising only three team members: myself, Major Dennis McGurk (now a lieutenant colonel who served as the Senior Science Officer on the team) and Specialist Matthew Baker (who left the Army shortly after this deployment as a sergeant). The fourth MHAT would utilize in-theater support to assist in survey distribution and administration. And the entire report would be written in theatre, with a detailed outbrief given to key deployed leaders prior to the team leaving theater.

The fourth MHAT would also differ in two other important ways. General Casey, the commander of the multinational forces in Iraq (MNF-I), instructed me as the leader of the fourth MHAT to include battlefield behavioral ethics questions on the

upcoming assessment. He further instructed me to include Marines that were under his command in the assessment.

Now, I knew that both of these issues could lead to potential problems in the reporting of the findings. First, there was a possible legal issue of including battlefield ethical questions on the survey. And second, there was the issue of the Army including Marines in what many believed to be an Army assessment.

Colonel Brian Allgood, the Command Surgeon of MNI-F and the office that our team would be assigned during the MHAT assessment, told us not to worry about the legal issues as he would staff the battlefield ethical questions with the MNF-I legal team, which subsequently, much to my surprise, found no legal issue with the questions. Regarding the inclusion of the Marines in the study, Allgood stated that the Marines were under the command of Casey and that Casey had directed the inclusion of the Marines, case closed.

Soon after our mission was completed in Iraq, I had returned to the States to begin the series of briefs to the senior military and civilian leadership within DoD. Shortly after returning home, Allgood was killed in a helicopter crash; Colonel Elspeth Cameron Ritchie, the Army Psychiatry consultant, phoned me personally to give the news.

Before any findings of the MHATs are released, all key leaders are briefed on the study findings and recommendations. Thus, there are no surprises. Before leaving Iraq, I personally briefed Generals Casey and Mattis the Deputy Commander of MNF-I, who was also the senior Marine Corps general in Iraq, on the MHAT study. Both accepted the findings and recommendations and stated that they felt the findings represented their own impressions of the mental health status of the forces in Iraq. In addition, we also briefed Commander (now Captain) Paul Hammer, the Navy psychiatrist in charge of providing mental health support to the deployed Marines. Hammer totally supported the findings and recommendations and stated that he hoped our report would garner him the additional resources that he had been asking for but was denied.

When Vice Admiral Arthur, the Navy Surgeon General, discovered that we included Marines in our MHAT assessment he was furious, although in conversations with Captain Robert Koffman it was never clear why. Our assumption at the time was that he was upset because he had not been consulted before including Marines in the assessment. Yet, the Marines in our study were not under the command of Arthur so he had no authority over them. After speaking with Allgood, he told me not to worry about the Navy and make sure that the findings got released. It was shortly after this conversation I learned of Allgood's death.

After briefing the Army Surgeon General, Lieutenant General Kiley, who directed his staff to begin the immediate implementation of the study findings, we next briefed Arthur. The brief with Arthur would take place in his office at the Navy Bureau of Medicine and Surgery in Washington, DC. Accompanying me on this brief was Major McGurk and Colonel Charles Hoge, my boss at the Walter Reed Army Institute of Research (an Army psychiatrist and the world's expert on military mental health.) Arthur had arranged for three of his naval medical Admirals and seven Navy medicine Captains to be present. Throughout the brief, Arthur,

along with his medical officers, attacked the reliability and interpretation of the study findings. They also attacked our interpretation of the findings, along with our recommendations, using vague and nonspecific objections.

When I asked Arthur how the recommendations should be changed to address his concerns, Arthur made it clear that he did approve of the study findings being released, as the Marines would demand that the Navy provide more medical personnel to support the deployed Marines, which he did not want to do. Author then stated to me that I didn't have his approval to release the MHAT findings. I respectfully informed Arthur that this was not a decision brief requesting his approval to release the findings, but a courtesy brief to inform him about the study findings and recommendations. Arthur became very angry, with his face and neck turning visibly red. After the brief concluded, Arthur didn't thank us for the brief; and he refused to shake my hand when I extended it to him.

Following our briefs to the Army and Navy Surgeon Generals, we briefed the Army and Navy secretaries. During the brief with Secretary of the Navy, Arthur tried to get the Navy Secretary to block the release of the findings based on the battlefield ethics questions. Arthur didn't mention the additional Navy support that he feared the deployed Marines would demand. The Secretary of the Navy had no interest in blocking the release of the findings, and in fact challenged Arthur to do more to take care of the deployed Marines and those Marines who had already returned home. In particular, the Secretary wanted to know specifically what the Navy was doing to address the mTBI and PTSD in returning Marines, adding, "Please don't tell me you are waiting to see what the Army does." To which, Arthur responded he was waiting on the findings of an Army study! The Secretary was not amused. The Secretary of the Navy thanked me for the brief and gave me a Secretary of Navy coin, which I have somewhere in a box in my basement with all of my other military coins.

Next in the briefing chain was the Assistant Secretary of Defense for Health Affairs, who is the most senior DoD civilian medical officer. Once again, Arthur showed up with a few members of his naval medical staff intent on blocking the release of the study findings. Unbeknownst to Arthur, however, the current Assistant Secretary of Defense for Health Affairs was Dr. "Trip" Casscells, my battle buddy in Iraq. I briefed Casscells on the study findings while in Iraq, and he was a strong supporter of getting the study findings out. Indeed, Casscells greeted with me a hug and began the meeting by heaping loads of praises upon me. Thus, Arthur's attempt to gain Casscells support for blocking the release of the study findings was again thwarted. Casscells also presented me with his office's military coin at the end of the brief.

The last scheduled brief was with the Commandant of the Marine Corps, General Conway. This would be Arthur's final attempt to block the release of the findings. Conway had assembled numerous members of his senior staff including the Assistant Commandant of the Marine Corps and the Sergeant Major of the Marine Corps, among others to hear our brief. While Arthur didn't attend this brief, he did send several naval medical Admirals and Captains, many of them the same ones who were present at the early brief at the Navy Bureau of Medicine and Surgery,

with specific instructions to convince the Commandant to block the release of the report. Once again the Navy challenged the study findings based on sampling, analyses and interpretation. Some of the Navy officers present continued to challenge the study's validity even after the Commandant said that he was not interested in hearing any more comments about those concerns. Towards the end of the brief Conway became so frustrated with the Navy's obfuscation and refusal to address the recommendations in the brief that he physically turned away from them and turned to me for guidance on how the Marine Corps should proceed.

Since no date had been set for the release of the study findings, Arthur continued to try to block the release of the study findings through technical and bureaucratic maneuvering. Arthur might have been successful except for the actions of Conway. Conway e-mailed the study findings to all the general officers and senior sergeants major in the Marine Corps. Here is an excerpt from the e-mail Conway sent that was provided to me by a Navy friend:

> Generals and SgtsMajor;
>
> I believe we're facing an emerging issue, and I want to apprise all of you about it, and marshal your efforts to most properly address it. Three things have come together to bring this challenge to my attention. The first two are as a result of the most recent Mental Health Advisory Team (MHAT). It's attached to this email below. I took the brief from the study group members yesterday, though I saw earlier versions of this brief several weeks ago… This brief is important because…it is the first assessment that looked at Marines as well as soldiers. This study was done in support of OIF 05-07. While there is a lot of positive information in the brief, I am most interested in slides 21–25. These slides speak directly to battlefield ethics—how Marines think and act under the stresses of combat, and their attitudes toward the treatment of civilians, LOW *Law of War, and ROE *Rules of Engagement compliance. I am concerned with what we see here …
>
> Let me be very clear here: I am not interested in 'fighting the study,' or arguing about the technical nuances of the population sample size, the location of the Marines interviewed, or the MOS spread. I am convinced that in broad outline, this is an honest, sincere, and faithful effort that accurately captures what our combat-hardened Marines think and do. As a measure of my confidence in this report, I am encouraging the MHAT to continue to work Marines into their studies in the future, as I fully support their important work.
>
> —From an e-mail sent by General Conway, Commandant of the Marine Corps (20 April 2007)

Wow! Talk about a letter of endorsement. Conway got it. He understood that no study is perfect, yet importantly he understood that critical decisions can still be made with less than perfect data. Conway was focused on taking care of Marines and the Corps. Indeed, during the brief to Conway, COL Ritchie asked the Commandant if he was worried about how the media would respond to the Battlefield Ethics findings. To which Conway responded, "I am not concerned about what the media will do; the media will do what the media does. I am concerned about Marines." Despite this resounding support of the study's findings by Conway, some within the Navy medical department still maintained that the Marines didn't support the release of the study's findings. Over the objections of the Navy medical department, the findings were released two weeks later in a joint Army–Navy press release on 4 May 2007 in the Pentagon.

11.5 The Failure to Learn from Lessons Learned

Spencer J. Campbell and I often spoke during our long runs at Fort Leavenworth when we were students at the Command and General Staff School about writing a paper entitled, "Failure to Learn from Lessons Learned," in which we highlight many of the things we know that we have not learned. Tragically, the wars in Iraq and Afghanistan have lasted so long that we learned, unlearned, and relearned the same lessons over the course of these conflicts. For sure, it was not a smooth learning curve, and at times appeared to be slightly decelerating. Campbell, who served as a Marine infantryman in Vietnam and a social worker in the first Gulf War and in Iraq and Afghanistan, died suddenly after he retired from the Army as a lieutenant colonel. In respect to Spencer, I would like to conclude this brief essay with three of the lessons learned from the Iraq and Afghanistan wars.

The first lesson we must learn is that war impacts the mental and behavioral health of those doing the fighting, as well as those who aren't doing the fighting. Spouses and children are also impacted. For some reason or another, we always seem to be surprised that combat has adverse effects on the mental health and well-being of our service members. We also seem to think that the current war will be different and that we won't see any adverse mental or behavioral health effects. While we can work to lessen the impact of war, currently there are no remedies that eliminate the suffering and death that war produces.

We often confuse performance with mental health, believing that if the service member can perform under stress in combat then there won't be a mental health issue. This is the "inoculation fallacy" that despite all the evidence to the contrary is still being pursued today. We often mistakenly cite World War II as an example where there were not mental health issues in those who fought when in fact there was.

For some reason we always seem to want to blame the individual for how combat affects them. We will cite preexisting mental health conditions or childhood traumas, which while predictive of those likely to suffer the most, don't explain all of those adversely affected by combat. Regardless, we must work to prevent and reduce the expected and unexpected suffering that war causes, and be prepared to treat those who are affected.

The second lesson we must learn is that the presence of mental health professionals is essential for taking care of the mental health needs of service members and families. The bedrock of military mental health care is the concept of PIES (proximity, immediacy, expectancy, and simplicity). Yet for some reason or another, we invariably have to relearn these basic principles. For sure, there have been a few feeble and misguided attempts to undermine these principles; however, the principles embodied in PIES remain as true today as when they were discovered just over a hundred years ago during World War I.

Still many behavioral health care providers hunker down at the large base camps, refuse to conduct behavioral outreach, and then claim they have no mission because no one comes to see them or because they are not prescribing any medications and therefore should be sent home. Many behavioral health care providers continue to

base their assessments of need on the number of service members who walk into their clinic asking for help. We must never forget the importance of embedded behavioral health care and outreach, both in garrison and during deployments.

The final lesson learned that I would like to highlight is that behavioral health research must continue with the same vigor during peacetime as it does during wartime. Research is a time consuming enterprise. It can take years and even decades to solve behavioral care problems that are currently confronting our service members. Failure to solve these problems today will only lead to the problems resurfacing in future conflicts.

When the wars in Afghanistan and Iraq began, our behavioral health research efforts were on life support. There was less than $3M in the total annual budget for the entire Army, Navy, and Air Force behavioral health research program. Given that one randomized clinical trial costs approximately $12M and takes 5–7 years to complete, budget and time are critical. It took nearly 8 years to effectively engage the universities and business communities in helping us address the military's pressing behavioral health care issues and we mustn't let these relationships die.

All too often, things we have learned from past conflicts get dismissed as not being relevant to the current conflict. This is true for both medical and nonmedical lessons. Thus, it must be a natural tendency of mankind to ignore what others have learned. We must actively fight these tendencies by carefully documenting all of the lessons learned, not only from the current conflicts ending, but from all past conflicts. The lessons must then be embedded in all the training that our military and nonmilitary mental health care providers undergo. It is only by being actively vigilant of lessons learned that we have any hope of not ignoring them.

Carl Andrew Castro retired from the Army as a colonel after 33 years of service and is now a professor in the School of Social Work at the University of Southern California. Although the time frame of events described in this essay span over three decades, the key events occur from 2006 to 2007.

From Battalion Surgeon to Combat Psychiatrist: Three Tours in Iraq and Afghanistan

12

Kenneth Richter Jr.

It was the seventeenth of July, 2009. I graduated from residency a month prior, and was due to take my first week of call as a Staff Psychiatrist at the Naval Medical Center San Diego (NMCSD) the very next week. I stood on a stage with many of my colleagues from our large Mental Health Directorate awaiting the honor of having my shoulder boards replaced, reflecting my promotion to Lieutenant Commander.

My wife, Nicole, and dear friend Reese stood in the shadows ready to participate in the ceremony. It was a great moment of joy to stand there and be acknowledged for progressing with my military career. But, as this moment moved along and my shoulder boards were replaced, my Director, after making a few kind remarks, declared that I would be going to Kandahar, Afghanistan, in less than 1 month.

I could feel the celebratory nature sucked out of the room. My colleagues wondered if they should congratulate me or express their regrets. They also wondered how to console my wife: she didn't look to be in that much distress, but she couldn't have been too happy about her husband having to go away.

The announcement of my deployment to Afghanistan was not actually a surprise that day. A few days prior, I had received a call from my Director, who had offered the deployment to me. It felt like he was asking me, "Do you want to take what you know is behind door number one, or do you want to roll the dice on door number two, whenever it comes along?" He let me know whose name was next on the list if I were to decline, but I still went with my first reaction, which was to say, "I'm not ready to get back out there yet."

This chapter covers Kenneth Richter's time as a GMO from 2004 to 2006, residency from 2006 and 2009, and finally deployment as a psychiatrist from 2009 to 2010

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He understood my hesitation and told me he would call another Navy Psychiatrist.

As the minutes passed following the call, I thought about that colleague who was next on the list. I knew him, and I knew his life. I thought about the fact that he already had one child and that his wife was pregnant with their second, and I thought of him missing the birth—while my wife and I hadn't yet started our family. These thoughts gnawed at me.

After a few minutes, I picked up the phone, and in a conspicuously unemotional way, apprised my wife of the options: I could deploy for 7–8 months to a newly built hospital on a big base and get another deployment behind us, or, I could decline. We discussed this incredibly consequential decision for about 4 or 5 min.

The brevity of our discussion remains truly remarkable to anyone who knows us. Typically, we are known to be quite loquacious: our pastor who delivered our premarital counseling noted that we were "hyper verbal," and the reading nook in our bedroom has been renamed the "talking nook" to reflect our fondness for conversation. Indeed, five minutes of discussing a potential deployment to a war zone does seem brief, but in this particular moment, it was a simple conversation that we clearly had both thought about a lot before the moment of decision.

I hung up the phone and called my Director back. "Sir, have you called Troy yet?"

"No. Not just yet."

I will always wonder if he was waiting for my return call, or if he had just become distracted by another matter.

"I'll do it," I said.

He paused and probed, "This is an important thing for you to discuss with Nicole."

I assured him that I had, but I'm positive he wondered how such a consequential decision could have been discussed in such short a period of time. We spoke more, and he again gave me an *out*, letting me know that with my history of two prior combat deployments and having been wounded, I could reasonably expect not to be compelled back into such circumstances. Ultimately, he accepted that I had reasoned through the decision, and I was slated to deploy for a third time into a combat zone.

Being slated for my first psychiatry specialty deployment to Kandahar in the fall of 2009 might seem then to be the logical place for my story to begin. But, it can't properly begin at that time. The story doesn't begin there because my experience in Afghanistan was hugely shaped by my two prior deployments to Iraq as the Battalion Surgeon for Marine Infantry Battalion—1st Battalion, 7th Marines (1/7) out of the Marine Corps Air Ground Combat Center Twentynine Palms.

Those two deployments were both full of totally intense and foreign situations, especially for an only child raised in upper middle class suburbs who had just completed his internship weeks prior. The two deployments would expose me to some of the grizzliest battlefield trauma that people would never wish to imagine, let alone actually see. I would be shot at, blown up, and thrust into a myriad of utterly unfamiliar situations. The situations ranged widely from being a tactical medical planner for large operations and doing grim cause-of-death investigations, to living and working without power or a shower for prolonged periods of time.

Thus, as I relate my story about being a Combat Psychiatrist, I begin with my being a Medical Officer/Battalion Surgeon from mid-2004 through mid-2006. This time frame shaped who I am today and has shaded every clinical encounter that I have had with the active duty population, as they do their distinctive work.

12.1 Before Psychiatry

Working long hours as an intern at NMCSD in 2003, a frequent topic of conversation, amongst the fresh young doctors, was whether you were going to try to go "straight through" into residency, or, plan to be a General Medical Officer (GMO), for 2–3 years before returning to training. Forming two camps, there were those who were very excited about getting out of the hospital and to an operational command (e.g., serving afloat on a Navy ship or boots on the ground with the Marines), and there were those who wanted to push on with their training.

I must confess that I was among those who wanted to continue undeterred into residency training. My reasons were several: I didn't want to delay my progress toward specialization; and, I always felt general practice and the broad knowledge base that it demands is intimidating. Truthfully, perhaps most of all, volunteering to go into harm's way did indeed frighten me.

Even with individuals' preferences, the decision as to whether to become a GMO isn't entirely in the hands of the intern. In fact, those who are already GMOs have far greater priority in being awarded Navy residency slots. Thus, interns are (and remain) largely at the mercy of the quantity of GMOs who wish to return to training.

The year 2004 was not a good one for the prospect of "going straight through"; the wars in Afghanistan and Iraq were intensifying, and a GMO tour almost certainly meant deploying. Such circumstances drove a lot of battle-weary GMOs back to training.

In late March of 2004, I learned that I would be assigned to the First Marine Division beginning in July of the same year. In June, I learned that I would be assigned to 1/7 based at the Marine Corps Air Ground Combat Center Twentynine Palms in California's blistering Mojave Desert. Moments later, I realized that 1/7 would be deploying to Iraq's western Al Anbar province in a couple of weeks after my checking in.

At some point that I can't recall, the timeline hit me. Given the operational tempo at the time, being assigned to a unit that was immanently deploying meant that I would be completing two deployments to Iraq. Needless to say, that was a lot of information to swallow in a single bite, and the pace of reality's march didn't slow!

After some quick training on how to wear the Marine uniform and a wave of PowerPoint presentations on the United States Marine Corps (USMC), I was off to my unit. Days later I was standing in a parking lot in 29 Palms as families cried and little kids wearing patriotic attire looked sad, frightened, or confused, while wives and mothers fought back tears, trying to look strong. At 28 years old, I was sobered realizing that I was one of the most senior people in this group. They looked like boys, as they said goodbye to their families. The verisimilitude of the situation washed over me like a massive tsunami pouring over a beachfront village.

I held my wife in a tight embrace before I finally had to board the old school bus for the long drive to March Air Reserve Base (from which we would board a flight to Kuwait). She will admit that she couldn't let go of me. I will always remember the pain and a coarsening of my soul as I literally had to push her out of our loving embrace to go board that white bus.

It was a bus with many men. I knew that some of us would die, some of us would lose our sight or parts of our body, and all of us would be changed in unknowable ways by what would come. Most of all, we all faced the unknown together—many with great enthusiasm.

While I sat on that slow old repurposed school bus, not really knowing anyone, and feeling a vast disconnect from those who surrounded me—all of whom seemed to be elated at the opportunity to fight for their country—I felt more alone then than at any moment in my entire life. I was traveling into the complete unknown, fearful that I wouldn't be good enough at my job and that people would die because I didn't pay enough attention during a given rotation, wondering if I had what it took to do this job.

In retrospect, on that ride, I made the choice to become numb. I had to. It was fortunate that I could summon the ability to erect such a psychological defense and even more fortunate be able to lower it upon returning home. In retrospect, I consider this a *gift*, not a talent. This was a gift that saved my mind from being trapped in a prison full of the demons of war.

Stepping out of this moment of deploying into the unknown, in the here and now, when I struggle to explain some sliver of my combat experience to acquaintances, the question is asked, "How did you do it?" I'm not sure I know the answer to the question. For one thing, I didn't let myself think about it too much, not to mention that I didn't consider squirming out of my duty as a possibility. I never saw my Dad quit once in his life or know of his showing fear in the face of his duty in the invasion of Europe. I knew that it just had to be done. There was no question.

Reflecting on this first deployment, I must assert that modern travel to the battlefield is an exceedingly unpleasant experience, which vastly eclipses the worst nightmares of business travelers, and is a test for even the best-prepared psyche. The pain comes in the form of extreme boredom and being in a transient, unsettled state for an unknown duration, usually for several weeks. Furthermore, when traveling to a forward outpost, there is the added experience of seeing each successive base on the journey being increasingly austere.

As one example, I descended from trailered bathrooms, to outhouses baking in the 120 °F heat, to simple tubes sticking out of the ground in the center of an outpost, referred to as "piss tubes." As one makes this expedition into what the Marines might refer to as being "deep in the shit," you can't help but wonder, *How far down does this elevator go?*

The sense of uncertainty regarding how bad it was going to get was never more heightened than on September 3, 2004. Then members of the departing battalion's leadership were blown up by a massive improvised explosive device, while preparing to turn over their area of operations to our battalion and incoming team. The blast mortally wounded several Marines (including Commanding Officer Captain Alan Rowe of our own Weapons Company), all of whom I had come to know during our journey.

Thrust into mass casualty trauma management, I immediately learned the distinctive difficulty of rendering quality trauma care to a friend, while maintaining competent objectivity in the face of horribly disfiguring injuries. Now my painful

insight into this balancing act informs my understanding of one of the struggles of combat veterans, many of whom have had experiences where they had to maintain battlefield professionalism and commitment to the mission all while coping with a fallen or badly wounded brother.

Having been detoured to provide forward trauma care, my final destination was Camp Gannon on the Iraq/Syrian border next to the border-town of Husaybah. It was a "wild west" town that had been only limitedly under the control of Saddam Hussein's Baath Party. At the time of this writing, it is centered on the map of territory now controlled by the Islamic State of Iraq and the Levant (ISIL or ISIS). Camp Gannon was what is referred to as a company-size outpost. It was a place where about 200 Marines and Sailors endured daily open combat while holding the position. Then it was common for between 30 and 40 mortars or rockets to be fired into the base daily. It was rare that daily patrols left the base without taking contact from various ambushes. By the numbers, it wasn't the size of a base that determined whether a physician was necessary. Instead, it was the causality numbers for this isolated remote outpost that demanded that a physician be on site.

I arrived at Camp Gannon exhausted and dust covered, but there was a strange pleasure in knowing that I was at a place where I could finally settle in. I remember sitting outside the command shack, breathing in the dusty air and still awakening to the fact that we were in earshot of numerous different mosques in the nearby town and across the border with Syria.

Adding to the unfamiliar, I could not understand the words coming from the minarets, and they frequently sounded like a call to arms. At other times, I could hear the propaganda trucks driving through the streets of Syria. Again, I wondered what was being said to contain their citizens.

Sitting there in the dust, I dialed the satellite phone and was able to reach home. I could feel no greater drive than to assure my loved ones that I was safe and would be fine. I felt a dishonestly in my assurances, but I had to do anything to moderate their concern.

When I think back on my time on the border, I can't help but notice that my memory of the time is hazy. It is as though I made a deliberate decision to be present in the moments only as much as was necessary to do my job to the best of my ability. Yes, I have penetrating memories of moments managing multiple casualties and the emotions associated with being out of the relative safety of the compound. I remember losing Marines who I had come to know well and a steady stream of memorial ceremonies honoring the fallen—and the feel of cloth of their helmet or the appearance of their bloody boots at ceremonies where Marines and Sailors would line up to honor the fallen (Fig. 12.1). I remember being so dirty that I didn't care anymore, and in the winter, being bitterly cold with no hope of warming up for days and weeks.

Interestingly, though, stories that *should* be about fear end up being recoded into humorous self-deprecating tales. As an example, shortly after arriving to Camp Gannon, I was standing outside our aid station. I asked my Corpsmen what that strange popping sound was. As I was being tackled to the ground, I heard, "Doc, there is a sniper line of fire where you're standing." My Corpsmen loved this story

Fig. 12.1 A battlefield cross, or fallen soldier battle cross, is a memorial to a fallen or missing soldier consisting of the soldier's boots, bayonet, helmet, rifle, and sometimes dog tags. It is generally erected at or near the field of battle, allowing the soldier's comrades to pay their respects and to begin to process the loss. Among the military, the image has become quite iconic, and it appears in military tattoos and sculptures as a motif that is meant to symbolize loss and mourning for fallen comrades

about the rookie young doctor who was going to be their new subject matter expert. This is a well-known phenomenon of war, and it was true of my dad too. He fought in World War II, and despite being in Europe through several years of fighting, the only stories he ever told me of war involved his much loved technique for cooking crisp bacon or something of similar consequence.

What I remember most about my time in Iraq is the kinship that comes from working closely as a team on something so important, for so unrelentingly long. The bonds that come from such conditions warm my heart. Despite the moments of intense chaos, the storytelling and bonding in the fight against unrelenting boredom remain unbreakable.

I can't avoid recalling aching for the time to come when we would be relieved and could return home. We spent hours talking about food that we were looking forward to eating, or the view of the blue ocean or a green forest. We also coped with the uncertainty that begins to swirl around returning home, worrying whether we'd be "extended" by having our relieving unit's arrival delayed and thus our departure. Or, we might leave one area of operations only to have to go to a different area to fight.

This was the case when I was in Afghanistan; I treated Soldiers who were redirected to Afghanistan after spending time in Iraq and thinking they would soon return

to the USA. Definitely, looking forward to returning home and longing for home becomes a double-edged sword that different Service Members approach differently. Some find it best to put it out of their mind; others perseverate on it.

As the date for beginning the egress out of combat grew nearer, Marines and their Corpsmen began to count down in various ways. Some looked at how many more patrols outside the wire or how many more convoys there were. Anxiety grew as everyone can imagine calamity striking on that last mission and missing the finish line. For me, that occurred on February 25, 2005, 4 days before we were scheduled to leave Camp Gannon. I was 8 ft from a 120 mm mortar round that exploded, knocking me to the ground, knocking me out, blowing out my left tympanic membrane, and peppering me with shrapnel. As was the directive on our base, I was wearing my protective flak jacket and Kevlar helmet. Thus I was spared what could have been a much more serious set of injuries. To be so close to harm and walk away, I was quite fortunate.

As is true for so many others, having been so close to being killed has been a powerful factor in my subsequent life. And, it's yet another example of where a story that should be about fear, for me ends up being a story I tell with an emphasis on humor. I like to joke about my Corpsmen, who were very excited to throw me down on the gurney and cut off my pants. Or, I joke about convincing my wife not to worry when I told her I had to deploy a second time to the same area where I was in near constant danger—as though it was going to be a vastly different experience after a little over half a year.

Humor aside, I am all too aware of how minor my injury was, having directly cared for so many who were much less fortunate. I try to bring that humility into all of my life: when taking care of patients or being a father, a husband, and a member of society.

Fortunately, I was able to return home with my unit. It is an absolutely matchless occurrence to set off from such a dangerous place, where you truly feel that you have walked through the valley of the shadow of death, only to have your return date on the books. This phenomenon happens for Service Members every time they go out on a perilous patrol and make it safely back to the base, knowing they will return to that same danger the next day. There is a distinct feeling that you're pushing your luck.

Deploying again with 1/7 in early 2006, my assurances to my wife about my safety were actually quite truthful. I was on a bigger base within the same area of operations, and things had indeed quieted down. All of the anxiety surrounding the unknown was gone. I had living conditions that seemed opulent compared to my first deployment.

This second deployment (known as OIF 5/7) did present new challenges. Having other medical assets co-located on the base, various collateral duties were assigned. One duty I found the most challenging was conducting cause of death assessments for fallen Marines. This involved walking into a highly air-conditioned metal container to inspect a deceased Marine. I can still vividly remember the exact sound of the door closing behind me, or the feel of the cold body through my latex gloves. These experiences confronted all the senses, including smell.

These were fallen Marines who I had served with and knew increasingly well. I was prepared and able to do this kind of work, but it did impart a particular empathy for those who have to handle the dead. That can include Mortuary Affairs workers or fellow Soldiers who have to clean up the body parts of their fallen comrade.

I learned to appreciate the unique challenges of the many different types of work that are done in forward areas. Having deployed in three very different combat settings, it seems like a universal truth that there is always talk about how *we* have it the hardest. I have come to believe that are lots of hard jobs in war, whether it's the subspecialized surgeon who is the only one of his specialty at a major field hospital having to operate day after day for half a year, a nurse struggling with the indifference of an Afghani father to the death of his child, or the obvious emotional rigor of a Marine kicking in a door with no idea what he might find or if the door is rigged to explode.

12.2 When a Residency Feels Like a Chance to Catch My Breath

Returning to residency in mid-2006, I felt enriched to have the perspective that came from my time at war. I considered myself extremely fortunate to only have the minor scars that I do for the irreplaceable personal and professional insight that I gained.

I remember discussing with a fellow resident some of my thoughts on perspective and utilizing my memories of hardship as an emotional armor. I will always remember that she confidently told me that it would fade.

Additionally, it was a luxury to finally narrow my focus to the specialty of my choosing. I wanted to become a psychiatrist and I knew that I had seen enough blood and guts for one lifetime. I realize that others have a greater appetite for such things, but my stomach was full. The steady stream of casualties that were Marines and Sailors, whom I knew and had served with, led me to adjust my aperture to focus better on the mind. Lastly, I hoped that my experience would forever guide my empathy for the unique experiences of combat deployments. My experience would also direct my vision for an individualized and optimal path to recovery for those affected by war's invisible wounds.

Immediately upon completing my psychiatry residency, I was presented with an opportunity to deploy to the NATO Role-3 Hospital at Kandahar Airfield in Afghanistan. The use of the word *opportunity* may seem ill chosen, but as I had discussed in some detail prior, it was truly just that—for both selfish and altruistic reasons. Selfishly, it presented the opportunity to massively decrease the uncertainty that loomed over me as well as to further show my colleagues and future patients that I had the credibility that comes with not giving into fear. Altruistically, helping Service Members—as far forward as possible—for me, is the height of gratifying work.

Not to diminish the value of the work I have done with all my highly deserving patients, but I cannot compare the psychiatry that I practice within the comfort of

my office in the lovely San Diego area to the work I have done "forward." Actually, there is a never-ending continuum of "forwardness." As a Psychiatrist on a large and relatively secure multinational base, I was hardly "forward" compared to the Navy Corpsmen and Army Medics who rendered their care under the same fire that took down their brothers in arms. But, to be "in country" with the Service Members whom I would care for was something that I knew, from my time with the Marines, was an unrivaled therapeutic opportunity. All the therapeutic work that will be done and the therapeutic alliance which may develop (delivering care forward) rests on the foundation of the patient's understanding that the provider has come to them; he/she has placed him or herself in harm's way to be with them, to access them and to treat them. This foundation underlies much of the successful field psychiatry and accelerates the course of recovery.

12.3 A Return to War

Fully telling the story of my time in Afghanistan is an impossible task; thus, in this setting, I will focus on a few pieces with varied significance. My first thought is of a lighting changing from green to red. It was Saturday, September 12, 2009, after having completed a month of US Army pre-deployment training at Fort McGrady, South Carolina, with the Navy personnel who would all travel together to Kandahar, as the US Navy had taken command of the hospital, which had enjoyed a period of Canadian leadership.

The red tactical lighting signaled that our US Air Force transport jet had entered into Afghanistan airspace. Up until that point, my thoughts had been a mix of homesickness and excitement for the mission to come, but when that cabin turned red, there was a sobering sense of fear that came over me. It was not the sort of fear that incapacitates a person, but instead, the kind of fear that is fostered by having walked through the valley of the shadow of death before. It may seem odd to the reader that I candidly admit my "fear" and don't try to call it something more masculine. But, to do so would be dishonest. And maybe that is one of the benefits of having had three combat deployments—I'm not ashamed, nor do I feel diminished to admit my trepidation.

It is this sort of emotional journey into harm's way that helps me to connect to my patients. I can't say enough about how visible it can be to be speaking with a patient and to make a remark that validates their emotional experience in a way that can only come from "kind of getting it." The emphasis is on "kind of" because we all know that no one completely appreciates another's experience.

This element of common experience with my patients puts combat mental health providers in a position to share more of themselves with patients than many mental health professionals would feel comfortable with. I also think it provides uniformed mental health personnel with a unique vantage point to chime in on the discussion about how much of ourselves we should reveal to patients. Frankly, even if we choose to reveal nothing in our sessions, our patients are frequently our colleagues who we lived with, exercised with, ate with, and so on while we were deployed. I

imagine that professionals who work and live in small towns where they have grown up have a similar experience; without question, it makes for some very blurred lines. Conversations over dinner or discussions between sets at the gym can begin to resemble therapy sessions.

After we landed in Kandahar, we got a quick safety brief on the base, and were informed on where our temporary lodging would be, as we awaited the change of command and our assumption of clinical responsibilities. We were placed together in a gigantic tan tent full of bunk beds, each with two dusty, worn-down mattresses. It was a strange start to the deployment, with the big lead up to the mission, finally arriving, and then essentially being placed in a holding pattern. We truly had absolutely no professional obligations and nowhere to be. Our mental health team, feeling compelled to be doing *something*, formalized planning meetings that we conducted on a park bench in an area of the base referred to as the boardwalk.

I'm sure the Canadians would have loved to have returned home early, but international changes of command occur on a schedule. And, the scheduled date was October 1, 2009. Prior to that, there simply wasn't space for us. Apparently we arrived weeks early out of an abundance of caution. Once again, I was familiarized with something I had learned from my time with the Marines: periods of great intensity are often punctuated by long intervals of boredom. Luckily, my past experience had taught me many wonderful ways to squander the time.

Another significant point about this period in my deployment was the exposure of our temporary tent. Having been wounded by indirect fire in the past—and knowing that Kandahar Air Field does receive indirect fire—sleeping virtually under the stars in a completely unprotected setting was unsettling to me, and left me looking very forward to the bunker-like NATO barracks to which we would move after the previous hospital staff returned home.

I believe that my first nights in Kandahar have greater relevance than just as a personal disclosure; additionally, it supports my point that every Service Member has a *different* deployment, even if a company of Marines had a very homogeneous set of experiences. How they process the 6, 12, or 18 months on duty is unique to them. Their prior experiences, challenges, or support from home are all different. And so are their perceptions of their social experiences with their fellow Service Members, whom they are with 24/7 month after month, as well as the thoughts they have about their own mortality. All of these factors combine to shape a distinctive experience. This point is frequently taught to those being trained to provide the best care for combat veterans: never tell someone that you know what they're feeling because you *don't*! *Even* if you were *there*, you do not know what someone's deployment is like for *him* or *her*. You may know something about the setting and the emotions that come in the circumstances to which they were exposed, but you don't know what *they* have experienced.

During September, we laid down plans, developed relationships, and spent a lot of time in the gym. We built on our training foundation as a team as we prepared for the serious responsibility to come. We also did a lot of walking from place to place. Unlike being in the USA, where it is common to drive any distance greater than a quarter of a mile, we mostly walked everywhere on the giant Kandahar Air Field,

always through what was referred to as "moon dust," a sand like none other that I had previously experienced with a consistency and clinginess that could be likened to powdered sugar. The base was like a small city, swelling to accommodate 30,000 multinational troops and support contractors. In my correspondence home, I likened the look and feel of the base to the desert world of Tatooine from the Star Wars movies. As in the movie, there were people of all different sorts walking about. The structures varied from assembled trailers covered with antennas to thick, old partially blown-out pre-Taliban era Afghan buildings to contemporary buildings that you would expect to find in any major Western city. There was even a square wooden boardwalk with Canadian and American eateries and people strolling with iced coffees while some in the middle played sand volleyball. To say it was a *surreal mix*, understates the strangeness of the place.

Over time, I would come to feel a sort of embarrassment of riches when I would hear of the austerity that Soldiers who were out in the fight endured. My guilt, however, was offset by my knowing that I had my past history of being deep in the dirt.

In early October, we moved into our comparatively opulent NATO barracks, and our work at the hospital began. We had hoped to be in the newly constructed German-designed hospital. It was a structure that was "rocket-proof", yet would fit in as a regional medical center anywhere in the USA. Instead, due to construction delays, we worked out of the older structure, which was a combination of trailers and old battlefield hospital tents. It looked very modest compared to the imposing new building. But, that modest structure was a place of much healing and functioned with the speed and quality that you would find in any First World hospital. Really, it was a thing of wonder to be in such a space and see highly trained professionals working in unison through unyielding mass casualty situations.

Seeing the horrific and unrelenting nature of the wounded and dying flowing through the hospital, I quickly realized that a portion of my work would involve keeping the staff functional. The patients were most frequently from the US Army, but there were patients from all of our various service branches. There were Soldiers from various nations of our coalition, the Afghani Army, contractors, civilians and many others.

The kids were the hardest on the staff. Many struggled with an episode that occurred after a child was wounded by friendly fire. He and his father were flown by medevac from a small village. The father stroked his beard quizzically as he watched the heroic measures of modern medicine fight to save the leg of his son, who was probably 8 years old. As the clinical picture progressed, it became clear that the boy would have to have an above-the-knee amputation to save his life.

The father continued to convey a sense of confusion, ultimately leading a staff member to ask him if there was anything they could explain to him to help him better understand what was happening. With bewilderment, he remarked that it was inexplicable to him why we would make such an effort to save his son, when he would be a liability to his village after being handicapped in such a way. It was profoundly troubling that he then declared that his son was now worthless to him and that he would leave him at the gate. Immediately, it was clear that this boy would have been lucky to have died instead of being subjected to a withering death alone.

Episodes such as this one stand out, but the theme is frequently the same—First World medical staff struggling to make sense of a world where life seems cheap. Clearly, the Afghani people have had to lead lives in which they were forced to develop emotional calluses for the pain of such decisions.

During my prior, more austere deployments with the Marines, I had accepted the grunt mentality that those POGs (persons other than grunts) back on the big FOB (forward operating base) had it "easy." I had been wrong. Whether it was the nurses in the busy hospital or in mortuary affairs, the Soldiers of the 111th Quartermaster Company who ran the mortuary affairs collection, or a Solider on guard duty making sure the tremendous length of fencing was not penetrated by a suicide bomber, all the folks on the big base had their own hardships.

My clinical work took up most of my day and ranged from what would resemble outpatient or intensive outpatient care to problem-focused brief psychotherapy, frequently, and/or medication management. Like at home, I would sometimes find myself inheriting a patient with a murky polypharmacy regiment, which I either had to change or agree to continue. The environmental precipitants were caused by exposure to war, but especially the ways that deployments exacerbate partner relational problems and conflictual occupational relationships. I felt as though my patients offered little glimpses of life within the various micro cultures within the huge base or outside the base.

I recall one Solider telling me of a conversation with an Afghani villager: "This will never work (apparently speaking of our presence in his country)," he cautioned. "We will never accept foreign rule." The Solider related to him that our intent was not to "rule." The man laughed at the misunderstanding and said, "Not you, Kabul." Hearing this story, I couldn't help but wonder about our prospects for crafting a national identity when a city about 300 miles away was regarded in such a way.

One novel aspect of my time in Afghanistan was being able to be part of a multinational team. In our mental health department, including myself, we had two Psychiatrists, a Psychologist, and a Psychiatric Nurse Practitioner from the US Navy. Additionally, we had a Licensed Clinical Social Worker from Canada and a British Psychiatric Nurse. Leading a multinational team presented chances to appreciate how things we accept as "just the way it is done" are, instead, just the American way. For example, I remember reviewing my British staff member's notes. His notes included a robust subjective, objective, and plan section, but they seemed to be missing a diagnosis. I asked him about the missing diagnoses, and he replied, "My patients need some help, but they don't rise to the level of having a *diagnosis*!" Instantaneously, I realized that our US health care system is built on diagnosis.

Even in the Navy, we follow the lead of our civilian counterparts who bill based on the diagnosis and the treatment; this is how we capture productivity. However, from those who grew out of England's National Health Service, maybe a diagnosis is less important.

Our team was busy, but we looked forward to backup from the US Army's 467th and 1908th Army Reserve Combat Stress Control Detachments, who would regionally reinforce our Mental Health mission. However, in the case of a national tragedy impacting our affairs in Kandahar, on November 5, 2009, Army Psychiatrist Major

Nidal Hasan went on a shooting rampage, targeting uniformed personnel at the Soldier Readiness Center Fort Hood, Texas, killing 13 people and injuring more than 30 others. This attack potentially rendered his colleagues unable to deploy.

As we watched from a distance and mourned the loss of life, we also questioned whether additional mental health assets would be sent to assist us. Ultimately, after a month delay, the decision was made that it was in the best interest of the unit not to be defeated by this radicalized individual.

As a whole, my deployment to Afghanistan was a rewarding, fascinating and educational experience. I hope that I helped a good number of people stay in the fight and recognized those who could spend no more time in theater. Two-thirds of a year can't be condensed into a few pages, but I wouldn't trade the deployment for anything.

Kenneth Richter Jr. This chapter covers Kenneth Richter's time as a GMO from 2004 to 2006, residency from 2006 and 2009, and finally deployment as a psychiatrist from 2009 to 2010.

"Oh, The Things You Can Find"

13

Robert Koffman

"It's high time you were shown that you really don't know …
Oh the things you can find if you don't stay behind."

Dr. Seuss from On Beyond Zebra (1955)

And so it was that the recently identified findings I brought with me to the pentagon, epidemiologic data collected downrange, would be a punch to the gut of the leader of our Navy, to our highest ranking active duty member of the US Navy, none other than the Chief of Naval Operations (CNO). Accompanied by the Navy Surgeon General, my 15 min of fame—or is that infamy—briefing the CNO and his entire court in the sumptuously appointed private "E" Ring briefing room, on the mental health status of a high risk group of Sailors, as if time stood still, grew to 30 min, 45 min, an hour, or more.

Entering the room and repeating my new mantra to myself, a meditation on self-preservation, "please don't shoot the messenger!" I knew the findings I carried with me, data collected and analyzed, would not be well received. Would these findings—unclassified health care data, gleaned from an at-risk population based behavioral health surveillance—at least in senior leadership's mind, conjure up a failure of covenant responsibility and possibly forever contribute to for my wahrhol-esq fifteen minutes of CNO briefing fame?

The Surgeon General (SG), concerned not just for the welfare of the Sailors we identified at immediate risk, but how CNO would respond, rehearsed the brief with me, going over and over the data as we knew it, imploring me to "stay on script." I have a habit of enriching the discussion, even more so with flag and general officers.

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On more than one occasion my naïve offering of "too much information" culminated in gentle, but telegraphic, under the table kicks by lesser ranked officers reminding me to confine my digression to the topic immediately at hand.

As the Bureau of Medicine and Surgery's inaugural *Combat and Operational Stress Control Consultant*, Acting Director of Psychological Health, and clinical psychiatrist, I've completed more deployments, both combat and peacetime, than most Navy Psychiatrists rack up their entire career. With over a quarter century of operational medicine, I knew my findings would not be contested simply from the perspective of credibility. Furthermore, the MPH on my signature line meant that it was my job to identify occupational hazards: combat missions which put those who the CNO was specifically entrusted to protect at undue risk, whether that was attributable to lack of experience, leadership, training, or equipping. Not that there is ever an "acceptable" risk of developing a condition such as PTSD following service to this great country, however we are at war, and the length of war, chronicity of exposure, periodicity and extant nature of deploying, justify the roles and responsibilities of the COSC Consultant.

Even before I finished my presentation, upon seeing the morbidity stats sampled from an entire detachment of Sailors, CNO spoke, his court listening intensely. Dropping their heads in mutual and unanticipated disgust "How could we let this happen?" CNO spoke, admonishing his court. Surveyed using the same instrument (language and ranks slightly modified for Sailors) as the Mental Health Advisory Team, or MHAT, my findings indicated profound psychological injury, far in excess of front line infantry soldiers and surpassing the psychological impact of the most intense combat exposure.

How could Detainee Operations be so traumatic? Why should a battalion of Individual Augments, typically reservists made up from a broad sampling of rates, ranks, ages, Reserve Centers, backgrounds, and military experiences be so profoundly impacted by their mission of guarding OIF/OEF detainees down range? With Post Traumatic Stress Disorder and Depression scales "off the charts," it is little wonder that only a few months before, I received a distress call from the AO (Area of Operations). The Officer-in-Charge of a guard force of Navy reservists-turned-Individual Augments, had assumed command of battalion of reservists cobbled together, deployed to CENTCOM to replace an Army unit of MPs.

How did we get to this point? Several weeks earlier, across the pond, I was not aware that my collaboration with the Army's Mental Health Assessment Team, well circulated in behavioral health circles and with data published in the New England Journal of Medicine NEJM [1], would offer hope to the Officer-in-Charge of a battalion of Sailors. Speaking over poor quality DSN line, after first confirming that my lieutenant and I had conducted MHAT analogous surveillance of deployed Marines and Sailors, this OIC inquired if we could conduct an immediate epidemiologic assist visit—the tactical equivalent of popping smoke, the herald of a red star cluster. What would follow would be an unprecedented expedited request for surveillance.

A subsequent series of programs and deployments to identify other at-risk populations would usher in and presage an entirely new concept in population based, preventive medicine championed throughout Navy Medicine writ large. Like an

archeologist discovering artifact, now uncovered, our epidemiological findings, dusted-off and held to sunlight, contributed a critical piece of the puzzle, shameful as it be. On time and definitely on target, clinical observations from a population of guards accomplished what good science yearns to do: create hypothesis which, once tested and validated, guide efforts which improve the quality of life. PTSD underpinnings unearthed.

Before my 67 min of fame was to be over, before senior leadership could really get their arms around this concept of the unique and for the most part, preventable risks incurred by the Individual Augment, I would be tasked by the Vice Chief of Naval Operations (VCNO) to "find it-fix it." Much like Dr. Seuss' Cat in the Hat intoned, *it was high time our leadership was shown that they really did not know* what the cost of sending ostensibly well prepared Sailors to augment Army units in order to perform what would ultimately be appreciated as one of the most injurious missions the War on Terror has produced—guarding the angriest, rageful, deceptively dangerous prisoners in the world.

To accomplish the tasking of guarding detainees, the Navy would ask erstwhile sonar techs, aviation bosun mates, structural mechanics, even yeoman (administrative staff) to leave their ships, subs, flight decks, and indestructible Steelcase desks, don Army ACUs, qualify on service weapons (M4 automatic rifle and M9 Berretta pistol), mobilize onto active duty with 180-day orders, and receive just-in-time detainee ops training. "Fall in," was followed by, "aye-aye, sir," over and over again … *Oh, the things you can find if you don't stay behind* … Following my briefing to CNO, I didn't stay behind long, either.

In their defense, senior Navy leadership, and for this matter, probably the Air Force too, knew not the perils endured by Individual Augments, much less the psychological consequences of Detainee Operations. In theory, parts are parts; TDY is TDY (or as it is called in the Navy, TAD). Why shouldn't the Navy offer up US Navy personnel to assist the army in their effort to mend holes and patch thread-bare platoons, companies and even battalions. And holes there were: by early 2007, there were approximately 12,000 Navy personnel filling Army jobs in the USA, Iraq, Afghanistan, Cuba and the Horn of Africa. By 2008, about the time I received that sentinel call (heralded by the popping of smoke) more than 10,000 "sandbox sailors" (the pejorative moniker this group of dedicated Sailors were sometimes called) found themselves in receipt of IA orders. The utilization and demand for IAs could not be understated. Quite stunningly, according to the Defense Technical Intelligence Command, DTIC, since 9/11, the total number of sandbox sailors deployed throughout theater, actually surpassed the total number of Sailors deployed upon all Navy ships.

An Individual Augmentee is a formally defined as a US military member assigned to a unit such as a battalion or company, as a temporary duty assignment (TAD/TDY). Individual Augmentees can be used to fill shortages or can be used when an individual with specialized knowledge or skill sets is required. As a result, Individual Augmentees included members from other branches of service similarly plucked from their military family (and personal family), cleaved from the comfort and support of their organic command. The IA system was used extensively in the Iraq War, though with some criticism. Individual Augments served in vital roles,

typically inferred by their more traditional Navy roles such as USMC support, maritime security, port security, cargo handling, Seabees, and even, Joint Task Forces. However, it was the not-so-traditional occupations such as, Civil Affairs, Provincial Reconstruction, and perhaps the most insidiously damaging job, Detainee Operations which garnered my concern.

Back in the dark walnut appointed conference room, crown molding abounding, underscoring the thematic importance (if not sanctity) of unit cohesion I blurted out to the CNO and his court, "With all due respect, sir, Sailors called to serve in an IA capacity, particularly Detainee OPS, are not *plug and play* circuit boards that can be inserted into a mission or unceremoniously extracted." Clearly overstepping my bounds, now capitalizing on those 67 min of fame, I added, the practice of sending service men and women to Vietnam for a fixed period of time, 12 months for Soldiers; 13 months for Marines, meant that the service member deployed alone, and even more devastatingly, returned home alone! Given the enmity Vietnam veterans suffered upon returning home, no policy or practice directly under DoD control was probably more contributory to the development of PTSD—at least in this psychiatrist's mind. "Have we not learned this lesson?" now speaking with timidity, realizing that I had definitely overstepped my bound.

From my perspective, the situation was indeed urgent, worthy of the CNO's time and attention. At one point, more than half of all IAs were reservists, some on their second or even third mobilization. The fact is that not only would the unit to which the IA was temporarily assigned dissolve upon redeployment, but so would the active service, hence, so to, the naval identification which the mobilized reservist proudly wore. He or she would be re-introduced to a very different, now ego-alien world, where few friends, family members, or civilian co-workers could relate. *War changes everything, everyone*. Was I the only one who understood this seemingly trite, but never truer cliché. As the need for Navy Reservists swelled (as well as for other reservists, Air and Army Guard), so did the need for *dwell time*, the period of time home when one could reconnect with friends, families, and employers, to shorten.

Even though I was theoretically correct, speaking as if to not just exclaim but to educate these very senior officers, I was out of line. In my own mind, this lesson seemed to rebuke. Of course the CNO and his team care deeply about the mental health of each and every Sailor. However, we are at war. There are critical missions we must undertake. Surveying the dead pan expressions seated around the impressive expanse of the table, another swift but demonstrative under-the-table kick was warranted. To my great fortune, not only was I speaking from the walnut podium—but from the heart—the later, well beyond the SG's reach … I repeated my exhortation "Identified groups of Sailors performing duties as IAs in support of Detainee Operations are suffering," pleading the four-star seated directly across from me to take action … "Oh boy, is it ever high time you were shown that you really don't know," I thought to myself.

As a psychiatrist, a military psychiatrist, even more so, a combat stress control/Director of Psychological Health psychiatrist, it seemed more than intuitively obvious that the loss of one's shipboard and sailor-centric identity (replete with loss of shipboard support system—probably the single most important life-support

system a service member has), could contribute to the development of additional stress. Departing from the time honored admonition, *train-like-you-fight; fight-like-you-train*, the whole idea of the Individual Augment is anathema and smacks in the face of promoting resilience. After all, we military mental health types (I include the broad array of social workers, psychologists, therapists of all stripes) preach the gospel of Combat Operational Stress Control (COSC): unit cohesion is sacrosanct. It is in this collective sense of purpose, combined with competent leadership and supported by a comprable level of training, preparation, and physical conditioning that ARE the apostles in this congregation. Facilitated by unit identity, unit cohesion IS the reason young men (and increasingly now, young women) offer and sometimes forfeit their lives. It is not for God, or country, or some platitude artistically depicted in a music video; it is precisely and personally for that person on his left or her right. Protection of each other and the willingness to die for that brother or sister defines unit cohesion and underscores EVERY value, action or platitude. Traditions, rituals, and customs burnish unit pride and reinforce centuries of distinction. Wearing the cloth of his nation is intensely service-centric (to this I will add: *GO NAVY, BEAT ARMY!*)

If unit cohesion is inviolable, unit cohesion can be and most certainly develops within newly formed IA units, too. However, organic units/commands have the benefit of remaining intact post deployment. To be truly accurate, the need, and benefit, of mutual support, acceptance, and understanding, really begins once the mission is over. In the unkindest cut of all, once home, the opportunity to reflect upon the enormity of their contribution—inclusive of personal and private sacrifice, dramatically wanes. Overcome by events of living, looking back becomes as difficult as it does not to emotionally detach. Suppression, Repression, Denial … you name it: defensive operations keep distant memories just that. Problematically, there is no time downrange to grieve for what was, or perhaps even more importantly, what wasn't. Individual Augments, like reservists themselves, suffer a double dose of transition from deployment to redeployment. Alas, for most, redeployment will forever be incomplete. Unlike most of men and women seated around that table, having been a lone IA in the desert, I knew this too well.

A short digression to illustrate the critical importance of unit cohesion is warranted. From the time of Thomas Salmon, the early twentieth century neurologist who championed the foundational tenets of the treatment of "Shell Shock": *Proximity, Immediately, Expectancy*, or *PIE*s, the deliberate intervention of keeping traumatized service members as close to their organic unit as possible providing them rest, replenishment, and rehydration (the so-called three-hots-and-a-cot) remained the dogma of managing Combat Stress.

Previously referred to as Shell Shock, Battle Fatigue, the 1000 Yard Stare, this lesson of combat stress control has unfortunately been learned, forgotten, and relearned throughout history. What's more, practicing Combat Stress Control has been made exponentially more difficult in this now asynchronous battle sphere where classic "frontlines" do not exist. Indeed, Thomas Salmon could never have imagined the stress upon the IA.

I learned about PIES first hand during my early medical education. It was a lesson which has stuck with me throughout the many years of war this combatant has experienced and endured. In 1991, I was a young Lieutenant Commander. Though I had several overseas tours previously, they were all unit deployments in preparation for what was to, years later, arrive with the crossing of the proverbial "line in the sand." The coalition's buildup to the first Gulf War followed a long prelude in anticipation of Saddam Hussein crossing this line, a staging of forces which offered me the unprecedented opportunity to deploy to the Persian Gulf during as a PGY-4 resident.

Because of follow on orders to Camp Lejeune, where I was slated to become the 2nd Marine Division Psychiatrist, for the purpose of learning about this heretofore theoretical construct, *Combat Stress*, I wrangled my way to the Middle East for a several month-long "senior elective." In my efforts to understand, identify, and treat COSRs (Combat and Operational Stress Reactions), I came to appreciate that because our forces remained faithful to the canon: excellent training, realistic preparation, belief in the cause, and most importantly, a strong and covenant leadership up and down the chain, resilience during combat and post traumatic growth following redeployment was ostensibly the combat norm. As for doctrine, at this point in the desert conflict, naval Combat Stress Doctrine was lacking; something my mentor and I hastily constructed immediately prior to the kick-off of the ground war.

As validation, moreover vindication, of what I traveled to the desert to learn, when the ground war began, tens of thousands of Saddam's troops immediately abdicated their positions and surrendered in endlessly long, retreating columns causing the over-flow of hastily constructed Enemy Prisoner of War camps. As if Saddam had missed Salmon's historical lesson (indeed, history throughout, is rife with learning and relearning Combat Stress Control) every stressor operating to degrade the strength of his Saddam's Army was evident. And surrender they did … given an absolute dearth of US forces seeking behavioral health assistance at my lone Combat Stress Center outpost, due in large part to the speed at which maneuver units outpaced the static positioning of the surgical companies, I volunteered my medical officer skills to staff the burgeoning EPW stockade.

What I had journeyed to the Persian Gulf to observe and study, I was serendipitously confronted—if not rewarded—with hundreds and hundreds of COSR cases, not in our troops, but rather the enemy! As the General Medical Officer working the night shift, assisted by five Iraqi physician EPW interpreters, I observed the protean manifestations of Combat Stress; every possible presentation of conversion disorder, from pseudo seizure with "convulsion", to hysterical blindness and paralysis. I became a believer in this condition so tactically important, wars were won—or lost—on account of it. Like Salmon, I became a believer and would soon preach the gospel!

Cleaved from their families precipitously, conscripts to Saddam's Army (Republican Guard excluded), surrendered in droves, largely due to the stress inflicted upon them through the culmination of 30 days of B-52 raids, poor training and equipment (some soldiers wore empty sandbags as shoes), and ire and rage for Saddam and his government following payment in counterfeit dinars. Physically,

the fact that the hapless combatants remained sheltered for such a long period of time, immobilized by carpet bombs overhead, subsisting on limited rations of a cup of rice and a dry cheese stick, and forced to drink incompletely desalinated drinking water (we bombed the water desalination plant, too) further set these soldiers up for flagging moral, high anxiety, and mission failure.

Differential diagnosis was challenging, given the sea of somatization. Dehydrated and suffering from circulatory collapse, as well as venous stasis (many were required to squat for hours and days at a time), swollen legs with calf pain, like pain from other physical causes, was legion and contributed to and confounded the Enemy Prisoner of War's presentation. Was this a Deep Vein Thrombosis, the unconscious somatization of the wretched, or the conscious manipulation for an additional blanket and bottle of water? Virtually every stressor possible which could lead to the development of a Combat Stress casualty was in place.

The coalition forces fared much better. Reflecting upon Combat Stress gospel mentioned earlier, even those who fought valiantly on the so-called "Highway of Death," our own US forces were for the most part, psychologically unscathed. Such is the power of truly understanding Combat Stress. All the electives in the world could not have instructed me more elegantly in not just what went into the making of a combat stress casualty but, for the sake of our troops, how to prevent it!

When it came time to retrograde home following the quick win of Desert Storm, I was stuck. Following this unprecedented 6 month build up, there was an impossibly long queue of physicians, nurses, medical of all types, waiting to retrograde home. Learning that I was PGY-4 resident in need of finishing my residency only angered the colonel from the G4 shop even more. "You're a doctor, aren't you," the colonel inquired upon hearing my request to hurriedly depart theater in order to complete PGY-4 year … "Yes, ma'am, but I am a resident physician", I replied. "I need to return home to finish my residency," I added, knowing that other mobilized and recalled physicians would understand. "You're licensed, aren't you", clearly aware that her G4 shop could be in trouble if unlicensed personnel had been caring for her Marines. "Yes, ma'am," I dutifully replied … "You doctors—with your excuses of needing to get home to care for the sick, sickens me," she rebuked!

Humph … I was really stuck. In just a week, I was to continue my residency as chief resident. It was only upon the colonel's learning that under the terms of my elective, I was actually required to *pay my own way* to the point of embarkation that her curiosity piqued. "What kind of a residency do you need to get home to?" she asked, clearly disgusted with the litany of excuses from other doctors "Psychiatry," I informed her. "You're F__N crazy!" she shouted incredulously, "YOU'RE OUT OF HERE!"

Fortunately, notwithstanding this humorous digression, the breadth of my operational career bolstered my professional credibility. Two warfare devices, multiple pumps downrange, more than seven rows of ribbons on the left side of my chest—though not nearly as decorous as the CNO's remarkable rack—underscored my credibility and subsequent clarion call for aiding IAs. Who knew projectiles not of copper or lead, but of shame and guilt … bullets with which the detainee was psychologically armed … could wound so grievously. In a population of poorly trained and hastily assembled IAs, the casualty is not the individual, but the unit. The data did not lie.

Without the will and presence of mind, the soul and psyche, even spirit cannot be armored. Chinks in this armor then appear, quite insidiously, eroded by physical threats, hurtful, racist taunts, and lurid, sexist gestures. Danger for the guard force was everywhere. Detainees who could fashion shanks from bed springs, could similarly weaponize an adrift pen or pencil. Buckets of feces mixed with vile concoctions of urine and semen were tossed on unsuspecting guards. Like snipers picking off the psychologically weakest, IAs serving this most dangerous of mission fell quietly and surely. The cumulative effect of daily exposures of 15 h—or longer—produced non-stop interactions, replete with face-to-face contact with these *desperados*.

Shame, like fear, disarms the limbic system, and sets in motion, the desire for retaliation and retribution. Even more alarmingly, in the post Abu Ghraib world, the Department of Defense's pendulum swung widely the other way, from hard scrapple interrogation techniques replete with (inappropriate and illegal) highly publicized detainee abuse by a few miscreants to ICRC-monitored detainee "rights." From senior leadership's perspective, there must not, cannot be, any more flagrant mistreatment of the detainees at the hands of US military members.

Knowing this meant that the detainee could add to their armamentarium, the threat of uttering factitious and felonious abuses at the hands of the guard force to the ICRC (International Committee of the Red Cross). Reminiscent of the sadistically malicious, older brother who would beat the bejesus out of his whiney kid brother when mom and dad weren't around, the detainee population continued to strike out with malice and lethality, yet feign ignorance and innocence with impunity. In the unkindest act of all (at least during this particular visit), the guard would then be reprimanded for "allowing" himself to be beaten, or herself to be sexually groped—then beaten. Assaulted during a moment of inattention, then punished for same by the leadership set up a lose-lose proposition; the rat gets shocked no matter what. The detention facility became the detainees' new battleground. Given these dynamics, the detainee was now armed with spears capable of inflicting a new type of moral injury.

Upon arrival to this decrepit, dank, and immediately depressing facility in Afghanistan, the stench was staggering. As if not to be outdone by captive's cacophonic chorus, a mixture of human, rodent, and only God-knows-what, excrement pervaded the fetid stink. A milieu of various body odors and fluids, admixed with mold and mildew straight from the underworld was only partially masked by air sanitizers struggling to keep up. Large industrial sized fans, Springer-esq if not for the dashed humanity, circulated stale air among the din and clamor of the imprisoned. Not only was my olfactory sense overwhelmed, but so was my sense of humanity and the dignity which previously accompanied it.

This particular facility screamed of an earlier era during a time the Soviets learned a decades-old lessons of not tangling with the Mujahedeen. More representative of a Hollywood set within the cellblock, the most intimidating "actors" on this harrowing stage seemed to play the restive part well. Milling robotically in circles, pausing only when called to prayer, their stockade seemed to limit free will as it did physical movement. Suddenly, springing to menacing animation as if from the pages of a Mary Shelly novel, a detainee would grab the bars, reaching other-worldly. Tactically aware, waiting and watching for a that precise moment of

inattention, hopefully killing or at least maiming an unsuspecting guard, the prisoners were thoroughly skilled to play the part.

While there were a few Master of Arms (military police) mobilized to IA orders, the majority in this unit were Sailors from every rate in the Navy. Once assigned IA Guard Force duty, they were required to serve in the same capacity as fully trained military police. What these true patriots had in common, beside criminal justice naivety, was the willingness to fight—and if need be—to die for their country. Shared too among them, was the lack of training and staffing sufficient to endure hours upon hours, days upon days, months upon months, in this disheartening, demoralizing, dispiriting, and most perilous of all, dangerous setting.

Locked away with these heinously misbegotten souls for up to 18 h a day in an offensive, soon-be-closed facility, I could only wonder how the E3s, the most junior members of the Navy, Sailors who hadn't even really checked into their first duty station, could/should be in receipt of such IA orders. It would be several months following this maiden visit (and several subsequent visits after that) validation of our original findings data came in the form of the CNO's utterance, "How could we let this happen?"

Practiced in the world of military psychiatry where Combat and Operational Stress is the substrate of PTSD, once understood, Combat Stress could be managed. What my visits to this and other detention facilities taught me, was the unique kind of operational stress detainee operations imparts: an inescapable, unavoidable, and most treacherous experience of shame and guilt. Whereas guilt can be considered a feeling of remorse for oneself for an act one *did*—or did not—commit, shame is the pervasively negative state—an attack on one's self—for what they *experienced*. And the detainees were masterful at shaming, belittling, humiliating, chastising, debasing, and of course, when given the opportunity, attacking! Even though guards may not have committed shameful acts, shame, like fear, is not rational. Rather, it is a profoundly human experience endured by the civilized, the dignified.

The emotional environment paralleled the physical environment and compounded guard force stressors. Like heavy metal exposure and asbestos exposure (another real risk accompanying this mission), the lingering impact of shame and guilt were toxic to the autonomic nervous system. Other authors have noted the relationship of Shame and Guilt to PTSD. This dysregulation markedly impacts the sufferer's ability to process psychological traumas [2].

If I have learned one thing in my 30 odd years of active duty working directly for and with the line community is to never, ever identify a problem without also identifying a solution or solutions! (*Note*: The line community are those officers who command ships, fly planes, order around squadrons or battalions … the medical corps is NOT the line, rather a Staff Corps). For the most part, providers are considered non-combatants, servants of the line, imbued with certain skills, granted certain protections under Geneva Convention. As a Staff Corps, we work for the Line Community. Hence, it did not come as a surprise to me that when after CNO heard about the morbidity statistics associated with Detainee Operations, I was asked, "So what are your recommendations, Captain?"

Fortunately, my lieutenant and I had thought this through. Given the ubiquity of the Individual Augment valiantly serving throughout the theater of operations, the solution needed to impact the thousands of other Sailors, in multiple locations, who were similarly affected. These *fish-out-of-water*, so to speak, needed advocates, monitors, reach-back to big NAVY. IAs could certainly be attached to Army units but not without Navy personnel providing over watch. Never again would a ships' store keeper show up at Fort Jackson to be assigned to a Stryker platoon as a communicator, then be hastily reassigned as combat replacement for a 50 cal. turret gunner without continued surveillance.

Alas, the concept of the Mobile Care Team (MCT) was born. For the first time in Navy Medicine, covenant leadership would be defined by the ability to monitor, surveil, and track through the use of standardized inventories and instruments, real-time health outcomes of active (and principally Reserve Component) Sailors *during actual combat*. Moreover, this same covenant leadership would ensure that by having a suitably trained clinical/investigative team on the ground, just-in-time, hands-on care could be rendered. Sailors caring for Sailors. Imagine that. The brilliance of the concept being the mobility of the team to go where covenant Navy leadership, oversight, and authority could not. The MCT could provide not just one-on-one care, individual and group psychiatric care, but armed with real time, actionable epidemiological data, offer consultative assistance at a command level also!!

Nine consecutive iterations of the Mobile Care Team followed, surveilling thousands of deployed Individual Augments, identifying countless problems *while* boots were still on the ground. Preventive Medicine re-imagined. Best of all, the MCT provided direct care to hundreds of Sailors, delighted to be visited by someone who spoke Navy, looked Navy, and reassured that "big Navy" cared enough to ensure the IA was not treated as a "fire and forget weapon" … "Oh the things you can find if you don't stay behind"—

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Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care
Robert Koffman served as a Navy Combat and Operational Stress Control Consultant, Acting Director of Psychological Health, and clinical psychiatrist, with over a quarter century of operational medicine. This chapter covers events from around 2006 to about 2008.

Chronicles from the Cradle of Civilization

14

Kaustubh G. Joshi

14.1 Green Clovers and Purple Horseshoes

After completing 2 months of Army pre-deployment training at Ft. Sill, OK, I headed to the other side of the world to work as a psychiatrist (and also work on my tan). As I never deployed previously, I had no idea what to expect about traveling to a warzone. The first lesson I learned was that there were no direct flights to Iraq (shocking, isn't it?). The second lesson was that a round trip ticket was not booked for me, i.e., there was no guarantee that I was going to return home. Awesome.

I was full of glee when I saw that my flight to Qatar was on a civilian DC-10 complete with flight attendants, tray tables, reclining seat backs, and lavatories. However, that spark of euphoria was quickly extinguished. The plane's air conditioner blew a balmy breeze throughout the cabin for the entire flight. I think this was the Air Force's crude attempt to get us acclimated to the desert heat before we even arrived.

As the cherry to this ice cream suck, the flight attendant got on the intercom as the plane was landing and said "Welcome to Qatar … the local time is 3:30 A.M. and the temperature is 104 °F. We would like to thank you for your business. Enjoy your stay in Qatar or wherever your final destination may be. We hope to see you in the future if you make it for a return trip. Flight attendants, please prepare for arrival and cross-check."

After a brief stay in Qatar (highlighted by my consumption of three beers in a 24-h period since it would be the last time that I could drink for a while), we left for Kuwait. I was in Kuwait until I could fly to Iraq. Due to the diversion to Qatar, we didn't have to complete further Army deployment training in the blazing tandoori oven that is the Kuwaiti desert. We were supposed to have left for Iraq 3 days ago, but we kept getting bumped. In the warzone, your ability to get on a flight was determined by how essential

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your mission was. I guess mental health was not important, especially when one of the missions that bumped us was rumored to have delivered toilet paper downrange. Of course, toilet paper is essential as a wiped ass is appreciated by everyone around you.

While we awaited a flight out of Kuwait, I wondered why I was doing this. I joined the Air Force for pragmatic reasons because the military would pay for my medical school education. 9/11 occurred in the second year of my psychiatry residency. Thus, I knew it was not a matter of if I would be deployed, but rather when I would be deployed.

I had no problems with deploying. Unfortunately the gods must have been playing a game of "Can you top this?" My father unexpectedly died 4 months prior to my lottery number being selected for an all-expenses paid trip to the battlefield. My mother was still grieving (they had been married for 38 years). Knowing the risks of deploying (e.g., being killed) and given that I was leaving my mother alone during her time of need, I asked those in leadership positions to push back my deployment tasking to the next cycle given the circumstances.

Sadly, no one gave a damn and I deployed at the appointed time. That was my first realization that the military's emphasis on "family first" was a nothing more than lip service. Despite this bitterness, I deployed … mostly because a Uniformed Code of Criminal Justice (UCMJ) proceeding was not on my bucket list.

Once I completed that trip down memory lane, I returned to the task at hand. The Kuwaiti base was not as good as the Qatari base in many aspects (e.g., no local vendors selling cheap rugs or giving camelback rides were found on the Kuwaiti base). Even worse, you did not get a beer ration card in Kuwait. Although real beer was not available, you could purchase "near beer" at $1.50 a bottle if you felt desperate. "Near beer" looked like real beer but had no alcohol in it. Not wanting to make a rash conclusion, I shelled out $1.50 and tried this "near beer." After I carefully examined my taste buds, I reached the conclusion that "near beer" was actually closer to crap than it was to real beer. It tasted horrible, but it did wonders for my jet-lagged digestive system.

Having been in Kuwait for a few days, I got bored and found humor in the most mundane things. Take urination, for example. Over each urinal, the military posted a urine color grid by which to monitor hydration status. Clear meant "excellent." Darkening shades of yellow meant you were one, two, or three quarts low. Brown, red, or black … seek medical attention. As I used the latrine one day, I met an Army sergeant who had his own interpretation of the urine color grid. He told me "If you see all the colors of the Lucky Charms rainbow when the sunlight hits your stream, you are doing good." That's probably the best piece of advice that I got since being there. Using his method, I was behind the power curve since my arrival because all I got were yellow moons. I started to drink more water after that encounter.

14.2 Aloha from Iraq: Wish You Were Here!

My jaunt around the Middle East eventually landed me in Mesopotamia (i.e., Iraq) at Contingency Operations Base (COB) Adder. After playing an Army grunt for the past 2 months, I found being at war quite soothing and relaxing. Before I get into my life there, it really pleased me to know that so many of my

friends back home paid closer attention to their hydration status. I thank them for sharing their experiences urinating, suggesting new techniques to measure hydration status, and providing thoughtful analyses on the different colors of urine they produced.

It gave my Iraqi excursion more meaning to know that, as a result of me being there, people built happier lives through hydration. Meanwhile I consumed water as if it was going out of style. The downside to my near continuous water ingestion was that I peed about every 30 min. My coworkers were convinced that I had an overactive bladder condition and/or a raging urinary tract infection.

It was a very unusual feeling when I finally stepped off of the plane and realized that I was in Iraq. The landscape was littered with rocks, sand, and dirt stretching to the horizon. This created a mosaic of every shade of brown and gray imaginable. As the outgoing psychiatrist eloquently stated, "It's as if God had used all of the pretty colors for the rest of the world and rushed through Iraq with the crap that was left over."

COB Adder was split into two parts (similar to post WWII Berlin): an Air Force side and an Army side. I lived on the Air Force side and worked on the Army side. I nearly soiled myself when I saw my living quarters. I lived in a trailer and had my own room with a full-size bed, a bathroom, and a television. It was actually better than my apartment. All the officers received similar living arrangements.

The poor enlisted guys shared tents and bathrooms. Needless to say, they were a smidge bitter. Their acrimony manifested itself as snide comments veiled as funny quips. "Hey Major Joshi, did they forget to fluff your pillows last night?" "Hey Dr. J, were you disappointed that the mini bar wasn't stocked?" "Oh Dr. J, were you upset that the jazz quartet lullaby ensemble had to cancel?" My standard retort was "No, those things don't upset me. What upsets me is that I have to ring a bell for my attendants to come wipe my ass. I mean, really, I shouldn't have to ring a bell." Only in Iraq was living in a trailer considered bourgeois.

14.3 Move Over Picasso

I had been there for about 45 days and I had been having a great time in Iraq. If by "I had been having a great time" you meant "This" and by "in Iraq" you meant "sucks." Our mental health clinic occupied the second floor of an old building. In fact, our entire base was an old Iraqi air base. The structures were made from mud, straw, and something called "concrete." They clearly fell below known building code standards.

If the mortars didn't get me, the shoddy construction would have. The steps leading to our offices were the most interesting that I had ever encountered. Each step was a different height ranging from 6 in. to 14 ft. In America, walking up steps is a fairly unconscious process. Your feet just know exactly how high they're supposed to be in order to negotiate each stair. Such thinking in Iraq could have ended your life.

The rest of the building had lots of character too. For instance, there were these sinister-looking hooks in the middle of all the ceilings of the large rooms. These hooks may have been used in countless ways to torture people. I was even more convinced that my office may have been used to facilitate such a purpose during the winter months as I had no heater. My patients had to wear their cold weather gear prior to entering my office.

I didn't expect too many referrals from them.

There was a TV in most buildings. I guessed even the torturers needed a break. AFN (Armed Forces Network) was the only television network here. AFN was an example of state-controlled media, commonly found in communist countries. Rather than showing the latest commercials AFN bombarded us with pro-military propaganda, prohibiting us from learning about the outside world. The lack of commercials about the latest episode of Pimp My Ride atrophied the brain cells that hadn't already been destroyed by alcohol, which resulted in a precipitous drop in IQ by about two points a week.

Since the TV spewed worthless rubbish and the internet was excruciatingly slow, where did one turn to get the latest current events? The answer was right outside most buildings: Port-a-Potties. Tormentors of my time at Ft. Sill, those much maligned and often ridiculed Port-a-Potties served as the bastions of free speech. If you ever wanted to get a sense of the issues that occupied the cortical space of the community, you needed to look no further than the plastic latrines.

Stepping into these synthetic commodes created a sense of nostalgia. In between the latest Paris fashions and war commentaries, there were exquisitely detailed anatomical drawings of the female and male mammillary and reproductive systems; veiled references about people's mothers engaging in the world's oldest profession; plethoric aphorisms bespeaking the assorted and impressive accomplishments of Chuck Norris; and introspective, eloquent discourses on each military branch's inferiority. Many were appalled by these literary monstrosities … I petitioned for their designation as national landmarks.

My favorite barbs were "The Air Fors [sic] Blows" and "The Armee [sic] Sucks." I wished I was joking about the misspellings. I often felt embarrassed and sort of sad for the authors of these statements. I had this compulsion to break out my Sharpie® and correct the spelling for these authors. But I resisted that urge.

And I continued drawing my voluptuous pictures.

14.4 Wasting Away in Mortar-Rita Ville

My COB (rhymes with sob) was pretty much out in the middle of nowhere, which was exactly where you wanted to be if you ever found yourself in a warzone. We shared our COB with armies from other countries, which made life there an interesting sociological study. Take a large group of people from different socioeconomic, cultural, political, and national backgrounds. Confine them to a relatively small base thereby forcing them to interact. Add the stressors of separation from family and loved ones. Finally, mix in the ever-present risk of a sudden and

brutal death. This basic plot is a TV producer's dream. Now, convoy in a bunch of alcohol and hot tubs while substituting all of us military types with attractive individuals lacking social graces and morals, and voila! You have MTV's new reality blockbuster: Pimp My COB.

I would have watched it.

The dining facility was the melting pot of our COB. Every day, I ate side by side with Romanians, Poles, Brits, Ugandans, and Australians. The Ugandans provided security into, within, and out of our COB. It was disconcerting to know that outsourcing was not limited to customer service calls. But considering where I was, I preferred the Ugandans to protect me. The Ugandans had a reputation of shooting first and asking no questions.

Not surprisingly, the Aussies seemed to have had the most fun there. Although they denied it, I think they had weekly keggers in their camp. Their denial was not helped by my discovery of a 40-oz can of Fosters™ outside their camp. It was hard to fathom that anyone could have had fun in Iraq unless they were plastered. Up until a few days after my arrival, I thought "Bloody Wanka" was an official rank in their Army. The Aussies also had the most interesting uniforms. They looked like desert camouflage polka dots. The Aussies would have been practically invisible on a Twister® mat. The Romanians' and Brits' uniforms resembled a pattern you might have considered for shower curtains. I think they would have looked really nice next to the urine color grid.

14.5 Sometimes a Cigar Is Just a Cigar

I was finally in a routine and saw patients daily. Deployment mental health was very different from mental health practiced stateside. Although some practices remained the same (e.g., don't have sex with your patients), other practices differed.

My workday never really ended. I was one of two psychiatrists on the base, thus I split all the medication management appointments with the other psychiatrist. I also conducted evaluations that other disciplines couldn't perform due to military regulations. As one of two psychiatrists on the base, I was always "on-call." If I didn't go into the "emergency room" to assess patients after hours or on the weekends, then I served as the "telephone" back-up to the social worker or psychologist who was evaluating the patients. Since I was the only forensic psychiatrist in southern Iraq at the time (as far as I was aware of), I served as a consultant for attorneys and other mental health professionals regarding mental health and the law.

There was no such thing as a "weekend getaway." On the off chance I had a day off, where could I have gone? I was stranded on a base where I lived with the same people with whom I worked and also with people who were my patients. I had to strike a balance between isolating myself from my coworkers (which could have been perceived as me being too important to hang out with them), and spending too much time with them outside work (which could have resulted in getting on each other's nerves and increased the risk of complacency). Pour in the additional fact that one had to be mindful of fraternization and you get the recipe of having to walk a very fine line to avoid getting into trouble.

As I mentioned previously, I lived on the same base as my patients. I saw them everywhere I went: the base exchange, the dining facility (D-Fac), the recreation tent, and the gym, as examples. Given that there was one D-Fac for the entire base with limited seating, there inevitably came a time when I had to sit down next to one of my patients so that I could eat. I did not have the luxury to go to an off-base Mongolian barbeque.

I could have not sat down next to my patient and waited for a seat to open up, but that could have taken a while. I chose to sit down next to my patient because I did not have time to wait. But what did I say to my patient? Did I make small talk or not say anything at all? If I didn't say anything that could have been perceived by the patient as arrogance ("I'm the doctor who is too good to even say hi," which would have been fodder for the next session). I decided to engage in small talk to avoid the awkward silence and got to know more about my patient in an informal setting (without breaching confidentiality). After we were done eating, we went about our business.

There were several major themes I encountered during my deployment: people having trouble sleeping, people trying to quit smoking, people with unfaithful spouses, people who want to "find themselves," financial problems at home, unruly children, and angry young men bearing automatic or semiautomatic weapons. With each passing day, I found more and more that I really enjoyed treating the smokers.

Deployment mental health required a malleable approach to treating patients. Allow me to give you examples:

Case 1 A 34-year-old Army National Guard E-5/SGT (Sergeant) with no prior mental health treatment presented to the mental health clinic with depressed mood of several weeks duration. He worked in the finance department on base and had been at COB Adder for approximately 2 months prior to his presentation to the clinic. When he was not activated to duty, he worked in technical support for a Fortune500™ company.

He denied experiencing manic or psychotic symptoms. He denied changes to his appetite or sleep pattern. He denied suicidal ideations. During the course of the interview, he reported that he had been struggling with his identity for several years. Further inquiry revealed that he had desired sexual reassignment surgery but he had not carried it out due to financial reasons. However, he started to assume a female identity by wearing a bra and panties underneath his uniform and wearing lingerie when he was in his room (he did not have a roommate).

Being deployed triggered his sadness as he was removed from his social support, but it also triggered a clash between his desire to be a woman and his desire to serve in the military (the military did not pay for sex reassignment surgery). He came to the mental health clinic for assistance with these issues. How did I help him?

I engaged this gentleman in individual psychotherapy. He did not require antidepressant treatment. This service member needed more than "band-aid" therapy until he returned home, given that he was going to be at COB Adder for 18 months. He had an inner struggle that could have interfered with his duties

and it was my job to make sure I helped him to the best of my ability so that he could complete his tour of duty.

Therapy was challenging in a deployed environment because his schedule varied daily and weekly, thus I had to be flexible in my time slots and fit him in at the last minute. I did not have an administrative assistant handling my appointments (I handled my own schedule).

I did therapy the same way I did therapy stateside, except that I had to tolerate blaring sirens and the ever present danger of mortars exploding around me. There were a few sessions where we were crouched under a table due to mortar attacks, but we continued our sessions as if nothing was happening (although the reality was that my last moment alive could have been huddling under a table with my patient … I said huddling, not cuddling). But I had to do what I could for this and every service member who walked through the clinic door.

Case 2 A 21-year-old Air Force E-3/SrA (Senior Airman) medical technician, with a prior history of experiencing anxiety symptoms in the context of basic training, presented to the mental health clinic with anxiety symptoms of 6 weeks duration without a precipitating event. His anxiety symptoms interfered with his duties, affected his ability to sleep, and resulted in physical symptoms. His anxiety symptoms were consistent with generalized anxiety disorder.

His anxiety symptoms predated his discovery that his fiancée (who was pregnant prior to his deployment) was expecting triplets. He came to the mental health clinic because he wanted help for his anxiety symptoms.

After performing an appropriate evaluation, I opined that he required medication to treat his anxiety disorder. Unlike the luxury of having a pharmacy at most street corners that carried every medication ever created in a laboratory, I did not have that option where I was.

The pharmacy in a deployed location carried a very limited formulary. Additionally, there was no guarantee that the pharmacy had medications available as there was a finite amount. The medications were either flown into the warzone or arrived on convoy (which were susceptible to attacks and thus may not make it to their final destinations). We had the option of a mail order pharmacy, which delivered medications to the service member in the warzone. However, there was a three month lag time. So I prescribed the appropriate medication one week at a time and checked with him weekly about his compliance and whether he was experiencing side effects.

Given the limited amount of medications available, I couldn't afford to have them wasted if they weren't efficacious or resulted in troubling side effects. Once he derived benefit from the medication, I initiated a mail order pharmacy prescription. I continued my frugal dispensation tactics until the mail order pharmacy service began.

There was still the issue of his worries about having triplets that needed to be addressed. As medication by itself will not target the reality of having triplets, he needed therapy. Like many 18–21 year old enlisted men and women that I had treated, he was not the most talkative individual. Opening up to a complete stranger (and an officer) was a daunting task for this service member.

During the course of my evaluation, he revealed that he played video games. I asked him if he felt more comfortable talking while we played video games. He replied "yes", and we decided to give it a try. The recreation tent was across the "street" from the mental health clinic. We went to the recreation tent and played an assorted array of video games. Although I had no idea what buttons to press on the controller, he was more relaxed outside the traditional "office setting" and spoke more candidly. We held our therapy sessions during clinic hours in the recreation tent (he was not concerned that other individuals could potentially overhear our conversations—limits of confidentiality were discussed with him prior to treatment). Over the course of sore thumbs that I developed, I challenged his concerns about having triplets and helped reduce his anxiety.

Playing video games with a patient as part of therapy was not a therapeutic intervention I engaged in stateside, much less play video games at all. But then again, I was not stateside. I had to use my limited resources to treat the patients who walked through the clinic door so they could continue to perform their duties in support of the mission. I had to maintain a flexible and adaptive approach in treating my patients as what I did had an impact on service members' abilities to perform their jobs.

Last but not least, there was a very small contingent of people who tried to use mental health as a way out of Iraq. They came in saying they saw little green men dancing on the floor. Meanwhile, they were smiling and showing absolutely no signs of psychosis. The bolder ones just came out and said, "Doc, can't you just send me home? I don't want to miss baseball season." In response to these very few individuals who were attempting to manipulate the system, the previous psychiatrist came up with a fool-proof plan guaranteed to get an individual out of Iraq. All they needed to do was run around the base naked with a pole up their ass. And by "a pole," of course, he meant a Polish soldier.

14.6 Whose Your Baghdaddy?

The pole plan failed. I was still in Iraq. Embarrassing.

Hell came out of hibernation and was on the prowl to quench its ravenous appetite. This was no more evident than on the first day of spring. I got to work around 0730. We had a clock-face thermometer on the side of our building. The outside temperature was 72 °F. I finished several appointments and went outside to drop off paperwork at the medical facility next door. It was 0930 and a few stragglers gathered around the outdoor thermometer. The temperature dial hovered near 90 °F. I completed my task and returned to my office to see more patients.

After these appointments, I caught an early lunch. I went outside again and saw that more people flocked around the thermometer. As the time was approaching 1100, the Army guys erupted into frenzy as they wanted to see the morning temperature over 100 °F.

They got their wish.

I don't know why they cheered and laughed. I returned to my office, closed the door, and cried quietly. Spring was a misnomer in that part of the world. There

really were only two seasons there: "Broil" and "Rotisserie." I felt like I was living on the surface of the sun and I feared that I would have spontaneously combusted at any moment. I had gotten somewhat used to the heat. Or maybe it was just that I tended to stay inside where there was air conditioning. I had gotten really comfortable with being sweaty. I spent most of the day a little moist. The Army had a term for it. They called it "living with swamp ass." I preferred to call it "making peace with my Iraqi experience."

I went on Spring Break during my deployment. That is if you considered going to Baghdad "fun in the sun." I attended an Army sponsored mental health conference at a base on the outskirts of Baghdad. That was my first time out of my COB so I really didn't care where I was going.

I got to fly in a C-23 Sherpa to this base. These planes were used in WWII to carry cargo. They were very small in size, much like a real sherpa. One look at these planes convinced me that they probably were built by them too. Passengers were an obvious afterthought in the design process. Two ruddy propellers powered these planes and the parts were held together by what sherpas considered space-age binding material: duct tape.

Unlike other aircraft, you sat across from each other. I had never felt more like cargo in my life. We were piled into the back of the plane and literally strapped to this nylon meshing. "For safety," said the flight crew. There was absolutely no way to get comfortable in that contraption. I felt like a dolphin caught in a tuna net. As the plane ascended, I looked out of the window across from me. It became painfully obvious that this was the harshest environment on earth. There were miles and miles of blazing hot sand—no water, no trees, no shrubs, no living organisms.

If left to my own devices, I would have survived in that environment for about 45 min. The first 15 min would have been spent panicking, the next 15 min spent withering in the fetal position, and the final 15 min spent intermittently twitching until death mercifully took me. The C-23 trip proved to be about as comfortable as a piggyback ride up Mount Everest on the back of an actual sherpa. It was also about as fast. I felt like a very, very slow moving target.

The night before our flight, a group of people discussed their past experiences with military transport. Not only were the flights notoriously loud and uncomfortable but pilots landing in Iraq performed what was called a "combat landing." Not knowing exactly what this entailed, I asked. My cohorts then ardently conveyed horror stories of past combat landing experiences.

In principle, combat landings were intended to make the plane a more difficult target for surface-to-air missiles. In reality, they were a sadistic plot by the government, and pilots in particular, to make me vomit. It was performed when the pilot essentially cuts off the engines in mid-flight and nosedives the beast of a plane towards Earth. For extra fun, he steered one way and then back the other way and then back again. He repeated this until all of the passengers prayed for a missile to just blow up the plane.

The actual combat landing was quite benign. Although the flight guys made jokes and provided everyone with barf bags, I survived the experience with only minor queasiness. I stepped off the plane and was amazed at what I saw: trees and paved roads.

It was mind boggling, but I was in for more surprises. There was a Pizza Hut®, Cinnabon®, Burger King®, Subway®, and Taco Bell®. And, to top it off, there were signs on this base painted in such exotic colors as yellow and orange. In addition, there were not one but two Olympic size swimming pools with clear blue water on this base (which I referred to as COB Heaven). And such a magnificent shade of blue it was. I hadn't seen anything blue in quite some time (for those of you who think the sky is blue in Iraq, you are horribly mistaken). Oh, and I attended the conference as well. Being at COB Heaven was an exhilarating experience. Sadly, I spent only 3 days there. I bawled on our departure day.

As relayed previously, having a reservation for a military flight doesn't guarantee that you will board the plane. On the day we were supposed to fly back to our COB, we reported to the terminal at 0645 for our 0730 flight. Our flight got cancelled, then reinstated, then cancelled again, and then reinstated once more. This carousal of emotional torture finally ended around 2100, at which point we were notified that we would definitely be boarding the aircraft and leaving this desert oasis, by Sherpa no less.

I was quite weary by this time. Growing a bit bold and passive-aggressive, I facetiously asked one of the flight guys what the in-flight meal would be and where I could locate my tray table. He replied that we would have pan-seared mahi-mahi cutlets with a spicy mustard sauce as an appetizer, duck a l'orange with a spring vegetable medley as the main course, and some "shut your hole" pie for dessert.

I kept my pithy remarks to myself for the rest of the flight.

I stepped off the plane at COB Adder and was overcome with despair as I regazed upon the never ending sea of gray and brown. I returned to my living quarters and discovered that our trailer was decked in new 1950s artwork during my absence. I had a painting of what I assumed to be an Iraqi town over my bed. There were some villagers in the painting going about their daily routine. I figured it must have been an Iraqi town because the artist used only gray and brown to paint it. I became despondent. But I overcame that sadness with the one thing that always cheered me up: drawing my voluptuous pictures.

14.7 End of the Road

After nearly 7 months since my original departure for pre-deployment Army training, I was in the final days of my Middle Eastern escapade. I was in a transient housing tent, which was essentially an Iraqi homeless shelter, for the remaining few days. And I couldn't have been happier to be homeless. If all worked out as planned, I was going to be home in time to be hammered for the 4th of July.

Our whole deployed crew was absolutely giddy. People were singing in the halls of the clinic, high-fived each other in passing, did mid-air chest bumps, laughed uncontrollably, and urinated rainbows all over the place. I asked one of my coworkers what was the first thing he planned on doing when he finally got home. His obvious response was "I am going to make passionate love to my wife." My

follow-up question was "OK, what is the second thing you are going to do?" He paused thoughtfully and said, "I guess I'll drop my bags."

It was difficult to live in the moment when the near future appeared so bright and wonderful. Everyone had essentially abandoned their work-outs and dieting. I had even given up monitoring my hydration status. It had become apparent that all of the exercising and healthy eating was done as a strategy to pass the time rather than for any real health benefits or fitness goals. After I achieved my goal weight about one month prior to leaving Iraq, I resumed my napping and chocolate chip cookie consumption while leaving my goal weight several pounds off in the distance.

I looked back at my time there and wondered how I survived in that cornucopia of sand and heat. I still don't understand how that barren wasteland served as the cradle of civilization. The land between two rivers my ass! Where were the rivers? I hadn't seen a single natural body of water the entire time I was there.

It was averaging 110 °F and it was still technically spring. I had Iraq's most powerful air conditioner in my office. I knew it was the most powerful because it required a remote to operate. The remote had numerous buttons as if the air conditioner came equipped with DVR (digital video recording). I just pressed a button and presto: hurricane force Arctic winds swept through my office, freezing everything in its path. I was the envy of all.

As my time there waned, I thought about what I saw and did in the past 7 months. If I helped just one patient, then the deployment was worth it. There were some memories I look fondly on and there were some memories that haunt me today. There are not enough words to describe the dangers that existed there. Even if there were, they wouldn't do justice.

Some of you called me a *hero*. Although that word is very humbling, I graciously declined that title. I usually enjoyed working with patients anyways, but my work seemed even more meaningful in the deployed environment. Not to sound overly sappy and patriotic, but the men and women in those combat units were true heroes. Literally every day, something bad happened to them while they were performing their missions. But they kept pressing forward despite the very real hazards. We may not all agree on the politics behind the war or the ultimate endpoint of it all, but those soldiers made daily sacrifices which dwarfed anything I had ever been asked to do.

The time came to say adieu, and I left my Sharpie® for the next psychiatrist.

Deployment is an unfathomable experience that can have a profound effect on service members and their families. Warzone mental health has similarities with mental health practiced stateside but also has unique challenges that require a flexible and adaptive approach to ensure service members can continue to perform their duties, with the ultimate goal of keeping our nation secure from our enemies.

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To Squander the Fighting Strength? Personal Experiences with Preventive Psychiatry and the Dilemma of Wartime Public Mental Health

15

Remington Lee Nevin*

My colleagues who have known me throughout my controversial military career and beyond, and who know in particular of my work on the antimalarial drug mefloquine (marketed in the US previously as Lariam), could be excused for assuming this was an early interest of mine. In fact, my work on the mental health effects of antimalarials began relatively late, and then initially only as an aspect of a much broader and newfound interest in public mental health that matured only during my first wartime deployment.

I am frequently asked if there was a specific patient or patient experience during this deployment that led me to my work in these areas. I reply that to assume as much is to misunderstand the public mental health perspective. The practice of public mental health deemphasizes the significance of individual clinical anecdote for the subtler but vital truths found in the dry statistics describing the health of populations. To practice public mental health is to not miss the forest for the trees.

In January 2007, I found myself serving as a Preventive Medicine physician newly reassigned to the headquarters of the 82nd Airborne Division. Our forces were to expand combat operations into dozens of remote locations throughout Afghanistan's restive eastern provinces, and although the public's attention was then mostly focused on the "surge" into Iraq, I knew that our units would be greatly tested by the rudimentary living conditions and the vast expanse of isolated, threatening territory under their command. The deployment would be, at the least, a stressful experience for our troops, and any healthcare—including mental

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healthcare—beyond that provided by a medic or physician's assistant, would likely be hours away via a harrowing helicopter ride over rugged terrain.

The "hurry up and wait" that dominated the early days of my deployment had given me time to ponder how I had come to that point—a patch of the 82nd Airborne Division on my left shoulder, preparing to live and work for months as a staff officer in the foothills of the Hindu Kush mountains.

I had grown up sensing a potential career path in the fictional portrayals of US military medicine that were popular at the time, such as television's M*A*S*H series, and the dramatic film "Outbreak." After college, I elected to take advantage of the free post-graduate educational and career benefits available through the US Army's medical training programs, confident that my college interest in statistics would be a good foundation for a career in military public health research, where I intended to focus mostly on infectious diseases.

I matriculated at the tuition-free Uniformed Services University of the Health Sciences (USUHS) School of Medicine in 1998 soon after college graduation, expecting an unremarkable 7-year period of obligated service owed of every USUHS graduate after residency training.

This was 3 years before the events of 9/11. In the weeks and months that followed that day, as the reality of the changing military situation became evident, I sensed that my career in military public health would take me not to the comforts of a major research center, but to "line" units on overseas deployments. I began trimming my hair shorter and visiting the gym with a little more regularity, and sought out opportunities to gain credibility with the combat units I expected to be assigned to as the Army prepared for the possibility of a "Long War." I took a month of my final year of training at USUHS to attend the US Army's Airborne School, becoming Airborne qualified (earning "wings" for my uniform) just prior to graduation and beginning my internship at Womack Army Medical Center, Ft. Bragg, NC.

There, I trained briefly under the physician who would become the future senior medical officer (or "Surgeon") of the 82nd Airborne Division, also headquartered at Ft. Bragg. Half a year into my internship training, I informed him of my acceptance to the Preventive Medicine residency, at which time he presciently advised me that he believed we would be working together again soon. Indeed, 3 years later, he would recommend me to be the 82nd Airborne Division's Preventive Medicine physician for his unit's upcoming deployment to Afghanistan. As my orders temporarily reassigning me to the unit directed, we reunited at Ft. Bragg days before boarding the charter flights that would take our unit to Bagram Airbase.

15.1 Preventive Medicine

Preventive Medicine is the medical specialty devoted to population health and the prevention of disease. As such, the training of Preventive Medicine physicians not only includes clinical training in the treatment and prevention of traditional domestic communicable diseases, as well as tropical and travel medicine—but also academic training in such areas as biostatistics, epidemiology, and health policy analysis. After completing internship, as part of my residency, I learned these skills by earning a

masters degree in public health (MPH) at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland. The next year, while still in training, I put this education to good use by developing a program to reduce redundant immunizations of Army recruits. At the time, in a somewhat misguided attempt at efficiency, the Army had been giving every recruit heading off to war the same four or five vaccines, regardless of whether they had previously received these. The program I proposed, which would implement a system for testing the blood of new recruits for immunity so as to permit customizing the vaccines they received, was clearly the right thing to do medically—but I knew if it slowed down the processing of new recruits, the Army would never permit it. Thanks to my training, I was able to demonstrate that the program could work within the tight schedules of the recruit centers. Additionally, it would save money, as the costs of expensive vaccines were used to fund the much less expensive blood testing and the staff needed to organize the effort. Within a few months of presenting my proposal to senior Preventive Medicine physicians, the Army Surgeon General gave formal approval to implement the program, and I received a letter of commendation from my commanding General.

At Johns Hopkins where I trained in public health [1], the Bloomberg School's motto had been "Protecting Health, Saving Lives, Millions at a Time." It pleased me to know that within a few short years, as the number of Army recruits increased by tens of thousands year over year, my program would protect the health and improve the lives—at least in some small way—of at least one million new soldiers [2]. Impressed early in my career by the power to make a difference within the seemingly impenetrable Army medical bureaucracy, I looked forward to my first assignment at the Army Medical Surveillance Activity (AMSA), in Washington, DC, where I hoped to continue to make a difference working in military public health.

It was there at AMSA, in the months before my deployment, that I supervised a team of civilian analysts who poured over military health data, conducting analyses, identifying patterns of disease, and informing recommendations to military leaders on how to better protect the health of the force [3]. The Army Medical Department's motto was, "To Conserve Fighting Strength." We considered it a critical component of living up to this motto to provide our leaders information on what diseases the fighting strength was being affected by, and how these could be better prevented.

Throughout the history of the US Army, the primary threats to the health of fighting forces had been from infectious diseases and injuries [4], and the work of AMSA had been primarily in these areas. The majority of my work consisted of overseeing injury reports, and conducting analyses on acute respiratory disease and infectious diseases such as malaria, influenza, HIV, hepatitis [5], and sexually transmitted infections [6].

As with my earlier work on vaccine policy, prevention strategies in these areas almost immediately improved the health of the force, and ensured that even more healthy soldiers were available for the war effort. This work was almost perfectly aligned with the goals of military leadership, so our efforts were strongly supported and well funded. With the benefit of supplemental wartime funding, AMSA soon moved into new office space just outside the Washington, DC beltway, to merge formally with an organization known as the Global Emerging Infections Surveillance and Response System (GEIS) to become the Armed Forces Health Surveillance Center, with a focus particularly on infectious diseases [7].

15.2 The Dilemma of Wartime Public Mental Health

Although my interests at the time had been squarely in the area of infectious diseases, in the months prior to my deployment, through my work I had become increasingly aware of the growing toll of mental illnesses on our forces. In a 2006 report, our analysts had identified a notable increase in the rate of clinical encounters for mental health disorders—up 12 % since the start of the wars—higher than in any other category of disease [8]. My analysts had also reported noting a high prevalence of psychotropic drug use in the sample pharmacy datasets they had begun examining. Yet when I recommended that our center devote more attention to the study of mental health problems, such as had previously been done [9], my proposal was initially met with disinterest. Much of the public health community appeared to feel that work of this nature was not the proper domain of epidemiologists and Preventive Medicine physicians, but rather of psychiatrists, a small group of whom were already involved in research in these areas [10].

It was around this time that I received my temporary reassignment orders. Increasingly intrigued by the idea of mental disorders as a potential military public health problem, it was with this perspective that I returned to Ft. Bragg to join the 82nd Airborne Division for deployment. Within days of my arrival, I would quickly realize how relevant this perspective would be to my deployment, and how my public health colleagues' perceptions of the problem posed by mental disorders lagged the realities I observed within front-line combat units.

This first became clear as we assembled at the airfield, preparing to board our flights for deployment. There, we were told by medics of the 82nd Airborne Division—much to my surprise—to reach into a large garbage bag and grab a box of medicine that had been collected in bulk from the local military pharmacy. The box contained mefloquine, which we were to begin taking to prevent malaria while overseas.

From my training in travel medicine, I was very aware that mefloquine could not be safely prescribed to those with certain pre-existing mental health problems [11]. How did whoever had prescribed the drug know that everyone deploying with me was free of contraindicating mental health conditions? The prior AMSA analysis had suggested that across the Army as a whole, these contraindicating mental health problems were relatively common. I convinced myself that the 82nd Airborne Division was an elite unit, with rigid eligibility criteria, and presumably the soldiers deploying with me had been carefully screened prior to deployment.

However, once in Afghanistan, over the long hours that would follow, I would gradually learn through personal discussions with a number of my fellow unit members that many were in fact taking psychotropic drugs that had been prescribed by military healthcare providers in the days prior to their deployment. As the weeks progressed, these colleagues—many still improperly taking mefloquine [12]—would confess their continued struggles with various psychiatric symptoms, some of which had been diagnosed, but some of which were being empirically treated with these drugs without documented indication.

Intrigued by what I now perceived as a potentially very serious public health problem, I undertook a formal analysis under the authority of the 82nd Airborne Division Surgeon. Reaching back to my AMSA colleagues outside of Washington, DC, I requested data on prescription drug utilization as well as the medical and psychiatric histories of our force. Working on a ruggedized laptop AMSA had provided me for my deployment, I spent my evenings in the relative comfort of our dusty Soviet-era office, combing through the data.

The results of my analysis were surprising: Of the force that had deployed to Afghanistan under our command, a significant number—slightly fewer than 5 %—had received a formal mental health diagnosis in the year prior. More surprisingly, as my anecdotal experience had suggested, approximately 7 % had received a psychotropic drug in the 6 months prior to deployment [13].

In one of our infantry battalions, on the front lines of a particularly grueling fight, these figures were even higher: 15 % had received a mental health diagnosis, and 7.7 % had received a psychotropic drug, within the year prior [14]. Among our female service members, these rates were even higher—approximately double that of the deployed force as a whole [13]. Examining specific diagnoses, my data indicated we had even deployed personnel with recently diagnosed psychotic and bipolar disorders [15].

The obvious question these data raised to me was, *how had this occurred*? In the weeks prior to deployment, the soldiers of our task force had been "screened" for eligibility, including through the administration of a health survey then known as a "Pre-Deployment Health Assessment" (PHA) that included the question "*During the past year, have you sought counseling or care for your mental health?"* Requesting the electronic responses from these forms from my AMSA colleagues, I then examined how those soldiers who had known medical encounters for mental health problems had responded.

On my completing this analysis, the answer to my question was immediately obvious: of those with documented mental health diagnoses, only 48 %—less than half—had admitted to their seeking such care on the health survey [16]. Rushed for time, often having to see hundreds of soldiers in a day, the healthcare providers conducting the pre-deployment checks as these surveys were completed were likely not reviewing, or did not have, the medical records that would have revealed this underreporting.

Unlike the scar or the crutch that betrays an earlier physical injury, these mental health conditions exhibited no outward sign, and went mostly unnoticed by the examining healthcare provider unless the soldier specifically admitted to them. And, as my discussions with many confirmed, our soldiers of the 82nd Airborne Division were motivated, willing, and able to remain silent about their conditions, in many cases so as to not risk being found ineligible for deployment.

Indeed, soon after I completed my analysis, a Department of Defense report was published that noted that members of its mental health study team "were told on multiple site visits that the validity of the Pre-Deployment Health Assessment suffers because service members underreport their mental health concerns if they are eager to deploy" [17].

In the months prior to our deployment, in response to Congressional direction, formal policy guidance had been published by the Department of Defense that had clearly stated that "[a]ny condition or treatment for that condition that negatively impacts on the mental status of behavioral capability of an individual *must be evaluated* [emphasis added] to determine the potential impact both to the individual Service member and to the mission" [18]. Interestingly, this same document noted that "*[i]t is the responsibility of the Service member* [emphasis added] to report past or current… mental health conditions… and associated treatments, including prescribed medications."

With my public health investigation substantiating published observations from site visits of the low validity of existing screenings, and with my analysis demonstrating that over half of those with mental health conditions were failing to meet their responsibility to self-report—it was clear that the evaluation mandated by this Department of Defense policy was often simply not being performed.

Although this large-scale circumvention of a Congressionally directed policy mandate may have seemed wholly unacceptable to a military culture obsessed with compliance with regulations, what I quickly came to realize, working within the headquarters of a deployed unit, was that the practice of relying on known inaccurate self-reported data—whether tacitly condoned or not—unmistakably benefited our military leadership, which was struggling after a half-decade of war with how to manage critical shortages in the number of deployable soldiers amidst the effects of recruiting shortages and the "surge" [19].

Such shortages would have been greatly exacerbated by the loss of even a few percent of a unit's strength, such as would have occurred if otherwise seemingly healthy personnel were to be found ineligible through a rigid application of published deployment mental health standards [20]. For example, in certain units in our task force, which deployed with little more than minimum staffing levels, disqualification of even a fraction of those with prior mental health histories or psychotropic drug use would have threatened the unit's ability to successfully "make mission" and deploy with adequate strength.

As I explored these issues more in private discussions with mostly junior 82nd Airborne Division officers, it became clear that such a critical failure would not have been considered acceptable among our senior commanders. There was consequently an implicit understanding that these mental health policies were not to take precedence over more practical military considerations.

I would learn through these revealing conversations that the practice of "turning a blind eye" to potentially disqualifying mental health conditions had become so widespread in certain units as to be almost an open secret. What had not been clear at the time among those officers involved in the practice was its relevance in predicting subsequent patterns of disease within the force. Later research would confirm that besides increasing the already difficult burden of providing effective treatment for prevalent mental disorders while deployed, exposing those with pre-existing clinical or even subclinical mental health disorders to the seemingly endless stresses of war would risk exacerbating the disorder, and could significantly increase the risk of new, more serious illness, including posttraumatic stress disorder [21, 22].

With full consideration of these risks, the faithful practice of preventive psychiatry would have required military psychiatrists to more frequently advocate for the early return home, and even the early separation from the military, of those seen for significant mental health problems on deployment. However, such a practice would clearly have been contrary to decades of organizational doctrine, which has long stressed the principles of expectancy and early return to duty, in consonance with the Army Medical Department's motto, "To Conserve Fighting Strength" [23].

Thus also, the faithful practice of public health would have required myself and other Preventive Medicine physicians to vigorously advocate for more effective predeployment screening, less flexible interpretation of published deployment standards, and the issuance of far fewer waivers than would become standard in future years even as screenings gradually improved [20].

For a junior medical officer, adopting either practice could have been perceived as at odds with the immediate needs of the military mission, and could have risked being seen by one's colleagues as "squandering the fighting strength." I learned this on my deployment as I increasingly stressed my belief in the significance of my findings and of the need for preventive action, first to the 82nd Airborne Surgeon, and then to the broader military Preventive Medicine community, only to be faced with significant organizational inertia and opposition. Unlike my earlier proposal to improve recruit immunization, my proposals to improve the study of mental disorders at AMSA, and then to improve deployment screening and mental health prevention efforts more broadly while deployed, were soundly rejected by medical leadership.

Although some of my efforts would soon inform a formal policy change first within the Army [24] and then across the wider force [25] to significantly decrease the use of mefloquine, my larger goals of emphasizing mental health as a significant public health problem throughout the military—perhaps quite understandably in retrospect—failed to meet with the success I had enjoyed earlier in my career.

With little focus on primary and secondary prevention [26], in the years that followed, the military, and particularly the Army, faced what can only be described as an unchecked epidemic of mental illness, psychotropic drug use [27], and suicide [28]. While I was deployed, AMSA updated its annual summary of clinical encounters to note that over the 2 years through 2006, the rate of visits for mental disorders had increased nearly 20 % in the prior 2 years to become the fourth most common category of disease [8].

Subsequent annual tabulations confirmed a steady increase in the number of ambulatory encounters for mental health disorders over successive prior 5 year periods: 27 % in 2007, 55 % in 2008, 68 % in 2009, and—remarkably—120 % by 2010—doubling since the year it had first attracted my concern [29]. Where once relatively uncommon, mental disorders became the second leading cause of clinical encounters in the military, behind only musculoskeletal disorders, injuries, and poisonings [30], and accounting, on average, for 150 clinic visits per 100 service members per year [31].

Where once used only rarely [27], antidepressants became the third most common class of drug prescribed within the military, behind only opioids and non-steroidal anti-inflammatory agents (e.g., Motrin), and prescribed within the Army at a rate of 50 prescriptions per 100 soldiers per year [32]. Mental health disorders also became the leading cause of hospitalization in the military [30], resulting in over 15 hospitalizations per 1000 service members per year, each on average nearly a week long [33]. In the Army, these rates were over double that of the other military services, resulting in the hospitalization of 28 per 1000 soldiers per year [33]—or nearly 3 %. Perhaps not surprisingly, excluding those due to war, suicides became the leading cause of death [34].

My deployment to Afghanistan in 2007—at the inflection point of this epidemic—made me realize how unprepared the field of military Preventive Medicine was for the professional challenges posed by this new epidemic. The profession's traditional practices—which emphasized the prevention of diseases where prevention doctrine almost perfectly aligned with the goals of military leadership—was challenged by the novel need to prevent mental disorders. For these, the only effective interventions, such as limiting the recruiting, deployment, or retention of particularly vulnerable individuals, would sharply diverge with the priorities of military leaders operating within the limitations of a shrinking all-volunteer force.

Owing to the negative attention my work attracted, my deployment also unexpectedly altered the trajectory of my career. Although I would continue my advocacy upon my return from deployment, the constraints of military service would frequently limit my ability to publish my findings and opinions without concerns of retaliation [35]. Early press reports of my work [15, 36] would also soon make me the subject of significant unwelcome scrutiny.

When my uncomfortable period of obligated service ended some years later, I reluctantly resigned my commission and returned to civilian life, where I elected to pursue additional graduate study at Johns Hopkins to further explore my developing interest in public mental health and the prevention of mental disorders among military personnel.

Now back in Baltimore as a civilian, I am now able to publish broadly and advocate for the prevention of mental disorders within the military, across such fields as traumatic brain injury [37, 38], the surveillance of mental health disorders [29], and, particularly, the mental health effects of antimalarial drugs [39]. Ironically, I now find myself a more effective advocate for the public health of those in uniform, than I was when this was notionally my duty.

The early satisfaction I felt speaking with young soldiers of the 82nd Airborne Division, who I was pleased to learn on my deployment to Afghanistan had been spared unnecessary immunizations thanks to my vaccine program, I now feel from those who tell me how they were spared from the risks of mefloquine as a result of its near-elimination from military use [40], or who were awarded fair disability compensation for its ill-effects [41]. Thanks in part to my work, these are now increasingly and more widely recognized. I could have never imagined, as I reached into the garbage bag to grab my box of this medication as I boarded the plane to Afghanistan, that this simple action would take my career in this direction, and lead me to the area of specialization and expertise I enjoy today.

15.3 Conclusions

My wartime deployment with the 82nd Airborne Division taught me that while the priorities of public health and military leadership may occasionally be fortuitously aligned, a true commitment to the practice of prevention requires the military preventive psychiatrist or Preventive Medicine physician to accept the potential for dual agency, and that, particularly in times of war, their professional obligations may differ from those of the commanders they are entrusted to advise and serve.

While my work in the field may be still seen by some as "squandering the fighting strength," I consider my wartime advocacy as having raised early awareness of the need to promote the good stewardship of the mental health of the young men and women entrusted to the temporary care of the military. As importantly, I consider this work fully consistent with the ethics, values, and responsibilities of the professions of public health [42] and Preventive Medicine [43], whose respective codes stress the importance of advocating for the health needs of disenfranchised populations, as well as the importance of acknowledging and working to eliminate conflicts of interest which may limit one's effective professional practice.

In the coming years, and hopefully well prior to the start of the next series of major wars our nation may face, the major challenge for those who value prevention, including prevention of mental disorders, will be to reconcile the tenets of these professions with their continued practice by those in uniform, in a manner that remains faithful to the needs of the military. Frank and open discussions among military leaders, psychiatrists, and public health practitioners—as were the conversations that informed my Afghanistan deployment—regarding the conflicts of interest and dual agency that contributed to the delayed recognition and ineffective early response to the military's mental health epidemic, will prove an essential element of addressing this critical challenge.

Acknowledgement *Disclosures*: Dr. Nevin receives consulting fees from attorneys representing clients alleging harm from their exposure to antimalarial drugs, including mefloquine, and has been retained as an expert witness in criminal and civil cases involving exposed civilians and military personnel.

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Learning to Scale the Wall

16

Vincent F. Capaldi II

One of my most vivid memories of Afghanistan was all the fences. I remember standing in a line looking out at an Afghan village wondering what life was like on the other side of all the barbed wire and security barriers. My attention was drawn back to reality with the sounds of gunshots. I had just realized that I left my earplugs in my bag at the stress control center. I just arrived in Afghanistan and I had to verify that my M9 handgun was in good operating condition, should I ever need to use it. Thankfully I only had to shoot three rounds and I can still hear out of both ears.

Getting to this point in my story was not exactly a straight shot. I grew up in a rural community in north western Rhode Island. I attended a boarding school in Connecticut for high school and then went on to Brown University for college. As I consider it now, I have been fenced in all my life. My high school is truly a beautiful place with buildings, walls, and arches made of stone. Brown has incredible rod iron fences which separate the people of Providence from students inside. Walking through the gates of Brown, I knew that I wanted to be a physician, but I had no idea that in 13 years I would be providing care with a weapon attached to my waist.

I started my career at Brown, like other freshmen, with lofty goals and ambitions. I decided to triple major in psychology, history, and music. The boarding school that I came from was very structured, requiring all students to engage in sports and arts. Brown was slightly less structured with no core curriculum with a more liberal, open environment. In an effort to recapture that structure and to challenge myself, I enrolled in ROTC.

Brown did not have an ROTC program (they kicked ROTC off campus in the 1970s) so every morning at 5 AM I would drive to Providence College to do physical training and to attend military education classes once a week in the

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afternoons. ROTC was my first exposure to military training and I enjoyed it, apart from the early morning awakenings. This was also about the time that I started pursing research in the field of sleep.

Shortly after being accepted to Brown Medical School, I was offered a 4-year scholarship with the Health Professional Scholarship Program. This scholarship requires 1 year of active duty service after residency for every year of medical school funding. I took the scholarship because I had enjoyed the comradery of being in ROTC and the values based culture of the Army.

My journey in becoming a military physician started in medical school caring for veterans on the inpatient psychiatric ward of the Providence VA. I cared for patients who were still dealing with physical and psychiatric injuries from wounds afflicted years or decades prior. In caring for our veterans, I developed an appreciation for the enduring consequences of trauma and the socially debilitating aspects of chronic psychiatric illness.

After graduating from Brown Medical School in 2007, I decided to complete a combined residency in Internal Medicine and Psychiatry. My residency at Walter Reed was one of the most challenging and rewarding experiences of my life. The fences in my life were changing in style, the ones at Walter Reed now included some chained links, armed guards, and the occasional vehicle checks.

I was seeing service members returning from the ongoing and intensifying conflicts in Iraq and Afghanistan. Predicting the long-term impact of the psychological and physical wounds of war is impossible. On the consultation and liaison service, we would see every service member who had been evacuated from the battlefield. The severity of the apparent illness or injury was in no way indicative of how an individual was coping with their new identity as a casualty of war. All of the service members that I cared for on the wards of Walter Reed were coming to grips with a new identity that included challenges, and at times bereavement, and regret.

There is no “normal” reaction to the horror of war or exposure to intense human suffering in combat. While serving as a resident I came to understand that the significant emotional and maladaptive reactions of my patients were only pathological outside of the context of combat. One of my patients, Sargent S, described to me his intense anxiety driving over bridges or going to a food court after returning from deployment. I began to see how these emotions and subsequent reactions are adaptive and lifesaving on the battlefield.

As a resident the concept of deployment was surreal and anxiety provoking for me and my family. While I was in residency I convinced my wife that there was no better place to be a behavioral health provider than in the military. My anxiety about deployment only intensified during my residency and as our family grew with the birth of my first child. Rounding in the hospital, on a daily basis, we would be confronted with the physical and psychological toll of combat, as we saw the gruesome consequences of blast injuries in men and women younger than we were. It was somewhat terrifying to envision your own reaction to the loss of a limb, eye sight, or the consequences of PTSD and combat stress.

It was not until I deployed to Bagram, Afghanistan, that I truly understood the development of the combat operational stress reaction. I was deployed to Afghanistan

to take charge of a Combat Operational Stress Control (COSC) center. Prior to deployment I completed a week long classroom course on running such a center and spent time in a simulated field environment getting to know and work with the 85th Combat Stress Control team based in Fort Hood, TX. The training was very useful in learning how to run a psychiatric clinic in a deployed setting.

When I deployed with the team I felt somewhat old on the base in Bagram, Afghanistan. As a major in my mid-thirties I definitely was in the minority in the deployed setting. The majority of service members on the base were single, young, and enlisted. I was impressed by their incredible adaptability to austere conditions and their resilience to constantly changing challenges. In a deployed setting you begin to appreciate the small things in life like, a private bathroom or living space, Internet, or even grass. Watching these young soldiers thrive under stress and their desire to learn and improve their lives encouraged me every day. While deployment is a maturing experience for most, there were some that required additional correction to succeed. Even in a deployed environment, many of the things that get soldiers in trouble in garrison are available downrange. Informally I was using techniques of motivational interviewing to keep my 15 enlisted soldiers safe and out of trouble.

Leading a COSC center was slightly different from the experience of the embedded provider (which is described in other chapters). Patients would often be referred to our center when they were unable to be successfully managed by the behavioral health provider in their command. Our team provided short term respite care for service members. Each week we would enroll a new set of service members in our soldier restoration program. Our program included individual therapy in addition to classroom activities where the service members learned coping skills to help them continue with their deployment. We acknowledged and validated their reactions to stressful conditions while providing them resources to enhance their resilience. One of the most valuable experiences they had was several good nights of uninterrupted sleep and three hot meals a day. The vast majority of our patients (around 98%) returned to their units and did not require leaving the combat zone.

We also started a suicide hotline for service members in Afghanistan. This was staffed by enlisted psychiatric technicians. They called me whenever we had a suicidal patient on the line. Prior to this deployment I had never had the opportunity to talk someone out of killing themselves in real time. Being able to affect change and potentially help convince a service member that there is hope beyond the barrel of their weapon was exhilarating and incredibly anxiety provoking.

Living in close quarters, surrounded by barbed wire, the threat of attack, and the possibility of injury or death is something that you have to experience to fully understand. Relationships that are forged under these conditions are literally tested under fire at times and can either sustain or drain the deployed service member.

For the deployed psychiatrist, serving in this environment has the possibility of being extremely isolative. During our psychiatric training we are encouraged to establish boundaries between you and the patient. These emotional fences are somewhat simple to establish and maintain in a civilian environment but this can be much more challenging in a deployed setting. In a deployed environment

it is not uncommon to see your patients outside of the office multiple times per day, share a table with them at the dining hall, or even share living quarters or bathroom facilities. You may be naked in the shower next to a patient. This provided a certain measure of opportunity and risk for treating behavioral health patients. I was able to observe patients inside and outside of the office and even identify when there was a change in symptoms that may not have been apparent in a single office visit.

The hierarchy and structure of the military rank system is designed for working in close quarters under stressful conditions. Relational boundaries between officers and enlisted is codified in military regulations to establish and maintain order. However, even with this structure, working with the same people all day, every day can strain even the most disciplined and well-adjusted individual. Conflict is inevitable in any relationship with another human being.

At work, here in the USA or "garrison," we are able to go home, vent to family or friends, avoid the offending individual and then work on mending the relationship. This is not the case in a deployed setting. You will often have to work closely with people that you have difficulty working with and for the patient, they will sometime have to receive care from a provider that they would have possibly fired if there were an alternative. One of the most important skills that I developed during deployment was a greater ability to adapt to the resources at hand and to work with challenging individuals and personalities.

Sharing the experience of deployment is essential to thrive in austere conditions. It is easy to feel alone and isolated as a deployed psychiatrist, but throughout my deployment I sought out opportunities to share my experience with others. I relied on the multiple Facetime calls and letters with family members and telephone calls with colleagues at different bases or still serving in the USA. They supported me by providing an outlet for venting about patients and coworkers, and gave me an anchor to the other reality outside of the small compound that I lived on for 6 months of my life.

I kept myself very busy during my deployment. I completed approximately 800 encounters while I was deployed, completed my Lean Six Sigma Greenbelt, and taught introduction to biology course to deployed service members. I also learned how to drive a manual shift, while becoming the most physically fit that I will likely ever be in my life.

Despite the barbed wire and constant surveillance, we occasionally were attacked by the enemy. I called it the voice of God. Whenever a rocket attack was detected, an alarm would sound and an inappropriately calm voice would announce, "Incoming, Incoming, take cover." The first couple of times that I heard this message I was terrified. I am not sure that anything can prepare you for an actual mortar attack. I have been told by service members who directly engaged the enemy in firefights, that indirect fire (i.e., a mortar attack) is more terrifying because you have no control. You cannot fire back because you do not know where it is coming from and there is no way to fully predict where it might land. Our center was directly adjacent to the flight line which was not a great place to two important reasons, (a) Jets are not quiet and (2) The enemy attempted to target high value assets (i.e., jets). This made the "voice of God" all the more terrifying.

After almost 6 months in Afghanistan, my departure was a bitter sweet experience. I left behind a team that I grew to love but I was going home to my family who I missed every day since my arrival.

Traveling to and from Afghanistan is not a simple experience, it took me a couple days to get back home to the USA. Every time I thought I was close to getting on the next leg of my trip home something else would happen. For example, as our bags were being scanned to get on the plane to the USA, we had to evacuate the facility because someone put a coffee cup that looked like a grenade in their bag. Of course that person was right behind me so we were all detained in the hot sand and sun until the bomb squad cleared the facility.

I finally made it home to my family and I hope it will be the last time that I will have to leave them for this extended period of time. But I know now that if I am called upon to deploy again, my family and I will make it through and will likely grow and mature in the process. Approximately 9 months after I returned home our family did grow with the birth of my second daughter.

My education as a military psychiatrist culminated in Afghanistan. It completed my exposure to the full life cycle of war related psychiatric trauma beginning with the battlefield and ending in the VA hospital. In Afghanistan I was able to evaluate and treat the acute impact of psychological trauma. One of the most valuable assets that I brought to these service members was the ability to listen to their experience, validate their emotional reactions to trauma, and give them hope that they are not alone in their experience and that there is life and a future beyond the tragedy of war.

I also learned what it meant to be a soldier. Sure I was commissioned as an officer several years before I deployed and served in a military treatment facility during my residency, but there is so much more to sharing life with other people in a war zone that gives a new appreciation for how much our service members sacrifice when they deploy abroad. The experience also helped me put my day-to-day struggles in perspective. Living in Afghanistan gave me a new appreciation for the everyday amenities and opportunities that I had taken for granted.

Going to Afghanistan also gave me an opportunity to better connect with the service members that I treat here in the USA. Beyond wearing a patch on my right shoulder to indicate that I deployed in combat, I am able to better integrate and understand military culture. While the majority of the military is based here in the USA, the experience, shared history, and even language of the military distinguish it as a separate subculture in America. While it is not necessary to be in the military to treat service members, being part of the culture helps quickly establish a therapeutic alliance, which is essential to psychiatric care. Our shared experience becomes a starting point to overcome some of the barriers to care which seem insurmountable to some service members.

It also caused me to realize that boundaries, walls, and fences serve both a valuable purpose and at times a challenge. Physical fences serve to protect us from the enemy while psychological boundaries and walls protect us from being emotionally vulnerable. As a behavioral health provider, gaining access to the invisible wounds of war and these vulnerable areas of the solider psyche is an

honor and a privilege. I would wholeheartedly encourage military psychiatrists to seek out a deployment opportunity as it allows you inside the wire of military culture and experience and enables you to better care for those who stand in harms way. My work in Afghanistan was not only a test of my skills in managing clinical depression and anxiety, it was a test of my own ability to deal with the uncertainty of my diagnostic decisions and acceptance of my limitation to guarantee the success or safety of every patient that I evaluated.

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Shrink in the Making: Learning to Become a Psychiatrist from the War Wounded

17

Rohul Amin

The Global War on Terrorism (GWOT) has resulted in numerous physical and psychological casualties. Mental health specialists have served with honor and contributed greatly to the care of these injured. The main focus of this volume is to provide insight into the experiences of mental health providers in combat. However the picture would be incomplete if it omitted the challenges in garrison, in specialized teaching military hospitals in the USA, caring for the physically or emotionally wounded.

The sheer length of GWOT has led to a generational impact on the organization and operation of America's military. In the Medical Corps, we have been forcibly re-reminded of the primacy of psychological well-being of the soldier to be mission effective. Although we have noted this in our past wars, it appears that in each new theater of war it is necessary to address it anew.

In this chapter, I share my experiences while training to become a psychiatrist, in the settings of supporting wounded service members from two wars at Walter Reed Army Medical Center, and later at Walter Reed National Military Medical Center. I provide a window into my decision and motivation for training as a psychiatrist. I describe the settings of constant exposure to war wounded my age and younger and its impact on my development as a physician and person. Additionally, I attempt to provide prospective on caring for the wounded in the garrison settings on the continuum of care. Sophisticated care that begins with "battle buddy care" on the battle field, encompassing deployed medical resources to finally more definitive higher echelon care in settings like Walter Reed. The chapter ends with my experiences practicing psychiatry in a deployed setting in Kuwait.

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17.1 Overcoming Stigmas

The reader might be curious about the title of this chapter. Am I attempting to stigmatize the field of mental health? Is the term *shrink* or *headshrinker* a slur that devalues the field? To many, the term may be neutral and just an alternative to mental health specialist. However, to me and many other medical students deciding on their specialty, the term might denote an unwanted and perhaps even feared profession. This idea of asymmetric power dynamics may have potentially given birth to the term, *headshrinker*.

It is speculated that this term was first introduced by *Time* magazine in 1950 while discussing the success of a Hollywood actor [1]. The literal meaning likely stems from the rituals of the Jivaro Indians of South America [1]. Once the enemy was killed in battle, the Jivaro Indian warrior would shrink the head to the size of fist while maintaining its facial features. The traditions were based on assumptions that a shrunk head assumed magical power. The intention was to humiliate the foe while bringing good luck to those who possessed the head [1]. There are other speculations about the term, *headshrinker*, but most of the amorphous meanings symbolize similar characteristics: that the psychiatrist is an authority figure with special powers, even magical ones, and possibly threatening or hazardous to one who is being "shrunk".

These ideas among many others fuel the stigma surrounding mental health. It highlights the experiences of many of my patients who not only struggle with their mental illness but also with having to see a psychiatrist. There is evidence from military population that perceived stigma increases with the amount of symptoms [2]. In other words, the greater the psychiatric distress in a soldier, the higher is his or her perception of stigma. Some of the factors behind it include fear of being seen weak, harm to career, or loss of confidence by leadership.

This stigma also existed for me when deciding on a specialty after medical school. It is not an uncommon phenomenon. Among physicians, there is perceived marginalization of the professional identity of the psychiatrist which acts as a deterrent when choosing psychiatry as a subspecialty [3]. Psychiatry has struggled in the recent years to recruit medical students into its ranks [4].

The stigma and aversion to the idea of becoming a psychiatrist developed much earlier for me. Prior to medical school, I served in the Marine Corps after high school. The typical story in my Marine unit among the young service members was threatening an underperforming Marine, typically referred to as a *shit-bird Marine*, with a "visit to see the headshrinker." In the hearts of many of my fellow Marines, this developed a visceral negative response. With this professional "baggage," then how did I ended up as a psychiatry resident at Walter Reed?

17.2 First Contact with Psychiatry Throuth Private First Class Smith

After the Marines and obtaining my undergraduate degree, I attended Uniformed Services University of the Health Sciences—the federal medical school that trains active duty officers. I had no interest in psychiatry and was dreading my

mandatory rotation as a third year medical student. I reported to the rotation at the intensive outpatient psychiatric service at Walter Reed Army Medical Center in Washington, D.C.

My ultimate goal was to survive the rotation and check the box. The intensive outpatient psychiatric service cared for patients who were too ill for routine outpatient care but did not necessarily require inpatient hospitalizations. Often, patients from the inpatient unit are transferred there after reaching certain therapeutic milestones. This was the case of my first psychiatric patient.

This patient was a young Private First Class (PFC), infantryman. I will refer to him as PFC Smith, who was in his late teens. Immediately after joining the Army, he proposed and married his high school sweetheart. Two weeks later, he was patrolling somewhere in eastern Afghanistan. He received terrible news from his father that his wife has begun a physical romance with one of his friends back home. This news pushed him to decide to take his own life. As any soldier in deployed settings, he had been well equipped to kill if needed. The training, possession of weapon, and desire to commit suicide can be a deadly concoction. Military psychiatrists have to juggle these realities when caring for patients.

This kind of news received by PFC Smith is greatly feared by service members. When I was in the Marines, we would run to cadences that had different messages and themes to motivate us. Some of these would describe the sacrifices and risks Marines are willing to undertake for their Corps and Country. In these cadences that are known to most enlisted service members, one recurring character is called Jody. He is an imaginary but an omnipotent civilian character who is living a luxurious lifestyle, a complete opposite of the life of a soldier or a Marine in the deployed settings. Jody in one particular cadence lures a soldier's girlfriend with his charm and steals her. The fear that their significant other might be seduced by this Jody is perpetually present among the minds of deployed soldiers.

PFC Smith's fear of Jody had come true that day. Unable to cope with this news, he started to have panic attacks and restlessness—describing severe anxiety. He described in details that his mind was racing but came to a sudden stop and the answer was clear: kill yourself. This idea brought a calm and he was mentally prepared. He decided to spare his face and instead go for his heart thinking it would also be the most effective way of killing himself. Using his assault rifle and appreciating his anatomy, he pointed the muzzle at his heart. He placed it slightly left of his sternum with extending his right arm to reach the trigger. He used his right thumb to push the trigger away as the muzzle rested on his heart. The very act of pushing the trigger to overcome the resistance caused the muzzle to move slightly. He missed his heart and aorta by a centimeter and depositing the bullet in his back. Despite his best efforts, he miraculously missed major vasculature and organs.

His life was saved by the actions of the medics and surgeons in Afghanistan. He had significant thoracic wounds and bleeding but minor in comparison to the worst-case scenario. He was flown back within 72 h to Walter Reed on the Air Force's "flying ICU" critical care aircraft. He underwent several additional surgeries requiring about 3 weeks of care on the surgical unit. The surgeons subsequently

took a consultative role after he was transferred to inpatient psychiatric ward for his suicide attempt. He finally came to see me after spending a month on the inpatient psychiatric unit attempting to deal with significant losses.

PFC Smith was the victim of Jody back home. Perhaps he hadn't been in the Army long enough. These cadences that perpetuate Jody's fear in the hearts of young soldier end with a certain advice: "Ain't no use in looking down, Ain't no use in looking down, Ain't no use in looking down …" It's repeated numerous times and the message is there to advice that being victimized by Jody is perhaps a fact of life with the intent to lessen the shame. Unfortunately, PFC Smith could do none but "look down."

He was drowning in shame and guilt. He was sewn to perfection by his surgeons with meticulous attention. He was kept under watch for an entire month on the inpatient psychiatric unit for his safety, but his most difficult journey yet had now begun.

Although I would only learn the labels later, he was devastated by narcissistic injury, perceiving himself as a failure. He blamed himself for his wife's actions, as well as "failing to kill when necessary" further devastating his soldier identity.

I learned a lot from PFC Smith for the one month I cared for him. He helped me realize the incredible privilege psychiatrists enjoy when permitted by patients to witness their utmost vulnerabilities and fears. He also taught me that the role of his prior surgical and medical care was to keep him alive but the role of psychiatry was to help him live again.

Over the course of years, I have understood that a lot of psychiatric disorders and disordered behaviors lead to social isolation. This fact is the complete opposite of what we desire from the moment of our birth: letting out a loud cry to surround ourselves by all that love us. This innate ability being present so precociously at birth places sociality as a top survival tool.

I had also realized that I was at great advantage with my cultural competency due to my prior service enlisted experience. It made it easier for me to connect with soldiers. I listened to PFC Smith, and my supervisor told me to help him reframe his aftermath. With that recipe, the soldier went from someone "looking down" from shame to eventually becoming a spokesperson for Army's suicide prevention. He traveled across the country and shared his story with deploying military units. He had found a new purpose and begun to live again. Like many medical students, during my other training rotations, I felt like an accessory to the treatment team and did not value my contributions. It was different on my psychiatry rotation when engaged with PFC Smith and others like him. This was the first time I felt I had made a concrete difference in someone's life. This gratification combined with superb role models were enough for me to want to become a psychiatrist.

17.3 Psychiatry's Impact on Military Missions

I may not have chosen this as a career were it not for setting and the mission value I had begun to realize. My service in the Marine Corps and then training in a military medical school had done a good job solidifying my military identify. Psychiatry brought a military relevance to medicine that helped foster that exact military

identify for me. My readings on this topic during this time helped to cement in my mind the value of psychiatry to military missions. There is a cyclical nature to the recruitment efforts in psychiatry in the USA. There is evidence that the historical upswings in psychiatry being favored as a career choice occurred after major military conflicts [4]. During World War II, the military psychiatrists helped take psychiatric practice, which for the most part entailed psychodynamic approaches and something previously for the privileged, and delivered it to the common masses [1]. The symbiotic nature of the marriage between American psychiatry and the military is well recognized. The military has had to struggle with the emotional costs of battle and its impact on the mission. Meanwhile, the American psychiatry can trace its approach to diagnosing mental illness to the nomenclature developed by US Army after World War II [5]. This organization of labels used to identify different presentations of psychiatric illness allowed disability evaluation and diagnostic uniformity. The DSM is currently in its 5th edition, but it can trace its roots to phenomenological and phenotypical observations made by military psychiatrists. Military psychiatry's contribution are numerous and during my medical school years, its impact became increasingly clear to me regarding missions related to GWOT.

Historically, infections and respiratory illnesses were leading cause of morbidity and loss of a soldier from the battlefield. Psychiatric causes were lower on the list. Between WWII and Korean War to Vietnam, mental illness jumped from 11th to 8th place as the leading cause of taking out troops from the battle zone [6]. Psychiatric illness rose to greater significant in more recent conflicts edging up to the fourth place in the British Army during their Bosnian operations [7]. The data from GWOT is similarly dramatic. A study looked at medical evacuations from Iraq and Afghanistan between 2004 and 2007 and noted over 34,000 troops brought to higher echelon out of the combat theater [8]. Only 14 % of the patients in this study were due to combat injuries. Psychiatric diagnoses led to the evacuation of 9 % of these troops. The most interesting findings were that psychiatric patients had the lowest return to duty rates [8]. It highlights both the breadth and depth of the impact that mental illness has on military operations, readiness and retention of talent. The next question that helped me understand the impact of a military psychiatrist during GWOT helped me see the value of the profession directly impacting frontline mission. Let's consider the data from Cohen's research above of those 9 % evacuated from theater. These 9 % being the numerator, then how did the denominator do? These would be all the soldiers coming in contact with mental health in the combat theater. How many were able to be returned to duty and kept in the fight? The answer to this question would help us understand the impact of military psychiatry towards the mission and motto of Army Medical Corps: To Conserve Fighting Strength. Data about forward clinical contacts and outcomes is scarce. There is only a single estimate early on during GWOT where the Army Medical Department reported that 97 % of forward deployed soldiers treated by mental health returned to duty and presumably stayed in the fight [9]. This figure plummets when the evaluations occur farther out from the battlefield. Only 11 % returned to duty when they were seen in Kuwait, 3.8 % when this was done at Landstuhl Regional Medical Center in Germany [9] and virtually no chance when the patient is sent to a place

like Walter Reed in the USA [10]. These facts and impressive return-to-duty rate on the battlefield are enough to warrant mental health professionals close to frontlines. There are probably numerous factors for these declining figures but one obvious one is that patients medically evacuated out to the USA probably had greater severity of psychiatric illness. These were the patients that colored my experiential lenses as a resident at Walter Reed as I learned the science and art of psychiatry. These are the soldiers that require the advanced care that garrison treatment facilities offer. It is indeed the role of garrison medicine at places like Walter Reed to meet the promise of caring for our wounded, veterans and their families.

17.4 Residency Training at Walter Reed

After my positive medical school experience and understanding the impact of psychiatry in the military, I decided to apply for psychiatry residency program. However, I found it difficult to entirely let go of the broad medical knowledge acquired in medical school. One of my mentors told me about the Army's combined residency training program that extends psychiatry residency by a year but the trainees receive training in both psychiatry and internal medicine. All the military services have their own residencies. The Army trains its residents in psychiatry at Walter Reed National Military Medical Center, Bethesda, Maryland and Tripler Army Medical Center in Hawaii. The Navy shares the Walter Reed program but also has a second residency program in San Diego. The Air Force has programs in San Antonio, Texas and Dayton, Ohio. The Army is the only service with the combined psychiatry and internal medicine program which is located at Walter Reed. Psychiatry programs are 4 years but combined programs tend to be 5 years, as was the case with mine. On July 1st, 2009, I began my combined medicine and psychiatry residency in the medical intensive care unit at Walter Reed.

One of my very first patients was a young man on life-support with severe delirium. He was evacuated out of Afghanistan after being found down. He had multiple seizures but without any clear etiology. Subsequently, findings on his blood gases were very suspicious for cyanide poisoning. The case was subsequently confirmed when his locally acquired Afghan chewing tobacco was heavily contaminated with cyanide [11]. He ended up with permanent hypoxic brain damage, neuropathic pain and severe Parkinsonian symptoms. I often saw him going to his appointments with his young wife pushing him in his wheelchair around the hospital. While initially the focus of his care was medical stabilization, his mental health took greater prominence over the course of several months. It was my early lesson in the artificial separation and compartmentalization of how we deliver medical and psychiatric care. Over the course of this month, I also helped stabilize two severe suicide attempts by young soldiers. One of these soldiers overdosed on valproate and came very close to succeeding due to liver damage and swelling in her brain. The medical care she received saved her life. The following year, however, she succeeded in killing herself by hanging. This was just the first month of my training and all of these patients were on my medicine rotation. Thus it became more and more clear to me that

medicine and psychiatry would be importantly linked in my future medical career. This dual role was greatly helpful among my interaction with those evacuated due to injuries from war related trauma or illness.

The majority of trauma patients were medically evacuated out of theater and brought to our hospital with polytraumatic injuries. Those with severe burn injury were taken to the Army's burn center in San Antonio, Texas. We were also tertiary referral center for the Department of Defense. When a soldier was deemed unfit on the frontlines, they were sent back, going up the echelon of care. As the earlier data from GWOT suggested [9], up to 97% of psychiatric patients were seen briefly, provided "psychological first aid" and returned to duty. If further care was needed, soldiers were sent up the chain and our hospital was usually the last stop, accumulating the sickest and more complicated psychiatric cases. Those troops with physical traumatic injuries would also eventually end up at Walter Reed. Most of the soldiers would arrive within the first 36–48 h after their injuries and salvage operations in combat theater. The majority of the wounded troops had polytraumatic injuries and were admitted to the surgical services. Patients with primarily medical problems were admitted to internal medicine service.

Psychiatric patients were brought back on the same flights. There was a big difference however between psychiatric and non-psychiatric evacuees. For safety, suicidal patients were escorted by 1–2 soldiers from their units. Essentially, each psychiatric casualty led to loss of several soldiers from that particular unit. Besides suicidality, patients often had combination of depressive symptoms and acute stress. We received brief summaries of presentations from the evacuations office in advance and reviewed electronic medical records to prepare for arriving soldiers. At the peak of war in Iraq, it was not unusual for psychiatric patients to outnumber patients with primary medical and surgical problems. Admitting these soldiers was often overwhelming amount of work with attempts to get collateral data from theater. This involved dealing with time zone differences and often worsened by uncooperative and sometimes angry patients who were involuntarily admitted. The majority of my psychiatric patients during residency came from Iraq when the number of troops serving there outnumbered those in Afghanistan. Most of these patients had suicidal thoughts serious enough to make them a liability on the battlefield.

The age of active duty military service members is skewed with a concentration of young adults. Their median age also happen to be peak age for the presentation of the majority of psychiatric disorders. It places disproportionate amount of risk for depression, anxiety and psychosis in the military. The age range also parallels that of suicidal behaviors. These facts also present unique experiences for military psychiatrists in-training. While majority of people who are diagnosed with Schizophrenia or Bipolar disorder with mania are well into their psychotic state when they are finally diagnosed, this is different in the military. In military medicine, soldiers often present with early and subtle presentations of these disorders. Unlike our civilian counterparts with psychotic disorders, our patients, being in the Army, are constantly under the magnifying glass and unit leaders pick up subtle changes in their soldiers. Sometimes these symptoms on the battlefield were not

subtle. I had several memorable cases where a soldier in his psychotic state would display bizarre behaviors that also placed the safety of other troops at risk. Safety is top concern for all psychiatric evaluations but this take special importance in the military. Our pool of potential patients are armed and well-trained in using them.

Over the course of my training from medical school into my residency, perceived stigma was a proven barrier for soldiers to seek mental health care [2]. The military and the Veterans Administration (VA) made great efforts to reduce these. Some of those interventions included education, as well as establishing certain financial incentives. These factors, such as financial incentives or attached meanings, made diagnostic process very nuanced. This helped me appreciate the power of diagnostic labels. We are demanded to balance the two roles as physicians and military officers: advocating for the patient, as well as ensuring Army mission obligations are met. There were also other lessons to be learned. It included the bureaucratic lessons that were important for my competent system based practice. Some of which were understanding reasons for discharging a soldier from the service or retaining them, influences of diagnostic labels on disability evaluation outcomes etcetera. It also required flexibility as these rules or practice patterns changed. For example, prior to GWOT, it was fairly expedient to discharge someone with a personality disorder who could not adapt to military life. This behavior on the part of psychiatrists had to change when almost all service members had at least one combat tour. The idea was that the deployment placed the individual at risk for psychopathology. The most important of these were post-traumatic stress disorder (PTSD) and mild traumatic brain injury (mTBI). At minimum, we assumed their symptoms were exacerbated by combat experience. These policies and decisions have implications for both the practitioner and the soldier.

When a soldier is medically discharged, the Department of Defense (DOD) and the VA has complex rating schemes which decide the type of financial compensation a soldier may receive. Often, percentage ratings are used which indicates a monthly disability payment of their discharging base pay salary. For example, a young soldiers such as PFC Smith with two year time in the Army earns $1838 a month in base pay salary in 2015. If he receives 50 % rating for a particular condition, then he would get half of that, a minute $919 per month. It could be a reasonable sum for anyone combining it with a full time salary. However, those leaving with disability that prevents them from doing any paid work leaves a lot to be desired. Anyone discharged with a personality disorder often did not rate any compensations. During the middle of my residency training, the military and the VA announced 50 % compensation for PTSD. This was a significant action besides the financial compensation. It communicated the disease nature of psychiatric illness and not a moral weakness. It also identified this diagnosis with combat service and in a sense became a badge of courage. These forces influenced the diagnostic climate significantly during my training. It attached caveats to the more puritanical approach to diagnostic aspects of psychiatry. Playing the dual role proved frustrating for me and it was the most challenging adjustment, balancing the two. The most helpful lessons came from my mentor who helped me realized that such constraints aren't unique to military psychiatry. That our civilian colleagues work within similar constructs. Their dealings

include disability considerations, insurance coverages, financial and access-to-care constraints. I am continuing to better myself dealing with these issues and my next job as a Division psychiatrist will provide significant opportunities.

I also discovered a significant number of negative preconceptions I carried about patients with addictions. I dreaded that particular rotation and was expecting a difficult time. The opposite came true. Most of my patients had struggled all their lives with substance, predominantly alcohol, before joining the Army. A lot of these patients had deployed. One such memorable case was of a soldier who was medically evacuated for going into severe withdrawals after landing in Afghanistan. A significant number of soldiers had combat PTSD and had begun drinking to self-medicate. Those with dual diagnosis were first intensively treated for addictions and then referred to our IOP's Trauma Tract at Walter Reed. For these patients, their combat experiences significantly exacerbated their addictions. I began to see addiction as a disease the more I learned. This was among the many ways I felt personal growth interacting with patients. They had lost significant amount of their dignity and self-respect. I found addictions to be an area that truly exemplifies the biopsychosocial model. Patient received individual and group therapy, had social interventions such as alcoholic anonymous, and benefited from advances in pharmacotherapies. I also enjoyed the training due to its high impact on physical health. While training as an internal medicine resident, I had taken care of patients with acute alcoholic hepatitis or end stage liver disease in the intensive care unit. I had also seen other chronic sequelae of substance use. One particular case was of a high ranking retired officer who had developed Korsakoff psychosis. This training helped me realize the potential for averting future disaster with successful treatment.

The greatest stimulation during my psychiatric residency came from working on the consult service. This service specialized in psychosomatics, geriatrics and pain. In the midst of the war, the wounded healed on surgical and medical wards and their only access to psychiatry was through the consult service. In the beginning of GWOT, hospitalized patients with clear need for psychiatric care often declined consulting with mental health specialist. The leadership attempted to target this stigma. They implemented policy to see all returning hospitalized soldiers. We identified ourselves as being from Preventive Medical Psychiatry service and would make it clear that we see ALL returning soldiers. It is on this service when I fully understood the value of supportive therapy. A modality that is there to support whatever rationalization or denials the patient has to keep them going. Many of the young soldiers, with the advent of advanced body armor, survived terrible injuries. This also meant prolonged hospitalizations, numerous surgeries with frequent exposure to deliriogenic medications such as anesthetics or narcotics, and majority being in constant pain. Literature shows, especially among young males, that this type of setting leads to a regressed state. We had plenty of patients that fit this profile. Our service was often called upon to assist with provider-patient frictions. As in child psychiatry, where the target of intervention is often the parents, we often identified care-givers in need of interventions. We assisted care-givers and providers by enhancing communications, supportive therapy and helping with recognition of provider burnout. The consultation service also played a significant role assisting

patients with pain using numerous modalities. It included treating underlying sleep problems or anxiety. We also used clinical hypnosis and progressive relaxation techniques. We also played a role in recommending psychopharmacological interventions to help with pain. Psychiatry also became a leading partner on the team in identifying complex drug-drug interactions. It was on this service, I began to fully appreciate the value of my dual psychiatry and internal medicine training using my medical and subcultural knowledge.

The military health system provided significant educational opportunities for those of us in training. It included unique opportunities to work with the war wounded who may be missing one or more of their extremities. Their realities also included permanent loss of independence with colostomy or ileostomy bags, and genital mutilations. However, from a broad psychiatric training perspective, there are gaps in exposure to type of patients and settings that are typical in community psychiatry. This includes patients with severe chronic mental illness, underserved patients, and inpatient child and adolescents. There is also limited exposure to civilian practices outside the single payer military health system. In order to make these gaps, we trained at numerous civilian facilities in the greater Washington DC area. Armed with the knowledge resulting from our residencies, military psychiatrists have been able to help keep our service members mission ready and in the fight.

17.5 Completing the Circle

I benefited greatly from the work of military psychiatrists who taught me during my training. I came to understand their legacies, and overcame the naive stigma I felt as a student toward to field. Exactly 13 years after completing my first deployment as a Marine Sergeant to Afghanistan, I returned to the Middle East in September of 2015. The military had invested 9 years in me to train me as a medical student and subsequently, a combined psychiatry and internal medicine resident. The immediate year out of my residency, I remained at Walter Reed as the Chief Resident for Internal Medicine. Mid-way through the year, I received my orders to be a "professional filler" or PROFIS for the 85th Combat and Operation Stress Control (COSC). After finishing my Chief year, I departed for Kuwait.

While the weather there in the summer was over 120 °F and I didn't see any rain for months, I was none-the-less drinking from a firehose in my job. I served as the solo psychiatrist for a population ranging from 9000 to 12,000 soldiers. I was well prepared and had the credibility of dual board certification in psychiatry and internal medicine the summer prior—however, the volume of patients were two- to threefold that of a typical psychiatrist in non-operational setting. I was on 24/7 call for our psychiatric emergencies for the duration of my deployment. The majority of the population were there to support Operation Inherent Resolve but were not involved in direct actions against enemy. While over-all this was a welcoming factor, it was also problematic to certain subpopulations of soldiers with combat occupational fields. These soldiers became victims of boredom. The clinical picture was that of perceived deficit of purpose and mission for these soldiers. Given most of them were still

between the age of 18 and 20, the predominant presenting complaints surrounded relationships. These included friction with command and co-workers with anger and rage. Soldiers also had interpersonal relational problems with bad breakups including in the deployed settings.

My residency training had prepared me to care for patients with severe psychopathology with significant functional deficits. The majority of my presenting patients had different kinds of problems. They were highly functional from a clinical scope with only mild psychopathology. They came to clinical attention for two main reasons: constantly being monitored 24 h a day, and a much restricted environment of the deployed setting. Take the same individuals and place them on Anywhere Avenue, Civilianville, USA, and these issue would never even make it to a psychiatrist's office. Operationally, however, these issues had to be addressed due to their impact on good order and discipline and I played the role of the behaviorist for the camp. The commanders had full expectations that I would be able to modify the behaviors of their soldiers through clinical interventions. I did have some soldiers who had severe psychopathology and significantly lacked functioning and were returned back to the US. Those cases probably could have been further reduced if better screenings were done prior to deploying them. In other words, they should have never been deployed. While I was well trained in the treatment of the sicker population, the majority of those "not-so-sick" soldiers needed something different: coaching.

I realized that I had to be more of a coach than a therapist. Clinical psychotherapy is more concerned with treating psychopathology, whereas coaching is concerned with improving performance or life-experience [12]. A lot of the younger soldiers were still traveling through their normal developmental stages from adolescence to adulthood. I read up on coaching strategies and settled on modalities informed by cognitive and problem-solving methods. I also made an effort to introject emotional and social intelligence based constructs and aspirations when using cognitively informed hypnotherapy with some soldiers. The majority of interventions were helping soldiers learn effective communication strategies, exploring their self-esteem, and understanding their cognitions. A number of these cases were followed by two of my behavioral health technicians after training them in basics of clinical coaching. There were also a significant amount of cases of generalized and social anxiety problems that surfaced when individuals no longer had access to their minimal privacy from living in 50-men tents to crowded dining and gymnasium facilities, and loss of support structures. The predominant presenting complaints among these soldiers were either irritability or insomnia. They responded very well to SSRI's and CBT. Overall, my deployment concluded with over 99 % return-to-duty rate. I compare that to the Army Medical Department's figures from 2003 of just 11 % return-to-duty rates from Kuwait [9].

While I never lacked a sense of purpose while deployed, being the busiest physician on the camp, my own return-to-duty figures do add to my sense of accomplishments. Yes, the Army had invested 9 years in my education, but I was finally paying back—conserving the fighting strength. At the conclusion of my deployment, my identity as a military psychiatrist had transformed and grown. I realized that my contributions of maintaining my forces mentally fit had butterfly effects on the

mission. We surrounded our enemy and our mere presence in the region worsened his effectiveness and perhaps gave him a few nightmares … or as the Javaro Indian warrior might proclaim, *head shrinkage*.

Acknowledgement *Disclaimer*: The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense, or the US Government.

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After the Smoke Clears

18

Shannon Merkle

Dedicated to the courageous men, women, and families of the US Armed Services who possess "… a firmness & perseverance of purpose which nothing but impossibilities could divert from its direction …."

Thomas Jefferson

18.1 August 7, 2012

Without warning, an excruciating sensation slams into my back and head. It is now dark and eerily still. A loud, shrill ringing fills my ears, and I'm struggling to breathe. My body will not follow my commands. My limbs are surprisingly unresponsive to my desire to move. Someone screaming, "stay down" pierces the ringing in my ears. Finally, my lungs respond drawing in the dusty, stale air that makes me alternate coughing with breathing.

Where is Technical Sergeant (TSgt) Kay? Just moments ago I was standing beside her; we were finalizing details for our upcoming battlefield circulation mission. Again, someone yells, "stay down." The delayed realization that we'd just been attacked now floods me with adrenaline and finally my body begins to respond to my desire to move.

My eyes strain to probe the darkness, looking for my colleagues. I'm not in the same place I was standing earlier—none of us are. I hear a muffled "boom"—a mortar or rocket. They are still firing at us. Captain (CPT) Walsh is kneeling a few feet away. I suddenly understand that she has been the one yelling "stay down." She

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Fig. 18.1 Inpatient room at the Concussion Care Center. FOB Shank, Afghanistan, 2012 (Courtesy of CPT Shannon Merkle, OT)

is yelling at TSgt Kay who keeps repeating the phrase, "I can't breathe", and seems to be struggling to get out from under a pile of debris.

Although shock, anger, fear, and confusion begin to compete for attention within me, I take comfort in the fact that she is talking. I know there were three other people here with us—where are they? The world seems to be in slow motion around me. CPT Gardner emerges from the darkness, but I can't really see his face. I hear someone yell, "MEDIC"!

Somehow the darkness turns into a scalding brightness; the pain sears my eyes. We are all outside of the now flattened tent that was the combat stress team's office, but I'm not aware of how that happened. I glimpse CPT Gardner helping TSgt Kay hobble away from us. I see CPT Walsh cupping her head, mumbling "my head hurts." She's headed in the same direction as CPT Gardner and TSgt Kay. I think they're headed to the Forward Surgical Team (FST), but I'm not sure. The others that were in the tent with us are already gone. I head toward the Concussion Care Center (CCC), checking bunkers along the way (Fig. 18.1).

I run the Concussion Care Center for the 173d Airborne Brigade Combat Team (ABCT) area of operations (AO). This morning we had expected to be able to finalize the discharge plans for our one remaining Service Member (SM). The well-being of Sergeant (SGT) Castro (the Occupational Therapy Assistant who runs the

CCC with me) and the Service Member in our care dominate my convoluted thoughts. We take indirect mortar and rocket propelled grenade fire (IDF) regularly here, and initially I assumed that this incident was more of the same. However, as I try to resist the fog that has invaded my mind, I realize that something more significant is happening.

I find the Service Member I'm looking for in the bunker nearest my clinic—he appears to be allright, but no SGT Castro. Someone informs me he's at the Concussion Care Center looking for me. I walk the short distance to the Concussion Care Center and find SGT Castro inside the damaged tent. Somehow, I end up back inside the bunker; SGT Castro standing beside me.

Our Service Member and several Afghanistan interpreters who live in the tent beside ours are also in the bunker. Ironically, it is not fear that I feel, but rather relief that SGT Castro and the other Service Member are allright. A wave of nausea washes over me, interrupting my slowed thoughts. I think I'm going to vomit, but no such relief comes. My head is pounding, and I begin to notice the ache in my back and neck. My thoughts are murky and disjointed as I try to make some sense out of what just happened.

I have no real concept of time. I wonder how long we've been in the bunker, but apparently it hasn't been long when I hear, "BREACH!" I look at SGT Castro. What is he saying? I'm getting frustrated trying to make my brain assign meaning to the conversations and chaos around me. "We're being breached," he says to me and takes off running back toward Charlie Company, toward the perimeter.

I don't specifically remember heading to the perimeter but I'm here now—full battle gear and M16A2 in hand. I see Service Members and local nationals stumbling all over the place. I notice Service Members standing on the Hesco walls at the perimeter pulling security.

Those who were roused from bed (night duty and special operations forces) are dressed in some combination of boxers, shorts, and flip flops while wearing their Improved Outer Tactical Vests (IOTVs) and Kevlars. The rest are in more traditional military gear. The perimeter (including the large hole in the perimeter) has already been secured.

"Captain! Captain!" A local national approaches me. He is dressed in primarily white attire, which contrasts starkly with the blood and dirt covering him. "My brother, my brother," he adamantly repeats and points toward the hole in the perimeter wall. He is pointing toward a group of "Haji Shops" (small shops owned by locals) along the inside of the perimeter. I follow his gaze and for the first time start to take in the destruction around me. The shops on the perimeter are in ruins. Alpha, Bravo, and most of Charlie Company living quarters are destroyed. Debris is scattered everywhere. The Charlie Company medical area is badly damaged. The structures that used to comprise the Forward Surgical Team area and the Combat Stress Center (CSC) have been destroyed. Charlie Company is busy consolidating resources, triaging casualties, and trying to pull survivors (and the dead) from the rubble. The medical evacuation landing zone is the new triage area.

One US contractor and three local Afghans died in the vehicle born improvised explosive device (VBIED) blast that day. Over the next several hours, more than 108 casualties were treated at Charlie Medical Company and at least 38 people were evacuated to Bagram Air Field [1]; others followed over the next couple weeks.

Most of those evacuated from Forward Operating Base (FOB) Shank left theater for additional care. Some who were evacuated to Bagram tried to return to duty on our Forward Operating Base, but many were unable to continue working effectively there and returned stateside for further care.

I was in the Combat Stress Center (CSC) finalizing travel plans to a remote outpost with a member of the Combat Stress Team (CST), when the VBIED was detonated. Five other Service Members (most of them members of the CST) were in the CSC with me at the moment of detonation. We were 75–100 meters from the point of detonation. Most of us sustained relatively minor orthopedic injuries and concussions. TSgt Kay was evacuated from theater approximately 1 week after the blast and later medically discharged from the military. CPT Gardner transferred off FOB Shank and finished his tour at Bagram. The rest of us were treated, recovered in place, and returned to full duty within a couple weeks.

18.2 Situational Context

I am an Army Occupational Therapist (OT). I have more than 17 years of clinical experience. I enlisted in the Army in 1999 and have been involved in some capacity, whether as a reservist or an active duty service member, since then. In 2012, I deployed to Afghanistan as an individual augmentee, which means I did not deploy as a part of a unit. Like many of my health care peers, I was needed to provide health care services that were not a normal function of the unit I was deploying to support.

I spent just under 9 months in Regional Command East, Afghanistan as the Officer in Charge (OIC) of the Concussion Care Center (CCC) on FOB Shank. I was allowed one Occupational Therapy Assistant (OTA) to help me run the center. SGT Castro and SSG Werner worked with me during the first 4 and the last 5 months, respectively. Our Concussion Care Center was one of 6 CCCs in the region. Although attached to three different commands at various times during my deployment (3rd Infantry Brigade Combat Team, 1st Armored Division (3/1 AD), the 173d Airborne Brigade Combat Team (173d ABCT), and the 30th MEDCOM), I was consistently co-located with the medical company of the corresponding support battalion (Charlie, 125th Brigade Support Battalion & Charlie, 173d ABCT) on FOB Shank.

FOB Shank had the capacity to provide Level II medical care. We treated primarily service members (Air Force, Navy, and Army), but also treated some contractors and detainees.

We were not a large medical center like that found at Bagram, but we had significant trauma surgical assets, air and ground medical evacuation assets, an outpatient clinic, an inpatient holding/treatment area, and limited radiographic capabilities. In addition to the surgeons, physicians, physician assistants, nurses, and medics we also had a physical therapist, an occupational therapist, and two clinical psychologists. US Forces shared the Forward Operating Base with international forces, including those from the Czech Republic, Jordan, and Afghanistan. Health care providers from Jordan, Afghanistan interpreters, and a few US health care providers were our closest “tent” neighbors.

The Afghanistan interpreters were courageous, hard-working, and friendly. It was not unusual for them to invite SGT Castro and I to their tent for Chai tea. I went several times with him intending to build rapport and learn more about their culture, but also realized the need to maintain an emotional and professional boundary. Although I appreciated and respected their efforts, I also recognized the inherent danger and vulnerable nature of their position. Additionally, given the cultural considerations of Afghanistan, we felt that male interaction was the most appropriate and respectful way to build professional rapport with the interpreters (all males). Since we had the capability to employ both male (SGT Castro) and female (myself) influences, we leveraged this quality, in addition to other personal and professional strengths, to care for those who were injured. Balancing each other in this way, SGT Castro and I were able to more effectively fulfill our responsibilities.

Our Concussion Care Center was initially responsible for the potential care of more than 3000 Service Members stationed at approximately 17 outposts in RC-East, Afghanistan. As the larger war strategy at that time was to train Afghanistan forces and transition security responsibilities to them, many of the outposts in our region were gradually closing or transitioning to Afghan control. The majority of our concussed patients were male, but we also treated some female Service Members. Although we were primarily tasked with concussion care, it was not unusual to also provide orthopedic/wound care services within our capabilities. In fact, Charlie, 173d ABCT supported and assisted our effort to add a small plywood room to the front of our tent so that we could also treat Service Members with orthopedic injuries which has been further described elsewhere [2].

We lived and worked primarily in a General Purpose Medium Tents, which are $16' \times 32'$ canvas tents, built to allow heat delivery via a generator. Our tent served both as our concussion care center and our home. Like most tents on our FOB, it had plywood partitions that served to provide some privacy to those who stayed there. Our Concussion Care Center had an inpatient capacity of 12 Service Members, plus 1 Occupational Therapist and 1 Occupational Therapy Assistant. The Occupational Therapy Assistant and I lived with the Service Members we were treating. Thus, in addition to working with them during the day, we lived with their restlessness, their nightmares, their anger, their fear, their determination, their courage, and their resolve to return to their units. Their steadfast resolve to return to the fight was one of many examples of their unrelenting spirit in the face of adversity.

The unique environment afforded us opportunities for impromptu "chats." These were sometimes as therapeutic for recovering Service Members as was the acute concussion management. At times, we simply sat quietly together outside the tent. More often, we would sit, talk, *and* smoke. SGT Castro was, like many of our patients, a cigar aficionado. He frequently took advantage of this commonality to build rapport with patients and other Service Members. Ironically, his love of cigars (combined with his calm demeanor and good listening skills) was an invaluable rapport- and trust-building asset. Although not a smoker myself, and not an advocate for smoking, I sometimes joined in their "smoke-shack therapy" (a term coined by a former, Army OTA) (Fig. 18.2). Considering the environment in which we lived and worked, it seemed pointless to lecture them on the long-term health risks of

Fig. 18.2 Modeling a healthier version of "smoke-shack therapy," MAJ Katie Yancosek and CPT Carly Cooper smoke *candy* cigarettes. Bagram, Afghanistan, 2012 (Courtesy of SGT David Price, OTA)

smoking. Rather, I (as many of my nonsmoking health care peers) decided to join them and make the most of this therapeutic opportunity.

In addition to our mission on FOB Shank, we regularly travelled to the outposts within our region to train/update the medical teams on each outpost about: (a) concussion management (Headquarters, Department of the Army, 2013), (b) the triage process to assist with evacuation decisions, (c) concussion resources in our region, and (d) expectations of recovery and return to duty. We saw this aspect of our mission as critical to the successful treatment/management of Service Members with concussions in our area. Not only was it a practical way to share this information with other commands, Service Members, and medical teams, it was essential to acknowledge that not all Service Members who needed our care would be able and/or willing to come to our Concussion Care Center at FOB Shank.

FOB Shank (nicknamed "IDF Alley" and "Rocket City") was an unusually kinetic environment during that period of the war. Indirect fire (IDF) in the form of mortars and rocket propelled grenades typically hit the Forward Operating Base multiple times a day. Stray gunfire also seemed to occasionally find its way through tent walls. Several people died and many more were wounded as a result of indirect fire. Some medical teams and leadership questioned the logic of sending their Service Members to our Forward Operating Base for concussive care, especially due to the fact that most sustained their injuries in blast-related incidents. We believed that our presence on other outposts in our area helped to address the fact that not all those who needed our services would come to us. We also believed that this approach would increase the ability of outlying medical teams and leadership to appropriately triage their concussed Service Members. Having the knowledge and skillset to retain and care for less severely concussed Service Members facilitated improved individualization of Service Member care

and allowed outlying medical and command teams more flexibility in addressing any comorbid behavioral health concerns.

Since the Concussion Care Center admitted and assessed Service Members 24 hours a day and we had only two personnel to cover the Concussion Care Center, only one of us rotated to the outposts at a time. We tried to keep visits short (2–3 days) and stayed in touch as much as possible via phone. Given the overlapping and sometimes comorbid symptomology of concussion and post-traumatic stress, we worked closely with the Combat Stress Team. Additionally, whenever possible, we paired travel to more remote outposts with members of the Combat Stress Team assigned to the medical company with whom we were co-located. This was a practical and efficient way to visit outposts as the Concussion Care [3, 4] and the Combat Stress missions were compatible.

18.3 Subsequent Events

SGT Castro and I both sustained concussions as a result of the VBIED explosion. In addition, I sustained relatively minor orthopedic injuries primarily in the form of abstract neck/back and hip pain and shoulder stiffness. Thereafter, I also had consistent foot pain, but since I was functional and felt I could perform my duties, I waited to seek treatment for what turned out to be two fractures in my left foot and a labrum tear in my right shoulder until I returned home. Aside from the minor physical injuries, upon resolution of the concussion, I continued to experience sensitivity to light, headaches, memory issues, word-finding deficits, and difficulty attending to and comprehending written information.

As health care professionals, many of you are likely aware of the generalization that "we are the worst patients." This generalization reflects our innate resistance to "taking our own advice" and "taking care of ourselves." While not true of all health care professionals, it is a generalization that held true in the case of Charlie, 173d ABCT. The majority of the medical company sustained some type of injury. Ironically nearly all the members of the Combat Stress and Concussion Care Teams had been concussed, and a couple members of the Forward Surgical Team sustained injuries which would necessitate eventual evacuation from theater. Some Service Members up to one mile from the point of detonation were affected by the blast. Retrospectively, I realize that most of us shortened our recovery-time and tried to stagger rare "downtime" opportunities in order to continue medical care for others.

Our Concussion Care Center did not have the capacity to treat all affected Service Members from that event. We worked with the medical company to screen and triage those who were symptomatic. We admitted to the Concussion Care Center all that we could, treated other Service Members as outpatients, guided and assisted concussion management of other Service Members who were being cared for by smaller medical assets on the FOB as needed, and sent other Service Members to Bagram for additional care.

We had the added challenge of needing to evacuate the patients from our Concussion Care Center and temporarily relocate them to a more secure area on FOB Shank. Much of the 173d Support Battalion's Bravo (maintenance) and Charlie

(medical) company areas and many of their living quarters had also been destroyed by the blast. The maintenance company relocated off the perimeter of the Forward Operating Base. In the midst of recovering from their own injuries, the medical company was tasked to stay in place, rebuild and return to full mission capacity, and to secure their perimeter.

It was during their efforts to secure their perimeter that we noticed our Concussion Care Center was inadvertently in their line of fire. We, of course, immediately drew this to their attention, created a patient evacuation plan that was compatible with the medical company, and joined their perimeter security plan. Although co-located with the medical company, we were not officially attached to them. Fortunately, their leadership and medical staff were generous in their advocacy and support of our efforts and mission.

Ironically, the VBIED detonation itself may have been the least stressful event of my deployment. There was nothing I could have done to prevent it. It was sudden, unexpected, and over before I fully realized what had happened. However, the stress and subsequent medical and emotional challenges that occurred as a result of the events surrounding August 7 were nearly overwhelming. It was only by working together, as a unit, that we and the medical company were able to continue doing all that was required.

The lead OT in RC-East, Afghanistan was stationed at Bagram. An honorable and compassiate leader, she insightfully relocated another Army Occupational Therapist in the region, CPT Powell, to FOB Shank to assist us in running the Concussion Care Center while we recovered. CPT Powell was invaluable to our ability to continue to treat Service Members in the week that followed the VBIED detonation. Additionally, CPT Nordstrom (Army Occupational Therapist) and SFC Butch (Labrador retriever) provided animal assisted therapy services not only after this event, but also throughout their tour in Afghanistan [for more information on occupational therapy roles in Combat Operational Stress Control units and Animal Assisted Therapy see [5]). Furthermore, higher headquarters behavior health care leadership at Bagram personally helped to rebuild the Combat Stress Center.

I would also be remiss if I didn't mention the support and assistance we received from the Navy Seabees and formerly concussed Service Members who had successfully returned to their units. We were truly blessed in every sense of the word. Not only were we receiving support in the form of Service Members (and sometimes contractors) stopping by to "see how we were doing," they also assisted in cleanup and repair projects. Occasionally we received donations of clothing, blankets, hygiene and food items from their families back home. Often there was a "thank you" note and a brief update about their loved one. Independently of the VBIED attack, we regularly received items from corporate, nonprofit, and individual donors throughout the USA. Since many wounded Service Members came to us from the battlefield without their gear/supplies, we relied greatly on these donations to provide those who stayed with us adequate supplies during their recovery.

To the best of our ability, we provided any extra supplies to the other medical assets at FOB Shank and at remote outposts to distribute to their patients. Although unfortunate that so many came to stay with us at the Concussion Care Center, the remarkable men and women with whom we interacted restored our perspective and renewed our resolve to fulfill of our purpose there.

18.4 After the Smoke Cleared

The VBIED detonation on August 7, 2012 impacted a majority of the 173d ABCT Brigade Support Battalion assets on FOB Shank, although I believe none more than the medical company. It was no small accomplishment for the leadership and the unit to overcome the obvious challenge of continuing to provide medical treatment for an entire region with medical staff who themselves were causalities. The days and weeks that followed VBIED detonation continued to present many challenges to FOB security and medical care delivery. In the end, 173d ABCT was able to thwart terrorist plans to overthrow FOB Shank and medical care continued with minimal interruptions.

Though this attack on FOB Shank was only one of many kinetic events during my deployment to Afghanistan, it is the day that I'm most asked about and the one I'm least willing to discuss openly for three primary reasons: (1) my memory of the events of that day and the sequelae of events that followed over the next several weeks are disjointed at best, (2) I am apparently an excellent compartmentalizer and sometimes hesitant to abandon this coping strategy, and (3) being involved in a blast event while deployed is, unfortunately, not a unique experience. More important than this specific event was the courageous and effective response of the 173d ABCT in dealing with it. As a unit, they chose to view this event as one more challenge that needed to be overcome in order to successfully complete their mission—they chose to move forward.

The months preceding and after the blast, were filled with significant actions that reflected the courageous perseverance of Service Members, civilian contractors, and Afghan interpreters. Together, their actions facilitated continued combat, support, and intelligence operations by enabling continuous care and evacuation of wounded Service Members across our area of operations. They accomplished their mission in the face of seemingly insurmountable obstacles and their selfless-sacrifice is a reflection of the larger purpose they serve.

18.5 Home Sweet Home

It wasn't until the flights returning me home that I became aware of a heightened sense of irritation and a shortened temper. If it was evident earlier, no one mentioned it to me. I, with many others, was assigned to baggage detail. My normal response would have been to shrug it off as an inconvenience and work amiably with my fellow Service Members to accomplish the mission. While I tried to project a positive attitude exteriorly, internally, anger surged. While physically, emotionally, and mentally exhausted, we loaded and unloaded duffle bags for each leg of our return home; civilian ground crews watched and instructed us in relevant aspects of loading a cargo hold. This wasn't a significant event compared to the events of the previous months and so my irrational anger surprised me.

By the time I arrived home, I had not slept more than a few hours in the previous few days. I had surprisingly limited insight into the personal and professional

challenges that awaited me. I thought I had it all under control; after all, I was a medical professional.

Returning home to an Army Medical Department (AMEDD) unit that doesn't deploy as a unit was challenging. First, most military medical clinics seem chronically understaffed, and the pressure to return to a full patient caseload soon after returning from deployment should not be underestimated. I was fortunate to have an outstanding supervisor. While demanding, she was also supportive, and she helped me overcome some of the professional challenges associated with returning from theater. Furthermore, post-deployment physicals and behavioral health screenings were, in my case and in the case of some peers, ineffectual. It appeared to me that any mention or even hint of deployment-related concerns led to dismissive responses designed to remind me that 'I'm medical, not a combat soldier,' and that 'I came home intact, so it can't be too bad.'

Ironically, gaining appropriate medical care seemed more readily attainable when I maintained a disingenuously positive attitude and avoided mentioning any deployment-related association with my injuries. Admittedly, I didn't try very hard at the time to seek appropriate care for my concerns. I, more than they, already knew how fortunate I was. I was able to return home to a loving and supportive family. I now had the opportunity to again participate in the growth and development of my twin toddlers. These factors alone, I knew, were advantages that many of those I served with didn't have.

I knew several medical and behavioral health providers and could have used my collegial associations to seek additional care as necessary. However, asking for assistance/opportunities outside of those typically provided others is not compatible with my philosophy of health care delivery. Additionally, it was far too opportune to quickly transition back into taking care of others, while compartmentalizing my own needs. Furthermore, my post-traumatic stress symptoms never converted to post-traumatic stress disorder. Some peers and colleagues didn't fare as well. Finally, I have also had the *honor* to interact with some of the most extraordinary Service Members and civilians, most of whom have stories significantly more involved than mine. Perspective, hope, love, and faith may be abstract concepts, but they were also powerful allies during my deployment and in my transition home.

As I write this, I still experience almost daily foot, back/neck/hip, and shoulder pain. Although not entirely back to pre-deployment levels, my memory, and attention/comprehension of written information has returned to *near* pre-deployment levels. Word-finding deficits and discomfort in large crowds continue to frustrate me, but they, as well as the headaches have significantly improved. The moments of irrational anger, nightmares, and the ringing in my ears have resolved. Writing this brief account of events still brought tears to my eyes with the complexity of emotions that comes with remembering those who were/are less fortunate. Without my admission of these challenges, no one would know of them. I function well in both civilian and military environments. In fact, I expect that I will graduate with my Ph.D. this year, which will see the conclusion of a goal envisioned long before August, 2012. I also anticipate continuing to serve my fellow Service Members and their families.

18.6 Concluding Remarks

Neither military nor civilian health care professionals are immune to the consequences of traumatic events. Military and civilian tragedies are a part of our lives and our chosen professions. Just because we are armed with the knowledge and skill to help others cope with the consequences of trauma, doesn't mean we will always effectively apply these same skills to ourselves. Sometimes we need to allow others to assist us. I did ultimately need to seek medical care for my orthopedic issues and relationship counseling to facilitate reintegration with my family. While there is often much camaraderie among Service Members who share similar warzone experiences, individual responses to traumatic experiences vary greatly. While personal vulnerability is often uncomfortable, professional and personal growth can result from shared responses and coping strategies. Ultimately, we must learn how to care for ourselves and each other with the same compassion and skillfulness as we do the non-health care professionals who enter our clinics.

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The French Fourragère: Gore and Lore

19

David Michael Hanrahan

The reasons for my signing of a US Navy contract at the age of 18 years old are a distant memory now. The year was 2000, I was a senior in high school, and I wanted to attend Northwestern University. My mother encouraged me to fill out a scholarship for the Naval Reserve Officer Training Corps. I filled out the paper application in pencil. It asked which single character trait could I offer that would provide the most benefit to the USA. Commitment. I wrote slowly and methodically, trying to hide a penmanship skill that I lacked, with words proving that I was ready to be committed. My commitment paragraph discussed scholastic commitments displayed in AP biology and musical commitments practiced with the violin. The only goal in my mind was acceptance and funding of college at Northwestern University. I signed the US Navy contract in my true sloppy handwriting, enjoyed the last few months of high school track meets and orchestra concerts with my sister, and packed my father's jeep with my belongings. Little did I know what commitment the US Navy had in store for the tall kid who spent his first eighteen years of life in the same town.

Naval Reserve Officer Training Corps (NROTC) at Northwestern University began on September 8th 2001. We were at Great Lakes Naval Station being screamed at by college juniors and seniors, the upper class midshipmen, in our abbreviated, intense, yet comical version of boot camp. However, three days later while we were having fun with icebreaker games and tying boating knots at the beautiful Lake Michigan marina the mood abruptly changed.

I saw terror in the faces of our Navy and Marine Corps instructors. I feel this now as I type and try to hold back tears. My best friend Michael Lee told the instructors his father was working in the Pentagon. Everything became surreal, but more real, more poignant, more powerful. We all packed our bags, got into the vans, and

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prepared to move off base back towards campus. I remember the uncertainty, yet the calm purpose as we all listened and moved as one. We would stay and complete the last few days of boot camp. Then it was back to the books. While US forces moved into the longest war in history, we would safely sit and study, training and waiting for our release into action.

My first distant look into the ability of combat forces came while I was a college freshman. I spent a week with the Marine Corps at Camp Pendleton, a base just north of San Diego. All of us midshipman spent a few summer weeks in this gorgeous city as a final wine-and-dine experience before we had to sign our binding, 4-year service commitments to the US Navy. It was during this time that the pheromones of the US Marine Corps got me, the glisten of sweat against Eagle, Globe, and Anchor tattoos on bulging biceps peeking out under crisp, rolled, Woodland-Pattern camouflage.

I continued and graduated from NROTC and Northwestern University, becoming a commissioned US Naval Ensign in May of 2005. My best friend Michael Lee and I were lucky enough to be selected straight into medical school. He went to the Uniformed Service University of the Health Sciences and I went to the University of Illinois at Chicago. Here was another four years of sitting, studying, and training while the disasters of war continued in a distant land. I was introduced to Nicole, a fellow medical student, and we engaged to be married. It was love at first sight, soul mates, but I knew we would have many geographical challenges. I was asking her to accept all commitments the Navy asked of me in addition to being personally committed to me. Upon graduation from my civilian medical school in May of 2009, the personal characteristic of commitment was finally going to be tested.

The US Navy superseded me to the rank of Lieutenant and shipped me to my dream duty station, Naval Medical Center San Diego. Nicole continued medical school in Chicago and would visit me on the weekends. After the Fort Hood shooting I felt determined to lead by a new example, and applied for residency in psychiatry. I was to start at Walter Reed National Military Medical Center, the US Navy's flagship of military medicine and the President's hospital. It would be my home for 3 years of difficult and heart wrenching training in psychiatry residency from July 2010 to July 2013. During this time my wife graduated from medical school and joined me in Washington D.C.

I was sitting outside by the flagpole in front of the Walter Reed when my psychiatry specialty leader, CAPT Gail Manos, called. A hot fill position had opened at Camp Lejeune with the 6th Marine Infantry Regiment. They needed a psychiatrist to fill their Operational and Stress Control Readiness (OSCAR) billet. I knew this would make the third year away from my wife since our marriage began. I stood up and reported to CAPT Manos that I was ready and would do a great job for the 6th Marine Regiment commanding officer. It was a bittersweet moment. Confrontational commitments of my purpose in the military and the love of marriage weighed heavily on my mind. How could I be a good husband to my pregnant wife when the military was asking me to be a geo-bachelor? Would I be able to drive home to see the birth of my daughter Stella or would I be deployed to a combat zone? I felt truly sad and wondered how thousands of other military service members had done this.

The conversion from a training physician to an operational and world-wide deployable psychiatrist was quick. I was lucky to be headed to Camp Lejeune with a fellow psychiatrist and former Naval Academy midshipman, Jonathan Dettmer. Where he surpassed me with intelligence, I had him on height. Dettmer and I were trained by Commander James West, a psychiatrist who had already served many years embedded with the Marine Corps. Commander West prepared us for the environment, capabilities, opportunities, and our role. Next, Captain Jack Pierce shared with us the original standard operating procedures for initiating OSCAR into the 2d Marine Division. Our purpose would be to preserve mission effectiveness and warfighter abilities, and to minimize the short and long-term adverse effects of combat on the physical, psychological, intellectual and social health of US Marines. This included consultation with commanders regarding the prevention, identification, and management of operational stress reactions in units and individuals to identify at-risk populations by assessing unit morale, cohesion, and stress levels. Additionally OSCAR providers are to evaluate and treat those Marines and Sailors suffering from serious stress reactions and mental disorders.

Dettmer and I fueled our last month in psychiatry residency with long balanced feuds on the racquetball courts of Building 17 at Walter Reed National Military Medical Center. I said goodbye to my close colleagues, Peter Armanas as he headed to Fort Drum and later to Afghanistan, and Rohul Amin as he continued in a Medicine-Psychiatry residency and later deployed to Kuwait. I said goodbye to my 6 months pregnant wife Nicole as she stayed in Washington D.C. to complete her residency in Physical Medicine and Rehabilitation.

On August 16th 2013, I put on the desert Marine Corps Combat Utility Uniform, with the sleeves rolled up extra crisp, and checked into 2d Marine Division. This was a distant 12 years after my first time putting on a camouflage uniform as a midshipman, but the War in Afghanistan was still active and there was work to be done. I walked to the 6th Marine Regimental Aid Station and received the most motivating salute of my life. Out front was HN (FMF) Andrew Backus smoking a cigarette, holding a broom, appearing high above me three steps up at the entrance. This one razor-sharp salute and motivating grunt from a Fleet Marine Force Warfare Qualified Hospital Corpsman was truly all the moral preparation I would need.

Backus carried on his shoulders the weight of a previous deployment with RCT-6, short for Regimental Combat Team. He had learned in the Afghanistan combat theater from previous OSCAR providers, and he shared that wisdom with me in garrison. The next day Bill Blair arrived from the beaches of Hawaii. He was a laid-back, born leader. Making up the Fightin' 6th Marines OSCAR Team were: LT David Hanrahan the psychiatrist, LT Bill Blair the psychologist, and HN (FMF) Andrew Backus. These three men were the 6th Marine Regiment's answer to 6,500+ Marines and Sailors. At a time when the 6th Marine Regiment was historically at its largest due to a combined force of seven battalions, we acted. We served at the pleasure of the commanding officer Colonel Ryan Heritage and the executive officer Lieutenant Colonel Jason Drake.

The 6th Marine Regiment falls under command of the 2d Marine Division of the II Marine Expeditionary Force. The role it provides to benefit our USA is to locate, close with and destroy the enemy by fire and maneuver. The Fightin' 6th Marines

have conducted that role seemingly effortlessly with mastery since 1917 and for actions at Belleau Wood, Soissons, and Blanc Month, was awarded the French Croix de Gueere three times. As a result the regiment is authorized to wear the French Fourragère. It was one of only two units in the Marine Corps to be so honored (the other being the 5th Marines Regiment and coincidentally a unit my fellow midshipman and Marine Officer John Scheler belonged to when he deployed to Iraq). The Fourragère thereafter became part of the uniform of the unit, and all Marines and Sailors of the 6th Marine Regiment are authorized to wear the fourragère while serving within the regiment.

I name this chapter, "The French Fourragère: Gore and Lore," because it embodies the meaning of my experience. The fourragère deals with hidden emotional and behavioral characteristics of an individual and the group. LT Blair, myself, and new infantrymen were formally presented with our French Fourragère during a formation upon arriving to the unit. Upon accepting we were asked to commit to the legacy, history, and tradition of the Fighting 6th Marines. The fourragère is a braided cord worn upon the left shoulder of dress uniforms. Originated by the Duke of Alva, a Spanish general, he ordered that any further misconduct or retreat on the part of his warriors, without regard to grade or rank, would be punishable by hanging. His troops hoping to reestablish themselves in the good graces of their commander wore a braided cord in the shape of a hangman's noose on uniforms. The noose went from a macabre symbol to a mark of distinction and honor.

I began to wonder what it truly meant to be a warrior and an infantry Marine. At a time when headquarters Marine Corps was helping establish suicide prevention programs, did the Corps realize some 6500+ Marines and Sailors were strutting around in dress uniforms with a hangman's noose prominently displayed for all to see?

Adversities and challenges presented themselves to us steadily. The first challenge was using the principle of proximity. Our goal was to treat the operational stress psychiatric casualty in a place as close to the unit as safely possible. Proximity is necessary because it keeps the Marine near his squad, and distance from the squad weakens his bond. Proximity was challenging due to the most common chief complaint reported to us in the field. Only a report of suicidal intent would rise to us through the chain of command. Anything less would be dealt with at the local level.

Marines have a strong warrior ethic of self-reliance. There is a perception that to seek help outside the squad is a weakness. With the strong application of prevention programs commands were very aware of the desire to prevent suicides in the Marine Corps. Therefore, command would immediately alert the OSCAR team if an infantryman spoke of killing himself. However, since this is considered a medical emergency, we diverted all cases directly to the Naval Hospital Camp Lejeune six miles down the road from our Regimental Aid Station. Nearly every single Marine's suicidal plan would fade away upon interview with the emergency department clinician, while the true symptoms emerged. This diversion of care due to red flags hindered our ability to practice the principle of proximity.

The second challenge was using the principle of immediacy. Treating the operational stress psychiatric casualty as soon as possible was our goal. Immediacy is necessary because time allows for development of rationalization of symptoms. The

individual benefits of having symptoms, such as to avoid a legal bind start to overwhelm the advantages of recovering. Immediacy was challenging because a Marine commonly expressed complaints once he was in a legal or administrative bind. This culture bound pressure to avoid seeing the OSCAR team for routine operational stress hindered our ability to later practice the principle of immediacy.

The third challenge was using the principle of simplicity. Treating the operational stress psychiatric casualty as simple as possible was our goal. Simplicity is necessary because higher echelons of treatment may only fortify the Marine's rationalization that he is mentally ill. Simplicity was challenging because every Marine has the right and responsibility to seek care, and care is offered at numerous treatment echelons on the Camp Lejeune base, from company embedded hospital corpsman and battalion level medical officers to the regimental OSCAR team. These players were considered green side and offered a simple treatment.

Further up the echelons of care was the Deployment Health Center and the Naval Hospital Camp Lejeune Mental Health Center. These centers were needed for more complex issues, such as performing computerized testing to detect subtle brain damage incurred from proximity to a bomb blast or bringing together multidisciplinary teams to treat difficult mental disorders. However, nothing stopped them from treating the more minor issues. This vast array of treatment echelons complicated our ability to provide simple treatments after rapport and treatment plans were established elsewhere.

The final challenge was using the principle of expectancy. Treating the operational stress psychiatric casualty and helping him expect that he would soon be rejoining his fellow Marines fit for full duty was the hope. Here we found the Marine Corps was aiming to decrease its numbers. A few Marines were nostalgic for home and their emotions and conduct was detrimental to the unit. We knowingly became aware of our own version of an evacuation syndrome.

An evacuation syndrome arises in combat or garrison training when a route towards home, usually through medical channels, opens for Marines displaying a certain set of symptoms. We had fit-for-full-duty Marines who had expressed, and then quickly resolved their suicidal thinking. They had mild feelings of depression and anxiety, but what they really wanted was to be out of the Marine Corps. This nostalgia could be treated by the OSCAR team with the principle of expectancy, but considering risk to others and the mission we decided a limited evacuation syndrome with loss of manpower was in line with the overall Marine Corps downsizing.

The successes of the OSCAR team with the 6th Marine Regiment were daily. The first success was reducing stigma. Marines could see us wearing their uniforms with pride at the rifle range, in the gas chamber, on ruck marches, speaking with their commanders, and pumping weights at the Wallace Creek Fitness Center. The French Fourragère was a braided cord that did not isolate and choke an individual, but actually bound us all together on a higher level of brotherhood. We Sailors from the Regimental Aid Station wore it with pride at the 2013 Marine Corps Ball. Stigma melted away when the Grunts (infantry Marines) treated us POG's (Person Other than Grunts) as one of them. They did this in a variety of ways that did not keep with military customs and courtesies, but were all together more motivating.

The second success was providing effective care within the small unit and increasing access to care. My office was 15 feet from the brightly painted red pull-up bars, 30 ft from the barracks, 45 ft from the chow hall, and 60 ft from the regimental commanding officers office. This allowed the OSCAR team to see a vast number of Marines in office, walk by the barracks and shake hands with Marines we would see the next day in office, workout in the gym with numerous Marines from the individual battalions of 3/6 and 1/6, and conduct a full scale force preservation meeting with the regimental commanding officer all in a day's work.

The final success, my personal favorite, was reducing long-term deployment-related stress problems. I established the 6th Marines first-ever war trauma T-group in the regimental aid station. We had no explicit agenda, structure, or express goal. Here men from all of the regiment's subordinate battalions could come once a week to discuss their experiences in war, the difficulties in returning home after witnessing hostilities and atrocities, and openly discuss secrets which left them feeling guilt, shame, and moral injury. My position in the group was to simply be present, to be a mirror, to offer a safe place for camaraderie to develop in these men before the intrusions, arousals, and negative alterations in cognition and mood set in.

There are four men whose relationships I felt a great spirit of friendship and loyalty. LCDR Jonathan Dettmer, the OSCAR psychiatrist of the 2nd Marine Regiment. He nourished my body with home cooked meals and was a strong sounding board. LCDR Bill Blair, the 6th Marine Regiment OSCAR psychologist and leader. He led the way out of the office and into the battalions and provided much needed rest and relaxation by taking the helm. HM3 (FMF) Andrew Backus, the 6th Marine Regiment OSCAR psych tech. He motivated me to become FMF qualified and saw the human side of Marines in the war group. Colonel Ryan Heritage, the 6th Marine Regiment Commanding Officer. He smashed his hands on the walls of my office until I came out and integrated with the Marines and he had ultimate trust and saw psychiatry as an ally in the pursuit of military goals. I was academically and peer supported via eclectic daily T-group texting sessions with MAJ Peter Armanas and MAJ Rohul Amin, two US Army psychiatrists.

My greatest source of support and the one who bore the true challenges and adversities of my geo-bachelor operational tour with the US Marine Corps was my wife, Nicole Hanrahan. She gave birth to our daughter Stella and continued her role as doctor, wife, mother, and best friend all in my absence. She also gave life to all of my successes while I was the OSCAR psychiatrist.

My final clinical pearls are to take leave as much as possible and to develop a T-group in every practice. I will forever be grateful for the opportunity that presented itself to me and to be open-minded of any future deployment opportunities. The Fightin' 6th Marines, the lore of the French Fourragère, and the displayed commitment of those Marines and Sailors I will keep forever.

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Leaving Our Mark

20

Peter Saulius Armanas

20.1 September 2014 to January 2015

I never thought I would volunteer to go to war again. My first deployment had been physically and emotionally brutal. I was a young enlisted US Army artilleryman in Iraq in 2003. The living conditions were Spartan with tents, pallets of prepackaged Meals Ready to Eat, and the only source of water being a big 30 gal tank. We were running 24/7 operations in the streets of Baghdad and the surrounding area. The exposure to the realities of war was a life altering experience and left me, at the time, with what I thought was a profound love of a desk job and air conditioning.

This started changing after I arrived to Fort Drum as a new psychiatrist in the summer of 2013. Listening to the war stories of my patients left me a new and intense desire to go back to war. Each month of psychiatric residency training brought a new assignment and new things to learn and places to see. However, after about 6 months of working in the same office at Fort Drum, living in the same place, and having the same job, I was feeling restless.

I was originally supposed to go to Afghanistan in the spring of 2014 but this was pushed back to September of 2014. However, that summer it seemed like my deployment may once again get delayed. It was at this point that I started feeling a frantic need to deploy and made contact with my branch manager to advocate for myself in a desperate hope to deploy in September 2014. One of the happiest days of my life was in late summer 2014 when I found out that I had a confirmed "Battle Roster Number" which meant that higher headquarters had identified me to deploy.

When I left for Afghanistan on 20 September 2014, I expected that my main duty would be to serve as a clinical psychiatrist. I anticipated that I would be performing psychotherapy and prescribing medications just like I did at home, but in a more

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austere environment. Little did I expect to be the sole Army Psychiatrist in theater and responsible for guiding and shaping policy for the largest troop drawdowns since the end of Operation Iraqi Freedom.

When I first arrived at Bagram, there were four Army psychiatrists in Afghanistan and an approximately sixty personnel strong Combat Operational Stress Control Unit (COSC). A description of how Behavioral Healthcare was provided to our soldiers in Afghanistan in the fall of 2014 follows. The vast majority of US Forces were concentrated at about ten Forward Operating Bases (FOBs). Some of the individual units had brought with them their own Behavioral Healthcare Officers (BHOs) who were either Clinical Psychologists or Licensed Clinical Social Workers. These are the BHOs which we called "organic", as they were directly assigned to the unit they were responsible for providing Behavioral Healthcare for. They were not expected to provide Behavioral Healthcare to soldiers who were not assigned to their unit. There were five of these organic BHOs in Afghanistan in the fall of 2014.

All of the other US Forces in the theater had their behavioral healthcare provided to them by my unit, the 528th COSC out of Fort Bragg, North Carolina. We took care of all the US troops without their own organic support. In order to accomplish this mission, we were responsible for three primary tasks—Traumatic Event Management (TEMS), Prevention, and Treatment.

The first of these tasks, TEM, was what we did in response to a significant event which involved loss of life to or near loss of life to US Forces. In most cases, a team from the COSC consisting of a BHO and an enlisted Behavioral Health Specialist, would go directly to the affected unit wherever they were located, and provide counseling and education to help the unit members cope with their recent loss.

Before I deployed to Afghanistan, I had a preconceived notion that humans are resilient and that there was no evidence base suggesting that TEMs improved behavioral health outcomes. This viewpoint changed dramatically after I actually was responsible for directing the COSC's TEM response. When a soldier dies in combat, the effect on the unit members is profound. Immediately after a TEM, our COSC prevention team provided a critical source of support to the affected units. I was amazed by how strongly commanders wanted behavioral health intervention for their units after a traumatic event and by how positively soldiers viewed our response.

I believe that our TEM mission helped soldiers to feel that what they were suffering through emotionally was expected, important, and that the command cared about how they were feeling. It was also a truly rewarding experience for the BHOs tasked with conducting TEMs in that we had the special opportunity to help our fellow soldiers cope with the acute feelings they were having after their painful loss. I learned that TEMS is so important because it provides us, as warriors, an opportunity to grieve and comfort each other in our shared loss.

Ensuring prompt and adequate TEMS response is probably the most important mission of the COSC not only because of the impact it has on the affected soldiers but also because of the effect it has on the COSC BHOs. Whenever a soldier was killed in theater, we all knew about it, and we all grieved as a result. Our level of grief was undoubtedly less than that of the affected unit members but engaging the unit with TEMs allowed us to redirect our emotions towards altruistically helping our fellow service members grieve.

The second task, Prevention, generally consisted of being actively involved with the individual units to ensure that they were aware of the Behavioral Healthcare available to them while also decreasing the stigma associated with seeking care. The COSC prevention team would try to make frequent appearances at morale events on FOBs, as well as ensuring a presence throughout the FOB at areas of high foot traffic like Dining Facilities. The prevention team would also be called on by commanders to perform Unit Needs Assessments where they would survey the unit and provide feedback to the commander about the state of the mental health of his or her unit.

I felt that probably the most important part of the prevention mission was to ensure that everybody on the FOB knew what resources we offered and also how to access them. In addition, by calling ourselves "Combat Stress," and not "Behavioral Health," we were able to decrease the stigma that prevents soldiers from seeking Behavioral Healthcare in garrison. The presence of BHOs in units and a strong media campaign on the FOB helps soldiers to realize that combat is emotionally taxing and that it is not a sign of mental illness to seek help.

The third task of the COSC is our traditional Behavioral Health treatment mission. In keeping with the combat mentality though, we referred to treatment in Afghanistan as "warrior restoration." A combat stress control clinic in Afghanistan in the fall of 2014 was surprisingly similar to an outpatient garrison community behavioral healthcare center.

The clinic at Bagram consisted of a concrete hardened building about 1500 square feet in size. We were lucky in that we were there so late in the conflict that the structure was built to withstand artillery fire, so that when we received incoming indirect fire we continued our mission without interruption. When you walked in the front door there was a small waiting area with couches and a large flat screen television showing movies. The front desk was usually manned by an enlisted behavioral health specialist who would check the patient in on the computer system and secure his or her weapon. When it was time for the patient's appointment, they would come into the back of the building where we had small individual offices to see the patients. The building was heated, air conditioned, and usually had a better supply of coffee and chocolate bars than most community mental health centers in the USA. Clinically, we essentially performed the same type of assessment and treatment that we did in garrison. I discuss later in further detail the unique clinical challenges we faced during troop drawdown in the fall of 2014.

In October 2014, we closed our Warrior Restoration Center. The Warrior Restoration Center was an inpatient psychiatric unit modified for a combat environment. Unlike a regular inpatient psychiatric unit where a patient would stay until his or her symptoms were adequately improved, the Warrior Restoration Center was designed for a fixed 5-day stay. Patients would be admitted on a Monday and leave on Friday. Each cycle would consist of about 5–10 patients.

The purpose of the Warrior Restoration Center was to allow service members whose psychological coping mechanisms were acutely overtaxed to take a respite from the stress of their day to day combat operations and focus on behavioral healthcare treatment. Patients were admitted to the Warrior Recovery Center with the expectation that at the end of their 5-day stay they would be able to return to full duty with their unit.

Much like an inpatient unit, patients at the Warrior Recovery Center spent most of their day engaging in a full spectrum of behavioral healthcare to include individual psychotherapy, medication management, group therapy, occupational therapy, recreational therapy, and spiritual support from the Chaplain Corps. At night they remained at the Warrior Recovery Center and stayed in barracks style rooms. The Warrior Recovery Center served as an important treatment modality to rehabilitate patients in order for them to remain deployed and combat effective.

With our number of COSC personnel dropping from approximately 50 down to 10, we no longer had the staffing available to man the Warrior Restoration Center and so we were forced to close it. At this point, we were left with a limited range of treatment options. The first option was routine outpatient care. For most of the patients this was a reasonable option and we were able to see patients on a weekly basis, or even sometimes three times a week, if they needed it. However, at this point, I had to make a theater wide decision on how we would treat our soldiers that were suffering from a more severe burden of mental illness.

Probably the most significant thing that made managing psychiatric patients in a combat zone very different, from those outside of a combat zone, was that every patient was carrying a weapon at all times with a full magazine of ammunition. The fundamental question that every BHO had to ask themselves when treating patients was, "Do I feel comfortable letting this soldier carry a weapon?"

When soldiers presented with suicidal ideation, plan or intent, this was not a difficult decision and we would promptly notify the soldier's commander that the soldier should not be allowed access to weapons. As one could imagine, the answer to this question was not as clear cut in other cases.

What should a provider do, for example, if a patient was having angry outbursts, poor yet not clearly dangerous judgment, or unsubstantiated collateral information that the patient had made some form of self-injurious statement or gesture? Complicating this decision was also the fact that when a soldier is not allowed to carry his or her weapon in a combat zone he or she immediately becomes identified to the rest of his or her unit as not being mentally healthy.

In garrison, soldiers can come to behavioral health without most of their unit knowing. As soon as a soldier is observed without a weapon in Afghanistan it is immediately known that the person has been judged to be a threat to themselves or someone else. In many ways, this carries a high level of stigma and shame for the soldier that is not allowed to carry his or her weapon. This burden of shame and stigma can then be relevant in the patient's recovery.

The most challenging part of my mission in Afghanistan was leading soldiers in combat. When I deployed, I expected that I would be serving primarily as a clinician and was held responsible for only myself and my patients. On arrival to Bagram, I was introduced to my COSC commander, another Army Major, and saw how busy she was leading the soldiers, managing administrative duties, and performing battlefield circulation. She was an excellent commander and freed me to focus on managing just the clinic and Bagram and performing my clinical duties.

In November of 2014 we were notified that as part of the troop drawdown, most of the non-clinicians assigned to the medical task force were being forced to redeploy.

This meant that my COSC commander was redeploying. As the highest ranking officer in the COSC left in theater, when my commander redeployed, I was officially designated the Office in Charge of the COSC.

In the Army, a leader with the title of "Commander" has special legal, tactical, and administrative powers over the soldiers he or she commands. As a result of the transformation of the configuration of my COSC, when my Commander left, I was left with almost all of the duties and responsibilities of command but without some of the powers that the title of Commander would have carried with it. I initially saw this as an obstacle because I could not directly take action against one of my soldiers under the Uniform Code of Military Justice. In hindsight though, it helped force me to become a better leader.

With my experiences as an enlisted combat artilleryman, West Point education, and time as an active duty Military Intelligence Officer, I was at first overconfident that I had all of the training and experience necessary to lead the COSC. My previous combat experiences had left me with a profound sense that effective combat leadership required a combination of stringent enforcement of all standards and a persona of bravado and aggression.

During Operation Iraqi Freedom, I had observed that there were many soldiers who became so frightened by the enemy threat that they were combat ineffective. I saw leaders who never displayed fear and frequently used threats of violence and aggressive posturing towards their subordinates as a way to inspire their soldiers to complete their combat mission.

There was a soldier in the unit located next to mine at our camp in Iraq that it was rumored had refused to go outside the wire on missions. His nonjudicial punishment was 18 h a day of hard labor. I observed him in the hot Iraqi sun breaking rocks, crying frequently, digging holes, and then filling the holes he had just dug back in with dirt while simultaneously being cursed at and berated by his fellow soldiers.

My experiences in Iraq immediately came forefront into my mind when I found myself in charge of my unit in Afghanistan 13 years later. I remember I was having a severe amount of indecision on how to proceed in dealing with one of my Behavioral Health Officers who I felt was being oppositional towards my directives. How to proceed with this leadership challenge had been consuming my thoughts for most of the previous day and night. I found myself on my daily morning run around Bagram ruminating on my different courses of action. I thought about all of my previous leaders in the Army and how they had conducted business.

I thought about my company commander while enlisted ripping off a private's rank in formation in front of the entire company as a form of public humiliation. I remembered my Tactical Officer at West Point explaining that how he prevented any major misconduct problems in the company was to take away people's weekend passes for minor infractions like socks that were too short. I remembered my Officer in Charge at Ft. Huachuca Military Intelligence Officer Basic Course making veiled threats towards Lieutenants referencing his combat experiences with terms like "I will shoot you in the face."

I remembered that minor deficiencies like falling behind during a unit run were dealt with by a counseling statement that always included a few sentences that

continued poor performance could result in a courts martial or separation from the service. I asked myself, "How would the leaders I look up to handle this situation?" Based on my previous experiences my answer to myself was that I should immediately proceed with formal counseling, threats of courts martial, and strongly worded negative performance statements on an official document.

Luckily I had my colleagues to discuss my planned course of action with. I sent two of my trusted colleagues the counseling statement I was prepared to give my BHO and asked for their feedback. Their response was that I should not proceed and that the counseling statement sounded excessively derogative and demeaning. This feedback, or as I like to call it "sanity check," from my colleagues was critical. I started thinking about my leadership style that I had been using for the last 5 years or so with my medical profession subordinates.

An Emergency Room physician mentor of mine once told me that a good physician should strive to be affable, available, and able. I had been making those three characteristics my primary goals since medical school and they had always seemed to be more than adequate to complete my mission of taking care of patients. This brought me to the realization that medical service soldiers were a very different type of soldier than combat arms soldiers and both required and deserved a different type of leader.

As a result of my Afghanistan experience I firmly believe that medical soldiers are absolutely the best soldiers in the world. They may not be able to ruck march up as steep of a mountain nor employ violence as effectively as combat specialists, but they have an internal sense of dedication to duty that far exceeds that of other soldiers. I realized that my fellow Behavioral Health Officers and enlisted personnel were just as deeply committed to caring for their fellow soldiers as I was.

When there was a traumatic event anywhere in Afghanistan or an upset soldier knocking at our door asking for help, I knew that my COSC personnel would let no barrier prevent them from helping that soldier. When I was in the Field Artillery in Iraq we were going outside the wire every day with the constant hazard of being shot or blown up. We performed our mission in large part because of the sense of discipline imposed on us by our leadership. We felt that our daily mission in the streets of Baghdad was strategically and operationally unimportant, so it required strict discipline and tough leadership to keep us motivated and combat effective.

What I realized though with medical soldiers is that they do not need as much discipline imposed on them from leadership because they knew that their day to day mission was important and critical in providing behavioral healthcare to our fellow soldiers. It felt like a massive paradigm shift for me to realize that I did not have to treat my behavioral health personnel like artillerymen to keep them combat effective because they were innately combat effective. Knowing that there is a fellow soldier who needs behavioral healthcare inspired my subordinates to brave any conditions and conquer all obstacles to complete their mission.

I did not have to be overly zealous in enacting discipline because my behavioral health officers had all of the preexisting internal motivation and discipline they needed. I think all healthcare providers are unique in their compassion for their fellow human beings who are experiencing suffering. They also have more discipline than other

profession because a medical mistake can mean death. It is those intrinsic characteristics of compassion and discipline that make medical soldiers the best soldiers.

I expected to have better intelligence. I expected that when I took over as the Theater Behavioral Health Consultant, I would have a clear understanding of how my unit and our coalition maneuver units were arrayed across the Area of Operations. During my training at West Point and my experiences as a Military Intelligence Officer I had grown very accustomed to having up to date schematics of the location and composition of friendly forces with which to plan operations.

As the Theater Consultant and Officer in Charge of the COSC it was my responsibility to position my limited behavioral health assets across Afghanistan in a manner that would provide the most effective coverage in proximity to the maneuver forces that we were supporting. My initial thought was that I would be able to easily obtain intelligence on where our forces were and based on that be able to anticipate the amount of behavioral healthcare assets I would allocate to different parts of Afghanistan.

I asked the Theater Consultant and the COSC commander that I relieved if they had access to this information but they did not. I then inquired up to the commander of my medical task force as well as the chief theater surgeon if they could provide me with the intelligence I was looking for. Once again, I was unable to obtain any further information. Our higher command, Central Command (CENTCOM), also had extremely limited visibility on what was happening in Afghanistan. In fact, it was the CENTCOM theater consultant that would ask me for updates on our Behavioral Health forces in Afghanistan for his situational awareness. I quickly realized that medical assets did not have much communication with the other combat forces engaged in Afghanistan.

Our medical task force and my COSC were essentially responsible for finding out on our own what was going on in the area of operations and determine where we were needed. I had inherited from my predecessor an email list of the Behavioral Health Officers in theater as well as a map of where they were distributed. It was up to me to keep that up to date and ensure that Afghanistan has adequate behavioral health resources located in proximity to where they were most needed. I found that the best way to conduct battlefield intelligence was by picking up the phone and calling the other medical providers in the theater to find out what their tactical situation was where they were located.

Each Forward Operating Base had at least one forward surgical team or medical treatment facility and it was by talking to the medical providers at these facilities that I maintained an understanding of what was going on in the theater. They were the ones who told me what kind of patient volume they were seeing, how intense of combat the units in their area were engaged in, and whether or not they needed additional behavioral healthcare support.

It would seem that this method of conducting planning for wartime medical operations would not be efficient or effective. One would think that with all of the technology and resources that were strategically oriented towards the fight in Afghanistan we would have had a more efficient intelligence and operations system. However, in hindsight, I feel that we did in fact have enough of the primary resources that we needed.

That resource was the dedicated professionals and warriors that I worked with. I found that technology and centralized command and control is no substitute for a team of people that work together to accomplish a common mission. All of the officers I served with were always willing and ready to share information with me and I did the same for them. The theater surgeon, medical task force, and organic healthcare providers all worked together to keep each other up to date so that we could accomplish our group task of providing healthcare to the individual warfighter.

The medical mission was very much a reactive one in that we would notice an uptick in casualties and then request additional assistance if needed. Or, if we noticed a paucity of patients, we would volunteer to help out and relocate to other locations in theater. We worked together, we communicated, and were always willing to help each other out.

Prior to my Afghanistan deployment, I had believed that all military operations were facilitated with extensive intelligence information and executed with detailed operations orders—almost like a more complex version of moving pieces on a chess board. As theater consultant I realized that our medical task force and COSC operations were conducted on a more personal level and that word of mouth was our primary asset. This goes back again to what I realized about leading individual medical soldiers—we know that our task is to help wounded soldiers and we do what we need to do in order to make that happen. All that myself, and any of the other medical leadership in theater needed was to know who needs help and we made it happen.

Most behavioral health providers are very cognizant of the laws, legal precedent, and regulations that govern how they practice. In Afghanistan, I had the responsibility of interpreting the military regulations and providing guidance to the BHOs in theater on how to practice. This resulted in me having to make some significant decisions that would have a large impact on all of the service members receiving behavioral healthcare throughout the theater of operations.

Outside of the combat zone, Army BHOs generally practice in a manner similar to their civilian counterparts. In garrison, BHOs manage service members with complex diagnoses, severe mental illness, poor prognoses, and at high risk of harm to themselves or others over long time periods and with the assistance of a robust Behavioral Health support network.

However in Afghanistan we had extremely limited psychotherapeutic treatment options, medications, and staffing. The first major difference between care at home and in Afghanistan was in regards to homicidal threats or voiced ideation. In the USA, it is generally accepted that people who express homicidal ideation and feel that they may not be able to control their impulses to hurt others can and should be evaluated and treated in behavioral healthcare. This frequently means inpatient admission or psychiatric commitment for the patient with homicidal or violent impulses.

In the combat zone, I took the precedent set by the previous Theater Consultant and directed that all homicidal or violent threats or actions would be treated as a criminal act and not a Behavioral Healthcare symptom or problem. This meant that the theater policy I established was that all soldiers who had physically threatened someone or voiced homicidal ideation should be referred to the Military Police prior to any behavioral healthcare evaluation.

This resulted in a couple of cases in which I had to tell commanders that if they wanted their soldier evaluated by Behavioral Health following an incident where the soldier threatened someone then the soldier would only be allowed into the Behavioral Healthcare clinic if restrained in handcuffs. While this policy may seem extreme to civilian of military behavioral healthcare providers in garrison, it is a good example of how the combat mission of deployed BHOs resulted in them having to make significant changes in how they practice.

The second major decision I had to make was how to interpret our MOD-12 guidelines of expeditionary fitness for deployment to the Central Command (CENTCOM) Theater of operations. When I first got to Afghanistan, my initial read of the regulation and interpretation of it was that it applied to soldiers coming into Afghanistan but that once they were there, it provided no specific guidance on how they should be managed in theater.

I discussed this with the outgoing theater consultant and he convinced me that MOD-12 applies to soldiers while in theater. Interpreting the regulation in this manner meant that any service member who had a severe enough burden of mental illness that they would need more than one visit to behavioral healthcare every 3 months did not meet the standards of expeditionary fitness and would be referred for medical evacuation back to their home duty station.

This is another example of how dramatically different practicing in Afghanistan was compared to garrison. Most patients in a garrison Behavioral Health Clinic require much more frequent visits than quarterly to maintain adequate functioning. In combat though, a soldier could be reasonably expected to have to go to a remote location for an extended period of time and perform their duties without behavioral healthcare intervention. These operational requirements were what I had to take into account when interpreting regulations and set precedent throughout the theater.

The most emotionally difficult part of my deployment to Afghanistan was redeploying back to the USA. I will never forget sitting on the plane flying out of Bagram looking around out the fellow members of my unit that were also on the airplane. I was filled with so much pride at everything they had accomplished. I did not want to see them disperse back to their home duty stations. They were the finest soldiers I had ever had the honor to lead and serve.

Major Peter Saulinus Armanas is an Active Duty Army Psychiatrist. This chapter focuses on events of his deployment to Afghanistan in 2014–15 and how he perceived it in light of his previous experiences.

Last of the OSCAR Psychologists in Afghanistan: An Expeditionary Model of Care

21

Jesse Locke

"Where have you been? The MEF has been calling looking for you. They have been calling all morning. You are supposed to check in today. You are going forward with them." Welcome to the Marines. That was how I was greeted as the new Operational Stress Control and Readiness psychologist for First Maine Division at Camp Pendleton, a large Marine Corps base north of San Diego. There were a few problems. I didn't know what a MEF was, where I was supposed to check in, or what it meant that we were "going forward." Forward, I asked? It was my first day.

I stood slightly uncomfortable in the woodland digital camouflage of my new Marine uniform. Up until now, I usually reported for work dressed in the Navy officer's khaki uniform. Not too long ago, there had only been civilian clothes … facial hair too. I joined the military after attending graduate school in the San Francisco Bay Area, about as far from combat as it is possible to get, both physically and intellectually.

Nearing graduation, I looked through the options for internships. I knew I wanted a hospital setting so I could use their rotations as a way to get the most experience in the shortest amount of time. Not wanting to miss out on an internship by being too narrow in my choices I applied to both the civilian and military hospitals listed.

When the Navy flew me down to San Diego and interviewed a group of us, what stood out the most was meeting the current interns. At that time I did not realize that they had only been in their position for a few months. They were an impressive bunch. They were confident, looked sharp in their uniforms, and it was clear that they had a level of responsibility and independence that would be hard to match anywhere else. Being an athlete my entire life and confident in my abilities, I could relate to these young Naval Officers. I wanted to be where they were.

The Navy took me and trained me. I was selected and moved to Bethesda to start my journey as a lieutenant. After a year at the Naval Hospital in Bethesda I moved to Great Lakes, the Navy's only boot camp north of Chicago, to work screening

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Navy recruits. I was so busy that it felt as though I had given a career's worth of patient care in just 3 years. I had learned a lot, but I was treating Sailors in the comfort of a clinic setting. My next job assignment, the one I just started today, was with the Marines, who rely on the Navy for their medical care. It was like learning a whole new culture with a new language to boot.

"Marine Expeditionary Force," someone kindly explained the meaning of MEF. "That's the command element. Building's over there."

"And, 'going forward'?" I asked for further linguistic assistance.

"Afghanistan."

That was clear enough.

I knew this was coming eventually. It was what I had signed up for. My assignment was as the Operational Stress Control and Readiness psychologist, or OSCAR. The idea behind an OSCAR job is that a mental health provider embeds with infantry units both on base and while deployed. Instead of stressed Marines, and their guns, being pulled off a small base to visit a psychologist, the OSCAR provider goes to them (Fig. 21.1). Since no one has to abandon their post to ask for mental health care, this reduces the stigma of seeing a shrink. It also keeps more of the fighting force where they are needed most. As far back as the First World War, Doctors noticed that the farther back from the front line service members were treated, the less likely they were to return to their unit [1].

The final part of the job, the part I was still missing that first day, was that an OSCAR provider was supposed to fit in with the Marines. A Navy officer, and particularly a psychologist, can be an alien creature on base. In OSCAR, we wear the Marine Corps uniform and are trained to have an understanding of the Marine Corps organization and culture. This goes beyond just fitting in, because one of the first things you learn about the Marines is that it isn't all about the individual. Decisions and recommendations

Fig. 21.1 Preparing for a convoy to meet Marines at a small isolated outpost

have to be in line with both patient care and mission accomplishment and at times the latter takes precedence. You have to know who you work for.

Three months and a crash course in Marine Corps culture after getting lost my first day at Camp Pendleton, I would find myself moving forward on the mission. With three bags and an automatic rifle over my shoulder, I boarded a plane for a year combat deployment to Afghanistan. It was exactly what I had been looking forward to since I joined the military.

I had been trying to deploy since 2010. Three previous opportunities arose and then faded away. I was disappointed each time those orders came and went. I had wondered if I would ever get the chance to test my skills in an environment where the need was high and the stakes were even higher. I was nervous, but ready.

I started putting that Marine Corps lingo to use right away in Afghanistan. I was flying around the Area of Operation (AO) in helicopters, convoying in the MRAP or Mine-Resistant Ambush Protected vehicles (think HMMVEE on steroids), and, patrolling to Forward Operating Bases (FOBs), smaller Combat Out Posts (COPs), and the smallest outposts of all, Patrol Bases (PBs). Sometimes treatment would need to take place in bunkers or in between HESCO barriers (boxes filled with sand to stop bullets and shrapnel) (Fig. 21.2). Even in the drab of desert living, I was adapting to the life of "Green Side," what the Navy calls it when you are embedded with the Marines.

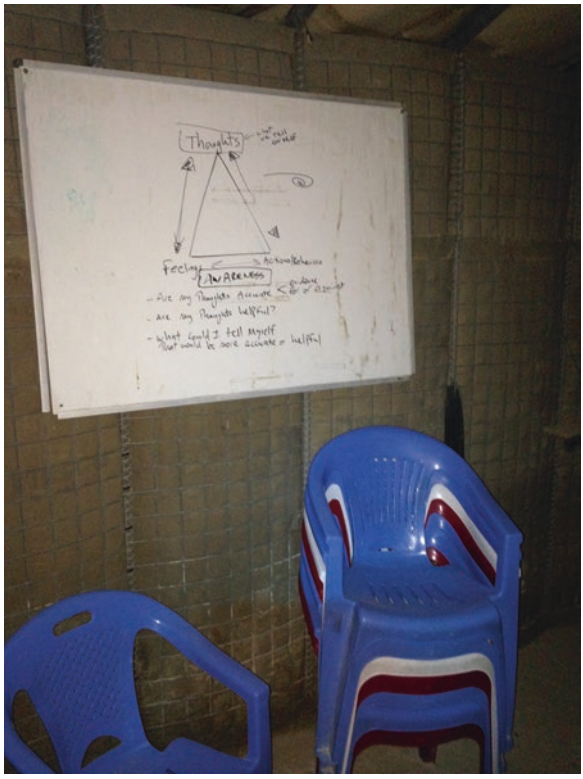

Fig. 21.2 A CBT lecture against the HESCOs

There was an element of fear, but also excitement. I was doing things those working in an outpatient clinic or community mental health agency could never imagine. I drank tea with Afghan National Army doctors, lifted weights with real life warriors in the dusty heat of the Afghan desert, and carried an automatic machine gun (plus pistol and knife) at all times.

When I arrived at Camp Leatherneck in January of 2014, the main Marine Corps base in Southwestern Afghanistan, combat operations were winding down. Infantry battalions and advisor teams were still spread throughout the Area of Operations, but the smaller FOBs were being closed regularly. At one point, a few weeks before the very end, I commandeered a jeep and drove around Camp Leatherneck for 10 min without seeing a single person.

The Marine Corps mission at this point was twofold: shutting the base down, and helping the Afghans to function independently so things didn't fall apart when we left. We were reversing a trend. Previous waves of coalition forces had been focused on building the base up. All the units that went before us knew that someone would be there to relieve them, that there would be someone to whom they could pass everything over. We did not have that luxury. We had to account for everything, to minimize, to leave as little as possible behind, and to use even less while we were still there. Do more with less was the theme of the overall mission.

For the mental health team, the practical impact of this drawdown was that we had fewer people to do the work. Previous OSCAR providers had a psychiatric technician (psych tech) to help them. These are enlisted members who, while lacking the years of formal schooling of a psychologist or psychiatrist, have special training in providing mental health to the military. They also often have the general military street smarts to assist with travel, "tactically acquire" things, and mix with the enlisted to provide education about psychology that doesn't sound like the droning on of an officer, something most enlisted are used to tuning out. I had no psych tech. I had to figure out how things work from the bottom up, but it made me incredibly independent.

"And you are now the division officer for medical," a senior officer in the medical department informed me.

A division officer is a type of middle manager, not necessarily the highest ranking person on a team, but nevertheless in charge of the day-to-day operations of a military functional unit. My unit was the medical clinic and staff: doctors, Independent Duty Corpsman (IDC), and your salt of the earth, jack of all trades, General Duty Corpsman … Corpsman for sort. I was now a clinic head. Everyone had to wear multiple hats.

My main hat was to meet the mental health needs of the individual Marines and Sailors as well as to ensure unit wellbeing and functioning. Even this was really a multitude of jobs. Four days a week, I maintained what passed for a normal clinic at Camp Leatherneck. The other 3 days were spent traveling to small, outlying bases. This was called Battle Field Circulations or BFC.

I spent most of my time on BFC trying to break down cultural barriers. This was the idea of OSCAR, that we could reduce stigma by simply being there and hanging out with as many people in as many situations as possible. Was the psychologist there just chatting, or doing therapy, or talking about the overwhelming stresses of

being at war? Who knew? And that was the point. Regardless of how many Marines and Sailors I saw formally, I always saw Marines and Sailors informally in the smoke pit, gym, chow hall, shooting range, etc. We talked.

Away from a clinic, service members felt more comfortable opening up about the serious things. We would talk about home, about their current deployment or prior deployments. The conversation might flow from the last argument they had with their girlfriend to the time they were blown up on a convoy. Did they need to come to a formal mental health clinic for an appointment? Probably not, would they if they needed to … probably not.

> I'm fine Doc, but let me tell you about this thing that has been on my mind.

Many of the service members with whom I interacted had issues that were not what I had trained for in graduate school. There was no opportunity for formal psychotherapy in the desert environment. Typically, the Marine or Sailor just needed to know that someone had listened. Sometimes they needed practical interventions, something as simple as recommending that they take deep breaths when they were stressed.

Other times they needed an intermediary, for me to suggest to their chain of command that a Marine having trouble getting along with his peers be moved from the day shift to nights. Rarely, they needed more intense medical care. In those cases, I would work with the military physician to get a patient started on a medication, or to have him transferred to a larger base for more regular follow-up. I did as much as I could in the limited time we had.

This way of doing things wasn't my idea alone. Moore and Reger [2] described this same model of simple and rapid intervention in order to preserve the fighting force. They coined the term "one-shot" interventions to describe how help could be rendered in remote locations that lacked access to regular mental health care. Everyone, it seemed, discovered this idea on their own.

I always had to be on the move. Beyond giving me access to more service members who needed help, this also gave me an appreciation for how my patients lived. My home base, Camp Leatherneck, had seemed austere to me when I first arrived. I quickly learned how good we had it. People who lived off the camp affectionately termed the main base "Pleasure-neck" because of all the great amenities: hot showers, air-conditioned workspaces, Wifi, fresh food, and walls … big concrete ones. In the small bases—the FOBs, COPs, and PBs—these simple luxuries were not taken for granted.

When I traveled I packed light and slept in whatever space was offered. Usually these were the spartan facilities called transient quarters. That is a fancy name for tent and a fold-out cot in the desert. These minimalist hotels were saved for the infrequent visitor, perhaps a contractor there to fix a security camera or generator. They were not comfortable, but I could leave. Every few days, I would regroup and heading back to "pleasure-neck" for a hot meal, hot shower, and cool bed. The service members left behind were not so lucky.

Because my own time on the small bases was so brief, I found that much of my job was not providing the psychological care, but rather teaching others how to do it. Most bases are too small to rate a psychologist. A few might have a general

medical officer, what the military calls GMO's. Others were served by a physician assistant, an officer with 3 years of medical training or more. Most health care, for problems physical and emotional, is provided by Navy Corpsman. Corpsmen are enlisted staff with 19 weeks of formal medical education, plus whatever on-the-job training they get in the field. Real life, especially in war, can be quite the educator.

If the OSCARs are embedded, the Navy Corpsmen are *implanted*. They live, sleep and breathe in the same tents as the Marines they care for. They also fight, going out on combat patrols, often multiple times a day. Navy Corpsmen learn a great deal of medical intervention for combat trauma and have saved countless lives on the battlefield. With a heavy focus on the physical nature of combat, few Corpsmen have had any real training in identifying psychological distress, or in what to do about it when they find it.

Lack of formal training didn't mean Corpsmen didn't treat psychological injuries. One Corpsman in our AO spotted a Marine acting oddly and got him to the medical officer just before a full scale psychosis set in. Similar was a story about a Corpsman who noticed a Marine isolating himself, only to find out after engaging the person in conversation that he was depressed and suicidal. The night before the Marine had the barrel of his M16 in his mouth and his finger on the trigger.

I thought it was imperative to insist that the Navy Corpsman would not only be there for the bullet wounds, but for the "emotional stuff" as well. The Corpsmen I met seemed interested in learning about psychology. Perhaps it was just that they were looking for something to do with the long, boring hours, between patrols or sitting in the aid station while waiting for the terror of the next casualty, but I was always impressed by their eagerness for knowledge.

I focused my lessons on simple cognitive-behavioral concepts. Cognitive Behavioral Therapy, or CBT, is a pretty usable and easy to understand method for psychotherapy. It teaches how to use logic to question false beliefs that can lead to distress, and to change behaviors that aren't psychologically healthy. No one has time in a combat zone to dive into the Freudian unconscious intrapsychic conflict, but, no matter where you are, helping someone to stop beating themselves up for something they can't change or control is a useful thing to do.

Getting buy-in about the connection between thoughts, emotions, and behavior was essential to empowering the Corpsmen to help others. Other lectures focused on assessment of psychiatric conditions like Major Depressive Disorder, Generalized Anxiety, Post-traumatic Stress Disorder and other common mental health diagnoses. These lessons focused on being applicable to the current environment and situation, but also were relevant for when they came home.

If a Corpsman had a question about why it was important that we assess for alcohol use in a place where no one had access to booze, the answer was that we would be the same people seeing these Marines when they return from the deployment. I wasn't going to see these Marines on the plane ride home, but the Corpsman would. He would probably go to the parties that celebrated the homecoming, and hangout with the family members of the Marine at a barbecue who noticed that the man they sent to war wasn't the same as the person who came back. It would be the Corpsman, probably living in the barracks, who could stop things at the first drink rather than the DUI or drunken brawl.

It was clear why the embedded providers are so essential. An insider always has more impact than an outsider. No one has the ability to build rapport like embedded providers. Because of that, we have a greater responsibility to help.

Help is sometimes difficult to accept, however. There is a saying in medicine that there is no help without harm, and although we leave no surgical wounds with our treatment, the great enemy of military psychology is stigma. The dictionary defines stigma as a mark of disgrace associated with a particular circumstance, quality, or person, and the Marines will have no dealings with disgrace.

I found stigma to be a self-perpetuating process. By this I mean that the military has a fear of disgrace in revealing any mental health problem, but also that mental health providers have a fear of military judgment, and each feeds on the other. There is still a widespread belief in the military that if a service member seeks help he must be weak, or malingering to get out of something. This causes a fear that going to talk to a psychologist will end a career, which leads people to hold out until they are at their breaking point before coming in for help.

To try and save the careers of some, or perhaps just to hide from the Marines sideways glances, mental health providers are often very secretive about their work, beyond the ethics of confidentiality. We only inform superiors when the situation is hopeless and someone needs to be sent home. Thus the only interaction the command has with mental health providers is about people who are "broken."

So what is the natural conclusion of those in command? Anyone who sees mental health is weak or trying to get home, and mental health providers are weird little wizards who sit in their caves before popping up to make someone disappear. This is a terrible way to be perceived by leadership, one that does not engender trust and teamwork, but is exactly how they see you when you hide in your office all day long.

My trips to the smaller bases helped to change some of this. I would often talk to someone, and that was the end of it. The service members who talked to me weren't tainted or sent home. They had just had a conversation. I like to think that I seemed a little less weird, or at least less mysterious, when people had seen me a few times. The psychologist wasn't a strange witch doctor in a cave. He was just another guy in a Marine uniform, willing put himself in harm's way to help, and who popped into the base from time to time.

One Marine from a small and very active patrol base stopped me in the chow hall on Camp Leatherneck and said, "Hey, do you remember me? I was the guy waiting for the helicopter with you a few weeks ago."

I did remember him; his risque jokes were hard to forget. We ate lunch together and chatted about his deployment and his apprehension about life after Afghanistan. He had been in combat steadily for 5 months. Now he was going home, and somehow this seemed scarier than getting shot at every day. He hadn't talked about this in the helicopter, but now I wasn't only the psychologist. I was someone he had met on his home turf. Now he could talk about those fears without fear. Nothing he had on his mind was overly concerning; just the kinds of things 18-year-olds do not feel comfortable sharing, especially not with other war fighters. I like to think that lunch together was helpful.

Not all doors opened up so easily. Within a few months I had traveled to all of the bases around the Area of Operation except one. Although successful in general, I was still unsatisfied. My predecessor did not have access to this base, either, but I felt a void by not regularly having a presence there. I was determined to get in, to be seen as an asset.

I started trying to gain access by reaching out to their medical staff. This was the standard way of things. Work within the system that knows you. This time, however, I got no answers. The standard chain of command was not hearing my plea. After a couple of weeks of attempts to get invited to the base, I was told that the physician's assistant, or PA, out at the small base did not want me, or at least the concept of me. OSCAR was not welcome.

I knew of this PA. Several of his Marines were my patients at Camp Leatherneck. Most of them were angry about it. According to their version of things, the PA's standard procedure was to send anyone with a mental health issue away. The Marines who had asked for care would land in Camp Leatherneck, where their only duty was to count their days until they were sent back home. Even though they were still physically in Afghanistan, they didn't feel they were contributing. They felt trapped and useless, and this just made everything worse.

Regardless, this process seemed to be working for the PA. There were no mental health problems lingering on his base. His Marines were all still in the combat zone so his numbers looked good. The idea that something could be improved was not on the top of anyone's list, especially if it meant breaking from routine. Routines during a deployment are like the glue that keep most people together for months on end and thus are hard to change without upsetting even the most hardened of men.

I do not intend to paint the PA as the villain here. He was hard working and in a hard place. He had seen combat, and was still seeing it daily, in a place where others were getting hot showers and Wifi. The whole base had had negative experiences with battle field voyeurs—this may seem impossible to others, but officers would show up unannounced to these small outposts with the intention of "seeing some action." These interlopers posed great dangers, but rarely offered real help. The PA and those on his base also had a strong us-against-the-world mindset engrained by living in harsh conditions, and cemented by multiple exposures to combat and loss. It was almost like a form of PTSD for a whole base, with mistrust well earned.

Changing the status quo in any system or organization is never easy. The assessment that the base did not want me there was accurate. It was not personal. They did not want any outsider. They did not want what the Marines coined "an eater and a shitter" or a person who used resources without offering anything useful in return. If you didn't have a purpose they didn't want you.

I did have value to add and a purpose and I also wasn't giving up so easily. I introduced myself to the PA via e-mail. The medical clinic at his base at least could still receive this form of communication. His response was terse. There was no reason why I should visit, although he clearly didn't understand what I did, he had no problem saying there were no "OSCAR related issues." No one had ever visited before and everything had been fine. So why start now? We engaged in additional email exchanges over a span of weeks until he said that he would reconsider after he

returned from a 2 week mission. Since this was not the first time this had happened I felt that he was avoiding me. I was getting nowhere.

Frustrated, I tried a different tact. I contacted the senior military combat officer on the base. Perhaps he saw a need where the PA did not. True to typical Marine Corp loyalty, however, he was sticking by his own. The officer said that he would follow the recommendation of his medical provider, the PA. However, he did make one concession. He would allow a single, 4-h visit so that I could familiarize myself with the one base that had hitherto been a blind spot in my radar. I jumped at the chance.

Although I packed quickly, no visit was going to happen before the PA learned of it. He was not pleased. He told me to "PLEASE BACK OFF," in the yelling script of military e-mail. I had gone behind his back he said, or worse, "above his head," a strict taboo in the military culture of chain-of-command. He further asserted that I was being counterproductive. Now I was the stressor.

I wrote back that I appreciated his position, but that I did not have to get his permission to do my job. In hindsight, that might not have been the best of wording, but after months of struggling and staying persistent I finally had everything in place. I wanted to work with the PA if I could, but, regardless, I was going to do what needed to be done. Part of that mission was about building rapport with the PA and the chain of command, but the most important part of the visit was about serving the grunt (infantry Marine) on base. Hell, high water, or a grumpy PA were not going to keep me from doing that job.

I spent the first hour alone with the PA. I learned his background. I apologized for my role in the intense exchanges and emphasized that I knew he was looking out for his guys. I also made sure to highlight that I knew he cared about his men and that they were lucky to have such a passionate provider. I told him that I cared equally about my job. If my persistence came across as pushy, I was sorry. The rest of the time we spent walking around and talking to Marines.

The PA got to see how I interacted with his men and by the end of my short time there he wasn't so hostile. He had a good sense of who I was and the value that I could offer. He also seemed to realize that I was not looking for problems, but there to keep his forces on base and healthy. I knew the trip had ended well when, before I loaded back on the helicopter, he invited me back anytime.

A couple weeks later the payoff from my initial trip came through. The PA called me to help him with a patient who had just tried to hit another Marine with the butt of his M16. The offending Marine has lost the encounter, ending up with a punch to the face, split lip, and five stitches. Now the Marine was angry, injured, and his mental state was in question. What was to be done with him? I hopped on a helicopter the next day. I met with the Marine, gave my recommendations, and my advice worked. The Marine stayed on base and thrived. I had one fewer patient at Leatherneck. The base got to keep a good fighting man.

I thought I had won. Not only had I managed to get onto the impenetrable base, but I had helped someone, helped the whole team. Even the previously hostile medical officer realized I was committed to his cause when I dropped everything to get back to his base that day. Unfortunately, in the Marines, as in regular life, winning is not always a guarantee of reward or praise.

Back home on Camp Leatherneck, news of what had happened spread. Whereas the ends had turned out well, the means were not to be forgotten. The Executive Officer (XO) for the Battalion, the second in command for all the small bases in the area, called me into the office. The XO explained, in a tone reminiscent of an angry principal disciplining a wayward student, that I had gone outside the chain of command. In doing so, I had forced him to step in. I really had become a distraction. Despite winning over the PA, the XO, who is responsible for the lives of his men and fighting a war, had to focus on me. I was distracting him from more important issues. My ability to be effective with this Battalion was hampered because now I was the issue that needed dealing with. I was no longer welcome back to the base I had fought so hard to enter.

I have played out this scenario in my head many times since that encounter. The Marine Corp had taught me that aggressive thinking is an asset. The point of the OSCAR program was to think and act like a Marine, to belong. To stop persisting after the initial backlash would have solidified my place in their mind as a useless person, but in pushing back, in fighting, I was not what the Marine Corp expected of a psychologist. Perhaps it was not what they needed at that time.

I still hold pride that I got to a place everyone said I would never go. I built successful relationships with the medical staff, gave helpful intervention when needed. I think the Marines at the lowest levels appreciated that I was willing to take some of the risks they did to try to be helpful. That was good. But I am also disappointed in the situation, the outcome, and in myself for not finding a better way. There was surely a better solution that could have had me as a regular presence there helping the guys. I try and take my own advice, use my CBT skills, and not beat myself up too badly for not being perfect. On the whole, like those that came before me in the OSCAR role, I was helpful and got the job done. I can live with that.

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Out of Residency and into the Field: Reflections of a Junior Psychoanalytic Psychiatrist on a Iraq Deployment

22

Joseph E. Wise

22.1 Mobilization: A Pre-deployment Introduction

I was deployed from June 2010 until Jan 2011 with 21st Combat Support Hospital (CSH) to Contingency Operating Base (COB) Speicher near Tikrit, Iraq. The deployment time spanned the draw down from Operation Iraqi Freedom (OIF) to Operation New Dawn (OND), which was the final year of US troops in Iraq.

Regarding integrating my deployment experience, I am one of the few contemporary military psychiatrists who pursued additional training in psychoanalysis. A feature of psychoanalysis is to highlight the interaction between the mind's internal structure and external concrete reality—how these separate internecine worlds influence each other. Though I was first deployed in 2010, my internal experience of combat began much earlier.

I had joined the Army through West Point. For me, the time there had been very difficult and fundamentally at odds with my identity; but it was a great education and a great experience. Growing up with roots in the more rural and lower socioeconomic status West Virginia, West Point was a path to success. I had studied chemistry and biology there, and on my graduation, due to many additional hours in the chemistry lab, I was given a deferment to attend medical school to become a physician.

I learned during my time at West Point that my classmates both loved the Army and wanted to be leaders. This was not in my disposition, or there in a very different

In this chapter the author reflects on his personal experiences of a 6 month deployment to Iraq in 2010, as a US Army psychiatrist for 21st Combat Support Hospital (CSH). The author describes his duties, typical types of cases, general military experiences while deployed, and possibilities for psychodynamic/psychoanalytic work.

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way; so, it suited me to go onto medical school, while the others went on after graduation to Ranger school and/or to be junior leaders in combat units.

After West Point I went to the University of Cincinnati for medical school. When 9–11 hit, I was in histology class looking at slides of lung alveoli. There was commotion.

I can remember it like it was yesterday. We invaded Afghanistan next. It was soon after that we had troops in Afghanistan and later in March 2003 that we were in Iraq—I was to follow 7 years later. I remember looking at the New York Times online daily, where pictures of all deceased military were displayed and updated instantaneously.

It was on this website that I learned of several of my West Point classmates who had been killed during the invasion of Iraq. They seemed so young—my age, at the time, in my early 20s. It was unbelievable to think about these guys, by whom I sat in class, ended up giving the ultimate sacrifice. As the wars have officially ended, or winding down, the NY Times online post has closed down, but the war continues for me, and it keeps going in the minds of many of my patients, despite the fact that it is just a faint memory for the general public.

Surprisingly to my family, who saw real doctors as surgeons or general practitioners, I chose psychiatry as a specialty, and started residency at Walter Reed. I was first there in 2004, just at the wars were in full swing. The hospital was in a huge transition at this time. This eventually led to the creation of "Warrior Transition Units," which have a sole mission to administrative oversight and case management to the injured, "Wounded Warriors."

After finishing residency in 2009, I spent my first year out of training at Ft Campbell. One patient I remember vividly was a non-commissioned officer (NCO), and I treated him for a few months prior to his retirement, when I first arrived to Ft Campbell. He had severe PTSD, and I remember how he longed for "crossing the finish line" and retiring. He had in his mind that he would live on his farm and being away from people (unfortunately such isolation is a common response to deal with PTSD related hypervigilance).

I was basically just prescribing medication since his ability to be with other (including me) was extremely limited. He also had an irritable edge (also very common in PTSD), and there was one time when this was especially apparent—he pointed out that I did not have a combat patch (on the Army Combat Uniform (ACU), the patch of unit with which one has deployed is worn on the right shoulder sleeve). With a certain sadism, knowing that it was going to shame me, and to point out that I didn't know what I was talking about, he said, "how can you have been in the Army 5 years and not deployed? Have you not gone down-range? I just can't believe that."

It was true. I had been in the Army since the start of the wars, but I also hadn't been in the "real Army," since I was in medical training at a military hospital and distant from any sizeable Army post. And, he was letting me know that—putting me in my place.

This same story played out as well when I was awarded the combat patch during deployment. When I had been there for a month and got my combat patch, there was a young officer, whom I outranked, who had conflicts regarding authority, and who

I treated as a patient in weekly psychotherapy. He commented in a way designed to demean me (or perhaps rebalance the authority), that I had finally "joined" the Army, upon receiving a combat patch, when he already had one.

Before flying out to Iraq, I remember being in the hangar at Ft Benning. I was aware that I was leaving the USA and heading to war. My rationalizations were protective, in that I knew it was unlikely that I as a medical officer, in a medical unit, would be harmed; but, as I look back, I can remember how terrified I was. Sitting there, ready to fly off, it was Psalm 23 moment, "… yay, though I walk through the valley of the shadow of death …."

I was scared, but I went and made it! I was helped by those who had gone before: There was a Sergeant First Class (E-7) who was sent from Speicher to Kuwait to get us. As we were sitting in the C-130 before we flew and then before we landed in Iraq, he let us know that he had been there before and that it would be "ok"—just follow his lead. The NCOs are the backbone of the Army.

Upon arrival to the Combat Support Hospital (CSH) in Iraq, I replaced my inpatient attending, from residency. The comradery of knowing him, as well as the few other psychiatrists downrange, goes a long way towards providing comfort; and it is another demonstration of the utility of military residency programs. The uncertainties of the fog of war, and all of the concomitant annihilation anxieties, were mitigated by the comfort of a "family" reunion, of a sort.

At Camp Speicher, my duties included almost anything that one could think of under the rubric of general psychiatry. By this point, the war was winding down and US troops were being withdrawn, so behavioral health activities once handled by the myriad of Division, area support medical, and combat stress were essentially consolidated and managed by me.

I managed inpatients, initially one or two in designated psychiatric beds on a general medical ward. Later in the deployment I very rarely needed to admit anyone. As the only psychiatrist situated in the area—there was a Division psychiatrist collocated, but he was often doing battle field rounds to the different forward operating bases (FOBs)—I also covered after hours consults to small ER set-up by my hospital and any consults needed on other inpatient medical patients. The vast majority of my time, I saw outpatients in a clinic, that prior to draw down and consolidation had been set up by the combat stress unit.

22.2 Examples of Cases Treated

(Most clinical material comes from a compilation of cases treated or is otherwise disguised. Any correlation is simply coincidental.)

While down-range, I treated everything from first-break psychosis, to depression, to PTSD, to substance intoxication, and beyond. I also had a chance to meet less typical psychiatric cases. For example, there was one very stoic infantry Soldier Sergeant who happened to come in one afternoon. He was quite sheepish, showing up to the mental health building—not something an infantryman does often. He sat and described sudden paroxysms of racing heart and breath (he had already seen primary care already with normal EKG).

He was describing a typical, and quite ordinary new onset panic disorder. But I think it was the humility and simpleness of his request (from a psychiatric perspective, not at all from his perspective) that got me. It was a highlight of my time to shepherd this proud man, who did not until then believe in mental health, to being panic-free, via an SSRI and basic psychotherapy. It helped him weather the time of going back to the Infantry living area, and participating in wrestling, weight lifting, and other things that these seemingly uninitiated into any mental health did to pass the time.

A bit more extreme, but unfortunately another typical experience in general psychiatry, is first break psychosis. One episode happened one early evening when I was called by radio (our downrange equivalent of, what we would have here, CONUS, a pager, or cell phone) to see a young Soldier brought in by his friend. The reason for coming in was apparently strange behavior. He believed his video games were talking to him, specifically, and that he was being called by God, through crop circles on YouTube, to solve mankind's problems by converting everyone to vegetarianism. In addition to the psychiatric management of the psychosis, this story highlights the 24-7-365 nature of deployment for a psychiatrist. It is true that technicians and social workers and others can assist in many things; but, in complex situations, needing admission or evacuation, such as psychosis, there needs to be a psychiatrist—and, in this case, like most downrange, there is only one psychiatrist.

In another case, I treated a soldier who felt that he was in severe danger, despite that fact that during my deployment on the COB was generally safe. It is true there was a rare rocket attack or mortar, and even rarer landing in the LSA (living support area), but it was rare enough to be believed safe by many there. Notably, I do find myself minimizing the exposure, probably as a grandiose defense against my own annihilation.

Additionally, his intelligence on military entrance exams was on the lower range, which might explain the limited ability to integrate a more realistic appraisal of the threat into his own experience. This patient presented mainly with problems of concentration problems, which responded well to regular supportive psychotherapy. For him, somehow the regularity of the containing and holding functions for his affects in the therapy allowed him to continue his mission.

I also treated a case of PTSD, presenting as depression, from rape. She had been a younger Soldier who was "taken under the wing" of a more senior NCO. They would spend some evenings studying for the "board," a demanding oral exam of military regulations and culture, which the younger soldiers have to pass this in order to advance. It was in that context one night that they were studying that the rape occurred. It was an assault in the purest sense—there was no ambiguity. She was held down, and he forced himself upon her. The patient did not want to tell authorities at that time or when I saw her, which was a little over a year from the event, due to concerns about stigma and that her unit might ostracize her. Additionally, reporting requirements in the military regulations were less clear at the time, so I maintained her wishes that the event remain in the confidences of the doctor–patient relationship with me. Notably, she was withdrawn, her affect was not very interactive in session, and she was clearly in a low energy, depressed state. I prescribed medications, and there was some benefit, but she otherwise remained symptomatic.

Despite her symptoms, she had always remained very functional in her job and her military command—she had since PCS'd, so it was different from the unit in which the rape occurred—had no idea that she was getting care for depression. This vignette illustrates the challenges of treating non-combat trauma in a combat zone, and how destructive military sexual trauma is to the force, despite the resilience and dedication of those who have experienced it.

22.3 A Psychoanalytic Perspective During Deployment

I am a general psychiatrist but my passion and that for which I have sought out additional training is psychoanalytic psychotherapy. This modality tends to work well for those struggling with longer term anxieties or mood symptoms, which have some origin in chronic ways of interacting with one's self and others—personality. It is a treatment that helps the patient elaborate verbally on his or her experience, especially as it relates to the therapy relationship (transference).

There was one senior officer with whom I met in such a therapy while I was deployed. He was struggling with finding his own identity within his marriage and some other anxieties. We met in a twice weekly long term therapy, sometimes three times per week. The increased frequency allows for a deeper exploration and more ease in using the relationship with the therapist (me), the transference. Ultimately, I do believe the treatment was helpful in the sense that he was more fully able to understand his issues, including in the context of his marriage.

But it was strange for me to be in such a close and revealing (for him) professional relationship and also be in such close quarters (there were so few officers). I would run into him, outside of the therapy, frequently. I would take pains to ensure I kept my distance, to maintain the professional nature of our interactions and to not be so awkward for him and for me. Notably, he out-ranked me, but as the therapist I was the one who was charged with ensuring the proper balance of interaction with professional distance, especially as he was able to make sense of his mind in an experience-near way in the transference/therapy relationship.

Psychodynamic work involves mostly listening and being a psychiatrist is a privilege. In the famous Jaffe v Redmond decision, which established the psychotherapist-patient privilege, written by Justice Stevens, he speaks about the positive societal function of being able to have a place to bear ones soul (akin to the well-established religious priest-penitent privilege) (1996). In that sacred secrecy of a psychiatrist consultation, there is exposure to parts of life that are otherwise not in the open discourse. One might hear about such things as adultery, fraud at work, or pornographic masturbation fantasies.

In my time in Iraq the "underbelly" and the unspoken of what happens during deployment was revealed. I learned about the abuse of psychoactive substance. It seemed there was a flat rate for whatever ails you: 20 dollars for Ambien, 20 dollars for an Ativan, 20 dollars for a Percocet, etc.

22.4 Uncharted Medical-Legal Issues

I remember a civilian contractor, who presented for care, having been brought in by his contract company. In the USA, we have clear laws and regulations regarding those who have lost contact with, what is generally considered, reality. There are commitment laws of various types, and ways to pursue involuntary psychiatric hospitalization. Downrange, that is not the case—it is all very murky. The military is less murky since the same regulations apply, essentially the Department of Defense Instructions regarding Mental Health Evaluations. The civilians are set up for health care but the idiosyncrasies of loss of capacity for decision making or refusal due to psychotic illness are not established.

This case was one such example. The man was employed as a contractor, and was becoming increasing disorganized. He did not show up for work and his company decided to check up on him. His Containerized Housing Unit CHU was apparently a chaotic wreck. Not knowing what was going on, they gave him a warning to clean up and show up for work. When he did not, and since he was becoming unintelligible, they brought him to the CSH ER where I saw him.

Not knowing his history, and since psychosis in middle age is quite rare, I made efforts to rule out other processes (such as delirium, CNS infection, or stroke), but unfortunately we did not have a CT scanner, making the medical workup quite difficult. Luckily, he was coherent enough to tell me his mother's phone number in the USA. I used Skype to call her. I learned that he had a prior break many years before, but it had resolved after a brief psychiatric hospitalization. He had never required psychiatric medication, but he lived alone except for his mother. Essentially, he had these two psychotic blips, but otherwise was mainly schizoid. This history combined with the bizarre quality of the mental status change led me to believe that this was a psychiatric process, and I treated it as such.

I treated several other civilians, including those who weren't American citizens, not even NATO. Once again, these situations with civilians were cleared for medical care, but the psychiatric manifestations had not been fully considered, including how Behavioral Health conditions might affect executive function and rational decision-making. I reverted to a conventional medical model, in which I just tried to do what seemed best from my perspective.

22.5 Locked and Loaded: Safety Issues for a Deployed Psychiatrist

How can a psychiatrist practice safely, when there are loaded weapons? Practically speaking, the threat of an unsafe patient is partly dealt with by having the patients put their weapon in a rack prior to being seen, though combat weapons, including large knifes, are ubiquitous.

Firearms, aside, there was another time when a disgruntled Sergeant took to cleaning his knife in a session. I took it as a desperate veiled threat, and not surprisingly he was hospitalized shortly thereafter. Somehow on this one, despite, the 5 years of intervening time, I am still not in touch with my emotions regarding this episode—another example of an intense situation calling for strong defenses.

What I have not heard discussed is the meaning of the armed psychiatrist. I look back with a certain phallic narcissism, as I see pictures of my 9 mm holstered while I am wearing a T-shirt.

One afternoon I was in my CHU (container housing unit—a small living quarter made from a metal shipping container). There was a loud boom, an explosion, it was a mortar or rocket, and it hit just on the other side of the "T-wall" barrier near where I was living. I was fine, and it did not sink in immediately, but a few hours later, the reality of just a few meters hit me—had the mortar been aimed just slightly differently and landed on my side of the barrier, then I would have been seriously injured or even killed.

The next day two patients presented as walk-ins to our small clinic building, with acute stress symptoms from the same mortar/rocket attack. There were feeling acutely anxious, could not sleep, and were ruminating about their own potential death had they been closer. I saw these two patients, and provided several sessions of supportive psychotherapy.

What they never knew was that I had experienced the same explosion and existential anxiety. It is a rare thing for a psychiatrist to experience the same trauma, as a PTSD patient, but that happens on deployment.

22.6 Combat Stress Control: Prevention Downrange, as Preparation for Garrison

The "prevention" part was very different from other aspects of psychiatry, such as treatment. It was classes, debriefings, and the so-called "walk abouts" during which mental health providers checked in with various groups. These experiences in non-pathologizing work, rather than in the traditional model of seeing an individual and diagnosing an "illness," helped greatly in my future work in Garrison when I was Chief of Behavioral Health and Installation Director of Psychological Health at Ft Campbell, in working with preclinical programs such as resiliency and suicide prevention.

I got to know the function and limits of such health promoting, rather than disease treating, interventions. But I never seemed to be able to reconcile how effective such things are, or whether it was a good use of my time. (For monitoring by headquarters, the reporting was done in encounters or contacts with individuals. So there was no transparency between running a psychoeducation "prevention" class versus seeing individual patients in treatment.)

The debriefing experience remains probably one of the most controversial. Specifically, there is controversy about types of psychological debriefing intended to prevent PTSD. I remember one such incident during which I taught a series of classes to members of an allied military. Their senior enlisted person—a Sergeant Major equivalent—showed up at the clinic. He explained their annual training mandates were for something akin to psychological first aid and debriefing.

Not having been trained in either of these modalities, specifically, I did some research and I put together several hours of training for them, including didactic instruction, discussion, and role-play. In retrospect, I am impressed by creatively doing my part to advance our relationships with key allies.

Having had some training in organizational consultation and executive coaching at this point, I approached all of these requests with that in mind. Specifically, I ensured I met with the leadership of the requesting organization to help formulate exactly what they wanted and why, rather than somewhat impulsively and thoughtlessly jumping into the reaction of putting a class together. One such request from a Reserve unit activated for the deployment and ended up providing a snapshot of the COB security, in which the consultation evolved into a venue for the leadership to discuss their feelings of inadequacy, as Reservists, rather than to teach stress management class, as had been originally requested.

22.7 Final Reflections

Upon return, I landed back in the USA, since I was a medical PROFIS (professional filler system), I went back to my hospital position almost immediately. I say "almost" because I flown back CONUS on New Year's in 2011. This was prior to DADT (Don't Ask Don't Tell) repeal, and, in a clandestine operation, for the time, I planned to meet my partner for New Year's. We had planned to drive from Ft Benning, GA to Atlanta to take in the New Year at the fancy "W" Hotel with champagne and other activities. A series of sand storms and other bad weather delayed my flight, but, a day late, we celebrated my return to American soil in style.

Now, after about 5 years since I have returned from deployment, ISIS/ISIL controls portions of Iraq. The New York ran a shocking video of when ISIS captured where I had spent my time, at Camp Speicher, outside Tikrit, Iraq. The chilling story and video displayed how ISIS forces captured Camp Speicher, at this point a post of the Iraqi military. The story and video showed how Shia recruits were executed en masse. The images were shocking but even more shocking were what I recognized as where I had lived and worked during 2010. The same place where I had been was shown with black flagged fighters driving up to Hesko and T-wall barriers. Around the same time, the New York Times also ran an editorial linking the disheartened and dejection of Vietnam Vets to melancholic feelings of GWOT Vets, and I will say for me this rang true—brought into hyperfocus by watching ISIS storm the compound where I once worked.

In writing this, it has reminded me of many things forgotten. It seems like such as long time ago, even those as I pen this, it is 5 years ago. As I allow my mind to go back, I can see it and feel it in my mind's eye. It feels like so long ago, and so much has happened to me since then. I was such a young psychiatrist then, just a year out of residency. And, so much has happened since then, to me and the situation. There are no more troops in Iraq, and my life has changed dramatically since repeal of DADT. It is very strange to let my mind wonder to those days of a young psychiatrist heady and on deployment. I see myself now as young naïve, but dedicated, and just really trying my best.

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