Social Work in Mental Health
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wsmh20

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Published online: 23 Oct 2014.

To cite this article: Vaughn DeCoster PhD (2014) Combat Social Work During the Surge in Iraq, Social Work in Mental Health, 12:5-6, 457-481, DOI: 10.1080/15332985.2014.916647

To link to this article: http://dx.doi.org/10.1080/15332985.2014.916647

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Combat Social Work During the Surge in Iraq

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The military has long recognized the short-term psychiatric effects of war upon soldiers, a significant factor for combat operational readiness and strength (NATO, 2008). Currently referred to as combat stress reaction or combat operational stress reaction (COSR), the condition has debilitating, immediate effects as well as long-term consequences for soldiers and military units. For the wars in Iraq and Afghanistan, commanders expected psychiatric casualties rates equaling physical ones, stemming from the intensity and duration of these conflicts, nonlinear nature of the battlefields, unit morale, and soldier experiences and preparedness. For these recent wars, the concept of behavioral health, combat stress, and its military importance has dramatically changed, as have the protocols dictating the delivery of preventive and restorative combat behavioral health care. This article outlines the conceptual foundation of modern combat stress control, protocols, and the efforts of one social worker–led combat stress prevention team, forward deployed to a small base in a volatile area of Baghdad during the height of the surge in 2006–2007.

KEYWORDS mental health, social work, military social work, combat stress

The military has long recognized the short-term psychiatric effects of war upon soldiers, a significant factor for combat operational readiness and strength (NATO, 2008). Historically, this war induced condition was labeled as neuralgia, disordered action of the heart, DaCosta’s syndrome, functional nervous disorder, shell shock, neurocirculatory asthenia, thousand yard stare, war neurosis, or battle exhaustion or fatigue (Ellard, 2000). Currently, it is referred to as combat stress reaction or combat operational stress reaction.
(COSR). The condition can have a debilitating, immediate effect as well as long-term consequences for the individual. Historical accounts from the Civil War through Vietnam show that from 20% to 37% of casualties are psychiatric in origin, although mental health conditions were likely underreported (Ellard, 2000; Jones & Wessely, 2001). The severity of these wars and specific battles, reflected by the number of physical casualties, influenced the number of psychiatric casualties (Anderson, 2008).

In recent military conflicts, commanders can expect psychiatric casualties rates equaling physical ones, increases based on the conflict intensity, unit morale as well as the soldiers’ level of experience and preparedness (Grossman & Siddle, 2000). However, the number of delayed psychiatric wounds like posttraumatic stress disorder (PTSD) for the two wars in Iraq and Afghanistan double the number of physical casualties, 50,450 versus 103,792 (Fischer, 2014). One factor may be the duration of time “on the line,” a definitive battle line where combat occurs versus a safer “behind the line” non-combat area. In World War II, rates of combat fatigue significantly increased after 240 days on the line (Jones & Wessely, 2001). Iraq and Afghanistan are considered “nonlinear wars,” lacking clear lines of combat and safety, hence soldiers remain in harms way for most of their 360–450-day (12–15-month) deployments; marines typically deploy for 210 days (7 months) and airmen for 90–120 days (3–4 months). For these recent wars, the concept of behavioral health, combat stress, and their importance for the military has dramatically changed, as have the protocols dictating the delivery of preventive and restorative behavioral health care.

**COMBAT STRESS DOCTRINE**

The practice of combat stress control is based on a solid theoretical and operational doctrine. The seminal document responsible for much of the change is the *U.S. Army Field Manual for Combat and Operational Stress Control* (FM 4-02.51). Issued in 2006 (Department of the Army, 2006) and superseding FM 8-51 (Department of the Army, 1998), it details strategies to build soldier emotional resilience, minimize immediate psychological effects of war, and reduce psychiatric casualties. Theoretically, this intends to increase operational strength, soldiers’ mental capability to perform their combat roles, remain on duty, and “stay in the fight.” Behavioral health providers are touted as “force multipliers,” resources for commanders now held accountable for the mental health of their soldiers. Command ownership and responsibility “at all levels” (FM 4-02.51, p. 1-1) are significant factors for a military cultural change in reducing the stigma of behavioral health. As with other cultural transformations, such as those involving gender, race, and sexual orientation, some discrimination likely remains but is now not part of the accepted discourse. The concept of person-in-the-environment or in this
Case “soldier-in-the-environment” resonates throughout the combat stress doctrine, suggesting that the organizational (army unit) climate has a significant effect on solider wellness and operational capability. This shift in causation from individual to environment and, to some extent command climate, is dramatically different from the General Patton era of seeing psychiatric casualties as individual weakness or cowardness (Ellard, 2000). Even the term “psychiatric causality” suggests the experience of war can produce psychological injuries, similar to the wounds caused by bullets or mortar shrapnel. In addition to these conceptual shifts, FM 4-02.51 also promoted a change in operational procedures for deployed behavioral health units and providers. According to the FM, the purpose of combat operational stress control (COSC) is to “... promote Soldier and unit readiness by - enhancing adaptive stress reactions, preventing maladaptive stress reactions, assisting Soldiers with controlling COSRs, assisting Soldiers with behavioral disorders” (p. 1-1). Combat is a dynamic environment, unique to the type of war (linear with clear lines of battle or nonlinear with no distinct front), location (urban, rural, or large airbase base versus much smaller forward outpost), and stage of the conflict (initial invasion, occupation, withdrawal). It is also very much a unique, subjective, lived experience, shaped by what individuals bring to combat in their bio-psycho-social-spiritual makeups. Hence, combat psychological effects can vary considerably as does the COSC efforts to address them.

COSC efforts are guided by the principles of brevity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS, FM 6-22.5, Department of the Army, 2009). The initial intervention of “rest and replenishment” should be brief (1 to 3 days), as immediate as combat operations allow with soldiers maintaining contact with their units to maintain the “soldier identity” not that of a patient, with an expectation they will return to duty (RTD). Services are in close proximity to referring units and away from medical facilities like a battalion aid station (BAS), again to minimize the patient label. Interventions are kept simple, following the 5 Rs of COSR: reassure that the reaction is normal, rest, replenish bodily needs, restore confidence, then RTD to reunite with their unit. In essence, keep involvement brief, as immediate to the initial onset of symptoms, be in contact with unit to determine pre-condition functioning, normalize the response with the expectation they will return to duty, treat in-place proximate to their unit, and keep the intervention simple. Despite the detailed guidelines offered in field manuals, social workers and teams were constantly told to be “flexible like Gumby.” In other words, like the popular stop motion clay animation figure, behavioral health teams had to quickly adapt to unpredictable combat environments, changing strategies, and being creative to address the needs of those served. This article details the efforts of one social worker led combat stress prevention team (Team Rusty), forward deployed to a small base in a volatile area of Baghdad during the height of the surge in 2006–2007.
Team Rusty was part of the larger 113th Medical Company, Combat Stress Control (MED CO, CSC), an 80+ person Army Reserve unit that provided behavioral health and combat stress control for a Corp size operational unit, 20,000–40,000 soldiers commanded by a Lieutenant General. The Army has since collapsed CSC companies into more flexible, smaller detachments of about 40 personnel, making them easier to mobilize and deploy. As a Corp asset, teams are supported but not commanded by units served, an important factor when system-level change is needed to improve psychological–organizational climates. Combat stress companies are commanded by a social worker with the rank of Major or Lieutenant-Colonel and comprised mostly of social workers, occupational therapists, psychologists, a couple of psychiatric nurses and psychiatrists, all commissioned officers in the U.S. Army Reserve. The 113th had three fitness teams, also referred to as soldier restoration units, staffed with 9–10 personnel (social workers, mental health specialists, nurses, a psychiatrist) and 10 prevention teams. The role of a fitness team (center) was to provide physical and emotional restoration of soldiers needing extended services and care away from assigned units or bases. Fitness centers often were residential facilities with soldier-clients remaining for 7–10 days, receiving comprehensive workups, group/individual therapy, and psychiatric care. However, they were not locked facilities or considered inpatient psychiatric treatment centers. The closest inpatient psychiatric facility was at the U.S. Military’s Landstuhl Regional Medical Center in Germany. The 113th leadership avoided evacuation decisions by transferring patients to the Combat Support Hospital (CSH) and its lone psychiatrist and mental health specialist. The CSH also lacked a dedicated psychiatric unit. Typically when patients were evacuated to the CSH, the medical staff required the soldier’s unit of origin send two senior ranking sergeants (Noncommissioned Officers [NCOs]) to accompany the soldier-patient and provide 24-hour supervision, even escorting to Landstuhl if need be. This was excellent duty for these sergeants, especially if it resulted in a trip to Germany, but difficult for units that have limited numbers of senior NCOs, especially given the vital role of NCOs in combat operations and the high tempo period of the war during the surge.

The prevention teams were the first line of behavioral health defense, consisting of two or three soldiers, usually a social worker as the Officer-In-Charge (OIC), a NCO-In-Charge (NCOIC mental health specialist) and perhaps an enlisted soldier mental health specialist. Mental health specialists (military occupational specialty, MOS, 68X) require 20 weeks of advanced training, functioning similar to a mental health technician. Teams provided combat stress control services to brigade combat teams (BCTs) and all coalition forces in a given area of operation (AO). Prevention teams were located on Forward Operating Bases (FOB), serving personnel on it and smaller
FOBs or Combat Operations Posts (COPs) in the assigned AO. The author's team initially had himself as the social work officer (OIC) and two enlisted mental health specialists, one replaced with a NCOIC a few months into the deployment. This team was based at FOB Rustamiyah, located in southeast Baghdad between a waste incineration facility and a sewage treatment plant, adjacent to the NATO advised Iraqi Military Academy, and six miles southeast of infamous Sadir City. FOB Rustamiyah was known for horrible air quality and frequent mortar and rocket attacks, indirect fire (IDF). The CSC team at Rustamiyah, usually referred to as “Team Rusty,” served an AO consisting of eight smaller FOBs/COPs with a total population of 4,500 soldiers, sailors, marines, and airmen; NATO advisors; and about 1,200 civilian contractors and third-country workers. During the surge an additional 1,500 soldiers were stationed in this AO.

Services Provided
The U.S. Army commissions social workers, psychologists, and psychiatrists as officers in the Medical Service or Medical Corps. In times of war, the three are considered interchangeable by the military as mental health providers, assets to address the behavioral health needs of soldiers. With that being said, social workers tended to be the most flexible of the three professionals, addressing preventive and treatment needs through a variety of services. Team Rusty provided both preventive and treatment services for combat operation stress reactions (COSR) and behavioral health conditions, what the Army Medical Department (AMEDD) refers to as primary mental diseases (PMD). Figure 1 outlines the overall workload distribution by total number of service contacts per service category and Table 1 details the frequency of services for the 11-month deployment. Preventive efforts focused on walkabouts, psycho-educational groups and classes, and required briefings but usually started with a systematic unit needs assessment.

The Unit Behavioral Health Needs Assessment (UBHNA) was a 36-item survey instrument designed by AMEDD researchers to measure protective

![Figure 1](image-url)
and risk factors for combat stress and behavioral health issues. Using a stratified sample of soldiers according to age, rank, sex, and subordinate units, the team administered these anonymous paper-pencil instruments then entered the data into a computer database for analysis. Findings depicted deployment experiences, concerns and trauma exposure, morale, cohesion, unit confidence and enlisted and officer leadership, behavioral health training, mental health status and aggressive behaviors, behavioral health care resource use, stigma and barriers to care, alcohol/drug misuse, marital satisfaction, and marital and child concerns. Graphical analysis compared unit results with a comparison group of 5,500 soldiers. The social worker provided recommendations to address identified needs. The confidential report remained with the requesting commander, typically a Lieutenant Colonel in charge of a battalion size element (450–500 soldiers). Team Rusty completed 10 UBHNA analyses, surveying 1,774 soldiers, during their 11-month deployment. In addition to this formal evidence-based guidance, the social worker also provided command consultations on a host of soldier and organization issues ranging from low morale of administrative staff, conflict among medical providers or poorly adapting soldiers to trauma management, leader development, or personal issues such as intrusive memories, poor sleep, and panic attacks.

The team conducted routine “walkabouts” on all FOBs, informally visiting with as many soldiers as possible to build rapport, screen for individual and unit-level issues, and offer as needed “help-in-place” counseling. Walkabouts were considered an essential ingredient for CSC success, providing BICEPS to those symptomatic for COSR but also connecting with non-effected soldiers, building rapport and gaining trust as a referral source and for later potential care. Team members often enjoyed walkabouts,
allowing them to interact with functioning service personnel throughout the AO and getting time away from the hectic demands of the two COSR/PMD clinics the team operated. The team’s travels to smaller FOBs also became therapeutic. Visited units took care of the team and, on many occasions, offered respite like makeshift shooting ranges, movie nights, or non-alcoholic beer and cigars. The CSC team also facilitated activities to foster interactions among soldiers, such as CSC movie nights, private pilot aviation classes, and dance lessons, the later two being immensely popular. These novel approaches were possible because Team Rusty’s OIC was an instrument-rated private pilot and one of its mental specialists worked as a dance instructor back home. A National Guard military police company from Puerto Rico had problems adapting to the rigors of active duty in Iraq but became less problematic after Team Rusty facilitated a monthly salsa night, typically attended by 50–60 soldiers. It was not that salsa dancing cured the adjustment problems but it increased positive social interactions, reduced isolation, reinforced their cultural strength and uniqueness, generating a positive image of the Puerto Rican soldiers. The concept of the Army as “family” was touted frequently stateside (Continental United States, CONUS) but truly actualized when in a warzone, with soldiers providing care, support and nurturing to one another. This concept of “Army as family” was a critical component of soldier behavioral health that the CSC team benefited from as well. This sense of belonging, camaraderie and friendship reinforced the adage that soldiers do not fight for causes, countries or politicians but for each other.

The OIC reported all of the above soldier contacts, along with other activities, in a weekly workload and situation report (SITREP) to the supporting BCT command and 113th MED CO headquarters to gage the rate of psychiatric casualties from combat operations. The effectiveness of walkabouts to build rapport with soldiers, NCOs and officers became apparent with the number of referrals and requested repeat visits by Team Rusty by soldiers on other FOBs/COPs. Soldiers and commanders used these friendly and informal sessions to unofficially process stressors and problems. By mid-deployment, though, the demands for other services reduced available time for walkabouts (see Table 2 for monthly contacts by type of service). This left even less time for the team itself to decompress from practicing mental health in combat.

Psycho-education groups, classes, and briefings were considered a preferred preventive method. Typically, team mental health specialists taught ongoing classes (6–12 participants) on anger management, stress management, home challenges, alcohol misuse, or tobacco cessation, usually accompanied with an ongoing process group. The social worker conducted more formal single-session briefings on suicide prevention, sexual assault, resiliency infused Battlemind training, or re-deployment (going home) briefings. Along with the walkabouts, these briefings were considered important
V. DeCoster

TABLE 2 CSC Contacts by Type of Intervention Across Months

<table>
<thead>
<tr>
<th>Month</th>
<th>PMD/COSR</th>
<th>CEDs</th>
<th>Walkabouts</th>
<th>Psycho-ed groups &amp; briefings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>137</td>
<td>28</td>
<td>105</td>
<td>518</td>
</tr>
<tr>
<td>Nov</td>
<td>212</td>
<td>192</td>
<td>204</td>
<td>255</td>
</tr>
<tr>
<td>Dec</td>
<td>143</td>
<td>221</td>
<td>719</td>
<td>321</td>
</tr>
<tr>
<td>Jan</td>
<td>169</td>
<td>61</td>
<td>770</td>
<td>79</td>
</tr>
<tr>
<td>Feb</td>
<td>177</td>
<td>41</td>
<td>561</td>
<td>104</td>
</tr>
<tr>
<td>Mar</td>
<td>227</td>
<td>30</td>
<td>744</td>
<td>249</td>
</tr>
<tr>
<td>Apr</td>
<td>274</td>
<td>159</td>
<td>619</td>
<td>137</td>
</tr>
<tr>
<td>May</td>
<td>346</td>
<td>179</td>
<td>1,084</td>
<td>95</td>
</tr>
<tr>
<td>Jun</td>
<td>351</td>
<td>144</td>
<td>768</td>
<td>256</td>
</tr>
<tr>
<td>Jul</td>
<td>264</td>
<td>58</td>
<td>690</td>
<td>447</td>
</tr>
<tr>
<td>Aug</td>
<td>396</td>
<td>60</td>
<td>582</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>2,696</td>
<td>1,173</td>
<td>6,846</td>
<td>2,514</td>
</tr>
</tbody>
</table>

strategies for combat stress prevention, providing knowledge and skills to enhance coping and, more importantly, supportive networking and self-help opportunities for participants. The social worker also provided weekly briefings at battalion battle update briefings (BUBs) to commanders and first-sergeants, reporting the frequency of COSR and PMD casualties, identified trends, and possible solutions. The fact that battalion commanders and their staff scheduled time during a BUB to review behavioral health concerns speaks to its present value in military culture.

Individual assessments and treatment for soldiers suffering from COSR or PMD followed similar protocols as medical sick call, Army’s version of primary care clinics. First, soldiers seeking services were seen by a mental health specialist, obtaining chief complaints, signs and symptoms. The specialist then briefed an available provider, either the social worker or psychiatrist. In some instances when both mental health providers were unavailable, the specialist would brief the on-call physician or physician-assistant (PA). The successfulness of this varied according to the provider’s specialty; family medicine physicians were more comfortable addressing psychosocial issues. Although Team Rusty tried to maintain a routine clinic schedule, as done in sick call, medical staff had a standing order for the medics to automatically and immediately refer any soldier with COSR/PMD complaints, without the physician or PA actually seeing the soldiers. These 24/7 referrals for the comparatively small team of two behavioral health providers, compared to over ten medical providers, became problematic. As the volume of referrals exceeded Team Rusty’s resources, the social worker trained medics, chaplains and chaplain-assistants to screen soldier-clients for COSR and PMD issues and the “red flags” warranting a referral, including basic help-in-place strategies like supportive listening, rest, nutrition, and reduced caffeine consumption. The social worker also addressed the automatic referral habits with the brigade surgeon who encouraged
medical providers to at least attempt to address some of the combat stress issues on their own before referring out.

Presenting Problems and Diagnoses

The most common diagnosis was combat operational stress reaction (COSR), considered a normative response in the warzone and less serious for soldier careers. According to FM 4-02.51 (Department of the Army, 2006), “Many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, hallucinations), but they are only transient reactions to the traumatic stress of combat and the cumulative stresses of military operations” (p. 1-5). COSR signs and symptoms were part of a continuum of responses to combat operations, varied by severity and differentiated from those considered adaptive (e.g., loyalty, alertness, courage), misconduct and criminal (e.g., mutilating enemy dead; killing prisoners, civilians, or animals; looting) versus long-term (e.g., guilt, social isolation, depression) (see FM 4-02.51, Figures 1–3, for more examples, p. 1-6). As with mental health disorders, soldiers could present sub- or non-clinical symptomatology for COSR. Providers also diagnosed traditional Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) conditions, referred to in the Army as primary mental disease (PMD). These diagnoses were considered more serious, eventually became part of the official medical record, and had the potential to affect career progression, dependent on specific diagnosis, severity and treatment outcomes. PMDs seen by Team Rusty included adjustment and anxiety disorders, panic attacks, major depression, posttraumatic stress disorder (PTSD), and attention deficit disorder (see Table 3). The team also treated a few cases of obsessive-compulsive disorder, eating disorders, and substance abuse. Addiction use and abuse were uncommon but the rule-of-thumb was it would take a person with an addiction problem 10–14 days in Iraq to acquire substances. Soldiers huffed canned air, received phencyclidine (PCP) in a plastic bag buried in a jar of peanut butter, misused prescribed medications, consumed massive

<table>
<thead>
<tr>
<th>Presenting Problems</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicidal</strong>—ideations, plans, family history, past attempts.</td>
<td>79</td>
</tr>
<tr>
<td><strong>Homicidal</strong>—“I am going to kill all Hajis . . .”</td>
<td>28</td>
</tr>
<tr>
<td><strong>Psychotic</strong>—tactile, visual, olfactory hallucinations, delusions, disorientation.</td>
<td>10</td>
</tr>
<tr>
<td><strong>Various mental health issues</strong>— depression, anxiety, panic attacks, adjustment disorder, relationship problems, obsessive compulsiveness.</td>
<td>408</td>
</tr>
<tr>
<td><strong>Combat operational stress reaction</strong>—sub-clinical condition with similar symptomatology as PTSD (e.g., poor concentration, confusion, flashbacks, excessive emotions, numbness, rage, mood swings, nightmares, nausea, fatigue).</td>
<td>653</td>
</tr>
</tbody>
</table>
quantities of energy drinks like Red Bull, Monster, or RipIt or abused diet pills sold on the FOBs. General Order #1 prohibited alcohol in the warzone, yet soldiers illegally purchased it from Iraqi merchants either outside “the wire” (the FOB) in the surrounding communities or from one of the dozen “Haji stores” run by local merchants in the FOBs. Borderline, narcissistic, or histrionic personality disorders were occasionally present but less common with these soldiers typically screened out early in their military careers.

Presenting Problems and Referrals

Every participant in the surge, including the suspected enemy (detainees), was represented in referrals to Team Rusty for behavioral health care. Soldiers came on their own, with battle buddies or were brought by squad leaders, sergeants, first sergeants, or chaplains. Presenting problems ranged from refusing to return to duty, pervasive arguing, insubordination, as well as malingering, isolating, sleeping too much or too little, or being habitually late for duty. More serious problems included things like threatening others with a loaded rifle, non-suicidal “cutting,” un-holstering a pistol during a physical fight with a fellow NCO, or throwing and breaking a M-16 rifle from a guard tower during a temper tantrum. On one occasion, a 22-year-old medic complaining of tactile hallucinations, feeling the wounds of those he treated, improved with supportive counseling and sleep.

A leading cause for referral involved the proverbial “Dear John” or “Dear Jane” e-mail. Stereotypically, a soldier would marry shortly before deployment to Iraq (war bride/groom), re-enlist when down-range to receive the sizeable (tax-free) combat re-enlistment bonus, despite wanting to get out of service before getting married. The newly wedded and re-enlisted soldier would then find their banking account drained, credit cards maxed, and discover their loved-one flirting with others on MySpace or found consuming a “friendship” during the soldier’s absence. Their spouse would proclaim incredible distress and loneliness, helped only by spending money and being with others for comfort, stating “...if you were not gone so much I would be fine.” It also was common for marital bonds to loosen for deployed soldiers as well, engaging in what was referred to as “12-month marriages,” sexual relationships with others during the deployment. On one occasion, two soldiers presented for couples counseling to decide if they should divorce spouses back home to pursue this new relationship. They were referred to their battalion chaplain for couples counseling, who reminded them that adultery was punishable under the Uniform Code of Military Justice (UCMJ).

In other situations, bullying brought soldiers to the combat stress team for assistance. As with other forms of bullying, targeted soldiers typically had limited social networks, were isolated, had low self-esteem, a sense of helplessness, sometimes an ongoing difficulty adjusting to Army life, frequently
made mistakes, and were often labeled as problematic soldiers, or were not “squared away.” A dysfunctional soldier, sometimes referred to as “Gomer Pyle,” served the classic small group role of scapegoat, the focus of ridicule, allowing others to avoid the target of critical sergeants. Officers often used unofficial visits to process problems like frustration over senior leadership incompetence, feelings of depression, low morale, cheating wives, or panic attacks from daily advising missions with the Iraq Army. Although higher command discouraged services to non-military clients, the team provided care to civilian contractors, third-country nationals, and insurgents, the latter two often through an interpreter.

Many civilian contractors (firefighters, maintenance supervisors, law enforcement officers advising Iraqi police) also sought care for anxiety and depression. A civilian clinical social work contractor was available at the Victory Base Complex (one of the largest overseas bases ever built in U.S. history) and made a visit to FOB Rustamiyah to check in with contractors. Although past civilian contractors had vehicles, the proliferation of roadside bombs in the form of improvised explosive devices (IEDs) and explosively formed penetrators (EFPs) made travel in these unarmored vehicles too deadly. This forced them to travel on military Blackhawks or convoys, receiving lower passenger priority versus military personnel. Hence, a one-hour appointment at Victory Base, 10-minutes away, could take 7–10 days due to routine travel requirements and delays. Team Rusty also provided care for third-country nationals, usually from India, that worked for companies like Kellog, Brown, and Root (KBR) in the FOB’s kitchens, laundry, and maintenance.

Referrals also came from the detainee holding area (DEHA) where suspected insurgents were temporarily held before transferring to a larger facility for formal processing and interrogation. On one occasion, detainees became distressed after the DEHA was hit in a mortar attack. Another DEHA referral involved a scared Iraqi teen with a conduct disorder disrupting the normally quiet milieu. The CSC team also had several referrals for detainees complaining of anxiety, insomnia, headaches, racing hearts, palpitations, and difficulty breathing. The social worker determined, in collaboration with soldiers staffing the DEHA, it was caffeine and nicotine withdrawals after being denied their incredibly strong and sweet chai and unfiltered Turkish cigarettes. Team Rusty’s solution was to let them smoke more and give them a few RipIts, the Army’s free version of Red Bull, or Mountain Dew. The soldiers working the DEHA worked 12 hours on, then 12 hours off, many for the duration of their 12–15-month deployment—a difficult, stressful, and less than desirable role for soldiers, resulting in a degree of occupation stress as well.

Team Rusty had 23 command referrals, an official order by a company commander or higher for a soldier to seek a behavioral health assessment or treatment. Doctoral-level providers like a psychiatrist, psychologist or
doctoral-level social worker only did these. Command referrals could be 
“discretionary” to encourage care or “non-discretionary” (regulatory) to 
formally assess fitness-of-duty and remaining in service or for those wishing to 
become a recruiter, drill sergeant or attend sniper school. Most command 
referrals involved suicidal soldiers, malingering, or failure to adapt to mili-
tary culture. One unique command referral involved a NCO climbing a guard 
tower on a Iraqi military base and exposing himself to others, including an 
Iraqi general. This was the only soldier evacuated from the theater in less 
than 48 hours, likely an effort to avoid an international (news press) incident. 
A second involved a decorated infantry staff sergeant (SSG) with multiple 
past deployments who became homicidal: “I am going to takeout anyone 
that looks like a fucking Haji . . . gonna kill’em all.” The psychiatrist asked for 
the military police (MPs), who became baffled at the request: “We are not in 
garrison, we do not take calls like this on Rusty.” The social worker defused 
the situation by removing the sergeant from the growing audience, feeding 
him homemade bread, and letting him cry. The soldier was re-assigned a 
non-combat duty and told by his first-sergeant, through coaching from the 
social worker, that he was “. . . a killer they wanted to keep in reserve and 
not waste his talent on just any mission.” It helped the soldier save face 
yet addressed his call for help. The soldier remained in treatment and was 
eventually returned to combat operations without problems.

Individual Interventions
The Team Rusty social worker relied on supportive counseling, psychoe-
ducation, behavioral, solution-focused, psychodynamic as well as more 
humanistic approaches, whereas the psychiatrist routinely prescribed, per-
haps a holdover from 20 years of private practice. Walkabouts effectively 
used supportive counseling techniques such as active listening, empathiz-
ing, and normalizing. These informal, help-in-place sessions also relied on 
advise-giving and psychoeducation, the latter sometimes through simple 
pocket guides. These homemade index-card sized pocket guides (pam-
phlets) adapted existing more complex soldier pocket books by listing 
10–12 things to do for different common problems like stress, suicidal 
battle buddy conflict, surviving the holidays, or family challenges (see 
Figure 2 for examples). The team custom-made these pamphlets to address 
AO-specific issues, written in a no-nonsense, sometimes tongue-in-cheek 
manner and inexpensively printed, then mass distributed to soldiers, medics, 
chaplains, as well as left on dining facility (DFAC) tables and morale, wel-
fare, and recreation (MWR) areas. Taking a public health perspective, these 
simple “pamphlet interventions” expanded the team’s coverage, another 
attempt to reach soldiers in need. Soldiers responded remarkably well 
to more insight-oriented and expressive psychodynamic and humanistic 
approaches. The social worker found supportive-expressive (SE) dynamic
FIGURE 2 Examples of soldier mini-pocket guides.

<table>
<thead>
<tr>
<th>SUIQUE</th>
<th>The only thing that will save a human life is a human relationship.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WARNING SIGNS</strong></td>
<td><strong>WARNING SIGNS</strong></td>
</tr>
<tr>
<td>Appears depressed: sad, tearful, poor sleep, poor appetite, hopeless - isolates;</td>
<td>Appears depressed: sad, tearful, poor sleep, poor appetite, hopeless - isolates;</td>
</tr>
<tr>
<td>Threatens suicide, talks about wanting to die;</td>
<td>Threatens suicide, talks about wanting to die;</td>
</tr>
<tr>
<td>Shows changes in behavior, appearance, mood;</td>
<td>Shows changes in behavior, appearance, mood;</td>
</tr>
<tr>
<td>Abuses drugs, alcohol;</td>
<td>Abuses drugs, alcohol;</td>
</tr>
<tr>
<td>Experienced a significant loss, breakup or divorce;</td>
<td>Experienced a significant loss, breakup or divorce;</td>
</tr>
<tr>
<td>Deliberately injures self, cuts himself;</td>
<td>Deliberately injures self, cuts himself;</td>
</tr>
<tr>
<td>Giving away possessions.</td>
<td>Giving away possessions.</td>
</tr>
</tbody>
</table>

**ACT!!**
1. Take it seriously, acknowledge don’t debate
2. Listen, convey concern
3. Don’t leave person alone
4. Inform chain of command
5. Get help immediately: Chaplain, Combat Stress, Aid Station

**SLEEP**
Average adult needs 7-8 ½ hours. Getting enough sleep? Test this: if you fall asleep when sedentary, you’re sleep deprived!

**MEASURES TO INDUCE SLEEP (SLEEP HYGIENE)**
1. Avoid caffeine, nicotine, alcohol, excess sugar, and any other stimulants. We know this is tough but will help tremendously.
2. Separate room from being awake – get up after more than 20 minutes of not being able to sleep. Do something dull, read manual, then until sleep.
3. Limit daily in-bed time to bed-related activities. No TV in bed!
4. Sleep schedule by getting up at same time every day. Set the brain’s alarm clock by exposing yourself to light in the morning when possible.
5. Nightmares? Try directed dreaming, concentrate on what you want to dream (how you want it to go differently) as you go to and lay in bed.
6. Don’t face or watch the clock!
7. Avoid daytime naps or keep them to 20 minutes or less.
8. Regular exercise early in the day (3 hours before bedtime).
9. Avoid eating stimulating (coffee, soda, tea, cigarettes, energy drinks)
10. Try very hot, body temperature-raising, shower near bedtime.
11. Eat at regular times daily; avoid large meals near bedtime. Sleep promoting foods: milk, tuna, pumpkin, almonds, eggs, walnuts, oats, potatoes, & bananas
12. Practice evening relaxation routines: deep breathing, prayer, repeat a relaxing word in your head, imagine being in a peaceful place, have a bedtime ritual.
13. Mind or thoughts keep you awake? Write down your worries before bedtime. Maintain comfortable sleeping conditions: dark, cool, quiet.

**STRESS**
Stress comes from any life change, good or bad, adds up over time, and will eventually affect our mind and body in some way.

**STRESS MANAGEMENT TIPS**
1. Decrease or eliminate caffeine, nicotine, alcohol, excess sugar, and any other stimulants. We know this is tough but will help tremendously.
2. Deep breathing – take a deep breath, fill your lungs until your chest is tight, hold 5 seconds, then slowly exhale. Once more, then focus on normal breathing.
3. Pray, repeat a short verse, say a mantras.
4. Read a good book, a magazine, anything for FUN.
5. Go workout for 30 minutes, cardio exercise significantly improves mood.
6. Watch or listen to something funny, 20 minutes of humor reduces stress for as long as 14 hours. Seriously, we’re not joking!
7. Garbage in – avoid stressful movies, music, and people, focus on positives, be around supportive people, stress is contagious, spreads like the flu!
8. Go to your happy place: imagine yourself at a place or time when you were at peace, felt good. Stay there for 10 minutes, remember the sights, smells, sounds.
9. Don’t worry be happy! 90% of our mental energy targets things we have little control over, past events we can’t erase or future events that may happen.
10. Random acts of kindness, do something nice for someone without any strings attached. Better yet be anonymous, keep it a secret. You’ll feel great!
11. Put things into perspective. “How will this affect my life 10 years from now?”
12. A problem shared is a problem halved. Talk to someone, anyone that’s a good listener that you trust: buddy buddy, NCO, chaplain, combat stress.

**113" COMBAT STRESS CONTROL FOR RUSTY – 302-772-8016**
**ROOM 159 HOSPITAL**
psychotherapy (Connolly, Crits-Christoph, Shappell, Barber, & Luborsky, 1998; Luborsky, 2000) very effective. Dramatic levels of psychological stress sometimes uncovered unresolved past issues as well as traumas from past deployments and SE’s brief characteristics were ideal to help soldiers gain self-understanding and release repressed emotion. In other instances, the stress of war created a profound sense of “existential angst” with soldiers asking “why did this happen... how could I have done that... what kind of person am I,” questioning their beliefs, values, and identity, encouraging a more humanistic approach. In a Rogerian-like style, emphasizing non-judgmental, unconditional positive regard, the social worker aided soldier-clients in finding meaning and understanding to their personal experiences to war. Although many benefited form this insight-oriented approach, enlisted soldiers tended to respond better to more solution-focused approaches, whereas officers and senior NCOs responded to insight-oriented methods.

The team involved supportive NCOs were involved in behavioral contingency contracting to reinforce desired soldier behavior. The social worker did behavioral rehearsals with soldiers trying to be more assertive, address performance anxiety, and develop basic social skills. In one instance, a female mental health specialist successfully worked with a young soldier to improve his demeaning comments toward female soldiers, explaining her impressions of his vulgar and crude remarks, and then coaching on appropriate responses. Progressive desensitization was also common to address debilitating fear of going “outside the wire,” riding in a HUMVEE, or walking outside (a requirement for getting chow). Interventions requiring too much homework, in particular cognitive therapy, had less adherence than the more action-oriented behavioral methods.

Critical Event Debriefings

It was customary for military behavioral health providers in Iraq and Afghanistan to conduct critical event debriefings (CED) for teams involved in significant combat engagements, normally those resulting in significant casualties or deaths. Following a process akin to the Critical Incident Stress Debriefings (CISD; Mitchell, 1983, 1988), the social worker conducted one-time group sessions with soldiers involved in the incident. Although CISD has been controversial and is generally contraindicated for individuals (Rose, Bisson, & Wessely, 2003; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002), more recent evidence supports group psychological debriefings (Adlet et al., 2008; Tuckey & Scott, 2014; Pender & Prichard, 2009). The CED was one component of a broader trauma management response. The team’s standard operating protocol for traumatic events began when injured soldiers were first seen in the Level II Aid Station for emergency stabilization before being medevac’d to the CSH. The behavioral
health provider on-call, either the social worker or psychiatrist, and a mental health specialist would be present when casualties arrived at the aid station, referred to as “code blues,” providing crisis intervention counseling, building rapport with non-injured soldiers, and collecting information to understand the critical incident. These were highly emotional and adrenaline-charged events with soldiers racing to the aid station with wounded battle buddies as well as the bodies of fallen comrades, occurring any time of day or night. The team’s typical involvement consisted of handing out water or sport’s drinks, listening, and reminding soldiers to clear their weapons (unload and safety firearms). On many occasions the social worker and specialist responding to the “code blue” were enlisted to carry liters. During mass causalities situations, when the number of wounded exceed aid station resources, the combat stress teams provided first aid to the less seriously wounded. After the “code blue,” the team also had a presence during the ceremony on the ground transporting the bodies of soldiers within hours of death by Blackhaws, referred to as “Hero Flights.” Team Rusty staff also attended the formal memorials, usually conducted within a week. The team’s presence at these events was strategically done to build rapport for the CED or other clinical involvement.

The CEDs were done no earlier than 24 hours after the event, giving soldiers time to physically unwind and complete the numerous tasks required after the death of a soldier, yet within 72 hours to assure adequate recall. After the code blue, units returned to their smaller FOB or COP, necessitating the social worker and a mental health specialist to arrange transportation out to their location. The brigade commander gave these combat stress missions travel priority over all other non-combat missions, allocating two Blackhawk helicopters. When flying was not possible due to weather, units would send a four-vehicle convoy to transport the team to provide the CED and any additional counseling. This allocation of scarce transportation resources during the busiest time of the war shows the importance of behavioral health to these commanders. Once the team arrived, the social worker explained to the unit’s commander the protocols, in particular the need to organize CED groups according to trauma exposure. In other words, those that were directly involved in the engagement would be present in one group, those that were part of the quick reaction force (QRF) that aided the attacked team would be in a second, those that recovered the vehicle and human remains a third. This minimized secondary traumatic exposure, although insurgents often would upload videos of the attack to the Web, again exposing soldiers to the traumatic event. Sessions lasted between one to two hours, depending on the breadth of the event, depth of involvement, and degree of trust for what was expressed in the CED not becoming public. The social worker assessed soldier engagement in the process by their language and emotions, which were often intense, unfiltered, and raw. Initially, a mental health specialist would attend the session to observe soldiers and help identify
those in need of additional care. Later, specialists were excluded to reduce secondary exposure to these traumatic stories and intense expressions of anger, fear, sadness, and grief. Chaplains often attended CEDs, another useful observer of soldier participants and a resource when the team departed. In some instances, though, soldiers were uncomfortable with the chaplain’s presence. This did not occur very often and the social worker found many chaplains well trained to provide supportive counseling, a valuable resource when demands exceeded team abilities. Immediately after the CED, the social worker would process the event with the mental health specialist and then de-brief the unit’s commander or first sergeant regarding the effected unit’s operational readiness and additional care needs. The CSC team would remain with the unit for a day or two, providing additional counseling, too often cut short due to needs on other FOBs or the unit’s combat operations. The 113th CSC company protocol dictated that any team conducting a CED be allowed 24 hours to recuperate once returning to home base. This was rarely followed because of the volume of behavioral health needs.

Modified CEDs were done for units with repeated incidents, Iraqi interpreters working with U.S. Forces, as well as civilian workers, many directly exposed to traumatic events like mortar attacks or dealing with the loss of colleagues and friends. These modified protocols involved revised prompts and questions appreciating their repeated exposure to trauma, language and cultural differences, or summarizing previous discussions of the psychosocial reactions and coping responses. The social worker also assisted those effected by secondary exposure to the trauma: the lone mortuary affairs NCO responsible for preparing bodies for transportation home, medical staff, and volunteers sanitizing vehicles after horrific IED/EFP attacks. Vehicle sanitization was a systematic cleaning of a vehicle to respectfully remove and, if possible, identify human remains. Team Rusty conducted 91 formal CEDs during their 11 months in Baghdad, responding to most events within 48 hours. It is not the intent of this article to detail the specifics of these traumas but, suffice to say, the nature of combat during the surge resulted in horrific events that no one could be prepared to face regardless of training or previous professional experiences.

Outcomes/Dispositions

Intervention outcomes were basically measured in two ways: whether the soldier returned to duty with or without limitations or evacuated to the next higher level of care (fitness center or CSH). Although combat social work’s politically corrected mission was to provide behavioral health care, its primary directive was to be “force multipliers . . . maintain fighting strength” by returning soldiers to their jobs. This screening and returning to duty was routine and sometimes covertly done, achieved by psychologically patching soldiers up “good enough” to get them “back in the fight.” This
kind of psychological first aid, sometimes for emotional chest wounds, was intellectually justified by theories from psychologists like Peter Levine (1997). In his treatise on trauma, he suggests that working through the trauma as quickly as possible was essential to long-term adjustment, something the Army interpreted as quickly returning to duty for the benefit of the soldier, despite the risk of additional traumatic experiences. Logically, as with any organization, the Army was concerned with its short-term need to maintain combat operational strength during the deadliest and most crucial period in the Iraq War. Although many practice environments return clients to at-risk situations (child protection, domestic violence) and client self-determination (decision to join the service, re-enlisting) must be valued, few areas of social work practice return clients to conditions where the likelihood of life-changing injuries or death is as high as combat. Team Rusty returned to duty nine soldiers that were eventually killed and countless others that were seriously wounded. Researchers have found a significant relationship between earlier childhood trauma, combat trauma, and later PTSD diagnosis (Breslau, Chilcoat, Kessler, & Davis, 1999) as well as the negative affects of repeated combat traumas and re-traumatization (Kuhn, Hoffman, & Ruzek, 2012). Yet, there are no specific studies for soldiers RTD and the effects of cumulative combat trauma and resulting long-term negative consequences like PTSD, substance abuse, and accidental death from high-risk behavior or suicide. For all soldier-clients receiving care for COSR/PMD (1,061), Team Rusty had a 99% RTD rate, the most successful rate for teams from the 113th MED CO (CSC). Table 4, depicts the dispositions of PMD and COSR clients served.

The vast majority of soldier-clients seen for COSR or PMD were helped within the AO and not referred to the rest and relaxation program (R&R at Freedom Rest on FOB Freedom in the Green Zone), evacuated to a soldier restoration program (fitness program), or the CSH for more in-depth assessment or hospital care at facilities in Landstuhl, Germany. Travel within the Iraq theater of operations was highly problematic, as described earlier for civilians, and dangerous. For instance, one battalion commander insisted on sending a group of soldiers that had experienced multiple losses and injuries to Freedom Rest for a week of R and R. The soldiers preferred to not travel

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evacuated to Combat Support Hospital (CSH)</td>
<td>11</td>
<td>1.0</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Killed-in-action</td>
<td>9</td>
<td>0.8</td>
</tr>
<tr>
<td>Returned-to-duty</td>
<td>1,040</td>
<td>98.0</td>
</tr>
<tr>
<td>Total</td>
<td>1,061</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4 Dispositions for PMD/COSR Cases
and requested to remain in place to recuperate, to which the social worker agreed and advocated for. Nonetheless, they were ordered to make the trip, only to be hit by an IED in-route to Freedom Rest. No one was seriously wounded but the television and X-Box gaming system in the vehicle were destroyed.

All of the psychiatric evacuations were for suicidal soldiers who were not responding to treatment and whose safety could not be reasonably assured. Suicidal soldiers were closely screened and provided immediate and ongoing care, sometimes necessitating their relocation to FOB Rustamiyah to be closer to Team Rusty. The social worker and psychiatrist alike made “barrack calls,” met anyone in need 7 days a week, 24 hours a day. Considering the ineffectiveness of “no harm contracts,” suicidal soldiers where routinely removed from duty, bolt taken from their weapon, and put on one-on-one, 24-hour observations. Lacking the personnel to provide this level of care by the CSC, it was customary to have the soldier’s unit provide this observation, escorting soldiers to counseling sessions, meals, gym, and other therapeutic activities. This strategy compromised confidentiality. In less serious suicidal cases, barracks observation involved suicidal soldiers restricted to their barracks, as long as other soldiers were present. In situations requiring closer one-on-one observation or when no one in the unit could remain with the soldier in the barracks, he or she was assigned to duty and to live in the company’s tactile operations center (TOC). The TOC was staffed 24 hours a day to monitor radios and supervise company-level operations. No one would willingly sleep, eat, work, and live in this noisy and disruptive environment with little privacy or confidentiality. On most occasions, suicidal soldiers under TOC observation miraculously improved within a day or two. The social worker had to carefully assess the soldier’s suicide risk because even under barracks or TOC observations, weapons and ammunition were plentiful and within easy reach. When the acuity level warranted, a few suicidal soldiers were placed on medical hold in the battalion aid station (BAS). Located a few steps from Team Rusty’s main clinic, the eight-bed medical hold area was staffed by a nursing officer and was seldom used for medical patients because they were routinely medevac’d to the CSH within hours. When barracks, TOC, and medical hold options were not enough, the soldier would be medevac’d by Blackhawk helicopter to the CSH.

Medevac’ing a patient with a life-threatening behavioral health condition involved specific steps, handled in a respectful and confidential manner, although everyone on the FOB or near the aid station knew something was up because two medevac helicopters were impossible to hide. The soldier was informed that given his condition and inability to assure his safety during the flight, he would be restrained on a litter using leather restraints. This happened only once because the set of restraints never returned; later restraints were done using ace-like bandages and once by restraining the soldier between two litters. Thirty minutes before the flight, the patient was
brought to the aid station with only essential care staff present, sedated, and blanketed to cover the restraints. They were then transported by Army ambulance the short distance to the helipad and placed on the waiting helicopter. With only a single CSH psychiatrist and specialist to treat evacuated patients, the soldier’s unit had to send two NCOs to provide 24-hour observation and supervision. About nine months into the deployment, soldiers reported bizarre behavior from the sole CSH psychiatrist: cursing, short-tempered, repeating questions, looking disheveled. The psychiatrist was likely burned out from being the dumping ground for problematic soldiers and the refusal of other providers to make the tough call to evacuate someone to Longstuhl, something that was discouraged for fear of looking like a ticketing agent for Germany. After hearing the medevac procedures and the requirement to send NCOs with the patient, units became very cooperative and supportive to provide care at the FOB and soldiers usually improved quite rapidly.

Access to care was excellent, typically better than stateside, with the majority of soldiers seen by a provider within a day. A number of soldiers on smaller FOBs, however, had to travel to clinics on FOB Rustamiyah or FOB Loyalty for care because visits to smaller FOBs/COPs became difficult as the demand for services increased and travel by air and ground became more dangerous. In 11 months, Team Rusty evacuated only 11 soldiers to the CSH or a fitness center, had six suicide attempts, and one completed suicide. A few soldiers sought behavior health care as a means to return to CONUS, fixated that returning CONUS was “the solution” to their problems. Seeking behavioral health care was occasionally a strategy to avoid combat operations or unpopular work details. This kind of malingering was rare, less than a dozen soldiers during the deployment, and not tolerated by the CSC team.

Treatment Adherence and Confidentiality

Considering the structure of the military and the controlled environment of a FOB (a prison keeping people out rather than in), soldier-client treatment plan adherence was excellent. Likewise, the rise in status of behavioral health in the Army almost assured unit cooperation with written soldier care plans, with hopes to be seen as proactively involved in soldier care. Involving the soldier’s unit and, in particular, NCO leadership, greatly added to the likelihood of successful outcomes. Most NCOs took their job of “taking care of soldiers” seriously but some maintained archaic attitudes about mental health, and considered seeking help a sign of weakness. Interestingly, Special Forces (SF) units, the most esteemed and rigorous elements of the U.S. Army, welcomed combat stress visits and readily sought assistance. Their open affiliation with Team Rusty added significant credibility to behavioral health services.
At the time of the surge, many mid-level NCOs had left service due to multiple deployments or injuries, requiring more rapid promotion or assignment of responsibilities to younger, less experienced and mature NCOs (Lubold, 2007). A similar pattern also was occurring for senior captains, those typically commanding company-size units (Shanker, 2006). Sometimes this inexperience, combined with harsh leadership styles, created a bullying-like atmosphere for junior soldiers, akin to a hostile work-environment where the employees stayed under the influence of their employers 24/7. Helping the soldier develop positive coping skills and supportive networks within the unit was desirable but sometimes the situation necessitated a move to a unit with more experienced, understanding NCOs. First-sergeants and commanders wanted to avoid letting situations escalate, affecting unit morale, or necessitating an evacuation and the resulting loss of manpower.

To assure confidentiality, the Army requires separate behavioral health records from their medical charts, usually inaccessible to medical providers. Interestingly, a battalion surgeon (primary care physician of almost any specialty), a physician assistant, and a cadre of medics were under the command of a battalion commander, a non-medical Lieutenant-Colonel in charge of the 500–700-soldier combat or support unit. Battalion surgeons were under orders to report conditions and trends to both their command and the brigade surgeon, often done in the BUB, so there was limited true confidentiality. In the civilian world it would be akin to going to a factory owned and operated medical clinic that routinely reported employee health issues to upper management. On more than one occasion, a battalion commander or his Sergeant-Major would appear in the CSC clinic demanding to know specifics about their soldiers seeking care. Often they would attempt to coerce lower ranking mental health specialists to tell them what was going on, which they deferred to the social work officer. Although soldiers could sign a release of information, likely under coercion, the social worker would convince leaders that all they needed to know was if the soldier could be returned to duty, whether this was with or without limitations, and what specifically those limits would be. Soldiers seen for COSR or PMD routinely received a “sick call slip,” a small paper form noting the date/time seen, RTD status, and basic follow-up care instructions. The provider or specialist would collaborate with the soldier on the care plan and the sick-call slip’s contents, adjusting for maximum soldier benefit. Although not orders per se, these sick-call slips carried a lot of weight, especially if problems escalated and the situation was later investigated.

In one instance, the remnants of a squad of infantry Rangers with multiple casualties and loses came pleading for CSC to “Do something . . . we have had it and are afraid we are going to do something really bad.” When asked the solution-focused approach’s miracle question, the soldiers said, “We shouldn’t go out any more.” The social work officer granted their request by writing a sick-call slip stating the unit was not mission capable.
and could not be RTD. The social worker contacted their battalion executive officer (XO, second-in-command), someone he had solid rapport with, and explained about the sick-call slip and likelihood these soldiers only needed a day or two but, in particular, needed an advocate. The Rangers returned the next day and said they appreciated someone “giving a shit” and were ready to return to combat. Although these sick-call slips were not on the same magnitude as a physician or commander’s orders, they were documented professional advice that non-adherence, in the event of a negative soldier outcome (self-inflicted injury or accidental weapons discharge from a overstressed soldier), would have to be explained to Army investigators. Although these could affect NCOs’ careers, the greatest risk was to senior officers with family complaints that their son or daughter was not receiving care.

Families often voiced concerns of the welfare of their soldier to rear-echelon leadership at home, chaplains, or congressional representatives. A “congressional referral” started with a family member’s call to their representative or senator, who inquired with the Secretary of the Army, who then contacted the soldier’s battalion commander for an answer within 48 hours. Units that were resistant to behavioral health services rapidly became cooperative under the scrutiny of a “congressional referral.” The social worker always worked to build trust and rapport with less cooperative units and never “directly” encouraged soldiers to solicit congressional referrals from family back home.

Researchers have consistently shown the importance of the therapeutic relationship in behavioral health (Krupnick et al., 1996), something paramount with soldier-clients. Although both clinicians were excellent at quickly building rapport, soldiers sometimes maintained rigid military boundaries, given that the providers were senior officers. The mental health specialists and NCOIC was the stand-in therapist to accommodate this rank-induced resistance with enlisted soldiers and sergeants. The specialists excelled at getting soldiers to talk about difficult subjects by their gentle demeanor, listening skills, and gender; two were college-age females. On a few occasions, soldiers requested to speak to the male NCOIC or OIC because, according to one soldier, “It is like coming into a super model’s office . . . I have a hard time talking to beautiful women.”

DISCUSSION

The role of behavioral health and combat social work has come of age during the wars in Iraq and Afghanistan. Team rusty served as a true “force multiplier” in southeast Baghdad during the surge, providing 6,846 walkabouts, 2,696 individual sessions, reached 2,514 in psycho-education classes or groups, and 1,173 in CEDs, achieving a 99% RTD rate. The team was
flexible and adapted to the intense combat conditions of the surge, operating two mental health clinics and conducting routine visits to nine smaller bases in the AO. The social worker was resourceful, acquiring additional physical resources like counseling rooms, as-needed transportation, additional weapons, and expanded his original team of three to six. From this experience came a number of lessons as well as concerns.

As the Army has realized, social workers possess a unique set of useful characteristics for combat behavioral health practice. First, social workers are well-trained and flexible behavioral health professionals, adept at working with few resources, quickly adapting to challenging practice environments. Second, the biopsychosocial approach, command of systems theory, utilization of brief interventions, and value for person-in-the-environment where an excellent fit with revised CSC doctrine (FM 4-02.51). Third, social workers’ ability to build rapport, quickly establish therapeutic relations, and network with soldiers and their leaders proved essential in the rapid-paced and dynamic combat environment of the surge. The military, however, may not fully appreciate this feminist-based profession, and its call to promote social justice, advocate, empower, flex rules to benefit their clients, or passion for system-level change.

There also are a number of personal lessons learned from this combat experience. First, the necessity of physical, emotional and spiritual self-care to endure this kind of intense trauma work and practice environment. Healthy exercise and nutritional and personal habits should be established well before being subjected to the demands of combat practice. Second, humor was a remarkable resource, as was establishing some kind of daily routine in an unpredictable environment like a warzone. Third, combat is best survived as a shared experienced, requiring the ability to quickly form friendships from a diverse and meaningful support network. Combat social workers must be open to not only giving but also receiving support from others, regardless of rank. Akin to this lesson, is the fact that the brotherhood (sisterhood) experienced in combat will never be experienced stateside, a valuable point for post-combat readjustment. Fourth, people are drawn to trauma like moths to flame, obvious from rubbernecking that occurs around automobile accidents and sensationalized news stories of traumatic events around the world. The social worker needs to limit exposure to traumatic events: potential, experienced, and secondary. Team Rusty could have reduced its exposure by not responding to aid station “code blues” and limiting travel “outside the wire.” Lastly, the military prides itself on being mission focused, pushing through difficulties to get the job done, and exploits workaholics that accomplish these missions. Many health professions have similar selfless service mindsets, placing patient needs first. However, this mindlessness of the personal effects of practicing combat social work has consequences. Superb social work and military training, excellent coping habits, and supportive networks do not make practitioners
immune from natural caregiver stress and burnout. As warned by the outgoing psychologist, the author experienced a profound sense of professional fatigue at about 7–8 months. As Figure 3 depicts, this burnout coincided with the most intense period of the surge (April, May, June), highest casualties rates, and the three deadliest consecutive months for the entire Iraq War.

This burnout manifested itself as a lack of emotions (e.g., fear, sadness, happiness), difficulty empathizing, decrease in energy, and an overall sense of numbness. Although this emotional shutdown was likely a protective coping mechanism from profound sorrow that follows exposure to horrific loss of life, it took a couple of years to reverse once stateside. This was likely complicated by the failure of the Army to adequately de-brief CSC teams during the 10-day de-mobilization process after the combat tour. The 113th MED CO commander advocated for a 10-day extended debriefing in Germany but was denied his request because of costs.

There is indeed a limit for experiencing human tragedies and living in a life-threatening practice environment for most social workers, including one with a doctorate and years of experience. Before choosing military practice, social workers need to closely examine their ethical comfort for enabling a institution whose primary function is to conduct war. Many commanders and NCOs truly care for the psychological welfare of their soldiers, but the needs of the Army and the mission come first. Although combat social workers provide a valuable caregiving, supportive, and nurturing presence, make no mistake, CSC teams are force multipliers. Our primary client is the military

![FIGURE 3 Frequency of Team Rusty CSC contacts and Iraqi theater casualties by month: October–August.](image-url)
and its needs come first, with the psychosocial consequences of combat taking second place to accomplishing the mission. Daley (2012) identified this struggle as an ethical quandary of dual-loyalty (profession versus military) in addition to other dilemmas involving confidentiality as well as hierarchy and power. Again, social workers must discern the goodness-of-fit between their professional and personal values and the demands of the military social work practice.

REFERENCES


