Psychiatrists in Combat

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Editors

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Mental Health Clinicians' Experiences in the War Zone

Springer

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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.

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