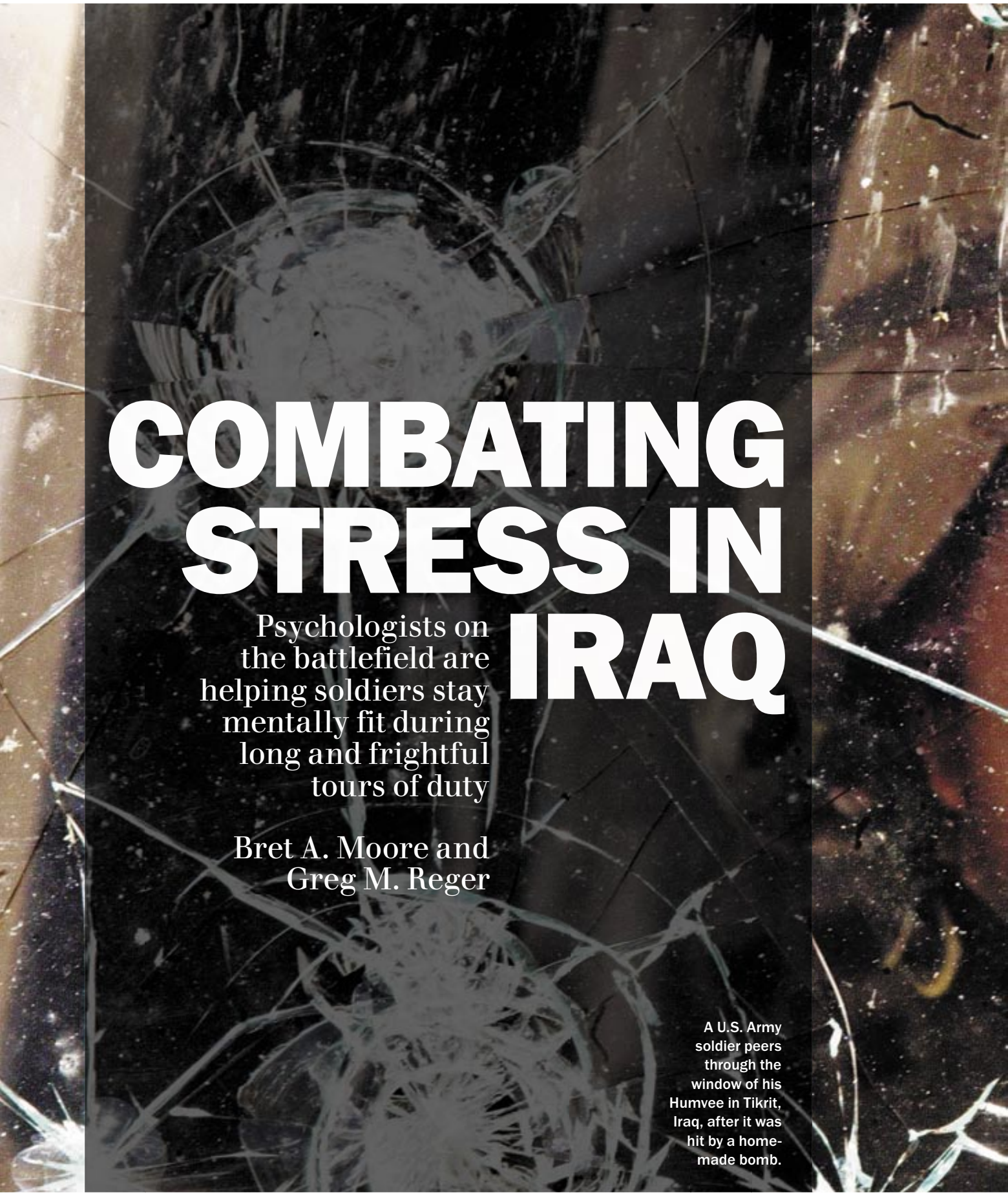


COMBATING STRESS IN IRAQ

Psychologists on the battlefield are helping soldiers stay mentally fit during long and frightful tours of duty

Bret A. Moore and Greg M. Reger

A U.S. Army soldier peers through the window of his Humvee in Tikrit, Iraq, after it was hit by a homemade bomb.

During a routine patrol outside a small village in eastern Iraq, a four-vehicle convoy was suddenly blasted with an improvised explosive device (IED). Michael (not his real name), a 22-year-old combat medic who was riding in one of the vehicles, lost consciousness for several moments. As he regained his senses, he saw that the gunner had been thrown from the turret. Michael immediately scrambled out of the mangled vehicle and began to apply first aid. After stabilizing the injured soldier, Michael proceeded to the next truck ahead to see if there were further casualties. As he approached, a second IED detonated. Michael was knocked out again. When he came to, he saw that the driver was seriously injured. Michael gave him CPR and struggled over him for 10 minutes, but the man died in his arms.

Two days later, as part of the routine follow-up to such an incident, a psychologist with the unit's combat stress control team conducted a debriefing of the members of the convoy. Throughout the discussion Michael was quiet and reserved, showing no emotion. Then, six days later, he appeared at the psychologist's quarters and reported that he was having trouble sleeping, was experiencing nightmares, had lost his appetite and had an intense fear of going on future missions.

The psychologist promptly initiated treatment for Michael, assuring him that what he was experiencing was to be expected. The therapist taught him behavioral techniques that would help him sleep, facilitated a brief course of sleep medication, and educated him on the importance of maintaining a regular exercise and work routine. The psychologist also started Michael on daily therapy sessions, and he was placed on restricted duty for the next seven days. At the end of that time Michael reported that he could sleep better and was clear of nightmares. He regained his appetite as well as his confidence in his abilities as a soldier and a medic. The unit's commander placed Michael back on full-mission status, and he continued with his military duties.

Army psychologists are playing a critical role in maintaining the emotional and psychological well-being of service members in Iraq. Their ability to get to the troops quickly and treat them on the battlefield is making a difference in how well our fighting men and women are able to deal with the potentially disabling consequences of combat stress. Michael's story highlights the toll that combat exposure can take, and it illustrates how prompt and targeted intervention can mitigate the present and possible future effects of traumatic experiences. The case also illustrates the tactical and operational importance of the army psychologist in Iraq. Helping emotionally stressed service members return to their prior level of functioning is not only the best medicine for their mental health, it is key to a military unit retaining valuable soldiers, which is crucial to operational success.

Unable to Function

Traditionally, the human cost of war has been viewed primarily through physical lenses. Talk of combat casualties usually refers to physical injury or death on the battlefield. Yet the emotional and psychological effects of combat on service members can also be devastating. It can even be the critical factor in whether or not a military force is successful.

The first accounts of combat stress on warriors can be traced back to early mythology. But it was not until the 17th century that military leaders began to realize that the stress on soldiers could have a profound influence on the success of military operations. The condition was originally called "Swiss disease," because doctors and leaders in the Swiss Army noted that some men no longer had the motivation or ability to continue fighting. Many would just give up

ARKO DATTA *Reuters/Corbis (preceding pages and this page)*

JACK WHITE, ARMY STAFF SGT., 116TH BCT PUBLIC AFFAIRS (*top*); LEK MATEO, ARMY MASTER SGT., 56TH BCT PUBLIC AFFAIRS (*bottom*)

or become so incapacitated by fear that they could not physically function. Over the next centuries this phenomenon went through several name changes, including nostalgia, irritable heart, shell shock, battle fatigue and the current designation of combat stress reaction.

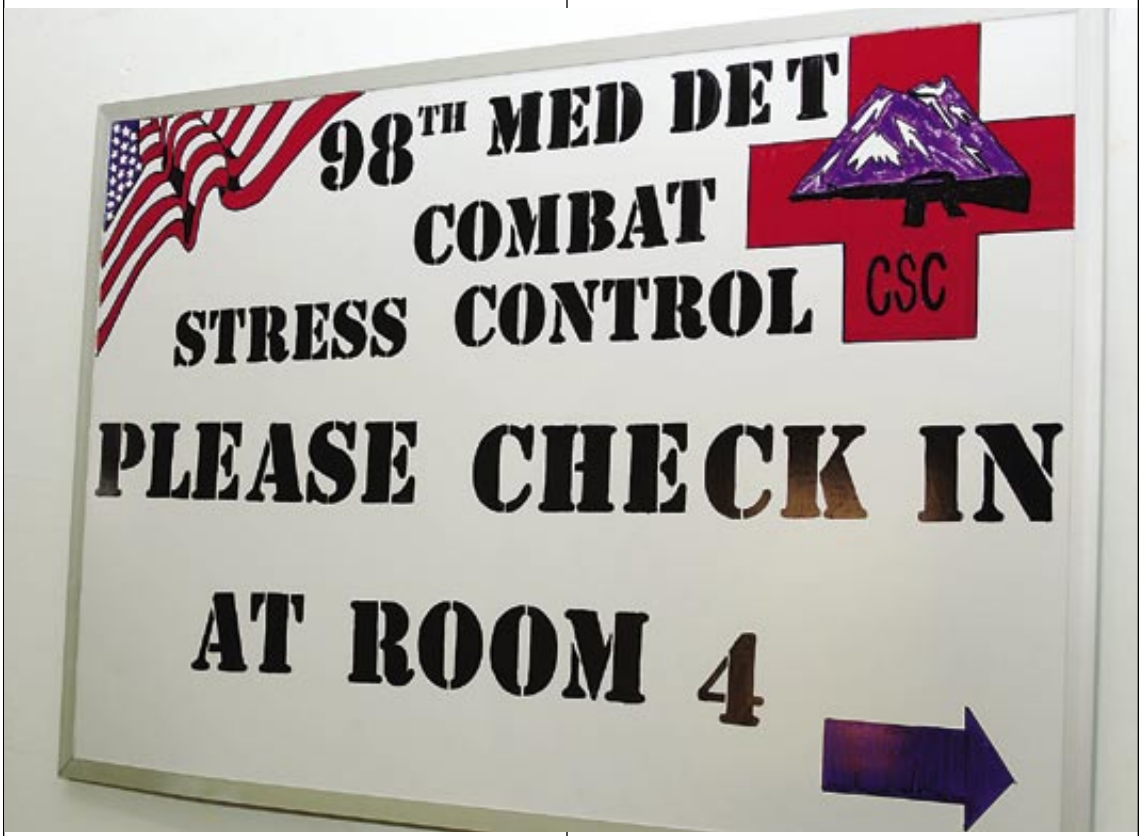
Combat stress may arise when an event, situation or condition in a fighting zone requires a soldier to alter his or her behavior in response to new demands. The change typically presents cognitive, physiological and emotional challenges. Such stress is a normal and expected experience for deployed personnel, and the vast majority of soldiers manage it effectively. Many actually perform better under reasonable levels of stress. But certain situations can place so much strain on an individual that he or she cannot maintain a normal level of functioning. Emotionally, a service member suffering from a combat stress reaction may exhibit sadness, worry, fear or even inappropriate euphoria. Cognitively, the person may experience disorientation, confusion, memory loss or inattention. And behaviorally, he or she may exhibit an increase in aggressive or suicidal behavior. In extreme cases, the service member could potentially engage in hostile behavior toward local civilians or enemy detainees.

We should note that the term "post-traumatic stress disorder," or PTSD, is often used to describe a service member's reaction to battlefield events. PTSD is a specific psychiatric diagnosis, however, characterized by emotional trouble months or years after trauma. A combat stress reaction may or may not lead to the development of this disorder.

Soldiers in Iraq are affected by the same problems that military personnel over the centuries have been forced to endure. Still, for the American troops currently deployed overseas, two important differences can further impinge on their psychological health. First, at no other

Author Bret Moore (*top center*) discusses stress with soldiers at their compound in Iraq. Author Greg Reger (*bottom*) stands before an armored vehicle that medical personnel use on the battlefield.

> The anxiety of knowing that an attack can occur anywhere, anytime, can be difficult to manage.



Personnel who cannot shake fear after being treated at their camp may be sent to a base that has more extensive therapeutic resources.

LEK MATEO, ARMY MASTER SGT., 56TH BCT PUBLIC AFFAIRS

time in American military history have service members been required to take such a defensive and reactive posture in combat operations. Although the initial assault on Baghdad in the early months of 2003 and the retaking of Fallujah in November 2004 were aggressive operations, much of the troops' time is spent patrolling villages, convoying between forward operating bases and searching for unexploded IEDs. The anxiety and fear of not knowing if or when an attack might occur can be difficult to manage. Second, everyone is in harm's way. The days of the soldier with the "gear in the rear" are over. There is no more "front line"; the linear battlefield has given way to self-supporting bases and camps strategically scattered throughout the region. Many support troops who would have been spared the emotional strains of combat in previous wars are now as vulnerable as the infantrymen. Consequently, larger numbers of combat stress casualties are possible. Fortunately, the military has recognized these changes and the potential problems that may arise. It has gone to great lengths to increase the number of mental health providers in Iraq. Army psychologists and combat stress control teams have become important operational assets.

Little Time to Talk

When asked to describe a psychologist, the public often imagines an older middle-aged man with a graying beard, probably with a cigar and

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A Soldier First

To ascertain how stress is affecting behavior, psychologists take part in dangerous assignments and must therefore be reliable soldiers as well.

It was late on a Tuesday afternoon when the platoon sergeant stopped by my makeshift office. Because of a recent increase in activity among nearby Iraqi insurgents, the platoon would be conducting traffic checkpoints that night in a densely populated city in northern Iraq. Concerned about his men, the sergeant asked me, the psychologist deployed to support his platoon, to accompany the unit so I could observe his soldiers. He wanted to know if stress was adversely affecting their performance. I had been on missions before, but none with this much potential exposure to enemy contact. Nevertheless, I agreed to go.

After cordoning off an area in the heart of the city, the unit began to stop and inspect vehicles. Even with temperatures still hovering around 100 degrees Fahrenheit at 11:00 P.M., the traffic was steady and the streets were bustling with bystanders. About an hour into the mission, a small car carrying four young Iraqi men approached. One soldier was at the checkpoint gate with me, and several others were close by. While the soldier was checking identifications, he realized that one of the passengers in the rear seat met the description of a wanted insurgent. As he questioned the suspect, a verbal confrontation ensued, and the two men in the front seats began to exit the car. As instructed in my previous training, I raised my gun and directed it at the men in an aggressive posture. Within seconds four other soldiers from the unit surrounded the vehicle with weapons drawn. A full search turned up several illegal weapons and materials used to make improvised explosive devices. The men were detained and taken to the local Iraqi police station. I breathed a huge sigh of relief.

Unlike in past world wars, today's battlefields do not typically have clearly delineated front lines and somewhat safe support positions in the rear. Violence erupts anywhere at any time. Explosives can be hidden in seemingly innocuous items such as cars, roadside debris and even baby strollers and can be carried by insurgents dressed in civilian clothes. Given this ease of disguise, today's army psychologists may find themselves alongside combat troops in dangerous situations. As a result, the army is reemphasizing the importance of psychologists and all support professionals being proficient not just in their occupational skills but also as soldiers.

I certainly did not relish standing at that checkpoint. But it was necessary for me to observe how stress might be affecting soldiers' actions, and if I had not reacted quickly enough, or had overreacted, my inappropriate actions could have allowed or caused a deadly fight.

Later, I told the sergeant that although his men were experiencing elevated levels of stress, they were still performing their jobs competently and safely. To reach that conclusion, I had to be in the midst of an important tactical operation. Furthermore, by inserting himself or herself in harm's way, a psychologist achieves two other crucial goals. First, the soldiers in a unit may develop a greater sense of trust in the psychologist and therefore be less reluctant to participate in mental health services. And second, the psychologist is better able to appreciate the stress unique to a combat environment, thereby imparting a far deeper understanding of what soldiers experience. *—B.A.M.*

JOHN MOORE *AP Photo*

an Austrian accent, who quietly takes notes alongside a patient who is lying on a couch. This image is as out of place in the army as the Freudian theories associated with it [*see box above*]. Historically, mental health providers have treated patients from a variety of psychoanalytical or psychodynamic theories that generally conceptualized an individual's problem as stemming from unconscious, repressed thoughts or feelings. Clinicians intervened with long-term talk therapy that attempted to bring this hidden material into consciousness, in hopes of giving the patient insight into the supposed root of his or her symptoms or finding a corrective experience in therapy.

Even though army psychologists may continue to draw from these theories to conceptualize a soldier's difficulties, the realities of a combat zone make long-term talk therapy impractical. Soldiers' mission schedules are unpredictable. Troop movements and unit reorganizations occur regularly. Psychologists may have only brief access to soldiers traveling through a particular forward operating base. As a result, army psy-

A soldier in Baghdad mourns at a memorial service for a 19-year-old compatriot killed when the truck he was riding in was hit by a rocket-propelled grenade.

DAVID LEESON *Dallas Morning News/Corbis Sygma*

chologists rely on more recent therapeutic models of short-term treatment.

One approach often employed is cognitive behavioral therapy. This practice recognizes the important role that thinking has on an individual's feelings and behavior. Challenging a person's irrational, illogical or dysfunctional beliefs can alter his or her moods and actions. For example, a soldier who feels angry with other members of the unit may have vindictive thoughts and act in verbally aggressive ways toward them. By recognizing and altering how the person thinks about his or her peers, the intensity and duration of the anger may wane. Although psychologists certainly take into account a soldier's environment, background and family history, short-term, nonpharmacological interventions such as cognitive behavioral therapy are the backbone of treatment in a combat zone.

Immediate Attention

The mission of an army combat stress control (CSC) team is straightforward: provide prevention and treatment as close to the soldier's unit as possible, with the intent of keeping the soldier with the group. CSC teams are specialized mobile mental health groups that are typically deployed to distant battlefields. They may supplement existing mental health teams or function independently, depending on the need or battlefield configuration. The development of these unique teams springs from lessons learned from World War I: if combat stress cases were evacuated to the rear, they seldom returned to their units, but when soldiers were treated close to the front, they were more likely to return to duty and less likely to have ongoing mental health problems on their return home.

Among the military's diverse mental health providers—which include psychiatrists, psychiatric nurses, occupational therapists and social workers—psychologists play an integral role in CSC units. We operate under four basic treatment principles: proximity, immediacy, expectancy and simplicity, a scheme known as PIES. Proximity refers to treating the soldier as close to his or her unit as possible. Immediacy acknowledges the importance of intervening as quickly as possible, to mitigate the impact of traumatic events and ward off potential long-term problems. Expectancy means helping the soldier realize that symptoms such as being afraid to go on further missions after being hit with an IED are expected, or typical, reactions to an abnormal situation and that with time these feelings will subside and allow for a full return to duty. Finally, simplicity encompasses the short-term and evidence-based treatment techniques such as cognitive behavioral therapy as well as ensures that the soldier's basic needs of rest, food and hygiene are met.

Psychologists in a CSC unit serve in two main ways: prevention and restoration. Preventive teams are typically found in remote battlefield areas. Their primary responsibilities are working to ward off combat stress, triaging it and setting up short-term treatment if it occurs. A CSC psychologist educates personnel in a va-

riety of areas such as how to avoid acting on thoughts of suicide, handling conflicts and reducing stress. In triage, the psychologist may have to travel to an outlying camp that was subjected to a traumatic event to assess and identify soldiers who are having acute stress reactions. At this point, the psychologist can decide whether to initiate a regimen of short-term therapy or to refer someone to the restoration team for more extensive care.

Restoration teams are usually located at a base that has greater access to resources than the remote units do. Here a psychologist works with a soldier on a longer-term basis, which in the army may mean anywhere from three days to two weeks. In certain cases, treatment could extend for several months. The soldier may receive daily individual and group therapy and training on stress and anger management, relaxation, and ways to get a better night's rest. Furthermore, the psychologist can help coordinate medication for sleep problems, depression and anxiety, as well as utilize the unique skills of occupational therapists. Prevention and restoration work together:

On his weekly visit to a remote camp that housed several infantry units, a preventive team psychologist learned from a sergeant that three days earlier one soldier was killed and several were seriously injured after an enemy rocket hit the camp's crowded dining facility. The psychologist immediately brought together the personnel who were involved and held a crisis debriefing—a one-time group session that allows everyone to discuss and process what happened.

Over the next several days, the psychologist worked one-on-one with a number of soldiers who were still struggling with the attack. Through individual therapy, coordinating sleep medication with the camp's physician assistant, and placing some of the soldiers on restricted duty to ensure they received adequate rest and recovery, he helped most of the personnel regain the level of functioning that they had before the incident.

The psychologist did identify two soldiers who had begun to suffer panic attacks, develop intense fear and feel hopeless about their ultimate survival. He coordinated an air evacuation of the two men to a regional restoration team, where they received more intensive and comprehensive services. Six days later the soldiers were able to return to mission status with their unit. Although some residual fear remained, the two men and their providers judged that the linger-

Psychologists may have only brief access to soldiers passing through. Treatment must be short-term.

ing stress was not sufficient to prevent them from doing their job or to put them or other members of their unit at risk.

The stress of war can have a tremendous impact on a service member. But with targeted and prompt intervention, a psychologist can help mitigate the acute effects of combat stress and, it is hoped, prevent the development of future mental health problems when the soldier returns home. Combat stress can also hurt a military unit as a whole. Without the appropriate level of manpower, the unit may be unable to function optimally, compromising an important military operation and placing many troops at risk.

Fortunately, the military has recognized the importance of ensuring quality mental health care to its members. At a minimum, our country owes these brave men and women a return home to their loved ones and a future not plagued by emotional and psychological problems. We are not so naive as to believe that these warriors will be completely unaffected by their experiences. But by adapting psychological principles common in the civilian sector to the battlefield, psychologists and combat stress control teams can alleviate the damaging effects of the inevitable stresses of war. M

(Further Reading)

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