

# Appendix 2

## OPERATIONAL PSYCHIATRY IN OPERATION ENDURING FREEDOM

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### INTRODUCTION

#### A BRIEF HISTORY OF AFGHANISTAN

#### US MILITARY INVOLVEMENT IN AFGHANISTAN

#### US ARMY MENTAL HEALTH OPERATIONS IN DEPLOYMENT

- Preparation
- Outreach
- Prevention
- Education
- Consultation
- Clinical Operations

#### MENTAL HEALTH OPERATIONS IN AFGHANISTAN

- Chain of Command
- Logistics
- Communication
- Travel
- Documentation
- Data Collection

### CONCLUSION

### CASE STUDIES

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## INTRODUCTION

The mental health mission in support of Operation Enduring Freedom (OEF) possesses numerous challenges unique to the region and history of the nation. To best understand the complexities associated with mental health operations in this theater, a logical starting point is a brief history of Afghanistan itself and the United States military involvement in support of OEF. This will provide the basic construct

as to the evolution of the mission and its inherent obstacles.

The appendix will then cover deployment-related mental health issues and an overview of the mental health mission in OEF. Five clinical cases are presented at the end of the appendix to facilitate learning by emphasizing the wide array of subject matter that will test the skills of the deployed mental health clinician.

## A BRIEF HISTORY OF AFGHANISTAN

The Islamic Republic of Afghanistan has a turbulent history dating back to 2000 BCE and has endured countless warring factions and oppressive regimes. From the Aryans to Alexander the Great, from Genghis Khan to the Soviet Union, and most recently, the Taliban, Afghanistan has known little stability and peace.

Afghanistan, or "Land of the Afghans," emerged from the Iranian state of Khorasan and won its independence from Britain in 1919. Failing economic and social reforms in the 1960s and 1970s led to public discontent and invigorated the Marxist People's Democratic Party of Afghanistan (PDPA). In 1978, the PDPA overthrew the government and established the Democratic Republic of Afghanistan. Unfortunately, political infighting and Marxist-based reforms imposed upon the overwhelmingly Muslim population fueled a rebellion and ultimately a civil war. To bolster the communist influence, the Soviet Union deployed the 40th Army in December 1979. The Soviet war in Afghanistan, aimed at crushing the antigovernment Mujahideen insurgency and empowering the PDPA, ended in failure 9 years later.

The social, economic, and cultural void that ensued provided fertile ground for the rise of the Taliban, a politico-religious force that oppressively imposed a strict interpretation of Sharia law. By the mid-1990s,

the Taliban had seized control of the majority of the country. Their tenure was relatively short, however, as the Taliban's support and harboring of international terrorists led to its demise in 2001. Significant steps toward achieving national self-sufficiency and stability have occurred recently. A ratified constitution, free elections, emphasis on education, and enhancement of a national infrastructure are all prominent examples of this progress.

Although the recent discovery of vast mineral stores, valued at approximately 1 trillion US dollars, may translate to economic security and prosperity for the nation, the realization may take decades. Currently Afghanistan remains one of poorest nations outside of Africa, and one that relies on an agriculturally based economy. Unfortunately, only 1% of its land is suitable for agroindustry, and only one-tenth of that used for farming. Cash crops are in demand and poppy production fills that void. Poppy production accounts for 57% of Afghanistan's gross domestic product. Aside from Afghanistan's reliance on the poppy industry, the ongoing insurgency, susceptibility to corruption, high rates of illiteracy and unemployment, oppression of the female population, rugged terrain, and rich history of tribalism present formidable challenges to the nation and its people.

## US MILITARY INVOLVEMENT IN AFGHANISTAN

In response to the terrorist attacks of September 11th, President George W Bush demanded on October 7th, 2001, that the Taliban "close terrorist training camps; hand over leaders of the al Qaeda network; and return all foreign nationals, including American citizens, unjustly detained in your country." This ultimatum was rejected. On October 20th, 15 land-based bombers, 25 Navy strike aircraft, and Tomahawk missiles from US and British ships launched the first strikes of Operation Enduring Freedom. The initial aerial assault targeted terrorist strongholds in Kandahar, Jalalabad, and Kabul, and was soon followed by the deployment

of ground forces.

The theater of operations in Afghanistan has matured significantly since the onset of military action. A multinational coalitional force, dominated by US personnel, is now directed by the International Security Assistance Force (ISAF). The North Atlantic Treaty Organization (NATO) took command and coordination of the ISAF in August 2003; it represents NATO's first mission outside the Euro-Atlantic area. ISAF's role is to assist the government of Afghanistan and the international community in maintaining security within its area of operation. ISAF supports the government of

Afghanistan in expanding its authority to the rest of the country, and in providing a safe and secure environ-

ment conducive to free and fair elections, the spread of the rule of law, and the reconstruction of the country.

## US ARMY MENTAL HEALTH OPERATIONS IN DEPLOYMENT

The primary mission for US Army psychiatry and the mental health team derives from the US Army Medical Department's mission to "conserve the fighting strength." In the combat theater, mental health providers accomplish this mission through an array of services that assist the chain of command in controlling mental illness and combat and operational stress through sound prevention programs and effective treatment modalities that establish the expectation of recovery.

Mental health providers deploy immediately with a combat force and may include psychiatrists, psychologists, psychiatric nurse practitioners, social workers, or mental health technicians. Typically, the total number and type of providers vary from one rotation to the next. Assets are often in the form of combat and operational stress control (COSC) teams, division mental health providers, brigade behavioral science officers, and technicians or activated reservists, and may incorporate all branches of the military at any given time. Such a convoluted arrangement demands a well-delineated command structure and working agreements between all parties to greatly improve mission effectiveness and quality of care. To successfully execute the mission in any combat endeavor, providers must employ sound preparation, outreach, prevention, education, and consultative and clinical practices.

### Preparation

Predeployment planning is often limited in its scope or absent altogether. However, when the opportunity avails itself, the behavioral health professional should identify the mission, its requirements, and available assets. Familiarizing oneself with the theater prior to deployment is crucial and can be accomplished in myriad ways, ranging from participation in the predeployment site survey to a simple call or email to the team that will be replaced. Reviewing after-action reports and speaking with providers from previous deployments may be beneficial as well. Collecting pertinent and accurate information will greatly assist with the determination of staffing needs. Once staff members are identified, it becomes possible to know the team prior to departure. Furthermore, establishing relationships with commands, chaplains, and medical providers and screening deploying troops before departure will serve the mission well.

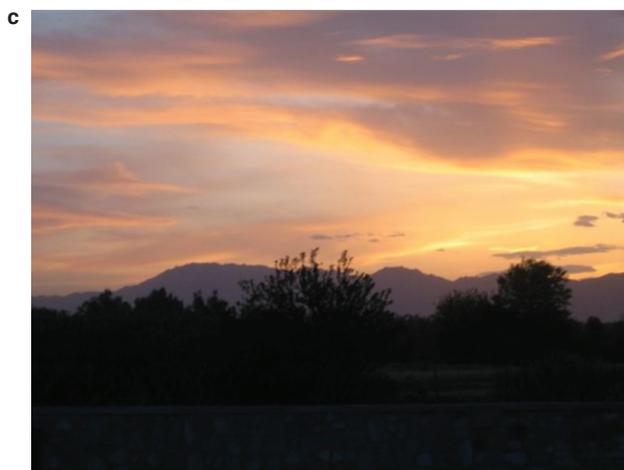
### Outreach

Recent combat operations have engaged the enemy in a low-intensity, nontraditional battlefield. Such conflicts are characterized by an insidious sense of randomness and loculated pockets of activity within a large geographical space, using conventional weapons typically combined with asymmetrical tactics ("terrorism") and applied use of intelligence.

In accommodating this type of mission, troops are often strategically scattered across the area of operations and reside in rustic installations called firebases or forward operating bases (FOBs). Based on mission necessity, the troop population, capability, and firepower, these outposts are in a nearly constant state of fluidity. Accordingly, it is critical that a relationship develops between key personnel at the smaller forward posts and mental health providers in theater. Meeting the senior leadership, medical assets, and chaplaincy will be essential, as they will serve as liaisons between individual and unit needs, and the mental health assets. Assigning specific providers (who periodically visit their catchment) to particular FOBs and firebases will further this dynamic by advocating for basic needs to improve morale. These behavioral health personnel provide a sense of familiarity to both the local troop population and leadership, and a commitment to



**Figure A2-1.** The mental health mission in OEF demands mobility from its providers.



**Figure A2-2.** Credibility is gained not only with clinical knowledge but also by sharing soldiers' experiences, such as foot patrols (a); sharing in their daily activities in remote locations (b); or just enjoying an Asian sunset with them (c).

continuity of care for those relying on their services (Figure A2-1 and Figure A2-2).

### Prevention

From a classic medical model, prevention is any activity by which an individual avoids the development of a disease or condition (primary prevention), diagnoses a disease in an early stage or prevents its recurrence (secondary prevention), or avoids a disease's worsening and restores oneself to an optimal level of functioning (tertiary prevention). The importance of prevention efforts cannot be understated in the theater; they can play a pivotal role in troop readiness and mission effectiveness.

Most often, deploying service members receive an array of predeployment training that typically includes psychoeducational briefs on broad mental health topics, such as the emotional cycle of deployment or general psychiatric symptomatology. However, this training is not guaranteed, and the content and quality may vary; primary prevention must be

augmented in theater. An excellent means of accomplishing this is securing a platform at the theater-wide inprocessing brief that all arriving US personnel attend. Another option is meeting with local chaplains and medical providers to provide information on common symptoms and issues, and how to engage mental health services.

As in any wartime period, there will be certain military occupational specialties (MOSs) with greater exposure and risk for emotional issues. These groups should be identified early and visited regularly utilizing the "therapy by walking around" concepts described by Milliken with the goal of providing a means of decompression, assessment, and formal mental health services if needed. Typically, mortuary affairs, combat medics, medical evacuation (medevac) crews, physicians (surgeons and trauma doctors in particular), nurses, chaplains, vehicle drivers, and senior leadership, among others, would benefit from secondary prevention.

Following a discrete, often traumatic event, tertiary prevention may be implemented. Currently, there is much debate as to the value and efficacy of critical incident stress management or debriefings, the seven-step Mitchell model in particular. Army mental health now supports the concept of traumatic event management (TEM), which enables the clinician to develop a program tailored to the specific needs of the unit considering the actual event, theater tempo, unit history, and response.

Regardless of the model employed, tertiary prevention will be a high-profile item in theater. Clinicians will be responsible to intervene at their discretion,

while assessing, supporting, and educating various command elements that may still be fluent in the “antiquated” critical incident stress management (CISM) dialect.

### **Education**

Developing a modified, yet aggressive, education plan will enhance quality of care while blunting the workload burden. A well-trained mental health technician can effectively serve as an intake coordinator, supportive or skills-based therapist, group facilitator, prevention specialist, liaison to the enlisted ranks, and representative to forward installations. Investing time in supervision and basic instruction will greatly improve the efficiency of the deployed team.

Besides enhancing intrinsic resources, educational efforts intended for medics, physician assistants, physicians, and chaplains can improve care throughout the area of operations. Broad topics such as terminology, diagnostic assessments, basic psychopharmacology, relaxation training, and sleep hygiene instruction can effectively accelerate initiation of treatment plans and reinforce their efficacy, reduce the need for unnecessary evacuations, and filter legitimate mental health cases from administrative or occupational issues of discord.

### **Consultation**

Deployed mental health providers serve as the subject matter experts for mental health and combat and operational stress. Commanders will often seek the expertise and recommendations of the behavioral health professional concerning individual or unit issues in the forms of a command-directed mental health evaluation or unit climate assessment, respectively. Furthermore, input will be requested for larger policy issues affecting the deployed force, such as suicide prevention, sexual assault programs, and redeployment planning. The behavioral health provider will also serve as a theater-wide consultant to medical

providers from all branches of the US military, as well as those employed by civilian contracting agencies and coalition nations.

### **Clinical Operations**

Although much of the mission will be firmly rooted in the principles and practices of COSC, placing a provider at each site in theater is impossible because of the numerous forward locations and limited mental health staffing resources. Thus, the mental health assets are typically divided into smaller teams and placed at several mature locations that have sizeable troop populations, access to intratheater transportation, and appropriate medical, intelligence, and command support services.

The pace of routine clinical work in the deployed setting is usually less demanding than one might experience while in garrison. It is recommended that set hours of operation are established and an on-call schedule is developed to preserve boundaries and protect against burnout while maintaining availability for those in need. The scope of practices in the clinic depends on the vision, resources, and staffing of the unit but ordinarily consists of individual counseling and brief therapy, time-limited skills and cognitive behaviorally based groups, medication management, mental status evaluations (for special schools/duties or administrative separation), command-directed evaluations, and seminars on topics such as anger management, stress reduction, smoking cessation, and relationship issues.

As with all clinical operations, standard operating procedures should be developed and followed. Roles, responsibilities, command structure, documentation, record storage, admission, evacuation, on-call coverage, and policies for various programs (such as suicide prevention, command-directed evaluations, TEM, and so forth) are topics that should be formally outlined in a standard operating procedure that is clear, concise, and understood by all members of the mental health team.

## **MENTAL HEALTH OPERATIONS IN AFGHANISTAN**

In late 2001, mental health assets sparsely populated the Afghanistan theater of operations. A pair of mental health technicians supported Kandahar, and a team of four (social worker, occupational therapist, and two technicians) were in Uzbekistan before relocating to Bagram Airfield in early 2002. A psychiatrist and social worker in Kuwait provided consultative services. Each rotation since then has witnessed an improved presence.

Common presentations include occupational discord, partner-relational problems, sleep problems, and stress. Psychosomatic, anxiety, and depression conditions represent a modest number of overall cases, while psychotic disorders and purely combat-related presentations are fairly rare. One can expect a robust stream of requests for command-directed evaluations and other administrative psychiatry tasks, and providers must maintain a healthy skepticism for secondary gain issues.

Effective screening and prevention programs, access to care in theater, and an underlying expectation of recovery has led to a return-to-duty rate in excess of 98% in recent years. Despite the success, Afghanistan presents an array of unique obstacles that may compromise satisfactory execution of the mental health mission. These obstacles must be addressed to ensure mission effectiveness.

### **Chain of Command**

Serving under ISAF, there are many layers of command intricacies that are often magnified by joint-service endeavors and the modularity of the Army. Providers should anticipate working closely with other branches of service and learn to negotiate across command structures. Further, roles and responsibilities, and the chain of command, should be promptly established so that all stakeholders understand mission specifics.

### **Logistics**

Clinical operational sites are selected based upon activities in theater, troop populations, and the availability of infrastructure, intelligence, command support, resources, and travel opportunities. Considering these variables, recent clinical sites in Afghanistan have included Bagram, Kandahar, Orgun-E, Jalalabad, Kabul, and Salerno. With troops spread across the theater, and highly mobile in response to mission evolution, clinical sites may have to change during the course of a rotation. Additionally, temporary prepositioning of mental health assets at selected FOBs and firebases based on tactical operational intelligence can be a valuable tool. Ultimately, COSC forward activities must possess flexibility to accommodate the fluid battlefield.

### **Communication**

Although the theater has evolved significantly, telephone and Internet access remain unreliable. Developing contingency plans and creative problem

solving must suffice until communication systems fully mature.

### **Travel**

Movement throughout the area of operations is critical to mission success but remains profoundly inefficient. COSC teams tasked to forward locations routinely wait multiple days for travel on both sides of the mission. Flights are often cancelled due to combat operations, maintenance issues, or weather conditions. Ground convoys present many of the same limitations, along with the risk for attack from improvised explosive devices (IEDs) and vehicle-borne improvised explosive devices (VBIEDs). To ameliorate this situation, establish a good rapport with the local air and ground movement request officers, learn all the potential means of travel to particular areas (scheduled "ring" helicopter flights, special rotary flights, C-130 and STOAL [short take off and landing] flights, and ground convoys), and prepare for delays.

### **Documentation**

OEF has introduced the electronic theater medical information (TMIP) program. This will ultimately help with patient care, but not all locations will possess the same technology or maintenance capabilities. Establish documentation standard operating procedures and rely on "FOB logs" to create a patient list and foster seamless transitions of care at each site.

### **Data Collection**

Historically speaking, there has never been a consistent outcome measure or statistical collection system that has passed between rotations. Hence, it is nearly impossible to compare relevant statistical rates with previous deployments. TMIP will assist with some of the demographic and diagnostic data collection, but the development of a comprehensive program that provides meaningful outcome measures has yet to be implemented.

## **CONCLUSION**

Providers face an array of challenges in delivering quality mental health services in the deployed setting. Further, OEF introduces unique obstacles that synergistically complicate the already challenging mission.

However, relying on sound strategies firmly rooted in conceptual military psychiatry will foster a comprehensive system of care for soldiers on the ground and will be effective in conserving the fighting force.

## CASE STUDIES

### **Case Study A2-1:** Importance of History of Present Illness (HPI)

*Situation:* A married active duty Army E4 white male with no past psychiatric history self-presented to the mental health clinic in Bagram complaining of suicidal ideation and poor sleep for the past 5 days. The soldier explained that his wife was possibly cheating on him and the only way to salvage the marriage was getting home. If he could not get home, “life is not worth living.” A detailed interview and suicide assessment revealed low risk for self-harm, with no plan. He had just returned from midtour rest and recuperation (R&R) leave 3 days prior to presentation and was waiting in transient status at Bagram for a flight back to his FOB.

*Assessment:* marital discord, occupational problem with conditional suicidality.

*Treatment:* supportive therapy daily while awaiting flight, symptom relief with Ambien, return to FOB as soon as possible.

#### *Teaching points:*

1. Expect to see a bump in self-referrals during the midtour R&R leave window.
2. Conduct a thorough evaluation of every soldier.
3. Target tangible symptoms such as sleep; educate and support.
4. Firmly set expectation that service members will return to their unit.
5. Identify funneling points for R&R and establish a clinical presence at those locations. When soldiers return to theater, they often have to wait days for travel back to their FOB. During that time they are in transient status with no significant accountability. Work with unit liaisons at such sites to assign daily tasks for these personnel and expedite their return to the FOB and unit.

### **Case Study A2-2:** Traumatic Event Management Gone Wrong

*Situation:* A tragic helicopter crash occurred in theater resulting in several deaths. Approximately 1 week later, the clinic was asked by the chaplain and flight surgeon to assist with a “debriefing.” Eager to help with this high-profile incident, mental health resources were pledged in support.

*Process:* The accident was detailed by the flight surgeon; the chaplain provided the unit history. A suitable place of meeting familiar to the unit was selected. Due to the number of individuals, it was decided to have two sessions—one for officers and another for enlisted. The sessions began with the commander providing a review of the accident and an update on the investigation. He then entertained questions. Troops were then allowed to depart or continue with the vol-

untary group debriefing. All stayed, many of them reluctantly. Unknown to the mental health providers, members of the command stayed in the room, taking notes. The chaplain assumed a role as a co-facilitator, yet would leave the group, interrupt, and make off-target statements. The resentment among the soldiers was palpable and the provider was clearly seen as an agent of the command.

#### *Teaching points:*

1. Obtain a thorough unit history; an inadequate report was provided in this situation because there was long-standing animosity, stemming from myriad issues, between the soldiers and command.
2. If your TEM includes a group modality, make sessions truly voluntary, with no command influence and no note taking.
3. Determine who is facilitating before proceeding.
4. Be sensitive: don't patronize or insult the dynamics by splitting up teams that may include both officers and enlisted.

### **Case Study A2-3:** Use Skills and Get Creative

*Situation:* A unit was involved in a noncombat motor vehicle accident in an area densely populated with civilians. Despite their best efforts, civilian casualties and deaths resulted. As the soldiers began to aid the injured, the crowd swelled in number and voracity. Many soldiers likened the masses and situation to the film *Blackhawk Down*. All feared for their safety as the atmosphere soon became confrontational; rocks and other debris rained down on the soldiers. Upon return to their FOB, the unit commander requested assistance for his soldiers. A psychiatrist visited the FOB, spending a few days helping soldiers normalize their reactions and consolidate their feelings. He suggested, if at all possible, a graduated return to activities outside the wire. Accordingly, a humanitarian mission was arranged at a nearby village. The psychiatrist accompanied the unit on the convoy, serving as a primary care physician for the medical component of the humanitarian mission. He was also present for the soldiers, many of whom were ambivalent about departing the confines of the FOB.

#### *Teaching point:*

1. Credibility is achieved through clinical competence, effective communication, honesty, and relating with soldiers. Creative approaches in developing rapport will augment this process.

### **Case Study A2-4:** The Barber From Russia

*Situation:* The division psychiatrist was walking across the post and came upon a suspicious young man squatting alone by the roadside. Efforts to negotiate the language bar-

rier were fruitless, so the psychiatrist went for help. The man followed and lunged for the officer's sidearm. The psychiatrist swatted the hand away; the man then retreated to seclusion. Shortly thereafter, the military police brought the man to the combat support hospital; they had found him scaling a fence to a minefield. A Russian interpreter translated a psychiatric diagnostic interview. The young man had a history of depression that was treated successfully in Russia. He was hired by a contractor to work at the installation barbershop. Since his arrival in Afghanistan, he became increasingly depressed with ruminations, hallucinations, and suicidal ideation. He was maintained at the combat support hospital (CSH) with a company escort and improved slightly with olanzapine. He was evacuated from theater 48 hours later and returned to Russia for definitive treatment.

*Teaching points:*

1. Although there are rigorous screening procedures for US service members, the same cannot be said for the large numbers of contractors working in support of OEF.
2. As one of only a few behavioral health subject matter experts in the country, you will find that skills in cultural psychiatry—from local Afghan nationals to civilian contract employees and Coalition forces—will be tested.
3. There are no inpatient psychiatric units in the CSH system. If individuals need admission, they can

usually board in the CSH with an escort until they are evacuated.

**Case Study A2-5: Keep the End State in Mind**

*Situation:* Medical providers in southeastern Afghanistan became increasingly frustrated with the medical rules of engagement (ROE) of perserving “life, limb, or eyesight” as they pertained to the hundreds of local nationals who came to the front gate begging for medical care. The physicians organized and contacted the Minister of Health as well as the dominant nongovernmental organizations that were providing medical assistance in Kandahar. In the process, the former dean of the then-defunct medical school was found, a medical library was created through donations from the deployed physician's home departments, and classes were taught. The US physicians instructed the medical students in their specialties and arranged for logistical medical support for the local hospital. By the end of the 12-month rotation, the local hospital could handle treating mild and moderate wounds from an IED mass casualty event in the city.

*Teaching points:*

1. Counterinsurgency conflicts are partially won with robust humanitarian efforts.
2. If frustrated by the challenges offered by deployment, do something productive to change the situation.