

Just Show Up: Building Therapeutic Relationships in Combat Zones: OEF Afghanistan 2010-2013

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Abstract: Establishing, maintaining, and developing therapeutic relationships with Navy personnel in non-traditional settings during Operation Enduring Freedom (OEF), Afghanistan, required flexible professional strategies while maintaining professional boundaries and mission-oriented interventions. The Navy Mobile Care Team Five (MCT-5) consisted of five Navy personnel including two Licensed Clinical Social Workers (LCSWs), one of which additionally served as the team's Officer-in-Charge (OIC), a Navy Research Psychologist, and two Navy Hospital Corpsmen Psychiatric Technicians. MCT-5's official mission was to target all Navy Individual Augmentees (IAs) in Afghanistan from December 2011 to July 2012 (approximately 2,200 IAs) to provide preventive mental health care, surveillance, and command consultation, including care for the caregiver, at static medical commands, by engaging in routine site visits outside the traditional medical settings in an effort to reduce mental health stigma and remove barriers to care. The team motto, "Just Show Up," reflected a strategic shift from a more traditional client/provider relationship in which traditional office structures and engagement are more carefully constructed and regimented, to a process of engaging any and all units and individuals across Afghanistan in a more collegial camaraderie in which embeddedness with each unit was central and behavioral health activities were strategically structured and conducted with full anonymity and confidentiality. This narrative addresses challenges, insights, and implications to include nebulous professional boundaries among the various disciplines, official processes and protocols for addressing clinical problems, and "care for the caregiver" strategies employed by MCT-5 to provide its own mental health hygiene and support. While the narrative is factual and accurate, no names were used and details of all situations were altered to preserve security and sensitivity for all persons and situations described.

Keywords: Navy medicine; operational social work; Navy mobile care team; Afghanistan; strengths perspective; Operation Enduring Freedom

"Just show up" became the mantra for our Navy Mobile Care Team Five (MCT-5) mission to Operation Enduring Freedom (OEF) in Afghanistan from December 2011 to July 2012. Our five-person team consisted of two licensed clinical social workers (LCSWs), a Navy research psychologist (RP), and two Navy Hospital Corpsmen trained as Psychiatric Technicians. Our official mission called for the team to "emphasize preventive mental health care, surveillance, and command consultation, including care for the caregiver, at static medical commands, by engaging in routine site visits outside the traditional medical settings in an effort to reduce mental health stigma and remove barriers to care." The author served a dual role as Officer-in-Charge (OIC) of the team and as a licensed clinical social worker (LCSW), commanding and performing a preventive mission.

Our target population included every Navy Individual Augmentee (IA) we could possibly locate and contact in Afghanistan, approximately 2,200 at

the time. As the name implies, a Navy IA is an active-duty or reserve sailor deployed as an individual to an assignment with a Navy or Army unit without the benefit of belonging to a designated unit prior to deployment. Some IAs meet other deploying unit members during pre-deployment training, but most are assigned alone, or with one or two other IAs, to units consisting of strangers who are often members of another service.

This IA population had been identified through prior surveillance as being at high risk for mental health issues because of the lack of pre-established unit support, frequent assignments to duties outside their areas of expertise, ambiguity of joint service protocols and systems. They often experience and frequent marginalization, ostracism, and relative isolation among teams consisting of strangers – characteristics that arguably constitute the "perfect (mental health) storm."

This selective narrative describes MCT-5's efforts to

create an integrated mental health outreach strategy (requiring seamless collaboration with established mental health services for referral of issues requiring formal mental health clinical assessment or treatment) and specifically our strategies, models, and processes, often developed in real time, to develop and enhance therapeutic relationships with military men and women across Afghanistan in very different jobs and circumstances with a wide array of needs and interests.

The primary mission was focused on formal surveillance that consisted of written anonymous questionnaires augmented by individual interviews and focus group sessions in addition to real-time unit, individual, and command feedback briefs. All our therapeutic outreach efforts were grounded in the structured surveillance/consultation process but, as expected, the limitless range and array of personal issues and circumstances quickly became the order of each day.

Of necessity, we conceptualized our broad mission strategy according to all three of the Institute of Medicine (IOM) levels of prevention interventions to target potentially everyone in our IA population (Universal Prevention), target subgroups of IAs at increased risk (Selective Prevention), and target specific individuals actually suffering subclinical distress or impairment (Indicated Prevention). We recognized the limitations of attempting to address each level of prevention but commonly reviewed the three levels to frame our population outreach and establish specific mission goals given the dynamics of a particular target group or area.

A pivotal factor, often overlooked by us as team members, was that each of us, in addition to being a team member tasked with providing constant and professional support to other IAs, was also an IA among all of our colleagues, many of which were actually in far more supportive routine circumstances than we. Some of our more humorous (and therapeutically bonding) moments came while interviewing a group of geographically-isolated sailors after we had travelled for hours with little sleep, arrived disheveled and mentally foggy, and had our “clients” look at us sympathetically, laugh, and ask if there was something they could do to help us, as we were obviously more in need of support than they at the moment.

This poignant reality – that we the “supporters” and they the “clients” were all in this together, constellated into our “Just Show Up” motto and modus operandi. Though we initially chuckled at the cliché, considering it a desperate form of gallows humor, we came to understand the conceptual power and strategic relevance of a very cognizant shift from a paradigm of seeing ourselves (and presenting ourselves) as “helpers” seeking “clients” to “treat,” to a model of “total situational embedding” within a group of peers and colleagues without preconceived expectations or assumptions of dysfunction or pathological needs.

Certainly, we found individuals and groups with significant issues and needs, but focusing on commonalities and circumstantial strengths within a group or unit proved a pivotal watershed point for empathic and therapeutic engagement that would have been impossible had we presented as rigid mental health assets seeking to assess and treat dysfunctional people.

Word traveled astonishingly fast in theater and being perceived as intrusive, invasive, or psychologically or mentally superior shut doors tight and could have derailed our entire outreach mission; trust was *essential*. The “strengths perspective” (Saleebey, 1992, 2001), commonly recognized and promoted by social workers, was not simply a “perspective,” it was a reality and requirement for theater-wide buy-in for a complex and diverse population of men and women living and working in a war zone.

Our first conscious recognition of the “Just Show Up” strategy occurred completely by accident. It happened when we set out on a mission to a painfully inaccessible forward operating base (FOB) along a hostile national border. Because of grueling winter weather, active hostilities, and limited means of transportation, we were delighted to finally catch a flight headed to the remote location – only to find ourselves landing unexpectedly in a completely different location than intended. According to our records, there were no Navy IAs assigned to the post in which we unexpectedly landed. Furthermore, we were told it would be two to three days before we could expect a chance to continue our trip to the target location.

We shouldered our backpacks and equipment and

began the half-mile walk to where we expected to find shelter and food. By sheer accident we passed a post office and stuck our heads in to get directions. To our astonishment, we found ourselves face-to-face with a unit of Navy IAs assigned to run the post office. We didn't expect them, they didn't expect us – but there we all were, face-to-face.

The first stage of our “Just Show Up” strategy, evolving unexpectedly from this encounter, consisted of – drum roll – shaking hands, piling into a vehicle, and heading out to find food and sleeping quarters. Introductions, a description of what we did (our mission), descriptions of what our host colleagues did (their mission) and substantial trust-building and therapeutic alliance were naturally grounded in light conversation, sight-seeing, ribald joking, and common commiseration about our mutual plight of facing yet another night in a combat war zone far from family and loved ones. A meal and a sleeping tent arranged with complete reliance on those we theoretically should “treat” (Exchange Theory) created a solid and appropriate therapeutic alliance that would dramatically set the stage for events that would follow in a very few days.

During our introductory meals and information sharing, we scheduled appointments with the unit and with various individuals (always anonymously and voluntarily) and the next day we set to work conducting our normal surveillance, focus group work, and training modules to all that were interested. We all worked together to establish a working environment with appropriate boundaries fixed both mentally and by the structure of the meeting rooms, private session spaces, etc.

I emphasize that we were becoming extremely aware that the success of this therapeutic bonding scenario with a group and its individuals seemed to be uniquely created by the *informal* and *collegial* strengths-based circumstances in which we all met as colleagues. We proceeded to clearly spell out our respective professional roles and boundaries and then agreed to proceed into the more formal helping encounter framed in our mutually established and respected professional roles.

After this serendipitous initial bonding and round of

formal surveys and interviews that occurred over a three-day period, we finally were able to book a flight out and flew back to our home base. We were never able to reach the base we had originally set out to visit – making our impromptu connections at this accidental stop even more serendipitous.

Fast forward approximately eight weeks, and we got the disturbing news that this FOB had been attacked by insurgents, massive explosives were detonated in the common area, live small arms fire had been exchanged, and there was a U.S. fatality, in addition to the fatality of all involved insurgents. We learned that several of our colleagues from our initial visit had been personally impacted during the attack, including potential injuries.

From our home base, we immediately arranged a visit back to the FOB and, based entirely on relationships and contacts gained in our earlier impromptu visit, were able to quickly schedule both group discussions and individual sessions as needed; we are convinced this would not have been as effective had we not formed the initial camaraderie earlier. The unit commander told us we had been specifically invited back based on our prior visit with them. Bearing in mind that our mission was preventive, not directly clinical, we quickly arranged visits and briefs with all available clinical assets, including assets from other service branches, and learned what resources, personnel, protocols, triaging systems, and routine services were available. We learned from our involved Sailors what services they had needed, whether they received needed assessment and follow-up, and got updates on their progress; however, the most poignant, and time-intensive work was the narratives – the stories.

Two had been eating inside the chow hall when the building exploded and they suffered from various injuries. Both described the chaos and surreal experience as the chaos ensued and everyone inside struggled to exit the building and find their units. Another described in harrowing detail watching the direct exchange of gunfire barely 50 feet away while trying to calm the small group with him that had clustered behind a concrete barrier. All fully expected the insurgents to rush the barrier and many expressed being concerned about who should be in charge and issue orders to engage, given the group

included members from different service branches and included no direct combat specialists. The Sailor described his feelings, first of alarm and fear, then of the calm emergence of his combat training. He took charge, gave orders to prepare weapons, and established positions around the concrete block to return fire if the insurgents attacked. The insurgents ran a different direction and were either eliminated as threats or committed suicide using strapped-on explosive devices. Still, the immediate and close danger triggered an astonishing array of reactions among the small group and the group bonded in that instant to the degree they continued to be close friends in the following weeks.

We spent many hours over the next week listening to the individual experiences, the moral and values impact, i.e., the “moment-of-truth” moments several individuals described in detail. It was at moments like these when they had to decide whether to fire their weapons, where to take cover, who to answer to or who to give orders to, and how to gauge the extent to which their traumatic response and fear impacted them or jived with how they had imagined they would respond in such a situation.

The narratives, the stories, were rich, intense, and extremely varied. The stories ranged from accounts of intensely emotional phone and video-camera conversations with spouses and family members to the choice of some to not tell their loved ones at all, in which cases some expressed guilt over the secrecy, but opted to spare their families increased fear or uncertainty for the future. In all cases, the sessions revealed dramatic “coming of age” insights in which we relived with them what it felt like to face death and possibly killing others – an experience that to them marked a passage from a state of innocence to the ultimate maturity of facing mortality and standing firm in the face of death. Most described a quiet certainty and satisfaction that they had stood up to real combat, survived, performed well, and attained states we defined as early stages of post-traumatic growth capability within themselves.

Not ironically, my own experiences, and those of our team, mirrored those of our colleagues in type and intensity. We didn't bond with these colleagues simply because we wanted to manipulate into their confidence – we bonded out of necessity based on

identical experiences and needs. My traveling companion on this trip had a birthday the day prior to our departure. We spent his birthday night sleeping on the wooden boardwalk at the air strip, waiting for our flight. Early the next morning, I awoke and found my partner nearby in a light sleep on a wooden bench, fully clothed and weapons at hand. Even in sleep, he appeared peaceful and accepting – even happy – perhaps more in sleep than awake. I found a power bar, inserted a toothpick in it for a candle, and when he woke, we quietly celebrated his birthday amidst the uncertainty and danger. We took time to take birthday photos and post on our Facebook accounts – a birthday neither of us will ever forget.

Camaraderie formed in a war environment is based not only on trauma bonding, but largely on shared routine experience and mutual purpose – usually simple survival and dealing with the austerity and absence of family and quality of life. I recalled what the skipper of a ship told me years before during my welcome and in-brief: “Life aboard ship is about sharing everything. It's not just that everyone knows everyone aboard ship, it's that everyone knows *everything* about everyone!” That wisdom applied here. My greatest discomfort, I found over time, was the lack of privacy and the constant interaction with friends and strangers in the most intimate settings. Bathing and toilet facilities were public and usually required a substantial walk from wherever we slept. Both women and men walked openly to toilets and bathing facilities and joined others in that walk.

During a sub-zero degree night in a tent city in Kabul, I awoke after midnight when a group of French soldiers arrived. Apparently by design and practice, men and women in this group all stayed together. The group found a block of bunks that allowed them to space the women together among the men. No one in this environment completely disrobed, and all clothing changes occurred discreetly behind sheets or towels strung from the bunks to provide screens. The respect and group cohesion based equally among members of these multinational groups, were generally the safety net against isolation and crime. While sexual assaults in theater are well documented, I found much consolation observing the underreported and underappreciated protective environments and

habits that allowed the most privacy and respect possible among members of numerous different countries, and between women and men.

Observing how mutual inclusion, respect, and equality between women and men, and among diverse groups of all types, was generally practiced in all the allied forces I experienced, I came to appreciate that modeling this diversity and equality was most likely our primary mission in Afghanistan.

The highlight of this tour for me came during a mission to Shindand province accompanied by my female Assistant Officer-in-Charge. We spent two days conducting interviews and surveys with multiple individuals and groups and spent an entire night with security forces visiting Afghani families that had been blacklisted and dislocated. I took my first (and hopefully only) puff on a Hookah pipe offered in a post-midnight multi-family gathering around a campfire discussing the recent capture and beheading of some of their employees scarcely a week earlier and only a few hundred yards from where we sat. Thankfully, one puff of Hookah was enough to show my respect and engage the trust of the group as they went on to pass the pipe and more openly describe their losses and non-deterred aspirations.

All eyes, female and male, remained constantly on my uniformed female comrade. The equality between us, the professional demeanor, and the open discussion between us did more to establish the purpose of our mission than anything we could have said. The children, shy at first, soon approached her and began touching her uniform and staring in awe at her weapon. We moved naturally into a discussion of equality and professional interdependence as perhaps our primary political platform. We showed it by Just Showing Up – not by pontificating on human rights, or problems. The nasty taste of Hookah from my one puff was forever transformed into a memory of that night of deepest camaraderie with a family from a very different culture grieving murdered friends.

The following day we were awakened early by the Commanding Officer who loaded us into a truck and took us to a ceremony being held to present awards to local farmers who had undertaken agricultural and business courses and who were establishing

themselves as pillars of the community. Attended by several multinational military leaders and the Governor of the province, the event began with high-level speeches about cooperation and peaceful collaboration on local economy and self-sufficiency; however, my female colleague and myself, standing at the back of the room, noticed a disturbance and side conversations among the dignitaries at the podium, who began smiling and pointing toward her – the uniformed female in the room.

A translator was quickly dispatched to us and began interpreting the discussion for us. The Governor of the province was saying that having a female officer in the meeting was a pivotal symbol of this collaborative ceremony and requested that she be allowed to join the group of dignitaries in presenting awards to the farmers.

She was ushered to the front and thrust into the line of dignitaries and assisted in greeting and handing out certificates to the graduating farmers, while the dignitaries spoke of the power of gender equality and participation, using her as an example. Afterward, the delegation moved outside where we mingled with the group and the female officer became the star subject of photos with both men and women and with the flag level officers of the multinational assembly.

Once again, more was accomplished by Just Showing Up and modeling our values than could ever have been accomplished by lectures or potentially condescending teaching about gender equality and participation. While the impact of such chance encounters was random and anecdotal, we were firmly convinced that the strategy of Just Showing Up and building a collegial bond extended beyond just our military population to direct pivotal relationships with our host citizens at the local levels.

Overcoming my discomfort with constant scrutiny and lack of privacy – opting to simply Show Up with my personality (introverted though it may be) as fully intact as possible, helped me engage others and form personal and therapeutic bonds among both military and civilian individuals and groups that no degree of professional bearing could accomplish.

Upon leaving Afghanistan, I found what I valued most was a simple private shower and room – a degree of distance, artificial as it was, from other people for moments of respite. The constant, polite (usually) interactions with strangers in casual encounters in laundry and dining lines, in transportation ports, and in late night gatherings around campfires and cigar nights created a common bond, but constantly left me feeling low-level anxiety and hypervigilance. There was simply no place to find personal space. For the extraverted, the environment was stimulating and exciting; for me, a strong introvert, the constant interaction was draining and stressful. It was my emotional discipline and team orientation that made me maintain friendly and supportive demeanor throughout each day – it was not my personal inclination. This was especially important for me to bear in mind when encountering our clients. I realized that for many, the additional burden of outsiders intruding into their fixed daily routines was a primary inherent burden – even without the extra burden of fearing my role as a potential mental health provider. Establishing thoughtful and respectful personal boundaries was essential from the outset – being a good *neighbor* was essential before any hope of being a mental health professional could be established.

We came to appreciate the impact of our therapeutic bonds formed through these encounters, only several weeks later, when our team and several of the many individuals we had encountered in similar situations throughout the mission prepared to leave Afghanistan. As we made farewell email and phone contacts with IAs we had encountered throughout Afghanistan, we found that many would be departing when we did from our base, and that most would be staying in extremely uncomfortable living quarters for the days leading up to our departure. We quickly saw the opportunity and made arrangements to have all who wanted or needed our living quarters to Just Show Up and “join our Mobile Care Team” - we determined to leave together as a group if at all possible.

In the end, our team of five had increased to approximately 15 and we all spent the final days sharing living spaces, often make-shift sleeping pads on the ground, taking our meals together, and spending evenings processing our deployment over

campfires and late-night discussions.

We had met many of our “clients” in the stateside combat training programs. Many of us had bonded in our journey into Kuwait, then into Afghanistan, and now that it was time to leave we had reattached to as many as possible to depart together as a team. And at no point did we detect lowered “professional boundaries” or feel compromised professional boundaries.

Not surprisingly, many of our “client colleagues,” over campfires or meals, openly discussed their relationships with us, overwhelmingly agreeing that what made the most impact was our willingness to “Just Show Up,” and to ground even our most clinically sensitive issues in the broader context of shared therapeutic alliance. Specifically, we heard numerous times that while most had expected us to approach them with strict rigor and stultifying “professional distance,” the time spent bonding as colleagues over meals and routine events helped establish a solid, trusting environment, one in which they felt very comfortable when they needed “the next level” of help – the formal referral for mental health assessment or treatment.

One typical formal referral resulted when I was approached by a Sailor in a busy hallway. The Sailor began a conversation by saying, “This tour has been challenging, but I've learned a lot,” but before I could direct him to a more private area, he began naming some specific issues that I felt were far more suited to a private discussion. I immediately asked if there was a place we could speak more privately and the Sailor escorted me outside the facility to the fire pit area where no one was around. “I have gotten into some issues since something happened a couple of months ago. They are trying to send me home now, but I'm not ready to go home. I don't want to be around my family. I'm checking to see if I can start divorce proceedings from here.” I learned quickly that this Sailor had been sexually molested. He had also since then had a significant affair. He was having serious financial problems, was not sleeping or eating adequately, was experiencing nightmares related to a recent missile attack on the FOB, and was facing disciplinary action. While the command had taken steps to address the legal issues and was preparing to try to send the Sailor back to the United States, no one had arranged for mental health care. Even

though the member was reluctant at first to consider mental health help, after discussing the combination of events and problems with eating, sleeping, and nightmares, the Sailor agreed for me to discuss mental health care with the commanding officer, who immediately arranged for the Sailor to be transported to the nearest mental health facility for an evaluation. The flow from collegial to professional intervention was smooth and grounded in a more trusting relationship.

Despite the periodic shift from collegial support to formal referral, to our knowledge, we heard of no complaints or reports that members felt uncomfortable with our more collegial interactions. Au contraire, we found that in many cases, the less formal interactions and forced close proximity (given the base security needs), resulted in individuals approaching us openly, in front of others, asking us for formal sessions and/or beginning to speak (what we considered to be) too openly in front of others. In such cases, we simply quickly set individual private meetings and did not engage the more sensitive issues openly. Such seems to be the nature of wartime camaraderie and collegiality. The isolation from broader society and the forced proximity can as easily promote open exchanges and trust as they can generate feelings of invasion or stigma. While stigma proved to be very alive and well, “just showing up” and being part of the overall team proved to show promise of a positive receptivity to “all things mental health.”

As always, not everything was perfect and certainly we had to move quickly on occasion to move individuals into formal clinical care. This was substantially less prevalent than we expected (less than 1% of our encounters outside of formal medical settings resulted in formal referrals for mental health conditions that required clinical assessment or treatment). Our interpretation of this finding was two-fold: (1) the formal mental health clinical providers were doing a remarkable job of maintaining overall mental health hygiene for a potentially enormous pool of individuals who could easily succumb to more serious mental health needs, but alternatively, (2) individuals in a war zone, even under the most daunting biopsychosocial circumstances, prove to be incredibly resilient.

A third interpretation, which we have no real way to

measure or prove at this point, is that fielding a high-visibility, leader-sanctioned, and approachable preventive mental health outreach program may actually help offset isolated instances where the stressors and conditions could lead to more serious stress injuries, and stress illnesses. Directed by the Vice Chief of Naval Operations, the Deputy Surgeon General of the Navy, and the war zone command structures, the Mobile Care Teams were seen as an inherent part of the combat zone environment and simply one more group of IA colleagues with which to commiserate and bond.

Insights, Issues, and Lessons Learned

While certainly a cliché, the phrase “Just Show Up” is firmly grounded in four valuable contemporary concepts practiced by social workers and mental health practitioners. First, it clearly implies *expanded access to care*. The official Mobile Care Team Mission specifically addressed the identified goal of extending preventive mental health care beyond the normal formal auspices – actually implementing “house calls” where licensed service providers were scarce.

Second, a process of “just showing up” implied, and actually delivered, a robust multi-disciplinary *continuum of care* model involving a multidisciplinary, and multi-level team that included surveillance, group information gathering, and when required and possible, a first-level clinical pre-assessment component. Given that the team’s primary mission was non-clinical, the mixture of surveillance and mental health expertise provided a self-contained assessment team that was able to address a wide array of needs or issues, and immediately invoke either team-internal, or external resources needed to provide the service or expertise needed by a particular unit.

Third, the team saw the term “Just Show Up” *psychodynamically* in terms of Von Franz’s (1993) notion that psychotherapy requires providers to present with each client with their *full personality intact*. Von Franz saw that only in fully engaged holistic therapeutic encounters could genuine positive growth or change occur. Hidden or unconscious motives on the provider’s part (as well as the client’s part) could result, at best, only in partial healing, commensurate with the degree that both provider and client allow their full personalities

to engage in the therapeutic encounter. Combat zone dynamics (isolation, group cohesiveness, long periods of time together as a group, etc.) lend themselves to more natural openness and reduce the artificiality of “staged” therapeutic encounters.

Fourth, “Just Show Up” is grounded in the strengths perspective (Saleebey, 1992, 2001). Rather than approaching each target individual or group as a potential “problem situation,” having the entire target population as the focus of the engagement can help reduce stigma and foster a more holistic preventive mental health atmosphere. Formal non-invasive surveillance and focus groups, that focus first (and last) on strengths and coping mechanisms, serve both to bolster therapeutic alliance and to provide a discreet opportunity for evaluation of personal or group challenges and identification of more serious issues and needs.

Issues

Major challenges for multidisciplinary Mobile Care Teams include: (1) credentialing, privileging, and licensure auspices, (2) consistency of approach (given different disciplinary scopes of practice, and limited team members to address particular high-level situations that may be encountered), and (3) care for the caregivers (the team taking care of the team).

Licensure and Privileging in Theater

The team consisted of two Licensed Clinical Social Workers, a Research Psychologist, and two Navy Corpsman Psychiatric Technicians. The mission was limited to “preventive mental health” services, discipline-specific licensure, credentialing, and privileging. Oversight of team members was contained within the team and supervision was provided by the team Officer-In-Charge (OIC), and a Licensed Clinical Social Worker. While fully licensed and credentialed through each member's home station, the MCT-5 was “owned” and sanctioned by the non-medical operational command. As such, the team was not authorized, during this mission, to provide direct clinical services. The team protocol called for us to refer those needing clinical services to the nearest, or best-fitting, formal clinical services at established mental health departments across Afghanistan.

The team's protocol consisted of a stringent process

whereby all indicated clinical issues were to be staffed from the non-clinical team members to one of the two team LCSWs, and ultimate referral decisions were made by the OIC as an LCSW. The process entailed extensive training and preparation of all team members to identify any pressing or outlying issues from individuals self-reporting, or by command referrals made by unit commanders informing the team of potential clinical needs by a unit member. When an individual was identified as potentially needing clinical assessment or treatment, the individual was consulted in private and, when indicated, was engaged by a team member in determining the most appropriate clinical provider or mental health department as near the unit's position as possible.

In all cases, even in cases of command referral, the commander was notified only of the need for clinical services and was engaged in the formal process of transferring the member to the appropriate clinic or provider. In all cases, the team consulted extensively with the commander to ensure mental health issues (especially those that were self-reported and already known between a troubled individual and the commander) were “normalized” and the negative impacts of stigma and labeling were addressed. It bears repeating that of all IA individuals contacted by MCT-5 during the mission, less than 1% required formal referral to a formal mental health provider.

In all cases requiring referral, a team member was instrumental in contacting the identified clinical provider or mental health department to insure smooth transportation and assistance (using “warm handoffs,” which required any referred individual to be accompanied to a treatment facility by a mature and trained unit member). A referral process was considered complete only when the referral and transfer of an individual was completed and notice of successful transfer was received from the clinical team.

As such, the Mobile Care Team addressed gaps in privileging levels through the hierarchy of licensed providers on the team and documented completion of warm handoffs to providers actually privileged by in-theater medical auspices.

Varying scopes of practice for each team member

created logistical challenges at times. Given the massive MCT-5 to target-population ratio (five team members, two of whom were LCSWs, to a target population of about 2,200) required frequent splitting of the team to conduct simultaneous missions in different areas of Afghanistan with two groups of two team members each. In some cases, it was not possible to send one of the two LCSWs on a particular mission.

The team protocol in such cases was to establish and maintain dependable communications (via email or phone when possible) and to clearly delineate each member's scope of practice. In all cases, the formal preventive mission was primary, i.e., the preventive mission involved providing anonymous and confidential surveys, conducting factual focus groups, and identifying potential morale and/or cohesiveness issues. When an LCSW was not a member on a particular mission, any and all potential clinical mental health issues were immediately deferred by phone to an LCSW, who would either arrange a separate visit or negotiate a warm handoff referral to a formal mental health provider.

Consistency of care was assured by stringent delineation of each member's scope of practice, communication requirements for all issues, and ultimate approval and action taken by a licensed clinical provider on the team (and ultimately the OIC) in conjunction with clinical providers privileged in-theater.

Care for the Caregivers

Mobile Care Teams are especially vulnerable to burnout, vicarious trauma, and both acute and cumulative stress injuries. Teams and team members are especially vulnerable, because not only are they required to model positive and adaptive mental hygiene to all individuals they encounter, but are simultaneously exposed to the very same risks, potential dangers, and daily cumulative stressors faced by their target clientele.

In addition, MCT-5 traveled over 9,000 cumulative team miles across Afghanistan in order to reach the most outlying units possible. This travel aspect of the mission added a burden beyond what many individuals in fixed locations had to face as a regular part of daily routine. Travel in extreme cold

(and heat, depending on the month), coupled with travel security concerns, intensified the acute and cumulative stressors on both the team and each of its members.

The dual-role (IA Sailors and preventive mental health team member) components of the mission were addressed by our team, beginning in pre-deployment training and team discussions prior to deployment. Daily schedules were clearly established to allow adequate personal time for each member to “escape” the daily grind and develop support relationships outside the team.

The team discussed its “game face” – our requirement to maintain superb military bearing and protocol in all official contacts – as well as how to provide opportunities for self-regulation and self-restoration. Since, as is normal in combat environments, all five team members worked out of the same small office, schedules were staggered flexibly throughout the 24-hour day to overlap, so each member could have “quiet” office time to use computers, make phone calls, and complete routine personal as well as mission paperwork. Generous gym and workout time was encouraged throughout work days when the mission allowed. Naps at various times of day were heartily encouraged as were regular substantive meals. Holidays (official or simply made up by the team), birthdays, and any other special occasions were enthusiastically celebrated and generated a rich collection of personal and team photos, videos, and email exchanges. Whenever possible, the team ate meals together, while each member was also encouraged to develop outside friendships or eat alone when feeling the need for personal time.

Perhaps the most important aspect of team self-care consisted of insistence on healthy team dynamics, including commitment to minimize triangulation of team members (forming exclusive cliques among team members). We insisted on emphatic total-team adherence to maintaining a positive, non-toxic office and work environment. Days began and ended with attention to the location and mental state of each member. The work was demanding enough without fostering intra-team conflict or a toxic work environment.

It is important to note that our team, like every other

team, had its crisis moments and conflicts. However, anticipating team challenges and dynamics, addressing them early and openly, and demanding positive team engagement were instrumental in establishing a very cohesive, growing, and emotionally stable team which, to this day, regularly communicates and shares memories and unique experiences.

Implications

Preventive non-medical and medical mental health outreach and deployment of embedded provider teams consisting of multi-disciplinary teams of professionals with hierarchically-diverse educational and skill levels is increasing dramatically in current war time strategy. Inherent in deployment of such teams are strategic consideration of both the engagement and therapeutic relationship-building paradigm and the varying discipline-specific scopes of practice and professional limitations and boundaries of all team members.

Formal institutional preventive outreach is increasingly important, both to help offset the development of more serious mental health issues and to expand the mental health footprint in circumstances such as war and major disasters, when clinical treatment services cannot logistically hope to adequately address all emerging clinical needs. Evolution of multidisciplinary and multi-tiered teams is an appropriate focus for all mental health professions.

Boundaries between the preventive and clinical functions can be expected to blur and it will be up to each discipline to work internally and with other disciplines to establish flexible and eclectic protocols and processes and educate, train, and prepare new practitioners to establish and practice in diverse and unexpected circumstances within ethical and effective protocols. In many cases, such as in the war zone scenario presented in this narrative, providers will be required to practice ethically and effectively with limited supervision and direction, and frequently with very limited resources.

Seeking out and providing supervision and peer guidance both from within one's discipline and from sister disciplines will become increasingly essential and licensed clinical providers will be required to

establish intervention protocols and processes for non-clinical team members. As much emphasis must be placed on the team's own members and mental health hygiene as on the targeted client population.

Finally, "client" engagement can be expected to evolve beyond the 50-minute session model (very useful and appropriate in established settings), to a more embedded and holistic mental health intervention model. The massive emerging need for mental health services to address a large population of returning and wounded warriors and the continued call to proactively take services to the population, rather than waiting for the population to come to the services, will benefit from dedicated teams of exceptionally-prepared providers being ready and willing to...

Just Show Up.

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