A Social Work Academic in Iraq?

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Abstract: This essay describes a social work professor's experience of serving in the United States Army Reserve as a clinical social worker during the height of the surge in Baghdad. He reviews his ethical discernment to serve, mobilization before deployment, and his roles as social work clinician, teacher, and researcher.

Keywords: social work roles; Operation Iraqi Freedom; life trajectory; subjective diversity

Prologue

A brief explanation is needed before my story of going to war as a social work scholar-clinician. I wrote much of this shortly after returning from a 16-month deployment, 12 months of which were "boots on the ground" in southeast Baghdad during the surge in Iraq. This period from September 2006 to August 2007 was one of the most volatile periods of Operation Iraqi Freedom (OIF), with 1,167 military personnel killed, 24% of all deaths from the entire war (Fischer, 2014). Countless veterans I had known or worked with at the Veterans Administration (VA) told me that "Going to war is easy; it's the coming home that's hard." They were right; I struggled to get my bearings after returning. I was a tenured professor, surrounded by social workers but had scant conversations about the deployment. Hindsight tells me that I needed to interactively and repeatedly go through this narrative with others to try and make sense of it and, more importantly, accept it for what it was. I believe my need to "process" was the dominant drive to be around other combat veterans and my leaving academics to run a VA Readjustment Counseling Center for Combat Veterans (Vet Center). I suspect this post-combat struggle to find meaning then acceptance is something facing many veterans. Interestingly, Stur (2012) explored a similar disconnect between the warrior myth and post-war realities in Bruce Springsteen's songs addressing the readjustment struggles of Vietnam veterans. I think understanding this struggle is critical for joining clients where they are and establishing a meaningful therapeutic relationship.

One the most significant and difficult moments for me occurred on a Friday in the spring of 2008. I had been doing clinical drills as part of my Army Reserve obligation in the outpatient mental health clinic of a VA Medical Center and knew the staff quite well. That morning I was at the end of my rope and called the Chief of Psychiatry's nurse. "I'm not doing well and really need to see someone to talk, but no meds," I told her. She said, "I'll call you right back." She called and had me scheduled to see a psychiatrist who would listen, not prescribe. This started a deeper process for me that truly took a village: my wife, parents, two therapists, VA colleagues, and, most importantly, fellow vets. I truly believe that we process traumatic experiences through shared narratives. In the six years since returning from Iraq, I am 95% back to normal, still married, and returned to academics. This narrative was part of that process of accepting the experience and may prove useful to other clinicians assisting combat veterans.

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It was after 9/11 and the United States invasion into Iraq that the thought of joining the military crossed my mind. This wasn't the first time – in high school I had considered the military academies and then again after graduating from Tulane University with my Master of Social Work. The incongruence between my political beliefs and the military created a barrier to signing-up, yet the desire to serve remained. Furthermore, the social work profession's national organization strongly opposed Operation Iraqi Freedom (OIF). Nonetheless, I convinced myself this time that volunteering was right for several reasons.

History tells us that wars are fought by people from lower socioeconomic positions, many with GEDs, little technical training and few options to earn a livable wage. Many are "at-risk" even before going off to war. Kriner and Shen (2010) offer sobering

evidence supporting a "casualty gap" for wars fought by the United States over the past 75 years and the government's efforts to hide and exploit this gap. As a social worker/sociologist I was convinced I could help. Serving as a mental health provider, in my mind, would allow me to operate on a different set of principles and ethics, a Hawkeye Pierce paradigm I told myself. I also was irritated by the assumption that only conservatives act on principles of "selfless sacrifice," patriotism. I would prove this erroneous myth wrong and show that someone from the "other side" of the political aisle, an academic moreover, could answer the call to serve.

In March 2004, I received a direct commission in the United States Army Reserve Medical Service Corp as a social worker. In June 2006, my unit, a combat stress control (CSC) company, received orders for activation and began training (mobilization) for deployment to Iraq. The group was mostly social workers, occupational therapists, psychologists, two nurses and 20 or so mental health technicians. Many of us were new to the military; officers came from jobs in the VA, mental health facilities or social service agencies. The enlisted came from colleges, culinary school, used car sales or dance studios. Few had experience in the jobs they were about to do for the next year.

Mobilization training or "mobbing" tested our resilience: sleeping in World War II-era barracks, eating awful food, attending dozens of PowerPoint "enhanced" briefings, getting up at all hours to stand around and wait. We were told to be like "Gumby," the clay animation figure from the 1950s, i.e., to be extremely flexible. We learned basic soldier skills, things like throwing grenades, hand-to-hand combat, tactically clearing rooms, guarding bases, frisking insurgents and conducting convoy operations, things most of us never actually would do in Iraq. Whereas this skillset transition from reserve component to active duty was in many ways entertaining, the mental transition was more difficult, almost surreal at times. Courage (2013) describes this transition, its challenges and stressors for when a part-time job in the reserve or guard becomes a "full-time life" (p. 63). "This is not my full-time job – I have a real life and I am going back to it as soon as I finish…" (p. 65), stated a mobbing senior army reserve officer, showing how this mental transition is perceived as a temporary one for most of us but has permanent consequences to our post-war realities and narratives. Towards the end of mobbing, my thoughts bounced around from "I'm never leaving Ft. McCoy, when will this monotonous training end, if I watch one more Army PowerPoint show I'll vomit…" to "Let's get the show on the road so I can get my life back!" Mentally, mobbing is a numbing experience, creating a desire for combat just to leave a purgatory-like waiting state. Unfortunately, where the religious conceptualization of purgatory is a cleansing period before entering heaven, mobilization purgatory is the opposite. In less than 90 days, my narrative, as with many part-time soldiers, involved acquiring a temporary identity of active-duty Army officer and major life changes, dramatically different from my known reality as a scholar-clinician.

The Ivory Tower versus FOBs

As the commander of a combat stress team, I was responsible for providing combat stress and mental health services to soldiers in our area of operation across seven forward operating bases (FOBs). In some ways, FOBs were similar to life on a college campus – thousands of young adults away from home, stressed, abusing caffeine and sometimes alcohol, chasing the opposite sex through social media and trying to figure what they're going to do in the "real world" when they get out. Like students, soldiers also spent too much time playing online role-player games like the fantasy based *World of Warcraft* or the interactive combat game *Halo*, tried to function on perpetual sleep deficits and habitually texting, although the content of these messages likely varied tremendously. With the college-age mental health specialists on my team, two being female, we received timely texts on significant events in our combat area of operation, often knowing ahead of official channels. Many soldiers spoke highly of higher education, a justification for their entry into the military to qualify for the Post-9/11 G.I. Bill. When soldiers learned my civilian occupation, the response I got was, "What are you doing here?" but there was also a significant degree of respect, trust and confidence.

Soldiers and students under 25 years of age also share underdeveloped frontal lobes, resulting in poor or risky decisions easily influenced by peers and questionable impulse control (Steinberg, 2005).

Considering my experience teaching college students from modest upbringings, soldiers and students alike viewed their present paths as opportunities to improve their life situations. By all accounts, enlisted soldiers reminded me of my undergrads: young, idealistic and impressionable. This was a safe, albeit deceptive, association within my personal narrative; the reality was starkly different. Doors do not necessarily open for combat vets like the recruiting propaganda suggests. War veterans are more likely to suffer from depression, anxiety, alcohol abuse (Thomas, Wilk, Riviere, McGurk, Castro, & Hoge, 2010), posttraumatic stress disorder (Smith et al., 2008) and have higher rates of unemployment (Kleykamp, 2013), domestic violence, divorce (Karney, Loughran, & Pollard, 2012), and suicide (Hargarten, Burnson, Campo, & Cook, 2014) than non-combat vets or the civilian population.

These and other factors create a life trajectory dissimilar from civilian college grads and vastly different than the life courses soldiers imagined for themselves. This dissonance between their believed narratives and experienced post-war realities creates significant anxiety, anger, sadness, and perhaps existential angst. It became apparent that soldiers employ rationalization as much as students but this coping mechanism only takes you so far. Attempts to answer the unanswerable question, "Why did this happen to me, him, us, them…" usually leads to a series of "Because I am…" answers or simply, as Kushner (2007) suggests, "Because I am a bad person." As I learned in the post-war readjustment experiences, there is rarely a satisfying answer and acceptance is critical to accommodating this experience into life after war (Wolfe, Keane, Kaloupek, Mora, & Wine, 1993). Nevertheless, we must travel our narrative's sometimes-crooked pathway in a delusional culture, at our own pace, requiring a patient spouse, friend, or therapist.

Social Work Clinician

With over 16 years of experience, I was comfortable in the role of clinician: assessing, diagnosing, counseling. Soldiers weren't just dealing with combat but also things like cheating spouses, bankruptcy, U.S. immigration problems, military legal actions, child protection cases, or conflicts with non-commissioned officers (NCOs, sergeants). To the credit of the "Big Green Machine," *General Order Number One* (GO #1) prohibited the consumption of alcohol in theater, a smart move that reduced the drinking and drug issues. It also prohibited private firearms, entering a mosque, possessing any form of pornography, photographing or filming detainees or casualties, gambling, proselytizing, or cohabitating with the opposite sex.

As we now know, the first six months of 2007 were the deadliest in Iraq. This was our biggest challenge, dealing with the volume of death, horrific experiences and the resulting emotional trauma facing these soldiers. The loss of a friend or two to an explosively formed penetrator (EFP, a deadlier copper version of a IED), the inability to remove the driver of a Bradley fighting vehicle engulfed in flames, the instantaneous sniping death of a fatherly sergeant. After such "significant emotional events" I always led critical event debriefings, synonymous with a Mitchell's Critical Incident Stress Debriefing (CISD, Mitchell, 1983, 1988), used for years with emergency workers in the United States. I'd travel by helicopter or unarmored Humvee to coax the stories of unbelievable tragedy and incite emotional catharsis from the survivors. The years of professional training, supervision, reading the literature and, for me, teaching graduate clinical courses gave a false sense of confidence, challenged by the reality of war. To psychologically patch them up for a quick return to duty, soldiers needed a companion that was non-judgmental, accepting, supportive, open to their experience, and not driven to make things better. Soldiers are keen observers of people, trained to quickly determine friend or foe, safe or dangerous situations. The problem with recent wars is the enemy is indistinct from civilians. The battlefield is non-linear, and lacks a definitive front line. This inability to determine friend from insurgent, a safe route from one laden with IEDs, or predict a mortar cutting through a tin living quarters generates a level of uncertainty regarding basic security, a fundamental psychological need (Maslow, 1943). As one officer, being seen for combat stress, asked, "If I was wrong here (combat) at such an important time, how can I trust myself making easy decisions back home?" Again, a focused presence and listening to the individual was a powerful tool (Baer & Krietemeyer, 2006). Increased mindfulness also helped me become open to my own experience. But it is daunting to accept a 12-month experience filled with horrific events such

as those that occurred during the surge in Iraq, acceptance that seemed nearly impossible the first few years after deployment. These losses took their toll on everyone, myself included. Other than eliminating wars entirely, building psychosocial resilience seemed the key to helping soldiers cope, something academic skills proved invaluable at doing.

Teacher

Psychosocial education is a major tool in preventing normal combat stress from progressing into more serious mental health conditions. My combat stress control team and I routinely taught classes on stress management, anger management and tobacco cessation, the latter being our most popular class. Interesting how soldiers living in a deadly war zone wanted to prevent early deaths by quitting smoking or dipping.

Combat environments are dynamic and the military mission always takes priority, leaving little time for substantial psychosocial education. Going back to the mobbing advice of being like Gumby, we found flexible, brief, bottom-line upfront, referred to in Army-speak as the BLUFF approach, highly effective ways of teaching. I designed mini-lessons that were taught in minutes by enlisted mental health specialists, medics, chaplains or their assistants. These were one-page handouts or mini-pamphlets on topics like suicide, bereavement, combat operational stress reaction, sleep hygiene, depression, and positive coping. We wanted our messages to get out to everyone, not just the soldiers who came to see us. We'd wander around bases talking/teaching soldiers anywhere we could find them (e.g., chow halls, maintenance areas, flight lines, command posts), a CSC practice referred to as "walk-abouts," but we were doing "teach-abouts."

We also took these lessons to leaders at battle up-date briefs (BUBs), the Army's version of faculty meetings. After gaining rapport, I was allowed to give a 60-second report on combat stress, anonymous aggregate stats on soldiers seen and observed trends. Soon the officers and senior NCOs asked, "So what f*&# can we do about it!" The hook was set; they wanted solutions. I kept these mental health lessons short, personally useful and humorous, a lesson I learned from students when teaching unpopular subjects like research and statistics. It worked, maybe too well, because soon I was enduring five or six of these BUBs a week! I enjoy teaching and found comfort doing something that reminded me of what was becoming a past life. There reached a point, though, that it felt as if I would not see that life again. Caregiver stress, combat operational fatigue, burnout, PTSD – whatever you want to call it – is an awful state of numbness that happens in combat and follows many soldiers home, taking years and a dedicated effort to disentangle from one's narrative (Hoge, 2010).

The secret to this teaching role was the ability to quickly and meaningfully foster an educational version of therapeutic regard, making the interaction personal, building a sense of trust. Academics understand the benefits of student rapport in education (Jaasma & Koper, 1999). Mine was challenged by rank, education, age and professional role-induced status differences. I combated this through the use of humor, using similar language as soldiers and encouraging them to speak in their "native tongues," i.e., not judging them from their use of curse words, sometime crude slang, or politically incorrect expressions. I heard accounts of other officers voicing disapproval of such language with disastrous effects on their rapport with soldiers. In one occasion, the commander of a combat battalion denied a social worker from working with his soldiers and requested my team because, according to the Lieutenant Colonel, "I heard you get along with combat soldiers... don't judge us for how we talk." One of the most valuable compliments I'd receive was "You're not like those other docs." If you cannot tolerate the word "fuck," it is probably best to not work with soldiers or veterans. Yes, it's a vulgar word but it doesn't even come close to the vulgarity of war itself. I don't normally use crude language, don't tolerate it from my sons, but in permitting this less censored communication, soldiers were more open to the information being taught, placed greater value on my perspective, and perhaps engaged in a more genuine discourse within and among themselves.

Researcher

My skills as a sociologist also proved quite handy, from literature reviews showing the detrimental effects of sleep deprivation to statistical analyses showing the significant increase in combat stress during the big troop surge. Crunching numbers and

writing in that dull-scientific prose felt like a comfortable set of worn Levi's.

The Army loves numbers and encouraged CSC teams to perform battalion behavior health needs assessments using a representative sample of soldiers, a standardized questionnaire, and focus groups. The hardest part of these assessments was coming up with solutions. Multiple deployments affect people and there just aren't any magical solutions to reduce the psychological strain of a prolonged war. It gave commanders a snapshot of how well the soldiers and their families were doing with the deployment. Unfortunately, it wasn't a good picture. Towards the end of my deployment I began to feel limited in "making things better." My jaded advice was to send everyone home; there's only so much separation and stress a person and his family can take. I was myself reaching a state of burnout, something I had seen for months among other soldiers and health providers. In some ways I blamed myself for the burnout: "I should've taken better care of myself, paced things better, limited exposure to trauma, not gone out so much." This type of discourse is common among soldiers and vets too, questioning their own decisions and actions in impossible situations and owning too much of the experience. "I should've gone right instead left on that road… I could've been better at starting an IV… Why did I assign her to go on mission that day?" These were common statements I heard from combat soldiers. Soldiers, their leaders and combat social workers do the best they can in atypical situations. A few years later, my statistical skills helped validate this feeling state towards the end of the deployment. At the time of my burnout, we were experiencing the three most volatile and deadliest months of the war in Iraq (April, May, June in 2007), resulting in a 27% increase in referrals for combat stress, mental health, and critical event debriefings (DeCoster, 2014).

Conclusion

My background as a sociologist/social worker suited me well for deployment to Iraq, giving me an advantage and an unexpected degree of respect among soldiers and commanders. CSC teams are embedded with forward-deployed combat soldiers, living in the same environment and sharing similar risks. The Army has never done this before and the attitudes about mental health will change for thousands and thousands of soldiers. Social work is now on the top ten lists of medical professionals for Army recruiters. It's interesting that they are seeking a profession based on a feminist paradigm, following principles of empowerment, egalitarianism and advocacy. Social workers see themselves not only as clinicians but also as organizational change agents. It'll be interesting to see just what change this will have on the Army and its collective narrative as well as the tens of thousands of individual ones.

The above was my initial summation for this paper, a rather neutral ending inconsistent with my skepticism and genuine feelings that were not readily apparent. Many vets may experience similar contradictory feelings regarding service, hating and loving it at the same time. We yearn to return home when deployed but then wish to return to the simplified mission-focused existence of war. Nonetheless, I don't miss the "hurry up and wait" bureaucracy, mortar attacks, persistent deployment angst that was common during my time in service, and the senseless "mission above all else regardless of the cost" mindset. I do miss the people, the incredibly diverse, supportive, and selfless group of individuals in military service. Life is full of incongruences but combat military service demands the entire self, a total commitment, with tremendous physical and emotional consequences, possibly paid long after the actual deployment. As discussed earlier, the post-war realities of veterans (e.g., higher rates of unemployment, divorce, depression, suicide, homelessness) don't coincide with the "hero" status afforded them by the media and general public. I had contradictory thoughts and feelings about service from the beginning but now oppose war as a nation-state problem solving method, supporting the *Veterans for Peace* organization and movement.

Those that have firsthand experience of the costs of war often are most vocally opposed to it (Palaima, 2011). Double *Medal of Honor* recipient, Marine Corps Major General Smedley Butler's book, *War Is a Racket* (1935) is one of the most poignant and controversial criticisms of the United States Military and our foreign policy love of warfare. Commenting on the price of war he stated, "This bill renders a horrible accounting. Newly placed gravestones. Mangled bodies. Shattered minds.

Broken hearts and homes. Economic instability. Depression and all its attendant miseries. Back-breaking taxation for generations and generations" (p. 2). This was post-WWI but seems applicable to our current state of affairs in the U.S. after the Iraq and Afghanistan wars. War is a very subjective experience, framed by the uniqueness of each participant. Understanding this subjective diversity will greatly aid the therapist working with veterans, helping them discern post-war realities and the incongruences entrenched in this experience and their lives that follow.

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