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Psychological Consequences of Detainee Operations: What DoD and VA Health Care Providers Need to Know

Detainee operations is a dark topic and one that often is avoided in the welcome home of veterans participating in detainee operations. Many veterans who have been involved have hidden these missions, fearing that they would be tarnished by past scandals. However, the burden of these detainee missions may contribute to depression, moral injury, and suicidal behaviors.

The recent conflicts in Afghanistan and Iraq have produced many opportunities for lessons on detainee operations. Unfortunately, often the lessons learned from one conflict have not been carried forward to the next. The scandals at the Abu Ghraib prison in Iraq and the continuing controversy over practices at Guantanamo Bay (GTMO) in Cuba illustrate these lapses. This column will not dwell on these issues but on what has been the psychological effects on U.S. service members of guarding and caring for detainees.

BACKGROUND

Since 9/11, military service members have been involved in detainee operations in many roles, including at the point of capture (when the detainee is taken into custody), guarding the detainee; interrogating the detainee, and providing medical and psychological care.

Our service members have been woefully underprepared for these missions, and as a result may have faced adverse psychological consequences. The work is often dangerous and tedious. The following dangerous or frustrating examples are from my experiences:

- Correctional staff at GTMO had feces thrown at them;
- U.S. staff were targeted by rocket propelled grenades at Abu Ghraib and moved into jail cells for protection;
- Medical personnel at Camp Bucca in Iraq were attacked by the detainees who used hand sanitizer and latex gloves to make miniature fire balls;
- Insufficient medical equipment at Abu Ghraib and other facilities to care for detainees;
- An overall lack of perceived support from the medical and correctional chain of commands; and
- Numerous different chains of commands with different priorities, leading to a sense of chaos.

CORRECTIONS OVERLAP

There is overlap with traditional correctional medical care, including the care of prisoners in traditional jails and prisons. Likewise, there are similar issues with migrants from Central America and other regions who enter the country illegally and often are put into makeshift camps or overcrowded jails. However, there are key differences when treating detainees in facilities outside the U.S.

These differences include the cultural aspects in caring for detainees from the Middle East and elsewhere, large holding areas with 200 to 300 detainees, such as Camp Bucca and Abhu Ghraib, indefinite terms of confinement, such as at GTMO, and high-visibility political implications especially suicide attempts and interrogations.

There are many challenges to providing medical support in detainee operations that may have adverse psychological consequences. These include the following:

- Care for detainees when first captured;
- Fear of infectious diseases in detainees;
- Care for detainees in the correctional facilities in Abu Ghraib, GTMO, the Theater Internment Facility at Bagram Air Base Afghanistan; and other facilities;
- Involvement in force-feeding and during hunger strikes;
- Avoiding abuse of detainees by military staff;

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- Providing psychological support to interrogation efforts often known as Behavioral Science Consultation Teams; and
- Challenges in treatment of complex medical and psychiatric conditions among detainees, which may include a limited formulary, lack of full medical equipment, and austere conditions.

PSYCHOLOGICAL REACTIONS

These challenges contribute to the development of negative psychological reactions, including posttramatic stress syndrome (PTSD) and moral injury, in medical and corrections staff. The negative view of the American public toward these correctional issues contributes to a sense of shame among those who have guarded or treated detainees.

One veteran who worked at GTMO and the jail in Bagram reported that 10 of his colleagues killed themselves. Although there is robust literature on suicides in army and other military personnel, I do not know of any studies that examine suicides specifically in detainee's operational staff.[1,2] There have been analyses of the relationship between suicide and military occupational specialty (MOS).[1] However, personnel in detainee operations may come from many different disciplines, including medical, correctional, and others.

Again, data here are anecdotal, since there is no public information available. However, I was sent to Abu Ghraib and Camp Bucca in 2004 to evaluate these issues. I have been to GTMO 5 times. Thus, I have personal experience that informs this column.

Often the veteran will not bring up these experiences because of the shame and stigma. Therefore, clinicians need to ask about the veteran's experience and whether he or she served at GTMO, Abu Ghraib, Camp Bucca, the Theater Facility in Bagram, or other points of capture.

Although there are many books and manuals about treating PTSD and some literature about providing mental health care to detainees, there is little published about providing care to staff involved with detainee's operations. I postulate that many staff will have shame, guilt, or moral injury, which leads to suicidal thoughts. Treatment thus needs to be supportive, whether with medications or psychotherapy.

CONCLUSION

All these issues should be considered by clinical staff who are caring for service members who have been involved in detainee operations. Veterans may not volunteer that they have been involved in these operations; it is important to ask.

Guilt and shame may be large components of the presenting psychological presentation. This may lead to moral injury. Careful exploration of depressive and suicidal thoughts with these patients is needed. An understanding of these challenges will help with clinical care. ●

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