Becoming a Successful Division Psychiatrist: The Sequel

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Psychiatric residents in military residency programs participate in military-oriented training designed to help them prepare for military operational positions. One such position is that of the division psychiatrist. There are many differences in the duties of such an operational psychiatrist and those of their civilian counterparts. This article is meant to outline guidelines and tactics for success in a military operational environment. The article covers the topics of personal preparation, clinical and preventive duties, and leadership roles of the division psychiatrist. Much of the article may be generalized and beneficial to mental health and non-mental health Army, Navy, and Air Force personnel as well.

Introduction

Each Army division has an assigned psychiatrist who oversees the mental health of division soldiers and family members in peacetime and war.¹ The division psychiatrist is a member of the division and serves as the chief of the division mental health section comprised of mental health officers and enlisted mental health technicians.² The position is usually given to new psychiatrists who are just finishing their residency training. Since Ritchie and White’s ¹⁹ ninety-three article, “Becoming a Successful Division Psychiatrist: Guidelines for Preparation and Duties of the Assignment,” little has been written to guide the new division psychiatrist. We the authors, each a division psychiatrist during Operation Iraqi Freedom and/or Operation Enduring Freedom, wish to add to Ritchie and White’s article and share our experience and advice on “Becoming a Successful Division Psychiatrist.” In addition to division psychiatrists, the article may benefit other mental health providers who find themselves in a combat or operational environment or general practitioners who interact with military mental health teams. Many of the principles discussed may be generalized to other professional operational assignments, especially those concerning logistics, rating chains, and moving into and integrating with the new unit. The article will also be of use to those (Medical Service Corps, Medical Corps (MC), Nursing Corps, and other military branches (Quartermaster, Transportation, etc.)) who find themselves supervising mental health personnel and may help to reduce misconceptions of the mental health mission. Given the ever increasing role of Navy and Air Force medical personnel in providing support for Army ground troops, the article may also be of use to Navy or Air Force medical and mental health providers who find themselves interacting with Army soldiers and commanders.

History of Division Psychiatry

In 1917, Thomas Salmon formulated the American War Neurosis Program after observing the British and French experience. His program called for placing psychiatrists in Army divisions. In 1918, psychiatrists were added to the staff of the U.S. Army divisions. They managed to return a significant 50 to 70% of battle fatigue casualties to duty. By World War II, there were no psychiatrists assigned to combat units and U.S. medical personnel were unprepared to provide forward psychiatric care. Soldiers were treated in rear echelons with about a 5% return-to-duty rate. At that time, mental health screening of new conscripts was the primary plan. When this failed, military commands returned psychiatrists to the divisions and reestablished forward treatment of soldiers.⁴ ⁵ Psychiatrists are still assigned to each Army division and their roles and duty descriptions can be found in Field Manual (FM) 8–51.² The division psychiatry position is considered an “operational position” or one that involves direct support of, and membership in, a combat or support unit that is likely to deploy.

Each year, the MC selection board meets to determine the rotation and manning plan for the coming year. The decisions are usually finalized by January or February. Below are the authors’ step-by-step recommendations for medical officers who learn they will be moving into a division psychiatry or other operational position.

Logistical Preparation

It is recommended that the medical officer moving into an operational tour make contact with the person they will be replacing at the earliest chance. From this person, they can learn about their new unit, the social norms and leadership interactions (known as the command climate), deployment possibilities, ongoing deployment preparation, role expectations, resources available, and items to bring.

It is important to contact the local credentialing officer for the new area. They are usually assigned to the nearest major military medical center. By sending the credentialing packet in advance, the medical officer will reduce down time in the new position waiting for approval of credentials. If it is the first time the medical officer is getting credentialled, the office will likely require copies of diplomas, graduation certificates, and other documents based on local requirements. It is wise, in addition to sending copies of these documents in advance, to hand carry the original documents when traveling to the new site.

In most cases a sponsor, an officer at the new location, is assigned to contact the incoming officer and smooth the transi-
tion and move. They are expected to contact the incoming officer, although a proactive incoming officer will not wait for such contact. It is recommended that the incoming officer contact the sponsor as soon as possible. Sponsors can help the incoming officer prepare for the move, arrange transportation from the airport, arrange hotels in advance, send information about housing arrangements in the area, and assist with the in-processing that begins upon arrival. In Europe and Korea, in-processing may take up to a month and include an orientation to the culture and language of the host nation. Sometimes the incoming officer may get a chance to visit the area and begin arrangements in advance. Off-post housing may be nicer and more private but may be isolated and distant from resources such as schools, military facilities, and social supports. Shipping a car can take up to 2 months; if planning has not been careful, a car may need to be rented upon arrival. Many soldiers buy an inexpensive used car to get around. There are usually quite a few of these passed on from soldiers who are leaving.

Incoming officers should meet with their supervisors and chain of command as soon as possible, establish expectations, and define the rating chain. It surprises many incoming military officers to find that their rater and senior rater are not medical officers. The raters will likely be commanders of the support companies, battalions, and brigades to which the medical officer is assigned. The division surgeon generally serves as the primary or intermediate rater for the division psychiatrist and certain other medical officers. This ensures medical input in the evaluations. Predecessors may have left old Officer Evaluation Report Support Forms (Department of the Army 67-9-1) to guide the incoming officer in establishing duties and expectations. It is wise to discuss progress with the rating chain at least quarterly to ensure expectations are clearly understood and being met.

Most units recognize incoming officers during a “hail and farewell” which should occur shortly after arrival. Other military personnel who are leaving will be hidden farewell at the function. Hail and farewells are often held at local restaurants and kept informal. The commander usually introduces the incoming personnel and may present some of their biographical information. Even when not arriving or departing, it is prudent for the military officer to attend.

Arriving officers find that they are expected to hit the ground running. Many subordinates will have been without a supervisor for weeks to months and will have many issues to present for consideration. The predecessor may have left a continuity book or files to help understand the efforts, issues, and policy of the past. It is wise not to make drastic changes but to develop a good understanding of the issues and discuss your plans with your team members before acting. Many ideas may have already been tried. Most officers will wait 1 to 2 months before making major changes in a system.

Army, Navy, and Air Force mental health teams all include enlisted mental health technicians although names and titles vary. In the Army, the division mental health services (DMHHS) should have three to seven enlisted mental health technicians (in the Army, military occupational specialty 91X). They are valuable resources in caring for the division. Typically, the 91Xs contribute by screening new intakes and running stress, anger, and coping skills groups. They visit soldiers at work and in the field and handle multiple administrative tasks around the office and company. When properly coached and supervised, they can extend their competency to higher levels of counseling. This military occupational specialty title number is being changed to 68X but the duties will stay the same. Details about responsibilities and training can be found at the U.S. Army website (http://www.goarmy.com/JobDetail.do?id=160&fw=reservePs).

Incoming officers should bring good textbooks about diagnoses, therapies, and medication treatment along to assist in training subordinates and teaching other professionals. Digital copies may be the most practical in the wartime environment and therefore may be the best investment.

The backbone of a division psychiatrist is found within administrative regulations. Copies of relevant regulations may be much easier to carry in this day of computer capability. Most of them can be downloaded in PDF from the U.S. Army Publications and Forms web site (http://www.army.mil/usapa/). Below is an initial list of regulations and doctrinal publications of which the division psychiatrist should be aware. Some of the more pertinent Army manuals are: FM 8-10-5: Brigade and Division Surgeon’s Handbook Tactics, Techniques, and Procedures (especially Appendix A which covers Division Mental Health); FM-4-02.51 Combat and Operational Stress Control (revised July 2006); Army Regulation (AR) 600-85: Alcohol Substance Abuse Program (ASAP); AR 40-501: Standards of Medical Fitness; AR 635-200: Separation of Enlisted Personnel; AR 40-216: Neuropsychiatry and Mental Health; and AR 600-8-24: Separation of Officers.

### Promotion Preparation

Most Army MC captains promote to major about 6 years after commissioning to captain (which was generally when they graduated from medical school). Promotion boards review the officer’s evaluations, awards, service records, officer record brief, and official military photograph in the class A uniform. The officer needs to make sure all of these are up to date. Senior noncommissioned officers or experienced officers may inspect the officer’s uniform before the photograph. Officer’s military records are available for review through Army knowledge online. Awards, evaluations, and promotions must be adequately documented in the electronic officer file. The 5-year physical examination must also be up to date.

The Army captain’s career course (officer advanced course) is an opportunity to learn intricacies of military leadership and how to be a staff officer. Due to the military operational tempo, constructive credit may be requested as opposed to attending the full course. Constructive credit for the advanced course is given after completing the correspondence portion of the course and usually requires a MC officer to have some form of operational experience and to have been on active duty for 6 years (3 years postresidency/fellowship training). The correspondence portion can be completed electronically at the duty station.

### Leadership Preparation

As with many medical professionals in operational environments, much of the professional success of division psychiatrists will depend on personal credibility with the soldiers and leadership of the unit. Although the best way to gain credibility with Army soldiers and leaders is to be confident, competent,
and caring, the fact that initial impressions may be made and solidified based on your uniform, badges, and attention to military customs and courtesies should not be overlooked. Clinical credibility is greatly enhanced by ensuring an adequate fund of knowledge and its application in the clinical setting. Caring for both subordinates and patients is vital and can be demonstrated by taking a personal interest in soldiers’ activities and lives and attending unit functions. Attending informal unit functions such as sporting events, Hall and Farewells, officer development programs, and other social functions will go a long way to establishing credibility with line colleagues. Formal unit functions such as the division support command ball provide excellent opportunities to be visible and network with soldiers and leadership. Wise Army officers will have their dress blues (formal uniform) in order and consider attending such functions.

Training in leadership decision making is often nearly absent from residency training programs. Some of the best sources for understanding the complex leadership issues of an operational medical officer are nonmedical military leaders in the community (line leadership) who are well trained in this topic. Line officers and colleagues can serve as mentors and give advice on issues the operational medical officer may face. Cultivating professional relationships with such line officers not only may prove beneficial when approaching such leadership issues, but also in increasing line awareness of mental health issues and defeating some of the stigma associated with mental health care. There will also be opportunities to attend unit-sponsored training, such as officer personal development programs, with fellow military officers and peers. Going to the field and providing actual mental health care in the field environment is a very efficient way to build a DMHS team, network with key leaders and to prepare for a combat deployment.

The division psychiatrist as a military psychiatrist fills dual and sometimes conflicting roles as a military command representative and as a patient representative. Patients may expect the psychiatrist to be their sole advocate, not realizing the nature of this dual role. Some medical recommendations will actually be for the good of the service which may be in opposition to the patient’s wishes.

Clinical Preparation

The military runs on the machinery of meetings and presentations. The military medical provider should plan on making presentations to soldiers, commands, and other health professionals. In the mental health arena, there are many such electronic presentations about common topics, such as combat operational stress control and suicide prevention, that are usually passed along to the new division psychiatrist. Also, many examples are readily found on the Internet.

In the Army, suicide prevention briefings are conducted by the Chaplain Corps. However, this duty is within the job description of the division surgeon and the psychiatrist who may not want to relinquish the role of the senior mental health officer in these briefings. It is recommended that the mental health officer visit the chaplains frequently and learn what they are doing, offering assistance as necessary. Working with the chaplains on a division-wide suicide prevention program is a great way to combine expertise and to build teamwork.

Stress, anger, and conflict resolution are important issues to address in both the combat and garrison environments. As mentioned earlier, 91X mental health technicians can assist efficiently and effectively with these missions by running groups and classes in which they teach fellow soldiers coping skills to help reduce problems created by insufficient stress management, poor anger management, and inappropriate styles of dealing with conflict.

Research and “keeping up” with current practice are important aspects of professional development. There may not be a good medical library near the duty location. Fortunately, research through the Internet is becoming the norm. There is usually a medical center that covers the area of the division and the librarian at that center may prove very helpful in locating and obtaining passwords to research sites, journals online, and other research questions. They can usually obtain paper or electronic copies of journal articles at your request. Operational mental health teams are in a unique position to conduct front line research. Such research should be cleared through appropriate channels such as the Army division surgeon and psychiatric consultant. Articles written for journals should also be cleared through the military chain of command beginning with the division surgeon and public affairs office.

Advising the Division Surgeon

The division surgeon is on the commanding general’s special staff and usually reports directly to the chief of staff. From a mental health perspective, they need to understand the status of mental health in the division. The division surgeon may need to know how many soldiers are on antidepressants, what the overall morale of the division is, what kinds of mental illness-related incidents are occurring such as driving under the influence, illegal drug use, substance abuse, domestic violence, fights, anger/aggression, or how many and which soldiers are nondeployable due to mental illness. They also need to be kept in the loop on serious incidents such as suicide attempts, completed suicides, admissions, and anything that they are likely to be queried on by the division commander. If appropriately advised by the DMHS team, the surgeon can ensure that the DMHS team has the resources and freedom to fulfill its mission. The division psychiatrist should be the final say for mental health issues in the division. Accepting that as a responsibility, taking blame if necessary, and actively asserting and maintaining command of the mental health efforts going on in the division will go a long way to gaining command support and buy-in.

Sun Tsu said, “Know the enemy and know yourselves; in a hundred battles you will never be in peril.” The value of getting to know the unit cannot be overstressed. The process of meeting unit members and learning about units should not be left to chance or conducted in a haphazard way. Scientifically approaching this task by using unit rosters to identify and plan mental health visits of units, commanders, and first sergeants pays off. As with other mental health providers, the division psychiatrist should keep a finger on the mental health “pulse” of the unit. Know the unit. Know what the unit does and what the soldier’s duties entail. Visit them in their place of work and understand what they do in their time off. Know the chaplains, commands, soldiers, and mission. Intelligence about illegal incidents is tracked by military police agencies and incident
reports can indicate increases or decreases in driving under the influence, assaults, domestic violence, etc., that may be influenced by mental health issues. Understanding what is happening in each community helps the mental health team report on the mental status of the unit and target appropriate interventions. Understanding allies such as Army CSC teams proves vital, especially in the deployment environment. During deployments, different mental health teams may work hand in hand and overlap somewhat in their functions.

Command relations are a vital part of the mental health program. Appropriate military leadership guided by mental health team members can protect subordinates from the effects of stress. This requires command buy-in of the mental health mission and team members. The mental health team may find it useful to survey soldiers about common problems affecting morale and cohesion and to work with command to develop a creative approach to problems identified. Feedback about a unit’s mental health standing should always go to the lowest level of command. First give the unit a chance to work on any problems identified. Avoid going over a commander’s head unless absolutely necessary. If not tactfully approached, an offended commander may prevent mental health teams from accessing their soldiers.

In garrison, medical sections sometimes fall at the very end of the command’s list of priorities. To the professional coming out of a well-resourced training or clinical environment, the communications assets may be surprisingly sparse. Telephones may be standard 1970s models with single lines, no answering machine, no speakers, and no forwarding. One six-person Army mental health team in 2003 had only one telephone that could be dialed in to. Telephone systems vary by location. In foreign countries such as Germany, the Defense Service Network (DSN) is the primary means for communicating with other U.S. facilities. Based on previous experience, the medical professional may not be familiar with the DSN system. There are also civilian telephone systems in such foreign locations which take some effort to get used to; DSM and commercial lines may not be available in a developing battle area. Sometimes, rustic field telephones with wire running over the ground are used.

In deployed environments such as Iraq and Afghanistan, communication can be difficult and the living and work space austere. Some deployed locations have a telephone and a computer at a desk in a fixed facility. In other locations, there are only Morale Welfare and Recreation “public” telephones and computers for communication and e-mail access. In more remote areas, soldiers may only have access to a satellite telephone for a few minutes a month. Computers are vital. Laptop computers are especially useful during deployment, field training, and during official travel.

In their clinical role, the Army division psychiatrist and team members act as the mental health gatekeepers for the division. There will be many other agencies involved in the unit’s mental health care. Since secondary gain and splitting figure prominently in the “adjustment disorder” and “failure to adapt to military life” patients that make up a majority of the DMHS case load, the better the DMHS monitors and coordinates with other mental health providers the better the overall situation will be. By regulating evacuations, treatment, and referrals, the DMHS team may vastly improve the division’s mental health readiness.

Some Army units are spread out geographically, as is the case in Germany and Korea. In most stateside locations, they are reasonably close or even compact. Brigade-sized elements will usually have local mental health support. That support can include chaplains (including some trained in marriage and family counseling), general practice clinicians, medics, and nurses, family advocacy services, marriage and family life counselors, ASAP counselors, educational and developmental intervention services counselors (including child psychologists), adolescent substance abuse counseling, Global War on Terrorism (GWOT) augmenters (GWOT-contracted mental health providers), and Army community services. Understanding these agencies (or allies) and building rapport with them is key to ensuring care of dispersed soldiers.

When a unit is spread over a large area, multiple clinic and hospital treatment facilities may provide for unit members. Maintaining mental health command and control can be quite difficult. Hospitals may be reluctant to contact the operational mental health team to advise them of admissions of soldiers from their unit. The ability of the mental health team members to network and establish credibility in this community as well as the unit’s command community is vital to producing a cohesive program. In some locations, the mental health team may be quite isolated from other mental health providers. Although the telephone and e-mail aid in communication with distant locations, it is advisable to develop working and social ties with providers and soldiers in the area.

Division mental health section missions may vary between garrison duty and deployment duty. Most military posts are staffed with some form of mental health team that stays behind when the soldiers deploy. These may be in the form of elaborate community mental health agencies, hospital psychiatric departments, GWOT-funded providers, or other providers placed with Army community services, social work services, ASAP, or other agencies. Given the DMHS mission to provide support and preventive efforts during deployment, a large portion of DMHS time should be spent preparing mentally and physically for deployment and establishing working relationships that will allow this mission to be performed when deployed. It may be tempting for the DMHS team to adopt solely clinical roles while in garrison, especially given the scarcity of mental health resources in some garrisons. However, this may adversely impact the mission capability of the DMHS team and negatively impact the battle readiness of the entire division.

In the deployed environment, a division is usually spread out geographically. Similarly, it is wise to distribute the various mental health assets across as much of your area of responsibility as possible, thereby increasing access to care and minimizing the need for travel. Regardless of how the mental health assets are distributed on the battlefield, travel is often necessary to perform medicine evaluations, assist with difficult command problems, and effectively lead and mentor the dispersed mental health team.

There are many mental health assets on the battlefield to assist with the unit mental health team’s mission. These assets include chaplains, general practitioners, and medics (including 91X mental health technicians), as well as psychiatric nurses, social workers, psychologists, and psychiatrists located in combat support hospitals, CSC units, and other division mental...
The Operational Mental Health Provider and Prevention

The U.S. military has long advocated early intervention and prevention of mental illness programs. These programs are designed to ensure a mentally healthy military force and are important in both deployed and garrison environments. It makes sense that the screening for mental illness starts at each soldier’s recruitment. Ideally, soldiers with mental health disorders and high-risk histories are screened out. This does not always happen and many such soldiers will end up in the local mental health clinic. One major responsibility of the mental health team is to identify, treat, and sometimes recommend administrative or medical separation from the service, especially for those soldiers with personality problems or severe mental illness.

Thorough, realistic training builds cohesive units, esprit de corps, and protects soldiers from battle fatigue. The mental health team can assist by providing specific training in combat and operational stress, conducting mental health surveys, and performing command consultation.

Debriefing after critical events is expected by commands and other military personnel. Chaplains and CSC team members are trained in various methods of debriefing. However, this has recently become controversial and may even be harmful. There are other models for response including trauma-risk management, which is based on a program developed by the Royal Marines. Preventive programs are an important focus both in the deployed and garrison environments. Unfortunately, due to emphasis on numbers-driven clinical work, preventive efforts often receive less emphasis and command support. Attempts to align the military system with civilian health care systems may often receive less emphasis and command support. The psychiatrist may be asked to assist with treatment of comorbid disorders or with substance abuse treatment drugs like naltrexone, acamprosate, and antabuse. In the deployment environment, there usually is not an ASAP program, and the DMHS team may need to organize available resources such as Alcoholics Anonymous groups and chaplains to create a more comprehensive program.

Defeating Stigma

A major obstacle in the mental health care of soldiers is the stigma associated with treatment. Much of what keeps a soldier going through tough times is machismo, rugged self-reliance, and interdependence on other soldiers. Perceptions of mental weakness compromise this both for the soldier and for other unit members. Units do not want a “crazy” or “weak” person on their team. Lives may depend on that person. Such a soldier may require “too much” effort and support by command and fellow soldiers. Likewise, soldiers usually do not want to be seen as “crazy” or “weak.” Commands and soldiers may reject mental health services if they are perceived as annoying or intrusive. Mental health providers are often viewed as disconnected and uninformed about the military culture. Subsequently, soldiers will not access care. Maintaining proximity to the unit by visiting them in their place of work, attending unit formations, attending unit functions, attending physical training with them, and going to unit administrative meetings helps the mental health team integrate in the unit and develop the trust of the soldiers. By uniting with chaplains, they can sometimes get past the initial stigma in the unit. Chaplains often have a known presence in the unit and are accepted by the soldiers. The mental health team must always maintain balance between credibility and appropriate assertiveness. This includes choosing the battles well because it may not pay to offend the command.

Building mental and emotional resilience in soldiers is a key leadership function. Tough, realistic training, unit cohesion, and a sense of eliteness all seem to promote soldier resilience. In addition, mental health units sponsor various programs such as the combat stress liaison course, trauma-risk management, Navy bootstrap intervention, and others, hoping that training in various skills such as communications, recognizing suicidal soldiers, and listening to each other may help units gain stronger cohesion and decrease the risk of mental illness or disabling combat stress. Most Army mental health providers have courses and material on multiple programs that are passed on from team to team.

A key factor in the resilience of soldiers is the resilience of their families. The families need to be prepared for the potential absences of their service members. A large percentage of deployment-related problems are due to home front (family) issues. Based on our experiences, family problems were the direct cause of mental health problems in approximately 40% of the soldiers seen in Iraq, 30% of the cases in Afghanistan, and 30%
of the patients in Kosovo. It is necessary to work with the community to develop resilience in the family members and to create a supportive community alliance.

Transformation into the 21st Century

Army transformation has brought some notable changes to the number of mental health personnel assigned to the division and how mental health is delivered in a division. The transformed army division is more modular than before and is more focused around the brigade rather than the division. In each maneuver brigade, there is now assigned one behavioral officer (psychologist or social worker) and one E-4 91X. The sustainment or support brigade (which is the old division support command) has one psychiatrist, one psychologist, one social worker, and one E-6 91X. For most divisions, there is a net gain in mental health officers, a net decrease in enlisted 91X, and a net loss of total mental health workers assigned to the division. Command and control of the mental health providers is decreased somewhat with transformation due to the fact that the mental health personnel are assigned to three separate brigades and work for three separate chains of command. Generally, the mental health personnel still work in the same location and share the duties of taking care of all division soldiers.

The roles and allocations of combat psychiatrists are constantly changing. Psychiatrists and other mental health workers may find themselves supporting combat units in positions other than as a division psychiatrist such as CSC teams or other medical units. Many of the principles outlined in this article may have application across services and through different professions. The mental health doctrine and allocations will continue to change but many of the basic principles, such as how to gain the respect of the soldiers and commands and reduce stigma associated with mental health, will remain vital topics. It is our hope that these topics will be useful in the many future operations and situations that are expected to occur in the continuing worldwide military mission.

References