

The Evolving Role of the Division Psychiatrist

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With the recent restructuring of Army infantry divisions in the new brigade combat team model, division psychiatrists are facing new and unique demands. This article outlines the varying perspectives of the position and the duties and responsibilities of a division psychiatrist. It provides guidance on how to negotiate the myriad of challenges unique to the position. Discussion includes planning and supervision, providing command consultation, educational efforts, fulfilling the roles of an officer and leader, and future directions for the position.

Introduction

Behavioral health issues have been documented throughout the history of warfare. Since World War I, the U.S. Army has been deploying psychiatrists with infantry divisions to provide front line treatment of combat and operational stress.¹⁻³ Since the Korean War, the division psychiatrist has led the division mental health (DMH) activity (DMHA) both in garrison and during deployment.^{1,3} The roles and responsibilities for a division psychiatrist were first outlined in Army Regulation 40-216: Neuropsychiatry and Mental Health in 1957.⁴

The division psychiatrist serves as the leader of the DMH team whose mission is to assist command in controlling combat operational stress through training, consultation, and restoration.⁵ Until recently, the DMHA consisted of three providers (a psychiatrist, a psychologist, and a social worker) complimented by six mental health technicians (Fig. 1). However, in the midst of the War on Terror, the Army began its largest restructuring since World War II changing the emphasis from the division to the brigade combat team (BCT).⁶ This restructuring effort is designed to make the Army a more modular force, increase efficiency and combat power, and increase BCTs from 33 to 43.⁶ This restructuring has resulted in explicit and implicit tasks and challenges for the behavioral health system.

In conjunction with the reorganization, there has been an increase in the behavioral health assets assigned to each division. Before the restructuring of the force, each division was staffed with a DMH section consisting of three providers (a psychiatrist, a psychologist, and a social worker) and six enlisted mental health specialists. The new force structure elimi-

nated a formal centralized mental health section and created a modular DMHA. The new modular DMH structure, outlined in Figure 2, includes a division psychiatrist and senior noncommissioned officer located with the division surgeon at the division headquarters unit and a behavioral health officer (psychologist or social worker) and an enlisted mental health specialist assigned to each BCT. Multiple BCTs are under the control of the division, such that six to eight mental health providers (psychiatrists, psychologists, and social workers) can be assigned to a DMHA during deployment. This new modular design yields more providers and allows for projection of resources to commanders at lower levels (i.e., battalion and company). With this rapid expansion and evolution of DMH, the role of the division psychiatrist has become more diverse and complex.

The complex effects of combat on soldiers in modern warfare demonstrate the importance of combat and operational stress control during deployment and the need to monitor mental health issues following deployment.⁷⁻¹⁰ This has led to recent updates in U.S. Army doctrine, but unfortunately little guidance on the specific roles of DMH has been provided.¹¹ The purpose of this article was to outline the role and utilization of the division psychiatrist in both the division and in the DMH activity. We will begin with a literature review, discuss perspectives of the position, outline various aspects of the job, and conclude with future directions that address the evolving role of the division psychiatrist.

Literature Review

We conducted an extensive literature review of both Army doctrine and the medical literature (MEDLINE) searching specifically for guidance on performing behavioral health care in an infantry division and the role of the division psychiatrist. The search parameters used and number of articles found for each are listed in Table I. Although much has been published on the psychological consequences of combat and deployment, little has been published on the specific roles of the division psychiatrists in garrison or during deployment.¹²⁻¹⁸ Most of the references were old or did not address current missions and structure of Army mental health assets.

Army regulations associated with mental health care have not been updated since 1984 and cite only that the division psychiatrist will lead the DMH section, serve as a consultant on neuropsychiatric issues, and will provide care to soldiers with neuropsychiatric conditions.⁴ Field Manual 8-51 was released initially in 1994 and then updated in 1998.⁵ It provided an outline of the overall mission and role of the DMHA and gave some additional insight into the roles and responsibilities of the division psychiatrist as a supervisor. This manual was recently updated to outline Combat and Operational Stress Control in

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Presented at the 2006 U.S. Army Force Health Protection Conference, August 7-11, 2006, Albuquerque, NM.

This manuscript was received for review in January 2007 and was accepted for publication in June 2007.

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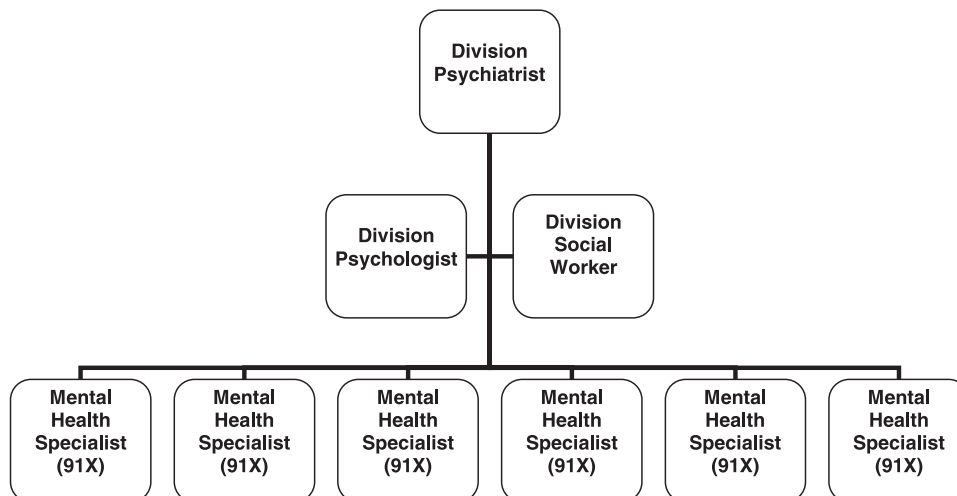


Fig. 1. Previous structure of DMHA.

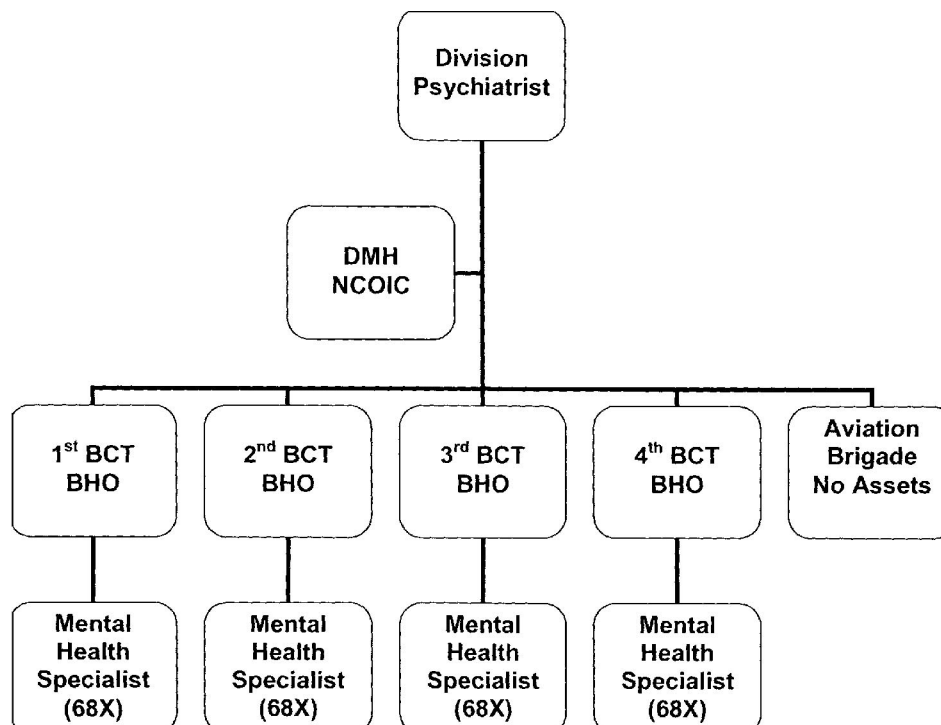


Fig. 2. Current structure of DMH in modular army. BHO, Behavioral Health Officer (psychologist or social worker).

TABLE I
RESULTS OF MEDLINE LITERATURE SEARCH

Search Term(s)	No. of Results
Military psychiatry	407
Army psychiatry	525
Military division psychiatrist	138
Military combat stress	718
Military division mental health	112
Army mental health	267
Army military division psychiatrist	16
Division mental health	

Field Manual 4-02.51, but provides little guidance on the operation of a DMHA or on the roles and responsibilities of a division psychiatrist.¹¹

Other resources were found in textbooks. The “War Psychiatry” volume of the *Textbook of Military Medicine* had two chapters which outlined the historical roles and development of DMH and the position of the division psychiatrist. Glass¹ discussed the role of “Psychiatry at the Division Level.” This in-depth review outlined the specific principles for evaluating, treating, and disposition of soldiers in a combat environment. Additionally, this chapter provided historical data analysis, but unfortunately, the data are from World War II.¹ Rock et al.³ discussed the historical development of U.S. Army mental health resources in “U.S. Army

Combat Psychiatry.” This chapter provides insight to changes that were made in doctrine and in the development of DMH units from World War I through Vietnam. However, as Army mental health care evolved into the 1980s, it moved away from the roles of the divisional units and focused on the development of nonembedded combat stress control units.³ Although both chapters are an excellent source of information on the historical development of military mental health systems and the treatment role of a division psychiatrist, they provide little guidance on other duties and responsibilities of the position.

In 1993, two articles were published in *Military Medicine*. Engel and Campbell¹³ noted the challenges facing a DMH unit. They discussed the minimal attention focused on their role while not deployed and noted the importance of ongoing preventive missions based on their lessons learned from deployment to Operation Desert Storm.¹³ Ritchie and White¹⁴ outlined the guidelines for becoming a successful division psychiatrist providing practical guidance for preparing psychiatrists who were relatively new to the military to interact and engage with infantry commanders. Additionally, the latter article outlined the various duties and responsibilities of the position including (in their listed order of importance): behavioral health provider, supervisor of other behavioral health providers, educator of division medical providers, administrative psychiatry, consultation to command, planning and oversight of the DMH section, and serving as an officer in the division.¹⁴ This guidance was recently revised by Hill et al.¹⁵ Their focus was on what psychiatry residents should do to prepare for assuming the role. Despite the rise of asymmetric warfare and the modular transformation of the Army, little has been written about how the role has evolved within the context of these changes.

Perspectives on the Position

The division psychiatrist position tends to be assigned to junior officers who have recently completed their residency or fellowship training and have not performed any previous operational tours. Few of the incoming division psychiatrists are familiar with the operation and function of a division staff and most have not attended the Captain's Career Course where staff officer training is provided. Yet, according to one division commander, the division psychiatrist is responsible for “maintaining a ‘finger on the pulse’ of the unit.” This provides a global commander's intent to division psychiatrists, but interpretation and execution of that intent is subject to individual variability. We will look at this issue from varying perspectives which are outlined in Figure 3. The position requires staff, supervisory, consultative, and clinical skills.

In keeping with their recent training program experience, many incoming division psychiatrists tend to focus on their role as a clinician. Although caring for soldiers is the primary responsibility, many do not rapidly embrace their role as a staff officer and advisor to the division leadership or comprehend how this role impacts care for soldiers. In some instances, division psychiatrists have relinquished their leadership and administrative responsibilities to a brigade behavioral health officer to increase time available for their own clinical work.

Division surgeons see the division psychiatrist as a consultant in maintaining the health and readiness of personnel. They

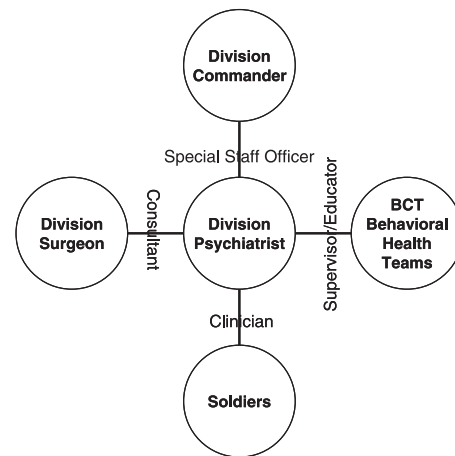


Fig. 3. Perspectives on the position of the division psychiatrist.

expect the psychiatrist to provide assistance in planning for the behavioral health aspects of the entire spectrum of operations and coordinating behavioral health support resources for garrison and deployed activities. They expect the division psychiatrist to be able to identify the behavioral health threats to the units and make recommendations on preventive mechanisms for the division.

Division commanders expect their staff officers to be able to provide expert advice and alternative courses of action so that they can make educated decisions in the best interest of the unit. Many commanders see the division psychiatrist as an important part of the division medical team and expect them to analyze behavioral health trends and the potential impacts of mental health on unit readiness. Additionally, they expect expert consultation on what they, as commanders, can do to mitigate the inherent stress of deployment, ensure proper surveillance of mental health issues upon redeployment, and to reduce the stigma of seeking care and help their soldiers.

These various duties, responsibilities, expectations, and external pressures on division psychiatrists pose a formidable challenge for relatively junior officers to properly prioritize their duties. In this setting, optimal performance will be achieved through proper professional development and updated doctrine.

Duties and Responsibilities

A comprehensive listing of the multiple duties and responsibilities of the division psychiatrist can be found in Table II. However, we have identified several areas of responsibility of particular importance which are expanded upon below.

Planning/Oversight for Division Behavioral Health Care

The division psychiatrist is the unit's subject matter expert on the behavioral health effects of combat. As such, it is imperative that he/she serve as a staff officer within the division leadership to provide recommendations on the positioning and utilization of behavioral health resources both in garrison and during deployment.

Prior to deployment, the division psychiatrist is responsible for developing and implementing training programs for primary care providers and nonmedical officers and noncommissioned

TABLE II
DUTIES AND RESPONSIBILITIES OF THE DIVISION PSYCHIATRIST

Planning/Oversight for Division Mental Health Care	Supervisor of BCT Behavioral Health Officers and Enlisted Mental Health Specialists
<ul style="list-style-type: none"> - Plans and Coordinates Pre/Post-Deployment Mental Health Screening - Provides recommendations on positioning of Division Mental Health Assets in Garrison and Deployment - Develops Division Traumatic Event Management Plan - Consults with Combat Stress Detachment (CSC) Commander on placement of resources within Division area during deployment - Monitors and provides guidance on use of psychotropic medications <ul style="list-style-type: none"> • Determine which medications medical logistical personnel need to have on hand during deployments • Generally use of antidepressants and mild sleep aids is common practice. Use of other psychotropic medications such as benzodiazepines, stimulants, and antipsychotics should be considered on a case by case basis and based on current guidance from higher levels. - Liaisons with other support resources in garrison and during deployment <ul style="list-style-type: none"> • Garrison: Medical Treatment Facility, Army Substance Abuse Program, Chaplains, Army Community Services, Military One Source, and local civilian mental health providers and hospitals. • Deployment: Chaplains, Combat Stress Detachments, and Medical providers. 	<ul style="list-style-type: none"> - Serves as the Officer in Charge of Division Mental Health - Establishes the standard of care for practice within the Division Mental Health Activity <ul style="list-style-type: none"> • Should be published in some format and reviewed on a regular basis. - Supervises all BCT Behavioral Health Officers <ul style="list-style-type: none"> • Frequent supervision and chart reviews • Ensure that BCT Behavioral Health Officers are adequately supervising their enlisted Mental Health Technicians - Continuing Education <ul style="list-style-type: none"> • Develops a continuing education plan for each provider including local training (morning reports, routine training) and other opportunities (Combat Operational Stress Course, Behavioral Health Short Course) • Ensures that all providers are obtaining necessary continuing education requirements and completing necessary tasks for licensure, etc. - Officer and Non-Commissioned Officer Development <ul style="list-style-type: none"> • Ensure that all personnel are working towards advancement and achieving necessary requirements to include schooling (Captain's Career Course, NCO Academy) and civilian schooling • Serves as a rater for all of the behavioral health officers
<ul style="list-style-type: none"> • Consultant to Commanders and Division Surgeon on Behavioral Health Trends/Issues <ul style="list-style-type: none"> - Behavioral Health Prevention <ul style="list-style-type: none"> • Provides routine consultative updates on behavioral health threats through monitoring of utilization rates of the Division Mental Health clinic, behavioral health hospitalization rates, child/spouse abuse cases, DUI reports, positive drug test results, and pre/post-deployment health assessment results. • Oversees standardized Army Battlemind training for development of mental resiliency of soldiers, spouses, and their families. - Potentially Traumatic Events <ul style="list-style-type: none"> • Works with Commanders, Chaplains, and other Medical Personnel to develop a unit Traumatic Event Management plan for addressing potentially traumatic events. - Issues of Public Attention <ul style="list-style-type: none"> • Educates the Commander about current ongoing issues of mental health significance and advises Commander about potential mental health impacts of varying policy/strategic changes. • Provides Commander with information updates and potential questions/answers for media encounters about mental health prevention and ongoing issues within the unit. 	<ul style="list-style-type: none"> • Educator of Division Medical Providers <ul style="list-style-type: none"> - Ensures that all medical providers are educated about most up to date practices in recognition and management of: <ul style="list-style-type: none"> • Posttraumatic Stress Disorder • Sleep Disorders • Depression and Anxiety • Psychiatric Emergencies • Traumatic Event Management • Use of Psychotropic Medications during Deployment • Clinician <ul style="list-style-type: none"> - Serves as a direct provider both in garrison and during deployment - Care generally limited to medication management due to limited resources • Administrative Psychiatry <ul style="list-style-type: none"> - Perform Command Directed Evaluations <ul style="list-style-type: none"> • Guidance provided in Department of Defense Directive 6490.1 and Department of Defense Instruction 6490.4 • Can be ordered by the commander or required by Army regulation - Perform Security Clearance Evaluations - Perform Forensic Exams (Sanity Boards) - Write Medical Evaluation Boards (MEB) - Write Army Suicide Evaluation Reports (ASER) • Officer and Leader in the Division <ul style="list-style-type: none"> - Maintain personal readiness - Serve as a leader and example for junior officers and enlisted soldiers

officers. Training should focus on prevention and management of operational stress and other mental health problems which may be encountered during deployment.

During deployment, it is the responsibility of the division psychiatrist to assess the behavioral health threat of the envi-

ronment and work closely with the division surgeon to review how behavioral health assets are being deployed within the theater of operations. Sources of information include historical data from previous conflicts both in the unit and for that area, rates of combat stress in other units deployed to the conflict,

and rates of behavioral health issues in the unit in garrison. The division psychiatrist can make recommendations to the command on where to position and how to implement the behavioral resources within the unit. Additionally, it is imperative to coordinate with the Corps level assets, such as combat stress control units, on how they are positioned within the area of operations.

Prior to redeployment, the division psychiatrist must establish the redeployment mental health assessment plan and the postdeployment mental health referral and treatment network. During deployment and in garrison, the division psychiatrist must coordinate between and communicate with ancillary resources available both within the unit, such as the chaplains and medical providers, and external to the unit including the local medical treatment facility, representatives from Military One Source, Army Community Service, the Army Substance Abuse Program, Social Work Services, garrison chaplain services, and civilian community agencies. Coordination and discussion with these assets arm the psychiatrist with an array of resources available for individual soldiers, families, units, and commanders.

Consultant to Commanders and Division Surgeon on Behavioral Health Trends/Issues

One of the vital roles of the division psychiatrist is the consultation that he/she provides to the commanders and medical staff. There are many aspects/areas on which the psychiatrist can provide expert advice; however, the two major areas are prevention and responding to potentially traumatic events.

Preventive advice involves prioritizing the threats identified and making recommendations to the medical staff and command leaders on measures to be taken and areas requiring command emphasis. The outcome of crucial, predictive information could help enhance placement and effective use of the limited resources available.

Division psychiatrists can also have a significant impact on command responses to critical incidents. Working with the unit chaplains, medical resources, and commanders, the division psychiatrist can advise and determine how to respond to deaths, injuries/casualties, and other significant events within units. This collaborative effort requires good communication, knowledge, and understanding of current medical literature, and pre-established relationships with unit commanders and other support resources.

Supervisor of BCT Behavioral Health Officers and Enlisted Mental Health Technicians

The division psychiatrist establishes the standards of care and practices for all the behavioral health providers in the division. The standards must be maintained through ongoing supervision and routine feedback for all brigade behavioral health officers. Geographic dispersion of providers during deployment complicates the task of supervision.

The division psychiatrist is also responsible for ensuring education for the behavioral health officers. This includes ongoing training opportunities for educational advancement and access to teaching on the latest information and practices in combat operational stress management. Consideration can be given to morning reports, monthly training sessions, use of sergeant's time training, utilization of local medical activity/medical center

training, or sending personnel to training schools or conferences such as the annual Army Behavioral Sciences Short Course or the Combat Operational Stress Control Course.

Educator of Division Medical Providers

In view of the broad dispersion of soldiers during deployment, primary care providers can serve as a mental health force multiplier. Their education should include information on recognition, diagnostic evaluation, and pharmacologic management of mild to moderately severe mental health problems. Providers should understand the indications for use, common side effects, drug interactions, monitoring requirements, and deployment considerations of each medication.

Direct Care Provider

As previously mentioned, the division psychiatrist functions as the senior behavioral health provider for the entire division. Due to other demands, direct clinical opportunities for the division psychiatrist will be limited and will most often involve brief interventions and medication management. However, to maintain skill and credibility, it is important that the psychiatrist continue to maintain practice both during deployment and in garrison.

In garrison, the division psychiatrist will be a provider at the consolidated DMH clinic. Where the division psychiatrist should be located during deployment has been an area of ongoing debate since World War I.³ With enhanced battlefield communication capabilities and other widely dispersed mental health providers, placing the division psychiatrist within the division surgeon section allows him/her to perform as a staff officer and consultant to the command while also providing consultative advice on care, medication management, and other guidance throughout the division via telephonic, e-mail, and, when required, face-to-face evaluations. However, the division psychiatrist should frequently travel to remote sites to provide on-site care, supervision, consultation, guidance, and teaching. This practice also ensures that the division psychiatrist has a clear understanding of conditions and potential problems throughout the division, but it also enhances visibility from all elements of the forward line units.

Administrative Psychiatry

Administrative responsibilities include command-directed evaluations, security evaluations, forensic psychiatry evaluations, medical evaluations boards, line-of-duty investigations, and Army suicide event reports following a suicidal gesture/attempt or complete suicide. These duties can be time consuming, but must be performed in a timely manner in support of the command mission.

Officer and Leader in the Division

The division psychiatrist must remember that he/she is an officer in the unit. The division psychiatrist must ensure that he/she is maintaining personal readiness and weapons qualification, actively participates in physical training, and attends all functions. It can also be expected that he/she assume additional taskings; it is their responsibility to perform those duties to the utmost of their ability.

Challenges of the Position

Balancing the duties and responsibilities of being a division psychiatrist requires continued attention and focus on all aspects of the position. Other factors contribute to the challenge.

Division psychiatrists tend to be junior in rank to other division staff officers. Additionally, the majority of the officers who directly advise the commanding general are senior in rank to the division psychiatrist; this makes it difficult to gain the trust and respect of the key leaders and advisors. Some behavioral health officers working for the BCTs may also be senior in rank to the division psychiatrist, thus potentially placing the psychiatrist in the position of supervising those who are senior, in rank, to him/her.

The division psychiatrist has to coordinate with other behavioral health resources. In garrison, the division psychiatrist needs to coordinate resources and the flow of information with the local medical treatment facility and/or the local civilian hospitals, at times educating them on the need for release of medical information. The local medical treatment facility might also request that a division psychiatrist work at their facility and share duty responsibilities. There are no guidelines on this matter and all such requests should be coordinated locally with the supervising division surgeon.

During deployment there is potential that a division can be spread over a large area making it difficult for the unit's assets to respond to all of the behavioral health needs. To ensure adequate coverage, it is imperative that the division psychiatrist coordinate with other behavioral health assets (such as combat/operational stress units and field hospitals) for coverage. In these situations, the theater behavioral health consultant will assist with coordination.

Another challenge in the theater of operations may be assuming unanticipated roles, such as mental health consultant for detainee operations. In most cases, these operations have designated mental health attachments; however, should this service require support of the division psychiatrist, review of local policy, current Army regulations, and Department of Defense guidelines is critical. Comprehensive reference documents would include Army Regulation 190-8: Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees, and Annex F of the Mental Health Advisory Team II Report.^{19,20} These along with current guidance from the U.S. Army Surgeon General can assist the division psychiatrist in ensuring ethical mental health care of detainees.

Other stressors in the garrison environment are finances and man power. The DMH clinic may be owned by the division, or in other instances it may be part of a larger behavioral health department at the local medical treatment facility. Regardless of the specific arrangement, clear boundaries and working agreements must be established between the various organizations to address budgetary, logistical, maintenance, operational, and personnel issues.

Future Directions

With increased public awareness of behavioral health effects of deployment and the shifting of the Army to a more modular force, the division psychiatrist occupies an extremely challenging position. This position involves a variety of duties and re-

sponsibilities that demand a clinically competent physician fluent in the art of multi-tasking and executive decision making. With the recent Army changes and the increase in size of the DMHA, it is imperative that capable, well-prepared psychiatrists are placed in this position. With that in mind, we provide several areas of discussion for future consideration.

In the last two decades, the U.S. Army has shifted focus away from medical assets internal to the combat units, placing emphasis on area support resources (combat support hospital and combat operational stress control units) which provide coverage based on region as opposed to units.³ The combat operational stress control units are larger, more diverse teams normally containing several psychiatrists, psychologists, social workers, and mental health specialists, but also occupational therapists and psychiatric nurses.¹¹ These units are then spread over a large area providing both preventive and restorative care often with a centralized restoration center which can provide up to 2 weeks of care.¹¹

Many of these units are called to duty from the Army Reserve or from another branch of service. Few, if any, of these units have any contact with the units in garrison and have no established consultative relationships with the commanders before the deployment. They therefore do not have the pre-established credibility to provide effective education and consultation to commanders. The importance of this credibility has been established throughout history. In World War I, Salmon and colleagues² noted the value of maintaining a psychiatrist on the division staff and working directly with the surgeon to provide consultation and the importance of the role as a staff officer for the command. GEN Omar Bradley realized the value of organic mental health assets during the North African campaign of 1943 and re-established the division psychiatrist position that had been abolished in 1939 after being declared unnecessary.³

Furthermore, Department of Defense Directive 6490.5 states that each unit should have training, curricula, and guidance on combat operational stress control with a focus on primary, secondary, and tertiary prevention in garrison.²¹ Combat operational stress control units are generally not available in garrison for teaching and many medical treatment facilities are not currently capable of providing the primary and secondary prevention and training due to ongoing demands for treatment of soldiers and their family members. This role is therefore ideal for the DMH team and allows for development of strong bonds with units and a sense of ownership among the behavioral teams in their units.

In its new format, DMH is now more valuable. The new structure projects mental health resources to lower levels and further toward the front lines. It also allows for development of long-term consultative and treatment relationships at the battalion and company level and can help to strengthen and emphasize pre- and postdeployment mental resiliency and medical provider training. Maintaining both division and combat stress control mental health resources in a collaborative working environment where patient-specific issues and policy decisions are jointly determined allows for continuity of training, education, consultation, and treatment during nondeployed times with additional mental health resources available during a deployment. Similar lessons are being seen within the U.S. Marine Corps which led to the development of their Operational Stress Control

and Readiness program which, like the U.S. Army, increases the behavioral health resources within the units. That system is placing two psychiatrists within divisions with one focusing toward the consultative and administrative aspects while the other is leading a multidisciplinary treatment team.^{22,23}

The position of division psychiatrist presents many challenges, especially in the aspect of balancing responsibilities. The U.S. Marine Corps is the only other U.S. military service that embeds mental health assets with their soldiers and has recognized these same challenges. Due to the complexities of staff, consultant, leadership, teaching, and clinical roles, future assignments to the position of division psychiatrist should be based on knowledge, skills, and experience. Preferably, such individuals should: (1) be a field grade officer, (2) have served at least one utilization tour after residency to gain experience as a practicing psychiatrist, and (3) be a graduate of the Captain's Career Course.

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