

Chapter 9

PSYCHIATRIC CONSULTATION TO COMMAND

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INTRODUCTION

Command consultation in the field of military medicine is the process of providing expert mental health advice to commanders on matters affecting the mental health and performance of military personnel, usually in the context of their military organization. The term *unit consultation* is a synonym that emphasizes the unit-based focus of command consultation rather than the focus on the individual. Command consultation normally occurs on the request of the commander or another person in the chain of command who has detected the potential for or existence of a problem that could be helped by mental health consultation. While this topic is presented from a psychiatric perspective, many of the principles presented here can be applied to consul-

tation by physicians in other branches of medicine. The same principles and methods of consultation are practiced by the other disciplines in the mental health or combat stress control team: social work officers, clinical psychologists, psychiatric nurses, occupational therapists, and their noncommissioned officer counterparts.

We begin with a brief review of the origins and development of command consultation in the military. The balance of the chapter is devoted to highlighting the major steps involved in performing the consultation, ethical considerations, and risks to the consultant. We have provided many examples of previous consultations and included the experiences of senior consultants to illustrate these points.

ORIGIN AND HISTORY OF PSYCHIATRIC COMMAND CONSULTATION

Psychiatric consultation in the U.S. Army began in World War I, based on the experiences of British psychiatrists as reported by Salmon.¹ A psychiatric consultant was assigned to each corps and division. Army psychiatric consultation continued to grow, learning from the experiences of World War II^{2,3} and the Korean conflict.⁴ As the understanding evolved of how the stresses of military service and combat affected soldiers, the approaches of psychiatrists and other mental health professionals also evolved.

The Attempt to Screen for Psychiatric Vulnerability

Before and during the early part of World War II, psychiatrists followed the theories of psychoneurosis that were prominent at that time. These theories held that the personality was vulnerable, and breakdown occurred as a result of exposure to extreme stress.⁵ They believed that psychiatric disorders did not occur in normal persons, but in weaklings or those with emotional instability that predisposed them to emotional breakdown and psychiatric illness, illness that required evacuation.⁶ It was also thought that psychiatrists could screen out such conditions in advance.⁷ Short interviews with psychiatrists and nonpsychiatric physicians were set up at induction stations to examine recruits for the presence of or potential for psychoneurotic illness. This screening proved to be a failure and

was one of the great lessons learned in World War II psychiatry. Menninger noted that "From the point of view of manpower, we must frankly face the fact that although they were poor risks, many unstable individuals could and did make excellent records. Many men who were rejected as questionable prospects might have been good soldiers under favorable circumstances."^{8(p289)}

Effective screening would have required examiners to accurately judge the degree of resistance a soldier could marshal against stress. The strengths of the emotional supports provided by social forces operating in the army were underestimated, and there was no way to measure the capacity of the soldier to identify with his unit and to obtain strength from such a social process. The resiliency of the soldier and the capacity to regain equilibrium under stress was not anticipated.

Forward Management of Psychiatric Casualties

On the war front, there was a clear need for the forward management of psychiatric casualties; major manpower losses occurred where such efforts were not made. Forsaking the practice of World War I, psychiatrists were not assigned to U.S. Army divisions until November 1943. The principles of combat psychiatry required that psychiatric casualties be treated close to their units, as soon as possible, and with the expectation that they would

soon return to duty. These ideas were later conceptualized by Artiss⁹ as proximity, immediacy, and expectancy, abbreviated to the acronym PIE by others. As it was put by Colonel William C. Porter, "Treat them within the sound of the artillery."^{10(p350)} The implementation of these principles resulted in the return to duty of the majority of psychiatric casualties following very brief treatment and rest. It was very difficult to obtain reliable figures on the numbers of troops returned to duty, but the estimate was that after 1943, psychiatrists returned 70 to 80% of psychiatric battle casualties to duty who were thereafter indistinguishable from their soldier comrades.⁸

Whether psychiatrists could predict behavior, especially in combat, was another matter. Fortunately, some kept notes on what they did and wrote about their experiences. Several rich anecdotes were provided by Plesset¹¹ based on his forced "experiment" with soldiers who would most likely have been screened out by both the psychiatrist and the commander:

It is not always possible in the army to dispose of men who appear to be undesirable. Furthermore, it is, and has been, one of the functions of the division psychiatrist to salvage and to encourage the retention of men rather than to increase the loss of manpower. For these reasons and others, there were remaining in my division after the gang plank was raised, 138 men who during training had presented sufficient adjustment difficulty to necessitate psychiatric attention. Most were the chronic complainers who were referred by their unit surgeons. They represented an assortment of neuroses and so-called constitutional psychopathic states. It was with some apprehension that I viewed their future adjustment to combat, and in order to salvage some satisfaction through the virtue of prophetic powers, I labelled the records of 25 of these as especially poor risks. I anticipated seeing most of the group of 138 in the first few days of combat or perhaps even earlier, for these were the "known" problems.

Case History: Soldier aged 28—married with two children—first seen June 1944, at which time he had more than 3 years' service. Family history revealed that his parents had been separated for 16 years, and that his mother had been in a state mental hospital for 4 years. Work history indicated intermittent and variable employment. Soldier completed the 7th grade at the age of 16. He complained of headaches, dizzy spells, nervousness. He said that he felt "all tore up" and that he had periods when he remembered nothing he did for a whole day. During the interview, he was tense and fearful. He had four

courts martial for A.W.O.L. He was labelled as a poor risk for combat. During combat he served in an infantry battalion and received the Bronze Star Medal for heroism. At termination of the war he was still on duty.

At the end of 30 days of combat, only one of the entire group had been evacuated for "exhaustion" (army terminology in medical units forward of evacuation hospitals for psychoneurosis or other psychogenic disorders). No other had been evacuated for any reason—137 were still on duty. . . . During the first month, one had been decorated with a Bronze Star for bravery. After 60 days of combat—3 had been admitted to the Division Clearing Station for "exhaustion," 134 remained on duty. In the subsequent 3 months of combat there were no other admissions from this group for "exhaustion." Eighteen had been evacuated or transferred for other reasons (2 had been killed in action, 1 was a battle casualty, 7 were non-battle casualties and 8 were transferred for various reasons). At the termination of the war there were 120 remaining on duty. Nine had received a Purple Heart for wounds; eight had received a Bronze Star Medal for heroic or meritorious service.^{11(p88)}

Army policy regarding combat psychiatry did not change until the spring of 1944, from screening to conservation of manpower,⁷ and the psychiatrist's role changed from disposition of personnel to advice on how to use marginal personnel. Psychiatrists then began to function in a true preventive fashion advising on training, personnel, morale, and discipline, and lecturing on mental health and human relations. War Department Circular 48 in February 1944^{7(p400)} specified the commander as responsible for developing the mental health of trainees and officially designated psychiatrists to give mental hygiene lectures to officers and enlisted men at all training camps.

Development of Preventive Psychiatry and the Consultative Approach to Mental Health Problems

Based on their findings from combat, psychiatrists felt that they had proved that social-environmental circumstances were overriding determinants of behavior, and the basis was set for wider application of preventive and consultative psychiatric services. Rioch⁶ wrote that during World War II, psychiatric concepts of prevention and treatment underwent pronounced changes, almost reversals, and Appel⁷ wrote that prevention began where

screening left off. The preventive measure that Rioch⁶ considered most important was the understanding of human relationships. The greatest defense against breakdown in combat, which can be considered a form of acute situational stress, was the development and reinforcement of group cohesiveness. One of the major lessons learned in World War II was that psychiatric disability correlated positively with external stress and was not limited to so-called intrapsychic determinants, as had been predicted.

While many psychiatrists were occupied with screening, others had been assigned to training camps. Consultation services by psychiatrists were seen with suspicion by higher level commanders who thought that consideration for the adjustment of the individual soldier was mollycoddling and would weaken the fighting man. They thought that the existence of such clinics would give official recognition to maladjustment and that lectures about mental hygiene would give soldiers the tools to malingering. These fears proved to be unfounded because 80% of maladjusted soldiers were returned to their units to complete their training, and the others were expeditiously removed.¹⁰

After World War II and before the consultative approach was taken, trainees with adjustment problems were treated as patients in outpatient clinics. These clinics were overwhelmed by disgruntled soldiers. Extensive psychiatric and psychological examinations did not predict future performance. Information derived from observations of work and study of the actual nature of the soldier's relations with persons in his unit were more valid predictors of performance than were extensive psychiatric and psychologic examinations. In doing traditional psychiatric examinations of trainee adjustment problems, U.S. Army mental health professionals over-emphasized pathology and overpredicted failure of adjustment.¹² Psychiatrists assigned to training centers organized mental hygiene consultation centers to apply what they considered to be preventive psychiatry concepts to the stresses of basic training. During World War II, mental hygiene consultation centers were established but, after the war, were abandoned. After the Korean conflict, 35 were again established.¹³ These facilities were located separately from the hospital, both geographically and administratively, and were attached to the training center headquarters. For this reason, and others, they became identified with the viewpoint of the troop commanders instead of the hospital.⁷ Psychiatrists frequently observed the behavior of the

troops on duty and participated in training with them, thus learning important aspects of camp life. Cases of maladjustment in training were treated by attempting to increase the soldier's affiliation with his unit and to make his adjustment to the military a positive occurrence in his life.¹⁴ Efforts were centered on prevention: primary, secondary, and tertiary.^{4,15} When treatment was performed, it was done in a milieu, mostly by technicians with the psychiatrist as supervisor.¹³

Cruvant¹⁶ commented that the intelligent line officer is the military psychiatrist's first bulwark of offense and defense for early prevention, recognition, and prompt elimination of the psychiatrically unfit. One of the major goals of early preventive psychiatry was education of the line officers about the functions of psychiatrists. Cruvant wrote about the need for a close relationship between the line and training officers, a need that remains unchanged today. This relationship was called laborious ". . . when the psychiatrist exists as a remote, unapproachable entity within the cloistered halls of the station hospital."^{16(p42)} War Department Field Manual 8-10, June 1946,^{7(p410)} noted that the majority of the factors that determine the mental health of troops fall in the province of command, that staff psychiatrists and commanders would maintain close liaison, and that the psychiatrist would monitor the mental health of the command and conduct a continuous education program by formal lecture and informal discussion to instruct enlisted people and officers in mental health. He was also advised to closely monitor such matters as training schedules, leave policies, disciplinary procedures, and the need and opportunity for rest and recreation. The three areas that most affected the mental health of the men were morale, leadership, and personnel policies. The idea that psychiatric knowledge could be helpful in these areas was new to army leadership.

True primary preventive psychiatry occurred late in World War II when psychiatric advice was applied to large numbers of men. For example, psychiatrists in the Fifth Army recommended that infantry replacements be sent forward in groups who had trained together rather than as individuals.⁷ Other preventive measures that were recommended were discussed by Appel and Beebe:¹⁷ providing incentives and rewards for infantrymen, establishing a length of combat tour policy, increasing the meaning of the importance of tactical objectives for soldiers, and communicating to the soldier the reasons for fighting the war. They also noted that for preventive psychiatry to be successful, it had to

demonstrate that environmental changes can contribute to the mental health of the population. Its ultimate success depended on whether stress factors could be identified that were both important causes of psychiatric disorders and subject to modification or control.

The efforts of the World War II and Korean conflict era consultative and preventive psychiatry programs were judged to be successful although evaluations of the effectiveness of the preventive psychiatry programs were difficult to obtain. Menninger¹⁸ noted that preventive efforts during World War II were an outstanding achievement, but that no statistics were available. He concluded that the education of line and medical officers and their advice to command on mental health and morale undoubtedly accounted for a tremendous saving of manpower.

In 1960, the Group for the Advancement of Psychiatry prepared a report¹⁹ to summarize the programs of preventive psychiatry in the armed services, to evaluate their effectiveness, to derive operational concepts, and to indicate possible ap-

plications of the principles to nonmilitary settings. The group found that there had been a decrease in the hospitalization of identifiable psychiatric disorders both in war and peace; there had been a continuing decline in medical separations for psychiatric illness; there had been no corresponding increase in loss of manpower through administrative channels or through medical separation for nonpsychotic illness when corresponding periods of time were involved; and there had been a decrease in the number and rate of disciplinary confinements. The group concluded that although the data were not as complete as might have been desired, they did indicate a significant trend showing that a loss of manpower from psychiatric disorders had been prevented. The group noted that the data could not support the idea that emotional difficulties had been prevented, but rather that ineffectiveness had definitely been reduced through the early recognition and prompt outpatient treatment of emotional difficulties during adjustment situations, combat, and noncombat.

CURRENT MODELS OF COMMAND CONSULTATION

Training

Command consultation is not a subspecialty of any mental health discipline, but is a set of skills that begin in training and increase as the individual gains experience. The same consultation skills that are used in command consultation are used in other areas of psychiatry. For example, similar skills are used by a child psychiatrist consulting to a school, in community psychiatry consulting to community agencies, and in the hospital consulting to other physicians. In hospital-based training programs, one model that seems particularly useful is that of liaison training in medical and surgical consultation, often based in consultation-liaison psychiatry training.²⁰ This area of training and practice is multidisciplinary and involves many of the same medical and behavioral sciences disciplines, for example, psychology and social work, that consult to commanders.

There are no firmly established training models of command consultation training, but we note one example of what was reported as an effective training program. In one psychiatric residency, command consultation training was provided over a 1 year period, consisting of consultation to a unit in

the field on a weekly basis.²¹ A biweekly seminar on consultation by an experienced consultant was also held in the hospital. A recent article by psychiatrists at Letterman Army Medical Center describes a similar program.²² A good base of literature in the command consultation field is severely lacking. Most of the writings tend to be oriented around consultation in different settings such as in combat,²³ in training environments,²⁴ or in esoteric settings such as a refugee camp.²⁵ Other authors have stressed technical points such as the development of roles for the various professions in consultation,²⁶ the necessity of having high-level command support for consultation to be maximally effective,²⁷ unit group consultation,²⁸ and the allocation of resources to consultation.²⁹

Development of a high level of skill in consultation seems best taught in an apprenticeship model in which a senior psychiatrist takes a resident or junior staff member with him on a consultation visit and teaches the particulars of the case.

On a local level, the primary basis on which a good consultative relationship between the mental health professional and the commander is often established is by the good clinical work of the would-be consultant. The consultant who gains credibility

through his clinical work is then likely to be sought for future work. The assistance of the mental health professional is made known to the higher levels of command, and he soon has a reputation as being helpful and competent or not useful.

There are many types of problems for which mental health consultation is sought, from the adjustment problems of recruits at a training center to questions of the conduct and judgment of high-level officers. The knowledge, skills, and attitudes of the consultant will change with experience, and the approach will vary depending on the type of consultation. It is difficult to anticipate all the types of consultation that could occur, but the following seem to be the major categories.

Problem-Oriented Consultation with Local Unit

A psychiatrist is called on to consult with a unit with which he has a history but does not maintain a close relationship. Accidents involving military personnel, for example, provide a scenario in which a consultant can provide assistance to a unit, as well as form a relationship with a commander.^{30,31} A common example of this type of consultation is the army division psychiatrist who consults to units in the division. Another example is the air force psychiatrist who consults to the flight surgeon. Flight surgeons often call on the psychiatrist for assistance with cases, particularly pilots about whom there is some question about their fitness to fly.³²

The need for consultation in a combat environment is given by Kurtz,³³ who described his observations as a commander in Vietnam with a nonpsychiatrist physician who helped his unit. The education of other physicians by psychiatrists to do consultative work is one of the most important tasks of the psychiatric consultant:

My best experience with doctors was in Vietnam when I was a battery commander. The battalion surgeons were young captains. As far as treating wounds went, they hardly ever got into that process because the evacuation system was so efficient. No matter where we were, even when I was wounded, the brigade aid station was usually the first stop, if any, before reaching a surgical hospital. They [the battalion doctors] didn't serve a real medical purpose in combat; they weren't there doing open heart surgery on the battlefield, but they were there, and did a great job, along with the chaplains, with keeping the lid on things in terms of human emotions. They had just enough training, enough general knowledge of psychiatry and psychology to where they were able to handle things. If a kid was under

stress, they were able to identify that and they were able to create little situations to alleviate that stress. I think they took very good care of commanders, and I think they knew to keep anybody healthy, they kept the commanders healthy. So they were able to take care of a commander who was getting tense to the point of almost becoming dysfunctional. They, in their own way, put their arms around company commanders who were getting stressed out. Almost all of what they were doing was keeping us functional.

Kurtz³³ also noted some problems that could be of interest to a battalion commander. These consultations were not performed, but were needed:

I would say, "I'm trying to raise standards in my battalion and it's going to cause stress. Advise me, what do I do. How do I package the program? What kind of stress can I anticipate? How do I deal with it?" Or, "We are going into a night training cycle. What do you know about sleep deprivation? Can you watch my outfit work for awhile and tell me who is sleeping and who is not. Why are things going wrong? Why are staffs up 24 hours? Give me some background, what happens when we don't get enough sleep?"³³

Problem-Oriented Consultation with Remote Unit

This type of consultation is sometimes called a "one-shot consultation" because the consultant or consulting team will go to a site, perform the consultation, return home, and be unlikely to see the recipients of the consultation again. These consultations tend to occur with units that have no ongoing mental health contact, such as on a ship. Common examples of this type of consultation are seen when there has been a problem such as a severe training accident, disaster, a number of suicides, or unit performance problems. A particularly exciting development in this type of consultation has been the concept of the U.S. Navy's special psychiatric rapid intervention team (SPRINT).³⁴ These teams are located at major U.S. Navy hospitals (Bethesda, Portsmouth, and Oakland) and are available to consult with commanders, usually on ships, when there has been a serious incident with the high likelihood of mental health consequences for the crew. SPRINT has been used following the collision between the USS *John F. Kennedy* and the USS *Belknap*,³⁵ the strike of the Exocet missile on the USS *Stark*, and the explosion aboard the USS *Iowa*.

An example of a problem-oriented consultation is provided by Crigler,³⁶ who described the results of part of a team consultation for a problem aboard an aircraft carrier:

The aircraft carrier was having some friction between the air boss and the commanding officer of the ship. They wanted to know what was that about. The psychologist and psychiatrist took the tack of doing a full evaluation of both of them, and were getting lots of interesting data, but it was not relevant at the time, though some of it became more relevant as time went on. We decided we would split up and each do our own thing, getting together after dinner. What was interesting was that neither of us had ever been on a ship for an extended period of time, and had never seen the sort of personality dynamics that evolve on an aircraft carrier.

There was a definite split between the "black shoe" navy which are the men who drive the boats and run them. They deliver the goods, whether it's people, airplanes or Marines, vs. the "brown shoe" navy which are the fly boys, the men in the squadrons. Very, very different kinds of people. When we went to the wardroom of the black shoe officers, they were cordial, polite, civilized, on their good behavior, as you might see in an officers' club. They had linen on the table, etc. The whole thing was genteel and the conversation was wide-ranging: music, literature, movies, politics. The next day, we had lunch and dinner with the brown shoe guys. They ate at plain long wooden tables with nothing on them but bottles of ketchup, mustard, and hot sauce, at least 50 people at a table. It was located right under the flight deck. The noise was bad and the jet fuel smell was pervasive. You would hear the planes slam into the deck as the hook caught the plane's cable. They all came in their flight suits, which were basically scruffy. They all looked like they hadn't shaved, washed, or combed their hair in two or three days. They were amazingly crass to me and to the male psychiatrist. Obviously, they were not trying to be anything they weren't; this was their normal style of camaraderie. I felt as if I were at a fraternity party in the middle of football season about an hour before the game starts when everybody is almost totally blitzed. These guys had not been drinking, but they were giddy. All they could talk about was "flying and broads." It was a fraternity, a rah-rah immature, bravado, narcissistic type of response. I admit that when you are trying to land a plane going 600 miles per hour on a postage stamp in a bouncing sea, you had better have a narcissistic trait or two or you are not going to do it very well and if you don't do it very well you are not going to live very long. It was easy to understand some of the differences, but it was also easy to see why these people were not

getting along very well. They were operating out of two very different cultures. The commanders of both of the groups were as clearly dominant as you could find, so when we talked to the two commanders and the admiral, we said "Well, basically we have found a difference in personality styles and we are surprised that you are finding this a problem only on this particular ship." He said, "I picked one at random." Given that this situation is typically going to occur, we helped him find a way to institutionalize techniques to help those two very different kinds of people interact more effectively and smoothly. I don't know what happened to the study, but I know they did change the way they ran staff meetings and how the two admirals of the surface and squadron communities related to one another at headquarters.³⁶

In some cases, the consultation may really be on system-oriented problems that are common to a number of units or types of people. Fragala³⁷ provided some examples:

Part of the mystique of the fighter pilot rests in the congruence of her or his actions in terms of the legends of the old West. The heroic cowboy comes upon trouble alone and fixes it his way and on his terms. This kind of independence and autonomy used to be rolled into the idea that fighter pilots were to be trained to be "tigers." The problem is that "tigers" take big risks and don't generally operate well as part of a team. If you train people to be professionals first, think and talk to them as executives, issue them briefcases, etc., you end up with a different product. Even better, you teach that there is a time to be a tiger and a time to be an executive, and that *both roles* (along with others) are required; that is, that the roles really must be integrated to achieve the desired result.³⁷

Primary Prevention or Public Health Consultation

In this situation, the consultant is asked to advise on policies or procedures that may affect large numbers of people. This type of consultation often depends on the consultant having specific scientific expertise in the area required. Recent examples have to do with advising command about continuous military operations and sleep discipline³⁸ and developing cohesive military units that are considered more combat effective than noncohesive units.³⁹

Educational Consultation

A final type of consultation provided to commanders and units is one that has been frequently

used to educate commanders about stress and mental health. During World War II, education was one of the goals of preventive psychiatry. Lectures to commanders were a part of preventive psychiatry, aimed at improved mental health and psychological education of officers. Today, there are several types of educational consultation. All of the services have requirements for classes on various mental health subjects to troops. For example, health promotion activities are required of all the services under Department of Defense (DoD) Directive 1010.10.⁴⁰ The elements of this program include smoking prevention and cessation, physical fitness, stress management, alcohol and drug abuse prevention, and early identification of hypertension. Three of these programs, suicide prevention, stress management, and combat stress, provide the opportunity for the mental health officer to come to the unit, teach a class, and attempt to form a consultative relationship with the unit officers and senior noncommissioned officers.

Gelles⁴¹ described a consultation that developed from a request for stress management training:

This consultation was to a medical command, one that deals with a combat unit. They were functioning inefficiently and then were stressing out the combat end of it [people they were serving]. They lost 13 of their people to Desert Shield [personnel who were deployed to Saudi Arabia from 1990 to 1991]. There was a problem in the unit which seemed to be some kind of acting out, a lot of stress. A lot of people had friends deployed and people were very anxious about this war. They wondered when they were going, too, and they had all kinds of excuses. I brought information on deployment and combat stress. I talked to people and found out there was gross inefficiency in communication in the command about the way people are feeling. They were not talking to their seniors because they thought their seniors were not effective. I tailored a lecture around communication and the feelings of stress about not being able to communicate about how they were feeling, the exacerbation of their own anxieties, the potential losses of friends deployed, and their own fears about being deployed. We talked about combat and delayed stress responses in anticipation of how they would manage friends or flyers that came back wounded. The other thing that was interesting was that there were some Vietnam veterans who had been corpsmen in Vietnam and had become officers and nurses. One doctor had bad experiences in Vietnam. The Persian Gulf war was exacerbating a lot of very uncomfortable feelings and they were not talking. They were looked at by

the staff as role models for how you manage yourself during a war and they were actually role models for shutting down. I encouraged them to have their own group where they could talk with each other. In about a month, I made a follow up call. They said things were better. I sent them an after action report with recommendations, from clinical and organizational perspectives. They were encouraged to look and listen for the cues of what is symptomatic of dysfunction in the group and realize it may not be the individuals.⁴¹

Following the recent combat operations of the U.S. military, Operation Just Cause (Panama, 1989) and Operation Desert Shield/Storm (Persian Gulf War, 1990 to 1991), many mental health professionals have been called on to provide debriefings to returning units or classes on post-traumatic stress disorder (PTSD). In most of these situations, the mental health professional provides an attempt at prevention of later disorders through familiarizing troops and commanders with the usual sorts of symptoms that occur after a traumatic event. This approach is usually aimed at normalizing such symptoms as sleep disturbance, intrusive thoughts, dreams of the event, disturbances in interpersonal relationships, and understanding the need for a recovery time. Commanders often are very resistive to such interventions because they fear that such a class will traumatize their people by reopening subjects that they would like to see forever closed. Another common means that units use to deal with trauma is to make the training schedule very full. Consequently, anything that interferes with ongoing training activities is not allowed. Special programs, such as stress management classes or combat psychiatry classes, are often mandated by high-level authority, and units are required to make time for the consultant. In some cases, a meaningful dialogue can take place, but in others, the commanders are hostile and provide many obstacles to the consultant.

Fagan⁴² reported that in the Persian Gulf War, perhaps as many as 1,000 units were given consultation for stress management, a need that the commanders of the units thought would be of help to the soldiers and was considered essential. In one sense, this might represent naïveté in that officers may see stress management functioning like a vaccination. On the other hand, it seems to be the first time that mental health resources have been requested on such a large-scale basis, indicating that officers and noncommissioned officers see mental health services as valuable to them.

PERFORMING THE CONSULTATION

Differences between Clinical and Consultation Questions

The consultation question is often framed in terms of one or more individuals but is also, to some degree, about the health of the command. An analogous process for psychiatrists may be school consultation and hospital consultation-liaison psychiatry. In both these cases, an assessment may be performed on an individual but also on the milieu in which the person interacts. In addition, in both cases, the clinician must serve the needs of the client and the system.

Clinical training frequently neglects the work environment, which probably reflects a devaluing of the ways in which work contributes to health. Work is often seen as a stressor, and not as something that maintains and sustains people. An example of this attitude was given by Ursano:⁴³

Clinicians ask, "Tell me what's going on in your family," but, unless there is something dramatic going on at work, they may not have a lot of interest in it. Command consultation, by definition, deals with the organization and looks at the work environment and its contribution to performance and health and is different from psychiatric care in terms of its focus on performance in addition to just health. For example, a healthy service member may present with depressive symptoms which are secondary to poor performance and disciplinary actions because he has personality conflicts with a supervisor.⁴³

Cross-Service Consultations

For those persons making consultations across services, Ursano⁴³ described both advantages and disadvantages:

There are frequently substantial advantages to wearing a blue suit [U.S. Air Force] when consulting with a green uniform [U.S. Army]. There can be disadvantages early on, it seems, in terms of getting into the system, because you have to give more explanation, but once you are in it is frequently an advantage because you are seen as someone who is not in the usual chain of authority or command. You are clearly identified as not a part of the usual chain in contrast to when a green suit consultant shows up, someone always wants to know "Where is it going to? Who is he or she reporting to? Which commander is going to hear about it?" When you are in a blue suit consulting to a green suit you are in fact

already identified. You have trouble getting in, but once you are in, you may have a more clear definition in the eyes of the consultees which will assist their talking to the consultant. Being an outside consultant provides advantages and disadvantages; we can trivialize those issues if we think only of a consultant as working from inside. There is another aspect of being the outsider which is that the outsider provides a certain kind of validation to the experience of the consultees, which it is not obtained by someone on the inside.⁴³

Uniform

The uniform of the consultant is of great importance. It is important to wear the same uniform as that worn in the unit. When the unit wears a work uniform, the consultant should wear the same. This is a nonthreatening way to begin a consultation and decreases the psychological distance between the unit members and the consultant, particularly important when psychiatric consultation is involved. When people hear that a mental health officer is coming to the unit, in most cases, they expect him to wear a white coat and are relieved when they find that such is not the case. However, there is a caution in wearing the same uniform as the troops being visited. Mateczun⁴⁴ noted that while a consultant may gain credibility by wearing the same uniform as the unit to which he is consulting, there is also a danger in thinking that you know what it is the unit does simply because you wear the same uniform.

Language

Using the language of the group to which one is speaking is a primary skill involved in being a consultant. Ursano⁴³ noted:

Although we get kind of glib about that [the language], I think when we consult with commanders we sometimes act as if we already know it. I don't think that's true; I don't think the language of commander A is the same as that of commander B. The language of a commander of a hospital is not the same as the language of a troop unit, which is also not the same language as that of the commander of a support unit. The ability to identify what language is being spoken and to be able to speak that language becomes important. It is also important to remember that you can also fool yourself. You can learn the language and think that you automatically understand what it is that the unit does.⁴³

Forming a Consultation Team

The U.S. Navy SPRINT is an example of a group brought together to perform a consultation but is not the only instance. More common is the ad hoc team that has been created for a specific consultation. When this is done, team composition must consider the expertise of each member, the group they represent, and the ability of each person to function in the type of team envisioned by the leader. In addition to the military personnel, team members may be needed who have special ability to understand the problems of members of other services, civilians, and family members. In a consultation that is expected to be lengthy and difficult, the ability of a group to work together and to support each other must be considered in addition to the other factors listed above. An organization is being created and then sent to do the consultation. For the SPRINT, no less than three people are sent out. In addition to the three traditional mental health professions, other line officers or noncommissioned officers and enlisted personnel, chaplains, nurses, and lawyers can be of assistance.

Formulating the Consultation Question

When a consultation has been requested, the consultant should help the requestor clearly formulate the goals of the consultation so that there are no unwarranted expectations. Leaders of military organizations often have very little idea of what they specifically would like you to do. Setting goals with the consultee is somewhat like making a therapeutic contract with a patient. You tell them what your limitations are, what you can and cannot do, and what it is that you have to offer them.

Gaining Entry to a Unit

The consultant who wishes to provide professional input for the purpose of improving the health and performance of the members of the unit must obtain a means of entry to the unit. The process of consultation may begin with a request for consultation from the unit commander or from an official outside the unit such as a higher level authority with an official interest in the unit. In addition to permission to visit the unit and talk to people, entry to the unit also means obtaining the willingness of individuals in the unit to disclose factual and emotional material on the subject of the consultation. This willingness seems to occur most easily when

the following has occurred: the consultant has previously provided assistance to the unit, has spent time with members of the unit and is perceived as someone who is available and can be counted on to be around to discuss follow-on action, is not there to investigate or blame the unit for its problems, or is a well-recognized individual with outstanding credentials in the field in which he is asked to consult. Simply advertising oneself as a consultant in the military and having credentials to support that stance frequently leaves individuals disappointed when they are not called on.⁴⁵

Explaining the Purpose of the Consultation

When the consultation involves an evaluation of one or more individuals, particularly in cases of fitness for duty, a question in the mind of the consultant sometimes is how much to tell the subject of the evaluation. Fragala³⁷ described the need for all parties in the evaluation to be clear about all the issues involved. Although these comments refer to evaluations of high-level personnel, they are generally applicable to all ranks in the fitness for duty type of consultation:

I address that issue [the purpose and results of the consultation] right out of the box and tell them forthrightly that they will get to see and get a copy of everything I write, and that I will tell them who I talk to and about what. I also communicate the notion that, if indeed they are sent to me, I insist that they know who sent them so that I take of the purchase and the mantle of how ever many tea leaves [stars] it takes to get the person's attention. I insist, when I can, on a telephone or a face-to-face between the individual to be evaluated and the person who is referring them so it's real clear that somebody they respect is saying "Go do this and tell the doc the straight scoop." I will very often call the referring individual when first notified and say, "Look, please have the following conversation with the person that you are sending." I am not an MRI scanner.³⁷

Approaching the Organization

A consultation usually begins with the head of the organization. Remembering the model of the consultation-liaison psychiatrist, just as in starting with a patient, his anxiety about being the subject of a consultation must be allayed. Mateczun⁴⁴ reported that he typically began with the question, "Tell me what it is you do and how do you do it. I'm here to learn about what it is you do."

The commander and others in the unit may tend to view themselves as passive recipients of the consultation process. It is preferable that they be active participants. Just as an understanding of the patient's concept of their illness is needed, that is, the chief complaint, so is getting the commander's view of what is happening. If the request for the consultation came from someone other than the commander, the initial concept of the problem will be that of the consultee, not the commander of the unit. There is usually a difference between the two. Each has his own perception.⁴⁴

Understanding Unit Structures and Functions

For an unfamiliar unit, the first task of the consultant is to learn exactly what it is that the unit does. The formal structure of the unit is learned by looking at the unit organizational chart, but one can mistakenly believe that everything that goes on in an organization is listed on the organizational chart. In addition to the formal structure, the consultant must attempt to become familiar with the set of informal subgroups to understand how a unit really operates. For example, one must have some concept of the enlisted structure because enlisted personnel do most of the actual work in a unit. It is different in every service and is separate from the administrative structure. For example, in the army and the marine corps, the officers administer and the enlisted personnel fight; in the air force and navy, it is generally the opposite. One must also learn something about the enlisted working conditions, how communications flow up and down, and those who have power in the organization that comes from their own personality characteristics.⁴⁴

Interventions

In doing a consultation, one must learn to distinguish between organizational consultation and intervention. Sometimes the process is an intervention or it can lead to a discrete intervention. For example, SPRINT has elements of command consultation built into it. They are not necessarily called that to the commander, but some of the concepts and techniques are the same. Mateczun⁴⁴ described the process of distinguishing between consultation and intervention this way:

The intervention itself interacts with actually doing a consultation. When you are interviewing, you are performing a triage of your decisions and actions at the same point. You are constantly making deci-

sions as you are finding out more information about where it is you are headed and what it is that you need to do. For instance, you may discover an individual who is obviously having problems of a suicidal, dangerous, or psychotic nature. You will make an intervention at that point and not wait for the process to end. You have to take a somewhat different framework with you. You have to know a little bit about systems theory and organizational psychology. The usual tendency is to frame things in terms of individual psychopathology, or organizational pathology, just as we sometimes want to deal with a client in a diagnostic sense. This is probably not the best approach. The tendency of many consultants is to use pathological language rather than a language that addresses function and ability which are more understandable to the consultee. You approach the consultee emphasizing that you are his or her consultant and, as such, are to be used as a resource to him. That is indeed what you are and failure to establish this understanding will likely result in a failure to establish rapport. The usual consequence is that your interventions will not be accepted. In other words, the likelihood of your interventions being accepted often depends as much on your style as it does on the perceived worth of your ideas.

As an example, there is a squad where someone is being scapegoated. They have identified somebody as strange, different, or odd, and the squad is going through a process of group formation through exclusion of that individual or that has already happened and they have had a suicide. People may think that the person actually was odd or unusual and not understand the process of the group formation that went on or how leadership may not have been optimal during that process. To educate them you can say, "This is a process that can occur in groups, but you as the leadership can learn how to effectively intervene to educate people about this process and why it may endanger the function of the group." If they ask, "Why?", say, "Well, if this happens to an individual, the thought in everybody else's mind is that 'This may happen to me.' You have to keep this in mind in group formation." You may meet resistance from the other members of the squad, but the result should be a squad where soldiers feel safe. It should be emphasized that loyalty within the group to each is the basic strength of that group. Or, because of identification with the group, the leader may say "No, this guy really is weird." You have to work with them on that.

You must continue that process as time goes on. Periodically check with them and remind them of your availability. You cannot just go off and never come back. One good method is to establish a regular meeting time. Your goal is to have the consultee

value and appropriately seek your counsel, not create dependence on you.⁴⁴

Terminating the Consultation

What happens at the end of the consultation depends on the type of consultation arrangement with the client. If it is a one-time consultation, the relationship usually ends at that point. If it is ongoing, you will close out a particular question, but you will continue the relationship that you have established with the consultee. Mateczun⁴⁴ described important aspects of the termination process of the “one-shot consultation” and its aftermath, particularly for the consultation team:

In either case you may be required to do something such as provide a report, and you have to bring closure to the relationship or that phase of it. In this process you may have to close a lot of loops and talk to a lot of people. You have learned something from them, and they expect you to reciprocate. There are certain people to whom it is crucial to give some immediate feedback: the commanding officer or leader and the person who consulted with you originally. When you have finished, you want to debrief yourself and your team. This is crucial. Usually you have gotten very involved in the process. One way to look at it is as a “no fault” process for yourself and your team. Depending on the situation, you may have been exposed to a particular psychological trauma or been confronted with the stress of extremely unpopular recommendations to a hostile group. While you hope your recommendations will improve the function of the group and the individuals in it, there are always doubts. So you want to talk it over and debrief yourselves.⁴⁴

Reporting the Consultation

The report prepared by the psychiatrist, in addition to being a legal document, is what the commander will pay the most attention to, and the success or failure of the consultation may ride on

the ability of the officer to report his findings. If both sides are serious about solving problems, the report is a critical step in the consultation. Fragala³⁷ provided his views on preparing reports of consultations:

Critical to the written report is the formulation of the case. The commander is trying to solve a problem first and foremost. Doctrinaire statements will often be followed by a return letter which says, “Please answer the question. . . .” The mental health professional must first be clear about what the real question is in a given case, and must also realize that it may not be the question that seems to have been asked. The consultation is a process. Once you decide that an Axis I mental disorder is or is not present, you need to realize that only if you are going to hospitalize the individual (and even then only if there is no chance that he or she will ever return to duty) is the commander not ultimately responsible for the health and welfare of the member. Commanders are selected, in part, because they take this kind of responsibility very seriously. They really do want to be given a professional’s perspective so as to better understand who this person is, and how they work. Reporting Axis I as “Occupational Problem” doesn’t quite do it.³⁷

Mateczun⁴⁴ advised caution when preparing a report from an extended or a one-shot consultation:

You need to exercise some caution before sending out a report from the unit. Usually someone else is there like the skipper, and he wants things to be finished and reports sent out and the case closed. Meanwhile, you have been working for 16–18 hours a day, constantly dealing with people, and you are tired. Your judgment is just not as good, and it is not wise to formulate your report until you leave the consultation site. Reflecting after you have left the place often gives you a great deal of information; you realize how enmeshed certain organizations are, what was going on and how you got involved in it. Consultation is not only a cerebral, objective process. We have to use ourselves as instruments, and measure how and why we respond to things.⁴⁴

RISKS TO THE CONSULTANT AND ETHICAL ISSUES IN CONSULTATION

The Ex Cathedra Statement

Mateczun⁴⁴ cautioned the consultant in believing too much in his own infallibility:

There is a tendency to see yourself as an expert, and as you become known in the larger, overall organi-

zation, you may tend to make pronouncements that are not warranted by the data. You have to constantly remind yourself not to make these ex cathedra statements. It will relieve your anxiety to believe that you possess this power and your consultees will likewise feel less anxious because of your certainty. It is, of course, delusional on your part and

theirs. Humility not only protects you but makes you less threatening to the consultees. Every problem is new and deserves the same approach.⁴⁴

“Lone Ranger” Status and Low Rank

Military positions in which the incumbent has the best opportunity to consult are frequently entry-level positions for military mental health workers. Examples of these positions are the division psychiatrist, psychologist, or social worker in the army and the sole mental health provider at a clinic in the air force. These people are usually junior in grade to the commanders with whom they are asked to consult. Rosato⁴⁶ pointed out some of these demands on new mental health professionals:

We have now about 121 USAF military treatment facilities and many are clinics with no beds at all. Of the ones that have beds, many of them are 25 or 50 bed facilities and smaller. These are smaller facilities than the other two services which have fewer facilities, but much larger facilities. What that can translate into is a lot of isolation among our people. Of those 120 facilities, about 35 have sole providers which means, at that particular installation, the mental health person operates all by him- or herself. They do all the psychiatric evaluations, they take care of the drug and alcohol evaluations, they take care of the child and spouse abuse problems, they take care of the exceptional family member program. They are Mr. or Ms. mental health for that base which means a lot of responsibility falls on their shoulders. It means often times that they may have to call and get consultation on things that are more complicated or beyond their level of expertise. At the same time, it allows them an especially close relationship, because they don't have as many medical colleagues. The tendency at smaller bases is to be more tied into the line community, to be more a part of the military community.⁴⁶

In addressing the issue of how does a young officer consult with a relatively senior commander, Rosato⁴⁶ reported:

Typically, I find new people or younger people a little ambivalent about consultation. They know that it needs to be done, but they are not sure how to do it. In these cases, you are talking about a lieutenant or a captain who might need to go into a squadron with a unit commander who is a lieutenant colonel or colonel. They are really not sure about how to approach that individual, whereas if that same lieutenant colonel or colonel were in their office and having a marital problem, they would have no problem. When you get into questions of

managing people or organizations, then they are a little reluctant due to their inexperience within the organization.⁴⁶

Breaking Boundaries

Mateczun⁴⁴ pointed out unexpected risks to the consultant in doing mental health work outside the patient setting where other than the usual roles apply:

You have to go out and talk to people if you want to understand what's going on. Fortunately, the consultant can break boundaries with impunity. You walk all over a ship, or spend time with a unit that you would otherwise be unable to do. Usually in our day-to-day environment, we are in a very defined role and we interact with people in a very defined way. If you take the consultant's stance, "I'm here to learn what it is you do and how you do it," you go around and talk to anybody. There's an inherent danger in the consultative process. You may become involved, particularly when something bad has happened. You can lose objectivity, and it is very likely that at some point you could become enmeshed in the process and lose track of what you are doing there. It's important to constantly check yourself and debrief with your teammates. This is one of the many reasons to have teammates with you during this process. When you are out in a unit alone, you lose communication with everybody else that provides any kind of reality check.⁴⁴

Double Agency

Adams and Jones³² wrote on the dilemmas of evaluating pilots. Ursano⁴³ amplified their points:

There is a dilemma for the person who serves as a consultant to a flight surgeon who is then a consultant to the commander of a flight line. When you evaluate a pilot for the presence or absence of psychiatric illness, you have the dilemmas of establishing rapport and getting information from the patient who sees you as the representative of the commander. You recommend medically to the commander and the pilot that the pilot should not fly. This is a dilemma because it seems that the recommendation would be different for the two. In fact, the best interest of the pilot and the unit are served when an honest evaluation is rendered. The pilot should not be placed in an airplane when not fit because of the danger to himself as well as the damage to the system. A parallel is security evaluations in which you are assessing the ability of someone to carry a weapon or their propensity for disclo-

sure. The dilemma of the flight surgeon is similar to that, although maybe more so because the flight surgeon may also be the one treating the patient or having to recommend treatment. This is called double agency; one is representing two different organizations, goals, or tasks simultaneously.⁴⁷ One appears to be representing the organization against the individual. When the pilot says, "But you can't ground me. I've got to fly. It's what makes me happy. If I'm not flying, I'll feel even more depressed," it may be helpful to point out that "Flying was never meant to be a therapeutic activity." The consultant doesn't keep them in or out of their jobs. He simply renders a medical opinion. Another thing that is helpful in this setting is recognizing that one is dealing with ability to function and trying to maximize return to performance levels and functioning. You must remember and emphasize that removal from one's job based on psychiatric reasons is not an indictment or a declaration of lack of worth.⁴³

Confidentiality

To some degree, confidentiality does not exist because the mental health professional works for the commander as well as the patient. The extent to which it exists is determined by the consultant who must frame the answer to the question, "What is it the person needs to know?" There is actually very little problem in preserving confidentiality with commanders because they only want to know, "When can I expect him to be back at work, if at all?" and, "Is he going to continue to have problems?" You are dealing with issues of prognosis and performance. While you generally give a psychiatric diagnosis, you do not give the intimate details that are shared with you by the patient. For there to be a breakdown in confidentiality, the commander has to be asking inappropriate questions, and the consultant has to be answering inappropriately by providing information that is not needed.⁴⁸

Another view of confidentiality addresses the needs of the consultant, the consultee, the patient, and the organization. Fragala³⁷ addressed this problem:

Very often military mental health professionals who are at the beginning of their careers think of themselves as working for the patient's interests exclusively. This immediately leads them into difficulty since the service sees them as its agent as well. Splitting one's allegiance does no one a service. The professional must realize that she or he must arrive at a solution which serves both ends; the needs of the individual and the needs of the service. Any

solution which respects the needs of only one agency is always the wrong solution.³⁷

Community vs Patient

When consulting to an organization in your own military community, you have to be particularly sensitive to the danger of losing objectivity. One has to have an understanding of the community from which he operates. One way that this understanding occurs is through maintaining an intellectual distance from it. If the consultant is part of it, he not only has a sense of what the community needs and risks, but also a personal investment in that community. If there is too strong an identification with a community, one can lose track of the patient; if one lacks any identification with his community, he may not appreciate the seriousness with which the community views the issue. In the latter case, the consultant may be seen as a threat to the community and be devalued and dismissed.⁴⁹

Closeness and Intimacy

As part of a military unit, one usually develops bonds or emotional ties to the unit and the people in that unit. On the positive side, because of this position, many informal mechanisms of consultation become available. However, it can be an extremely difficult task to remember which role one is operating in, comrade or consultant. An example is the flight surgeon, who is assigned to a squadron and flies with the people there. He is able to make use of informal consultation, such as suggesting that somebody not fly today rather than formally grounding them. That consultant must remember his responsibility to ground the pilot if the suggestion is not heeded.

When the consultant has developed a close relationship to a unit, as in the case of flight surgeons operating independently, he can be powerfully affected emotionally by losses. In addition to the family and other members of a squadron, the death of a pilot is also keenly felt by the flight surgeon.⁵⁰ This exemplifies the intimacy and closeness in these settings, particularly during combat when unit bonding typically becomes tighter. The consultant can also become a victim of the particular disasters or traumas of the unit to which he is trying to consult.⁴⁹

Short vs Long Consultations and the Development of Relationships

The differences in a short- and long-term consultation may be related to the analogy of short- and

long-term therapy.⁵¹ Both short- and long-term consultative relationships have unique elements to them that are potentially very powerful and emotional, providing opportunities for self-disclosure and self-growth. In the short encounter, one may regret the brevity that precludes an enduring sense of relationship, but it frequently opens up avenues for self-disclosure by virtue of the expectation that the consultee will not have to interact with someone who knows too much about them. At times, there is an advantage to being a one-shot consultant where the subject of the consultation will never see the consultant again. It is a similar issue in assessing certain patients for psychotherapy where one needs to be somewhat confrontive and challenging. The confrontation may disrupt the ability to do ongoing work, but it brings the problem into awareness and makes future work on the problem possible. The recipient of the consultation may not be able to hear you later when you talk in a very different tone about information you want to provide to them. You have established a confrontational style of relating to them. This raises another parameter of being a consultant: that of duration and how that influences all one's behaviors, presentation of data and expectation of outcome provided in consultation.⁴⁹

Shame, Guilt, and Victimization

When the consultant establishes an ongoing liaison with a group, he becomes familiar with all of its intricacies and informal systems used in its day-to-day operation. There is a disadvantage to this development because the consultant, based on what has been learned about the people, may carry senses of shame and guilt that the people in the unit may or may not carry:

To help minimize this it is important to establish early on that you as the consultant are human with all the attendant frailties and shortcomings, but will try not to let these interfere in your work. However, if despite your best efforts they do, the consultees should feel free to let you know in order that you can take the appropriate corrective action. This should serve to let people know that you accept human weaknesses without being judgmental and models the attitude that the consultees should be open and help each other to work more effectively in an emo-

tionally safe environment. Needless to say it is always helpful to remind ourselves that we are not employed to cast judgment but rather to assuage guilt in the interest of more harmonious human relations and more efficient organizational function. When you do become aware of personal issues that need to be addressed to individuals, remember that these issues are usually painful and should be treated with great sensitivity. One good way to highlight shortcomings to someone is to report one's own similar shortcoming in the past and your appreciation of the situation.

In terms of disaster and trauma, when you are dealing with vulnerable individuals, this can affect the consultant's sense of himself or herself. If he or she is not able to provide something, and there is exploitation going on because of the victimization of people, the experience of the consultant is that of being someone who is also victimizing. That can be mitigated by the process of being able to provide something to them and thereby of experiencing oneself as helpful.⁴⁹

Investigation vs Consultation

Consultation involves the collection of information and determining how to use it. While this aspect of consultation is rarely part of an actual investigation, it may appear as such to the consultee. Ursano⁴⁹ described some emotional and behavioral aspects of this sometimes subtle interplay between consulting and investigating:

Another difficult aspect of being a consultant is that of balancing an investigative and a helpful mode because you are always collecting information. Whenever you meet somebody, there is always this sense of intrusion, that you are investigating. So one has to develop ways to deal with the anxiety from people that you are consulting to, particularly when the consultation occurs after a disaster or trauma, where investigations are being conducted to assess blame. The expectation is that you are also investigating something to find guilt, and you have to work to dispel that idea. The consultant usually has pieces of knowledge or information that can be given to provide consultees with something that they feel is helpful relatively early. It provides a certain sense of give and take that this is not going to be a one way street, that there is something coming back.⁴⁹

RESISTANCES TO CONSULTATION AND SYSTEM LIMITATIONS

Changes in the military structure have to some degree conspired against both the mental health

professional and the commander to create conditions where neither talks much to the other. Increas-

ing centralization of support resources makes close associations difficult and thereby decreases the understanding built through frequent contact. The company mess hall became the battalion mess hall; the battalion surgeon and company medics relocated to a troop medical clinic rather than in the unit area; the battalion chaplain splits his time between the unit, the post chapel, and facilities such as a post family life center; and the division psychiatrist, psychologist, and social worker have been pooled at post level. All these assets are seen by the commander as having been taken away from him, leaving his unit to fend for itself while requirements have increased so that officers and noncommissioned officers may tend to see themselves as having little time to concern themselves with day-to-day troop matters.

With increasing automation in the military, the day is either here or very near when reports can be generated quickly on the referral rates by battalion, including comparisons with other units, all of which are unlikely to improve relations between the line and the mental health providers or consultants. Military units, like most organizations, do not like to make their inner workings and problems public. Commanders are acutely aware of negative indicators that may be taken by others as poor leadership on their part. Some indicators that make commanders nervous are poor performance on military tasks, unauthorized absences, courts-martials, venereal disease rates, police blotter reports, and mental health referrals. As a result, the consultant who notices that a unit has a high rate of mental health visits is not likely to be seen, at least initially, as bearing good news or offering a welcome service. Commanders are rated on their performance, and anything that reflects negatively on their unit is generally avoided and potentially reflects adversely on their leadership. As a result, it is important for the consultant not to appear as a critic or investigator, and thus a consultant stance is helpful.

Command consultation is not practiced as frequently as hospital-based mental health practice whether in psychiatry, psychology or social work. The limitation often seems to lie in the worker as well as in external constraints. The officer who wishes to spend time consulting with a unit is rarely forbidden from doing so, but usually he is not encouraged to do so either. The emphasis tends to be on the discouraging side rather than the encouraging.

Rodriguez⁵² identified six resistances to involvement in community consultation programs: (1) ethi-

cal issues such as confidentiality; (2) time constraints; (3) discomfort with systems because of lack of familiarity with community-based programs; (4) fear or stigma by association with community programs, competition with nonmedical personnel, nontraditional identity, and political programs; (5) identification with the medical model of treatment with emphasis on individual treatment, hospital base, and medical therapies; and (6) role-identity conflicts related to public programs.

A very serious drawback to consultation by military mental health professionals is the lack of credit because of their efforts in terms of patient counts. With increasing emphasis on management in military medicine, the number of patients seen per provider is the basis for staffing and budgets. Preventive and consultative efforts produce few patient counts—little that the psychiatrist can take to his commander as evidence of his contribution.

In the air force, mental health professionals have a different distribution than they do in the army and navy. Often, only one psychologist or social worker is assigned to a clinic at a small air force base. Army and navy mental health providers are rarely totally professionally isolated. In these cases, the mental health service functions like a small town private practice. In some of these cases, the mental health professional must also provide specialized services to the community, such as drug and alcohol treatment and family advocacy. These services are required by the air force to be provided at every base and are staffed by or consulted to by psychologists and social workers and psychiatrists. Consultation is much more likely to occur in these locations than in the larger medical centers because there is a need for practitioners to help each other and there is more involvement with the line that does not usually occur at the larger medical centers.

Training programs have emphasized individual treatment and biologic approaches to psychiatric treatment.⁵² A consequence of this emphasis has been less interest in community psychiatry and less attention to the importance of the family in sustaining the soldier than during the time when a preventive and community approach was emphasized. In an effort to indicate the current need for preventive programs, Rodriguez⁵² noted that efforts to reduce family problems as a way to help reduce stress on the soldier are valid uses of a psychiatrist's time. Such family problems are often based on unit policies such as frequent deployments and field duty, irregular hours, and differences in policies toward married and single soldiers. Psychiatric consulta-

tion could benefit preventive as well as ameliorative efforts. Rodriguez⁵² suggested five specific areas in which psychiatric leadership in the community could be affected: (1) weekly consultations at day care centers and schools including sessions with teachers, nurses, administrators, and students; (2) routine informal meetings with hospital physicians and nurses, monthly inservice education programs for staff, and special inservice courses for emergency room personnel on emer-

gency and preventive psychiatric care; (3) alcohol and drug education at all commands; (4) lectures and discussions on television and radio and before community groups on mental health issues, such as alcoholism, isolation, and other military-related family problems, family stress, and child and spouse abuse; and (5) community seminars on subjects such as child-rearing, assertiveness training, women's issues, and relaxation techniques.

RESEARCH IN COMMAND CONSULTATION

Research in this area is hard to do, and most clinicians who perform consultation do not have the training or the time to do it anyway. Nevertheless, the Group for the Advancement of Psychiatry¹⁹ identified some research needs that are still current. They recommended the following six areas as deserving of special consideration:

- (1) That statistical methods of the three branches of the armed services be made uniform; so that *experiences* and *methodology* can be readily compared.
- (2) That records be kept of policies, directives, or preventive and treatment measures that are initiated and might be expected to influence the indices of effectiveness.
- (3) That particular attention be devoted to factors that are emotionally supporting in the face of

unusual stress; e.g., motivation, values, attitudes, needs, and communication, as well as environmental manipulation.

- (4) That the natural history of individuals undergoing basic training, overseas assignment, isolated assignment, and similar peacetime stresses be studied . . . to gain insight into the processes of adjustment and breakdown of individuals exposed to such situations.
- (5) That research teams be formed to function under operational conditions in the field and that, in the event of war, such teams be available to implement previously planned research studies.
- (6) That controlled studies be done using social science skills in the utilization of marginal manpower during peacetime . . . to avoid undue wastage of human resources during national emergencies.^{19(pp296-297)}

SUMMARY

The task of consulting to command is not easy. The needs of the services have remained relatively similar over the years: Soldiers, sailors, marines, and airmen still have adjustment difficulties, and units still have difficult mission challenges, suffer disasters, and have leadership and performance problems. Ways of operating have changed both for military units as well as for the mental health community. For both, control has become more centralized, and more is demanded of officers. For example, automation has made it possible for people to count events in a way that was not possible earlier and has generated many more reporting requirements. Reporting takes time away from other activities. Within psychiatry and the other mental health disciplines, practice has changed. For psy-

chiatry, the focus has gone toward biological and individual treatment rather than toward communities and group treatment. Of the other mental health professionals, social workers are the most likely to be interested in group and community processes.

Consultation started as a mass movement, at least in the U.S. Army. It has now become more of a specialty than it used to be, both in terms of the skills required and the number of people who attempt it. Today, the consultant must have a broad range of skills. He must know not only his own organization but also many others including other services. Such skill development takes time and, more important, the presence of a mentor who can teach younger people "the ropes" of consulting. Our impression is that most people who perform

consultation successfully enjoy it and have a sense of having contributed something as well as having obtained something special that is not ordinarily encountered in clinical or administrative life.

Ultimately, consultation tasks are meant to improve the capability of the military unit to carry out its mission. This difference between civilian and military psychiatry has been noted in this chapter,

but it may be of value to point out that the task of the consultant is not to please everyone.

The tasks for the mental health officer and consultant will not stay the same in future environments. Rather than applying principles without thought, the critical contingencies of conflicts must be observed and analyzed to apply mental health skills to their solution.

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