CAREER FOCUS

A Career in Military Psychiatry?

I Palmer

Why Military Psychiatry?

Why would anyone in their right mind not want to become a military psychiatrist? Most individuals have a view about psychiatry and psychiatrists, some of which are printable; but don't forget military psychiatry is not like the psychiatry you've had exposure to during your training in the NHS. Military psychiatry is a core DMS speciality, central to the smooth functioning of the military machine and equally as important in combat as immediate resuscitation. It is a uniquely challenging job working in an unusual culture and offers a chance to develop skills and knowledge beyond your NHS counterparts.

It is a little-known fact amongst general practitioners, physicians, surgeons and other specialists that up to 50% of their work is either directly psychological or has a psychological dimension revealing itself in poor compliance, treatment failure, "heart sink patients", recurrent attendees and a host of other problems. Indeed, it is probably fair to say that the average GP, dermatologist, neurologist or gastroenterologist (to name but a few) see more new psychiatric cases a year than a consultant psychiatrist!

Currently, military psychiatry is at the forefront of psychiatric thought and research into the psychological sequelae of injuries, both physical and psychological; of medically unexplained symptoms following combat; of brief psychotherapeutic interventions; of the social construct of mental illness; stigmatisation and the occupational and public health aspects of mental health in the workplace.

Military psychiatry can offer a truly intellectual, military, clinical, administrative and organisational challenge, a unique experience that offers clinical and military satisfaction whilst retaining exceptional quality of life.

What is Military Psychiatry?

It is not NHS psychiatry!! Military psychiatry is an occupational service and like forensic psychiatrists and prison doctors, the military psychiatrist has responsibilities to both the individual and the organization. Military culture stands apart from mainstream civilian culture and offers a unique social system in which to practise psychiatry.

There is no civilian equivalent to military psychiatry; the closest would be liaison psychiatry. The speciality involves an interesting mix of adolescent; forensic; psychotherapy (individual and group); rehabilitation psychiatry (physical and psychological injury); Public Health; Occupational medicine and trans-cultural work. Serious Mental Illness, other than index psychotic episodes, is rare. Personality difficulties, post combat (traumatic) mental health issues; somatisation; abnormal illness behaviours and sequelae of childhood abuse; reactions to extreme stress; hostage taking scenarios; teaching para- and non-medical personnel; providing psychological advice, provision of threat assessments for commanding officers; working with welfare and religious organisations; undertaking psychological autopsy; aviation and underwater psychiatry are all part of a uniformed psychiatrist's remit.

Origins of Military Psychiatry

Military psychiatry can look to 1904/5 as its birth date. It was the Russians who first enunciated the basic principle of military psychiatry which relates to the social context of an individual's distress. They found that when soldiers were removed from their social role and evacuated from combat their psychological symptoms became fixed and they suffered long-term mental illness, the so-called Evacuation Syndrome. They also found that the symptoms of many of those soldiers who were kept close to the front, with their colleagues and units improved, indeed some could even return to duty.

WWI revealed that every man has his breaking point. WWII showed the importance of the group dynamic before, during and after combat in protecting and supporting combatants. The Vietnam War reminded us of the long-term psychological sequelae of combat. The Yom Kippur served as a reminder that acute psychological breakdown could occur rapidly. The Gulf War reminded us of Post-conflict War Syndromes seen first in Scottish and Swiss mercenaries in the eighteenth century.

Psychiatric casualties are now as much a part of military medical planning as gunshot wounds and infectious diseases. Their

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initial management is primarily the responsibility of command and only subsequently the responsibility of medical officers and psychiatrists, a task with its unique moral and ethical dilemmas.

Current Service Organisation

Defence psychiatry is coordinated through the Defence Director of Psychiatry, a senior consultant psychiatrist with a role similar to a NHS Trust Chief Executive, and is part of the Defence Secondary Care Agency which acts like a NHS Health Authority.

DMS psychiatry is tri-service. It serves 210,000 service personnel (and when abroad their dependants). The service is community-based in Departments of Community Psychiatry (DCP) with an inpatient assessment and treatment facility in North Yorkshire at the Duchess of Kent's Psychiatric Hospital (DKPH) and Wegberg in the FDR.

Community Service

There are 16 community psychiatric departments spread over the United Kingdom, Germany, Gibraltar and Cyprus which manage 4,000 new referrals and 20,000 outpatients per year. Each DCP serves a catchment population of 15,000 servicemen. Manning consists of consultant psychiatrists, community psychiatric nurses, psychologists and social workers. The DCPs act as gatekeepers for the psychiatric inpatient service and are the initial referral point for over 200 service medical centres.

In-Patient Services

DKPH has 20 beds and a day hospital. There are General Adult, Substance Misuse, Psychological Injuries, Medical Discharge, Rehabilitation and Military Re-Training Teams. Social work, psychology and occupational therapy departments are staffed entirely by civilians. As DKPH is not a hospital, within the meaning of the MHA 1983, 'sectioned' patients are detained in local NHS facilities.

The Military Re-Training Team is a form of social therapy with its genesis in WWI and aims to reintegrate service personnel into military life by using elements of group and physical activities undertaken in a military environment and atmosphere. The Psychological Injuries Team provide a comprehensive 3-day assessment and treatment package and, where co-morbidity exists, there is close liaison with substance misuse services. The Service's Substance Misuse Team is based in DKPH and has a small number of beds.

Where it is decided that an individual's prognosis is not compatible with continued military service, a comprehensive package of care is organised, aiming at reintegration into civilian life and social work follow-up is

organised for the 12 months following discharge. The inpatient unit receives approximately 450 referrals per year and also acts as a triage and receiving centre for all psychiatric aeromedical evacuations, worldwide. The staff working within DMS psychiatry are a mixture of tri-service uniformed personnel and a large contingent of civilians.

Spectrum of Clinical Disorders

Contrary to many of the misconceptions about service personnel, psychopathy is not a common problem. A significant proportion of the workload is a result of life events acting on predisposed individuals leading to adjustment disorders. Although in the NHS these individuals are mostly contained within primary care, the operational and occupational requirements often dictate that unwell individuals have to be repatriated from theatres of operations. Substance misuse problems also present much earlier than would be found in the NHS. This gives exciting possibilities for early interventions, including group and individual treatments (motivational, CBT and solution focused approaches).

Cases of significant severe affective and psychotic disorders are uncommon and can present quite a diagnostic challenge, they count for about 8% of presentations. The military's close knit structure means that such disorders are not only recognised much earlier than they would be in the NHS, but also offer opportunities for early therapeutic intervention.

Training

General Duties

Prior to undertaking training in psychiatry all military psychiatrists, even those with previous (NHS) psychiatric experience, spend time on general medical duties in order to develop an understanding of the environments in which their patients live and work. During this time they should undertake training in battlefield advance trauma life-support (BATLS) and advanced life-support (ALS) techniques; tropical medicine, rehabilitation services, sports medicine, aspects of chemical and biological warfare etc. This training and work gives early managerial experience and man management responsibility to junior doctors and most individuals look upon this period fondly, in retrospect, if not always at the time!

Professional Training

All psychiatric training is currently based in North Yorkshire and integrated into the Leeds scheme. There is ample support for courses and membership training and the option of time away from the scheme. As

trainees receive a military salary many NHS Trusts are happy to offer placements, as they are effectively 'free'.

Specialist Registrars may undertake their training in centres of excellence of their choice, most however take advantage of the excellent North Yorkshire rotation. Liaison psychiatry is the preferred speciality as training mirrors service psychiatry more closely than any other NHS sub-speciality. It also provides great flexibility in training to reflect individual interests. National Training Numbers are allocated to SpRs by the Defence Postgraduate Medical Dean who is responsible for overseeing their training.

As a consultant there is scope to work in both community and inpatient settings. Active continuing professional development is encouraged and well funded in terms of time and finances. With the opening of the Centre for Defence Medicine in Birmingham there will be increased opportunities for academic work with an emphasis on occupational, health education, epidemiological, socio-cultural and organisational aspects of military psychiatry.

Joining up

It is never too late, nor too early, to express an interest in training in military psychiatry. It is, in fact, a positive advantage to have wide clinical and military experience, as you are of no value to the services if you do not have an intimate working knowledge of the conditions under which your patients live and work. True military psychiatry should be undertaken on the 'shop floor' rather than the clinic as its aim is to empower medical, nursing, regimental, staff officers and other commanders to fulfil their role and responsibilities in managing the health of their units. This has always provided a real challenge to psychiatrists over the years and requires the development of political and diplomatic skills seldom learnt in the NHS early in a career.

Use your time enjoyably in the service. It is vital that you develop common sense and understand and become fully conversant with your service. Undertake as much active service as you can, mix and work with all ranks and observe how individuals function within the service structure. Attempt to understand the motivation, mores and culture that allows the services to undertake their roles. Learn of the sacrifices, standards and resilience to stresses and strains, both physical and mental, required of service personnel. Time spent on military training and operations is **never** wasted. There is no need to rush into early exam mode as it serves little purpose, military psychiatry is greatly different from its NHS cousin. Having said this, further training in any speciality is useful, especially

General Practice and the Royal College of Psychiatry will accept certain training (e.g. a year in a GP vocational training post) as counting towards your eligibility to sit the MRCPsych examination.

Contact

Initial

If you are interested go and see the military psychiatrist in your area, speak to them about the speciality to get a feel for it, you might also talk to one of the community psychiatric nurses with whom you come in contact. Alternatively you can contact the Director of Defence Psychiatric Services, Group Captain Frank McManus RAF, DKPH, Horne Road, Catterick Garrison, North Yorks, DL9 4DF or The Tri-Service Professor of Defence Psychiatry, Lieutenant Colonel Ian Palmer RAMC, RDMC, Fort Blockhouse, Gosport, PO12 2AB.

Formal

Through your chain of command to the Consultant Adviser in Psychiatry in your Service:

- RN: Surgeon Captain C Churcher-Brown RN, RH Haslar.
- Army: Lieutenant Colonel D Gamble RAMC, HQ NI.
- RAF: Group Captain G Reid RAF, RAF Brize Norton.

Copy your letter to the Director of Defence Psychiatry and inform the Postgraduate Medical Dean at RDMC or CDM of your career intentions. If you are looking to change speciality contact the Dean's office for the necessary paperwork

Research & Audit

Whilst much of the research is based clinically there are opportunities to become involved and sponsor research in areas of recruit selection, post-deployment surveillance, health education, occupational medicine, social and epidemiological surveys. Whilst there is close clinical liaison with General Practice, military psychiatry also has a particular input into Public Health and Occupational Medicine within the Forces.

Current clinical research relates mainly to psychological injury, risk assessment, computer administered Cognitive Therapy for affective & anxiety disorder, substance misuse epidemiology, post-conflict War syndromes and medically unexplained symptoms following combat. There are plans for the development of a clinical research department within DKPH.

Regular inpatient and community clinical audit is held to monitor quality and effectiveness in both the settings.

Challenges of Military Psychiatry

Military psychiatrists have 3 roles: psychiatrist, doctor and officer. It has been said that in time of crisis and conflict the Organization rather than the individual is the patient. It, therefore, beholds military psychiatrists to undertake military training in order to understand the role of the military in modern society; the structure and functioning of the organization and, to be effective, identification with the military culture and those individuals who volunteer to serve their country. Combat psychiatry is unique, there is no civilian equivalent. At times of crisis military psychiatrists may find themselves helping-out and practising general medicine (indeed many will have training in General Practice – one even delivered babies in Rwanda). They are uniquely placed to influence occupational and social factors as they relate to unit and individual mental health and, therefore, require to develop inter-personal and teaching skills that allow them to influence commanders, individuals and groups. Military psychiatrists may be tested physically, intellectually, emotionally, ethically and morally, some will witness history in the making.

Current serving psychiatrists have had key roles to play in the Gulf War, Former Republic of Yugoslavia, Rwanda and hostage taking situations. Some have served with the Royal Marine Commandos; the Special Air Service; Parachute Field Ambulance; Highland Regiments, others on or as part of the RAF's aeromedical evacuation team. There is an annual military psychiatric conference open to all NATO, Partnership for Peace and Commonwealth countries.

Conclusion

Military psychiatry is unique and at the forefront of current interesting psychological, social and cultural issues. It is not a special interest group; it is part of a National psychiatric resource that offers a markedly different cultural and clinical experience. Clinical care is but one facet of the job, in which there is an unparalleled opportunity to recognise, intervene and manage mental ill health at an earlier stage than would normally be possible, thereby (hopefully) having a positive impact on prognosis and future occupational abilities. Few NHS psychiatrists will encounter such a diversity of challenges or experiences. Join now...

Recommended Reading

Binnevel, H. (1997). *From Shellshock to Combat Stress. A Comparative History of Military Psychiatry.* Amsterdam, Amsterdam University Press

Hynes, S. (1998) *The Soldier's Tale. Bearing Witness to Modern War.* London, Pimlico

Shephard, B. (2000) *A War of Nerves.* London, Jonathan Cape.

Recommended Films

All Quiet on the Western Front

From Here To Eternity

The Cruel Sea

Full Metal Jacket

Platoon

Das Boot

Saving Private Ryan

The Thin Red Line

Pretty Village, Pretty Flame

Pearl Harbor