INTERVIEW

Military Psychiatry: Perspectives From Two Army Medical Officers

Sean Wilkes, M.D., M.Sc., and Aaron Wolfgang, M.D.

The dialogue in this interview is an abridged version of the original podcast transcript titled "Military Psychiatry: Perspectives From Two Army Medical Officers." Drs. Wilkes and Wolfgang are guest editors of the section on military psychiatry in this issue of the Residents' Journal. *Dr. Wilkes is a first-year child and adolescent psychiatry fellow, and Dr. Wolfgang is a fourth-year resident—both at Tripler Army Medical Center, Honolulu. Dr. Wolfgang is a captain, and Dr. Wilkes is a major in the U.S. Army. Drs. Wilkes and Wolfgang are collaborating with the* Journal's *editorial board to make the podcast available to* Residents' Journal *readers. The purpose of the podcast was to discuss what psychiatry is like in the Army and to familiarize people with some of the unique aspects of the role of military psychiatrists and some of the fascinating issues that these psychiatrists face. The aim was to highlight that U.S. Army psychiatrists are similar to civilian psychiatrists, with the exception of some additional aspects of their jobs. The views expressed in this interview are those of the authors and do not necessarily reflect the official policy or position of the U.S. Department of the Army, Department of Defense, or U.S. government.*

Dr. Wolfgang: Sean, what led you to want to be a military physician and ultimately a military psychiatrist?

Dr. Wilkes: You know, I get that question a lot, because my path to becoming a psychiatrist was a bit circuitous. I started out in the Army as a science and engineering officer with the Army's Public Health Command before medical school. I got to do a lot of really cool things, and I got to travel all over the world, and even to engage in some clinical field research. And while working in the field, I found that what I enjoyed most was working with patients, learning about them, hearing their stories, and solving problems with them. That's what ultimately led me to attend medical school. And psychiatry was the absolutely perfect blend of that personal side of medicine with my longstanding interest in neuroscience.

Dr. Wolfgang: And what are your future plans as an Army psychiatrist?

Dr. Wilkes: I love teaching and research, so I'd like to continue working in academic psychiatry, and the military is a great place to do that. There are several residency programs across the country, not to mention the Uniformed Services University, the military's own medical school right across the street from the NIH [National Institutes of Health], so there are a lot of great options for researchers and educators alike.

How about you? What led you to want to be a military physician and psychiatrist?

Dr. Wolfgang: So, I actually grew up around the military my entire life. My dad was an Army intelligence officer who served in the first Gulf War. And even after he got out, he still worked in government, which meant that I grew up on an Army base in Seoul, South Korea, until I graduated from high school. Growing up around the military really emphasized the importance of service as a core value, and because of that, service has been a common thread throughout my life in a lot of different ways. When I had the opportunity to go to the Uniformed Services University for medical school, the choice was pretty clear to continue that thread.

Dr. Wilkes: And what are your future plans as an Army psychiatrist?

Dr. Wolfgang: I'll be starting an addictions fellowship at Yale this summer, and after that I hope to serve as a faculty member in one of the military residency programs, where I can teach students and work on some innovations for how we treat PTSD and addiction.

Dr. Wilkes: What is day-to-day life like for a psychiatrist in the Army?

Dr. Wolfgang: We treat active duty service members from across the military as well as their families and retirees. So, we see the entire spectrum of patients, from those with depression, anxiety, trauma, addiction, eating disorders, schizophrenia, bipolar disorder, children, the elderly, you name it.

Dr. Wilkes: And you might be doing this work in an outpatient clinic at Fort Bragg, North Carolina, working with paratroopers and Special Forces? Or you could be assigned to a large academic medical center like this one?

Dr. Wolfgang: From an academic perspective, the Army has some great opportunities for faculty appointments at the Uniformed Services University or at one of the Army residency programs in Maryland or Hawaii. As a resident, there's an incredible amount of camaraderie not only between residents but also with faculty. There is this added element that, even after residency, we'll be constantly crossing paths and serving the same mission for the rest of our military careers. And I think that really brings us closer together and adds a layer of collegiality and interdependence.

Our faculty also brings a range of experiences to the table, including combat experience. In addition to preparing us clinically, there's additional emphasis on

the nuances of military medicine both on and off the battlefield. For example, when we see soldiers in the clinic or on the ward, we'll often also interact with their commanders to advise them on how they can best support the soldier. Sometimes this means implementing a military medical order to mandate additional support for the soldier, such as ensuring the soldier has 8 hours of protected time to sleep. Sometimes we'll recommend certain changes in the occupational environment, such as ensuring the soldier doesn't have access to weapons. And on rare occasions, we'll recommend separation from the military. But that point typically isn't reached unless the soldier has undergone extensive treatment and still carries a poor prognosis.

So, I touched on several different aspects of what it's like to be an Army psychiatrist in a nondeployed setting. But that's only one side of the coin. Would you mind telling us more about the Army psychiatrist in the deployed setting?

Dr. Wilkes: One of the unique aspects of military psychiatry is our role not only as clinicians, caring for individual patients, but also as advisors to military leaders and managers of behavioral health across the battlefield. Operational psychiatrists work to ensure the provision of care with maximal proximity, immediacy, expectancy, and simplicity. That is, treat close to the front lines quickly and simply, with an expectation of return to duty

Dr. Wolfgang: You mentioned the idea of "operational psychiatry." What is operational psychiatry exactly?

Dr. Wilkes: Broadly speaking, it refers to the provision of psychiatry within the context of a military operation. Perhaps the quintessential example of this role for an Army psychiatrist is the division psychiatrist. In the Army, a division is a largely self-sufficient organization of between 10,000 and 20,000 soldiers made up of still smaller organizations known as brigade combat teams. Each of these is assigned its own individual behavioral health officer, typically a psychologist or licensed clinical social worker. The division psychiatrist serves to oversee behavioral health within the entire division and is the division's subject matter expert on the behavioral health effects of combat.

During deployment, it is the responsibility of the division psychiatrist to review the situation on the ground, to assess the behavioral health threats of the combat environment, and to work closely with the rest of the division's medical team to determine how behavioral health assets are being deployed and utilized within the operational environment. Working with the division surgeon, the division psychiatrist makes recommendations to the division's commanding general on where to position and how to implement the behavioral health resources within the unit.

Dr. Wolfgang: So, you've painted a really great picture of how Army psychiatrists provide leadership in the deployed environment. Do you mind speaking more about what it's like to actually deliver direct clinical care in a deployed environment?

Dr. Wilkes: Any deployed psychiatrist is likely going to be involved in seeing patients too, but another role that Army psychiatrists might serve in within the deployed setting is as a member of Combat and Operational Stress Control teams. These flexible, mobile teams of psychiatrists, psychologists, social workers, and behavioral health technicians are designed to be positioned close to the front lines to provide prevention and treatment as close to a soldier's unit as possible. They're designed to take the treatment to the soldier in need rather than necessitating his or her transportation far from the line of battle. A lot of their work is in the realm of prevention to provide soldiers with support as they experience the stressors of combat, but they also provide treatment of psychiatric casualties by offering resources and opportunities for recovery at specified locations in the deployed environment, rather than necessitating evacuation. And they are also able to provide commanders with boots-on-the-ground assessments of the state of mental health of the force.

Dr. Wolfgang: You just described Army psychiatrists interacting with commanders to discuss the mental health of their soldiers. Would you mind speaking more about the ethics surrounding this?

Dr. Wilkes: Military psychiatrists have to follow the same ethical principles as any other physician, and that includes respecting patients' privacy and autonomy. But there are some unique needs of the military and risks of the combat environment that require some information to be shared with commanders in order to ensure that the military mission can be carried out. There are two ways we approach this. The first is to provide information to commanders in aggregate—a lot of the decision making at the command level is more dependent on looking at trends rather than at the details of any given specific patient. Second, when it is necessary to discuss an individual patient with a commander, it is the psychiatrist's ethical duty to ensure that only the absolute minimum information necessary is provided—and only to the specific leaders who need to know. We take this role protecting patient privacy and autonomy very seriously. For example, if one needs to tell a commander that a given patient cannot be deployed, one might share the general diagnosis or the class of medications that makes the patient nondeployable, but one wouldn't share any details discussed in therapy or the patient's full psychiatric history. It is a careful and precise balancing act between individual patient needs and the needs of the Army, and it is just one reason we place such a significant emphasis on medical ethics in our residency programs.

Dr. Wolfgang: Wow, that is so interesting, and in fact that is just one of the many topics that is going to be covered in the *AJP Residents' Journal* special issue on military psychiatry, right?

Dr. Wilkes: Yeah, I'm excited about what we've got in store for readers, because there are going to be some really interesting pieces on the subject of military psychiatry that I think our readers will enjoy, so stay tuned for that!