Mental Health Care During Military Deployment

9

Christopher H. Warner and Teresa D. Murray

Vignette

Sergeant S is a 24 year old U.S Army Non-Commissioned Officer in an airborne infantry brigade who is on month seven of his second combat deployment. He spends on average 50–60 h per week "outside the wire" leading his squad of eight to ten soldiers in stability and security operations interacting with the local leaders and populace in ongoing efforts to restore essential services (water, power, etc.) for the village. His squad has encountered numerous improvised explosive devices during their operations and on multiple occasions have engaged in direct engagements with insurgent forces who sought to ambush them. One week ago, one of Sergeant S' soldiers was killed by an improvised explosive device and two others wounded while they were coming back from one of their missions. Since that time, Sergeant S has noted increased anger, irritability, difficulty sleeping, and has frequently been playing back the events of that mission in his head questioning if he made all of the correct choices.

Introduction

The presence of mental health providers on the battlefield directly coincides with the emergence of modern psychiatry. Prior review of medical casualty data from the United States Civil War identified that it was very rare for a service member to be given a mental health diagnosis (3 per every 1000 Union Soldiers) even though battlefield physicians were describing conditions such as nostalgia and Soldier's

C. H. Warner (✉)
Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, MD, USA

T. D. Murray
Army College of Social Work, University of Kentucky, San Antonio, TX, USA

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Heart [1]. However, by the turn of the century, multiple nations were becoming increasingly aware of the impact of combat and operational stress. This led to the development of the first formal battlefield mental health treatments initially by the Russian military medical team and subsequently by the Russian Red Cross during the Russo-Japanese War. These lessons learned, coupled with the emergence of a new condition known as "shell shock" early in World War I, led to all major military participants initiating trial and error battlefield mental health treatment [2, 3].

As the United States Army prepared to potentially enter World War I, the Army Medical Department enhanced their mental health capabilities within the United States and Dr. Thomas Salmon established the first deployable mental health capabilities for the United States military. Under Salmon's leadership, the first successful battlefield mental health system was implemented incorporating treatment, prevention, and consultation. Many of the principles that guide the current approach to combat and operational stress casualties were outlined by this team [4].

In the aftermath of World War I, much of the military mental health effort focused on mechanisms for screening out mental health disorders with an expectation that if screening was successful, the battlefield capabilities would not be necessary. However, by the North African campaign of 1943, it was evident that battlefield mental health capabilities would be a necessity and have been deploying with United States military personnel since that time [2, 3]. While the conditions treated and mechanisms for delivery have changed over the years with the United States Army developing Combat and Operational Stress Control teams during the Korea and Vietnam wars to provide more area support versus unit specific support and the United States Marine Corps implementing their Operational Stress Control and Readiness program, the need to provide battlefield mental health has remained [5].

Changing Nature of Demands

While the mental health impacts of war have long been recognized and are documented both in historical accounts and classical literature, the medical community did not begin to recognize the effects sustained from combat until the mid-eighteen century. Auenbrugger coined the diagnosis of nostalgia in 1761 to describe the condition of French soldiers losing hope and becoming sad, isolative, inattentive, and apathetic in the aftermath of combat [6]. Subsequently, during the United States Civil War a new condition identified as DaCosta's Syndrome or sometimes referred to as Soldier's Heart was identified for an anxiety condition characterized by fatigue upon exertion, shortness of breath, palpitations, sweating, and chest pain with a normal physical exam [7]. As warfare evolved into the twentieth century and the destructive capabilities of military forces fueled by the industrial revolution expanded, physicians began identifying service members presenting with symptoms ranging from panic attacks to near catatonia after periods of intense combat, especially those involving field artillery shelling. This new condition was termed, shell shock [8]. The discovery of these conditions led not only to the employment of mental health professionals on the battlefield but also to changes in the treatments

provided. Prior to World War I, those identified with a mental health condition were evacuated off the battlefield and many times out of the theater of war [9]. However, the presence of mental health professionals established the implementation of forward treatment principles and battlefield mental health professionals identified that the optimal window for treatment was within a few hours after combat exposure. Over the course of the subsequent decades, these conditions were later referred to as war neuroses and then as combat operational stress. The specific treatment principles for combat operational stress are outlined in greater detail in this book in the chapter on combat operational stress.

As the presence of mental health professionals on the battlefield continued to evolve, so did an understanding of the factors impacting combat and operational stress. Analysis of World War II data showed that while combat exposure was a significant driver of combat operational stress citing a strong correlation between combat stress casualties and the intensity of combat and total number of wounded personnel; it did also identify other key factors including deployment length, unit cohesion and morale, and unit leadership effectiveness [10]. This led to an expansion of the roles and responsibilities of the deployed mental health capabilities. During the Korean and Vietnam Wars, the United States military began deploying area support mental health capabilities that began employing not only treatment capabilities but for the first time, preventive focused capabilities focused on assessment and consultative services to enhance resiliency [2].

The most recent prolonged United States conflicts in Iraq and Afghanistan have identified new mental health challenges. These wars presented the first major test for the all-volunteer military force which dictated new military employment and deployment strategies and has led to a large number of military personnel being deployed multiple times into the combat theater. Additionally, the advances in our mental health treatment capabilities including safety profiles and transportability of medications and the interconnectedness of our world has had a significant impact both in care delivery and the stressors that our deployed service members face.

During the Persian Gulf War in 1990–1991, service members who were suffering from depression and/or anxiety were still dominantly being treated with tri-cyclic antidepressants and would not be capable of deploying. Those who did deploy, would wait for weeks to months before receiving letters from their loved ones and may have an occasional opportunity to make a brief phone call home. Over the next 10 years, the introduction of the internet, the propagation of cellular phone technology, and medical advances including the expansion and increased understanding of Selective Serotonin Reuptake Inhibitors brought dramatic change. A 2005 utilization review of one Division Mental Health unit deployed to Iraq found that nearly 6% of deployed personnel sought care for mental health conditions that existed prior to the deployment including Major Depressive Disorder and Generalized Anxiety Disorder. That same review identified that the most prominent causative factors for combat operational stress reactions was not combat exposure, but rather home front stressors such as failing relationships and financial problems [11]. These changes drove significant changes to battlefield mental health delivery.

Evolving Role of Treatments

Prior to World War I, the majority of mental health casualties were evacuated from the battlefield and most often out of the theater of war. World War I brought the introduction of the forward psychiatry principles that provided not only treatment near the front lines but also established an expectancy that service members would be returning to the fight. These principles, outlined in greater detail in the chapter on Combat and Operational Stress, served as the cornerstone of battlefield mental health intervention for nearly the next century. It is important to note, that in persistent, high intensity combat, these principles would remain the bedrock of care, and likely only measure that could be delivered without evacuation. However, as theaters of war mature, battle lines become more established, and/or phases of war transition into stability operations, modern psychiatry has additional resources which can serve as additional interventions.

Psychotherapy in Theater

Due to the mission-oriented nature of the combat environment, therapy while deployed centers on meeting immediate psychological and emotional needs in order to enhance combat readiness for both the individual service member and the unit. These encounters must be time-limited, brief interventions as the high operational tempo and geographic placement of units and their behavioral health providers may not allow for regularly scheduled sessions [12, 13]. Therapy sessions in theater often look quite different compared to those in garrison as they may take place at unconventional times to accommodate for unit mission schedules and in unusual locations, such as in shipping containers that have been converted into work spaces or supply closets in the unit aid station.

Thanks to advances in battlefield communications, therapy sessions, risk assessments, and intake assessments may also take place over virtual means using telebehavioral health capabilities through either computer-based video chatting or over the telephone in the event of technological difficulties. This capability can be especially helpful when conditions limit travel to or from the location of the patient or the behavioral health provider, or for those far forward outposts that may not receive routine visits by a behavioral health provider [14]. Because of the possibility for high-risk situations where a patient's safety may be in question, it is critical that these sessions are held in close coordination with the medical personnel on the ground with the patient as these individuals will be crucial in responding to any potential safety concerns that may be disclosed during the therapy session [15]. Command consultation may also be critical in these situations to ensure appropriate measures are taken to ensure patient safety. Privacy is another important consideration when using tele-behavioral health to conduct therapy sessions. A private space must be established for tele-behavioral health services so that service members will feel comfortable participating in the session and so that the conversation will not be overheard by others.

As previously mentioned, therapy in the deployed environment must provide some immediate relief or reduction in distress that will allow service members to remain ready for upcoming missions. The focus of therapy sessions in theater may often include education on coping skills, relaxation techniques, and other measures to help reduce physiological and psychological arousal that is common among service members while deployed [16]. Service members in the combat environment are frequently exposed to dangerous situations and may find themselves in a sustained high level of vigilance that can make it difficult to relax or rest between missions. As a result, therapy sessions that include education on relaxation techniques, such as diaphragmatic breathing, progressive muscle relaxation, and guided imagery can help service members decompress between missions when they have the opportunity [17]. This education also helps to teach service members about the link between their physiological and their psychological states and can help them to become more effective in future anxiety-provoking situations.

Additional psychoeducation and coaching focused on the importance of healthy eating, physical activity, and sleep routines can give service members a way to combat anxiety and control factors that they can control within the constraints of the combat environment [16]. Of course, even these areas can be difficult to control while deployed due to unpredictable work-rest cycles, lack of access to regular healthy meals on remote bases, shared living quarters, austere conditions that are not conducive to restful sleep, and the prevalence of caffeine and nicotine use among many service members.

In addition to education on relaxation techniques, therapy provided downrange often focuses on adjustment disorders, relationship difficulties, anxiety, depression, post-traumatic stress, combat operational stress, grief, occupational problems, and insomnia [18]. Although most of these are topics that frequently emerge in the garrison environment, treatment interventions for these conditions in the deployed setting must be approached in unique ways. Therapy must always be focused on individual readiness as it relates to mission success, and must be scheduled around the service member's mission requirements. Behavioral health providers should use time-limited, brief therapies that can produce tangible benefits in a short period of time, such as solution-focused brief therapy, cognitive behavioral therapy, and psychoeducation, among others [19]. These modalities may be especially helpful as they can provide instant reframing and challenging of cognitive distortions, a focus on strengths and resilience, and practical skills that can be implemented outside the session. Additionally, these brief interventions are important because the unpredictable nature of the combat mission may make it difficult to schedule future sessions. Mission requirements, hectic schedules, and a lack of privacy may make homework or out of session work impractical or impossible, so practical exercises and assignments may have to be completed in the therapy session with the provider. However, for those service members whose jobs primarily keep them inside the wire of the base and who are co-located with their behavioral health provider, regularly occurring therapy sessions with homework outside the session may be feasible.

Treatment using manualized approaches, such as prolonged exposure therapy and cognitive processing therapy for post-traumatic stress disorder, can be

challenging in the context of the combat deployment [20]. As previously stated, it can be difficult, if not impossible, to schedule regularly occurring therapy sessions due to the operational tempo and time constraints; however, providers have had success with truncated or shortened versions of these modalities [21]. The homework assignments that often accompany these modalities may not be feasible due to environmental and time constraints. It may also be unrealistic to challenge irrational beliefs associated with previous traumatic events when the service member is still being exposed to new potentially traumatizing events. The vigilance and arousal a service member exhibits while on a mission serve a very real and important purpose as they are realistically facing dangerous threats on a regular basis [22]. Therefore, the behavioral health provider should practice caution when deeming certain thoughts to be maladaptive or irrational as healthy behaviors and thoughts held on deployment may differ significantly from those considered to be healthy in garrison.

Advances in technology, including wireless internet, cell phones, laptops, and gaming consoles, allow service members in a combat zone to remain connected to their family members despite being thousands of miles away. Although this connectedness can certainly facilitate communication and strengthen relationships, it can also lead to service members with one foot in the combat zone and one foot back at home, potentially distracted while on mission by a stressful situation that is happening on the home front.

Medication Management

Before the United States Global War on Terror operations in Iraq and Afghanistan, the use of psychotropic medication was limited to emergent use and was frequently accompanied with evacuation from theater [23]. Due to the improved safety of psychotropic medications, Iraq and Afghanistan brought about a change in attitude towards the deployment of service members on psychotropic medications and the prescribing of those medications in a deployed environment. The new guidance recommended using medications when appropriate, emphasizing the importance of considering side effects, limited availability of laboratory monitoring, and continued application of the forward psychiatry principles [5].

While the United States military provides policy guidance on medication management of mental health conditions in the deployed environment, it is ultimately the psychiatrist who will have to make decisions regarding the extent of services they can safely and effectively provide based on patient and unit safety, the deployed environment and military situation, and supply and monitoring capabilities.

When considering prescribing psychotropic medications in a deployed environment, psychiatrists must consider several factors including the ability to provide follow up care and availability of medication re-supply. In general, providers will prescribe Selective Serotonin Reuptake Inhibitors and/or Selective Serotonin/

Norepinephrine Reuptake Inhibitors as well as some Atypical Antidepressants for treatment of depression, anxiety, and trauma related conditions. The use of atypical antipsychotics, benzodiazepines, and stimulant medications is less common and requires a case by case evaluation. The treatment of conditions such as acute psychosis and/or mania would receive immediate treatment with appropriate medication interventions but will generally be followed by a rapid evacuation from theater and should not managed for prolonged periods of time or in a maintenance period in a deployed environment [5].

For those who are preparing to deploy and are already prescribed a psychotropic medication, their unit medical screening process will review their requirements and apply the current Department of Defense minimum mental health standards for deployment [24]. These requirements emphasize a need for medication stabilization prior to deployment consideration of storage and monitoring requirements, as well as, resupply capabilities. For example, a service member prescribed a Selective Serotonin Reuptake Inhibitor within 1 month of deployment may be delayed in their deployment until their condition stabilizes and they are not exhibiting significant side effects, but will be able to subsequently deploy. In contrast, a service member on lithium even at a maintenance dose is unlikely to be cleared for deployment because of the inability to continue laboratory monitoring and the environmental risks to the service member while taking the medication. Of note, one study showed that establishing a continuity of care plan for deploying service members reduced the risk of worsening symptoms, mental health evacuations, and serious events for the duration of the deployment [25].

Restoration and Disposition from Theater

Patient disposition options in a deployed environment are limited with the majority of resources available being outpatient settings. Theater level hospitals may have a small inpatient psychiatric holding capacity specifically designed to manage an acutely psychotic, manic, or suicidal patient who is receiving acute treatment and pending evacuation from theater. Within the deployed environment, the majority of service members are treated locally at the mental health unit. If there is a requirement to have them spend a night away from their unit to ensure accessibility to resources or services, this generally can be accomplished at the nearest aid station. Service members who present a safety risk concern will be placed on a “unit watch”. Service members who symptoms persist for 72 h or are more significant can be sent to a restoration center. These centers, located within the theater of operations but generally further away from the front lines, can provide focused, intensive, outpatient treatment for up to 7 days. The majority of service members seen and treated at the restoration center recover and return to duty; however, those whose symptoms worsen or do not resolve within the 7 days are evacuated from theater [5].

Prevention

The role of psychiatrists in the deployed environment began transitioning solely from treatment and disposition to prevention in the latter years of World War II with the establishment of command consultation and the development of mental hygiene training programs [26]. The effectiveness of these programs was highlighted in the Group for the Advancement of Psychiatry's 1960 report that cited preventive military mental health care allowed for early recognition and prompt outpatient treatment of emotional difficulties thus reducing combat ineffectiveness [27]. More recently, prevention has expanded to include pre/post deployment mental health screening. The challenge to military mental health providers is balancing the available time to conduct prevention work with the demands of identified mental health patients. Additionally, providers must commit time to building relationships with the unit leaders to maintain credibility, to garner support for their recommendations, and to ensure that they have situational awareness and understanding of the ongoing mission to help shape their recommendations.

From a primary prevention standpoint, there are two measures that deployed psychiatrists can implement to encourage the development of adaptive stress responses and resiliency: health promotion/mental health education and battlefield circulation.

Psychoeducation can be conducted prior to and during deployments and should be tailored in product and delivery to match the audience, setting, and military situation. These efforts should focus on recognition of key stressors associated with these situations, recognizing service member's strengths, and teaching service members how to develop resiliency [28]. Further discussion on resiliency development and these tools can be found in a separate chapter of this book.

Vignette

During a unit's repeated deployment to Afghanistan, mental health and unit leaders were concerned about how to promote adaptive stress responses. The combat stress detachment and unit behavioral health personnel including psychologists, social workers, behavioral health technicians, chaplains, and chaplains' assistants, we planned and executed a full-day stress management education event that was centrally located on the forward operating base. The event was conducted at a central location near the dining facility which allowed large groups of service members for participation. The event included brief psychoeducational classes on stress management, healthy coping skills, relaxation techniques, and other helpful subjects that were deemed appropriate based on previous presenting difficulties that the mental health professional encountered during the deployment. The event also incorporated games, yoga classes, and free giveaways of snacks, toiletries, and other desirable items that served as non-stigmatizing ways for mental health professionals to interact with the service members and to provide them information about who they were and the services they could provide if needed in the future. Additionally, they provided attending service members with psychoeducational pamphlets and audio recordings that service members could take with them and read in their free time.

Battlefield circulation, sometimes referred to as therapy by walking around or walkabouts, describes time spent traveling around the battlefield visiting with service members and leaders to develop a better understanding of the overall situation and the needs of subordinate commanders and service members. These interactions allow psychiatrists to educate, counsel and advise junior leaders and service members on applicable mental health topics and coping strategies. During these visits, psychiatrists sometimes meet individually or with a group of service members and junior leaders to assess unit climate, morale, and cohesion and to provide psychoeducation on relevant topics such as sleep hygiene, dealing with loss, and anger management. Additionally, this circulation provides opportunities to advise unit leaders on actions they can take which may impact the mental hygiene of the organization to include potential improvements to operational and environmental factors such as living conditions, work/rest cycles, etc. [29].

Vignette

During a recent deployment to Afghanistan, a unit mental health team (consisting of a psychologist or licensed clinical social worker and a mental health technician) frequently included walking around the internal perimeter of their forward operating base with the sergeant of the guard in their routine. This action allowed the mental health team to interact and check in with the service members assigned to guard tower duties. Guard tower duty tends to be an isolative task that involves long shifts for multiple days in a row. Additionally, those service members assigned to these duties might have limited accessibility to medical and mental health services. These circulations were coordinated ahead of time through the unit who owned the base security mission to ensure that they were conducted in a way that would not detract from that mission. At each guard post, the sergeant of the guard would take over the guard mission so that the assigned guards would be able to take a break and speak with the mental health team while not leaving their guard posts vacant. As the team visited with the service members, they offered cold drinks and snacks, introduced themselves and provided the service members with information about the available mental health services and where we were located on the base. As part of this visit, the team engaged in casual conversation with the service member developing a rapport and gathering information about potential stressors that not only the individual service member was facing but the unit as well and taught the service member about basic relaxation and stress management techniques. In summary, these encounters developed low-threat opportunities to educate service members about available services and how to access them, while also providing an opportunity to gain helpful information about soldier concerns, unit trends, and other factors that might be impacting service member well-being and unit readiness.

Commonly employed secondary prevention measures include mechanisms for early identification of those at risk of developing mental health problems and employing interventions to prevent worsening of or development of symptoms after exposure. These include individual and unit level screenings, as well as, traumatic event management.

The United States military implemented post-deployment physical and mental health screening in the late 1990s to identify all of those service members who may have had potential environmental, physical, or mental health exposures [30]. This screening initially included only a few questions but with lessons learned from Iraq and Afghanistan expanded to included objective scales for Posttraumatic Stress Disorder, Depression, Substance Use Disorders, and Domestic Violence. Additionally, the frequency and timing was expanded to include multiple iterations [28]. Later, a pre-deployment screen was implemented to identify whether a service member should be deployed or if they were and had a mental health condition, included a care plan for ensuring their continuation of care [25]. While these tools have a number of limitations to include a reliance on self-reporting and a lack of such reporting due to the lack anonymity, they provide key touchpoints for both education on resources available and how to access them, as well as, for psychoeducation on tools that service members can implement. One key aspect to these screenings being successful is the coordination of care between the screening team and either the unit mental health team or the home station mental health team to ensure that those who are identified receive further evaluation and treatment. The deployed mental health team plays a key role in this process both when they are conducting screenings for returning service members and when they are receiving those who are arriving to theater who will require continuation of care. This communication is accomplished through multiple mechanisms including the world wide electronic medical record, secure communications, and coordination with unit leaders.

Within the deployed environment, military mental health providers may be asked to assess the mental health and welfare of a unit. These teams are equipped with service developed assessment tools and also have psychologists on their teams capable of developing specific screening and assessment tools based on the needs of the unit. The mental health team can conduct interviews, surveys, or other assessment and provide recommendations to unit leaders on actions they can take to improve unit resiliency, morale, cohesion, and quality of life. These are all factors which can not only enhance a unit's effectiveness in combat, but also reduce the rate of combat operational stress reactions during the deployment [28].

Another frequently used prevention mechanism is traumatic event management. Traumatic event management is an intervention that occurs after exposure to a potentially life threatening or deadly event. These interventions are meant to decrease the effect of the event and prevent long term mental health complications from them. Of note, traumatic event management is a process that includes consulting with the onsite leaders, conducting a needs assessment for the unit/organization, and subsequently employing appropriate interventions. These interventions serve as an opportunity to reduce stigma and barriers to mental health care by showing that the leaders recognize and support mental health assistance in response to these events and also provide education to those impacted on resources available [5]. However, some interventions may be more specific.

One such intervention is the use of psychological debriefings. Over the past 20 years, there has been significant debate about the risk/benefit of debriefings with the World Health Organization issuing a strong recommendation that single session

debriefing after a traumatic event not be conducted due to evidence that not only does it not prevent the emergence of post-traumatic mental health conditions, but may potentially increase the development of Posttraumatic Stress Disorder [31]. Despite these concerns, debriefings remain a technique that the United States military continues to use in the deployed environment [5]. Current United States military doctrine leaves the decision of whether to conduct a psychological debriefing and what method to use up to the deployed mental health provider [13]. These types of findings show the importance of continued research and study to ensure that our understanding, treatments, and interventions evolve.

Challenges in Deployed Mental Health Care

Up to this point, this chapter has focused on the mechanisms for delivering mental health care in a deployed environment; however, we would be remiss if we did not also highlight a number of the unique challenges to the provider operating in this environment. It is important to recognize these challenges as they impact both the therapeutic alliance and the patient's perception of the care that they received. This section will focus specifically on deployment related issues as a number of the broader ethical challenges such as confidentiality and dual agency are covered in other chapters.

Safety

The mental health provider on the battlefield has a unique role that will require, at times, a level of personal risk beyond that experienced by most providers in a non-combat setting. It is not uncommon for providers to be asked to travel into areas that may be subject to enemy fire or improvised explosive devices. Additionally, providers must consider safety measures beyond those encountered in a routine setting in the United States. First, due to the fact that they are in a combat zone and need to be prepared to respond to potential enemy attack, service members are armed with automatic weapons and ammunition at all times, including the mental health provider. While access to weapons increases the potential risk for self harm or harm to others, restricting access to weapons must be balanced with providing the service member with the ability to defend themselves and their unit. If weapons restriction is required such as in cases of patients who are dangerous or have impulse control issues, then providers should consider evacuating the service member to a safer location. Other possible interventions include temporarily confiscating the service members weapon or removing their firing pin.

It should be clarified that mental health providers do not have direct authority over service members' mission status, but rather makes recommendations to commanders. Providers do not remove, stockpile or store suicidal patients' weapons. Instead, mental health providers must engage and ally with the unit to keep service members safe. In making their recommendations, however, providers can work with unit

leaders to help them maintain an appropriate balance of limits and support. Providers must also manage the fact that leaders themselves may need clinical support.

For patients who require inpatient psychiatry, other solutions need to be found. Inpatient psychiatry in a deployed environment is not the same as in the United States. Inpatient psychiatric beds, of which there are few, are beds in a medical ward with a sitter; there is no therapeutic milieu. Restoration programs provide a therapeutic milieu in a day-treatment, or partial hospitalization setting with service members living at the facility, but not typically in a fully-supervised or locked setting. Service members with suicidal or homicidal thoughts that are not resolved by being temporarily removed from the immediate situation and setting require urgent evacuation.

Boundaries

A deployed environment can be similar to operating in a small community. Providers will likely live amongst their patients and encounter their patients in non-clinical settings such as mess halls, gymnasiums, and even in shower stalls. While providers want to avoid establishing social relationships with current or potentially future patients, they must also develop their own social support network. It is recommended that they choose stable, resilient service members for their social circles. Perhaps the most challenging request a deployed provider may face is when a previous non-patient, such as a tent mate, exercise partner, or friend comes to need mental health care. If there is no other mental health provider to whom to refer, then the social relationship changes which can be awkward and isolating for a provider and for the new patient as well.

Furthermore, with some regularity, senior officers and supervisors of the mental health provider, request treatment. Depending on the situation, there may be no other provider to whom to refer, and providing treatment is not only in the senior officer's best interest, but the entire unit's. In cases of potential dual relationship, boundaries must be clearly discussed at the outset of treatment, separating the treatment from the professional relationship and establishing expectations on both sides.

Lastly, deployed environments do not always permit a traditional office type setting for a mental health encounter. Deployed mental health providers should whenever possible arrange a specific time and place for therapy even if they are not in an office setting or during traditional office hours to ensure that the service member knows it is a therapeutic encounter. This emphasizes the importance of differentiating therapeutic from social encounters. At the beginning of treatment, the provider should discuss with the service member how both parties will handle daily interactions such as seeing each other at the dining facility, the gym, or in the general living area. Key areas to be discussed include whether and how each party would like to be recognized and greeted in a non-clinical setting and appropriate times to approach with non-emergent questions or concerns. If not discussed, these boundaries can negatively impact the therapeutic alliance between the service member and the military mental health provider.

Detainee Care

The role of deployed mental health providers in the care of detainees is generally limited to providing assessments and care when a detainee is displaying odd behavior or there is concern about suicidal or homicidal thoughts. In these cases, the provider will conduct a safety assessment and determine if appropriate measures are being taken and necessary facilities and equipment are available at that location to safely care for the detainee and if not, clearly state the necessary safety requirements so the detainee can be transferred to an appropriate facility. These evaluations can be very difficult as there are likely to be language barriers requiring evaluations to be conducted through an interpreter. Furthermore, there will be cultural barriers and generally a lack of trust by both the provider and the detainee [32].

In some instances, deployed military mental health providers will serve in hospitals where their primary mission is to care for the medical needs of the detainee. Prior to this assignment, the provider will be given specialized training on interacting and caring for detainees [32]. An additional challenge in these settings is caring for the service members who serve as guards. Working as a guard can be very stressful, and it is imperative that the mental health providers assigned to detention centers help the service members develop adaptive responses [33]. This development is accomplished not only through ensuring that readily accessible care is provided, but also through frequent circulation throughout the unit's area to help identify detention facility guards and other personnel who may be developing a combat operational stress reaction [32].

Lastly, many non-medical personnel may not be aware of the scope, capabilities, and limitations of a deployed mental health provider. At times, the provider may be asked to participate in or review an interrogation to provide insight or asked to provide information from a patient encounter with a detainee so that the information can be used during an interrogation. In these instances, the provider should reject this request and set very clear boundaries. They need to be sure that their mental health staff and the leadership understand that providers cannot be involved in these activities at any level.

Future Directions

Despite the changing nature of war, the scientific advances of medicine and pharmacology, and the increasing impact of technology, mental health providers will continue to play an instrumental role in the deployed environment. Continued research will be required to determine the most effective treatments and methods of delivery, but the requirement to provide direct care to patients in a high stress environment and to provide consultation towards the prevention of psychological casualties will remain paramount.

Clinical Pearls

- The bedrock of deployment mental health care in persistent, high intensity combat are the combat operational stress control principles.
- As theaters of war mature, battle lines become more established, and/or phases of war transition into stability operations, modern psychiatric resources including select pharmacotherapy and limited psychotherapy can be employed.
- When considering prescribing psychotropic medications in either a deployed environment or to a service member preparing to deploy, psychiatrists must consider several factors including the ability to provide/access follow up care, availability of medication re-supply, and potential inability to access lab or special storage resources.
- Telehealth capabilities are expanding the ability to deliver mental health services to forward deployed locations.
- Military mental health professionals employ multiple methods to promote adaptive stress responses to the combat and operational stressors service members face during deployments including battlefield circulation, health promotion, psychoeducation, early identification screening, and traumatic event management.
- Deployed mental health providers should anticipate some specific challenges for which they need to mentally prepare for how they will handle including considering that in a deployed environment all mental health providers and their patients are armed with deadly force, boundaries will be challenged when the provider may be living and operating in close physical proximity to their current and potential patients, and mental health providers may be asked to evaluate and provide care for enemy prisoners of war and other detainees.

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