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EDITORIAL

A Decade of War: Adapting to Meet the Mental Health Training Demands

Christopher H. Warner[1]

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War has long yielded advancements in medical techniques and understanding. The past 13 years have seen the USA fight two enduring wars and have brought forward numerous medical advances to include those that have impacted pre-hospital care, medical evacuation, bleeding control, and trauma response; however, some of the most critical advances have occurred in the identification and treatment of the invisible wounds of the war, posttraumatic stress disorder, and traumatic brain injury. With increased awareness and understanding of these conditions, nearly one out of every five returning combat veterans is identified with a mental health disorder [1]. This has significantly increased the demand for military mental health services and the requirements for military mental health providers. In the US Army alone, there has been a more than 150 % increase in mental health providers required to meet the mental health care needs of the returning soldiers [2]. The other military services and the Veterans Affairs (VA) hospitals have seen similar increases in demand.

This situation was further complicated by the fact that during the post-Cold War era of the 1990s, the uniformed services underwent a significant personnel reduction and Base Realignment and Closure. The result was a 30 % reduction in the uniformed medical provider force and closure of three of the nine military psychiatry training programs during this time frame [3, 4]. Because those military training programs produce more than 90 % of the uniformed service psychiatrists, growing the force in short demand presented numerous challenges.

✉ Christopher H. Warner
christopher.h.warner.mil@mail.mil

[1] 61st Multifunctional Medical Battalion, Fort Hood, TX, USA

This prolonged period of war impacted those training programs. The type of patient and care demands at the teaching facilities significantly changed, teaching staffs were temporarily decreased in size as many of the military psychiatry staff were deployed to Iraq or Afghanistan, and residents were prepared for not only upcoming board certification exams but also soon-to-occur deployments to war zones. Additionally, faculty were challenged to manage and cope with their own deployment experiences while facing demands to teach new residents all while the profession of military psychiatry was facing increased scrutiny over rising suicide rates, deployment mental health screening, quality of posttraumatic stress disorder treatment, and even one military psychiatry graduate conducting a mass shooting. The purpose of this special collection of *Academic Psychiatry* is to highlight some of these unique challenges and address both the lessons learned and the advancements made in military psychiatry education.

This collection opens with perspective and commentary pieces written by graduates of several military psychiatry training programs. Groom et al. [5] provide an interesting view from resident training at different points in time during the war effort. The period early in the war was marked by anxiety and unknown futures, whereas later in the war, challenges shifted to the expectation of deployment to a war zone as well as a growing sense of negativity toward the profession on the basis of enduring media reports. Complementing this perspective is a commentary from Capaldi and Zembrzuska [6] that highlights the challenges graduating residents faced deploying to a war zone less than a year after completing their training. Of note, military psychiatric residents completed all of the same Accreditation Council for Graduate Medical Education requirements as any other trainee but also had to prepare for the challenges of the battlefield. West et al. [7] highlight a specific training program that provides some of that preparation called Operation Bushmaster.

Whereas much of the media reporting and medical research has focused on the impact of these long wars on service members and veterans, a second area of research has focused on the impact on the families of those individuals. Although the primary purpose of the military medical services is to support the service members, they also are tasked with supporting the family members. Both Lee et al. [8] and Weston et al. [9] discuss key initiatives designed to support those very efforts, including redesigning child and adolescent services to better integrate with primary care capabilities and preparing providers for the demands that military families face.

As previously mentioned, these wartime demands required ongoing growth and adaptation by the military training programs. Diebold et al. [10] outline both developments in military training programs and new routes for entry of uniformed services psychiatrists. Additionally, they outline initiatives for assisting in developing the rapidly growing number of civilian psychiatrists who are working at both military and VA hospitals. Further, Welton et al. [11] highlight how military psychiatry programs might look to evolve in the future both to maintain their faculty and program stability during war time and increase the civilian psychiatry exposure to military medicine.

Lastly, nearly 2.5 million personnel have served in Iraq or Afghanistan with over 1.5 million of those individuals already moving on to veteran status [12]. Although some of these veterans will receive care through military or VA facilities, a large number will move on to civilian lives and seek care at facilities throughout the USA. Great efforts have been made by the VA and Department of Defense, but stigma toward seeking mental health care remains and many of the soldiers do not report their symptoms while still in uniform [13]. The result is a need for all psychiatrists to develop a greater understanding of military culture and awareness of potential exposures [14]. Meyer et al. [15] report on a pilot tool to assess competency in this area and help push us all toward increased competency in dealing with the unique military culture.

In closing, I would like to thank the editors of *Academic Psychiatry* for helping to bring this important issue to the forefront. Military psychiatry leaders face continued challenges, and our uncertain future in this complex world will continue to present needs for military deployments. Even as we have concluded the war in Iraq and are nearing the end of operations in Afghanistan, we find service members returning to previous locations such as Europe and the Middle East due to increasing threats or being called upon for unique challenges such as to aid in the battle against a deadly virus in Africa. Our military training programs benefit significantly from our partnerships with civilian training programs as well as organizations such as the American Association of Directors of Psychiatric Residency Training, Association for Academic Psychiatry, American Association of Chairs of Departments of Psychiatry, and Association of Directors of Medical Student Education in Psychiatry. Continuing to enhance those relationships, adapt our training, build bridges to increase nontraditional mechanisms for serving in military psychiatry (whether in uniform or as a civilian), and develop better understanding of a veteran's experience and exposure will ensure that our brave men and women who answer the call to defend our nation continue to receive the outstanding mental health care that they both deserve and will need.

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