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"I'LL NEVER CALL YOU DOCTOR": AN EXERCISE IN COGNITIVE DISSONANCE

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In his closing comments on solving community entry problems by the clinician Nottingham (1975) states "You could have been a steeplejack or a chiropodist, but you chose community psychology. So, having made your bed, rest ye well. The nightmare and the morning, commeth" (p. 309). Similar choices and responsibilities are not foreign to those mental health clinicians who have ventured into nontraditional areas for delivery of services. This is logical and appears quite simplistic on the cognitive level. Yet, the "nightmare" appears as a more pressing issue for those mental health clinicians in the U.S. Army who sometimes venture, sometimes fall into and yes, sometimes choose non-traditional settings for the delivery of services. As an example, I refer to the Division Mental Hygiene Consultation Service, specifically, of the 82nd Airborne Division located at Ft. Bragg, North Carolina.

The author of this paper was originally requested to present an overview of the problems of such an organization as if to imply that they would be different and unique, which again seems like a logical statement. The every day, ever present and visible testimony of the preparedness to go to war in a moments notice alone creates differences along physical, intellectual and emotional dimensions for the members of this unit. But it too, like a MEDCEN or MEDDAC, has an organization and a structure with some policy, standards and principles to achieve outcomes and missions. And as Nottingham suggests, a clinical psychologist having made the choice to work in this Divisional setting, should live with it and make the organization or structure work for him/her. Quite logical again, until the "nightmare" suddenly evolves and then the challenge begins.

The focus of this presentation therefore will not be a challenge of or a presentation of alternates to the existing system of MHCS within the Division. Rather more basic issues of survival and belongingness are addressed with consequential attitude changes and problem solving strategies provided.

The creature comforts of a MEDCEN were my initial experience base as a new clinician in the field of psychology. Yet, I was continually aware of other places less attractive which I actively sought as part of an overall career progression plan (or as some say, to pay my dues). Therefore the choice. The "bed" began to be made in jump school with the intent of becoming the new Division Psychologist for the 82d, bald-headed and bear-lipped I attempted to do what some say is intended for birds and fools. Sustaining an injury, I was

relieved to be sent to Ft. Bragg where I later might become jump qualified and immediately get down to the business of psychology. The "nightmare" was interrupted...I thought.

A look at my new work environment. Huge, active, bustling, and noisy with maroon berets everywhere....Sounds of combat boots uniformly striking the hard asphalt in a four-mile run to the cadence of a deep-throated sergeant gruffly shouting "If my main don't open wide..." The interruption of six or so C-130 troop transport aircraft at 500 foot altitude and several volleys of fire nearby prevented me from taking this chant too seriously. Eventually...on to meet what I later came to realize was the first in a long line of "bosses" I was to have in the Medical Battalion...the XO (others were the Division Psychiatrist, the Battalion Commander, the Division Surgeon and to a lesser extent, the Company Commander of the headquarters and Support Company).

When I walked into his office, little did I know that this interaction with the XO would be the start of a cognitive dissonance for me. His words were "I just want you to know Captain, that I run the staff here and you are part of the staff....Also, I'll never call you doctor." My gosh. I had heard about the different perceptions of mental health professionals within a unit of this sort but had calculated that it might be more subtle with the professional directing efforts at defining and delimiting a role and position in a diplomatic fashion. However this statement from the XO was quick, blunt and admittedly, somewhat offensive. My first challenge to professional integrity...or so it seemed. Seconds later I responded with "All the way, Sir" considering the possibility his statement may have had its basis in a historical unfruitful experience with a member of the mental health profession or a test to see how easily I would be unnerved. Regardless, this was the beginning. What was to follow, as seen in the experiences and actions as a mental health professional in this Division, was a multiplicity of this interchange with the XO in principle.

With this brief entry description, I would like to focus and highlight certain impacts on the delivery of mental health services within the 82 Airborne Division followed by quite tentative prescriptions for those that might enter such a system in the future.

Organizations are comprised of basic common elements of people, resources, purpose and structure. What seems to differ from organization to organization is the degree of overlap among these categories. Certainly, some degree of shared interchange is necessary for the organization to function effectively with more complexity in the system creating greater likelihood of overlap. Additionally, these elements themselves do not exist in a vaccum; they too are a part of a larger microsystem which impacts on it. Therefore, overlap is crucial.

Consider the 82d Airborne Division to be a complex microsystem. It has its structure (the traditional wire diagrams), people (airborne qualified personnel across a wide range of MOSs), resources (weaponry, machines, paper, etc.) and mission. The later deserves more detail. Simply stated, the mission is to be prepared to go anywhere in the world at a moments notice and with the capability

THE MISSION. The MHCS of any Division had two kinds of missions...that for peacetime and that for wartime or combat. To accomplish the latter, the guiding principles for MHCS are and would be akin to those of other medical operations during war, i.e. immediacy, proximity and expectancy, or to treat as soon as it happens, where it happens, and with the notion of returning personnel to the mission if possible. In combat, the Medical Battalion of the Division, with its Clearing and Ambulance platoons and supporting elements, is one of the earliest echelons of medical treatment and disposition. MHCS, as part of the Medical Battalion, becomes involved in a triage process where, depending on the Commander's evacuation policy, patients are given an expedient disposition keeping the three principles in mind. For MHCS, some dispositions may involve bed rest and food for 24 hours for combat fatigue to injections of thorazine with possible evacuation to the rear to ventalation of depressed feelings. Fast and furious is the name of the game. Other activities of the Medical Battalion also affect the wartime operation of MHCS. The 91-G Behavioral Science Specialist may be utilized as a 91-G medic in the case of a mass casualty or as permanent or temporary perimeter guards in foxholes. A remote possibility is that the Division Psychiatrist, Psychologist or Social Worker might consult with other elements in the chain of command if there is time and accessibility to these individuals and units.

The peacetime/garrison mission of the MHCS provides an opportunity for slightly more definitive treatment to take place. Often times I have witnessed the Division Psychiatrist refer to our mission in garrison to be "wartime psychiatry" and we are doing very closely in peacetime what we would be doing combat. In some sense this is accurate. The majority of our patient activity ranges from the toxic psychoses as a result of drug ingestion (e.g. PCP) to the depressed person who makes a suicidal attempt or gesture to the angry passive aggressive young trooper who has a long history of problems with authority figures (a true neurotic rarely presents for treatment). If a patient is seen longer than 4 or 5 times, something in the system may not be functioning properly, primarily due to the emphasis placed on a crisis intervention model aligned with the principles mentioned before. A soldier in garrison with the 82d is continually engaged in some sort of mission readiness and therefore long-term treatment could mean a loss of badly needed mission resources.

One last point with respect to the peacetime mission of MHCS, i.e. there is an overlap with the other peacetime missions of the Medical Battalion. To cite a few examples:

(1) ARTEPs and field exercises both local and extended geographical.
(2) IGs
(3) Motor pool activity
(4) NBC proficiency and training
(5) Airborne operations
(6) Weapons qualification

On the average, a least one member of the MHCS staff or personnel is on an airborne operation once a week which means the loss of one complete day.

to respond in a combat environment with the maximum amount of power. Implicity therefore, in a non-combat posture, is the notion of constant preparedness and readiness...not testable once or twice a year (as in the usual ARTEPs) but every hour of every day. Now let us deal with the MHCS mission in this system.

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(7) Daily physical training
(8) Officer and enlisted staff duty
(9) Continuous updating of forms of personnel
(10) Human relations training
(11) Administrative meetings
(12) SQT training
(13) Other schools and training for EMs

What about Consultation which is supposed to be an integral part of the mission of any MHCS? A continual awareness exists on the part of the 82d MHCS staff of the need to perform in a consultative capacity as well as in the traditional patient care modes. Of necessity, the former has been restricted to case and consultee centered types of consultation interactions. The organizational effectiveness folks absorb more of the complex interventions at the organizational level.

THE STRUCTURE. The structure of the MHCS within the Medical Battalion is simple and designed keeping in mind the three basic principles of patient care as well as to insure that all aspects of medical care are mobile and self supporting as much as possible. This simple structure in actual function however displays a high degree of overlap with other functions or missions. Examples are:

(a) Physically, the Division Surgeon is in the Medical Battalion although he is actually on the Division Special Staff. He is responsible for the professional aspects of medical care throughout the Division as well as the Medical Battalion. As part of this activity therefore, he is interested in the professionals who are rendering services to the Division. Input to the Division Surgeon by these professionals.

*There are those that would advocate co-locating the Division MHCS with the Department of Psychiatry and Neurology of a MEDCEN or MEDDAC during peacetime. Although several advantages might be raised for this decision, doing so might remove the MHCS too far from the actual activities of the division and therefore reduce an awareness for a sometimes austere environment that attempts to approximate a combat mission.

is crucial. However the Medical Service Corps officers and some of the Medical Corps officers are also considered to be part of the staff of the Medical Battalion and come under the responsibility of the Battalion XO.

(b) The 91-G Behavioral Science Specialists are assigned to the Medical and Support companies within the Battalion. The same 91-Gs are also receiving supervision from the Division Psychiatrist who also may be a part of the rating scheme of these individuals.

(c) The Division Psychiatrist position concerns itself with a dimension of influence coming from the hospital commander of the local MEDDAC who also happens to be the Corps Surgeon who has professional input and influence on the Division Surgeon.

With these few examples of the overlap in the structural elements between the MHCS and the Medical Battalion, it is clearly evident that one person's professional body or position comes under the scrutiny of several other persons and positions.

PERSONNEL: As indicated, all personnel of MHCS in theory belong to someone else in the Battalion. Control of professional issues concerning mental health are chiefly the responsibility of the Division Psychiatrist. Yet, reflecting on the multiplicity of the Medical Battalion's mission, a high degree of overlap exists between the professional activities that a member of the mental health team is responsible for and those activities that come from the Battalion which are also the responsibility of the member. For example, we are all well aware of the necessity for grooming 91-Gs after they have been assigned to us after completing their course at Ft. Sam Houston. A lot of effort and planning is constantly taking place to develop his/her skills to a level of minimum clinical expertise. Yet the 91-G in the Division MHCS (especially in the lower rank) is keenly aware and constantly reminded by their Company commanders of the need for promotion points or readiness requirements that are usually acquired through additional schooling or training in the Medical Battalion or at other locations. Therefore, there can be a considerable loss of time for the 91-G to provide services and certainly a degree of difficulty in planning ahead for a long period of time. If the Medical Company to which the 91-G belongs is preparing to go to the field, usually a 90% accountability of personnel within that company is required for that mission. The 91-G might be strongly encouraged to fulfill this mission requirement again creating some difficulty in patient services planning. Such a duality of missions for the 91-G create not only potential problems in patient care but also engenders a duality of perceptions as to the primary role of the 91-G, i.e. soldier/therapist. The staff of the MHCS contend that the 91-G functions quite differently than a 91-C or a 91-B in their respective settings. The latter two will treat patients as a part of a larger triage system and deal with the preliminary work and data gathering for the PA or physician. The 91-G, with supervision, is responsible for a specified number of intakes, diagnostics, dispositions and treatments for the patients. This necessitates advanced scheduling for this activity. Even more crucial is the fact that the primary medium for treatment in the MHCS is the relationship between the therapist and the patient; this is not easily altered or transferred when other missions of the Medical Battalion are to be met. As a result, it is sometimes difficult to keep company commanders informed, and more so, sensitive to the differences in patient care provided by the 91-G versus the 91-B or 91-C.

RESOURCES: The primary source of logistical and supply support for MHCS comes from the S-4 and the DMSO (Division Medical Supply Officer) of the Medical

Batallion. The problems that arise in this area are not so much a function of overlap with other elements within the system but rather a problem of priorities. If it is a request for stationary supplies, there does not seem to be any major delay but when it is a question of obtaining certain diagnostic instruments or resupplying forms, for these, a continual "squeeky wheel" principle needs to be enforced.

Support becomes even more elusive when considering more subtle issues which impact on the effectiveness of patient care (e.g., the comfortableness of patients in the waiting room and in the therapy rooms, the environmental setting of the building itself, appropriate temperature control*, freedom from noise interference and distraction**). One aspect of the problem is that MHCS is now the only occupants of an entire TMC building, which, for many issues of control and accountability, are under the local MEDDAC. Yet there is a grey area where the MEDDAC and the Medical Battalion overlap in responsibility for the MHCS operations (e.g. for some of the furniture, the MEDDAC is responsible; for IG inspections, the Medical Battalion is responsible; as of yet, no one knows or will admit who is responsible for the physical plant itself). The conclusion at times is confusion.

For MHCS the issues go on and on in the overlap of the dimensions of mission, structure, personnel and resources. At times, these issues seem as plentiful and new as days in a year. What has been related is but a sample of what can utimately develop into frustration, if not blatant anger at time for the mental health professional despite the level of expectations and drive for the accomplishment of these.

What seems to take place in the developmental scheme of things for the newly arriving mental health professional in order to cope with the perceived frustration is to organize certain elements in an intellectual fashion to rationally understand a system that on occasion seems largely irrational. Furthermore, these conceptions have a tendency to be simplistic in design to arrive at a sense of control of matters. The following is such a conceptualization which I am certain is simplistic, reductionistic and does not afford much by the way of addressing the preparedness for the "nightmare". But it was the beginning of the resolution of the dissonance.

Using the traditional ven diagram approach, a system, with the basic elements of mission (purpose), structure (organization alignment), people (manpower) and resources (materials) with some necessary degree of overlap for minimum functionality, might be portrayed as such:

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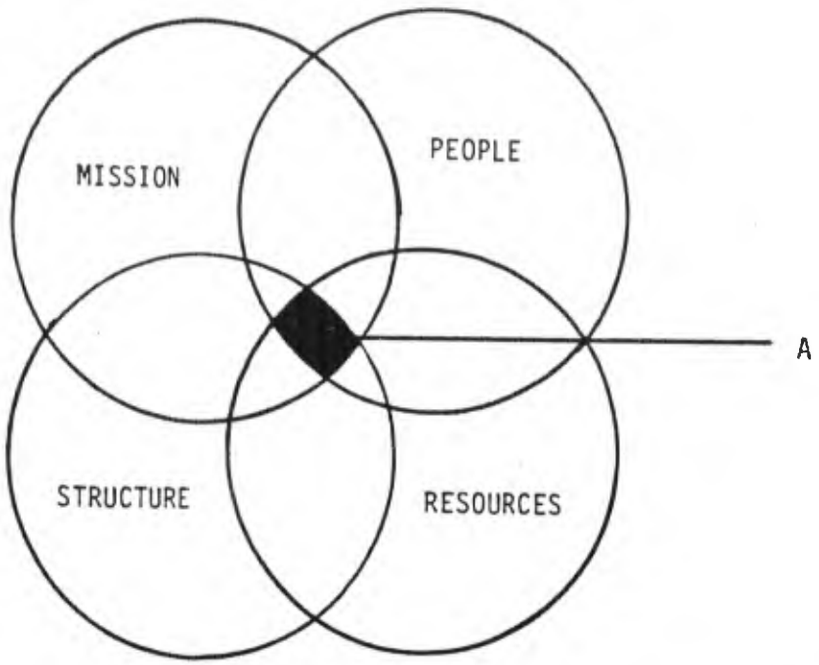
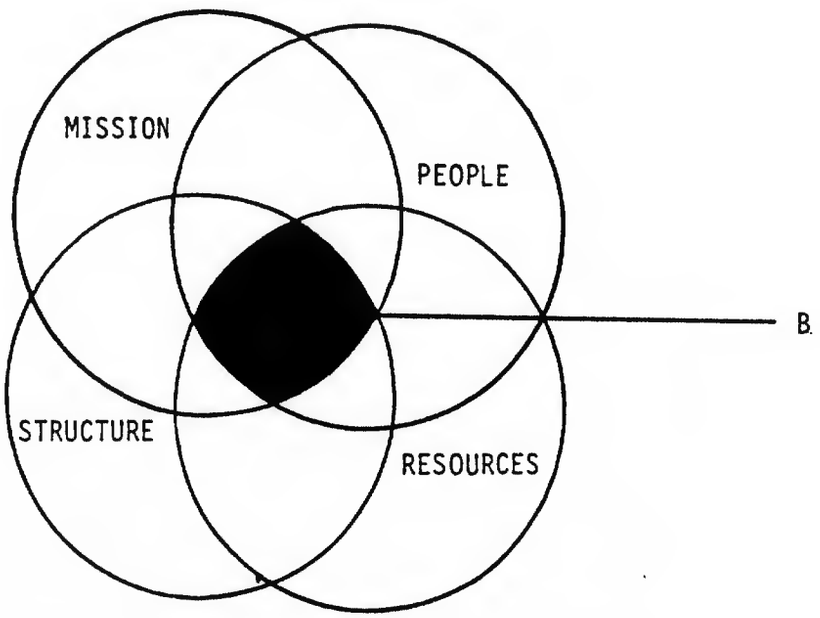
*This fall, the DAFE thought that MHCS building had been abandoned and therefore did not turn on the heat when all other buildings were.

**e.g. Tree-top C-130's and C-141's, helicopters, heavy machinery.



Assuming that the basic principles of permeability of or fluidity between boundaries are not necessarily fixed for each of the elements, and assuming that the size of the circle representing each dimension may, in reality, be different for each (depending on the idiosyncratic style of the organization's priorities), overlap does occur across all combinations. The amount of overlap "A" is an area for potential "loss of identity" of an original dimension (M,P,R, or S) which may be attributable to a decrease in the level of effective communication or interchange. Similar overlap might occur between all combinations of the dimensions with the more combinations generating greater probability of confused messages.

A more complex organization (complex in one or all of its elements) might be pictured as such:



With the same assumptions, "B" compared to "A" would have an increased probability of confusion, frustration and more specifically "lost" or partially altered identity of a dimension that may or may not be determinantal.

If the entire ven diagram were to represent the Medical Battalion of the 82d, and if the MHCS were considered to be a part of each of the four elements of the system and if the structure is assumed to be complex (as in the description of "B" relative to "A") then some intellectual, cognitive grasp of the aforementioned issues facing the present MHCS has begun. For the new mental health professional in an organization of this type, such an approach might be viewed as the primitive beginnings of an attempt to resolve or reduce cognitive dissonance, i.e. attitude change.

This simplified systems viewpoint to facilitate an understanding of a highly active and complex organization such as the Medical Battalion of the 82d provided the mental health professional with a framework in order to maintain (or attempt to) a sense of professional identity. Yet, in the developmental sequence, the utility of this perception, although necessary, is passive and limited. Activating the framework necessitates behavioral guidelines that I have labeled as prescriptions (for survival) that may expedite the resolution of the cognitive dissonance or attempt to hasten the end of the "nightmare".

PRESCRIPTIONS:

(1) Resolve issues of integrity based on labels or positions as soon as possible. Mental health professionals assigned to a new organization that drastically departs from more traditional settings might be inclined to prematurely delimit the range of professional activity that may be based more on past needs, experiences, etc, rather than newer demands of the situation.

(2) Be visible but cautiously so. The caution specifically refers to one's efforts to define or redefine the professional role. Herein, lies an inherent danger of wanting to become like "them" based on at least a questionable premise of "if I am like them, the better I can render the services that I have to offer". Observe and be visible from a distance and appreciate the differences.

(3) Be informed to inform. The resultant overlap of elements within the organization create a high probability that decisions made elsewhere within the Medical Battalion will have an impact on MHCS. A periodic phone call to the S-1, the Headquarters and Support Company Commander might be revealing; attendance at Commanders' meetings might be useful. Designating a representative from the enlisted ranks of MHCS to attend the First Sergeant's meeting is necessary to keep in touch with policies and missions that affect your Gs. Be aware of the doctrine that affects the functioning of those that work with you. Interact frequently in

person with the Division Surgeon, the S-1, the XO and the Company Commanders of the Medical Battalion.

(4) Be prepared to set limits and to provide the rationale for such. Adopting a crisis intervention model creates a vulnerability to excessive and ineffective "extinguishing of fires", a percentage of which might not be in the best interests of the patients, a company commander, an organization or the mental health professional. The ability to diplomatically say "no" is crucial.

(5) Differentiate between nice-to-have (or do) and-need-to have. In a peacetime posture, there is an increased opportunity to expand services which may be of the nice-to-do or have variety but which may cloud the ultimate combat mission of MHCS.

(6) Closely monitor your own physical, emotional, and educational health. Typically, the day is long and hectic. Over a long period of time, a decrease in functionality and effectiveness of the mental health professional may become apparent and may affect home life. Your professional colleagues are an invaluable source of data feedback along this principle.

Some other general guidelines might be:

(1) Make input for change in the combat posture of MHCS and seek opportunities to test these as do other services (e.g. optometry, dentistry), especially as it may relate to readiness, organizational role and function of MHCS in such an environment.

(2) Establish a relationship with those that logistically support you e.g. the S-4, DMSO.

(3) Create a bond with the Headquarters and Support Company Commander as he is one of the "bosses" of a majority of the MHCS staff.

(4) Be sensitive to and prepared to respond to the demands placed on the Gs from outside of MHCS but not to the detriment of patient care.

Probably, the merger of all these prescriptions and guidelines is based on higher order combinations reflected in the notions of tolerance for uncertainty parallel to the inevitable conclusion that what is certain in an organization such as this is change. If the mental health professional discovers in himself/herself less agitation, less upset and less intimidation by the potential "losses" of professional integrity, then these might be indicators that the resolution is moving at a steady pace. To say "It's only a dream" and "I'm not going to be hurt professionally in this organization" and to continue to experience the "nightmare" generates a sense of comfort because now one begins to detect a control of the situation. And ultimately, things are bound to get better. "...the morning commeth".