AD-A265 561

AMEDD CLINICAL PSYCHOLOGY SHORT COURSE

DTIC
ELECTE
JUN 09 1993
S E D

93-12826

DISTRIBUTION STATEMENT A
Approved for public release;
Distribution Unlimited

5 - 9 June 1991

BROOKE ARMY MEDICAL CENTER

San Antonio, Texas

93 6 08 083

NOTICE

The findings in this report are not to be construed as an official Department of the Army position unless so designated by other authorized documents.

* * * * * * * * * * * * *

Regular users of services of the Defense Technical Information Center (per DOD Instruction 5200.21) may purchase copies directly from the following:

Defense Technical Information Center (DTIC)
ATTN: DTIC-DDR
Cameron Station
Alexandria, VA 22304-6145

Telephones: AUTOVON (108) 284-7633, 4, or 5
COMMERCIAL (202) 274-7633, 4, or 5

All other requests for these reports will be directed to the following:

U.S. Department of Commerce
National Technical Information Services (NTIS)
5285 Port Royal Road
Springfield, VA 22161

Telephone: COMMERCIAL (703) 487-4600

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; distribution unlimited
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION US Army Health Care Studies & Clinical Investigation Activity 6b. OFFICE SYMBOL (If applicable) HSHN-T	7a. NAME OF MONITORING ORGANIZATION Office of the Surgeon General
6c. ADDRESS (City, State, and ZIP Code)	7b. ADDRESS (City, State, and ZIP Code) Clinical Psychology Consultant/SGPS-CP 5 Skyline Place Falls Church, VA 22041-3258
8a. NAME OF FUNDING/SPONSORING ORGANIZATION Department of the Army 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO.: OMA PROJECT NO.: TASK NO.: WORK UNIT ACCESSION NO.:

11. TITLE (Include Security Classification)
(U) 1991 AMEDD Clinical Psychology Short Course

12. PERSONAL AUTHOR(S)
A. David Mangelsdorff

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Proceedings	FROM 05Jun91 TO 09Jun91	January 1993	136

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	Clinical psychology; neuropsychology; forensic psychology; health psychology; stress.

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT ☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT ☐ DTIC USERS	21. ABSTRACT SECURITY CLASSIFICATION Unclassified
22a. NAME OF RESPONSIBLE INDIVIDUAL A. David Mangelsdorff Ph.D., M.P.H.	22b. TELEPHONE (Include Area Code) (512) 221-0671 22c. OFFICE SYMBOL HSHN-T

DD Form 1473, JUN 86 Previous editions are obsolete.

SECURITY CLASSIFICATION OF THIS PAGE
Unclassified

AMEDD CLINICAL PSYCHOLOGY SHORT COURSE

5 - 9 June 1991

BROOKE ARMY MEDICAL CENTER

SPONSORED BY THE OFFICE OF THE SURGEON GENERAL
UNITED STATES ARMY

COURSE DIRECTOR
LTC Dennis Grill, Ph.D., MS
Psychology Service
Brooke Army Medical Center

PROCEEDINGS EDITORS
LTC A. David Mangelsdorff, Ph.D., M.P.H., MS
CPT James English, Ph.D., MS

Menger Hotel
San Antonio, Texas

Accesion For
NTIS CRA&I ☒
DTIC TAB ☐
Unannounced ☐
Justification
By
Distribution /
Availability Codes
Dist | Avail and / or Special
A-1

TABLE OF CONTENTS

DISCLAIMER i

REPORT DOCUMENTATION PAGE (DD Form 1473) ii

TABLE OF CONTENTS v

PROGRAM FOR 1991 AMEDD Clinical Psychology Short Course vii

PRESENTATIONS:

James M. Stokes, M.D. 1
Combat Stress Control Training in U.S. Army Medical Field Training Exercises

Robert C. Hulsebus, Ph.D. 9
To Saudi and Back: A Prelimninary Report of Psychiatric Casualties Evacuated From Operation Desert Shield

Katherine J. Stephens, Ph.D. 17
Summary of Lessons Learned in Providing Mental Health Care to Soldiers During Operation Desers Shileld and Operation Desert Storm

L. Scott Fairchild, Psy.D. and Robert Roland, Psy.D. 27
Human Response to Operation Desert Shield/Desert Storm: A Comprehensive, Multidisciplinary Community-Based Approach

Joan Kakascik, Ed.D. 36
New Jersey Family Support During Operation Desert Shield/Storm

A. David Mangelsdorff, Ph.D., M.P.H. 38
Psychological Support - International Efforts

H. Frank Edwards, Ph.D. 39
Treatment of Bulima Nervosa

James V.English, Psy.D. 40
Chronic Headache Pain: Comparison of Nonpharmacologic Treatment With Prophylactic Pharmacological Treatment In An Active Duty Population

Nancy K. Willcockson, Ph.D. 48
Utilization of Mental Health Services In A Military Population

John P. Allen, Ph.D. 49
New Psychometric Instruments for Alcoholism Treatment Planning

Kathleen S. Mayers, Ph.D. 53
Non-Leading Techniques in the Assessment of the Alleged Child Molest Victim

Kathleen S. Mayers, Ph.D. 64
A Sentence Completion Task in the Assessment of Psychotic Patients

Fred J. Brown, Jr., Ph.D. 74
An Investigation of the Relationship Between Self-Report of Memory and Memory Test Performance

P. Andrew Clifford, Ph.D. 83
The BASIC-ME Questionnaire and Structured Clinical Interview (BMQ)

Mark L. Paris, Ph.D. 105
On Striving for Excellence: A Board-Eligible Psychologist's Experience with the ABPP Preparation Course

Hodges J. Glenn, Ph.D. 110
Stress Management--Taking It To The Troops

John D. Rugh, Ph.D. 114
Psychological Factor In the Etiology of Temporomandibular Disorders

John D. Shoberg, Ph.D. 117
Twenty Years Before the Bench: The Far Side of the Law

Dennis M. Kowal, Ph.D. 121
The Psychologist Role in Special Operations or Jumping With the People Whose Parachutes You Pack

Dennis M. Kowal, Ph.D. 124
What You Need to Know About the Psychological Screening of Personnel for Sensitive Positions

PROGRAM

1991 AMEDD Clinical Psychology Short Course

Menger Hotel, San Antonio, Texas
3 - 7 June 1991

Overview

Day	Date	Time	Area of Concentration
Monday	3 June	0800 - 1700	Professional Issues
Tuesday	4 June	0800 - 1700	Operation Desert Shield/Storm
Wednesday	5 June	0800 - 1130	Psychological Assessment - MCMI-II
Wednesday	5 June	1300 - 1700	Discussions with the OTSG Consultant
Thursday	6 June	0800 - 1130	WAIS-R & Neuropsychological Assessment
Thursday	6 June	1300 - 1430	Poster Session
Thursday	6 June	1500 - 1700	Special Operations Psychology Symposium
Friday	7 June	0800 - 0930	Health Psychology
Friday	7 June	1000 - 1130	Psychology and the Law
Friday	7 June	1130 - 1200	Closing

COURSE OBJECTIVES

AMEDD clinical psychologists practice in a wide variety of settings to include MEDCEN or MEDDAC Clinical Psychology Services, Community Mental Health Services, division consultation sections, and at numerous DOD, OTSG and MACOM staff levels. In 1991, AMEDD clinical psychologists strongly supported the Persian Gulf War through the provision of direct services, training and research. The short course program was designed to accomplish three objectives:

--To promote knowledge and understanding of the significant issues and challenges facing AMEDD clinical psychology;

--To examine AMEDD clinical psychology's support of the Gulf War; and

--To provide a forum for continuing education, exchange of ideas, and maintenance of high levels of competence for AMEDD clinical psychologists.

Monday - 3 June

0700 - 0800 Conference Registration

0800 - 0815 Opening Remarks
LTC Dennis J. Grill, PhD, Health Services Command Clinical Psychology Consultant, Community Mental Health Service, Brooke Army Medical Center, Fort Sam Houston, Texas

0815 - 0830 Welcoming Remarks
COL Thomas P. Hamilton II, MD, Commander, Brooke Army Medical Center, Fort Sam Houston, Texas

0830 - 1000 "Current Issues In the Practice of Clinical Psychology"
Dr. Robert Resnick, PhD, Department of Psychiatry, Medical College of Virginia, Richmond, Virginia; President, Division 42 (Psychologists In Independent Practice), American Psychological Association, Washington, D. C.

1000 - 1030 Break

1030 - 1130 "Current Trends in AMEDD Clinical Psychology"
LTC(P) Gregory Laskow, PhD, Clinical Psychology Consultant To the US Army Surgeon General, Clinical Psychology Service, Walter Reed Army Medical Center, Washington, D. C.
LTC Gilbert Turner, Medical Service Corps Career Activities Office, Washington, D. C.

1130 - 1300 Lunch

1300 - 1500 "The Military Ambulatory Classification System (MACS)"
LTC James Georgoulakis, MSW, PhD, Health Services Command Health Care Studies & Clinical Investigation Activity, Fort Sam Houston, Texas
MAJ Nancy Willcockson, PhD, US Army Reserve, Omaha, Nebraska

1500 - 1530 Break

1530 - 1700 "Clinical Psychology & The Medical Service Corps: Year 2000"
LTC Peter Leventis, AMEDD Personnel Proponent Division, Academy of Health Sciences, Fort Sam Houston, Texas

1730 - 1900 Reception

Tuesday - 4 June

0800 - 0830 "OM Team Training"
COL James Stokes, MD, Behavioral Science Division, Academy of Health Sciences, Fort Sam Houston, Texas

0830 - 0900 "Operation Desert Shield/Desert Storm Support: U. S. Army Reserve Psychologists Backfill Experience"
LTC Dennis J. Grill, PhD, Health Services Command Clinical Psychology Consultant, Community Mental Health Service, Brooke Army Medical Center, Fort Sam Houston, Texas
LTC Lawrence Maier, PhD, US Army Reserve, Clinical Psychology Service, Blanchfield Army Community Hospital, Fort Campbell, Kentucky
MAJ Walter Skinner, PhD, US Army Reserve, Community Mental Health Service, Martin Army Community Hospital, Fort Benning, Georgia

0900 - 0930 "To Saudi and Back: A Report of Psychiatric Casualties Evacuated From Operation Desert Shield/Desert Storm"
LTC Robert Hulsebus, PhD, Clinical Psychology Service, 97th General Hospital (Frankfurt), Germany

0930 - 1000	Break
1000 - 1130	"Mental Health Support in Saudi Arabia, Kuwait & Iraq" COL Joseph Fagan, MD, Psychiatry Consultant to the US Army Surgeon General, Office of the Surgeon General, Washington, D. C.
1130 - 1300	Lunch
1300 - 1500	"First Hand Experience in Operation Desert Shield/Desert Storm" MAJ William Rigby, PhD, (528th Medical Detachment (OM)), Clinical Psychology Service, Martin Army Community Hospital, Fort Benning, Georgia MAJ Linda Walker, PhD, (531st Medical Detachment (OM)), US Army Reserve, Westchester, Pennsylvania CPT Kathrine Stephens, PhD, (Ist Infantry Division (Mechanized)), Clinical Psychology Service, Irwin Army Community Hospital, Fort Riley, Kansas CPT James Picano, PsyD, (531st Medical Detachment (OM)), Clinical Psychology Service, Letterman Army Medical Center, Presidio of San Francisco, California CPT Don Azevedo, PhD, (101st Air Assault Division), Clinical Psychology Service, Blanchfield Army Community Hospital, Fort Campbell, Kentucky CPT Lange Coleman, PhD, (Ist Cavalry Division), Clinical Psychology Service, Darnall Army Community Hospital, Fort Hood, Texas CPT Michael West, PhD, (101st Air Assault Division), Clinical Psychology Service, Blanchfield Army Community Hospital, Fort Campbell, Kentucky
1500 - 1530	Break
1530 - 1600	"Human Response to Operation Desert Shield/Desert Storm: A Comprehensive, Multidisciplinary Community-Based Approach" MAJ Scott Fairchild, PsyD, Clinical Psychology Service, Womack Army Community Hospital, Fort Bragg, North Carolina
1600 - 1630	"Psychological Support to Body Handlers" LTC Dennis Kowal, Alexandria, Virginia MAJ Kenneth Rollins, PhD, Intelligence & Security Command, Arlington Hall Station, Virginia
1630 - 1700	"New Jersey Family Support During Operation Desert Shield/ Desert Storm" CPT Tamara Knapp, Community Mental Health Service, Walson Army Community Hospital, Fort Dix, New Jersey LTC Joan Kakascik, PhD, New Jersey National Guard

Wednesday - 5 June

0800 - 0930 "The Millon Clinical Multiaxial Inventory - II"
Dr. Theodore Millon, PhD, University of Miami, Miami, Florida; Professional Assessment Services, National Computer Systems, Minnetonka, Minnesota

0930 - 1000 Break

1000 - 1130 "The Millon Clinical Multiaxial Inventory - II"
Dr. Theodore Millon, PhD, University of Miami, Miami, Florida; Professional Assessment Services, National Computer Systems, Minnetonka, Minnesota

1130 - 1300 Lunch

1300 - 1700 "Consultation With the OTSG Clinical Psychology Consultant"
LTC(P) Gregory Laskow, PhD, Clinical Psychology Consultant To the US Army Surgeon General, Clinical Psychology Service, Walter Reed Army Medical Center, Washington, D. C.

Thursday - 6 June

0800 - 0930 "The Wechsler Adult Intelligence Scale - Revised (WAIS-R) As A Neuropsychological Instrument"
Dr. Edith F. Kaplan, PhD, Boston University School of Medicine, Boston, Massachusetts

0930 - 1000 Break

1000 - 1130 "The Wechsler Adult Intel'igence Scale - Revised (WAIS-R) As A Neuropsychological Instrument"
Dr. Edith F. Kaplan, PhD, Boston University School of Medicine, Boston, Massachusetts

1130 - 1300 Lunch

1300 - 1430 "Poster Session"

"Psychological Support - International Efforts"
LTC A. David Mangelsdorff, PhD, MPH, US Army Reserve, San Antonio, Texas

"Bulimia Nervosa"
LTC H. Frank Edwards, PhD, Clinical Psychology Service, 2d General Hospital (Landstuhl), Germany

"Chronic Headache Pain: Comparison of Nonpharmacologic Treatment With Prophylactic Pharmacological Treatment In An Active Duty Population"
MAJ Alan Halliday, MD, Neurology Service, Brooke Army Medical Center, San Antonio, Texas
CPT(P) James English, PsyD, Clinical Psychology Service, Brooke Army Medical Center, Fort Sam Houston, Texas

"Utilization of Mental Health Services In A Military Population"
MAJ Nancy Willcockson, PhD, US Army Reserve. Omaha, Nebraska

"New Psychometric Instruments for Alcoholism Treatment Planning"
MAJ John Allen, PhD, US Army Reserve, Vienna, Virginia

"Non-Leading Techniques in the Assessment of the Alleged Child Molest Victim"
MAJ Kathleen Mayers, PhD, US Army Reserve, Tacoma, Washington

"A Sentence Completion Task for Use with Psychotic Patients"
MAJ Kathleen Mayers, PhD, US Army Reserve, Tacoma, Washington

"An Investigation of the Relationship of Self-Report of Memory and Memory Test Performance"
CPT(P) Fred Brown, PhD, Clinical Psychology Service, Womack Army Community Hospital, Fort Bragg, North Carolina

"Health Enhancement, Weight Reduction, Remedial Fitness Training With An Inpatient Setting: A Two Year Study"
CPT Andrew Clifford, PhD, Community Mental Health Service, Reynolds Army Community Hospital, Fort Sill, Oklahoma

"Multidisciplinary Multimodal Assessment & Treatment Planning: The BASIC-ME Questionnaire"
CPT Andrew Clifford, PhD, Community Mental Health Service, Reynolds Army Community Hospital, Fort Sill, Oklahoma

"On Striving for 'Excellence'" A Board-Eligible Psychologist's Experience with the ABPP Preparation Course
CPT Mark Paris, PhD, Community Mental Health Service, DeWitt Army Community Hospital, Fort Belvoir, Virginia

"Stress Management--Taking It To The Troops"
CPT Hodges Glenn, PhD, Directorate of Mental Health, US Disciplinary Barracks, Fort Leavenworth, Kansas

1430 - 1500 Break

1500 - 1700 "Special Operations Psychology Symposium: Roles, Functions and Future Directions"
LTC Gary Greenfield, DSc, Fort Bragg, North Carolina (Symposium Moderator)
LTC Dennis Kowal, PhD, Alexandria, Virginia
MAJ Larry Lewis, PhD, John F. Kennedy Special Warfare Center, Fort Bragg, North Carolina
MAJ Kenneth Rollins, PhD, Intelligence & Security Command, Arlington Hall Station, Virginia
CPT Mark Lowry, PhD, 160th Aviation Battalion, Fort Campbell, Kentucky

Friday - 7 June

0800 - 0930 "Stress & Other Psychological Factors In the Etiology of Temporomandibular Joint Disorders"
Dr. John D. Rugh, PhD, University of Texas Health Sciences Center, San Antonio, Texas

0930 - 1000 Break

1000 - 1130 "Twenty Years Before the Bench: The Far Side of the Law"
COL John Shoberg, PhD, Exceptional Family Member Service, 5th General Hospital (Stuttgart), Germany

1130 - 1200 Evaluation/Closing Remarks
LTC Dennis J. Grill, PhD, Health Services Command Clinical Psychology Consultant, Community Mental Health Service, Brooke Army Medical Center, Fort Sam Houston, Texas
LTC(P) Gregory Laskow, PhD, Clinical Psychology Consultant To the US Army Surgeon General, Clinical Psychology Service, Walter Reed Army Medical Center, Washington, D. C.

COMBAT STRESS CONTROL TRAINING IN U.S. ARMY MEDICAL FIELD TRAINING EXERCISES

James M. Stokes
Academy of Health Sciences
Fort Sam Houston, Texas

The United States Army usually conducts one large-scale medical field exercise each summer. Since 1984, these Field Training Exercises (FTXs) have rotated among several Medical Brigades (headquarters units). Each of these FTXs has involved between 3000 and 9000 medical troops. The Medical Brigade Headquarters commands two or three Medical Group Headquarters. Each Medical Group controls two to four hospitals (usually Evacuation Hospitals, Combat Support Hospitals and Mobile Army Surgical Hospitals (MASHs). The hospitals do not come at full strength and usually are staffed for 50-100 medical/surgical beds.

Each Medical Group Headquarters also usually controls one or more Medical Clearing Companies (with from 50-100 of its 250 patient cots). The Medical Battalion, or an Evacuation Battalion Headquarters, also controls several helicopter and group ambulance companies and detachments.

Additional medical/surgical specialty detachments augment the hospitals. Preventive Medicine, Dental and Veterinary Detachments are assigned to the Medical Brigade or the Medical Groups to provide area support. Simulated and actual medical supply and logistics for the many medical units are provided, as they would be in a combat zone, by medical supply units.

In all of these FTXs since 1984, there has been at least one United States Army Reserve "OM" team (psychiatric medical detachment) to play the combat stress control mission. An OM team at full strength has 48 persons. It includes five psychiatrists, six social workers, two psychiatric nurses, a clinical psychologist, and enlisted psychiatric and behavioral sciences specialists and a few administrative support personnel. In practice, most OM teams have come to these FTXs with between 20 and 35 personnel (with at most only one psychiatrist and no psychologist). They have been augmented by volunteers from the other OM teams, and by active duty or United States Army Reserve occupational therapists (OT) and by OT enlisted specialists. The OTs have been especially eager to demonstrate their field role in promoting return to duty of battle fatigue casualties. The OM team also has some (but usually not enough) vehicles, tents, and equipment.

In most of the FTXs, the OM Teams have operated according to evolving U.S. Army Combat Stress Control (CSC) doctrine. The OM team's Headquarters has been assigned directly to the Medical Brigade Headquarters. The detachment has divided into smaller, dispersed teams. Depending upon the numbers of each professional discipline and the vehicles available, they have tried to provide CSC support to one or all of the subordinate Medical Groups in the brigade.

Because these FTXs have been played at the level of the Medical Brigade in support of a corps, the OM (CSC) detachment has had as one mission the staffing of a "Reconditioning Center." "Reconditioning," by definition, is the 4-14 day treatment of those battle fatigue casualties who do not return to duty in the first three days of restoration treatment. Reconditioning cannot be simulated in real time in a 4-5 day FTX. However, the staff can do the admissions workup and then go through the daily schedule of structured activities in "quicktime" or "time compression," where 10 minutes equals four or six hours.

In the FTXs, as in evolving doctrine, the OM (CSC) reconditioning facilities have been co-located with an Evacuation or Combat Support Hospital. They have been dependent on the hospital for food, water, fuel, medical records, and often for borrowed tents and cots. This is as it would be in real combat. The CSC teams must work out duty-sharing arrangements with the host hospital without letting their personnel and equipment be absorbed into that hospital; absorption would rightly happen to a hospital augmentation detachment like a neurosurgery team, but must not happen to a mobile CSC team.

Experience has shown that the reconditioning center is best set up in the hospital staff quarters area, near the kitchen, mess hall, laundry and motor pool. It should not be among the triage or ward tents, and must maintain a non-hospital, soldiering milieu. The simulating patient role-players can be assigned to assist the host hospital with real work details, as well as being fed, showered, rested in the cots, and involved in recreational, physical fitness and group debriefing activities.

In these FTXs, other subteams of the OM detachment are normally deployed to attach to one or more of the medical clearing companies under the Medical Battalion in the Medical Group(s). These teams usually attach to the medical company for support and remain with it 24 hours a day to triage, evaluate and provide restoration treatment for locally-generated battle fatigue cases (both simulated and "real"). "Restoration," by definition, is the actual 1-3 day initial treatment of battle fatigue soldiers and is best done at the medical treatment or clearing company closest to the soldier's own unit, not at a "hospital." Restoration requires a reasonably sized tent, preferably with cots, dedicated to the recovering battle fatigue casualties.

The CSC teams at the clearing companies also provide actual preventive consultation, education and case evaluations to the medical company and all other nearby units. In some FTXs, when there are too few CSC personnel to provide a continuous presence at the medical companies, the CSC team has instead provided a regular schedule of circuit-riding. The team spends the night at the OM team headquarters or reconditioning center (base camp), and drives to visit one clearing company in the morning, then on to another each afternoon. The teams are prepared to spend the night at a clearing company if workload or the tactical situation requires. In this situation, the patient holding sections and medical treatment teams of the clearing company are trained to manage and restore all but the problem cases. The problem cases are evaluated by the CSC team each day and, if necessary, are taken back to the Reconditioning (and Restoration) Center by the team as it completes its daily rounds.

The medical FTXs also routinely include non-medical combat support and combat service support units, especially signal battalions and detachments to set up and operate the communications equipment. Some FTXs have also had military police companies to provide rear area security and manage enemy prisoners of war. Engineer units may be available to assist with hospital site preparation and personnel replacement elements to coordinate the return to duty of simulated casualties.

At some of these FTXs, the U.S. Air Force provides C-141 and/or C-130 aircraft to conduct simulated air evacuation from the combat zone (taking off with the simulated patients, flying around and landing nearby so the patients can be "recycled"). The Air Force may also provide a Mobile Air Staging Facility (MASF) with medical and nursing staff to hold and prepare the patients for the flight. In the future, it may be possible to involve a Navy hospital ship in these exercises, but that has not yet been done.

A few of the FTXs in California and Mississippi have combined the Medical Brigade's exercises with the annual training of the state's National Guard division or separate brigade. In some instances, the maneuver brigade or division medical companies and organic battalion assets have been included in the medical evacuation play, to be discussed below. On those occasions, the OM team has fulfilled its "forward" combat stress control mission by sending mobile teams forward to reinforce the division and brigade medical companies.

The virtue of such large-scale medical exercises for training in Combat Stress Control is that they suggest the magnitude and complexity of the real combat mission. The FTXs illustrate the real-world problems of exercising command/control through multiple layers of headquarters, communicating with dispersed teams over other units' overworked and breakdown-prone field switch boards and radio nets, traveling and navigating to find unfamiliar units, and negotiating allocation or loan of scarce resources such as tents, food, water and vehicle maintenance. All of these problems must be overcome in the combat theater.

The big FTXs provide actual supported units and audiences for staff briefings, command consultation advice and preventive educational presentations. They may provide extensive simulated patient play, which can include simulated stress and neuropsychiatric cases. They also invariably provide actual overstressed soldiers who need individual case evaluation and, when appropriate, on-site treatment. Exercises of this size also always provide one or more true neuropsychiatric cases, usually with pre-existing disorder, who decompensate and must be evacuated to the supporting hospital system.

The shortfall of these FTXs is that, large as they are, they are still only a small-scale model of a real Army corps' area of operations. The medical units are not surrounded by the many more non-medical combat service support units with which they would be aggregated into Base Defense Areas and Base Defense Clusters. The real world distances between clusters would be much greater than can be achieved at some of the posts hosting the FTXs. The rear battle threat may be simulated by "opposing forces" attacks, but there is little real danger or difficulty when going from unit to unit, which may create a false sense of security. Still, such FTXs are much better preparation for learning to live and function in the field as part of a huge system than are purely individual or small unit training exercises.

The major medical FTX typically has between 300 and 600 personnel assigned to play the simulated casualties. The FTXs generally try to achieve a mixture of simulated surgical wounds and injuries plus non-battle diseases (including neuropsychiatric disorders), which conforms roughly to the expected incidences in mid/high intensity conflict. They may include battle fatigue casualties. Chemical casualties are usually included, and nuclear casualties may be. The source book for patient play is FM XXX. This manual provides make-up and acting instructions for each of the patient categories, plus model Field Medical Care (DA Form XXX) entries which specify vital signs and physical findings.

Role-players who are playing diseases or minor injuries can be briefed quickly at the FTX Patient Operations Center (POC). Those role-players who play having surgical wounds must receive extensive make-up ("moulage" from a trained "moulage team" at the POC). The make-up artists do a remarkable job of mimicking serious and even grossly deforming wounds.

The realism of the moulage is one of the factors (along with sleep loss, field sights, sounds and smells, and sometimes the sound of actual artillery firing in the distance) that has provoked distressing and even temporarily disabling post-traumatic stress symptoms in some medical personnel who have had previous combat experience in Vietnam or other conflicts. Such persons may self-present or be referred to the CSC teams for help dealing with the memories. Many more may simply "tough it out" and then perhaps decide to leave the Army, National Guard, or Reserves rather than face another painful training exercise. This is one of the reasons why the CSC teams have active and visible outreach programs.

Most of the simulated patients are picked up at the patient moulage center and taken directly to one of the medical treatment facilities by the helicopter or ground ambulances that are dispatched to transport them. A few patients may be taken by truck to remote field sites, where the ambulances must find them. The patient players in these FTXs may be made-up and sent out once, twice or even three times in a 12-hour shift. The number of times depends on the degree of make-up and the prognosis of the injury. Those who can be treated and released quickly, or who are "dead on arrival" or "die" soon after can be returned to the POC by a shuttle service and be recycled quickly. For the role-players, the experience can be tiring and uncomfortable. They are covered with make-up and prosthetic rubber or plastic, strapped to a litter, then transported in the summer heat in a vibrating helicopter or bouncing ground ambulance to one or more medical facilities where one may wait for minutes to hours to be examined; it is not an easy job.

The patient players are often members of another medical unit within the Medical Brigade's area (such as a General Hospital) that has been tasked to provide "patients" as its part in the FTX. These role-players usually serve for all 4-5 days of continuous scenario operations. They are "guaranteed" time for food and sleep, but that may be disrupted by transportation difficulties or the inhospitable field or barracks environment. In other FTXs, the patient players may be borrowed from the participating hospitals and other medical units on a day by day basis. When National Guard divisions or brigades have been involved in the FTX, some line unit soldiers may be declared casualties and be evacuated through their organic medical platoons and companies to the corps facilities, one time only. These soldiers will not have extensive moulage make-up unless a moulage team is deployed forward. In some FTXs, there may also be volunteer role-players from other organizations, such as the state's National Guard cadet

program. These details of where and how the role-players are obtained have proven very relevant to the real-world stress control missions of the CSC teams.

A recurrent finding is that both the role-players and the medical units become involved in the scenario portion of the FTX with enthusiasm. However, for the medical units, the novelty of realistically moulaged patients wears off after a while, as the triage and surgical teams can only pretend to start the IV's and insert the nasogastric and chest tubes, and only get to explain what surgical procedure they would be doing. As the triagers, OR teams and ward staffs themselves become progressively more sleep-deprived, hot, dirty, and uncomfortable, they become increasingly short with and even negligent towards the role-playing patients. That increases the stress and undermines the motivation of the already uncomfortable "patients."

Those role-players who have been assigned to serve the full duration of the FTX (and even some of the volunteers) begin to grow weary of the exercise. Some may actually require the attention of mental health workers for the transient "exercise fatigue" they suffer. They begin to find ways to delay or evade being made-up and sent out again. By the last night, a few may even become "combat refusers," flatly declaring to the POC (or telephoning home tearfully to family) that they will resign from the Army if forced to go out again as surgical patients. The result has been that the OM teams have performed excellent service "treating" the "battle fatigued" surgical moulage players.

Anecdotes from actual exercises help to underscore these experiences. During the Wounded Warrior FTX (1985), the OM team elements at the clearing companies established ongoing "ventilation/gripe" sessions for the surgical/medical role-players. These sessions were reported by the role-players as being very helpful to them. A memorable moment in the FTX occurred during a brief afternoon thundershower, when lightning struck a pine tree, which fell and barely missed the tent in which such a session was going on.

During the Dusty Bull FTX (1988), the OM team is credited by the 806th Medical Brigade with "saving" the FTX. The moulage role-players became very disgruntled by the evening of the fourth day, and the Corps surgeon and POC leader consulted the OM team. They immediately implemented the recommendations to call a temporary halt to give all role-players food and sleep. Meanwhile, the OM team sent a contingent on night convoy to the POC, and early in the morning initiated a concentrated schedule of debriefing sessions mixed with entertainment that had the role-players ready to continue the FTX soon after sunrise.

It should be apparent from the preceding discussion that the psychiatric (stress control) detachments can be fully and profitably occupied in these FTXs by concentrating on their real world preventive and treatment missions. Unlike the surgical teams (and like the dental, preventive medicine and veterinary food inspection teams), they have plenty of real world missions, provided they are proactive, mobile and helpful. They must not remain in their tents waiting for "patients" to be sent to them. Indeed the people who would send such cases to them (or come on their own behalf) are more likely to misunderstand and mistrust the mental health teams if those teams are relying only on their professional reputations.

In fact, too much simulated stress casualty play may actually be counter-productive. It may keep the mental health teams so busy (doing what they already know fairly well how to do) that they put off undertaking the new challenges of going out, meeting, and forming trusting professional relationships with all of the units that they should be supporting. They need to become fully familiar with the missions and stressors of the supported units.

With that warning said, the major medicine FTXs (especially the earlier ones--Dusty Bull 84 and 88, Wounded Warrior 85 and MEDEX 86), did have extensive simulated stress casualty play. A Mobile Training Team (MTT) from the Behavioral Sciences Division, Academy of Health Sciences, U.S. Army (San Antonio, Texas) was invited by the Medical Brigades to assist in training the OM teams and guiding their employment. The MTT was also to assure that a suitable number and variety of simulated battle fatigue and neuropsychiatric casualties were played.

The moulage source book, FM XXX, provides only a very few neuropsychiatric and combat stress roles (with sample field medical cards). The battle fatigue cases are mostly the dramatic (but actually rare) and problematic cases. The neuropsychiatric cases are also rather limited. For example, the alcoholic with impending delirium tremens has physical findings (such as a large and tender liver with ascites). That would be common, perhaps, in a big city hospital emergency room, but would not be typical of the heavy-drinking but otherwise successful Army NCO or officer, who might go into delirium tremens if he suddenly cuts back from his regular heavy daily drinking. The soldier-alcoholic's general health and physical fitness might appear good with only the more subtle signs of heavy alcohol use.

Each instruction sheet included the field medical card (DA Form XXX) entries and physical findings. It included general instructions to the role-players plus a checklist of recent stress events they should incorporate into their story about themselves. It gives specific instruction on what to do, how to look, and what to say, plus further instruction on how to change or not change based on how they are talked to and treated.

The battle fatigue cases have been written in sets of 20 cases. Each case is unique, but in each set there are three simple exhaustion/sleep deprivation cases, five with primarily anxiety symptoms, five with primarily depressive and/or survivor guilt symptoms, three variations on dissociative (memory loss) symptoms and four variations on conversion symptoms. This breakout still somewhat favors the dramatic and problematic end of the battle fatigue spectrum, at the expense of the more common exhausted, anxious and depressed forms. However, that shift is appropriate for corps-level or division rear-level exercises, where most of the simpler cases can be assumed to have been treated and released further forward.

The instructions have deliberately omitted the stereotypic "pseudo-psychotic," "acting out" and potential violent types of battle fatigue cases. This was done for two reasons. First, they are actually rare, and it is important to counteract that stereotype lest it become a self-fulfilling prophecy as soldiers become overly suggestible with battle fatigue. Second, there will always be a few role-players who will overact, or use this opportunity of playing a stress casualty as their license to play "psycho," in spite of warnings not to.

In addition to the sixty variations on battle fatigue, instructions have been written for neuropsychiatric cases, including a manic episode, paranoid schizophrenic-like psychoses, acute organic brain syndromes (atropine or anti-cholinergic type), alcohol withdrawal and other substance abuse problems. Some of these cases require additional administrative or legal action. Some of these cases do provide for the players to become threatening and disruptive. This will give the medical or psychiatric triagers/treaters opportunity to practice safe management and restraining techniques without erroneously targeting battle fatigue as the likely cause. The players of these roles must be strongly instructed not to continue their resistance to the point where they or others get hurt.

Interestingly, we observed a time when one of the non-violent battle fatigue cases--a soldier with psychogenic deafness who was pretending to be unable to hear instructions or questions--was wrestled to the ground and his eye glasses broken by over-zealous triage and security personnel who mistakenly identified him as either a "psycho" or an enemy infiltrator. All of the observer/controller personnel in the FTXs must be trained to intervene to prevent such unnecessary safety violations whether by the role-playing patient or the treaters.

Several "special cases" which involve misconduct combat stress behaviors and other legal issues have also been prepared as role-player instruction sheets. Examples are the soldier who confesses that the guilt he is feeling comes from having participated in commission of an atrocity or the "combat refuser" who describes having had a pacifistic religious conversion experience while under extreme stress. These cases provide training not only in clinical management, but also in the administrative actions that should be initiated and followed through the system.

The role-player instruction sheets are sufficiently detailed that a reasonably literate and motivated soldier could take one out of his pocket, read it carefully, and know how to play a fairly detailed case, using his imagination to fill in the necessary details. However, experience shows that it is best to invest more effort in the selection and training of battle fatigue and neuropsychiatric role players. If there are psychiatric nurses as members of the moulage team, they may be recruited and trained to choose only those role-players who are themselves mentally stable and able to act the part. Otherwise, members of the MTT must be detailed to do this.

FM 22-51

LEADER'S MANUAL FOR COMBAT STRESS CONTROL

FINAL DRAFT

THIS PUBLICATION IS FOR REVIEW PURPOSES ONLY.
IT DOES NOT CONTAIN ARMY APPROVED DOCTRINE.

HEADQUARTERS, DEPARTMENT OF THE ARMY

ACADEMY OF HEALTH SCIENCES
UNITED STATES ARMY
FORT SAM HOUSTON, TEXAS 78234-6100

JUNE 1991

TO SAUDI AND BACK: A PRELIMINARY REPORT OF PSYCHIATRIC CASUALTIES EVACUATED FROM OPERATION DESERT SHIELD

Robert C. Hulsebus, Ph.D., David Ruhland, Ph.D., Elizabeth E. Correnti, M.D., Frank P. Gonzales, Ph.D., Alice Nelson, M.A., M.Ed.
97th General Hospital
Frankfurt, Germany

This presentation describes how the medical evacuation for psychiatric casualties from Operation Desert Shield/Desert Storm was implemented and functioned. Medical support for this operation was unique in that the medical evacuation system was set up and had begun functioning effectively before the outbreak of hostilities. Another factor of importance was that there was very rapid deployment of regular military as well as reserve military units to Saudi Arabia. The 97th General Hospital is perhaps the major military hospital in the medical evacuation system in Europe. The 2nd General Hospital in Landstuhl and the Wiesbaden Air Force Hospital also receive psychiatric casualties. An evaluation program was established at the 97th General Hospital before the first psychiatric casualties arrived. Each patient was administered an MMPI-2 and Shipley and was interviewed by a psychologist or a psychiatrist. The interviews were designed to obtain data about the reason for evacuation, previous history of mental problems, involvement of alcohol, drugs, or medications, and to evaluate the diagnosis which the person had been given. Data presented included MMPI-2 values, Shipley scores, summaries of diagnostic groupings, comparison of initial and subsequent diagnoses, and demographic analyses.

Today I am going to describe our findings based on our evaluations of the psychiatrically evacuated soldiers who arrived at the 97th General Hospital from Operation Desert Storm/Desert Shield. Early in August, with the announcement of the decision to deploy U.S. Forces to Saudi Arabia to protect it from invasion, 7th Medical Command began planning for the medical evacuation of our soldiers from that region. There was considerable discussion about which medical personnel and units would be used in support of the operation. The plan which evolved was to use the Army hospitals in Frankfurt, Landstuhl, and Nuernburg as the primary receiving hospitals for medical evacuation. Since the 97th General Hospital was located near the Rhein-Main Air Base, we anticipated that it would receive the majority of medical and psychiatric casualties; in fact that is what happened.

There were several factors which led to our decision to conduct this study. We were interested in what the characteristics of our psychiatric casualties might be. Since this would be the first war wherein we would be able to plan for medical support and evacuation well before the onset of hostilities, we realized that this presented a unique opportunity to psychometrically evaluate psychiatric casualties much closer in time to the development of psychiatric symptoms than may have been done in previous wars. We believe that this was the case with American casualties at least. We had been using the MMPI-2 within our service for the previous year and we were interested in combining it with other measures in the assessment of these casualties.

Since we did not know what numbers to expect nor how long they might stay at the 97th, we developed a brief screening interview format. The information gathered was designed to be relevant to evaluation and treatment; it could also be used in the evaluation of how clinical services were provided. We followed the standard procedures we use in the evaluation of our patients. These patients were asked to fill out a patient data form, the Privacy Act Form, and the Psychology Service Limits of Confidentiality Form. Participation was voluntary; if a patient refused to take part, he was not assessed. Fewer than four refused to take part in our evaluation. Because of the potential numbers of such individuals, we decided to limit our assessment to the MMPI-2, a Shipley, and a screening interview by a psychologist or a psychiatrist. Later, as the workload increased, our behavioral science specialists assisted in the interviews. We were very fortunate in having exceptionally talented and dedicated individuals serving as behavioral science specialists--SSG Nick Elliotte, our NCOIC, CPL Frank Sires and PFC Craig Wheeler along with SGT Lisa Williams, a reserve 91G from Wisconsin, performed in a superb manner as they tested these patients.

Our knowledge about the importance of how medical evacuation is conducted began with our experience in the First World War. After that war our planners realized that soldiers who had been evacuated to hospitals closer to the front lines were able to be returned as effective soldiers at a significantly higher rate than were soldiers who were medically evacuated farther back from the front lines. Our experiences with psychiatric and medical casualties in subsequent wars were consistent with these findings. The principles of Proximity, Immediacy, and Expectancy have come to characterize our planning for medical/psychiatric support and evacuation from fighting. From our perspective at the 97th where we were farther back in the evacuation chain, it appeared that medical evacuation did not work in the manner it should have. Instead of being able to return the soldiers to Saudi Arabia, the system took the great majority back to CONUS. The evacuation system did not seem able to return soldiers to their units. Information which filtered back to us indicated that these soldiers were not wanted back in the theater. There are several perspectives which can be taken in examining this change. One is that during Desert Shield, units did not want to be involved with soldiers whose behaviors led to their evacuation for medical reasons. From another perspective, located so far to the rear, our patients may have been considered to be too far back to easily be returned to their units. Another consideration is the priority which may have been assigned to moving units, equipment, and individual soldiers back to Saudi Arabia.

The results are interesting. A total of 138 service members were psychiatrically evacuated through the 97th General Hospital during Operation Desert Shield/Desert Storm. Eighty two percent of them were evacuated during Desert Shield and 18% during Desert Storm. Of these, 114 were males and 24 were females. The racial composition was 70% Caucasian, 25% Black, 2% Hispanic and 2% American Indian. A broad age range was represented; the modal age was 20 years and the median age was 26 years. Looking at the branches of service, 52% were from the Army, 24% were from the Navy, 10% were from the Air Force and 13% were Marines. The modal rank was specialist fourth class, with the ranks ranging up to the level of colonel. When we examined the percentage of regular forces, reserves, and national guard components we found that 87% were Regular Army (Navy,etc.), 7% were from reserve components and 5% were from national guard units.

Table 1 portrays the initial range of admission diagnoses with which the casualties arrived at our hospital. The two largest groups were Adjustment Disorders and Major Depression; together they constituted over half of these diagnoses. The next two largest groups were Other Psychoses and Character Disorders. Table 2 presents the Axis I discharge diagnoses. Again, Adjustment Disorders and Major Depressions constituted just over half of all discharge diagnoses. The third largest category was Other Psychoses; Alcohol Dependence, Anxiety Disorders, and Other diagnoses were equally represented. The diagnosis of Bipolar Disorder is the smallest category. Table 3 reveals the distribution of discharge diagnoses on Axis II of the DSM III-R. Personality disorder diagnoses were made on 12% and the category of "other" was made on 5%. In the "other" category were Bulimia, Anorexia, PTSD, and Obsessive-Compulsive Disorders. A comparison of these three tables reveals that over the course of stay in our facility there were relatively minor shifts of distributions among the diagnostic groupings.

In our interviews we asked whether the patient had made a suicide gesture/attempt before being medically evacuated from Saudi, whether he or she had been hospitalized previously for psychiatric reasons, if he or she had received psychological/psychiatric treatment, if he or she had been psychologically tested before, and if the individual had had previous treatment for alcohol abuse/dependence. With regard to the issue of having made a suicide gesture/attempt, 9% of them said they had done so. Previous psychiatric hospitalizations were acknowledged by 14%. Twenty nine percent had received some form of psychological treatment. Previous psychological testing was administered to 9%. In response to the question of prior treatment for alcohol problems, 5% stated that they had received such treatment.

From the results of the MMPI-2 administrations three figures portray the information which seemed to us to be most interesting and important. The MMPI raw scores were given the standard K correction and transformed into T scores which were then plotted. The data for the males and females were combined when they were plotted. There were too few females in some of the groups to make the results graphically meaningful. With the results of combining the data, the elevations on scale 5 would not seem to be meaningful.

Figure 1 compares the MMPI profiles of those who were medically evacuated to CONUS with those who were returned to duty, either to Saudi Arabia or elsewhere. There were 112 individuals who returned to CONUS and 20 who were returned to duty. There were six individuals who did not have MMPI-2s administered for one reason or another. At times these patients were in the hospital for only a day before being moved to CONUS. The CONUS evacuees' profiles had a 2768 configuration which was clearly different from the duty returnees' profiles. The differences extend to both the validity scales and the supplementary scales.

Figure 2 portrays the mean MMPI-2 profiles for those with Major Depression and Adjustment Disorders. The numbers in these two groups are essentially equivalent. The validity scale configurations are similar for each group and the clinical scale patterns are very similar, with the depressed group means clearly higher than the adjustment group means.

Figure 3 displays the profiles of the group which engaged in suicide gestures with those who did not engage in gestures. Evaluation of the interviews revealed that in each of these cases a gesture and not an attempt was made. Comparison of the validity scales reveals that the F scores of the gesture group was 10 points higher than for the nongesture group. There is a clear and consistent difference in scale elevations across the clinical scales.

During our study other interesting findings emerged. The reasons for these findings are open to conjecture. They are listed below.

1. There were no changes over time in the marked trend of returning soldiers to CONUS.

2. Service members who had children did not return to duty.

3. Those who had made suicide gestures scored higher on the intelligence measure than those who had not made gestures.

In summary, this paper reviews the evaluation of psychiatric casualties evacuated through the 97th General Hospital. In the majority of cases involving casualties judged capable of returning to duty in Saudia Arabia, we were not able to have them returned. Comparisons of the diagnostic groupings of all of the casualties revealed that the two largest groups were adjustment disorder and major depression. Prior histories of psychological problems were noted in a significant number of patients. A small proportion engaged in suicidal gestures before being medically evacuated. The MMPI-2 results were clearly different for the two major diagnostic groups, for those medically evacuated to CONUS as compared to those returned to duty, and between those who engaged in suicide gestures and those who did not.

Table 1. Distribution of Admission Diagnoses of Psychiatric Casualties, DSM III-R.

Adjustment Disorder	28%	Alcohol Dependence	5%
Major Depression	25	Anxiety Disorder	6
Bipolar Disorder	6	Character Disorder	11
Other Psychosis	17		
			N=122/138

Table 2. Distribution of Discharge Diagnoses-Axis I, DSM III-R.

Adjustment Disorder	32%	Alcohol Dependence	7%
Major Depression	23	Anxiety Disorder	7
Bipolar Disorder	4	Other	7
Other Psychosis	10	No Diagnosis	11
			N=124/138

Table 3. Distribution of Discharge Diagnoses-Axis II, DSM III-R.

Personality Disorder	12%
Other	5
None	83
	N=131/138

Figure 1 MMPI profile

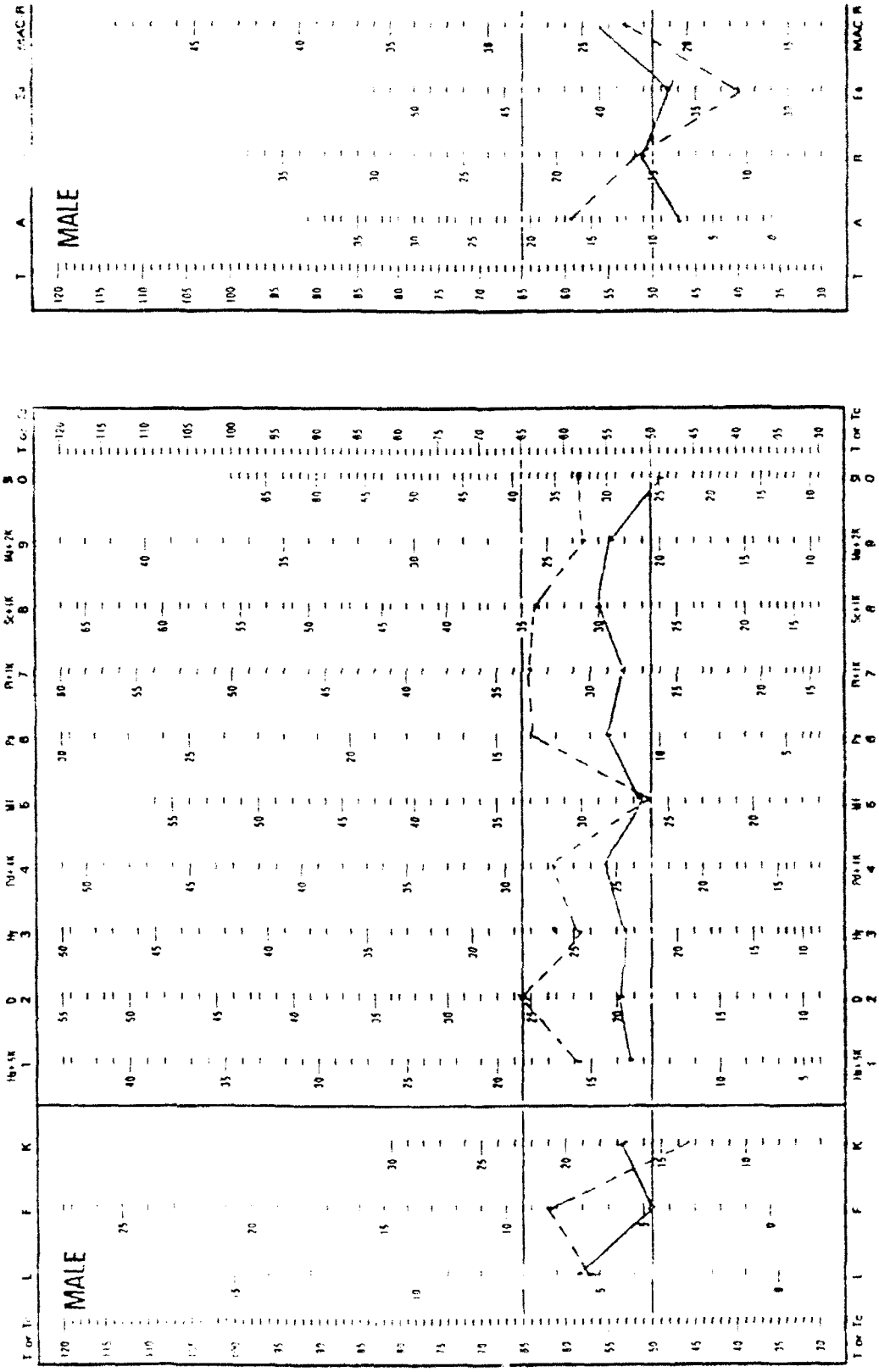

Figure 1. MMPI-2 mean profiles for medically evacuated to the United States(---)(N=112) and those returned to duty(—)(N=20).

Figure 2 MMPI profile

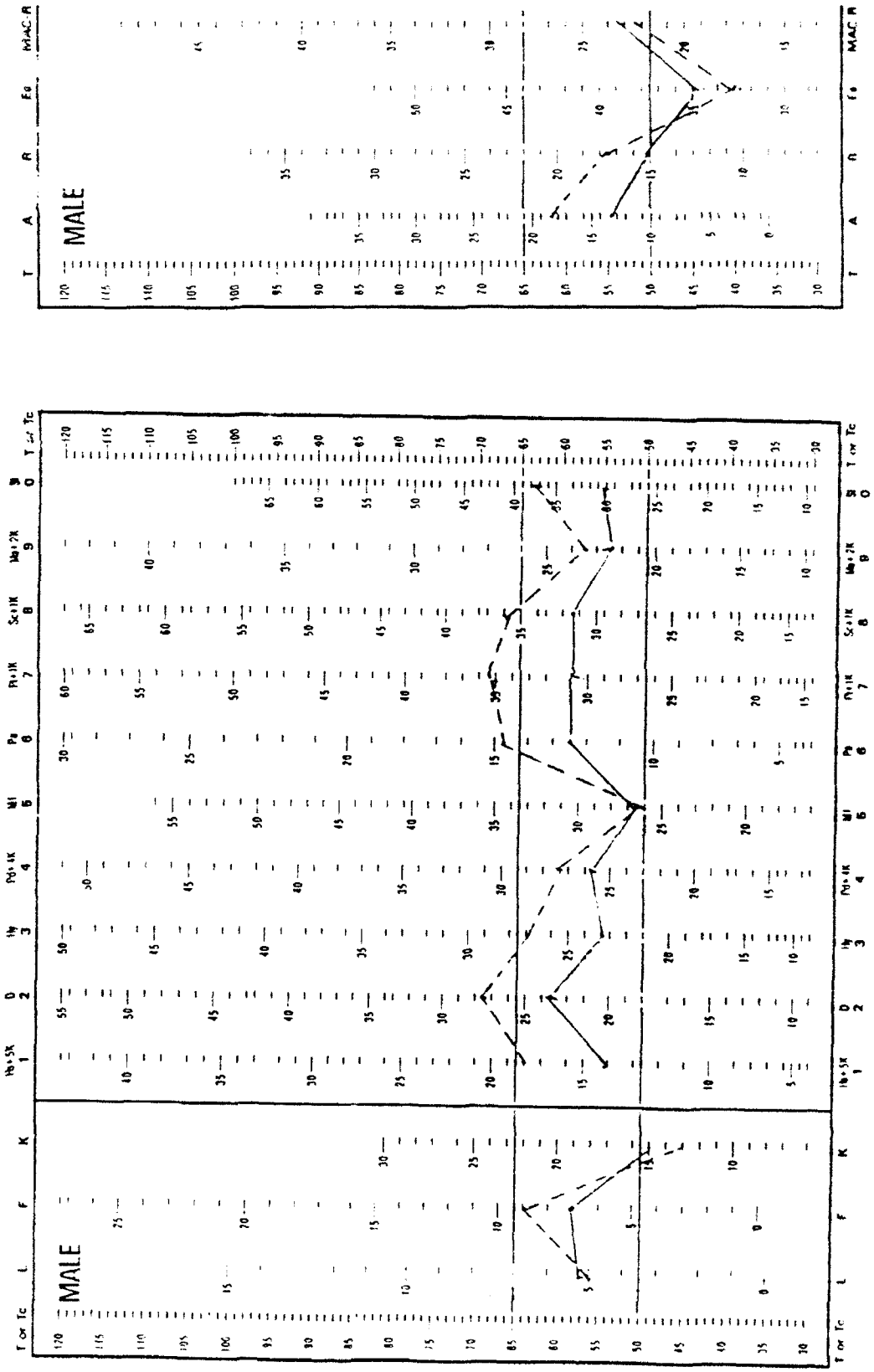

Figure 2. MMPI-2 mean profiles for those with diagnoses of Depression (---)(N=31) and Adjustment Disorder (—)(N=34).

Figure 3 MMPI profile

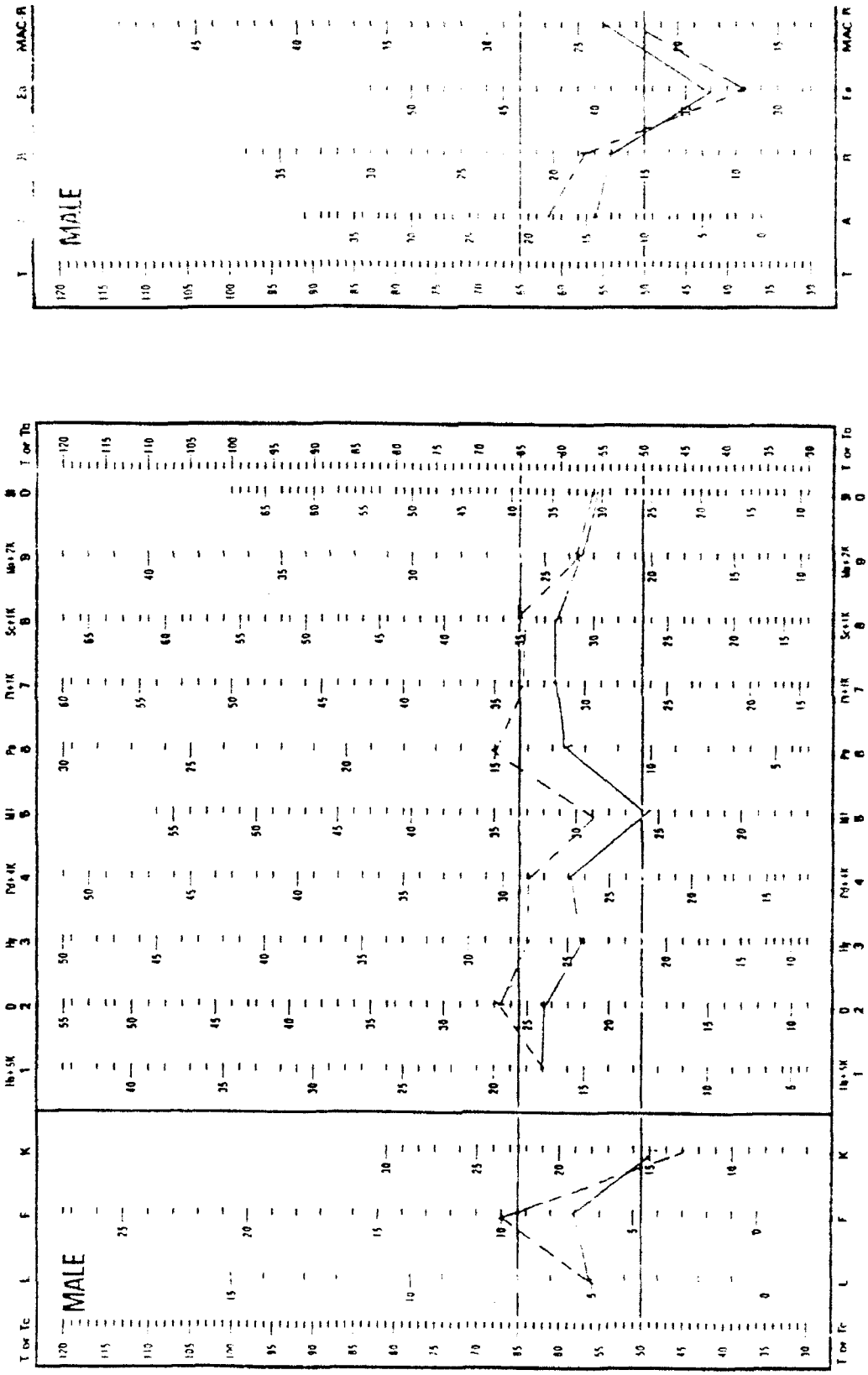

Figure 3. MMPI-2 mean profiles for servicemembers with suicide gestures (——) (N=12) and those with no suicide gestures (——) (N=125).

SUMMARY OF LESSONS LEARNED IN PROVIDING MENTAL HEALTH CARE TO SOLDIERS DURING OPERATION DESERT SHIELD AND OPERATION DESERT STORM

Katherine J. Stephens, Psy.D.
1st Infantry Division
Fort Riley, Kansas

This paper is a summary of comments provided by the following mental health professionals who served in the Persian Gulf War: MAJ Linda Walker, OM Psychologist, 531st Medical Detachment; CPT Jim Picano, OM Psychologist, 531st Medical Detachment; CPT Katherine Stephens, Division Psychologist, First Infantry Division; CPT Mike West, Division Psychologist, 101st Air Assault Division; and CPT Joe Pecko, Division Social Worker, 82nd Airborne Division.

I was unable to interview CPT Gary Southwell or CPT Danny Clark, active duty psychologists now in Germany, who also served as Division Psychologists during Operations Desert Shield and Desert Storm. Also, CPT Don Azevedo, Division Psychologist, 101st Air Assault Division, CPT Gary Hazelit, Division Psychologist, 82nd Airborne Division, and CPT Shirley Corsbie, Division Psychologist, 24th Infantry Division, served during the war, but have since left active duty and were not available for comment.

COMMUNICATIONS

Communications were very good in the 82nd Airborne Division according to CPT Pecko. He reported that subdividing DMHS assets and moving them forward into the brigades helped to facilitate communications, allowing more direct contacts with commanders. Communications rearward were not problematic. In fact, prior to the war, they had maintained communications with the 101st Air Assault Division and the 24th Infantry Division.

CPT West of the 101st Air Assault Division reported poor communications. There were no telecommunications with other units. In addition, there were difficulties with communications between echelons of care, creating some confusion as to who was supposed to be backing them up.

MAJ Walker of the 531st Medical Detachment OM team reported communications were facilitated by his commander, a psychiatrist who had worked with the State Department and was knowledgeable about how to deal within the power hierarchies. Communications were conducted primarily by the psychiatrist through the company TOC, although the equipment was at times faulty and interfered with making outside contacts.

CPT Picano, also of the 531st OM team, reported that communications difficulties were major issues in the theater for his consultation team. Because the OM team was split up into four separate consultation teams, the communications problems made it impossible to make contacts with the commander or with medical teams. Fortunately, CPT Picano's team ended up situated near a LOG base where they were close enough to the surrounding units that physical contact was possible. He recommended consideration of having adequate communication equipment organic to each of the four OM consultation teams.

CPT Stephens reported variable success with communications in the First Infantry Division. Much was dictated by the tactical position of the Division. During periods of rapid mobilization, communications were temporarily shut down, although it appeared that communications were one of the first priorities upon setting up at the new sites. The radios available in the Division functioned inefficiently much of the time. Connections tended to be poor. The primary method of communication was written, using the DA Form 3822R (Report of Mental Status), and sending it forward with the unit escort or medical transportation. Commanders tended to send written requests with their soldiers to the DMHS. Generally, this form of communication was adequate, although better radio equipment would have made consultations more efficient.

TRANSPORTATION

CPT Pecko reported that the Division provided his team with one vehicle, even though a vehicle was not authorized according to MTOE documents. He reported that a good working relationship with the medical company commander was imperative, as it was the commander who authorized the use of the vehicle. CPT Pecko believed that, ideally, there should be one vehicle per brigade (a total of three for the 82nd Airborne Division). In spite of the perceived shortages of vehicles, he reported that transportation proved to be no problem in light of the limited number of battle fatigue casualties. In addition, he reported that the mental health teams were situated close enough to the battalions that it was easy to travel to units to see individuals and to do preventive work.

CPT West reported that the DMHS at the 101st was not allotted a vehicle according to the MTOE. He believed the MTOE needs to be updated and he has requested that three HUMMV's be included in a revised document. He also pointed out that the doctrine concerning return to duty for battle fatigue casualties needs revision. He reported that, according to Geneva Conventions, medical vehicles are not authorized to transport stress casualties. However, utilizing supply vehicles to return soldiers to duty proved to be impractical, as they tended to be moving too far forward to maintain contact.

MAJ Walker reported that the OM consultation team of which she was a part had one pickup truck and one other vehicle, neither of which were in good mechanical condition. In fact, utilization of the vehicles generally had to be reserved strictly for mobilization because of their inefficiency and unreliability. As a result, MAJ Walker reported that her team was unable to do as many unit consultations as they would have liked. As the unit mission increased in scope (opening a 20 bed inpatient unit), and in personnel (2 additional 91Gs) the space provided by these two vehicles became insufficient. The team innovated by building a cabinet on one of the vehicles which allowed them to store equipment higher. She added that, while other units were able to take their personnel into the local community for R and R activities, soldiers in her team were not allowed to do so because of the poor vehicles. She believed this negatively affected morale within the unit.

CPT Picano reported feeling fortunate that his OM consultation team had a sufficient number (2) of well-serviced vehicles. He gave credit for transportation efficiency to the unit's maintenance personnel and to the executive officer who made vehicle maintenance a priority.

CPT Stephens reported having no vehicles authorized according to the MTOE. Vehicles were borrowed from the medical platoon, although vehicles were generally scarce in the entire medical company. As a result, consultation to forward units was limited and much of the preventive work which could have been accomplished was missed. Generally, professionals were required to "hitch rides" with ambulances or other medical vehicles going forward.

PERSONNEL RESOURCES

The 82nd Airborne Division DMHS was staffed by one psychiatrist, one psychologist, one social worker, and six behavioral science specialists. CPT Pecko believed the number of personnel was sufficient for their mission. He reported that they attempted to follow battlefield psychiatry principles by establishing far forward division of assets. In order to accomplish this, the DMHS staff was divided into three teams, each of which supported one of the three major brigades. Team 1 consisted of one psychologist and one 91G; Team 2 consisted of one social work officer and one 91G; and Team 3 consisted of one senior 91G and one junior enlisted 91G. The psychiatrist and two 91Gs were located centrally at the rear of the division. CPT Pecko believed dividing assets in this manner worked well, as each team deployed with its assigned brigade, allowing the command to easily identify mental health personnel, and allowing the mental health personnel to assess the unique needs of each brigade. Each team was responsible for providing mental health services to its individual brigade, as necessary. In retrospect, the social work officer believed the assets assigned to the rear of the division were underutilized in that position and would have functioned better had they been situated farther forward. He believed the professional and paraprofessional staff was well-trained, particularly because of their recent preparation for Operation Just Cause. He reported 91G training was ongoing throughout the Desert Shield/Storm deployment.

CPT West also believed personnel resources were adequate for the way the 101st DMHS was set up. However, he reported greater success was achieved by keeping the DMHS intact at one location in the HQ Company of the Main Support Battalion. The 101st DMHS consisted of one psychiatrist, one psychologist (although at one point there were two psychologists in theater, during transition from the MEDDAC psychologist to the Division psychologist), one social work officer and six to seven 91Gs. He reported that, although doctrine appears to support dividing assets to send out to forward units, his mission was performed more efficiently the way they were set up.

MAJ Walker reported that the number of staff members on the OM team was adequate. The team consisted of one psychiatrist, one psychologist, and five 91Gs (later, they were supplemented with two additional 91Gs). MAJ Walker expressed concerns about the training of the paraprofessionals. She reported variable skills, with two NCOs producing very good work, some producing mediocre work, and some of the more junior enlisted, having questionable skills. She believed the advice some of the less seasoned 91Gs gave during briefings was inappropriate, in particular it was difficult to determine the line between professional behavior and speaking as a "buddy" to fellow soldiers. MAJ Walker questioned some of the consequences of paraprofessional interventions and added that all mental health personnel should be carefully screened in order to insure their psychological functioning was intact.

CPT Picano reported that his staff consisted of one psychiatrist, one psychologist, one social work officer, one psychiatric nurse, and six paraprofessionals (approximately two 91Gs and four 91Fs) and was adequate for the mission. Nevertheless, he recommended closer scrutiny of professional credentials in order to insure that providers are equipped with the proper clinical training and experience. Within the 531st Reserve OM team, professionals who specialized in administrative work rather than clinical work, had difficulty functioning in the clinician role. CPT Picano believed professionals should be credentialed as though they were to provide care in a typical military treatment facility.

The staff of the DMHS at the First Infantry Division consisted of one psychiatrist, one psychologist, one social work officer, and four 91Gs (two of whom were located centrally with the professional staff within the medical company of the Main Support Battalion, while the other two were divided to serve individually in support of the two Forward Support Battalions organic to the two major brigades of the division). Fort Riley doctrine has held that the two forward paraprofessionals will serve within their Forward Support Battalions during all training, to include REFORGER, NTC, and FTX training. This seems to work well, as the forward units have, for several years, been accustomed to having mental health services with them. In addition, the competence of the two forward 91Gs was exceptional and both paraprofessionals were able to intercept, screen, and properly treat forward soldiers, thus supporting the DMHS mission of preventing over-evacuation. All referrals rearward by these two NCOs to the DMHS were appropriate. The NCOIC of the DMHS in the Main Support Battalion did an outstanding job as well, and brought years of experience in coordinating the establishment of mental health services within the battalion's medical company. He had also trained extensively during various field training exercises with the medical company. CPT Stephens reported some difficulties with the training and the level of competence of one of the junior enlisted 91Gs. In spite of several attempts to enhance the clinical skills of this junior 91G, both in garrison and throughout operations in theater, this 91G proved unmotivated to further training. CPT Stephens believes this is a major problem with the Army 91G program. She recommends an OJT program similar to the one utilized in the Air Force in which 91Gs are required to master certain clearly outlined skills (such as demonstrating psychological testing skills, reading designated literature, and demonstrating advanced interviewing skills) before being allowed to pass to the next skill level or to the next rank. CPT Stephens stressed the importance of field training experiences for 91Gs wherein personnel actively train with the medical companies they will serve in combat situations. In addition, she recommends assignment of two additional 91Gs which are, reportedly, provided for in the updated MTOE.

PSYCHOLOGICAL TESTING

CPT Pecko was unable to discuss the extent of psychological testing in detail, although he did report that CPT Hazelit did administer some testing, he believed, to include some neuropsychological testing. He reported that the DMHS did not bring the field testing kit with them, but CPT Hazelit brought his own supply of equipment to use in theater.

CPT West stated that psychological testing is definitely needed, although not during the heat of battle. He reported that the testing kit in the 101st's DMHS was outdated and the equipment he and the MEDDAC psychologist used was provided by the MEDDAC. In addition, they used a modified form of a hyperthermia index provided to them by WRAMC. He recommended the following updates: WAIS-R, WAIS-R (NS), Shipley Institute of Living Scale, Digit Symbol Modalities Test, Trail Making Parts A and B, MMPI, and Rorschach. He believed updates should include instruments which are sensitive to organic mental syndromes.

MAJ Walker reported that she did not administer psychological testing for two reasons. First, she reported the equipment was outdated, and second, that she did not find testing to be necessary (or even possible) during rapid mobilization forward. However, she reported that brief screening instruments would have been helpful while the team was more stationary at the HQ Company and while soldiers were being evaluated and treated on the psychiatry ward. She recommended a laptop computer for facilitating quicker, more efficient evaluations. In addition, she recommended updates to the testing kit in her unit to include the Shipley Institute of Living Scale and the MMPI. Overall, she believed there was not much call for testing in her situation, reporting that 72 hour rest and replenishment proved to be sufficient in most cases.

CPT Picano reported the outdated testing kits were useless to him. He recommended state-of-the-art equipment be included, suggesting a laptop computer with NCS software which could be loaded and purchased on a per-use basis. He recommended including automated neuropsychological batteries, as well as brief screening instruments such as the Hopkins Checklist or SCL 90. He was unsure about whether to recommend instruments such as the Rorschach and was generally reluctant to utilize psychological testing because he wanted to avoid instilling the notion of psychiatric pathology. He preferred a combat stress model of diagnosis and treatment which is more in line with battlefield doctrine, as opposed to a psychiatric model.

CPT Stephens reported utilizing psychological testing frequently, with approximately 20 to 30 percent of the soldiers being evaluated at the DMHS. She believes psychological testing had several uses within the theater, the primary of which involved utilizing the evaluation and feedback to soldiers therapeutically. She discovered that, contrary to the proposed literature, personality factors do seem to have an impact on how the individual soldier manifests reactions to extreme stress. In addition, the nature of surviving in such isolated conditions in the desert created a climate for soldiers to begin engaging in increased self-inspection. Engaging in psychological assessments while reconstituting in the Main Support Battalion for two to three days, appeared beneficial to soldiers and seemed to offer a way to enhance their lives. Interestingly, there was one soldier who was minimizing his emotional reactions to observing members of his unit killed in a tank explosion who, during projective testing (Rorschach) was able to relax his defenses sufficiently to begin projecting the destruction he had witnessed onto one of the cards. This situation allowed for a speedy breakthrough and a quicker recovery for this soldier, according to CPT Stephens. In addition, there were several diagnostic dilemmas with differentiating normal or severe battle fatigue reactions from psychiatric pathology which were resolved as a result of the scientific approach of testing. Finally, she believed the testing data she obtained in theater furthered her knowledge of battle fatigue reactions, which she feels is a legitimate use of psychological testing. It was CPT Stephens'

recommendation that psychologists use all tools available to them in order to better understand the soldier, to include psychological testing data. The three testing kits in the division were all outdated. Although recommendations for updates had been forwarded, funding was redistributed when the announcement of deployment came. During deployment, CPT Stephens emptied the kits and restocked them with the following equipment provided by MEDDAC: WAIS-R, Shipley Institute of Living Scale, Wechsler Memory Scale (Russell's), Rey Auditory-Verbal Learning Test, Wide Range Achievement Test-Revised, Beck Depression Inventory, Beck Hopelessness Scale, Sensory-Perceptual Examination, Incomplete Sentences Blank (Rotter), Millon Clinical Multiaxial Inventory, MMPI-2, and Rorschach. In addition, she utilized neuropsychological screening procedures from Strub and Black's The Mental Status Examination in Neurology. She reported that the MMPI-2 was inefficient without computerized scoring and the the MCMI would have been more efficient with computer scoring. She believed it was essential that 91Gs be properly trained in administration and scoring of testing, allowing for better utilization of professional time. In cases of longer deployments, she recommends including field expedient forms of the Halstead-Reitan Neuropsychological Test Battery.

SURVIVAL TACTICS

CPT Pecko reported that, as a whole, the DMHS was well-prepared to survive in the desert due to the extensive, ongoing training of the 82nd Airborne Division and past experiences in training for Operation Just Cause. He believed he had the basic necessities for survival, knowing how to quickly dig foxholes and protect himself from incoming rounds for, example. He added that he should have packed a few more personal comfort items such as binoculars and something with which to boil water.

CPT West reported that he had just graduated from the Officer Basic Course at the time of deployment and, since he knew he was going to deploy, he paid careful attention to training on survival tactics. As a result, he felt well-prepared. He reported one of the most difficult situations was in learning how the 101st Air Assault Division was set up in theater, as the Basic Course could not provide him with an adequate understanding of this unique division. He believed this was to be expected in most situations. He added that knowing one's chain of command is particularly important.

MAJ Walker reported that she had been with her reserve unit for four years and had very few practical experiences which could have prepared her for survival during combat situations. She reported that she had some CTT training and had previously fired her weapon during FTXs, but she reported the majority of her knowledge had come from attending AMEDD psychology short courses, from her time on active duty, and from her own reading.

CPT Picano reported that he had graduated from the Officer Advanced Course 18 months earlier and that this training had taught him to know what to do to survive during the combat situation. He believed field training experiences are necessary for all military mental health personnel. He believed that going directly from a MEDCEN to a combat environment without the training provided to him at the advanced course could have created problems with survival.

CPT Stephens believed she was well-prepared in survival tactics, having trained for almost three years with the First Infantry Division's Main Support Battalion during several field training exercises. She believed it was imperative to practice with CTT skills as much as possible, to regularly fire one's weapon at the range, and to test confidence in chemical gear in gas chambers. In addition, she believed EFMB training helped to further enhance survival skills. She would not recommend that individuals who had not had a sufficient amount of field experience serve in combat environments unless they were able to go through a fairly intense refresher course. Ideally, all military mental health personnel would be trained to be prepared to move into combat situations at all times, in her opinion.

BATTLEFIELD PSYCHIATRY PRINCIPLES AND PHILOSOPHY

CPT Pecko believed that the practice of providing mental health services as far forward as possible was most effective. He explained that, within the theater, operations were quick moving and DMHS assets could not afford to be stationary far to the rear if they were to be effective. He stressed preventive programs as the primary method of intervention, mentioning the battle fatigue briefings, stress management courses, and other educational groups which were well received within the 82nd Airborne Division. Every effort was made to evaluate and treat soldiers in the theater and evacuations were minimal (5). Incident rates dropped to approximately one third of those typically seen in garrison, and were even lower during the air war and ground war phases. His group concluded that classic battlefield psychiatry principles emphasizing unit cohesion and positive identification with an elite division contributed to the lower number of incidents. In addition, the brief nature of the combat and the high success rate further offset the rate of casualties. They believed the non-availability of alcohol in the desert was positive, and decreased the numbers of cases of soldiers experiencing fights, accidents, depression, insomnia, and other difficulties typically associated with alcohol abuse. Their group believed this finding supported the aims of the Army in attempting to decrease alcohol misuse in garrison. CPT Pecko reported that continuous training exercises, to include ranges were important in decreasing soldiers' boredom. He added that additional medical training proved helpful and he recommended that mental health personnel train in EMT and EFB skills in addition to clinical skills in order to further assist with the medical missions at hand. In general, he agreed with the doctrine of emphasizing continuous training for combat missions while in garrison. He also reported that the majority of the casualties treated within his brigade involved Iraqi civilians, and he assisted in conducting debriefings to natives in refugee camps with the help of an interpreter. This experience seemed to support the notion of maintaining flexibility of services provided by DMHS depending on unique situations which may present themselves during the course of combat.

CPT West believed the battlefield psychiatry principles we have developed to this point are sound. However, he reported that he experienced difficulties with some PROFIS physicians who continued to attempt to work according to typical hospital psychiatry principles and had problems with adhering to the doctrine suggesting brief intervention and speedy return to duty of battle fatigued soldiers. He suggested that the PROFIS physicians avoid thinking about stressed soldiers from a long-term treatment standpoint, and focus instead on basic skills, brief assessments, and brief interventions. In

addition, he emphasized the importance of maintaining a primary preventive model as opposed to psychiatric mode.

MAJ Walker felt that training in basic soldiering skills, including the proper use of the military chain of command, was imperative to functioning during combat.

CPT Picano believes that the principles of battlefield psychiatry are good, as they outline how battle fatigued soldiers can be handled in a straightforward manner. He thinks that viewing the provision of mental health services in combat and in preparing for combat from a human factors standpoint rather than in terms of a medical model of pathology, is preferred. For example, developing methods of enhancing performance, dealing with the impact of over-stimulation or under-stimulation, or assessing the effects of fatigue during continuous nighttime operations, would be more fruitful, especially in light of the highly technological Army today. CPT Picano emphasized flexibility in applying battlefield psychiatry principles, as he believes the psychological reactions to stress are changing even as treatment technologies advance.

CPT Stephens believed the principles of battlefield psychiatry which emphasize far forward treatment appear sound. She reported a community psychiatry approach is most consistent with the idea of keeping soldiers integrated within their military environments as much as possible. The 24- to 72-hour holding limitations in the DMHS, where a milit y atmosphere was maintained as much as possible, appeared appropriate in the majority of cases, with nearly all soldiers quickly reconstituting and subsequently wishing to return to their units as quickly as possible. The majority of commanders and First Sergeants, as well as NCOs and junior enlisted supervisors appeared to be sensitive to the unique needs of the soldiers under their supervision and were prepared to counsel their subordinates, when indicated. In most instances, it appeared that talking with one's peers or, if further intervention was needed, following one's chain of command worked well. Seeking professional treatment at the DMHS was generally a last resort. CPT Stephens believes bolstering the knowledge of battle fatigue and basic counseling skills are worthwhile and will enhance the effectiveness of the military chain of command. She recommends that professional military leadership courses continue to instruct new leaders in preventive mental health issues. Both in garrison and during combat, she found it was extremely important for soldiers to be able to adapt socially within their units. Soldiers who had difficulties with interpersonal functioning seemed to fare worse than those who had developed adequate skills for interacting with others in the unit. She believes that commanders would benefit from understanding what boredom means to their troops and how this may differ from their own interpretation. In an article entitled "Boredom in the Sinai," she found that commanders typically define boredom as a lack of activity and, as a result, attempt to counteract it by filling the soldier's time with activities and details. However, soldiers define boredom quite differently. The research suggests that soldiers use the term boredom to define a variety of fairly complex emotional reactions to isolation, such as loneliness, frustration, or lack of sense of purpose. The authors suggested that soldiers need some time to process these emotional reactions and that filling their time needlessly proved to be unfruitful. They recommended that, although soldiers were well aware of the fact that they are on duty 24 hours per day, and that this seems acceptable to them, what is most beneficial are attempts to more clearly differentiate "Army time" from "personal time."

As much as possible, clear delineation of personal time should be made even while in garrison.

During this time it would generally be considered unacceptable to pull soldiers for details which could just as effectively be accomplished during the next day's activities. When soldiers were given personal time "away from the brass," they began to develop their own group or individual activities depending on their own preferences. This seemed to have a positive impact on cohesion and morale. The non-availability of alcohol in the theater further enhanced individual coping skills, and appeared to contribute to the low numbers of stress reactions. In most cases, it appeared that soldiers had natural inclinations toward taking care of themselves; however, enforcement of military discipline continued to be important to the overall morale of the unit. A large number of soldiers manifested what Stokes refers to as Misconduct Battle Fatigue. Following brief intervention at DMHS, these soldiers were returned to their units for administrative counseling or disciplinary action. In general, the battlefield psychiatry principles emphasizing the maintenance of the military climate proved to be beneficial.

COMMAND AND CONTROL

CPT Pecko reported that command was maintained by the MS Corps officer who had commanded the medical company in garrison. The physician did not take command but, instead, worked side by side with the Medical Service Corps (MS) officer in providing consultation on medical issues. He believed this arrangement was successful. He reported that, for the most part, commanders throughout the 82nd Airborne Division demonstrated genuine concern about the emotional functioning of their soldiers. One Brigade commander within the Division was an exception. Within this particular brigade, soldiers had to seek mental health consultation secretly because they were not allowed to see the DMHS staff. CPT Pecko reported ongoing efforts to rectify a long-standing misunderstanding with this commander. He also reviewed the negative impact of rumors on the morale of soldiers in the division. The DMHS staff concluded that regular, accurate briefings were necessary, as unchecked rumors began to undermine the soldier's confidence in command. CPT Pecko believed that speculations tended to be taken as facts and should have been avoided.

CPT West reported problems with command and control within the Main Support Battalion, with the Division not being prepared to support DMHS in wartime. He believed better mechanisms for support from the S-4 in garrison would be a prerequisite for training to support DMHS missions in combat. Although the battalion was prepared to support the DMHS staff with tents, rations, etc., they were not prepared to accommodate the additional soldiers who were being treated for brief evaluations and R and R. Blankets, extra rations, and hygiene products were not provided, for example. In addition, he reported that soldiers reconstituting from battle fatigue were, at times, mixed with medical patients, which is against documented treatment recommendations. He recommended the provisions of separate tents for reconstituting soldiers be made at all times. He reported that PROFIS physicians should actively train with the units with which they will go into combat while they are serving in garrison, and that they should be properly trained in command skills. However, he believed a better solution may be to have the MS Corps officer remain in command and have the physician serve as advisor on medical matters. While the physician's emphasis is on patient care, the MS officer is better

equipped to deal with logistics and personnel management issues.

MAJ Walker believed it was essential that OM teams which have previously worked together as a unit be deployed as a unit. She reported that it was difficult to integrate herself into a unit that was already established. She believed that bringing in physicians to command positions tended to be disastrous. She reported that some of the physicians did not possess basic soldiering or military leadership skills. She reported that the OM team appeared to have had a long tradition of being headed by enlisted personnel, and that bringing in outsiders for leadership positions created conflicts between the ranks. According to MAJ Walker, it was difficult to differentiate who was in charge much of the time. In addition, she reported racial problems in the reserve unit. Although the active duty Army has worked diligently to decrease racial problems, this does not appear to be the case in the reserve components. Reservists from many different areas, who tended to group with their own ethnic culture in civilian life, tended to demonstrate the same grouping behaviors in the desert. She believed that the enlisted personnel were poorly supervised in general.

CPT Picano believed that the psychiatrist who commanded his OM consultation team, did well. According to CPT Picano, the psychiatrist's 11 years of active duty experience in the Army proved beneficial. At higher levels within the medical brigade, he saw command and control as a disaster, and leadership as inept. Even so, the psychiatrist expertly managed this situation, according to CPT Picano.

CPT Stephens saw several problems within each of the three support battalions when the PROFIS physicians took command of the medical companies. Leadership, discipline, and basic safety were all jeopardized when the residing MS Corps officers were replaced by physicians who were not properly trained in military matters. The situation of bumping the MS Corps officer out of command after he or she had spent their careers preparing and leading troops for combat situations was not only frustrating and degrading to the officers, but also had a grave impact on the morale and dedication of the troops, according to CPT Stephens. Loyalties were confused. Because the MS officer was spending all of his or her time insuring tactical security, medical company operation, and proper personnel management, he or she was the officer who appeared to be in control; however, it was the physician who had the title of commander and had UCMJ authority. CPT Stephens agrees with the suggestion of keeping the MS officer in command and having the physician serve as consultant. She recommended stringent training in battlefield tactics and field experiences for all PROFIS physicians and Division psychiatrists.

HUMAN RESPONSE TO OPERATION DESERT SHIELD/STORM: A COMPREHENSIVE, MULTIDISCIPLINARY COMMUNITY-BASED APPROACH

L. Scott Fairchild, Psy.D.
Psychology Service
Walter Reed Army Medical Center
Washington, DC

Robert R. Roland, Psy.D.
Command Psychologist
U.S. Army Special Operations Command
Fort Bragg, North Carolina

Operation Desert Shield/Storm heavily taxed the existing mental health resources and support systems in the Fort Bragg and Fayetteville, North Carolina community. Research has demonstrated the utility of employing proactive psychological response teams during such times of crises. Recognizing the gap between the needs of the community and available resources, the Community Mental Health Service coordinated resources for the most effective delivery of care to soldiers, families and the local community. The authors trace the origin, development and implementation of Fort Bragg's comprehensive Human Response to Operation Desert Shield/Storm program. The concept of a multi-disciplinary "family support team" is proposed as an effective means of meeting total community mental health needs during military mobilization. The authors present this multi-disciplinary model for other providers who may be challenged in similar stress producing environments.

In June of 1990, the cover of U.S. News and World Report reads "Saddam Hussein: The Most Dangerous Man in the World." On the 2nd of August 1990, more than 200,000 Iraqi soldiers, heavily supported by tanks and helicopters, roared over the southern border of Iraq and seized the tiny country of Kuwait.

Several days later the Iraqi army positioned its forces along the southern Kuwaiti border poised for a potential invasion of Saudi Arabia, another oil magnate. Expressing concern that the Saudi oil fields could be the next adventure on Saddam Hussein's agenda, President George Bush offered assistance to King Fahd, the Saudi ruler.

The King accepted the offer and on the 9th of August, the 82nd Airborne Division from Fort Bragg, North Carolina, was deployed to the deserts of Northern Saudi Arabia in an attempt to deter the unprovoked aggression. Shortly thereafter they were joined by units of the 101st Airborne Division (Air Assault) from Fort Campbell, Kentucky. With two lightly equipped Army Divisions moving rapidly into the Persian gulf region, Army General H. Norman Schwarzkopf and the Central Command were given the mission to implement a plan to defend Saudi Arabia. As the plan unfolded, it became known as Operation Desert Shield. There were concerns that the two highly mobile light divisions would be ill-equipped to defend against the well armed Iraqi mechanized Armor forces. The decision was made to send American mechanized and armored units to the developing theater of operations. Several days later the 24th Infantry Division (Mechanized) and the 197th Infantry Brigade (Mechanized) deployed from the United States to the Persian Gulf via Sealift. They were soon joined by the 1st Cavalry Division and one Brigade of the 2nd Armor Division from Fort

Hood, Texas. Soon levels approached that needed for offensive operations.

With the deployment of such a large number of XVIIIth Airborne Corps assets, consideration was given to increasing needs of the families of the deployed soldiers. Numerous references (Braza and Braza, 1991, Williams, 1987) demonstrated that early interventions are critical in reducing the long term impact of exposure to traumatic events.

Previous Exposure

The report of the Gander, Newfoundland, disaster, where 248 soldiers were lost in an aircraft accident on their return from duty in the Sinai, showed that leadership emerges as the key variable ameliorating stress in such an unprecedented massive single unexpected community stressor (Walter Reed Army Institute of Research, 1987).

During the Viet Nam war, most soldiers were deployed and returned individually. Although the devastating effect is not denied, a more "circumscribed" impact was experienced. In Vietnam exposure to conflict and the intensity was drawn out over a long period of time.

Units and elements of the XVIIIth Airborne Corps are relatively accustomed to short notice, world-wide deployments with the potential for intense conflict upon arrival. The establishment of the family support group network at Fort Bragg parallels the nature of the missions of these units. While soldiers experienced high intensity, short duration conflict during the U.S. invasion of Panama (Operation Just Cause), family support group networks at Fort Bragg and at other XVIIIth Airborne Corps units rapidly mobilized to provide support to soldiers and the community.

Operation Just Cause brought with it a high intensity of combat over a sort period of time, relatively few casualties and a hostile threat which markedly diminished after several days. As planned, family support groups operated with great efficiency during the comparatively short duration of the deployment (three weeks) and were highly effective in supporting the needs of the local community.

As the soldiers mobilized, family members initiated emergency telephone notification rosters and gathered in community meetings sharing information as it became available. Community gatherings initiated by commanders also provided updates on the mission status and on the anticipated mission duration.

By virtue of previous deployments to the Dominican Republic and Grenada, Fort Bragg, North Carolina, a community of 142,000 soldiers and family members was probably better prepared to manage the aftermath of the Operation Just Cause deployment. Mental health professionals and chaplains who provided support services and who in the past had focused on active duty soldiers, were now able to extend services to the limited treatment of dependents. Extensive unit debriefings allowed returning soldiers an opportunity to share and normalize experiences, understanding and preparing for whatever symptoms they might encounter.

Mental health care providers in the local community united to provide support to returning soldiers and their family members. Following a strong endorsement by the XVIIIth Airborne Corps Commander, leaders were debriefed by mental health professionals and advised of symptoms to watch for in their returning soldiers. Units participating in the debriefing process appeared to have fewer cases of substance, spouse and child abuse, and they had improved reenlistment rates and unit morale (conversations with Division Psychologist Hazlett, 1990).

With the deployment of 82nd Airborne soldiers and the commencement of Operation Desert Shield, the Fort Bragg community expressed the same vigor and enthusiasm they had demonstrated in support of Operation Just Cause. After several weeks of increasing mobilization, the community came to realize the gravity and potential duration of this particular deployment

The Deployment Cycle

Fort Bragg's experience differs from that of other military installations. Experience gained from repeated exposure to operational deployments has revealed several somewhat discrete stages of emotional response. Soldiers and community members progress through discrete the stages focusing on specific issues as they arise and demonstrating common responses to the deployment process. The stages are graphically portrayed in Figure 1.

Pre-Deployment

During the predeployment phase, couples focus on issues of disengagement. It appears that deploying soldiers and their spouses disengage in significantly different ways. While the deploying soldier may be future focused and interested in packing and preparing for going off to war, remaining spouses tend to focus on the here and now of saying "goodbye". As communication breaks down, anger accumulates and conflict arises. Conflict may also function to actually facilitate the separation process, making it easier to mask the difficulty of saying good-bye. Much of the emotional friction occurring during this phase lingers, only to be resolved later through letter writing or phone conversation, or to resurface upon reunion.

Further contributing to the difficulties of the Pre-Deployment phase is the uncertainty of the actual departure time. Some soldiers disappeared in a matter of hours, while many reported for numerous "pseudo-departures", putting additional stress on the family with repeated "good-byes". One family reported over eight such false alarms, before the soldier actually departed. This uncertainty further challenges the tolerance of all family members. The emotional upheaval experienced during the predeployment phase usually persists for approximately three weeks until the family situation settles (Jellen, 1984).

Deployment

After a realization that the deployment is not of short duration, attempts are made to settle into more of a general routine. In this deployment, the lack of a specific return date and the potential danger faced by the soldiers increased the levels of anxiety in families (McGee, 1991) resulting in the initiation of more long term coping mechanisms and attempts at sustainment. Some less prepared spouses, unable to cope with the additional stressors and

the isolation, departed the community to receive support from the extended family. The majority of families, secure in the support network established at Fort Bragg, adjusted to a healthy coping routine. Spouses met periodically in small groups to discuss their concerns and participated in larger group settings to gather new information on specific topics (coping, stress management, and to quell rumors). Many spouses who left the Fort Bragg area reported a lack of understanding from their families and feelings of isolation when away from the military support network. Observers from the Department of the Army in comparing the responses of various installations, interpreted the "business as usual attitude" at Fort Bragg as denial, when in fact, it appeared to be a much more healthy coping response than closing buildings, packing up bags, and "going home to mama."

Prehostilities

Although the risk to human life is present in every deployment and to some degree in extensive training exercises, the potential risks for massive loss of human life, as evidenced in the build-up for Operation Desert Storm had not previously been encountered. Contrary to expectations, there was an intense community interest in the casualty processing system, and family members began to prepare for potential losses. Some support groups viewed films on the Casualty Assistance Program, while others invited speakers from Casualty Affairs to speak at their meetings. Family members also took an acute interest in the processes for managing medical evacuation as the deadline for the ultimatum approached.

Hostilities/Casualties

When hostilities eventually broke out, family support group members increased the frequency of their meetings, depending more heavily upon the assigned Chaplain for spiritual support. Due to the intensive preparation of the battlefield by air power and the limited duration of the ground war, casualties were remained remarkably low. This allowed families an opportunity to "breathe easier" as they waited for the return of their loved ones. "CNN syndrome" kept individuals focused on the news, despite advice to the contrary. Some families who had previously disciplined themselves into watching one or two news broadcasts a day were now hopelessly glued to their televisions. Family members were encouraged to remain active, utilizing the resources provided in the community.

Redeployment

The rapid end to the war produced anticipation that soldiers would be returning to their home installations quickly. Unfortunately, the demobilization process is almost as complex as the mobilization. It is impacted by transportation and mission requirements and cleanup. The evening news clips showing soldiers returning daily, served to heighten frustration in spouses over the uncertainty of the return of their loved ones. Some of the anger of the spouses was directed at the soldiers themselves, who they blamed for not being more personally aggressive in the redeployment process. The Division Psychiatrist for the 1st Armored Cavalry Division describes this post-war phenomenon as a "Cease Fire Let Down" manifested in unusual feelings and bizarre behaviors during the lull following the extraordinary stressors of combat. These emotions are not only driven by past experiences, but also by the anxiety associated with the reunion that is to come (Sutton, 1991).

Reintegration

Eastern Virginia Medical School research reported by Jellen, 1990, states that reunions and homecomings are more stressful than the initial deployment. The changes produced by the deployment affect every member of the family. When the needs of individual family members go unmet, they generate frustration, irritation and eventual anger. This anger may be directed at the unit, the military, or even at the loved one for abandoning the family. Without an outlet, much of the anger is stored only to resurface during the reunion/reintegration process. The successful reunion depends upon a number of factors, not the least of which involves understanding the needs and the misgivings generated by their lack of need fulfillment.

There may be an unhealthy tendency to "compare wounds". Soldiers and spouses must be prepared to understand the reunion from each other's perspective and proceed slowly in getting reacquainted. Issues of trust, communication, respect, intimacy and management of the household all need to be addressed in time, however, pressing the issues only heightens anxiety and leads to greater frustration.

Returning soldiers reported that "although the airplane was capable of getting their bodies back home in 24 hours, it seemed to take three to four weeks for the mind to follow." The readjustment period can be characterized by physical symptoms, children's behavior problems and a spouse's lower tolerance for the demands of their loved one. In many cases, roles and responsibilities have become clouded during the absence with the spouse enjoying some new found independence.

Couples reporting the most rewarding reunions were those who "positively framed" the experience, treating it as a second courtship. They proceeded at a slow pace, attempting to improve communication by increasing it ten-fold. They limited their expectations and designed their reunion time in such a way as to have a brief reunion of the immediate family (several days), followed by a vacation for the couple (sans children) and an eventual inclusion of extended family members.

Similar to the adjustments required in the pre-deployment period, the most significant turmoil of the reintegration period appears to subside after a three- to four-week period. It is important to note that with the suitable resolution and positive outcome, this test of the family can actually result in a strengthening of family relationships, a phenomenon which may not have occurred without the challenge. The manner in which individuals respond to the reunion process is largely influenced by how well they have been educated and prepared by their respective communities. Ideally soldiers are prepared for family separation and the reintegration process through realistic and challenging training. Soldiers and family members who fully understand the requirements of a lengthy deployment, are better prepared to face the challenge and are less vulnerable to decompensating in face of the demand.

The Soldier and Family Support Teams

Soldier and Family Support Teams became the Heart of the Human Response to Operation Desert Shield Program at Fort Bragg. The proactive team approach had proven to be the most effective intervention at Fort Campbell following the Gander, Newfoundland, crash. The teams were utilized at Fort Bragg to augment staff agencies and provide a "shot in the arm" for community resources just as

coping mechanisms were wearing thin. Employment of the teams empowered family support group leaders and Commanders to provide continued quality support to the community.

There were 15 Soldier and Family Support Teams (S&SFT) to support the installation and community. Each team included a mental health professional and a family physician to provide training in stress management and crisis intervention, a chaplain to provide spiritual support and an enlisted soldier to assist with administrative support.

Team members were trained in stress management, crisis intervention, grief leadership, debriefings, the Army Casualty System and management of reintegration issues. The Soldier and Family Support Teams introduced themselves to their supported populations with a formal briefing and began to provide support by assisting in solving problems unique to their assigned community. Teams coordinated and conducted a Health Fitness Assessment identifying areas needing focus and presenting classes targeted at the identified issues.

Representatives of all 15 teams met periodically to surface generic problems for resolution and forward difficult issues up the chain of command for resolution. Solutions to generic questions and problems were published in the installation newspaper in order that many could benefit from the answers.

In addition to the support provided family support group members and commanders, teams conducted debriefings for health care providers, notification officers, casualty assistance officers, graves registration personnel and other high risk populations. Reserve and active duty soldiers were provided briefings and debriefings enroute and upon return.

A Community Response to Stress

The teams also educated soldiers, spouses and commanders on the human response to stress, emphasizing it as a normal response. They encouraged and taught positive coping strategies, empowering individuals to move from intense emotion to acceptance without experiencing extensive symptomatology.

Following Operation Just Cause, similar debriefings which focused on understanding the human response to stress helped to reduce disciplinary actions, substance abuse and spouse and child abuse. They also appeared to improve morale, increase reenlistment rates and improve unit readiness. See Figure 2.

Teams explained the nature of chronic stress and the cumulative build up of stress since the occurrence of Operation Just Cause. Anniversary issues were addressed and families were informed of the stair-stepping effect of cumulative stress during the operation Desert Shield deployment, the "no unit rotation" policy, the holidays, the beginning of Operation Desert Storm, the ground war and the impending stress of the reunion (Williams, 1987).

Team members were available at all times to answer questions, allay fears and quell rumors. Most important, they provided a powerful message to families and commanders--WE RECOGNIZE THAT YOU ARE STRETCHED BEYOND THE CAPABILITY OF YOUR RESOURCES, AND WE CARE.

LESSONS LEARNED

The Human Response to Operation Desert Shield/Storm Program with its Soldier and Family Support Teams aimed a preemptive strike at the stressors associated with a major deployment, demonstrating that a professionally integrated support system works and works well.

People do rely on previous experience. The theory and information from the Gander, Newfoundland, crash and from Grenada was instrumental in the development of The Human Response Program. As in previous experiences, the assumed rush of patients didn't materialize. Knowing this kept effective health care systems from overreacting.

Contrary to the initial concerns of command, an educated and informed community proved to be much less hysterical. Information dispel rumors and builds credibility and confidence in the leadership structure. Frequent community seminars and timely communication through the media served to keep accurate information flowing.

Preexisting relationships within and between organizations are critical to a successful outcome. Knowledge of who to contact in various community organizations, resulted in a more efficient and effective delivery of services.

It is important to note that no amount of community support and involvement will alleviate all of the stressors. Some level of stress in the individual, the family and the community is necessary to facilitate change and growth. A sense of empowerment in the population, resulted in a strengthening and sense of growth which served to preparing the family and community structures for facing future challenges.

Positive Outcomes

The program was successful at stimulating local resources and affording a community far from the front lines to make effective contributions to the war effort. It provided a centralized forum for problem solving and an opportunity to normalize fear reactions through mutual sharing and encouragement. Many installation personnel got to interact for the first time in accomplishing an important war time mission. These new found relationships will undoubtedly result improved interactions for a long time to come.

A wealth of instructional material was generated by program participants and shared with the entire community as a result of these blended efforts. Educational seminars were conducted for care providers to assist them in managing stress in their patients. The program also served to expose family practice residents to an extensive experience in community medicine and in interacting with other service agencies in their community.

Instrumental to the success of the program were the efforts of many unsung heroes who contributed innumerable hours to ensure the well being of the military family.

A Time for Healing

Seldom does a community or nation come so close together, as when bullied by an external enemy. And if there is a common good to emerge from the tragedy of this war, it is the opportunity which it provided for this nation to gain some unity from it.

In reflecting on Operation Desert Shield/Storm, many comparisons and contrasts have been made to Vietnam. Operation Desert Shield/Storm has provided an opportunity for the individual, the community and the nation to work through some of the unresolved guilt associated with Vietnam. Along with welcoming home the soldiers of the Gulf War, communities have used this opportunity to give Vietnam veterans their long awaited "Welcome Home" and in so doing have greatly advanced the healing process of an entire nation.

Through the experience of having successfully faced an external stressor of enormous proportion, citizens of this nation and other nations of the world have been able, in their unity, to see beyond their differences.

REFERENCES

Adams, V. (1990). Saddam Hussein: The most dangerous man in the world: U.S. News and World Reports.

Braza, J. & Braza, K. (1991). War and its aftermath. Hawthorne, NJ: Career Press.

Fairchild, L.S. & Griffiths, G.C. (1991) The human response to Operation Desert Shield/Storm. Unpublished manual. XVIIIth Airborne Corps, Fort Bragg, NC.

Hazlett, G. (1991). Personal conversations. Division Psychologist, 82nd Airborne Division, Fort Bragg, NC.

Jellen, L.K., (1984). The impact of deployment separation on Army families. Division of Neuropsychiatry, Walter Reed Army Institute of Research, Report Number NP-84-6, Washington, DC.

Jellen, L.K., (1990). Minimizing the impact of deployment separation on military children. Unpublished handout. Office of the Chief, Army Community Service, Washington, DC.

McGee, P., (1990). Human factors in Operation Desert Shield: The role of family factors. Presented at 2nd U.S. Army Family Support Conference, Washington, DC.

Pyle, R. (1991). Schwarzkopf: in his own words. Middlesex, England, Penguin Books.

Sutton, L. (1991). Cease fire let down. Unpublished manuscript, 1st Armored Cavalry Division.

Williams, T. (1987). Post traumatic stress disorder: a handbook for clinicians. Cincinnati, OH, Disabled American Veterans Books.

Wright (Saczynski), Kathleen (1987). The human response to the Gander air disaster: A summary report. Division of Neuropsychiatry, Walter Reed Army Institute of Research, Report Number NP-88-12, Washington, DC.

Young, S. & Holden, M. (1991) The formation and application of an overseas mental health crisis intervention team: Part I-Formation & Part II-Application. Military Medicine, 156, 443-452.

NEW JERSEY FAMILY SUPPORT DURING OPERATION DESERT STORM/SHIELD

Joan Kakascik, Ed.D.
NJARNG
NJP-CARE Task Force

Tamara Knapp
Fort Dix, New Jersey

Family Programs of the New Jersey Army and Air National Guard, the Army and Marine Corps Reserve, and the active duty Army at Fort Dix and Fort Monmouth benefited from two special human services program models during Operation Desert Shield/Storm. NJP-CARE, a project of the New Jersey Psychological Association, offers pro-bono services of licensed New Jersey psychologists to military families until six months after the demobilization of NJ units. The Bergen County Department of Human Services tailored community resources for military families at no expense to the families, to the tax payer, or to the military. The hallmark of the two programs was the close, joint planning between the civilian group and military representatives. Characteristic of each program was its local availability to all members of military families.

NJP-CARE

The contributions of the psychologist volunteers of NJP-CARE extended beyond offer of individual therapy, child therapy, family therapy, consultation, and education. NJP-CARE Task Force members provided recommendation on the ethicality of offers of therapeutic services for military from the general public to The Adjutant General of New Jersey, who commands the NJ Army and Air National Guard, and to the Commander, USAR 78th DIV (Tng). Psychologists served as clinical consultants to Family Program Coordinators, the military wives who led support groups. Issues raised by the Family Program Coordinators included: group-work strategies, stress management, referral procedures, cultural differences, and location of community resources. Family support groups invited psychologists to speak about the effects of war on children, and about reunion issues. Psychologists led group sessions with unit members as the units were mobilized and demobilized. Testimony was given before the NJ State Assembly Committee on Military and Veterans Affairs by psychologists who spoke to the inadequacies of the Soldiers and Sailors Relief Act. In concert with the Fort Dix Social Work Department, psychologists assisted with a training program for members of the National Association of Social Workers--NJ. While New Jersey civilian psychologists came forward with offer of professional expertise in a time of national crisis, a wide range of in-place community services was also available to address the unique needs of military families.

PARTNERSHIP

The Bergen County Department of Human Services collaborated with the Bergen County Commission on the Status of Women, National Guard psychologists, and Family Program Coordinators to tailor existing county and non-profit programs for military family needs. The goal of the "Partnership with Military Families Program" was to educate military families about the human

services system and about accessing particular programs. Programs within the Partnership were open to all without requirement of a qualifying income base. The ongoing programs were already relevant to the community at-large. Since a significant investment of public dollars had been committed to the programs, tax payers were not inconvenienced by additional tax burden. Information about the county-based programs was made available to military families through Family Programs and through the local media. There was a two-fold advantage to the county-based programs. First, the programs were available within the communities where the families resided. The majority of the Guard and Reserve families did not live near a military post. Second, programs were available to all members of military families including those on non-dependent status who were not eligible for active duty military services. The Bergen County "Partnership" process of local coordination with military personnel through the Family Program was seen as a model for other NJ counties. (See attached copy of Partnership Program.)

ISSUES

The issues raised by military families to CARE and/or "Partnership" programs included: children's school difficulties; parenting problems; loneliness; problems of the elderly; family discord; financial distress; spouse abuse; stress; anger; indefinite information about return dates; reunion issues. The majority of families coped with their life situations, found comfort and information in the support groups, and utilized appropriate civilian resources of all types. Families that were dysfunctional before mobilization, continued dysfunctional patterns.

For most family members of the Guard and Reserve, the reality of mobilization had been a very distant possibility. Many families found themselves emotionally stunned and financially threatened. The Soldiers and Sailors Relief Act of the 1940s did not address the economic realities of the 1990s. Most Guard and Reserve families experienced family incomes reduced by 48% upon mobilization. Some lost businesses. Insurance benefits now had to be paid by families, placing an additional financial demand on an already reduced budget. Guards and Reservists had been typically told at annual mobilization briefings that, upon mobilization, their status would become active duty military. Active duty military resources would be available to provide for family needs: medical, financial, legal, and social services. It was quickly apparent that the active duty resources were overwhelmed and that the system interface was exacerbated by wartime stress. Consequently, looking to the civilian community resources proved reliable, expedient, and a useful supplement to the active duty human services resources.

SUMMARY

NJP-CARE and the Bergen County "Partnership" programs represent only two civilian initiatives in support of military families during Operation Desert Shield/Storm. The success of each program can be attributed, in part, to the close working relationship between the civilian representatives from NJPA and Bergen County and the military representatives. The military representatives from the Guard, the Reserve, and the active duty Army did indeed function in the "Total Force" concept, working together and sharing information and experience. Importantly for military psychologists, it was both military and civilian psychologists who took the initiative and demonstrated the leadership to establish two programs of importance to the family program.

PSYCHOLOGICAL SUPPORT - INTERNATIONAL EFFORTS

A. David Mangelsdorff, Ph.D., M.P.H.
US Army Health Services Command
Fort Sam Houston, Texas

Psychological support for military personnel is an issue of concern to the United States and its NATO allies. The NATO Research Study Group on Psychological Fitness developed recommendations for the selection and training of military personnel for highly stressing military functions. It was recommended that a NATO Research Study Group on Psychological Support be formed. Psychological support deals with the improvement of the psychological situation of the soldier and military group with consideration for the improvement of the combat readiness of soldiers. Psychological support concentrates on management of combat stress and the respective preparatory measures including appropriate training.

This paper will discuss ongoing efforts in the United States and the NATO nations regarding psychological support. It will include a review of the ongoing training and intervention programs. Military and civilian training and intervention programs for recognizing and managing reactions to psychic trauma will be presented.

TREATMENT OF BULIMIA NERVOSA

H. Frank Edwards, Ph.D.
2nd General Hospital
Federal Republic of Germany

Bulimia has captured the professional media in the past few years due to the resistance of its sufferers to cease the practices which result in this dangerous eating disorder. Multiple theories have been advanced as to the cause of bulimia nervosa but few effective treatment programs have been reported. This presentation will focus on the psychological disorder, theories of causation, and treatment strategies. Emphasis will be focused upon the treatment program presently in operation at the 2nd General Hospital. Discussion will focus on self concept and the meaning of food to the sufferer. Application of the Eating Disorder Inventory will be presented.

OBJECTIVES

Upon completion of this presentation, the attendee will be able to:

1) define bulimia nervosa and distinguish it from anorexia nervosa;
2) distinguish between bulimia nervosa and bulimic behavior;
3) administer, score, and interpret the results of an eating disorder inventory;
4) identify two theoretical presentations on the causes of bulimia nervosa;
5) differentiate between three treatment programs commonly utilized in the treatment of bulimia nervosa;
6) identify three personality characteristics of persons with bulimia nervosa and report how these hinder effective treatment.

REFERENCES

Garfinkel, Paul L. and Garner, David M. (1987). The role of drug treatment for eating disorders. New York: Brunner/Mazel Publishing.

Neuman, Patricia A. and Halvoson, Patricia A. (1983). Anorexia nervosa and bulimia. New York: Von Nostrand Reinhold Company.

Vredevelt, Pam and Whitman, Joyce. (1985). Walking a thin line. Portland, OR: Multomah Press.

CHRONIC HEADACHE PAIN: COMPARISON OF NONPHARMACOLOGIC TREATMENT WITH PROPHYLACTIC PHARMACOLOGICAL TREATMENT IN AN ACTIVE DUTY POPULATION.

James V. English
Clinical Psychology Svc.
Brooke Army Medical Center

Alan W. Halliday
Neurology Svc.
Brooke Army Medical Center

This prospective study compares the efficacy of nonpharmacologic treatment (a homebased behavioral treatment) with pharmacological treatment (prophylaxis) for treating chronic mixed migraine and muscle tension headache in an active military population.

In addition, the study seeks to evaluate the predictive utility of psychological tests in determining response to treatment: and to determine if either behavioral treatment and/or prophylactic medication would reduce the high levels of psychological symptoms often seen in chronic headache patients. The assessment instruments selected for this study include: Minnesota Multiphasic Personality Inventory-2 (NCS-1989); Beck Depression Inventory (BDI; Beck, Ward. Mendelson, Mock & Erbaugh, 1961), and the Life Events Survey (Holmes and Rey).

Headache is a widespread problem. Controlled community studies have indicated that up to 73% of males and 77% of females admitted having a headache within the past year. Studies conducted in the US reveal that 13.7% of men and 27.8% of women either have headaches "every few days" or headaches which "bothered them quite a bit." (Blanchard & Andrasik, 1987). The literature concerned with the efficacy of biofeedback training in the treatment of headache pain is well established. Thermal biofeedback and relaxation-training interventions with recurrent vascular (migraine and mixed) headaches have been studied extensively, and a substantial body of literature has indicated that these treatments produce significant reductions in vascular headaches (Blanchard & Andrasik, 1982; Holroyd, 1986; Penzien, Holroyd & Holm, 1988). Currently several investigators are attempting to identify which patients fail to benefit from these treatments in order to reduce costs. Preliminary findings from these lines of research have suggested that the population of patients who do poorly with nonpharmacological (behavioral) treatment include patients with elevated scales on the Minnesota Multiphasic Personality Inventory (MMPI) or who exhibit continuous headaches activity.

Only three studies have been conducted utilizing controlled comparisons of behavioral and pharmacological treatments (Mathew, 1981; Sovak, Munzel, Sternbach, & Dalesio, 1981; Holrovd, Holm, Hursey, Penzien, Cordingley, & Theofanous, 1988), and these yield conflicting results. None of the studies involved included an active duty military population.

Prophylactic treatment of migraine and muscle tension headache has been regarded as appropriate for both mixed migraine and muscle tension headache. Patients are treated with a medication established for its prophylactic effects

(tricyclic antidepressants, calcuium channel blockers, or beta blockers) in accordance with the usual standards of care. The effective use of these medications requires that patients take them daily and does not involve complex instructions.

Active duty military personnel routinely perform duties which may be adversely affected by side effects of medications commonly prescribed in the prophylactic treatment of chronic headache. Prophylactic medications, such as beta andregeneric blocking agents, methysergide, tricyclic antidepressants, and calcuium channel blockers taken daily have a number of side effects, which may themselves cause morbidity. Weight gain, lethargy, water retention, constipation and hair loss are among to common side effects of these agents. Military personnel have duty requirements, such at the physical training test, which are adversely affected by these common side effects. In addition, personnel with sensitive jobs (aviators, security, etc.) are scrutinized for their use of medications. These personnel may avoid seeking medical treatment for headaches out of concerns that the use of medications may serve to reduce job efficiency or disqualify them from specific duties. Also, patients may fail to seek medical attention for headache, or comply with treatment advice, due to potential side effects.

DESIGN & METHODS

This study is a controlled comparison of behavioral and prophylactic pharmacological treatment. A compliance training intervention is included in this study to assist patients in making optimal use of prophylactic medication. This compliance intervention has the added advantage of giving a similar self management focus to our pharmacological and nonpharmacological treatments and both treatment groups will receive similar amounts of attention from health-care professionals.

Subjects

The subjects will be active military personnel who suffer from either chronic muscle tension or migraine headache as diagnosed by a Board certified neurologist. Data collected on all subjects electing to participate in the study include: age, sex, rank, years of military service, type of MOS and a headache history. Participants are required to be free from prophylactic medication for at least two months prior to treatment and to be free from abortive medication for at least one month prior to treatment. The inclusion criteria for headache is the clinical approach in which the classification criteria of the Ad Hoc Committee of the National Institute of Neurological Disease and Blindness is utilized (Ad Hoc Committee, 1962) (See Figure 1). (See Figure 2 for inclusion and exclusion criteria). Prevalence estimates of both migraine and muscle contraction headache in various populations indicate that persons younger than 40 years of age are at greatest risk for chronic headache. Generally, the studies reviewed include college age subjects and chronic headache also appears with more frequency in younger groups. Therefore, military personnel between 17 and 40 years of age comprise the subjects. Sex grouping of the sample will be controlled to approximate the distribution of sex and age in the general military population.

Additional clinical reasons make the patient eligible for prophylactic treatment and have been noted in the literature. These additional criteria include an inability to tolerate abortive agents, excessive intake of

abortive medications resulting in rebound headache phenomena, and the degree of disability caused by migraine attacks (Mathew, 1990). Only those active duty patients diagnosed as having either vascular or mixed vascular-muscle contraction headaches and meeting the eligibility criteria for prophylactic treatment listed above are included in the study.

Procedure

Pretreatment Evaluation (All subjects)

To be included in the study, patients must (1) recieve a diagnosis of either migraine or mixed migraine and tension headache (2) regularly experience at least two headaches per month (3) suffer from recurrent headache problems for at least one year and (4) meet the criteria set for prophylactic medication usage as previously described. Exclusion criteria includes the presence of pathophysiological conditions (tumors, cerebral vascular malformations, etc.) or illnesses in which the headache is a symptom of the underlying disease process. (Figure 1)

Experimental Groups

Non-pharmacological treatment group/home-based behavior treatment group: The experimental groups complete Phase 1 and continue in the study with treatment (Phase 2) consisting of a standard multiple baseline biofeedback evaluation that is conducted of headache patients seen in the Psychology Service. The standard evaluation involves measuring EMG levels at the frontalis, temporalis, masseter, splenius capitas, and trapezium sites. Finger temperature under both relaxed and stress conditions will be included in the initial profiling. Patients will receive instruction on general relaxation procedures followed by three individual biofeedback sessions. The purpose of the 3 initial clinic visits is to provide the subjects training in relaxation and to insure the subjects understand how to make use of home practice devices.

Pharmacological Treatment Group

Following pretreatment evaluations and the baseline headache monitoring period of 4 weeks, information about the proper use of prophylactic medication is provided and prescribed. At the end of the fourth week of treatment, medication use will be monitored by the prescribing physician at a second clinic visit. These clinic sessions will be conducted at the beginning and end of the study to instruct patients in the appropriate use of their medication and to identify and address compliance problems.

MEASURES

Psychological Testing

Psychological tests have been utilized as screening instruments to identify which patients may be good candidates for BFT (Blanchard and Andrasik, 1985; Rappaport, McAnulty, Vaggoner and Brantley, 1987). This sort of test screening has not been conducted for a military population of headache suffers. The literature on psychological testing with chronic headache patients suggests certain psychological tests are of value. The MMPI scales,

and Beck Depression Inventory (BDI) have been used successfully to predict treatment response for various civilian populations with chronic headache pain. The MMPI was updated in 1989, and the never version, MMPI-2, has not been utilized to predict chronic headache pain.

Headache Dairy

Information on headache frequency, duration and severity is derived from a headache diary. The headache diary is used in this study to assist patients in rating their level of headache, using a 0 (no headache) to 5 (intense, incapacitating headache) scale, four times per day (meal times and bedtime). It has been demonstrated to be a socially valid measures of clinical improvement. Patients will keep the diary for four weeks prior to treatment, throughout treatment, and for a follow-up check at 12 weeks after treatment.

Home Practice Device

All nonpharmacological group subjects receive a hand held, finger tip thermometer and digital band (available thru Biotic Bands, Inc). In addition, one relaxation tape, relaxation instructions, and educational material are given to each participant.

DATA ANALYSIS

Analysis

Sample Size - (N = 25 *for both groups*): The data will include nominal and interval data sets, therefore both Chi-square (multiple sample) and T-tests will be utilized.

The headache diary will be analyzed using a T-test to assess equivalence of symptoms at outset of the study. Chi-square multiple samples will be utilized to assess number of HA free days. Initially, a T-test for noncorrelated sample means will he conducted between the experimental and control groups. At follow-up, the same measure will be utilized for a mean difference between groups. For changes in the treatment group between or across phases of the study, a one-way analysis of variance (ANOVA) will be utilized. For psychometrics (MMPI.-2) mean elevations for scale 1, 2 & 3 with a T-test between groups initially. For the experimental group, scale elevations will be correlated with symptom change as reported in the headache diary (Pearson r). Similar measures will be obtained from the BDI and Life Events Survey.

RESULTS/DISCUSSION

At this early point in the study there is insufficient data to infer conclusions. We have noted that many soldiers seem to prefer to take medication rather than participate in a headache protocol which requires time. However, we believe that a nonpharmacological approach has a place in the treatment of chronic headache, and some active duty services members may benefit, even if the approach is not efficient for all active duty headache patients at this time. Since this is a lengthy procedure (biofeedback).

Psychometric screening, if effective, has the potential to reduce costs in this lengthy procedure.

REFERENCES

Ad Hoc Committee on the Classification of Headache. (1962). Classification of headache. Journal of American Medical Association 1 179, 717-718.

Blanchard, E.B. and Andrasik, F. (1989) Management of Chronic Headache - A psychological approach. Pergamon Press.

Blanchard, E.B. and Andrasik, F. (1987). Biofeedback Treatment of Vascular Headache. In, Hatch, J.F., and Rugh, J.D. (Eds.) Biofeedback Studies In Clinical Efficacy. New York: Plenum.

Blanchard, E.B., Andrasik, F. (1985). Management of chronic headaches - A psychological approach. New York: Pergamon Press.

Blanchard, E.B., & Andrasik, F. (1982). Psychological Assessment and treatment of headache: Recent developments and issues. Journal of Consulting and Clinical Psychology, 50, 859-879.

Blanchard, E.B., Andrasik, F., Appelbaux, K.A., Evans, D.D., Jurish, S.E. Teders, S.J., Rodichok, L.D., & Barron, X.D. (1985). The efficacy and cost-effectiveness of minimal therapist contact, non-drug treatments of chronic and tension headaches. Headache, 25, 214-220.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J., (1961). An inventory for depression. Archives of General Psychiatry, 4, 561-571.

Butcher, J.N. (1989). User's guide for the MMPI-2 Minnesota report: Adult clinical system. Minneapolis: National Computer Systems.

Diamond, S. & Dalessio, D.J. (1986). The practicing physician's approach to headache (4th edition). Baltimore, M.D.: Williams & Williams.

Hatch, J.P., Fisher, J.G. and Rugh, J.D. (Eds.) (1987). Biofeedback studies in clinical efficacy. New York: Plenum Press.

Holmes, T. H. and Rahe, R.H., (1967), The social readjustment rating scale. Journal of Psychosomatic Research, Vol. II, pp. 213-218.

Holroyd, K.A. (1986). Recurrent headache. In K.A. Holroyd & T.L. Creer (Eds.). Self-management of chronic disease: Handbook of clinical interventions and research (pp. 373-413). Orlando, FL: Academic Press.

Holroyd, R.A., Holm, J.E., Hursey, K.G., Penzien, D.B., Cordingley, G.E., Theofanous, A.G. (1988). Recurrent vascular headache: home based behavioral treatment versus abortive pharmacological treatment. Journal of Consulting and Clinical Psychology, 56, No. 2, 218-223.

Lance, J.W. (1978). Mechanisms and management of headache. 3rd Ed. London-Boston: Buttenworth, p. 201.

Levition, A. (1978). Epidemiology of headache. In B.S. Schonberg (Ed.). Advances in Neurology (vol. 19, pp. 341-352). New York: Raven Press.

Mathew, N.T. (1990). Abortive versus prophylactic treatment of migraine--A reappraisal. Headache, March, pp. 238-239.

Michieli, G., Piazza, D. Sinforiani, E., Cavallini, A., Trucco, M., Gabelini, S. Mancusco, A., & Pacchetti, C. Antimigraine drugs in the management of daily chronic headaches: Clinical profiles of responsive patients. Cephalalgia, 5 (Suppl. 2), 221-224.

Rappaport, N.B., McAnulty, D.P., Waggoner, C.D. and Brantley, P.J. (1987). Cluster analysis of Minnesota Multiphasic Personality Inventory profiles in a chronic headache population. Journal of Behavioral Medicine, 10 (1).

Figure 1

Inclusion Criteria for Headaches

(1) Vascular Headache or Migraine Type-

-recurrent attacks of headache, widely varied in intensity, frequency and duration

-frequently unilateral in onset

-associated with anorexia, nausea and vomiting

-some are preceded by conspicuous sensory, motor and mood disturbances and often familial

(2) Muscle-Contraction Headache-

-ache or sensations of tightness, pressure or constriction

-widely varied in intensity, frequency and duration

-commonly suboccipital

-associated with sustained contraction of skeletal muscles in the absence of permanent structural change, usually occurs in relation to life stress

Figure 2

Inclusion and Exclusion Criteria (Subjects)

Inclusion criteria:

1. Each subject
   a. Active Duty Army
   b. 17 to 40 years of age
   c. Diagnosed migraine or mixed muscle tension headache by a Board Certified Neurologist
   d. Fulfill criteria for migraine or muscle-contraction headache per ad Hoc Committee of the National Institute
   e. Regularly experience at least 2 headaches per month
   f. History of recurrent headaches for at least
   g. Free of prophylactic medication for 2 months prior to treatment
   h. Free of abortive medication 1 month prior to any treatment

Exclusion criteria:

1. Central nervous system disease/trauma
   a. seizure history
   b. head injury with loss of consciousness
   c. cerebrovascular occlusive disease
2. Cranial Nerve Disease/Trauma
   a. trigeminal neuralgia
   b. glossopharyngeal neuralgia
   c. postherpetic neuralgia
3. Peripheral Nervous System Disease
   a. motor/sensory damage to upper extremities
   b. thoracic outlet syndrome
   c. carpal tunnel syndrome
   d. peripheral vascular disease
4. Systemic Disease
   a. juvenile onset diabetes
   b. chronic obstructive pulmonary disease
   c. renal disease
   d. chronic alcohol abuse
   e. opiate dependence
5. Extracranial Pain Conditions
   a. dental pain
   b. temporo-mandibular joint disease
   c. otolaryngologic disease
   d. cervical disk disease
   e. ocular disease
6. Headache other than defined by inclusion criteria
7. Conversion Cephalgia
   Major depression
   Primary thought disorder

UTILIZATION OF MENTAL HEALTH SERVICES IN A MILITARY POPULATION

Nancy K. Willcockson, Ph.D.
James M. Georgoulakis, Ph.D.
Health Care Studies and Clinical Investigation Activity
Fort Sam Houston, Texas

Comprehensive data regarding the need for and utilization of mental health services within the military beneficiary population has previously been unknown. In addition, few studies have attempted to examine the provision of services across the various mental health disciplines. Comprehensive mental health utilization data provide epidemiological information regarding the treatment rates for various psychiatric diagnostic categories within the military population, and also has implications for resourcing mental health services based upon the population needs. The present study has developed a comprehensive data base for analyzing both ambulatory and inpatient mental health treatment. Data is provided on Active Duty, dependents, and retirees regarding types of diagnostic categories, differences based upon gender and age, and provider status (psychiatrist, psychologist, social worker, psychiatric nurse, 91G). Data regarding length of stay for inpatients and mean number of sessions for outpatient care are provided for selected diagnostic groups. Mental health services provided by military treatment facilities are compared to services provided through CHAMPUS. The implications of Veterans Administration mental health services for the overlapping (primarily retiree) beneficiary population are also addressed.

NEW PSYCHOMETRIC INSTRUMENTS FOR ALCOHOLISM TREATMENT PLANNING

John P. Allen, Ph.D.
USAR

A rather impressive array of psychological instruments has been developed over the past ten years to assist in the clinical management of alcoholism. These assessment instruments may be categorized into classes which correspond to the five phases of intervention: (1) screening for alcoholism; (2) diagnosis of chemical dependency and possible collateral psychiatric problems; (3) triage to a desired setting for and intensity of care; (4) planning of formal treatment interventions; and (5) monitoring outcome following treatment. In choosing instruments, it is necessary to identify phase in treatment and clinical questions to be resolved. Particular attention is focused on treatment planning instruments. Examples of such instruments are described, clinical rationale for their use is offered, and relevant research is cited. Clinical and research issues surrounding formal psychometric assessment in alcoholism treatment planning are summarized.

Role of Assessment in Alcoholism Treatment

Stage in Intervention	Usual Setting	Goals(s) of Assessment	Type(s) of Measures	Examples of Instruments
Screening	Medical Setting School Worksite	To quickly determine if an individual's drinking behavior requires indepth evaluation.	Biochemical/physiological indices Self-report (overt) Self-report (covert-content)	Liver function tests Michigan Alcoholism Screening Test Adolescent Drinking Inventory MacAndrew Scale
Diagnosis	Referral Unit	To determine alcohol related diagnosis.	Diagnostic instruments Measures of quantity/frequency, pattern, and consequences of drinking	Structured Clinical Interview for DSM-III-R (alcohol section) Alcohol Use Disorders and Associated Disabilities Interview Schedule

Stage in Intervention	Usual Setting	Goal(s) of Assessment	Type(s) of Measures	Examples of Instruments
Triage	Referral Unit	To determine appropriate setting and intensity for treatment.	Physical exam Assessment of psychiatric comorbidity Assessment of collateral life problems Measures of severity of dependence	Physical Status Measures Addiction Severity Index (psychiatric severity section) Alcohol Clinical Index Structured Clinical Interview for DSM-III-R (relevant sections) Alcohol Dependence Scale Clinical Institute Withdrawal Assessment Scale

Stage in Intervention	Usual Setting	Goal(s) of Assessment	Type(s) of Measures	Examples of Instruments
Treatment Planning	Treatment Program	To establish treatment goals and strategies appropriate to the patient.	Environmental factors associated with drinking Functional analysis of drinking behavior Alcohol expectancies Patient assets/ deficits/character-istics as they relate to choice of treatment	Personal Experience Inventory Alcohol Use Inventory Alcohol Expectancy Questionnaire Inventory of Drinking Situations Comprehensive Drinker Profile Drinking-Related Locus of Control Scale Personality Research Form
Outcome Monitoring	Aftercare Program	To determine if patient requires further treatment.	Drinking behavior (self report) Drinking behavior (biochemical measures) Drinking behavior (reports of collaterals) Quality of life functioning indices	Addiction Severity Index Psycholosocial Functioning Inventory

NON-LEADING TECHNIQUES IN THE ASSESSMENT OF THE ALLEGED CHILD MOLEST VICTIM

Kathleen S. Mayers, Ph.D.
Western State Hospital
Fort Steilacoom, WA 98494

When confronted with the task of interviewing a young child who may have been sexually abused, many mental health professionals experience substantial anxiety. In a brief play session or interview, it is often necessary to obtain sufficient information to determine the child's veracity and competency, to obtain detailed descriptions of the acts alleged, and to provide an opinion as to the severity of the long range effects on the child. Requests for evaluations from individuals and agencies, including Child Protective Services, private attorneys and prosecuting attorneys, demand a great deal of specific information, which is very difficult to obtain from a psychologically traumatized and anxious child who may continue to display substantial loyalty and affection toward the molester. The purpose of this paper is to describe several innovative techniques that have been successful, particularly with young children or those who are resistive and prefer to remain silent. Techniques described in this paper have been used with children ages 3 to 8, although the Mayers' CS-ISB (Child status - incomplete sentences blank) has also been used with children up through 15 years of age. Techniques used in the evaluation of children who may have been sexually abused have been described by Burgess and Holm (1), Sgroi, Porter and Blic (2), Bresee, et al (3), Friedrich, et al (4), Clark and Hornick (5), De Young (6), Wakefield and Underwager (7) and many others.

A brief review of approaches, terminology and general procedures will be provided to ensure that the reader is prepared to embark upon the evaluation in a sensitive manner.

DEVELOPING RAPPORT

Obviously, it is necessary to initially develop rapport with the child. While it is certainly preferable to exclude the parent from the room at this time, it is not always possible. A relaxed approach on the part of the evaluator is optimal; if the child needs the parent in the room at this time, it is far better to permit this than to force the issue with a young, anxious child; the parent can always be excluded from the session at a later time. Developing rapport through songs, games, coloring tasks, peek-a-boo, etc. are all effective. Some children benefit from an opportunity to present themselves as bright and capable; thus, giving a child an opportunity to display knowledge of numbers, ABC's, or colors may be of use in beginning the process of communication between interviewer and child.

SEXUAL ISSUES

Several approaches can ease the situation for the child as well as the evaluator. Using an educational approach generally eases tension and allows the child to understand that this is an issue of relevance for every youngster. School educational programs, training packets distributed through police agencies, parental discussion and brief educational commercials on television, all focus on the issue of molestation. The evaluator can ask the child if he or she is aware of these, if he has seen people on television talking about "bad touches," if Mommy or Daddy has talked to him about what to do if someone touches him in the area of his private parts. The evaluator can clarify by having the child point to or verbalize where the private parts are or the child can watch as the interviewer gestures on a doll or points to his or her own body. It is appropriate to take the approach that one's body parts and functions are normal and natural, that such matters need not be a source of embarrassment, and most importantly, to develop comfort in discussing such matters, including specific sexual words.

TERMINOLOGY

For the average child, terminology for private parts of the body is an extremely difficult issue. If the child does not wish to provide names for these parts of the body, and if the parent cannot offer any names used by the child, it becomes the responsibility of the examiner to offer the child some terms. If the examiner desensitizes the child by saying, "Kids call this part of the body all different kinds of names. You might find some of the words nasty; you might find some of the words silly. Some of the names I've heard are vagina, boo-boo, honey pot or just 'down there.' What do you call that part in your family?" Most children find this assortment of names humorous and realize this is a setting in which it is acceptable to use a term which parents might frown upon. Obviously, there is the potential for the child to experience substantial embarrassment. Further, the child may offer no word for an anatomical part and may latch onto the evaluator's term. This could be brought up in court. However, it is necessary to have some means to describe parts of the body where the child may have been touched and, in the long run, it seems far more appropriate to desensitize and calm the child, providing a word for the child than to insist that the child provide his own term, taking the risk of creating additional anxiety for the child.

One child had no term for genitals beyond "it" for both male and female genitals and was urged to use his term "it" for the male genitals while tapping once, while he used "it" for the female genitals, while tapping twice. Thus, non-verbal communication can be utilized or added to develop a common terminology which can facilitate the examiner's understanding of what the child is trying to communicate and what specifically has occurred.

The procedure of establishing terminology tends to relax the child, to establish that both the child and the examiner can say embarrassing words, and that open communication is acceptable.

Optimally, health care and educational professionals will utilize this humorous, non-judgmental approach with potential molest victims, as well as children in whom molestation is not identified or suspected. There is a potential for some parents to see this as inappropriate. It is as appropriate

to ask such questions as, "Do you ever have trouble seeing the blackboard?", "Do you get headaches?", "Do you like or dislike school?". The questions, "Has anyone told you what the private parts of your body are?", "Has anyone helped you to understand that it is wrong for someone else to touch you on your private parts?" are critical for children. It is the adults' awkwardness and embarrassment which is communicated to children that makes such questioning uncomfortable for everyone involved and, in some cases, places children at risk because of their unwillingness and inability to communicate embarrassing information.

ASSESSMENT PROCEDURES

In evaluating a child who may have been sexually molested, it is critical to avoid leading questions. In testimony on cross examination, one can expect several points to be addressed:

1. Any leading or overly directive questions to the child will indicate to the defense attorney that sexual abuse was suggested, that it may not ever have happened and that the child is talking about it because it has been discussed repeatedly with him or her.

2. It is critical to ask the child if the account of molestation is the result of someone suggesting it to him or her or telling him or her to repeat a made up story. A warm, joking, even surprised questioning style, for example, "Did that really happen?", need not communicate to the child that you are disbelieving him or her, but does allow the answer, "No, not really. I'm just kidding." It is also appropriate to ask, "Are you kidding or is this real?", "Is this something that really happened or something that someone told you about?", "What were you told to tell me today?". Asking these questions at the time the child is initially interviewed can be extremely helpful in a court setting; it will indicate that the evaluator is sufficiently sophisticated to have considered that the allegation could have come from other sources and has taken steps to try to rule it out.

Still, it is within the realm of possibility that the child will deny coaching or fabrication of a story when, in fact, these did occur. The likelihood of obtaining an accurate account of a molestation is enhanced by addressing these questions with a child, as well as giving the child permission to indicate that he or she is kidding, or that someone instructed him or her to make the allegation, etc.

INNOVATIONS

Paper dolls. Specialized, anatomical dolls have been developed which many evaluators view as facilitating the determination of sexual abuse. However, there is some concern as to whether these anatomically correct dolls tend to elicit responses of a sexual nature from children. It is this investigator's opinion that anatomically correct dolls are not necessary and that far simpler techniques may be preferable and less leading to the child.

One such technique allows the child, in conjunction with the evaluator, to draw figures, generally mother, father, self, siblings, and any other relevant individuals. Either the child or the evaluator may draw and color the figure; they may each draw a part of the figure, one may draw and one may color -- however the child wishes to complete this task. The end result is a series of paper dolls which are then cut out using scissors.

In the natural sequence of events in drawing doll figures, it must be determined if the figures are to be nude, wearing underwear, or fully dressed. Clothing may be drawn separately and affixed to the figures either by cutting tabs and slots, forming holes and using pieces of yarn, or simply using tape. Such figures are not sophisticated and, generally, unless the evaluator has artistic talents, not aesthetically pleasing. However, the child has contributed to the development of the figures and the determination of what they will wear. Permission has been given to include private parts of the body. The child has decided whether or not to draw genitals and has decided what degree of nudity is acceptable. In this procedure, the child is requested to complete the back and front of each figure. Optimally, the child will agree the clothing will go on the figure and that the figure itself will not wear clothing, although genitals may not necessarily be drawn.

Some children choose to be extremely specific and detailed in the manner in which genitals are drawn. Children with some familiarity with the penis often elaborate greatly on the drawing. The scribbling, coloring, over elaboration and precision which can occur in the completion of the drawing of genitals can certainly lead one to suspect substantial anxiety. The examiner and the child cut out the figure carefully. Paper dolls become an excellent tool with which the child can then demonstrate what happened. The penis can be erect or flaccid, figures can bend, can sit or lie, and one figure can easily be superimposed upon another to demonstrate what has happened. The mouth, anus and vagina can all be cut open to accommodate a penis, finger, sexual aid, vibrator, or whatever may have been used, but these are certainly not suggested to the child; they are permitted if the child wishes to offer this demonstration.

Paper dolls are a natural and traditional play item for most girls. Many boys, as well, are extremely comfortable coloring and cutting out the figures, particularly if this is not described as "playing with dolls." In the development of furnishings, one can also provide the child with an assortment of small boxes, which can be similarly decorated to resemble beds, bedspreads, carpeting, furnishings of a room. Such elaboration of the environment can be extremely specific information. The examiner should encourage the child to color the bedspread, carpeting, wallpaper, and clothing so as to make them realistic and to provide information as to what people really wore and what the furnishings really looked like.

Paper doll productions by the child can be taken to a court room setting, as long as precise information is provided as to what was the contribution of the child and what was the contribution of the evaluator in preparing the figures. Certainly, the investigator should do no drawing of genitals; the child's drawing and elaboration of genitals on a paper doll may be admissible as exhibits in court.

QUESTIONING TECHNIQUES

In an increasing number of custody disputes, a parent will manipulate the child to make the allegation of sexual abuse. This can be viewed as an emotionally abusive interaction with the child. Often, the child knows that nothing ever happened and experiences guilt at telling something untruthful. This may happen with a young child who may misinterpret a parent's action, make a statement which he believes is innocuous, and experience great confusion when the other parent instructs him to repeat the statement in slightly modified form.

It is critical to establish that the child understands the concept of truth. Children may engage in silliness, joking and telling stories, never recognizing the eventual consequences if adults believe that their jokes and stories are the truth. With young children, it may be useful to provide the child with a list of statements and allow the child to tell you whether each statement is true or untrue. Responses to such statements as, "I'm wearing a banana on my head," "You are 22 years old today," "I have two feet," "Crayons can be used to color," "A truck is something you can eat for breakfast," all help to establish that a child has sufficient maturity to distinguish between what is true and what is untrue and can communicate appropriately. The child who is a jokester is probably not reliable and allegations of sexual molestation need to be assessed thoroughly; information as to the child's lack of reliability must be provided to the court.

A child can also be asked to define the term, "true." Children below the age of 4 or 5 can rarely provide a definition, although they may talk about "going to hell if you don't tell the truth," utilizing a religious explanation. It is common for children who are in religious families to talk about Jesus or God being angry if you lie.

Children are becoming sexually active and knowledgeable at an amazingly young age. Youngsters who have experienced sexual interactions with parents or other adults may also engage in early consensual activities with other children. It is critical that one be aware of such involvements. Even relatively young children must be questioned as to whether they kiss, touch or engage in other sexual activities with anyone else. Certainly, this must be communicated in a manner that offers acceptance to the child and creates an environment in which the child can answer in a truthful way.

It can place the examiner in an untenable position when confronted with the fact that the child, who was allegedly fondled and penetrated by a step father, was also voluntarily engaging in this behavior with several neighborhood boys who would be quite agreeable to testifying to this experience with her. If the examiner has no knowledge of this, he may lose credibility. Thus, the examiner must ask if any forms of sexual activity occurred with anyone else. This a critically important question.

As closely as possible, the examiner should ascertain when the incidents happened, for example, close to what season, holiday, family event; during school or when the family was on vacation. Children in military families can often be very precise in specifying the country or city in which they resided at the time certain sexual activities occurred. Memories of seasons and dates can be facilitated by asking grade in school, temperature, foods eaten,

clothing worn, for example, "Was that when you were wearing a flannel nightie?" "Were you wearing a winter coat?" "Was that when you were wearing a swim suit or shorts?" The examiner should also question about the structure of the home, placement of the child's room and parent's rooms, living room, bathroom, and specific location where any sexual incidents occurred.

It is important to obtain information about the kinds of activities in which the child has been engaged, as this information may be relevant to specific penalties. For example, you might ask, "Was there penetration?" "Were there pornographic photographs taken for commercial purposes?" "Did the activities occur on a military base?" "Was anybody watching?" It is a difficult task, however, to ask questions without suggesting specific activities to the child.

It is far more appropriate to ask the child, "Did he put anything in your mouth?" than to ask, "Did he put his penis in your mouth?" Similarly, the question, "Did he touch you anywhere on your body?" "What did he touch you with?" allows the child to offer a bland, ordinary response, for example, "Yes, he spanked me with his hand on my bottom." "He touched my hand." Such questions also allow children to make specific statements of inappropriate sexual touching. After the child answers, it is always appropriate to ask whether there were other kinds of touching.

Providing a child with a picture or drawing of a person and asking where the child was touched, is also helpful. If there was no inappropriate sexual touching, the child feels relatively comfortable in indicating touches on non-sexual parts of the body.

One can also ask the child about photographs that were taken, for example, "Did he take pictures of you?" "What were you wearing?" "What were you doing?" "Would you show me?" Children who have not been involved in production of pornographic materials will generally not comprehend that this is another possible aspect of the molestation.

EDUCATING ADULTS

A child who has trouble describing certain incidents of molestation and who is highly loyal may still retain a sense that the molester's behavior was very wrong. Such children may respond favorably to being told that no one is perfect, that even moms, dads, babysitters, and other caretakers make mistakes. Approaching the subject by asking the child what he or she would like to change about Mom, Dad, another family member or friend, and providing specific ideas of changes suggested by other children may be helpful.

Thus, the examiner will say to the child, "If I were a fairy Godmother and I could change your mom in one way, how would you want me to change her? How would you want me to make her different? Some kids say their mom should stop smoking, should stop yelling, should believe them, should lose weight. What would you say?" A similar question is asked about the father or step father. More than one change per parent is permitted. While information obtained may provide no information about the possibility of molestation, it does lead the child to the realistic point of acknowledging that parents are not perfect and that there are ways in which they might improve.

It can then be suggested that the child set up "Daddy School" or "Mommy School." The goal is to develop and educate them, so that they will be the best possible daddies and mommies. The child is placed in the position of developing a series of topics that he or she thinks daddies or mommies should know. The child is also questioned as to the things that daddies and mommies should never, never do to their children.

In play, several small action figures are lined up as students of optimal fathering/mothering methods and are provided with instruction by the child. Specific topics that have been suggested by children include, "Don't smoke around the children," "Don't hit your little boy," "Feed your little girl good food," "Don't yell." The concept of "Daddy and Mommy School" seems to make sense to youngsters and they frequently respond with ways in which a molesting parent or caretaker should change, for example, "Don't touch your little girl's private parts." The majority of children view it as acceptable to discuss their own experiences with what they view as inappropriate parenting. If the child mentions touching of private parts spontaneously, the examiner should certainly note this, however, it would be inappropriate to direct the child toward this topic.

The "Daddy School/Mommy School" technique places the molesting behavior within the realm of other behaviors that the parent needs to learn to stop. Every child is familiar with the kinds of behavior that he or she has had to learn to stop; learning to control one's behavior, to refrain from tantrums, to conform one's behavior to social expectations is a developmental accomplishment familiar to all youngster.

If the child does talk about inappropriate touching as a behavior that mommy or daddy should discontinue, the examiner can question as to whether there are any other similar behaviors that the child would like the parent to discontinue. Once again, leading or directing the child is inappropriate and information should be permitted to arise spontaneously. However, asking the child if he or she wants to provide instruction about hurting children in any way -- either their bodies or their feelings -- is not particularly leading; every child is aware of the fact that some children are hurt through spankings, that some children's feelings are hurt when cruel or upsetting statements are made to them. Television has certainly provided this information and it is common knowledge, even for a three year old.

ASSESSMENT OF DEGREES OF AVERSIVENESS

It is unlikely that a child will be able to describe the "grooming" or premolestation phase, in which fondling or vague approaches to the buttocks and genital area are initiated. Generally, young children do not identify these caresses as abusive or inappropriate, but view them as affectionate displays. It is usually the specific sexual touches, fingering of the genitals, exhibiting the genitals, mouthing of genitals, and touching the child with genitals that result in the child viewing the molester's behavior as inappropriate and frightening. Consistently, children have described some aspects of molestation as "yukky," even if they enjoyed other aspects.

If the child has discussed sexual approaches as "yukky," he or she will often respond to questions about the "yukkiest thing" that happened. One can ask, "What is the yukkiest thing that happened," "What is the next yukkiest after that." Thus, the examiner develops a hierarchy of behaviors that were perceived by the child as being aversive and the child, in this context, provides a relatively complete list of the occurrences.

Several children have provided comparisons of yukkiness, so that "degree of yukkiness," for each behavior could be graphed. This provided highly specific information about the activities in which the child had been engaged.

This technique is particularly useful for children molested by more than one individual. It helps them to be able to provide very specific information which allows the distinction between molesters.

PICTORIAL FEELINGS DISPLAY

Another procedure that has been used provides data regarding the child's capability to cope with what has happened. The child is asked to draw a picture showing how he or she feels about what has happened. The child is given some examples of how other children react, for example, some children are so angry that they smear black crayon all over the paper, some children show their family with everyone hugging, some children have family members saying things using cartoon balloons. The child is then permitted to draw a picture to demonstrate his feelings about the situation, if he or she wishes. The child's uncontrollable rage over what happened is of importance to the therapeutic process and may be of interest to the court.

BRIEF SENTENCES BLANK INSTRUMENT

A brief sentence blank for children has been found quite useful and is included in the appendix. This can be provided in one of two ways -- either by reading it to the child and writing the answers (for young children), or allowing the child to complete the blank by him/herself. The sentence completion format was developed to encourage children to make statements about themselves and their lives while including specific data about interactions with parents that were troubling to them. The sentence blank technique is relative non-leading in that there is no suggestion of molestation; however, many children take the opportunity to comment about molestation or what they view as abusive actions on the part of parental figures, siblings, or peers.

The following are examples of responses of children who reported sexual abuse with a parent.

> The most awful thing that ever happened to me ... was I was sexually abused.
>
> I hate it when my dad ... touches me.
>
> It hurts when ... someone touches you.

It's absolutely disgusting to ... touch people in their privates.

Nobody knows ... that my Dad did some bad things, but he really didn't do it.

I think it's wrong to ... poke my bottom.

I sometimes cry when ... Daddy pokes me in the bottom.

I hate it when my Dad ... hurts me.

It would make me really angry if ... Dad pokes me in my bottom.

It hurts when ... Daddy pokes my bottom.

It's absolutely disgusting to ... Daddy poked my bottom.

Nobody knows ... that I got touched except my family.

SUMMARY AND CONCLUSIONS

Techniques to evaluate young children who may have been sexually abused are discussed; these techniques have been found particularly effective in eliciting information from very young, anxious, guarded or loyal children who are not willing to provide information readily. These techniques were developed to avoid leading or directing the child; they do allow the child opportunities to indicate that the alleged sexual abuse is a result of coaching. Further research with these tools is strongly encouraged.

ACKNOWLEDGMENT

The contributions of Connie Schnase in the preparation of this paper are gratefully acknowledged.

REFERENCES

Burgess, A.W., Holmstrom, L.L. Interviewing young victims, in sexual assault of children and adolescents. Edited by Burgess, A.W., Groth, A.N., Sgroi, S.M. Lexington Books, Lexington, MA. 1978.

Sgroi, S.M., Porter, F.S., Blick, L.C. Handbook of clinical intervention in child sexual abuse. D.C. Heath and Co., Lexington MA. 1982.

Bresee, P., et al. Allegations of child sexual abuse in child custody disputes: a therapeutic assessment model. Am. JU. Orthopsychiatry, 1986; 50: 560-569.

Friedrich, W.N., et al. Brief diagnostic group treatment of sexually abused boy. J. Interpersonal Violence, 1988; 10:235-242.

Clarke, M.E., Hornick, J.P. The child sexual abuse victim: assessment and treatment issues and solutions. Contemp Family Therapy, An International Journal; 1988; 10:235-242.

De Young, M. Issues in determining the veracity of sexual abuse allegations. Children's Health Care; 1988; 17:50-57.

Wakefield, H., Underwager, R. Evaluating the child witness in sexual abuse cases: interview or inquisition? Am J. Forensic Psychology; 1989; 7:43-69.

Kathleen S. Mayers, Ph.D. is a licensed psychologist in private practice and on the staff at Western State Hospital in Tacoma, Washington. Dr. Mayers may be contacted at P. O. Box 94134, Tacoma, WA 98494.

Copyright 1991, Kathleen S. Mayers, Ph.D.

MAYER SCS-ISB

1. I'm happiest when...
2. The most awful thing that ever happened to me...
3. Mom wouldn't care if...
4. I hate it when my Dad...
5. Nobody knows...
6. If you don't keep a secret...
7. It would make me really angry if...
8. It hurts when...
9. It's absolutely disgusting to...
10. If I had three wishes, I'd wish for...
11. Once I was so upset and unhappy I thought about...
12. The one person I can talk to about my problems...
13. Dad and I like to...
14. I sometimes cry when...
15. Activities I enjoy with Mom...
16. I don't like it when...
17. When I grow up I'd like to be...
18. I think it's wrong to...
19. I'm really good at...

A SENTENCE COMPLETION TASK FOR USE IN THE ASSESSMENT OF PSYCHOTIC PATIENTS

Kathleen S. Mayers, Ph.D.
Western State Hospital
Ft. Steilacoom, WA

Psychiatric interviews and behavioral observations are the most frequently used tools in the assessment of patients committed by mental health professionals for treatment in psychiatric facilities and hospitals. Occupational therapy evaluations (e.g., the Kels) can also be used to gain information about the individual's ability to independently manage his life. At the time of admission, many patients are too decompensated or hostile to participate in a psychiatric interview; while many are willing to interact with peers, they may view staff members with suspicion and anger. In most institutions, it is not common for psychologists to administer psychological testing early in the period of hospitalization following civil commitment; testing is an arduous and lengthy task which requires attention span and concentration, which most acutely psychotic individuals are lacking. Clearly, there is a need for additional tools with which to assess patients committed by mental health professionals.

In making a determination of grave disability, most courts require specific information about the patient's insight, judgment and ability to meet his daily needs. This paper is a description of the Mayers' GD - SCT (Gravely Disabled - Sentence Completion Task), a tool developed for use with civilly committed psychiatric patients to obtain further information about the individual's ability to meet his own needs and to assess his level of disorganization.

Sentence completion tasks have been used with a variety of populations. The Rotter Incomplete Sentences Blank is commonly used for adult, high school and college educated populations. Other sentence completion forms include the Forer, the Sentence Completion Blank (SCB) devised by Sheldon J. Lachman, the Incomplete Sentence Test created by George Spache for industrial use and college educated individuals, and the Industrial Sentence Completion Form (ISCF) by Martin M. Bruce: reliability data and norms are not available for all of these. The Sentence Completion Test (SCT) by Floyd S. Irvin offers information about aspects of personality, self-concept, parental attitude, peer attitude, need for achievement, learning attitude, and body image.

Sentence completion tasks have also been developed for specific populations. The Competency Screening Test was developed by Paul D. Lipsitt and David Lelos to determine whether a mentally ill defendant displays sufficient competence to stand trial. The Mayers' Child Status Sentence Completion Task (CS-SCT) can help to identify children who have had abusive experiences, as well as those whose environments are inadequate.

In developing a sentence completion task for newly admitted psychiatric in-patients, consideration was given to simplicity; thus, all sentence stems are quite short. Emphasis was placed on the individual's basic needs - food, shelter, cleanliness, medical services, psychiatric follow-up. Some sentence stems are purposefully vague to allow the patient to project his own thoughts and feelings. Sentence stems were developed to increase the likelihood that

the individual would provide a response; thus, the patient is encouraged to express his complaints and resentments about being locked-up in an institution as well as to describe his greatest pleasures and joys in life. Opportunities are provided for the patient to discuss his preferred recreational activities and the manner in which he spends his free time.

METHOD

The Mayers' GD - SCT (Gravely Disabled - Sentence Completion Task) was administered to 52 patients. Three of them took the procedure on two occasions, the first shortly after admission and the second, later in the period of hospitalization, one to two weeks later. All patients were committed on the basis of grave disability and were within either a 72-hour hold or the 14 day period of detention which immediately follows. The patient population included individuals who had been diagnosed with schizophrenia, schizoaffective disorder, bipolar mood disorder. The vast majority of patients were diagnosed as schizophrenics. Substance abuse was a complicating factor for some of the patients.

The instructions were given: "This is a sentence completion task. Please complete each item to express how you feel." If the patient asked questions about the test, he was provided simple, direct answers. The patient is encouraged to complete all items. No time limit is provided. It should be explained that the purpose of the task is to get to know the patient better, to obtain information about the patient that will be used in the evaluation.

The sentence completion task has been administered either by allowing the patient to read and complete the form or, if the patient is unable to do so, by reading the sentence stems to the patient and writing the responses for him. If the patient cannot understand a word or concept in a sentence stem, the simplest synonym is provided. For example, if the patient is not familiar with the term "recreational activities," the phrase "things I do for fun" would be provided as an explanation. similarly, the sentence stem "The most irritating aspect of being in a place like this" would be explained as "What makes me most angry about being in this place."

In scoring, spelling errors were tabulated along with an indication of psychotic thought processes - non-responsiveness to the sentence stem, unusual terminology/concept, or unclear logic. Grammatical errors and sloppiness (written information extending beyond the lines or writing up the side of the paper) can also be scored. No more than one point should be assigned to each item in each area: spelling, grammar, sloppiness, psychotic thought. Thus, the maximum score in each area is 21. Spelling errors, grammatical errors, sloppiness, and indication of psychotic thought are used in a comparative sense to determine whether there has been improvement or further deterioration. At this time, the indication of psychotic thought has not yet been validated against other measures of psychotic behavior.

RESULTS

Many of the patients were willing to complete the task independently. However, some requested that a staff member read the stems and write the responses.

Patients often enjoyed the task and displayed pride in their responses. However, some thought that completion of the task would win them their freedom from the locked facility. In truth, responses that are coherent, articulate and indicate the patient has a good grasp of reality and the knowledge of how to meet his basic needs may contribute to a decision on the part of the treatment team that prompt release is appropriate.

Results of the Mayers' GD-SCT results have been well-accepted in civil commitment courts in the State of Washington. As this is a production of the patient and another method by which he or she reveals his strengths and weaknesses, his understanding of his environment and how he plans to meet his needs, it is relevant to the civil commitment hearing and is admissible in court. The level of disorganization and confusion, any inappropriate responses to simple sentence stems about meeting basic needs, and bizarre statements were of interest to the court; there was no objection to the admission of such evidence. Just as an evaluator can comment about the respondent's behavior and verbalizations in the courtroom, he can also comment upon the patient's written responses. While results of the Rorschach and other projective tests may require further explanation to the court, along with information as to the relevance, the patient's responses to the Mayers' GD-SCT are self-explanatory and clearly indicative of his thought processes.

Typical records included sentence completions which were incoherent. Looseness of associations, meaningless responses and unusual verbalizations were also common. In all records, however, there were many responsive and appropriate answers, and some patients exhibited good insight.

Of note is the poor spelling, grammar and sentence organization of some psychotic individuals. At times, it is difficult to decipher what it is that the patient is trying to communicate. Certainly, this population often has a very low reading and spelling level.

The Mayers' GD-SCT can be used for comparative purposes; it has been used at two points in the patient's hospitalization, at the early stages immediately after admission and later, after the patient is stabilizing on neuroleptic medication. Thus, use of the sentence completion task with this population can provide an effective means of determining whether a specific neuroleptic medication is effective in decreasing cognitive disorganization.

Included in Table 1 is a blank Mayers' GD-SCT.

Included in this paper are responses from seven patients, patients A through G. Patient A completed the task on two dates, day one immediately after admission and day two after neuroleptic medication had been initiated. At day one, the number of misspelled words was 13; at day two, the number of misspelled words was five. While there was a comparable shift in the number of grammatical errors, it is far more difficult to obtain a precise number of grammatical errors because of the disorganized pattern of responses and the

fact that it is sometimes impossible to determine what the patient is trying to communicate.

In addition to the decrease in misspellings and grammatical errors, there also was a significant improvement in the precision and neatness with which letters were formed. At day one, handwriting was quite disorganized in appearance, with a greater number of statements extending beyond the lines and letters running into each other. By day two, this had decreased substantially.

Other notable aspects of this patient's responses include nonresponsiveness to the sentence stem, unusual terminology/concept and unclear logic. These were considered scoreable items. Assigning a numerical score of 1 to each sentence completion with one of these features, the total number of scoreable items was 9 on day one and 5 on day two. Of interest was the fact that the scoreable items represented almost totally different sentence stems; only one sentence stem received a score on day one and day two. Scoreable items were as follows:

Day 1

Patient A

A.1.(1) My greatest hope for the future is... resonible exponation.

A.1.(2) I think it's fun to ... resposibility and gramer language.

A.1.(3) I like to spend my time doing ... working and doing with others.

A.1.(4) What really bothers me is... simple sounds valeube reflect's.

A.1.(9) Recreational activities I enjoy include ... Bail church and main orchrastas.

A.1.(11) If I have free time, I will spend it... The money to the Doctor.

A.1.(14) I will have outpatient follow-up at... my resposine's in life.

A.1.(16) I'll stay out of the hospital for ... a reason I feel quiet and same all the time.

A.1.(21) I'm sick and tired of ... coming back to the very beginning of the mautiflets.

Day 2

A.2.(12) The ideal home situation for me is... To really learn.

A.2.(14) I will have outpatient follow-up at... my own office.

A.2.(15) I'm excited about the future because... I really have a lot of psy.

A.2.(19) A good friend is someone who... someone.

A.2.(20) The most irritating aspect of being in a place like this is ... that there is a private place.

On day 2, the responses were qualitatively less disorganized and unusual than those produced on day one.

Patients B, C, D, E, F, G offered the following scoreable items.

Patient B

B.5. I would like to live in... the whole city.

B.7. To wash clothes, I will... knew I did it ever since I was born.

B.11. If I have free time, I will spend it ... doing goose work with my hands.

B.12. The ideal home situation for me is... wait on Mom.

B.14. I will have outpatient follow-up at... home with business again.

B.16. I'll stay out of the hospital for ... time of being for out of so forth.

B.20. The most irritating aspect of being in a place like this is ... punch and kick.

B.21. I'm sick and tired of ... having demand of abilities on people.

Patient C

C.1. My greatest hope for the future is ... home.

C.2. I think it's fun to ... no.

C.3. I like to spend my time doing ... housing.

C.7. To wash clothes, I will ... wash the clothes as many a way possible.

C.9. Recreational activities I enjoy include ... darkness.

C.10. If I need to see a doctor for medical help, I will ... be bother good.

C.11. If I have free time, I will spend it... on money.

C.12. The ideal home situation for me is... to stay good, cleaning up.

C.15. I'm excited about the future because... it was good for me.

C.17. I'm happy when ... the darkness goes away.

Patient D

D.1. My greatest hope for the future is... conturuction more, less detroction.

D.4. What bothers me is ... always interuption.

D.7. To wash clothes, I will ... do it when I get axses.

D.12. The ideal home situation for me is... If it is my home.
D.14. I will have outpatient follow-up at... better hopefully.

D.15. I'm excited about the future because... ? to see what I haven't.

D.16. I'll stay out of the hospital for ... being well.

D.18. I love to be with ... Life.

D.20. The most irritating aspect of being in a place like this is ... alone.

Patient E

E.4. What really bothers me is ... having inadequate environmental behavior to produce the effects that I believe are essential to myself.

E.17. I'm happy when... I satisfy other people in developing friendships that are held within love dynamic.

E.18. I love to be with ... acquaintances who know their hidden boundaries.

E.19. A good friend is someone who ... can contain the emotions.

E.21. I'm sick and tired of ... monotony akin to benevolence.

Patient F

F.4. What really bothers me is ... people selling my one home out from under this thing arament.

F.5. I would like to live in ... the home that I am the only serviviair to my home (address).

F.6. When I'm alone, I like to ... think title words eatch driem.

F.12. The ideal home situation for me is... I will maek everyone moove out of my home!

F.16. I'll stay out of the hospital for... sanity reasons.

F.17. I'm happy when... future is n the past.

F.18. I love to be with ... my future haram.

It should be noted that sentence stems were written for patient B, patient C and patient E; thus, there are no spelling errors for these responses. However, even when an evaluator writes the responses for the individual, the cognitive disorganization, the unusual verbalizations and the lack of meaningful response still occur.

The only two sentence stems that received no responses were items 8 and 13, both of which address food preparation and preferences. Patients

consistently responded to the sentence stems, however, indicating these were non-offensive to this patient population. Items that received the most responses from the seven patients (four or more responses) included: 1, 12, 14, 16, and 18.

Items that could be provided in a court setting to document grave disability and inability to meet one's own needs because of substantial disorganization and inability to understand the demands of the environment include the following: Patient A(1) 1, 11, 14, 16. A(2) 12 & 14. B. 5, 11, 12, 14, 16. D. 12, 14. F. 5, 6. Several of the items provided by other patients could also be used to show the disorganization of thought processes, although they say little about the specific way in which the patient will meet his own needs. Responses to items about use of free time do tend to assess resourcefulness and judgment.

While the examiner can do the writing for all patients, this does change the nature of the test and the patient's responses. One of the specific purposes of using a written test is to determine how well the patient communicates using a different context, writing, rather than spoken language, which includes a social interaction. Clearly, individuals committed as gravely disabled have generally displayed through their spoken language and their behavior substantial confusion and disorganization. Offering them a writing task permits them to exhibit behavior through another mode and, in some cases, allows them to display far more insight and appropriate understanding. For some individuals, the written responses were so precise and appropriate that the patient was viewed as having a higher level of competence than was apparent from behavior and spoken verbalizations.

It should be noted that by completing this task, the patient gives the examiner a substantial amount of information about himself - what he likes and dislikes, how he fits into the world socioeconomically, what his expectations and hopes are from life. This can certainly be used as a starting point for a therapeutic interaction, instruction regarding need for medication compliance, housing opportunities, food preparation or hygiene, or to facilitate a peer group interaction.

The sentence completion task requires minimal time on the part of the psychologist or psychiatrist. It can be self-administered, or a mental health technician can help the patient by writing responses. The Mayers' GD-SCT can provide valuable information that can be used in court testimony; it can also increase knowledge about the patient, facilitate an understanding of an appropriate placement consistent with the patient's resources and desires,, and can allow the patient an opportunity to communicate about himself in the course of a therapeutic interaction. In addition, it provides a means of monitoring the relative level of disorganization of thought processes and can be used to ensure that neuroleptic medication is effectively decreasing psychotic thought.

Certainly, this task should be administered to a large population of patients in order to more precisely tabulate the specific kinds of errors made by patients with various diagnoses, and to validate it against other measures of psychotic thought. Use of change scores to determine decreased psychotic thought processes along with decreased disorganization may represent an effective and systematic way to compare effectiveness of various neuroleptic or other medications.

At times, an individual will offer a humorous or flippant remark. These are not scored: such responses occur far more often among non-psychotic individuals.

Some patients will not complete all of the sentence stems. For these individuals, it is inappropriate to use change scores. The patient's initial inability/unwillingness to complete items may be explained by many factors - paranoid thinking, lack of understanding, paucity of thought, etc. Thus, if the sentence completion task form is incomplete, only analysis of the content should be done, without scoring of items.

It is critical to avoid scoring grammatical errors, sloppiness and spelling errors unless change scores are being obtained. These errors may result from educational and cultural background, substance abuse, lack of eyeglasses, life experiences and other factors which are not related to psychosis or grave disability. Even when change scores are obtained, it is important to carefully assess the variety of errors to ensure they are not the result of changes in visuo-motor coordination resulting from medication side effects or other factors.

The specific reason for developing the task was to develop another means of generating information about these patients, particularly when they do not wish to verbalize; for that usage, the task can be used without further reliability or validity data and is effective and influential in a courtroom setting.

For advise about use of this tool, for additional information or to use this test procedure, please contact the author at:

P.O. Box 94134
Tacoma, WA 98494

The contributions of Danielle Haines in the completion of this paper are gratefully acknowledged.

This paper is included with the permission of the American Journal of Forensic Psychology and was originally published in the American Journal of Forensic Psychology, 1991, 9:19-30.

BIBLIOGRAPHY

Bruce, Martin M., The industrial sentence completion form, (1963), Martin M. Bruce, Ph.D, Publisher.

Forer, Bertram M., Forer structured sentence completion test, (1957), Western Psychological Services.

Irvin, Floyd, S., Sentence completion test, (1967), Psychologists and Educators, Inc.,

Lachman, Sheldon, S., Sentence completion blank (two forms), (1955-1966) Psychological Publications Press.

Lipsitt, Paul D., David Lelos and A.L. McGarry, (1971), Competency for trial: A screening instrument, American Journal of Psychiatry, 128:105-109.

Mayers, Kathleen S., Non-leading techniques in the assessment of the alleged child molest victim, (1991), American Journal of Forensic Psychology, 9

Rotter, S.B. and B. Willerman, The incomplete sentence test as a method of studying personality, Journal of Consulting Psychology, 11:43-48, 1947.

Spache, George, An incomplete sentences test for industrial use: employees, 1949 and an incomplete sentences test (college edition), Reading Laboratory and Clinic.

Table 1. Mayers GD-SCT

1. My greatest hope for the future is...
2. I think it's fun to...
3. I like to spend my time doing...
4. What really bothers me is...
5. I would like to live in...
6. When I'm alone, I like to...
7. To wash clothes, I will...
8. My favorite meal is...
9. Recreational activities I enjoy include...
10. If I need to see a doctor for medical help, I will...
11. If I have free time, I will spend it...
12. The ideal home situation for me is...
13. Foods I can cook are...
14. I will have outpatient follow-up at...
15. I am excited about the future because...
16. I'll stay out of the hospital for...
17. I'm happy when...
18. I love to be with...
19. A good friend is someone who...
20. The most irritating aspect of being in a place like this is...
21. I am sick and tired of...

Copyright 1990, Kathleen S. Mayers, Ph.D.

AN INVESTIGATION OF THE RELATIONSHIP BETWEEN SELF-REPORT OF MEMORY FUNCTIONING AND MEMORY TEST PERFORMANCE

Fred H. Brown, Jr.
Madigan Army Medical Center

Carl B. Dodrill
University of Washington
School of Medicine

Timothy Clark
Baylor Institute for Rehabilitation

Kenneth Zych
Madigan Army Medical Center

Memory complaints are some of the most common cognitive problems presented to clinical psychologists and neuropsychologists. However, the likely validity of memory complaints presented to a psychologist has rarely been validated by objective memory tests. Using the Memory Functioning Questionnaire (MFQ; Gilewski et al., 1983), 62 relatively young adults reported the extent to which they were experiencing various types of memory problems. These data were compared with findings of memory and non-memory tests on an expanded Halstead-Reitan test battery and with the MMPI/MMPI-2. Results showed that with the exception of persons with more than one MMPI/MMPI-2 elevations, memory complaints were not related more to memory than to non-memory tests. The data argue against neuropsychological test selection being solely based on patient complaints without at least sampling a range of abilities in every patient.

Memory complaints are among the most common cognitive problems presented to clinical psychologists and neuropsychologists, yet research supporting the accuracy of these complaints is meager. This is true for all groups of patients and especially so for younger persons with probable cognitive deficits. Factors which can lead to unreliable reports of memory problems by the patient include emotional, psychosocial, and behavioral difficulties as well as brain-related problems not explicitly related to memory. Reports by family members may be more objective in some cases, but they may also carry inaccuracies. Since many psychologists select tests for their patients based upon the pattern of complaints offered, it is important to know the likely validity of those presenting problems.

"Metamemory" is the term which has now been applied to the ability to judge the capabilities of one's own memory. A small number of questionnaires have been devised to assess this and several studies have now been completed. Zelinski et al. (1980) devised the Metamemory Questionnaire and found that older subjects were more accurate than younger persons in describing their memory functioning. Beginning with the same test, Gilewski et al. (1983) produced the Memory Functioning Questionnaire (MFQ), and statistically described it, including indicators of reliability and factor analytic validity. The factors varied with age, but always included frequency of forgetting and usage of mnemonics. In 1986, Gilewski and Zelinski reviewed the area and concluded that there is a reliable correlation between memory complaints and memory performance in community-dwelling elderly, that memory complaints assist in the assessment of dementia and its differentiation from depression, and that memory complaints are important in their own right as they provide information about how people view their cognitive functioning.

Other studies have provided information of interest. Larrabee and Levin (1986) drew attention to the importance of affective states which they found to be more related to self-ratings of memory in normal elderly persons than to objective measures of memory. Cavanaugh and Poon (1989) found that self-ratings of memory were much more related to prose recall than to word-list recall. Squire and Zouzounis (1988), using a small number of impaired patients, provided some information suggesting that self-ratings of memory could distinguish between depression and amnesia and that these ratings could help to identity amnestic patients who underestimate their problems. It has been suggested that memory complaints may provide information about a person's state of awareness and that conceptualizing awareness as different from learning helps to explain inaccuracies in self-reports of memory functioning. Finally, Prevey, Delaney, and Nattson (1988) propose that memory monitoring plays an important role in memory performance through the use of effective learning strategies.

The purpose of the present study is to determine if reliable relationships can be found between self-report and objective measures of memory in a younger group of patients with suspected/demonstrated neuropsychological dysfunction.

METHOD

Subjects

Sixty-two patients referred to the Madigan Army Medical Center Psychology Service for neuropsychological evaluations and who completed a full battery of tests were selected as subjects for this study. The group included 11 females and 51 males. They ranged from 18 to 60 years of age (M = 30.39; SD = 8.68) and 8 to 18 years of education (M = 13.15; SD = Z.09). Table 1 summarizes the breakdown of diagnoses found in this patient group.

Materials

In order to study the relationship between patients' self-report of memory functioning and their actual performance, the MFQ (Gilewski et al., 1983) was selected. The MFQ is a 64 item self-report questionnaire which requires a subject to rate themselves on different aspects of memory functioning on a seven point Likert scale with high scores indicating fewer problems. These items are scored to produce the following eight scales: MFQ1--general rating of memory; MFQ2--retrospective assessment of memory, MFQ3--frequency of forgetting, MFQ4--frequency of forgetting when reading a novel, MFQ5--frequency of forgetting when reading a newspaper or magazine, MFQ6--remembering past events, MFQ7--seriousness of forgetting, and MFQ8--frequency of use of mnemonics. Gilewski et al. (1983) report the scales to have good internal consistency with Cronbach's alphas ranging from .82 to .93. The authors also report test-retest scale reliabilities ranging from .22 to

All subjects were administered a standardized neuropsychological test battery which consisted of the Halstead-Reitan measures and allied procedures (Dodrill, 1978). The following were selected as memory measures on the basis of their appearing to have a significant memory component: Wechsler Memory Scale (Form I) Logical Memory immediate and 30 minute delay; Wechsler Memory Scale (Form I) Visual Reproduction immediate and 30 minute delay; the sum of

the first five trials of the Rey Auditory Verbal Learning Test (RAVLT); the recognition trial of the RAVLT; Tactual Performance Test (TPT) Memory; TPT Localization; Wechsler Adult Intelligence Scale - Revised (WAIS-R) raw score of Digit Span forward; WAIS-R raw score of Digit Span backward. These were the memory measures. The following were chosen as measures which appeared not to have a significant memory component: Finger Tapping Test (total of both hands); total number of errors made on the Reitan-Indiana Aphasia Screening Test; rate of the extent of distortion of the drawings on the Aphasia Screening Test; total number of errors of all types made on the Reitan-Klove Sensory Perceptual Examination; total Tactile Form Recognition Time; total name writing speed in letters per second for both hands combined; Stroop Test Part I time (simple reading of words; WAIS-R raw Block Design score; hand dynamometer (total strength in kilograms of both hands); and Speech-sounds Perception Test. These were the non-memory measures.

Procedure

All subjects were administered the MFQ prior to neuropsychological testing. The raw scores of the eight MFQ scales were summed to provide a "Total" MFQ score. A complete neuropsychological battery was then administered and scored according to standardized procedures (Dodrill, 1978). As an overall index of neuropsychological functioning from this battery, the percent of 16 tests performed outside of normal limits was also calculated. Fifty-two of the 62 subjects were also administered either the Minnesota Multiphasic Personality Inventory (MMPI; n = 41) or the revised MMPI (MMPI-2; n = 11). The number of significant elevations (i.e., number of MMPI T scores equal to or above 70 or the number of MMPI-2 T scores equal to or above 65) among the ten standard clinical scales was calculated to represent a measure of overall psychological status.

Analyses

Spearman rank order correlation coefficients were calculated between the MFQ variables and the memory and non-memory neuropsychological test variables. The Spearman rank order coefficient was chosen because of widely varying types and distributions of data. In order to further investigate whether the relationship between the MFQ and neuropsychological measures may be dependent upon age, education, level of neuropsychological impairment, or elevations on the MMPI/MMPI-2, for each of these variables the subject pool was divided into two groups of approximately equal size and the Spearman correlations were recomputed for each subgroup.

RESULTS

Table 2 summarizes the correlations found between the nine MFQ scores and the 10 memory and 10 non-memory measures. The correlations between the MFQ, the percent of neuropsychological tests outside of normal limits, and the number of significantly elevated MMPI or MMPI-2 scales (MMPI elevations) are also summarized. Only one statistically significant correlation was found between the MFQ scales and the ten memory measures, a finding which is less than the four or five statistically significant correlations expected on the basis of chance alone. Fourteen statistically significant correlations were discovered between the MFQ and the 10 non-memory measures. This pattern of correlations is exactly opposite to what would have been predicted from

Gilewski and Zelinski's (1986) findings. Also, there clearly were stronger relationships between the MFQ and the MMPI/MMPI-2 than for the overall indicator of neuropsychological functioning, the percent of abnormal neuropsychological scores. See Table 2.

Table 3 summarizes the numbers of statistically significant correlations which were discovered when the subjects were divided according to age, education, level of neuropsychological impairment, and number of elevations on the MMPI/MMPI-2. The number of statistically significant findings was greater for memory than non-memory tests only when subjects were older, less educated, and when they had more than one elevated MMPI/MMPI-2 scale. However, only in the last case did it appear that the number of statistically significant findings was truly greater for memory (23) than non-memory (12) tests. Thus, people with more than one MMPI/MMPI-2 scale elevation constituted the only subgroup whose MFQ and memory test variables were more related to each other than the MFQ was related to non-memory variables. See Table 3

DISCUSSION

The results of this study stand in contrast both to the proposals put forth by Gilewski and Zelinski (1986) and to the findings which we would expect according to clinical lore. The MFQ did not demonstrate strong relationships with commonly used laboratory measures of memory. If anything, it was more related to non-memory than memory measures in the subjects we studied. The only exception appears to be for subjects with more than one elevated MMPI/MMPI-2 scale. Such individuals were emotionally distressed but their own estimates of memory functioning were more related to tests of memory than was true for any other subgroup. The reason for this is not clear. It is tempting to suggest that such persons are more attuned to personal deficiencies either in emotional functioning or in abilities including memory, but this study does not provide clear evidence for this speculation.

Reference to Table 3 demonstrates that older and less educated subjects produced results which at least were not as contrary to the hypotheses of Gilewski and Zelinski (1986) as were those of younger and better educated individuals. This is potentially of interest when it is recalled that studies pointing to the value of self-ratings of memory typically used elderly persons, some of whom had limited education. In the present study, even our older group was quite young (M = 36.74 years) and our less educated group had nearly completed high school (m = 11.61 years). It is certainly possible that had we sampled older individuals we would have obtained results more consistent with the postulations of Gilewski and Zelinski (1986).

The findings of this study suggest that a patient's report of diminished memory functioning is not necessarily indicative of specific memory dysfunction, at least in our younger and better educated patients. Rather, it would appear that patients' memory complaints may represent a combination of general dissatisfaction with their psychological status as well as self-perceived limitations in abilities. The possibility exists that a patient's complaint of memory problems is more akin to a general statement of "Something is wrong with me" rather than the indication of a limitation in a specific cognitive domain. If so, examiners who plan their assessments based on patients' complaints may omit important areas and miss relevant problems if

they do not also provide for a sampling of a spectrum of neuropsychological abilities in every patient.

REFERENCES

Cavanauqh, J. C., & Poon, L. W. (1989). Metamemorial predictors of memory performance in young and older adults. Psychology and Aging, 4, 365-368.

Dodrill, C. B. (1978). A neuropsychological battery for epilepsy. Epilepsia, 19, 611-623.

Gilewski, M. J. (1983). Self-reported memory functioning in young-old and old-old age: Structural models of predictive factors (Doctoral Dissertation, University of Southern California. 1983). Dissertation Abstracts International, 43, 4170B.

Gilewski, M. J.. Zelinski, E. M., Schaie, K. W., & Thompson. L. W. (1983, Auqust). Abbreviating the Metamemory Questionnaire: Factor Structure and norms for adults. Paper presented at the meetinq of the American Psychological Association, Anaheim, CA.

Gilewski, M. J.. & Zelinski. E. M. (1986). Questionnaire assessment of memory complaints. In L. W. Poon (Ed.). Handbook for Clinical Memory Assessment of Older Adults, (pp. 91-107). Washinqton, DC: American Psychological Association.

Larrabee, G. J., & Levin, R. S. (1986). Memory self-ratings and objective test performance in a normal elderly sample. Journal of Clinical and Experimental Neuropsychology, 8 , 275-284.

McGlynn, S. M., & Schacter. D. L. (1989). Unawareness of deficits in neuropsychological syndromes. Journal of Clinical and Experimental Neuropsychology, 11, 143-205.

Prevey. M. L.. Delaney. R. C., & Mattson. R. H. (1988). Metamemory in temporal lobe epilepsy: self-monitorinq of memory functioning. Brain and Cognition, 7, 298-311.

Schacter, D. L. (1990). Toward a cognitive neuropsychology of awareness: implicit knowledqe and anosognosia. Journal of Clinical and Experimental Neuropsychology, 12, 155-178.

Squire, L. R.. & Zouzounis. J. A. (1988). Self-ratings of memory dysfunction: different findings in depression and amnesia. Journal of Clinical and Experimental Neuropsychology, 10, 727-738.

Zelinski, E. M., Gilewski, M. J., & Thompson, L. W. (1980). Do laboratory tests relate to self-assessment of memory ability in young and old? In L. W. Poon, J. L. Fozard, L. S. Cermack. D. Arenberq, & L. W. Thompson (Eds.), New directions in memory and aqing: Proceedinqs of the George A. Talland Memorial Conference (pp. 519-544). Hillsdale, NJ: Erlbaum.

TABLE 1

SUMMARY OF SUBJECT DIAGNOSES

Diagnosis	Number of Subjects
Traumatic Brain Injury	15
Vascular	8
Tumor	6
Human Immunodeficiency Virus (HIV)	22
Epilepsy	3
Other	8
Total	62

TABLE 2

CORRELATION MATRIX OF MFQ WITH NEUROPSYCHOLOGICAL MEASURES
WITH ALL SUBJECTS

	Memory Function Questionnaire Scales								
	1	2	3	4	5	6	7	8	Total
Memory Measures									
WMS Verbal Immediate	.09	-.04	.00	.12	.22	.03	.00	.03	.04
WMS Verbal Delayed	.19	.08	.09	.15	.23	.06	-.01	.02	.09
WMS Visual Immediate	.01	.01	-.02	.02	.05	-.17	-.04	.11	-.01
WMS Visual Delayed	.14	.17	.07	.04	.09	-.00	.03	.17	.10
Rey Trials 1-5	.18	.16	.07	.06	.07	.11	-.02	.07	.09
Rey Recognition	.21	.18	.22	.20	.19	.11	.11	.12	.23
TPT Memory	-.12	-.16	-.20	-.08	.05	-.25	.20	.11	-.02
TPT Localization	.12	.05	.14	.25	.24	-.11	.12	.02	.17
Digit Span Forward	.26*	.14	.18	.11	.16	.21	.14	.16	.24
Digit Span Backward	-.00	-.04	-.01	-.04	-.02	.05	.08	-.11	.01
Non-Memory Measures									
Tapping	.07	-.05	-.04	.04	.07	.19	.02	-.09	-.04
Aphasia errors	.05	.02	.04	.02	-.19	-.08	-.07	.14	-.02
Drawing rating	.00	-.04	-.04	-.10	-.21	.11	.00	-.16	-.03
Sensory errors	-.15	-.26*	-.16	-.33**	-.34**	-.10	-.09	-.09	-.18
Tactile Forms	-.15	-.26	-.213	-.38**	-.41**	-.07	-.12	-.29*	-.29*
Name writing	.19	.34**	.25*	.42**	.33**	.31*	.17	.11	.33**
Stroop 1	-.10	-.03	-.03	-.06	-.12	-.24	-.09	.02	-.16
Block Design	-.15	-.11	-.17	-.06	.08	-.16	-.12	-.01	-.14
Grip Strength	-.02	-.06	-.10	-.21	-.10	.02	.14	.13	.02
Speech errors	-.06	.04	-.06	-.10	-.11	.02	-.21	-.07	-.18
Other Indices									
% Tests Impaired	-.12	-.10	-.09	-.19	-.34**	-.08	-.10	-.02	-.15
MMPI elevations	-.34**	-.42**	-.38**	-.28*	-.31*	-.33**	-.24	-.03	-.37**

Note: * = p <.05, ** = p <.01

TABLE 3

SIGNIFICANT CORRELATIONS BETWEEN MFQ AND NEUROPSYCHOLOGICAL MEASURES AS A FUNCTION OF TEST TYPE, AGE, EDUCATION, IMPAIRMENT, AND MMPI

				Significant Correlations of MFQ with Test By Type	
Variable	n	M	SD	Memory Tests	Non-Memory Tests
All Subjects	62			1	14
Age					
18 to 28	31	24.03	2.88	2	18
29 to 60	31	36.74	7.84	5	4
Education					
8 to 12.5	32	11.63	1.06	8	5
13 to 18	30	14.78	1.65	4	10
Percent of Neuropsychological Tests in Impaired Range					
6 to 31	29	16.76	9.22	9	10
38 to 94	33	58.73	16.52	4	11
Number of Elevated MMPI/MMPI-2 Scales					
0 to 1	24	.33	.48	2	6
2 to 9	28	4.54	2.13	23	12

Notes:

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the Department of the Army or the Department of Defense.

This research was supported in part by Grants NS 24823 and NS 17111 awarded by the National Institute of Neurological Disorders and Stroke, PHS/DHHS, USA.

We gratefully acknowledge the assistance of Alberta Klaus-Hagan and Gordon Winslow for their help in collecting and coding the data.

Reprints and Requests: Fred H. Brown, Jr., Ph.D., Psychology Service, Womack Army Hospital, Fort Bragg, NC, 28107-5000.

THE BASIC-ME QUESTIONNAIRE AND STRUCTURED CLINICAL INTERVIEW (BMQ)

P. Andrew Clifford Ph.D.
Reynolds Army Community Hospital
Fort Sill, Oklahoma

The BASIC-ME questionnaire combines techniques of structured interviewing, checklists, and Likert-type scales to assess. 1) medical, neuropsychological, intellectual, and psychosomatic signs and symptoms; 2) family, interpersonal, educational, and occupational history; 3) subjective stress and emotional status; 4) cognitive schemata involving self-other scripts, dysfunctional interpersonal styles, and metacognitive coping skills; and 5) existential hardiness. The questionnaire takes about 30-60 minutes to complete. A completed form can then be used by a clinician as an effective structured interviewing and treatment planning tool. Information obtained from the questionnaire can assist clinicians in determining further assessment and possible referrals within settings that provide specialized multidisciplinary services.

DEVELOPMENT

The BMQ is an assessment and treatment planning tool for therapists providing Multimodal Therapy from an emergent interactional perspective -- BASIC-ME (Clifford, 1990). The questionnaire utilizes adapted items from Lazarus' BASIC I.D. Life History Questionnaire (Lazarus, 1981), the Adult Neuropsychological Questionnaire (Melendez, 1978), the Stress- Arousal Checklist (Mackay, Cox, Burrows, and Lazzerini, 1978), the Marital Happiness Scale (Azrin, Naster, and Jones, 1973), The Splitting Scale (Gerson, 1984), the Intrinsic and Interactional scales of the Religious Life Inventory (Batson and Ventis, 1982), and the Purpose in Life Test (Crumbaugh & Malolick, 1964; Yalom, 1980). Other items have been constructed based on schemata associated with personality disorders (Freeman and Leaf, 1989), or metacognitions associated with time management, problem solving skills, positive self-talk, and social support management (Flavell, 1979; Meichenbaum, Burland, Gruson, and Cameron, 1985).

THERAPEUTIC APPLICATION

The distinctive features of the BASIC-ME approach to assessment and treatment are:

1. The identification of seven emergent (hierarchical) subsystems which reciprocally determine the person's mental status and psychosocial functioning.

2. The assertion that an accurate evaluation (or complete diagnosis) requires a systematic assessment of each interdependent BASIC-ME level of causation and their interactions in determining the person's psychosocial functioning.

3. An integrated clinical approach that promotes multidisciplinary and multimodal therapy which intervenes in and through the BASIC-ME hierarchy.

RATIONALE

The BASIC-ME multimodal approach assesses seven levels or hierarchical subsystems of the human person (Clifford, 1990). The BMQ assesses biological/neuropsychological signs and symptoms, affective/ psychosomatic states and intellectual functioning, sociocultural history and schemata, interpersonal/preoperational scripts, dysfunctional cognitive- behavioral styles, metacognitive coping skills, and existential/religious processes affective mental health and illness. The BMQ can be used to construct a BASIC-ME Profile, which delineates several factors which reciprocally determine the client's problematic symptoms. Using this profile, the clinician is able to construct a comprehensive (multidisciplinary and multimodal) treatment plan with the client (Lazarus, 1981).

It should be stated that many people seek out medical, psychological, and pastoral mental health services for specific clarifications, brief emotional support, crisis-intervention, or immediate help with situational problems. In such cases, a complete BASIC-ME multimodal assessment may not be indicated, nor feasible. Nevertheless, cursory assessment of the client's BASIC-ME subsystems will prove helpful, even in acute situational reactions (Lazarus, 1981).

SUGGESTED ADMINISTRATION PROCEDURES

The BMQ is normally given to the client after the initial interview. As part of establishing a therapeutic alliance, the therapist discusses the BMQ's purpose with the client who then completes the form (preferably at the clinician's office, or at home) prior to the next session. The questionnaire takes 30-60 minutes to complete. The second session is usually used to review the client's BMQ responses and to ask specific clarification questions. After working through the BMQ with the client, the therapist is ready to negotiate a comprehensive treatment plan with the client.

INTERPRETATION

The clinician is referred to the references listed below and specifically Clifford (1990) and Lazarus (1981) for interpretive rationale. The author is presently developing norms for some scales contained within the BMQ for both normal and clinical populations. Until such norms are available, it is recommended that clinicians use the BMQ as a symptom checklist and structured interview. The BMQ Self-Other Concepts checklist was designed to elicit prominent self-other role-relationships experienced by the client (Horowitz, 1988). The BMQ interpersonal Dynamics scale is composed of items suggesting primitive defenses such as splitting and idealized-devalued perceptions (Gerson, 1984; Hamilton, 1988), and borderline personality disorder schemata (Freeman and Leaf, 1989). Other schemata associated with personality disorders are listed within the Cognitive Styles scale (Freeman and Leaf, 1989). These items are grouped in sets of five with coded initials of the associated personality disorders to the far right (PA = paranoid; SC = schizoid; AN = antisocial; HI = histrionic; AV = avoidant; DE = defeating and dysthymic). The Coping Styles scale surveys time management, problem solving, cognitive monitoring, identification, rehearsal, and utilization of adaptive cognitive-behavioral strategies. The Religious Orientation scale is delineated into the adapted versions of the Internal (IN) and Interactional (QU = Quest) scales (Batson and Ventis, 1982).

BASIC-ME QUESTIONNAIRE

The purpose of this questionnaire is to explore and gather information regarding your lifestyle and historical background. In counseling, an understanding of the many factors that effect you life, permit us to assist you in dealing more effectively with your problems. By completing this questionnaire as fully and as accurately as you can, you will begin your therapeutic program. You are requested to answer these routine questions on your own time instead of using up your actual consulting time. It is understandable that you might be concerned about what happens to this information because much or all of it is highly personal. This questionnaire is confidential, and no one outside this clinic will see your case record without your permission and/or knowledge. If you do not desire to answer any questions, merely write "Do not care to answer."

GENERAL IDENTIFICATION

Name: _____ Age: _____ Race: _____ Sex: M F

Sponsor: _____ Rank: _____ SSAN: _____ Unit: _____

Date of Birth: _____ Place of birth: _____

Marital Status: Single Engaged Married Separated Divorced Widowed

Remarried (how many times? _____) Living with someone: Yes/No How long? ____

Do you live in a house, hotel, room, apartment, or _____

PRESENTING PROBLEM

State in your own words the nature of your problem(s).

_____

_____

_____

_____

How would you rate the severity of your problems using the scale below.

Mildly Upsetting Extremely Severe

1 2 3 4 5 6 7 8 9 10

When did your problems begin (give dates): _____

_____

_____

_____

What do you think caused your problems? Give events, situations, that you think relate to the development or maintenance of your problems:

_____

_____

_____

What solutions have you tried? _____

What solutions have been most helpful? _____

_____

Have you ever seen a counselor or psychotherapist before? If so, please give the names, professional titles, and dates seen.

_____

_____

1. BIOLOGICAL FACTORS

Who is your present physician? _____ Phone: _____

When was your last medical examination (give date): _____

Medications: Please list any medications you have taken over the last six months (include aspirin, birth control pills, or any prescribed or over the counter medicines).

_____

_____

Medical conditions: Do you have any current concerns about your health or any medical conditions. Please specify:

_____

_____

_____

Underline any of the following that apply to you or your family members:

thyroid disease, kidney disease, asthma, neurological disease, infectious disease, diabetes, cancer, gastrointestinal disease, prostate problems, glaucoma, epilepsy (seizures), heart disease, stroke, others: _____

_____

Risks & Symptoms: Indicate the extent the following behaviors or symptoms apply to you:

	NEVER/RARELY	SOMETIMES 1-3/month	MODERATELY 1-3/week	FREQUENTLY daily
Aerobic exercise	1	2	3	4
*Alcohol use	1	2	3	4
Allergies	1	2	3	4
Appetite change	1	2	3	4
Aspirin/painkillers use	1	2	3	4
Balance problems	1	2	3	4
*Blackouts (alcohol related)	1	2	3	4
Body parts numb or hurting	1	2	3	4
Bowels/Bladder control problems	1	2	3	4
Cigarettes	1	2	3	4
Coffee/Cola/Tea use	1	2	3	4
Concentration problems	1	2	3	4
Coordination problems	1	2	3	4
Dizzy spells	1	2	3	4
Diarrhea	1	2	3	4
Dropping things	1	2	3	4
*Drug (illegal) use	1	2	3	4
Eating fatty foods	1	2	3	4
Hands tremble	1	2	3	4
Hearing problems/changes	1	2	3	4
High blood pressure	1	2	3	4
Headaches	1	2	3	4
Insomnia	1	2	3	4
*Intoxication (drug/alcohol)	1	2	3	4
Memory problems/changes	1	2	3	4
Muscle weaknesses	1	2	3	4
Nausea/vomiting	1	2	3	4
*Passing out/fainting	1	2	3	4
Sense of direction problems	1	2	3	4
*Sleep problems/changes	1	2	3	4
Sleeping pill use	1	2	3	4
Speech problems	1	2	3	4
Strength training exercise	1	2	3	4
Taste or smell changes	1	2	3	4
Visual problems/changes	1	2	3	4

Height and Weight: What is your height ____ Ft. ____ inches. What is your weight? _____ lbs. Has your weight changed recently? _____ How much? _____

Have you ever had any head injuries or episodes involving a loss of consciousness? If so, give dates and a brief description of the incident.

_____

_____

Please describe any surgeries you have received (give dates):

_____

Please describe any serious accidents or injuries you have suffered (give dates): _____

_____

2. AFFECTIVE/ORGANISMIC

Physical sensations/complaints: Underline any of the following that apply to you:

Lightheadedness	Stomach trouble	Skin problems	Hot flashes
Rapid heart beat	Muscle tension	Clammy hands	Tingling
Choking sensation	Unable to relax	Numbness	Fatigue
Restlessness	Joint pain	Feeling shaky	Dry mouth
Muscle aches	Fear of dying	Watery eyes	Chest pain
Irritability	Easily startled	Mind goes blank	chills

Keyed up or always on edge	Fear of going crazy
Frequent urination	Smothering sensation
Hearing things others don't hear	Increased thirst/drinking more
Trouble swallowing	Excessive sweating
Sexual problems/changes in sex drive	Shortness in breath

Menstrual History

Age of first period _____ Are you regular? _____ Date of last period _____

Do you have pain? _____ Do your periods affect your mood? _____

Subjective Stress. Indicate the extent each of the following words describe your feelings and mood over the last week.

	Definitely describes me	Moderately describes me	Slightly describes me	Does not describe me
Tense	4	3	2	1
Relaxed	1	2	3	4
Restful	1	2	3	4
Apprehensive	4	3	2	1
Worried	4	3	2	1
Bothered	4	3	2	1
Active	4	3	2	1
Energetic	4	3	2	1
Drowsy	1	2	3	4
Vigorous	4	3	2	1
Tired	1	2	3	4
Idle	1	2	3	4

S score = _____ A score = _____

Feelings and Emotions: Underline any of the following feelings or emotions that most often apply to you:

Optimistic	Joyful	Loved	Accepted	Bored
Panic	Shocked	Excited	Disappointed	Sadness
Disgust	Contempt	Anger	Aggressiveness	Anticipation
Euphoria	Happy	Intense	Moody/Hyperactive	Embarrassed
Guilt	Hunger	Pleasure	Frustration	Nervous/anxious

What feelings would you like to feel more often? _____

_____

What feelings would you like to feel less? _____

_____

When are you most likely to lose control of your feelings? _____

_____

Describe any situations that make you feel calm or relaxed. _____

_____

Have you ever experienced times when you needed less sleep for several days or longer? Yes/No If yes, please describe: _____

_____

Have you ever been troubled by abrupt changes in mood? Yes/No If yes, please describe: _____

General Cognitive/Mental Status

How many senators are in the U.S. Senate? _____.

Who wrote Hamlet? _____.

What is the capital of France? _____.

How is seeing and smelling alike (the same)? _____.

How is a car and a ship alike? _____.

How is a letter and a telephone alike? _____.

Name the last seven presidents. _____

_____

4 X 24 = _____ 3 X 17 = _____ 4 X 6 - 4 = _____

How many quarters are in $1.75? _____

What is the average MILES PER HOUR speed of a car that traveled 25 miles in 30 minutes? _____

What is the average MILES PER HOUR speed of a car that traveled 21 miles in 45 minutes? _____

COPY

DRAW

Draw a clock showing the time ten to eleven

Please read the next sentence carefully and do what it says using the numbers below. Except for the numbers 1 and 7, connect the numbers in sequence with a series of lines.

[1] [7] [8]

[4]

[2] [3]

[6] [5]

3. SOCIAL FACTORS, STRESSORS, AND PERSONAL HISTORY

Stressors: Check each of the following events that apply to you and indicate the year(s) it occurred and ended:

	Event		Year it occurred		Year it ended
[ ]	Death of a child		19____		
[ ]	Death of a spouse		_____		
[ ]	Serious physical illness involving yourself or a family member	(within 2 years)	_____	-	_____
[ ]	Victim of natural disaster		_____		
[ ]	Victim of rape/violence		_____		
[ ]	Physical or sexual abuse		_____	-	_____
[ ]	Recent divorce or separation	(within 2 years)	_____		
[ ]	Recent birth of a child	(within 2 years)	_____		
[ ]	Prolonged unemployment		_____	-	_____
[ ]	Income under $15,000		_____		
[ ]	Recent marriage		_____		
[ ]	Recent job loss		_____		
[ ]	Chronic marital or family problems		_____	-	_____

Social/Cultural Factors: Please list the places you have lived (Countries, States, and/or major cities:

Age 0-10 _____

11-22 _____

23-40 _____

40-present _____

Father: If alive, give father's present age _____ Health: good/fair/poor

Years of education: _____ Occupation _____

If deceased, age at death _____ Cause of death _____

(How old were you at the time of your father's death? _____)

Mother: If alive, give mother's present age _____ Health: good/fair/poor

Years of education: _____ Occupation _____

If deceased, age at death _____ Cause of death _____

(How old were you at the time of your mother's death? _____)

Siblings: Number of brothers _____ Ages: _____

Number of sisters _____ Ages: _____

Parental: If you were not brought up by your natural parents, who raised you, and give dates (in years) you lived with them.

Underline any of the following words that apply to those who raised you:

hard worker	very religious	moral	lovable
hurts others	seductive/sexy	available	important
mostly unemployed	emotionally close	playful	successful
mostly happy	affectionate	mostly angry	mostly messy
absent from home	unfair punishment	hostile	very neat
abusive	uptight	fearful	forgiving
strict	caring	educated	loving
worked long hours	often depressed	always busy	friendly
didn't care about me	used drugs	supportive	generous
understanding	trustworthy	interfering	nervous
3 or more drinks/day	respecting of others		

Childhood: Underline any of the following that applied during your childhood/adolescence:

happy childhood	drug use	sexually abused
unhappy childhood	school problems	physically abused
emotional/behavioral problems	medical problems	sexually active
learning disabilities	legal problems	family problems
strong religious convictions	alcohol use	other:

Religion: As a child: _____ As an adult: _____

Education: What is the last grade you completed (or degree)? _____

Scholastic strengths: _____

Scholastic weaknesses: _____

Occupational:

What kind of work are you doing now? _____

List your work/job history: List years worked, your position and why you left:

Years	Position	Why you left

Have you ever been fired or released from a job? _____ If yes, please explain. _____

_____

Does your present work satisfy you? _____

What is your family income? (Check one) [ ] under $20,000
[ ] $20,000-$30,000 [ ] $30,000-$40,000
[ ] $40,000-$50,000 [ ] over $50,000

Dating/Marriage/Household:

Did you date much in high school? Yes No

Age you became sexually active _____.

How many long-term (greater that 1 year) relationships have you been involved in since you started dating?

First names	Status: Spouse/live-in/intimate friends	Reason for breakup

How long have you been married or living together? _____

How long did you know your present spouse before you married? _____

What is your partner/spouse's age? _____ Occupation _____

Any abortions or miscarriages? _____

_____

Children's names, sexes, and ages: _____

_____

Do any of your children have special problems? _____

_____

Who is presently living in your household? _____

_____

Household relationships satisfaction rating. Circle one of the numbers that indicates your current degree of happiness for each of the areas listed.

SCORE: _____

	Not Applicable	Completely unhappy				Completely happy
Household responsibilities	NA	1	2	3	4	5
Rearing children	NA	1	2	3	4	5
Social activities	NA	1	2	3	4	5
Money	NA	1	2	3	4	5
Communications	NA	1	2	3	4	5
Sexual satisfaction	NA	1	2	3	4	5
Academic/occupational success of spouse or children	NA	1	2	3	4	5
Personal independence	NA	1	2	3	4	5
Spouse independence	NA	1	2	3	4	5
General happiness	NA	1	2	3	4	5

On a scale of 1 to 5, I would rate the independence in my family as:

1	2	3	4	5
(No one is independent. There are no open arguments. Family members rely on each other for satisfaction rather than on outsiders.)		(Sometimes independent. There are some disagreements. Family members find satisfaction both within and outside of family.)		(Family members usually go their own way. Disagreements are open. Family members look outside of the family for satisfaction.)

On a scale of 1 to 5, I would rate my family as:

1	2	3	4	5
My family functions very well together				My family does not function well together at all. We really need help.

Psychological history:

Have you ever been hospitalized for psychological problems? _____ If yes, when and where: _____

Have you ever attempted suicide? Yes No

Has any member of your family ever attempted or committed suicide? Yes No

Does any member of your family suffer from alcoholism, epilepsy, depression, or anything else that might be considered a "mental disorder?"

_____

Have you or any relative had serious problems with the law? Yes No

4. INTERPERSONAL SCHEMA:

Self-Other Concepts. Underline each of the following words that describes your feelings, actions and/or thoughts when you relate with people. Think about your relationships with your family, friends, work associates, and people you relate with on a day-to-day basis.

When relating to others, I often feel...or act....

like a child	innocent/naive	dumb	like a victim
like a servant	controlled	weak	bad
wrong	guilty	like a loser	like a fraud
defective	the best/greatest	admired	worthless
wounded	like an angel	hated	helpless
empty	not cared for	small	needy
crippled inside	persecuted	vengeful	like superman/woman
loved	cared for	selfless	loving
all bad	all good	like a rebel	like an underdog
like the target	a need to rescue	more capable	more intelligent
deprived	tough	wanting	better qualified
alone	distant	lost	like a guardian angel
professional	businesslike	emotionless	guarded
vulnerable	resentful	sorry/remorse	a nobody
useless	unlovable	undesirable	crazy
incompetent	attractive	humorous	hard-working
honest	sensitive	confident	ambitious
over worked	rushed	creative	pushed around

other feelings or actions not mentioned above....

When relating to others, other people often act or are....

patronizing	seductive	smarter
abusive	bossy	authoritative
controlling	assaulting	stronger
better	critical	judgmental
like they're hot stuff	scornful	suspicious
harmful	loving	giving
all good	all bad	evil
selfish	strong	superficial
very helpful	important	caring
supportive	good provider	nurturing
manipulative	persecuting	like a bully
aggressive	dangerous	violent
like conspirators	intellectual	competitive
vengeful	rich	dumb
like a chump	weak	distant
non-caring	uninterested	busy
too emotional	emotionless	imposing
resentful	good natured	fake

other feelings or actions not mentioned above....

Interpersonal dynamics. Using the numbered scale provided below, indicate the extent the following sentences are true for you. Place your number answer in the blank space BEFORE each sentence below.

Not at all true	Slightly true	Moderately true	Considerably true	Totally true
1	2	3	4	5

____ I hate to hear someone close to me being criticized.

____ When I'm with someone really terrific, I feel dumb.

____ When I'm angry, everyone around me seems rotten.

____ My friends don't know how much I'd like to be admired by people.

____ It's hard for me to get angry at people I like.

____ It's very painful when someone disappoints me.

____ I have absolutely no sympathy for people who abuse their children.

____ Sometimes I feel I could do anything in the world.

____ There are times my spouse, or lover, is as strong as iron, and at other times as helpless as a baby. (Consider your most recent relationship in the absence of an ongoing relationship.)

____ I often feel that I can't put the different parts of my personality together, so that there is one "me."

____ Sometimes I feel my love is dangerous.

____ When I'm in a new situation, there's often one person I really dislike.

____ It's hard for me to become sexually excited when I'm depressed.

____ Some people have too much power over me.

____ I am not sure who I am.

____ People always leave or abandon me.

____ My intense feelings control my behavior.

____ When people or things overwhelm me, I need to escape. Life doesn't seem worth living at those times.

____ One bad thing can ruin my whole life.

____ My emotional pain gets so intense, I can't bear it.

____ If I kill myself the world would be better off.

Mind set. Underline each of the following which apply to you:

I PICTURE MYSELF, THINK ABOUT, OR I HAVE DAY DREAMS INVOLVING ME....

being hurt	hurting others	being in charge
not coping	failing	succeeding
losing control	being trapped	being followed
being talked about	being promiscuous	being laughed at
having pleasant sex	being aggressive	being lonely
being sexy	being loved	being sexually used
being helpless	being successful	solving problems
overcoming difficulties	having a sense of humor	having fun
being in peaceful places	being rescued	being abandoned/left
reliving past experiences		

Of those listed above, which pictures, daydreams, or fantasies come to you r

mind most often? 1) _____ 2) _____

3) _____ 4) _____

Interpersonal support/stressors:

How easily do you make friends? _____

Do you keep the friends you make? _____

Were you ever bullied, abused, or severely teased? _____

List the people or relationships that give you:

(a) love & support: _____

_____

(b) stress & suffering _____

_____

Rate how comfortable or relaxed you are in social situations.

Very relaxed 1 2 3 4 5 Very anxious

Can you generally express your feelings, opinions, and wishes to others in an open, appropriate manner? Yes No Describe those individuals with whom (or those situations in which) you have trouble asserting yourself.

_____

Do you have friends with whom you feel comfortable sharing your most private thoughts and feelings? Yes No If yes, list their first names:

_____

5. COGNITIVE-BEHAVIORAL LIFESTYLES:

Cognitive styles. Using the numbered scale provided below, indicate the extent the following sentences are true for you. Place your number answer in the blank space BEFORE each sentence below.

Not at all true	Slightly true	Moderately true	Considerable true	Totally true
1	2	3	4	5

PA

____ No matter what you do, people will take advantage of you.

____ People go out of their way to annoy, hurt, bother, or frustrate me.

____ If someone does you wrong, don't get mad, get even.

____ To compromise with another is to allow yourself to be exploited.

____ I don't trust people, and I'm always on guard.

SC

____ I stay calm. Displays of emotion are useless and/or embarrassing.

____ I do not disclose personal information, or am I interested in gossip.

____ I enjoy time along, and I am my own best friend.

____ Being close to others is not important to me.

____ Sex is okay as long as it doesn't get serious

AN

____ I look out for number 1.

____ If it feels good, I probably do it, or have tried it.

____ I do my thing. If it offends someone, or inconveniences them, I'm sorry. That's their problem. It's a free country.

____ I'll do whatever it takes to get what I want.

____ Rules are meant to be broken by those who are smart enough to get away with it.

HI

____ Emotions should be expressed quickly, sincerely, and directly.

____ I must admit, I do enjoy being the center of attention.

____ People need to try and look the best they can.

____ I try not to get too frustrated. Life is too short not to enjoy every minute.

____ I can tell what a person is like in just a few moments.

NA

____ I like being the leader and being admired for just being me.

____ I hate it when people let me down, especially those who say they love me.

____ I have very high standards for people I associate with.

____ There's nothing more disgusting than a successful person acting like he/she is hot stuff. They tend to be show-offs and/or conceited.

____ It angers me when people don't come through for me.

AV

____ Being alone and stable is better than taking social risks and getting hurt.

____ Unconditional love or friendship is the only type of relationship I really want.

____ The world is a dangerous place.

____ Criticism is seldom constructive, and more often than not it is unfair.

____ I'll test people and demand their total loyalty before I'll commit myself to a relationship.

DE

____ I don't like being alone, or without someone who care for me.

____ Let's face it, my life is controlled by outside forces.

____ It is very important to be considerate and pleasing to other people.

____ I must admit, I enjoy it when someone takes care of me and I can take care of them.

____ I'll do anything for those I love.

OS

____ Emotions need to be controlled.

____ Basically, there are two ways of doing things, by the rules (the right way) or not by the rules (the wrong way).

____ I never discard anything that may be of some value later.

____ I'm into my work more than most people.

____ I like things in their place, and I enjoy following proper etiquette.

AG

____ No one can make me do what I don't want to do.

____ What bothers me is that my boss pressures me and then undervalues my work and worth.

____ I need to be able to work at my own pace; deadlines are usually unfair and exploitive.

____ Anger is dangerous and I tend to avoid expressing it directly.

____ If I can do it tomorrow, I'll do it then.

SD

____ I try to be good at everything I do.

____ When I don't know something, I pretend that I do.

____ I am a victim of fate and circumstances.

____ Other people seem to be happier than I am.

____ After what I've done, I don't deserve to be happy.

____ If I ignore my problems, they tend to go away.

____ It is my responsibility to make other people feel good.

____ I strive for perfection.

____ When I make mistakes, I feel like a failure.

Behavioral Patterns. Underline any behaviors that apply to you.

Overeating	Suicide attempts	Can't keep a job
Healthy diet	Voting	Fitness program
Take drugs	Compulsions	Non-assertive
Friendly	Organized	Helpful listener
Bulimia	Lack of exercise	Hurting myself/others
Smoking	Odd behavior	Take too many risks
Withdrawing	Lazy/bored	Drink too much
Nervous movements	Eating problems	Sleep problems
Outgoing	Good lover	Give good advice
Loss of control	Aggressive behavior	Crying easily
Procrastination	Work too hard	Dating problems
Concentration problems	Afraid of things	Outburst of temper
Law abiding	Cleanly or neat	Acts of kindness
Excessive arguments	Damaging my body	Inappropriate laughter
Can't carry out plans	Not being on time	Hitting my kids
Poor job performance	Not getting what I want	Fits of anger or rage
Hard working	Shy/inhibited	Professional skills

Not getting along with friends or family members
Not getting along with my boss or work associates
Giving in to people's desires and demands even when I do not want to.

What behaviors would you want to do more of? _____

_____

How do you spend your free time? _____

6. META-COGNITIONS (SELF UNDERSTANDING AND CONTROL):

Coping Styles. Using the number scale provided, indicate the extent the following sentences are true for you. Place your number answer in the blank space BEFORE each sentence below.

Not at all true	Slightly true	Moderately true	Considerable true	Totally true

____ I plan my daily activities by making a list of things to do.

____ I prioritize my daily activities.

____ I monitor the things I do daily.

____ I try to discover and understand the causes of my problems.

____ I explore options and seek out advice on difficult problems/tasks.

____ I prioritize options and devise a plan to complete difficult problems.

____ I break down lengthy projects or goals into smaller ones.

____ I actively avoid things that lead to problems developing.

____ I monitor my progress on carrying out desired plans.

____ I practice rewarding myself when I complete a plan or accomplish a goal.

____ I practice taking a positive outlook on life.

____ I identify my negative or self-defeating thoughts and actions.

____ I practice substituting positive thoughts for negative thoughts.

____ I practice positive imagery by imagining myself behaving and feeling in a desirable way, or thinking positive things about myself.

____ I try to understand and control factors that cause me to behave and feel the way I do.

____ When I am confused, I try to think things out or talk it out with a friend or family member.

____ I practice sharing my feelings and thoughts with others, and I am open to their feedback.

____ I am open to discovering better ways of doing things, and better ways of thinking about myself, my situation, and my future.

____ I practice clarifying my goals and values and then use them to make decisions that effect my life.

Do you have any personal characteristics that may be contributing to the problems you are experiencing? _____

_____.

How are you coping with your problems? _____

_____.

What coping strategies work best for you? _____

_____.

How do you think psychotheraby/counseling will help you? _____

_____.

7. EXISTENTIAL, AND RELIGIOUS FACTORS:

Life Purpose. Using the numbered scale provided below, indicate the extent the following sentences are true for you. Place your number answer in the blank space BEFORE each sentence below.

Not at all true	Slightly true	Moderately true	Considerably true	Totally true
1	2	3	4	5

____ I am NOT usually bored.

____ After retiring, I'm going to do some important and exciting things.

____ In achieving my life's goals, I have progressed to complete fulfillment.

____ My life is filled with challenges, stresses, and meaningful experiences.

____ If I should die today, I would feel that my life has been very worthwhile.

____ The world is meaningful and gives my life purpose.

____ With regard to death, I am prepared and unafraid.

____ I have a lot to live for.

____ Living and working is a source of pleasure and satisfaction for me.

____ I have discovered clear-cut goals and a satisfying life purpose.

Religious orientation. Using the numbered scale provided below, indicate the extent the following sentences are true for you. Place your number answer in the blank space BEFORE each sentence below.

Not at all true	Slightly true	Moderately true	Considerably true	Totally true
1	2	3	4	5

IN

____ It is important for me to spend periods of time in private religious thought or meditation.

____ If not prevented by unavoidable circumstances, I attend church.

____ I try hard to apply my religious beliefs to all my activities in my life.

____ The prayers I say when I am alone carry as much meaning and personal emotion at those said by me during services.

____ Quite often I have been keenly aware of the presence of God or a Divine Force working in my life.

____ I read literature about my faith (or church).

____ If I were to join a church group, I would prefer to join a study/prayer group, rather than a social fellowship.

____ My religious beliefs are what really lie behind my whole approach to life.

QU

____ Religion is especially important to me because it addresses many of my questions concerning the meaning of life.

____ I expect that my religious convictions might change in the next few years.

____ Questions are as important to my religious experience as are theological truths.

____ God wasn't very important to me until I began to ask questions about the meaning of my own life.

____ My religious development has emerged out of my growing sense of personal identity and growth.

____ I have been driven to ask religious questions out of a growing awareness of the tensions in the world and in my relations with the world.

____ It might be said that I value my religious doubts and uncertainties.

References

Azrin, N. H., Naster, N. J., & Jones, R. (1973). Reciprocity counseling: A rapid learning-based procedure for marital counseling. Behavioral Research and Therapy, 11, 365-382.

Batson, C. D., & Ventis, W. L. (1982). The religious experience: A social-Psychological perspective. New York: Oxford University Press.

Clifford, P. A. (1990). Emergent interactionalism & multimodal therapy: A bio-social-cognitive-existential paradigm of mental health assessment and treatment. Proceedings from the 1990 AMEDD Short Course. Letterman Medical Center, San Francisco.

Flavell, J. H. (1979). Metacognitive and cognitive monitoring: A new era of cognitive-development inquiry. American Psychologist, 39, 906-911.

Freeman, A., & Leaf, R. C. (1989). Cognitive therapy applied to personality disorders. In A. Freeman, L. Simon, L. Beutler, & H. Arkowitz (Eds.). Comprehensive Handbood of Cognitive Therapy. New York: Plenum Press.

Gerson, M. J. (1984). Splitting: The development of a measure. Journal of Clinical Psychology, 40, 157-162.

Hamilton, N. G. (1988). Self and Others: Object relation theory in practice. Northvale, New Jersey: Jason Aronson Inc.

Horowitz, M. J. (1988). Introduction to Psycholdynamics: A new synthesis. New York: Basic Books.

Lazarus, A. A. (1981). The practice of multimodal therapy: Systematic, comprehensive, and effective therapy. New York: McGraw-Hill Books.

Mackay, C., Cox, T., Burrows, G., & Lazzerini, T. (1978). An inventory of the measurement of self-reported stress and arousal. British Journal of Social and Clinical Psychology, 17, 283-284.

Meichenbaum, D., Burland, S., Gruson, L., & Cameron, R. (1985). Metacognitive assessment. In S. Yussen (Ed.). The growth of reflection in children. New York: Academic Press.

Melendez, F. (1978). Revised Manual for the Adult Neuropsychological Questionnaire. Psychological Press Inc.

Yalom, I. O. (1980). Existential psychotherapy. New York: Basic Books.

ON STRIVING FOR EXCELLENCE: A BOARD-ELIGIBLE PSYCHOLOGIST'S EXPERIENCE WITH THE ABPP PREPARATION COURSE

Mark L. Paris, Ph.D.
DeWitt Army Community Hospital
Fort Belvoir, Virginia

The demands and challenges of military psychology in particular, as well as clinical psychology in general, require practitioners to maintain the highest possible levels of skill and effectiveness. The national organization tasked with identification of excellence in professional psychology is the American Board of Professional Psychology (ABPP). The ABPP awards diplomates in various categories of professional practice, upon successful completion of a day-long oral examination. The present author, upon attaining the status of Board-eligible through application to ABPP in the Spring of 1990, attended an ABPP Institute preparation course for the ABPP examination in July of that year. The purpose of this paper is to describe the essential elements of the preparation procedure as outlined and described in the course, to include the emphasis on "Theory-Research-Practice Integration;" in addition, an attempt is made to give to the reader an idea of how differing examiner attitudes appear to interact in the evaluation process, as well as some of the changes presently being planned to "overhaul" the ABPP evaluation system.

---from instructions to ABPP examiners

The process of becoming a clinical psychologist appears, at first glance, to have a fairly extensive set of hurdles which must be cleared; afterwards, the expectation is that one is considered, having achieved a doctoral degree, to have met the standardized professional level of training and experience to practice independently. There are, as it were, no more hurdles and nothing more to prove.

The continuing competition, however, among psychology and its sister disciplines, psychiatry and social work, would now seem to dictate that a procedure in which determination of excellence in the field of applied psychology would be a necessary service contributing to the public welfare. Such a service is now performed by a body of psychologists known as the American Board of Professional Psychology (ABPP). Among the purposes and aims of the ABPP, as described in the Policies and Procedures, are examinations to determine qualifications for ABPP diplomas, awarding of such diplomas and maintenance of a registry of recipients, and the providing of these registries on demand to the general public.

The author applied for ABPP eligibility in early 1990, and was admitted to Candidacy in Clinical Psychology on 11 MAY 1990. In an attempt to gather as much helpful information as possible on the actual ABPP examination procedure, he attended the ABPP Institute workshop on Preparation for the ABPP Examination from 25-27 JULY 1990. An attempt will be made here to present the gist of what was communicated by the three presenters, all of whom were ABPP diplomates in

Clinical Psychology, and all of whom did or do sit on ABPP examining committees. The experience will be described sequentially, as it was taught, to include guidance on the application process, notification of Board-eligibility, preparation and submission of work samples, and a description of the oral examination.

THE ABPP APPLICATION

The ABPP awards the Diplomate in the following areas of applied psychology: clinical, clinical neuropsychology, counseling, forensic, industrial/organizational, and school. Essentially, to become Board-eligible for the ABPP, one must have a doctoral-degree in psychology, to include an internship, and five years of "acceptable qualifying experience," of which the internship is recognized as one. If the doctoral program was not approved by the American Psychological Association (APA), ABPP decides on qualification much as a licensing board would. In addition, the Board wants to see evidence of continuing education, membership in APA and a license in the state in which one actually practices. The applicant sends the application, with appropriate documentation (or has it sent), with $300. This fee pays only for the application process; the actual examination will cost another $400, plus any costs attributable to travel requirements of the examiners.

The process of determination of Board-eligibility/Candidacy begins at the time the application is initially sent; this time includes that required for the Board to receive transcripts and letters of recommendation. Once all is determined to be in order, the Board notifies the applicant of its decision. If the applicant is designated as a Candidate, then the complex task of creating and submitting the Work Sample begins.

THE WORK SAMPLE: WHAT IS IT & HOW DO YOU DO IT?

There are three parts to the Work Sample: the Professional Data Sheet, the Evaluation Work Sample and the Intervention Work Sample.

The Professional Data Sheet is the "cover sheet" to the Work Sample. It includes a description of work setting, a breakdown of normal activities, common forms used in the office (including consent forms), copies of tests most often used, personal business cards or advertising, and any other information that best illustrates what you do in your practice and how you do it.

The Evaluation Work Sample is usually a psychological test battery protocol (all raw data included), along with a psychological report based on that data. The workshop faculty warned that the test examiners have about 100 hours to prepare for your exam, and therefore they look very carefully at the protocols and scoring procedures; it was made clear, for example, that a scoring error which would account for a significant change in an IQ score is grounds for immediate failure of the examination. Likewise, such things as Rorschach protocols are examined for gross scoring errors. The test data and report must be accompanied by a statement which describes the context for the Work Sample (read HPI and Social History) as well as a rationale for the choice of the tests and how the test results help determine the treatment to follow. The faculty emphasized that the case should be one that you know well; it would be helpful if you already had positive feedback from colleagues regarding the

quality and usefulness of the report.

The intervention Work Sample also consists of two parts: an audio/video tape of a therapy session (to be accompanied by an accurately typed transcript of that tape) and a background description of the case. This background description would include identifying information about the patient and treating agency, information concerning previous sessions (again, to include HPI and social history), a formulation of the problem, goals or plans for the intervention, a rationale for the intervention and for any specific techniques, the status of the case at present, and any additional information that you might consider helpful or informative.

THE TEST ITSELF: WHAT IS TRPI?

The fundamental concept underlying the ABPP examination is Theory-Research-Practice Integration (TRPI). Essentially, the Board of Examiners wants a Diplomate to be more than a psychological tactician; their attitude is that anyone can apply techniques "at random" until something works. The psychologist should be able to conceptualize theoretically what is happening in a given case, and should be able to apply an intervention based specifically on what his particular theoretical formulation dictates appropriate. Additionally, there must be an expansive research base which supports the psychologist's choice of the particular intervention in that individual case. The ability to integrate (throughout one's practice, as well as throughout the ABPP exam) is the key to passing, according to this workshop faculty. Dr. Norman Sundberg, one of the instructors, recommends some pointed questions worth asking oneself during test preparation.

1) What basic psychological concepts do I use in daily practice? How do I formulate cases.

2) With my assessment cases, what is the research on the value of my procedures (real evidence of utility)?

3) What are the theoretical reasons for my interventions. Could I formulate intervention plans from theoretical orientations other than my own? Am I eclectic, integrative, or neither? What is my espoused theoretical orientation vs. my true theory of practice?

4) How do I evaluate success or failure?

A typical ABPP oral examination goes from about 9 a.m. to about 5:30 p.m., with a 1-1/2 hour break at 11 a.m. for "lunch" (if you can eat). It breaks down in the following way:

9-11 a.m.: The so-called In-Vivo intake. For up to two hours, you will be observed doing an intake evaluation by the examining committee through a one-way mirror. The case is usually one where the presenting complaint is one you often see in your practice. You need to consider whether or not to bring any of your own intake/evaluation materials for this interview. The committee want to see what you would usually do in this situation.

11-12:30 p.m.: While the committee eats lunch, you "process" what your intervention/treatment plan would be, being careful to invoke TRPI in your thinking.

12:30 p.m.: Intake discussion; you can expect to be asked your impressions of the patient, diagnosis, theoretical formulation, treatment plan, etc.

2-3 p.m.: The committee will take one hour to discuss your evaluation and intervention Work Samples. The typed transcript of your therapy session will have been carefully compared to the tape itself, to ensure that you have not deleted a part in the typed transcript that you felt "not supportive" of your candidacy.

3-4 p.m.: This time is spent exploring with the committee your own research interests and general professional knowledge.

4-5 p.m.: Ethics; you might very well be asked to describe an ethical dilemma you have faced, or you might be asked to deal with a dilemma that will be described to you.

5-5.30 p.m.: The committee will assess what it terms as your "professional commitment;" they will explore the extent of your interest/participation in professional writing, community work, and (apparently fairly important) pro-bono work.

WHAT'S NEW & DIFFERENT AT ABPP

An unusual aspect of the ABPP examination is that the outline provided here is consistent throughout the United States (the ABPP divides the country by regions), except in the Northeast Region. The exams in the Northeast Region are administered in a very different way than in the rest of the country; while the usual method, as practiced in most of the country is a simultaneous, joint effort by the committee (i.e., four people testing at once), the Northeast Region used a sequential model, something in the way of "cafeteria-style." The candidate goes from station to station, where one examiner watches the intake, another evaluates Work Samples, another assesses general professional knowledge/community activity, and a fourth assesses knowledge and understanding of ethical principles. It is questionable, because of internal pressures within the organization, as to whether this methodological inconsistency is going to be allowed to continue into the foreseeable future. The workshop faculty were fairly vague on specifics, but attempts are now being put forward to address what are seen as "wrinkles" in the evaluation process; the starting point will most probably be termination of the sequential Northeast Region method of examination.

It's also important to note that because of the very subjective nature of this examination, individual examiners <u>will</u> assess the attributes of candidates in different ways. Even among the faculty, it soon became clear that there was a range of "obsessiveness-orientation" that varied among the instructors; one even made reference to his obsessive style in the context of describing his own evaluation experience!

The ABPP estimates that it takes about 1-1/2 to 2 years of preparation before one is truly ready to sit for the ABPP examination. Exact statistics on pass-fail rates are unavailable, but the ABPP is actively encouraging psychologists to "strive for excellence" by becoming ABPP diplomates. Interestingly, the workshop faculty began by suggesting that their goal was to lower anxieties associated with taking the examination. After experiencing the three-day workshop and interacting extensively with several other would-be ABPP diplomates, it appears unclear to the author as to whether or not the faculty's goal was, indeed, ultimately realized.

APPLICATIONS AND INFORMATION REGARDING THE ABPP EXAMINATION ARE AVAILABLE FROM:

American Board of Professional Psychology, Inc.
2100 East Broadway, Suite 313
Columbia, Missouri 65201-6082

Ph: (314) 875-1267

REFERENCES

Maurer, D.C. Preparation for the ABPP examination. Article written for the ABPP Preparation Course, Portland, Oregon, July 1990.

Policies and procedures for the creation of diplomates in professional psychology. ABPP Inc., Columbia, Missouri.

Sundberg, N. The work sample and theory-practice integration: preparing for the ABPP examination. Article written for the ABPP Preparation Course, Portland, Oregon, July 1990.

STRESS MANAGEMENT: TAKING IT TO THE TROOPS

Hodges J. Glenn, Jr., Ph.D. & Scott Smith, Ph.D.

Military medical and mental health providers receive a large number of consultations involving an array of stress related disorders. This seems particularly true during times of "crisis" when there are extraordinary demands on the individual soldier and his family, as in the Middle Eastern situation. The authors have developed a structured, "portable", stress management program which consists of training in the understanding, recognition and resolution of stress related difficulties prior to their pathogenesis into "disorder". This stress management "road show" was successful treating units which remained in garrison as well as those units selected for deployment during Desert Shield/Desert Storm. Units in the following commands received the stress management "road show"; Military Police Battalion, Recruiting Command, Dental Research Activity, Military Intelligence Command, and Criminal Investigation Command. Feedback reports from the units which were serviced indicated that the program was useful and welcomed again. It is optimal if Army Psychologists can identify populations at high risk for stress related disorders and apply a primary prevention model of intervention. Use of a group format which meets with units at their location during training time seems to be the most effective, expedient and acceptable method of applying this model.

We are all bombarded with numerous types of stressors on a daily basis. Members of active duty units need to pay particular attention to the stressors encountered on their jobs. If left unmanaged, the effects of stress significantly decrease productivity, and depending on the job, could place individuals as well as the unit at risk of physical/psychological harm. Mental health workers at Fort Meade, Maryland, MEDDAC have developed a treatment program to meet the needs of the soldier regardless of the unit mission. This is an aggressive, adaptable program which can be tailored to fit the needs and expectations of each command.

In this paper we address four key components which made this program a success. First, we discuss the types of staffing necessary to make this stress management program work. Next, we cover the actual structure, organization and delivery of this program to the target audience. Third, we show how we were able to market the program in order to maximize referrals. Finally, we address why such a program is necessary.

The staff chosen to put this program on the road to the troops must be able to work together and relate effectively to each unit and its command structure. These staff presenters must possess a strong background in stress management training and be able to communicate this knowledge effectively to their audience. Listed below are examples of personnel staffing for two stress management programs of which one of the authors (Glenn, Hodges, Jr., Ph.D.) is very familiar.

One program is located at Kimbrough Community Hospital's Mental Health Center at Fort Meade, Maryland. The other program is located at the US Army Disciplinary Barracks at Fort Leavenworth, Kansas. The Fort Meade program consists of two clinical psychologists and a social worker. The program at the U.S. Army Disciplinary Barracks at Fort Leavenworth, is staffed by noncommisioned officers (NCO's) trained in the behavioral sciences (91G - military occupational specialty) and social workers.

Once a confident, competent staff has been assembled to provide stress management training, a complete, but flexible training package needs to be available for its use. The stress management program takes five hours and works best with a group of 20 individuals; it is presented in three phases. Stage one consists of lecture format. The purpose of the lecture is to provide the troops with a clear understanding of stress-related difficulties. The following topic areas are covered; (a) historical information on stress, (b) definitions of stress, (c) sources of stress, (d) physiological responses to stress, (e) negative effects of stress, (f) signs and symptoms of stress, and (g) techniques for relief from stress. Phase I takes sixty minutes to complete. The terminal objective of phase I is that all participants must be able to recognize stress related-difficulties when they see them, whether in themselves or others. At the completion of phase I, have them stretch and practice abdominal breathing as part of a relaxation exercise before moving on to phase II of the training.

The second phase consists of taking the information on stress-related difficulties and relating it to general health/wellness issues of nutrition, smoking, eating, weight control, and exercise. The outline for phase II covers the following information; (a) eating habits, (b) alcohol consumption, (c) regular exercise, (d) time management, (e) personal growth, and (f) relaxation techniques practice. Proper completion of phase II takes sixty minutes. The terminal objective of this block of instruction is to ensure that all participants are aware of the many practical short and long-term alternatives available to improve the quality of their lives.

The content areas discussed in phase II comes from the Army's "Fit to Win" training volume set, which introduces soldiers and commanders to this material in a way which is easy to understand. Suggestions are provided in this material for developing training modules from various topic areas. The "Fit to Win" training volume set can be requested through any post's local publication office.

Phase III, the final phase, focuses on group and individual needs. The outline for phase III follows this format; (a) individual stressors, (b) occupational stressors, (c) understanding your stress, (d) placing stressors in perspective, and (e) using problem solving strategies. The technique of group process is used to encourage sharing of individual stressors as well as areas of stress common to all. The goal of this technique is to assist the group members in developing realistic solutions for the group and/or individual issues. The group members agree to try the solutions, continue training on stress management, and provide feedback to the presenters using the pre-/post-test instruments provided during the workshop. The terminal objective of this phase of training is to get these individuals to function more cohesively as a team. The "road show" raises the awareness of the advantages of being a member of a team rather than isolating oneself because of the myth that one must solve his/her problems alone. Phase III takes three hours and includes sufficient time for questions,

debriefing of all group members and a final wrap-up by the presenters (subject-matter experts).

When commanders were having particular problems with personnel they called for our intervention. Close inspection of the facts surrounding many of the cases revealed that the soldier chose to respond in ways which escalated a situation, sometimes resulting in physical harm to himself and others, as well as decreased productivity. A review of the many cases referred to Community Mental Health from the Military Police Battalion, Recruiting Command, Dental Research Activity, Military Intelligence Command, and Criminal Investigation Command all revealed that significant individual and group stressors were present. Learning how to recognize these stressors and then respond in a controlled manner significantly increases options for more suitable behavioral responses to the situation under question.

Marketing a primary prevention program to units which are more reactive to events than proactive is difficult. Some of the stress management training was done at the request of commanders who were proactive. However, a great majority of our interventions came as the direct result of the successful treatment of a service-member referred from that unit. Once the invitation to present a stress management workshop was issued by the commander of that unit, the opportunity was used to tailor the program to meet the needs of that command. The general feedback obtained from units about the "road show" program was good.

The staff presenting the Fort Meade Community Mental Health program (two clinical psychologists and a social worker) found the program necessary because it gave them the opportunity to get out and spend time with the units. This resulted in increased rapport and trust between Community Mental Health and the unit. The stress management "road show" provided an effective psychoeducational tool in developing unit understanding, recognition, and resolution of stress-related difficulties prior to their development into a situation requiring crisis intervention by a mental health practitioner. Presenting the program to these units gave commanders a point of contact, making it easier for them to refer other individuals to Mental Health. Since each unit encountered had different needs, it was important to understand the special requirements of service-members working within that unit. For instance, the stressors encountered by Dental Research Activity personnel were different than the stressors encountered by the personnel assigned to Criminal Investigation Command.

The stress management program "road show" can have positive effects on the population served because it gets the material to the unit, presents the material so it's easy to understand, then relates it to their lives using current "Fitness to Win" doctrine. The "road show" provides a forum whereby unit members can grapple with their problems under clinical supervision. It builds group identity, cohesiveness, and mobilizes thoughts into action. Participants can discuss their problem areas with the presenting clinical team; and, through a group process, generate options for dealing with individual and group stressors. The final phase of the training requires clinicans and unit leaders to develop a follow-up plan for the unit.

Our society is very complex. The demands that are placed on us are tremendous. Any assistance that can be given to assist our soldiers needs to be offered. The stress management "road show" has proven that it can meet this mission.

REFERENCES

Fit to Win - Managing Stress, (1987), TVT 8 - 124, 23 minute videotape, 3/4 inch format.

Nutrition and Your Health, (1987), TVT 8 - 135, 20 minute videotape, 1/2 inch format.

What Everyone Should Know About Stress, c. 1985 Channing L. Bete Co., Inc. South Deerfield, MA. 01373 Printed for Community Mental Health service USA MEDDAC Fort George G. Meade, MD 20755-5800

Smith, Scott, & Glenn, Hodges, Jr., (1990) Stress Management Outline & Information Packet, MEDDAC (FT Meade) Handosut # 227

Fit to Win, Your Handbook - The Army's Health Promotion Program, Department of the Army, Pamphlet 600-64-14, September 1987

Stephens, C.R. Stress: An Unnecessary Fact of Life, (1987) Military Medicine, Vol 152(1) 19-24

Thompson, T.J. Mediating Stress in Army training: The Trainer Is The Critical Component (Final rept. Sep 88 - Apr 89) Army Research Inst. for the Behavioral and Social Sciences, Alexandria, VA.

Thompson, T.J. Cohesion as a Deterrent to stress for Rotational Deployment Units (Final rept. Jan - Sep 87), Army Research Inst. for the Behavioral and Social Sciences, Alexandria, VA.

Cruz, P.K. Preliminary Study of Navy Recruiters: Incentive Programs and the Effects of Job-Related Stress, (1988), (Master's Thesis), Naval Postgraduate School, Monterey, CA.

Mangelsdorff, A.D. Proceedings of User's Workshop on Combat Stress (6th), San Antonio, Texas 30 Nov - 4 Dec 1987 Army Health Care Studies and Clinical Investigation Activity, Fort Sam Houston, Texas

Kowal, D.M. Stress Management and Health Promotion: Two Sides of the Same Coin, Proceedings of the AMEDD Clinical Psychology Short Course: Military Applications of Neuropsychology and Health Psychology, Presido of San Francisco, California 9 - 13 Mar 1987, Vol 1.

PSYCHOLOGICAL FACTOR IN TEMPOROMANDIBULAR DISORDERS

John D. Rugh, Ph.D.
University of Texas Health Science Center
San Antonio, Texas 78284

Temporomandibular disorders refer to a group of painful and functional disorders effecting the temporomandibular (jaw) joint and/or the muscles which move the jaw. Typical patient complaints include dull, aching pain in the jaw muscles, pain in front of the ear, limited jaw movement or locking, and jaw joint noises (Laskin et al., 1983; AACD McNeill, 1990). The joint pain in front of the ear is sometimes sharp and frequently confused with earache. Pain from the temporalis muscle may fan across the side of the head above the ear from the temporal region and is frequently perceived as a tension headache. A distinguishing feature of most TM Disorders is that the symptoms are modified by jaw movement such as chewing or wide opening.

EPIDEMIOLOGY

Signs or symptoms of TMD are found in 60 to 80% of the adult population; however, 95% are mild, self-limiting conditions which do not require treatment. There is much confusion over what signs and symptoms to include in the definition of TMD. Only about five percent of the population are in need of professional care for one of the TM Disorders. Males and females have the same incidence of TMD signs; however, females seek care at a higher rate (Rugh & Solberg, 1985).

DENTAL TREATMENT

The dentist is usually the primary provider for TMD patients. The most common therapies include soft diet, physical therapy, pain and anti-inflammatory medication and a plastic intraoral appliance referred to as a splint or orthotic. Most patients respond to these reversible therapies within three to five days. Such reversible conservative care is recommended for most patients. In only a very few patients is surgery, orthodontics, or other nonreversible therapy necessary (AACD McNeill, 1990). Adjustment of the bite (occlusal adjustment) by the dentist has not been shown to be a useful therapy.

ETIOLOGY

The various temporomandibular disorders may be precipitated and/or maintained by a number of factors including trauma to the jaw, systemic conditions such as arthritis and fibrositis, nocturnal teeth clenching and daytime habits. There is reasonably strong evidence that a subgroup of TM Disorder patients have stress-related oral habits or generalized muscular tension as a primary etiology. Nocturnal teeth clenching or grinding is a problem for many people (Rugh & Harlan, 1988). Also, as with other illnesses, emotional and cognitive factors modify the patient's perception and reaction to the signs and symptoms.

The patients' experiences and beliefs about the origin and significance of the signs or symptoms dramatically modify their responses and illness behaviors. Of particular concern are patients who escalate their reports of pain over time as a way to justify a "definitive treatment" such as surgery which may not be indicated. Another problem is apprehensive disused atrophy (Rugh, 1987). Patients with this problem continue on a soft food diet until the jaw muscles atrophy. The muscles become fatigued and painful with even minimal function. The patient interprets the pain as a symptom of pathology and further reduces function. This cycle continues until the jaw muscles are very weak and the patient can no longer chew food or talk without pain. Anxiety, depression and secondary gain often complicate the management of TM Disorders. At this time, there are no definitive dental therapies and approximately 10-15% of patients seeking care for TM Disorders become chronic pain patients (Rugh, 1987).

BEHAVIORAL TREATMENT

Psychological factors are involved as primary or maintenance factors in a relatively large subgroup of the disorder patients. It is thus not surprising that a psychological evaluation may be requested after the dental exam, during dental therapy, or after dental therapy fails.

Psychological management of patients with TM disorders is similar to that of patients with other stress-related musculoskeletal disorders. If anxiety, depression or chronic pain are involved, these must also be addressed. Therapies may include modifying specific behaviors (oral habits and posture), altering misconceptions about the disorder, motivation, coping skills, stress control, biofeedback and other forms of relaxation training.

EMG biofeedback is often useful. One active electrode of a single channel instrument is placed over the left and right masseter muscle. The ground is placed under the chin. This broad electrode placement provided an EMG signal which is related to the jaw and facial muscles. During a couple of sessions, patients learn to relax the jaw muscles, keep the teeth apart and increase awareness of muscular tension in the jaw region. This training may be generalized to the natural environment through the use of portable EMG instruments. When using the portable EMG units, electrodes are placed unilaterally over the masseter or temporalis. Literature reviewing the efficacy of biofeedback and behavioral therapies for TM Disorders is generally very positive (Melamed & Mealiea, 1981; Dahlström, 1989; Mealiea & McGlynn, 1987). Behavioral therapies have been recommended in dental guidelines for the diagnosis and treatment of TM Disorders (AACD, McNeill, 1990; Laskin et al., 1983).

REFERENCES

American Academy of Craniomandibular Disorders, McNeill, C. (Ed.). (1990). Craniomandibular disorders: guidelines for evaluation, diagnosis, and management. Chicago: Quintessence Publishing Co., Inc.

Dahlström, L. (1989). Electromyographic studies of craniomandibular disorders: A review of the literature. J Oral Rehabil., 16:1, 1-20.

Laskin, D. M.., Greenfield, W., Gale, E., Rugh, J., Neff, P., Alling, C. and Ayer, W. A. (Eds.). (1983) The President's conference on the examination, diagnosis and management of temporomandibular disorders. Chicago: American Dental Association.

Mealiea, W. L. and McGlynn, D. (1987). Temporomandibular disorders and bruxism. In Hatch, J. P., Fisher, J. G. and Rugh, J. D. (Eds.), Biofeedback: Studies in Clinical Efficacy. New York: Plenum Press, pp. 123-151.

Melamed, R. G. and Mealiea, W. L., Jr. (1986). Behavioral intervention in pain-related problems in dentistry. In Ferguson, J. M. and Taylor, C. B. (Eds.), The comprehensive handbook of behavioral medicine, Vol. 2, New York: Spectrum, Inc.

Rugh, R. G. Psychological factors in the etiology of masticatory pain and dysfunction. (1983). In Laskin, D. M., Greenfield, W., Gale, E., Rugh, J., Neff, P., Alling, C. and Ayer, W. A. (Eds.). The President's conference on the examination, diagnosis and management of temporomandibular disorders. Chicago: American Dental Association, p. 85-94.

Rugh, J. D. (1987). Psychological components of pain. Dent. Clin. N. Am., 31 :579-594,

Rugh, J. D. and Harlan, J. (1988). Nocturnal bruxism and temporomandibular disorders. Adv in Neurol., 49:329-341.

Rugh, J. D. and Solberg, W. K. (1985). Oral health status in the United States: Temporomandibular disorders. J. Dent. Educ., 49:398-405.

TWENTY YEARS BEFORE THE BENCH: THE FAR SIDE OF THE LAW

John D. Shoberg, Ph.D.
5th General Hospital
Bad Cannstatt, West Germany

Psychological testimony has long been sought as a contributor to courts and board proceedings in the military. Of course, this practice has not been without controversy; especially since the very nature of these proceedings are adversarial in nature. Matarazzo (1990) has recently summarized the nature of validation in litigation and suggested future directions for further rapprochement in dealing with adversarial proceedings and questions. Despite the controversial and admittedly biased views introduced by Ziskin & Faust (1988) and Faust & Ziskin (1988a, 1988b, 1989) and countered by Brodsky (1989), Matarazzo (1990) and others it appears psychologists will continue to be called upon to add expert opinion to the quality of the "soup" to be considered by "finders of fact" (the courts and boards) within both the military and civilian arenas. This lecture is a discussion of the opportunities for the practice of consultation and testimony in various forensic situations where a psychologist's expertise may be helpful. The experience of interfacing with courts, investigators, lawyers, judges and boards will be illustrated with actual case and experience from 20 years of forensic practice. This presentation will include pertinent material from the American Bar Association (ABA) Criminal Justice Mental Health Standards (1986, 1989), the Manual for Courts Martial, and pertinent regulations and documents. Illustrations are courtesy of the law's "fair use" doctrine and the clear vision of Gary Larson and others. The author takes complete responsibility for their metaphorical interpretation and any fracturing of their original meaning. The ultimate purposes of this presentation are to assist psychologists (1) in identification of appropriate forensic situations for the presentation of psychological consultation and testimony, (2) in developing productive relationships with attorneys for the purpose of preparing to testify in various proceedings, (3) in selection of various methods of testimony that avoid incomplete presentation of the facts or your conclusions (within a reasonable psychological certainty), (4) in selection of strategies for handling disparate "expert opinion(s)" which may be introduced in the course of testimony, and (5) in understanding the nature of adversarial situations and the informal and formal aspects of presenting testimony effectively.

THE PSYCHOLOGIST ROLE IN SPECIAL OPERATIONS OR JUMPING WITH THE PEOPLE WHOSE PARACHUTES YOU PACK

Dennis M. Kowal, Ph.D.
INSCOM

This title may sound like an inappropriate analogy to most of you, but I hope that this paper will clarify its meaning and allow for a better understanding of the role of the psychologist in the special operations community.

There has always been a feeling of uneasiness between the psychologist and the members of the special operations unit. I eventually realized that it had nothing to do with me personally, but had much to do with the unit members perception that the psychologist was there for reasons that had little to do with their well being. As far as I was concerned, I was there to apply my psychological expertise to whatever purpose the commander desired. As with anyone who excels in a technical area, I was selected because of those skills which had little to do with my technical skills at all, but had a great deal to do with the necessity for clinical oversight. The other part of the equation was that the unit didn't identify with me or perceive that I was "one of them" because of a poor understanding on their part as to my function in the unit and the natural tendency to consider outsiders as threats, as not having the same commitment.

In order to resolve some of these misunderstanding, the psychologist has to learn something about them, their mission, and the unique nature of the organization and its operations. It begins by establishing a relationship with the people with whom you will be working -- by being accepted as a member of the family. It meant reading the voluminous directives that were imposed on the unit by superiors or coordinating agencies. It meant getting "face time" with the various squadrons and finding out what they did and the pressures they were under. It meant attending various staff meetings at different levels of the organization and finding out what kinds of attitudes, feelings, and problems were extant within the system. But his process can all be subsumed under the rubric of "earning your wings." The first time the unit members saw you rigging up for an airborne operation and participating in an exercise seemed to be the acid test that provides you with an entree into the unit. But this is not the only way that you gain credibility with a special operations unit. However, it does provide the basis for my introductory analogy. The acceptance within the unit has little to do with my professional credentials, although that would be tested soon enough, and much more to do with a rite of passage.

The special operations psychologist is still a rare bird within the armed forces, but they will, hopefully, continue to earn their wings and multiply. Likewise, they will continue to be increasingly integrated into the operational planning, selection, and development of special operations missions. The nice part is that, although there is a general expectation of what the behavioral science specialist can do, the positions are unique enough to be open-ended and allow for innovation and creative possibilities.

I will discuss five roles that represent the primary missions that the psychologist should perform in the organization.

First, the direct service role to provide unit personnel and their families with psychological consultation, diagnosis, brief therapy and referral. Because of both time and manpower limitations, my role is restricted to crisis-oriented intervention, with referral being the primary outcome.

The second role is that of a consultant to the commander. This involves dealing with the organizational problems inherent in this type of unit and is essentially that of the trouble shooter. This involves being available to the commander to check out something that he is concerned about but does not want to get into command channels -- or the rumor mill. It usually involves his desire to hire or fire someone, and he wants the opinion of an "honest broker." Inherent in this role is one of identification; are you primarily a mental health specialist concerned with the individual's well being, or an organizational staff member? In this regard, it is important where the psychologist gets plugged in. This determines how he/she is seen by other members of the organization, and the influence he/she will have on the decisions makers. However, at this point, I am convinced that success is largely determined by the psychologist's personal and social adaptability as much as by their intellectual and clinical acumen.

The third role of the psychologist is that of designing, presenting, and evaluating various types of training. This training must be driven by the mission or organizational needs of the unit. I have found that this is an ever increasing requirement as the unit's members realize that many psychological principles and concepts have applicability to their duties and will improve their duty performance or mission accomplishment.

The fourth role is that of gathering ideas and interacting with other agencies and organization to exchange information, as well as to provide a mechanism for professional and personal growth. It can be particularly lonely when you are the sole psychologist in a unit. I have also found it useful as a means to get professional consultation with others working the same field. It also provides for the quality assurance process which is obligatory.

The fifth, and the most talked about role, is also the one which is the biggest can or worms. The assessment and selection role that yields both valid and useful predictors of success is a constant nemesis in the special operations arena. This is complicated by the lack of clear mission tasking on which to base our selection criteria. We presently engage in screening out applicants who are unsuitable or emotionally unstable for the special operations missions, but the reality is effectively screening in individuals, based upon the specific task requirements has not yet been realized.

To function effectively in all these areas is a mammoth task -- maybe an impossible one. It will take almost three years for the learning curve to be completed and for the psychologist to be able to delineate his role and become effective. Likewise, it is difficult to judge the results of your efforts since it has been, largely, unbroken ground. At this point, only tentative opinions and conclusions can be drawn about the efficacy of our efforts since we have only scratched the surface in many of the areas of application of psychological principles to special operations missions.

My discussion has focused on the roles of the psychologist and attempts to provide you with examples from across the special operations community; if I have left any out, it is my failing. However, the article will provide some insights into how one gets a job like this and what are the prerequisites for being considered effective.

What about the future of psychologists in special operations? What do we see ahead of the psychologist in the special operations community? Hopefully, if we continue to be perceived as being beneficial to the organization, the demand for us will increase and expand to other like units and activities. This has already come to pass and by some accounts special operations has become the"growth industry" for psychologists over the last several years.

Where do we go from here remains to be seen, but at the very least, it will require some thorough planning to insure progress in the areas mentioned. One last consideration is that a mentoring program needs to be established so that we do not die of our own weight. It is very easy to delude ourselves that we have some special gift, rather than a skill that we have honed, and forget to pass these skills on to our successor.

WHAT YOU NEED TO KNOW ABOUT THE PSYCHOLOGICAL SCREENING OF PERSONNEL FOR SENSITIVE POSITIONS

Dennis M. Kowal, Ph.D.
INSCOM

Coping with the unique demands of sensitive missions requires a special kind of individual. This person must be emotionally stable and psychologically suited to the mission requirements and possess the "right stuff" in terms of their knowledge, skills and abilities (KSAs). Deploying unsuitable or emotionally vulnerable individuals on such operations increases the danger to the organization and its members and risks compromising the objective of the mission.

This hazard has been made disturbingly clear by several operational failures that were the product of sending someone with the "wrong stuff" or someone who was vulnerable at the time of deployment. The organization's inability to recognize these potentially susceptible individuals resulted in a serious compromise of the mission and nearly caused an international incident regarding the use of vulnerable personnel for sensitive missions. Since that time, some organizations have introduced both a psychological assessment battery into their selection procedure and a vulnerability monitoring procedure for personnel being deployed. Sensitive organizations are recognizing their responsibility for screening and maintaining their personnel's psychological fitness.

A comprehensive psychological screening program for applicants for sensitive organizations should consist of what? This paper will provide a practical framework for agencies and personnel administrators wishing to conduct a systematic psychological screening and monitoring program for use as part of the selection and assessment process for personnel.

Psychological assessment should be used as but one component of the overall selection process. It should not be used as the sole criterion for selection, employment, or deployment decisions. It is clear that a simple go/no go screening strategy can no longer be considered adequate with the increasing complexity of sensitive work. Likewise, such tools are not a replacement for sound leadership. However, it is essential to screen out those who are emotionally unstable or unsuitable because of unwanted traits, behaviors, or vulnerabilities.

The challenge for the leader and psychologist is to identify attributes, traits, motivations and reactions to stress that allow for selection of the right person. The combination of these data with an understanding of the specific task demands or areas of specialization and mission, can lead to the development of differential profiles for selection.

INTRODUCTION

Much has been written regarding the need for selection techniques that will yield both reliable and valid predictors of future behavior or mission success. However, selection methodology still remains a can of worms. There is not one set of instruments or one approach that has been reliably effective in selection for high risk missions or duties. Given the situational specificity of the desired behavior, the uncertainty of the events and the possibility of compromise or mission failure, the search for a selection approach with cross situational consistency has been frustrating. This, I believe, is largely a function of the persistent underestimation or inability to identify the "situational" component of the operational equation. This void results in our search for an individual with the proverbial "right stuff," forgetting that we may never find the "ideal" person who is always reliable or successful. A more appropriate focus might be on the selection of an individual who will respond correctly in the particular situation into which we are putting them. The realization of this fact has recently evolved into a consensus that it is the interaction between the person and the situation that supplies us with our most valuable insights into the individual's probable behavior under stress.

Consider, for example, how we might select the right person for a particular mission? Should we select someone who displays what could be described as the "right stuff," or should we note that this is really a questions about who has the "right stuff" for this particular situation? We are not interested in selecting just a good person but in selecting the individual who will be most effective under a particular set of situational conditions. This would include not only the person's knowledge, skills, and abilities (KSAs) but personality style, cultural background, appearance, language ability, as well as personal reliability.

Most sensitive organizations are now engaged in one of two existing and complementary selection procedures. One is the "screening out" of individuals who are grossly unfit for assignment based on relatively severe signs of emotional vulnerability or lack of appropriate KSAs. The second is the "screening in" of individuals based upon some ideal profile that has a highly subjective component representing the "like us" rationale for selection. This is not inherently bad, since the strong bonding necessary for high risk organizations to be effective has been well documented. We do need to consider this factor, as one of several, in the screening equation but not default to it. After all, the fundamental purpose of the screening process is to reduce the uncertainty about the unknown and match the mission needs with the appropriate individuals. Therefore, if I need an individual who speaks Russian and is knowledgeable about the customs and culture of the Soviet Union, then that is who I will select for the mission and not just a "good individual".

Likewise, no predictive process is infallible, and this is at the heart of the matter in selecting people for sensitive organizations. The approach to be described in this paper is one that attempts to make positive as well as negative screening more realistic and, in the long run, more effective. Considering both the psychological characteristics of the individual and assessing the conditions or situations under which the person operates can provide an important understanding of how this person-situation interaction affects performance and operational reliability.

A STRATEGY FOR THE PSYCHOLOGICAL SCREENING OF PERSONNEL

One of the most frequent questions asked of psychologists working the field is, "What kind of test battery do you administer to assist you in your screening of personnel?" The implication is that there is one set of instruments that can be applied to the full spectrum of needs. This is a common misconception. What is done is to identify several broad spectrum, well validated instruments. These are combined with a structured interview to assess the unique population being screened. The test battery consists of the following instruments and the rationale for their inclusion:

MMPI -- Although the MMPI has been utilized in clinical populations for quite some time, there is a dearth of research in the area of psychological assessment of sensitive personnel. There is available information on some similar groups involved in SWAT or special activities within the intelligence and police communities. It is used because it is widely known and assists me in the identification of emotionally unstable individuals as part of the "screening out" process. This test also provides a means of cross validation for the "screening in" of desirable characteristics such as emotional stability, ego strength, impulse control and feelings of adequacy.

16£ -- The 16PF provides a profile of normal range personality dimensions that can be the basis for the screening in of desirable characteristics. Also used are the California Personality Inventory (CPI) and the Clinical Analysis Questionnaire (CAQ) for this purpose.

FIRO-B -- The FIRO-B was designed to evaluate the ways in which people interact with one another, with specific reference to their feelings about inclusion, control over the relationship with others and the expression of needs. It is very useful to determine a priori likely responses of individuals to isolated environments.

SHIPLEY-HARTFORD INTELLIGENCE TEST -- The Shipley allows us to assess the verbal and abstract reasoning intelligence of the individual and the cognitive abilities that may be related to the job. It is a quick and accurate measure of overall intelligence.

STRUCTURED INTERVIEW -- None of the above instruments is entirely useful if not accompanied by a structured interview to assess the individual's honesty and integrity. It also is important in the assessment of the person's attitude and belief structure. The interviewer is bound by many restrictions and prohibitions about what he may ask. However, these should not result in an interview being reduced to a recitation of the obvious. Nor should it become so intrusive that it results in a confrontation. Considering the complexity of the task of assessing a person for a high risk job, the interview is the best means to validate the material provided in the background information and to assess the underlying motivations and beliefs that will assure individual reliability. The intrusive questions are designed to assess the quality of the information presented and are not designed to be a personal attack. How an individual handles past mistakes or errors in judgment is an important clue to how they will accept responsibility for future problems they are bound to encounter. The personal interview with an applicant for a sensitive position is normally part of the background investigation, but is generally not done by the investigative agency. Even when it is done, it is of such a cursory nature

that it is not effective. This is not a critique of the usefulness of the interview so much as a critique of the skill of the interviewers. The personal interview should represent the core of the screening process. It affords an opportunity for direct observations of the applicant's behavior during the review of relevant life history and background issues. How the individual handled past mistakes provides the most important predictor of future behavior and allows the interviewer to probe into areas that are vague or inconsistent. In the opinion of some experts the personal interview with the applicant is the single most effective screening tool available for assessing suitability. (Flyer, 1989) Interview validity, however, is not sufficient in itself. Interviewer reliability must be established and a structured interview format developed if we are to have a useful instrument that is free from bias.

SUMMARY

In summary, the use of the interview should conform to the standards established by the American Psychological Association (APA) for the validation and use of personnel selection procedures (1980), the Equal Opportunity Commission (EEOC) (1966) and the Committee on Psychological Tests and Assessment, of the APA. (1986) The evaluation cannot be accomplished without direct observation or examination of the subject and a review of the appropriate background data. A major problem is being able to select individuals that fit unique organizational needs. Often a person possesses all of the KSAs to do the job but lacks the emotional or trait qualities necessary to sustain the mission. Selecting the best fit between the person and the job presents a perplexing problem. This is especially the case when we must abide by EEO, legal and professional standards.

The predictive nature of these models creates another major problem. When screening people for sensitive positions we are trying to predict who will manifest unreliable or untrustworthy behavior, but we must recognize the inherent fallibility of most of our instrumentation. In any predictive model where the base rate for the attribute is very low, the majority of people predicted to be unreliable or untrustworthy will, in fact, be found to be reliable and trustworthy. Therefore, the use of multiple methods that provide the best cross section of behavioral samples must be used to increase the overall validity of the assessment process and to reduce the "false positive" error discussed above.

A second, but no less troubling, consideration is the fact that most wrongdoing or behavioral indicators of unsuitability seldom get detected during the background investigation or screening process. How we can overcome this latter problem should become one of our primary concerns after establishing the reliability and validity of the screening process. In this regard, the subject interview following a structured format with an understanding of the wealth of information often overlooked by the interviewer can be most beneficial. It is noteworthy that there are many research studies using multiple regression and discriminate function analysis with criterion referenced groups for predicting effectiveness and reliability. Selection methodology suggests that empirically based studies of job suitability using observable behavior as criterion measures are the most fruitful approach to developing this comprehensive approach to suitability screening.

In the fullest sense, suitability screening programs are a logical and prudent extension of leadership responsibility. It allows the leader to have a complete understanding of his most important resources, their strengths and vulnerabilities, and to be aware of indicators of unreliability and provide interventions to insure continued personnel reliability.