



Abstracts and Posters

2001 Behavioral Science Short Course

Bethesda, MD 13-17 August, 2001

Tele-Mental Health: Use of VTC and Other Computer Based Applications at a MEDCEN

13 August 2001
1000-1130

LTC Stephen Cozza, MC USA Chief, Dept. of Psychiatry, WRAMC
COL Swarnalatha Prasanna, MC USA Chief, Telepsychiatry and Community Mental Health Services, WRAMC
COL Ryo Sook Chun, MC USA Chief, Child and Adolescent Psychiatry Service, WRAMC
MAJ David M. Benedek, MC USA Chief, Forensic Psychiatry Service, WRAMC

Learning Objectives:

Participant will be able to:

1. Describe the use of advanced technologies (to include VTC) at a MEDCEN.
2. Describe the use of VTC interactions with adult and child mental health patients.
3. Describe the concept of a web based data collection system.

Abstract:

Advanced technologies such as video conferencing (VTC) and other computer-based applications support the development of Tele Mental Health opportunities. This workshop focuses on the use of these high technology applications at one of the Army's major MEDCENS. The workshop is composed of four separate presentations that highlight different areas of use. COL Prasanna's presentation, Tele Mental Health via VTC- an option to help underserved mental health needs, will focus on the clinical strengths and weakness of working via VTC to provide total mental health care to the adult population. Patient triaging, consent issues and other required non-equipment concerns will be addressed. LTC Cozza's presentation entitled Use of Tele Mental Health with children will describe an active three-year-old project that has been providing clinical consultation and treatment to children and adolescents at a remote Army clinic. Videotape segments of clinical sessions will be used. COL Chun's presentation, A Web-based Automated Mental Health Intake System, will describe a new web-based clinical data system that is being implemented to collect intake information via the Internet. It's utility in the areas of data collection and report generation timesaving, improvement in patient continuity of care and application in performance improvement activities will be addressed. Finally, MAJ Benedek's discussion entitled Implementing a Live Broadcast Distance Education Program will focus on practical aspects of the development and implementation of a live broadcast teleconference CME program. Relevant aspects of the CME application process, web-based program publicity, registration, and evaluation will be outlined, and resources for ensuring live audio-visual course content delivery to remote participants will be identified. Presentations will be focused in format, providing participants with an overview of technology projects ongoing at the MEDCEN. The workshop will afford time for a general discussion about the utility of these applications within Army Mental Health.

Starting a Bereavement Services Committee in your Military Hospital

13 August 2001
1000-1130

LTC Reginald W. Howard, CSW-PIP, Deputy Chief of Social Work, Madigan Army Medical Center

Learning Objectives:

Participant will be able to:

1. Discuss bereavement as a process in humans.
2. Discuss the Army's view of bereavement in our MTF.
3. Conduct formal and informal needs assessment of bereavement services at your MTF.

Abstract:

Most hospitals have included bereavement support in their service delivery as a medical facility, however, many times those efforts are fragmented without a central body providing a clear focus or vision. In most hospitals you find many different organizations providing "bereavement services". The chaplains, social work service, mental health clinics, maternal child health nurses and a host of off-post services all provide help to those who are grieving. The reality is no "center of gravity for bereavement policy, coordination or training exists in most hospitals. This authors belief is the establishment of a bereavement committee allows for coordinated bereavement services for our patients and families in a hospital as well as providing resources for staff members to deal with grief.

Empirical Measures of Outcome: So What is in it for Me?

13 August 2001
1000-1130

CPT Art Finch, PhD Clinical Psychologist, 254th CSC Detachment, Germany

Learning Objectives:

Participant will be able to:

1. Implement and administer the OQ-45 for outcome measurement.
2. Interpret patient responses to the OQ-45.
3. Use the OQ-45 integrated with an early warning system to enhance patient progress and Quality Improvement.

Abstract:

Recent JCAHO reviews have identified a need for outcome measurement throughout health care settings, to include the behavioral sciences. In response, many behavioral health clinics throughout the military began to adapt various outcome measurement instruments. Clinicians dutifully collected data from their patients, and then sat back and asked now what? To date, there have been few meaningful applications for the data, particularly with regard to the progress and course of treatment for an individual patient. As databases have continued to grow, it has now become possible to develop actuarial treatment response curves for the expected recovery of a given patient. These curves have been integrated into an "Early Warning System" that allows clinicians to meaningfully track an individual patient across therapy as well as identify potential treatment failures. These recovery curves and their potential uses are presented within the context of quality improvement in a clinical setting. This presentation will also include a basic explanation of the implementation, administration, and interpretation of the OQ-45, as well as potential uses and misuses for the resulting data

Implementation of a Comprehensive Combat Stress Control Program: The Fort Bragg Experience

13 August 2001
1000-1130

MAJ Steven M Gerardi, M.S. Chief, Occupational Therapy, Landstuhl Regional Medical Center, Germany
MAJ Jorge Torres, AN Cdr, 528th Medical Detachment (CSC), Ft. Bragg, NC

Learning Objectives:

Participant will be able to:

1. list the major requirements of DoD Directive 6490.5 (Combat Stress Control Programs)
2. employ a systematic process to develop and implement an interdisciplinary preventative behavioral health program.
3. discuss a method to mobilize and empower an interdisciplinary behavioral health team to accomplish a common objective.
4. describe the coordinated CSC program developed at Fort Bragg.

Abstract:

The purpose of this workshop is to describe and discuss the systematic process employed to develop and implement a garrison-wide Combat Stress Control (CSC) Program at Fort Bragg, North Carolina. In February 1999, a Department of Defense Directive (6490.5) was published directing that CSC programs be implemented throughout the DoD to enhance readiness, contribute to combat effectiveness, enhance the physical and mental health of military personnel, and to prevent or minimize adverse effects of Combat Stress Reactions. The 528th Medical Detachment (CSC), an interdisciplinary team led by an occupational therapist and psychiatric clinical nurse specialist, responded to this edict by implementing a comprehensive post-wide CSC program in support of units on Fort Bragg. Prior to implementation of this program, availability and delivery of preventative behavioral health and CSC services was disjointed and haphazard. The process employed by the 528th CSC mobilized and synchronized the interdisciplinary assets of the unit and harmonized with other behavioral health assets on post. The resulting CSC program is an organized, coordinated, multi-tiered curriculum that has optimized service delivery to the Fort Bragg community and beyond. Discussion will include: the program development process, utilization and coordination of human resources, product line development, hierarchical stress management/CSC training, community education, command consultation, and development of a marketing plan.

Innovative PTSD Training/Treatment in a VA Hospital and a USAR Hospital

13 August 2001
1300-1400

LTC (USAR) Michael Bridgewater, PhD, Clinical Psychologist, US Army Reserve, 405th US Army Hospital, Houston, TX
LTC (USAR) Thomas B. Horvath, MD, Chief of Staff, VA Medical Center, Houston, TX;
LTC (USAR) Betty J. Louis, MSW-ACP, Administrator and Clinical Coordinator, Continuum HealthCare Systems, Houston, TX;
MAJ (USAR) Ben L. Clark, Psy.D., LMSW-ACP, President/CEO, Winston & Clark, San Antonio, TX

Learning Objectives:

Participant will be able to:

1. Identify how USAR/AMEDD professionals can implement a positive training/treatment program for Trauma-Spectrum Disorders (TSDs) at a VA Medical Center
2. Identify 5 clinical principals learned in the treatment of Trauma-Spectrum Disorders (TSDs).
3. List 5 functional areas to which principals of TSD treatment should be applied in a USAR Hospital

Abstract:

Throughout their existence, Veteran Affairs (V.A.) Hospitals have been continually treating PTSD. USAR AMEDD professionals are continually required to perform until METL tasks that require the prevention/treatment of Trauma-Spectrum Disorders including PTSD. In USAR professionals (psychiatrists, psychologists, and social workers), work together through detailed planning, coordination, and leadership, they can create a unique training/treatment program at a V.A. Hospital/Medical Center. The 4005th U.S. Army Hospital has developed such a program at a local V.A. Hospital. This presentation will focus on the following principals of Trauma-Spectrum Disorders (TSDs) learned/treated at the VA Hospital: (1) Crisis events that may cause TSDs; (2) Individual mental adjustments that must occur before these disorders can exist; (3) Initial therapy and therapeutic responses that may prevent chronic TSDs; (4) Identification of individuals who require more prolonged treatment; (5) Examples of biological changes that occur in PTSD patients and how these changes are measured; (6) Explanation of the complex and intensive treatment necessary for entrenched cases of PTSD; and (7) How PTSD affects many geriatric patients. The clinical principals of TSDs learned/treated at the VA will be applied to a USAR Hospital in the following functional areas: (1) Solider and family mobilization briefings; (2) Solider debriefings and family reunions, (3) Unit mental health/resource training, (4) Personnel services support, (5) Performance of Psych METL on Active Duty; (6) Assessment of unit stress/cohesion; (7) Proactive consultation with key unit members; and (8) Brief crisis intervention.

Women who use violence in intimate relationships: Primary aggressor or self-defense

13 August 2001
1300-1400

CPT Sheila Adams, LSCS, BCD, Instructor/Writer AMEDD C&S Department of Preventive Health Services, Soldier & Family Support Branch FT. Sam Houston, Texas 78234

Learning Objectives:

Participant will be able to:

1. Discuss the current issues related to violence.
2. Demonstrate an increased knowledge in theoretical perspectives related to women and violence.
3. Discuss the context and motivations in which women offend.

Abstract:

The FAP standards require that we understand the difference between defending and aggressive forms of violence, thus, appropriate treatment will not be effective if motivations are not clearly understood. This course will discuss issues relevant to women and violence, focusing on the importance of accurately assessing motivations for using violence. This will be a valuable course for anyone working in the FAP. Often women who are violent are perceived to be responding in self-defense, but there are times when women are the primary aggressor, distinguishing between the two can be very difficult. A new tool will be presented that will assist in assessing motivations.

Virtual Primary Care Clinic

13 August 2001
1300-1400

LTC Gregory Gahm, PhD, Chief, Behavioral Health Clinic, MAMC

Learning Objectives:

Participant will be able to:

1. Understand how an electronic clinic can be set up.
2. Conceptualize behavioral health research within a primary care clinic.
3. Describe some strengths and limitations of electronic care.

Abstract:

The Virtual Primary Care Clinic is a web based e-health research initiative designed to improve access to, and quality of, care while simultaneously controlling costs. Specifically, this project provides patients a secure web-site with on-line appointing (booking, reviewing current appointments, cancellation of appointments), review of medication, laboratory, and radiology results, and asynchronous secure communication with providers. It targets health promotion and prevention through directed health information delivery, on-line access to health information, on-line home health monitoring and on-screen graphing, and provider profiling of patients by disease state and clinical needs. It includes specific measurement of total costs of this process to include provider time requirements, impact on workload accounting, and effects on overall healthcare system usage. Cost containment is a goal through appropriate provider level usage (nurses and paraprofessionals when appropriate to handle the information) and targeting high cost/frequency system users.

Survey of Alternative Medicine Use Study in a Military Population

13 August 2001
1300-1400

CDR Raymond Emanuel, MD, Director of Training, Dept. of Psychiatry, TAMC
CPT Millard Brown, Psychiatry Resident, TAMC

Learning Objectives:

Participant will be able to:

1. Be familiar with the current trends in alternative medicine and dietary supplement use in military and civilian population.
2. Recognize importance of assessing for alternative medicine use in clinical practice.
3. Be familiar with common risks associated with several popular dietary supplements.

Abstract:

Several studies have noted the progressive increase in the use of dietary supplements among the general population. A recent study in Military Medicine (1999) of dietary supplement use in 2, 215 males ranging in age from 18-47 (mean age 25) observed that 85% of the individuals in the survey had past or present use, 64% were currently using dietary supplements, and 35% reported daily use. The results of this study suggested that "military personnel might be considered a population at risk for the potential adverse effects of inappropriate use, toxicity, and poor manufacturing" of supplements. Many of these treatments have potential impact on medical treatment either by altering the way standard medical care is followed by the patient or by the potential interactions between dietary treatments and prescription medications. The use and abuse of these substances requires physicians to become informed about the use patterns among their patients and access current knowledge about the effects and interactions of these treatments. This is a cross-sectional study using a questionnaire to assess the prevalence of alternative medicine and herbal remedies use in a military environment and to characterize the substances most commonly used. Before the physician can apply any knowledge about various herbs and supplements, he/she needs to know about their use. Current research has found that patients typically do not tell their physicians about their supplement use. A secondary objective of the study is to survey the soldier's comfort with disclosing or discussing the use of these supplements with his/her physician.

Extenuation and Mitigation Testimony in Capital Offense Courts-Martial

13 August 2001
1300-1400

MAJ David M. Benedek, MD Chief, Forensic Psychiatry Service, Walter Reed Army Medical Center, Washington DC
CAPT Thomas A. Grieger, MD - Director, national Consortium Adult general Psychiatry Residency Program

Learning Objectives:

Participant will be able to:

1. Describe process by which Death Penalty is adjudged in Courts Martial
2. Differentiate between the insanity defense and other avenues of mental health expert assistance in Capital cases.
3. Outline an approach for consultative assistance and expert testimony in Capital cases.

Abstract:

While the death penalty continues to be controversial in the United States, it is currently a potential sentence for specific UCMJ Offenses. The rules for court martial allow for considerable latitude in the sentencing phase of a court martial which may mitigate against adjudgement of the death penalty. In this presentation, the circumstances under which and procedures by which the death penalty be adjudged in courts martial will be outlined. In addition, potentially mitigating psychiatric testimony will be presented through a discussion of applicable case law and case examples from the forensic experience of the presenters.

School Based Mental Health at Schofield Barracks

13 August 2001
1400-1500

COL Michael E. Faran, MD Chief, Child and Adolescent Psychiatry, TAMC
MAJ Jeffery Weiser, MD Assistant Chief, Child and Adolescent Psychiatry, TAMC
Albert Saito, MD, Child Psychiatrist, TAMC
MAJ Ronald Mrouzzi, MD, Child Psychiatry Fellow
CPT Sharette K. Gray, MD, Child Psychiatry Fellow

Learning Objectives:

Participant will be able to:

1. Define School Based Mental Health SBMH.
2. Discuss how a SBMH system directly supports the military mission.
3. Describe the SBMH program at Solomon Elementary School Schofield Barracks.
4. Discuss proposed studies to ensure quality and success of School Based Mental Health.

Abstract:

A School Based Mental Health SBMH Program is being developed at Solomon Elementary School at Schofield Barracks. Solomon has 800 students entirely from military families. TAMC Child and Adolescent Psychiatry has been providing school consultative services at Solomon for about 10 years. This year a collaborative project with the Department of Education Hawaii was initiated to explore the feasibility of SBMH. The objective of this project is to develop a comprehensive program to include: assessment, treatment, case management, prevention, classroom based activities, family assistance, parent support and therapeutic groups, individual therapy for parents, teacher programs, health programs, and community involvement. An Advisory Board will be established composed of all the major stakeholders such as parents, teachers, health care providers, commands, chaplains, and JAG. Outcomes will be evaluated using measures such as grades, attendance, behavior, and school climate. Currently Solomon's SBMH program is being used as a demonstration project for the State.

USAF Psychiatry and Mental Health Initiatives and Status Update

13 August 2001
1400-1500

Col. Karl O. Moe, USAF, BSC, Department of Family Medicine, USUH, Bethesda, MD

Learning Objectives:

Participant will be able to:

- 1 - understand the current low levels of psychiatry manning in the AF and strategies which have been adopted to deal with this difficulty.
- 2 - list several initiatives which the USAF is working to improve the quality of care for mental health issues, to include changes in confidentiality, suicide prevention, and population health.
- 3 - comprehend AF strategies for dealing with operational stress and force protection.

Abstract:

The USAF is currently faced with a critical shortage of psychiatric personnel. This has caused the AF to develop innovative ways to continue to provide top notch care for its population with these limited resources. This presentation will discuss how the shortage of AF psychiatrists has been managed through population based staffing models. It will also describe some of the initiatives we have undertaken to improve the quality of care we render despite these shortages. In addition, the presentation will cover current models for AF management of operational stress casualties in both peacekeeping and wartime. The strengths and weakness of this approach will be compared and contrasted in a limited manner to Army and Navy models.

CAO Update

13 August 2001
1530-1630

MAJ Phredd Evans, Career Activities Officer, Medical Service Corps

Learning Objectives:

Participant will be able to:

1. Discuss the current issues confronting the Medical Service Corps, especially those involving psychology and social work.
2. Describe how psychologists within the AMEDD can best meet the current and projected needs for supporting the Army of the 21st century.
3. Describe how social workers within the AMEDD can best meet the current and projected needs for supporting the Army of the 21st century.

Abstract:

This presentation will provide an overview of the major issues confronting the Medical Service Corps. The focus will be on career management issues pertaining to psychologists and social workers within AMEDD. Issues of accessions, retention, and distribution as they affect career progression and career options will be addressed. The role of psychology and social work in meeting the requirements for behavioral health support for the current forces and the Army's needs in the 21st century will also be addressed. There will be a questions and answer period at the end of the presentation.

Re-engineering Army Behavioral Health Services

14 August 2001
0900-1100

COL Rene Robichaux, MD - Chief, Behavioral Health Division, HQ MEDCOM, Fort Sam Houston, TX - U.S. Army
COL Dave Orman, MD - Psychiatry Consultant to the Surgeon General - Fort Sam Houston, TX, U.S. Army
COL Edward Crandell, PhD - Psychology Consultant to the SG -Fort Sam Houston, TX U.S. Army
COL Pat Patterson, Social Work Consultant to the Surgeon General, Fort Sam Houston, TX - U.S. Army
COL Bonnie DeMars - Occupational Therapy Consultant to the Surgeon General, Fort Sam Houston, TX - U.S. Army

Learning Objectives:

Participant will be able to:

1. Understand the main rationale of why BH services need to be reengineered.
2. Understand the elements of current BH clinical services that will undergo reengineering.
3. Participate actively in their local MTFs/units in the reengineering efforts.

Abstract:

The Chief of MEDCOMs Behavioral Health Division and the Psychiatry Consultant will layout the data and justification for conducting a comprehensive review of Army behavioral health services, to be followed by a description of the methodology being used to potential revamp said services. Progress to date in pursuing re-engineering will be presented, and then 30 minutes devoted to a dialogue with the members of the audience involving a panel of the 2 presenters and the consultants in psychology, social work, and occupational therapy.

Women Victims of Domestic Violence as Change Agents

14 August 2001
1230-1400

MAJ Claudia O'Quinn, LCSW, PhD student in Social Work, Catholic University
Ms. Cherie Cannon, MSW, Clinical Social Worker, FT Meade

Learning Objectives:

Participant will be able to:

1. Understand the dynamics that perpetuate spouse abuse among military couples
2. View spouse abuse from more than one paradigm
3. Understand how to work with women victims in a way that moves their relationships in a violence free direction

Abstract:

Domestic violence has a negative impact on military families and on military readiness. This presentation will examine the abuse of women from both a critical theory and a constructivist paradigm, identifying both the macro and micro dynamics that serve to maintain it. Research reveals that the primary focus for clinical intervention continues to be the male batterer, with the woman being viewed as a victim having little ability to effect change in the relationship. Although victims want the abuse to stop, they do not necessarily choose to leave their partners. When a therapist treats the victim's choice to stay as legitimate self-determination, then the empowerment process begins. This presentation will explore ways of working with the woman victim as a change agent. The overall concept is to teach the woman to communicate to her partner, in small incremental ways, her unwillingness to tolerate further abuse. The presenters will address potential criticisms that this approach blames the victim and makes her responsible for her partner's behavior. The presenters disagree and believe that the proposed approach is far more respectful of a women's self-determination than are current interventions. Once the victim develops a clearer vision of herself living in the partnership without the abuse, then she will be better able to interact in ways that will help to move the partnership in a violence free direction.

Army Psychology Training: Preparing Today for the Future

14 August 2001
1230-1400

LTC Mark Davis, PsyD, National Training Coordinator, Psychology Training Programs
LTC Gary Southwell, PhD, Director of Training, Psychology, TAMC
LTC John H. Trakowski, Director of Training, Dept of Psychology DDEAMC
MAJ Stacey Williams, Director of Training, Dept of Psychology, WRAMC

Learning Objectives:

Participant will be able to:

1. Review the current status of psychology training pre-doctoral training programs (recent APA-accreditation visits, current curriculum and rotational structure, military unique training, etc.)
2. Review current recruiting strategy and efforts to maintain and improve applicant pool (trends in applicants and schools, coordination with USAREC, training program responsibilities, USAREC responsibilities)
3. Discuss revision of recruiting strategy
4. Review training goals and objectives across the three training programs (Table 6 of Self-Study for APA Committee on Accreditation).
5. Discuss revision of training goals and objectives
6. Summarize comments from audience and presenters

Abstract:

Army Clinical Psychology Internship Programs have seen many changes over the last 15 years. We have changed from four training sites graduating 16 Army Psychologists a year to three training sites graduating only 11 residents this year. Though the future looks brighter for Army Psychology as a whole (resulting in increased accessions to 12 residents for Academic Year 2001-2002 and a possible additional resident for the following Academic Year), the demands on our training programs have also increased. Some of these demands for change come from APA-requirements for accreditation, APPIC requirements and the impact of the National Matching Program, and APA's policy banning advertising of military training programs in APA publications. However, of no less significance are the changes in the practice of Army Psychology. The requirement for child trained psychologist has decreased with the disappearance of slots for active duty psychologists in the Exceptional Family Member Program. There is the relatively new requirement to train psychologist for Combat Stress Control Companies and to meet the demands of a more deployable and fast paced Army. All of these changes require greater communication between training directors, recent graduates, and the more experienced Army Psychologists occupying a wide variety of positions. This panel discussion provides a forum to discuss all of these issues in order to ensure our training programs are congruent with the demands faced by Army Psychologist, particularly in their first assignments. Finally, this panel provides an opportunity to discuss our efforts to recruit high quality applicants to our training programs and to solicit comments from the audience.

Readiness Panel

Incorporating CSC Training Into Combat Simulated Battle Scenarios

14 August 2001
1230-1400

MAJ Kevin R. Stevenson, LMSW (Social Work Fellow, Walter Reed Army Medical Center)

Learning Objectives:

Participant will be able to:

1. Recognize the importance of CSC Observer Controllers.
2. Learn the importance of preparing a CSC estimate and plan.
3. Identify the importance of informing the Task Force Commander about your CSC mission and capabilities.
4. Learn how important notional CSC casualties and scenarios are in training CSC elements.

Abstract:

Greater emphasis is being placed on realistic training to ensure mission and combat readiness. The Army's training centers have been created to test individual unit's capabilities during a combat-simulated battle. However, the training centers have yet to provide training opportunities for mental health units that are realistic and challenging. Therefore, it is important that we make a concerted effort to ensure that training planners incorporate battle fatigue casualties and scenarios into the play. In addition, CSC or other accompanying mental health assets should be required to develop combat stress control estimates and plans to prepare for the combat stress threat in battle. This presentation will describe one CSC team's experience at JRTC and present some methods for selling the importance of CSC play and CSC real-world capabilities to the deployed senior leadership. Further the presenter will outline the production of a CSC/mental health estimate for incorporation in a training battle plan.

Readiness Panel

Pre Deployment Psychological Screening A Simple Approach

14 August 2001
1230-1400

MAJ Scott Uithol, MD, Chief, Inpatient Psychiatry, WOMACK Army Medical Center

Learning Objectives:

Participant will be able to:

1. Understand the basics of the Assessment of Right Conduct Screening Tool.
2. Identify useful criteria involved in classifying groups based on danger risks.
3. Discuss potential disposition options for flagged soldiers.

Abstract:

The purpose of this study was to psychologically evaluate a large military unit prior to deployment in order to minimize behavioral problems and maximize safety in the field environment. Approximately 750 soldiers of varying ranks and experience were given an 80 item questionnaire (Assessment of Right Conduct) and a 13 item written questionnaire as the first screening phase. Soldiers who gave answers which raised potential concerns were then interviewed for 5 to 10 minutes as a second phase, to determine whether they would require a more in-depth 30 minute interview as the final phase. Potential risks to self and others, substance abuse, acting out potential, and current stresses were evaluated. Approximately 75 soldiers were identified as having potential misbehavior in the deployment environment. Three soldiers were identified as potentially having safety issues unless supported by the attached Behavioral Science Specialist (91X) regularly. Seven soldiers were identified as poor risks for deployment due to significant safety issues or stress levels making an adverse outcome or early redeployment a possibility. Memorandum a were generated for the highest command levels and a meeting took place with the next higher command to discuss those recommendations against deployment. We concluded that psychological screening can be performed in a timely manner for large groups and efficiently reduce the potential for bad outcomes and early redeployments.

Readiness Panel

Combat Stress Lifesavers

14 August 2001
1230-1400

CPT Brett Schneider, MD., Division Psychiatrist, 1st Infantry Division.

Learning Objectives:

Participant will be able to:

1. Understand how deployment stressors and current mental health issues have made programs like combat stress lifesavers necessary.
2. Have the tools to train other non-mental health military personnel in identification and reduction of stress.
3. Develop ways to evaluate the outcome of such program.

Abstract:

Experience in current deployments suggests that numerous deployment stressors will interfere with mission execution and troop readiness. According to current Army doctrine, the preponderance of the above stressors fall into the category of "normal reactions to abnormal situations." Therefore, according to doctrine the majority of SM or FM who are identified as have these problems should be managed according to the PIES (Proximity, Immediacy, Expectancy, Simplicity) doctrine for stress related issues. Current numbers of Army Psychiatrist, Psychologists, Social Workers, Nurse Practitioners, and 91X'z do not provide for adequate Army wide and mission derived identification, referral, and treatment of all SM and FM's who fall into the above categories. Even if adequate numbers of Mental Health assists existed, it would be contrary to current Army doctrine for all of the above to be referred to Mental Health professionals, as this immediately stigmatizes and redefines the problem as "abnormal" vs. "normal." PIES doctrine suggests that identification and initial intervention should be done at the unit level if possible. Therefore, it is recommended that we identify and train a selected group of 91 Bravos in a limited number of skills to include identification of deployment stressors and stress related behavior, suicide risk assessment, and basic treatment and referral for stress casualties. The idea is to create a "mini-91X-Ray" out of non-mental health medics, much as the Combat Lifesaver Course creates "mini-91 Bravo's" out of non-medical troops. Other identified personnel could also be trained. Data should be collected and results studied.

Readiness Panel

Maximizing the effectiveness of 91X

**14 August 2001
1230-1400**

CPT David Fohrman, MC, Division Psychiatrist, 1st AD

Learning Objectives:

Participant will be able to:

1. Provide ideas on ways to provide supervision to 91X while still maximizing their effectiveness.
2. Stimulate discussion on what is the proper role of 91X in providing clinical care to service members.

Abstract:

There is always a balance between maximizing 91X (Behavioral Health Specialists) ability to treat soldier's in TOE assignments and maintaining an adequate level of supervision. This situation is especially challenging in the 1st Armored Division where we have three geographically separated clinics so that it is frequently impractical to provide continuous, on site supervision. The following two ideas were implemented in helping to maximize the effectiveness of the 91Xs while still providing adequate clinical supervision. The first idea was to separate all service members seen into three categories - I, II, and III Category I are service members who has a diagnosis of a V code or perhaps an Adjustment Disorder. These service members can be seen by 91X without on site supervision. Category II These service members have more severe psychopathology (Axis I Diagnosis) and the 91X s can only offer very specific services with on site supervision available at all times. Category III These service members have more severe psychopathology (Axis II) and, similar to the Category II service members, they can only be seen by 91X with on-site supervision. The second idea was to create a Suicide Assessment Matrix which incorporates all of the usual risk factors associated with completed suicides but does so in a structure that suggests what risk reduction measure should be taken. The advantage of using this Matrix is that when providing supervision the Suicide Assessment Matrix can be used as a checklists to objectively ensure that measures are being taken to, in fact, decrease this service member s risk for suicide.

Psychology Consultant Update: Current Issues in Army Clinical Psychology

**14 August 2001
1415-1700**

COL Edward Crandell, PhD Psychology Consultant to the Surgeon General

Learning Objectives:

Participant will be able to:

1. Identify three ongoing professional issues directly related to the practice of clinical psychology in the Army Medical Department.
2. Describe the role of the clinical psychologist in conducting a psychological autopsy.
3. Identify three changes in the current and proposed procedures for psychological autopsies.
4. Discuss two or more ethical issues which must be addressed before conducting a command-directed mental evaluation.
5. Identify three assignment options which provide career diversification for clinical psychology officers.

Abstract:

This presentation will review the major policy issues confronting Army Psychology. Current initiatives to include status updates will be provided. A review of promotion and retention policies for Medical Service Corps Officers will be presented. The presentation will focus on improved recruitment of qualified applicants for postdoctoral fellowship training and the need to develop a career track for officers interested in assignments to special operational units. The presentation is designed to address specific topics of current interest to Army Psychologists.

Social Work Consultant Update

14 August 2001
1415-1700

COL Virgil Patterson, DSW, Social Work Consultant to the Surgeon General

Learning Objectives:

Participant will be able to:

1. Understand the course objectives for Army Social Work.
2. Discuss recent changes in Army Social Work.
3. Identify purpose and mission of Army Social Work.

Abstract:

This presentation will cover the purpose of Army Social Work, staffing and organization, and AMEDD readiness issues as they relate to social work. Current issues that will be discussed include assignment policies, professional ethics, and career development. The concept of team building as it relates to Behavioral Health Teams and reengineering will be reviewed. Life cycle management, army social work careers, and mentorship will also be discussed. This presentation will also include time for a question and answer session.

Psychiatry Consultant - Annual Update

14 August 2001
1415-1700

COL Wayne B. Batzer, MD, Child & Adolescent Psychiatry Consultant, Tripler Army Medical Center
COL David T. Orman, MD, MC, Psychiatry Consultant to the Surgeon General, Fort Sam Houston, TX
LTC C.J. Diebold, MD, MC, Forensic Psychiatry Consultant, Tripler Army Medical Center

Learning Objectives:

Participant will be able to:

- 1) Describe the current issues facing Army Psychiatry
- 2) Describe current initiatives and plans for future initiatives to address Army Psychiatry's challenges
- 3) Provide overview on AD inventory, GME, and assignment concerns.

Abstract:

This presentation is intended for the audience of active duty U.S. Army psychiatrists. Drs. Orman, Batzer and Diebold will first provide a report of the current status of and challenges to Army psychiatry. Areas of concentration will include readiness & mission support, prevention, clinical care and teaching, the role of TRICARE, and the containment of soldier and psychiatrist manpower. The consultants will then discuss preparation for the future of Army psychiatry. Topics include recruitment, retention, automation, consolidation of services, the Suicide Prevention Program, TRICARE, and clinical outcomes.

The Psychiatry Consultant (Dr Orman) will present an overview of the significant issues facing Army Psychiatry for FY 2002 with emphasis on describing the challenges with regard to AD psychiatrist inventory, assignments, promotions, pay & compensation and GME. The Child Psychiatry Consultant (Dr Batzer) will discuss the status of the two child psychiatry training programs, the current child psychiatrist inventory, and challenges faced by Army child psychiatrists. The Forensic Psychiatry Consultant (Dr Diebold) will discuss the status of the forensic psychiatry training program at Walter Reed, the current inventory and utilization of Army forensic psychiatrists, and the mechanism to obtain forensic psychiatric consultation. There will be an opportunity for questions and discussion. Additional time will also be provided (aside from this presentation) for Army psychiatrists to meet individually with the consultants to discuss professional issues, including assignment planning and career development.

TRICARE Update

15 August 2001
0730-0830

CAPT Mark Paris, Phd. PHS, Deputy Director of Performance Improvement, Office of Clinical Operation, Tricare Management Activity

Learning Objectives:

Participant will be able to:

- 1 describe recent or pending changes in the TRICARE benefit
- 2 describe plans for implementation of TRICARE for Life (TFL)
- 3 describe potential TFL implications for MTF workload

Abstract:

The National Defense Authorization Act for FY 2001 will significantly impact the delivery of healthcare in the MHS. Included in the Act are such disparate legislation as TRICARE For Life, TRICARE Prime Remote, TRICARE Prime cost-sharing, and a demonstration project establishing mental health counselors as independent providers under TRICARE. Plans for implementation of the various elements of the Act are now being developed, with funding issues driving much of the discussion. This presentation will provide an overview of the current status of NDAA 2001, and will attempt to highlight its impact on MTF-level providers.

Army Suicide Prevention Program

15 August 2001
0845-1100

LTC Jerry M. Swanner, Army Suicide Prevention Program Manager , Office of the Deputy Chief of Staff for Personnel

Learning Objectives:

Participant will be able to:

1. Become familiar with the various Army Suicide Population Demographics
2. Understand the history of the Army Suicide prevention Program
3. Become familiar with the revised, 2001 Army Suicide Prevention Program Campaign plan.

Abstract:

This presentation will cover the history of the Army Suicide Prevention Program. Details of suicide population demographics, an examination of varying demographics by age, gender, rank, and marital status will be discussed. A comparison of suicide rates over the past 10 years will be made. Additionally, the origin and major developments of the Army Suicide Prevention Program (ASPP), as well as reasoning for recent revisions will be covered in this presentation. The 2001 ASPP Campaign Plan will be described. There will be time for a question and answer session at the end of this presentation.

Psychological Autopsies

15 August 2001
1230-1430

LTC E. Cameron Ritchie, Department of Defense/Health Affairs
MAJ David Benedek, Walter Reed Army Medical Center
CDR Kevin Moore, Naval Hospital, Charleston
LTC Carroll J Diebold, Tripler Army Medical Center
LTC Steven Knorr, Landstuhl Army Medical Center
LTC Jerry Swanner, DCSPER
COL David Orman, Ft. Hood

Learning Objectives:

Participant will be able to:

1. To understand the rationale for a forensic psychological autopsy
2. To learn how to do an investigation following a suicide ("PA-lite")
3. To learn about the new epidemiological database.

Abstract:

The Army has a 17 year history of programs that attempt to both reduce suicides and understand completed suicides, as embodied in the DA PAM "Suicide Prevention and Psychological Autopsies". The other Services (Navy, Air Force) have had separate programs and procedures for performing psychological autopsies. In 1996 the IG suggested that the Services request and perform psychological autopsies (PAs) in a uniform manner. A DoD wide group has been meeting to formulate the related areas of suicide prevention, an epidemiological database for all suicides, and a forensic psychological autopsy. This latter instrument would be requested by the medical examiner, and only done in rare selected cases (equivocal death, high-profile cases, etc.). Epidemiological data, which could easily be put into a data bank, would be collected in all cases. Questions of who would administer and resource the centralized data bank as still being worked out. The Army is currently developing policy about doing investigations (a "PA-lite") in selected cases. This investigation would include a bio-psycho-social discussion, answer questions about motives, and make recommendations to command. In this workshop we will: 1) Review the regulations currently governing the psychological autopsy process; 2) Illustrate, through a case example, the steps involved in completion of this task and methods to assist in accomplishing the task in a thorough and timely manner; and 3) Explain the proposed changes to the regulations in terms of a) how Army psychological autopsies are likely to change in format, and b) How these changes are anticipated to assist in the suicide prevention and c) demonstrate alternatives to the current PA which might serve to answer appropriate questions from command that does not warrant a forensic PA.

The Army Psychiatrist and Family Advocacy : A Critical Partnership

15 August 2001
1445-1545

MAJ Michele Sandberg, MD, Dept of Psychiatry, Walter Reed AMC, Washington, DC

Learning Objectives:

Participant will be able to:

1. Describe the history of Family Advocacy Program and Case Review Committees.
2. Describe past and present mental health involvement with FAP/CRC.
3. Describe the psychiatrists role as consultant to FAP/CRC.

Abstract:

This presentation explores the relationship of army psychiatrists and Family Advocacy Program. This includes attitudes and perceptions of clinicians and their past and present contacts with FAP. Until recent years, the U.S. Army Family Advocacy Program included Psychiatry and many others in its voting membership at Case Review Committee (CRC) meetings. Although no longer of voting status, army psychiatrists play a critical role in prevention, intervention and treatment of child and spousal abuse in military families. In addition to informal consultation to CRC members, the psychiatrist can offer unique services to victims or offenders. Additionally, psychiatrists and others may attend the Family Advocacy Staff Training (FAST) course which is available to applicants who are voting members or non-voting consultants attending CRC meetings. Content of the FAST course is diverse and important for a CRC member to understand. Advanced FAST courses are available beyond the basic course, addressing treatments for a variety of abuse victims.

An Outbreak of Suicidal Behaviors Among Basic Trainees: Epidemiological Investigation and Discussion of Intervention Measures and Recommendations

15 August 2001
1445-1545

Charles W. Hoge, MD, LTC(P), Walter Reed Army Institute of Research (presenter)

John M. Kirk, MD, COL, Chief, Behavioral Medicine, GLWACH, Fort Leonard Wood (presenter)

Co-Investigators: Robert Russell, CPT, Walter Reed Army Institute of Research; Charles Milliken, LTC, Walter Reed Army Medical Center; Paul Bliese, MAJ, Walter Reed Army Institute of Research; David T. Orman, COL, U.S. Army Medical Command, Fort Sam, Houston, Texas.

Learning Objectives:

Participant will be able to:

- 1) To learn about the multiple potential factors that contributed to a large outbreak of suicidal behaviors among Army Initial Entry Trainees.
- 2) To learn about interventions (multidisciplinary) that were used to address this problem.
- 3) To review recommendations that may be used in future outbreaks of a similar nature.

Abstract:

In late July /August, 2000, two Army basic trainees died due to suicide at Ft. Leonard Wood (FLW). This was associated with a significant increase in mental health referrals, overwhelming the inpatient capabilities. At the request of the MEDDAC Commander, an Epidemiologic Consultation (EPICON) team was sent to investigate. A population-based study of all initial entry trainees (IET) at FLW was undertaken. Hypotheses included prolonged time in reception center ("holdunder"), "contagion" or "copy-cat" behavior, and an "evacuation" syndrome, generated both by trainees' efforts to obtain early separations and the mental health referral environment. Between July 1 and Oct 11, 2000, 317 IET soldiers were identified who received mental health treatment, including 211 (67%) with suicidal ideation or act (gesture/attempt). Most were separated from service. Unit watch was used in over half of these cases. The rate of treatment for suicidal ideation was 2-2.5 fold higher than expected. Findings included lack of gender differences, significantly higher rates associated with the reception battalion, 1st 2 weeks of training, and longer time in holdunder, as well as evidence of clustering within units. In conclusion, a significant outbreak of suicidal ideation occurred at FLW in association with two completed suicides. Multiple potential factors contributed to this behavioral phenomenon. The presentation will include discussion of recommendations and interventions taken, including forward deploying mental health expertise, increased involvement of chaplains, establishing a 23 hour holding ward (thereby limited the use of unit watch), and isolation of the "contagious" through creation of a holding unit for those pending separation.

Emotional Impact of Mass Casualties and Fatalities

15 August 2001
1445-1545

MAJ Richard Keller, Clinical Nurse Specialist, Psychiatric Consultant, CL Psychiatry, Walter Reed Army Medical Center

Learning Objectives:

Participant will be able to:

1. Identify factors that affect individual coping.
2. Identify signs/symptoms of acute stress reactions.
3. Identify coping strategies for supervisors or participants training for the event.

Abstract:

Ethics Workshop

15 August 2001
1445-1645

Randy Howe , MD, JD, USUHS, Bethesda, MD

Learning Objectives:

Participant will be able to:

1. To understand the ethical framework for clinical psychiatry conflicts.
2. To understand the ethical framework for consultation psychiatry conflicts.
3. The know the ethical framework for military mental health conflicts.

Abstract:

This presentation will focus on ethical conflicts in clinical, consulting, and military psychiatry. Issues that will be discussed include committing a patient with alcoholism, self-disclosure, patients with HIV infection, and dying patients. Military specific issues to be covered include combat fatigue, forensic evaluations, and suicidal soldiers.

FAP Update

15 August 2001
1545-1645

Richard Stagliano, MSW. Family Advocacy Program Manager for the U.S. Army.

Learning Objectives:

Participant will be able to:

1. Identify and discuss changes in FAP that may result from the Defense Task Force on Domestic Violence, especially the recommendations contained in the DTFDV Initial Report to Congress.
2. Describe recent changes in FAP initiatives.
3. Describe the current information on FAP funding and future outlook.

Abstract:

This presentation will cover information on changes in the Army Family Advocacy Program (FAP) likely to occur over the next several years. How these changes may later the provision of FAP services in the MTFs will be addressed. These changes will be directly influenced by the work of the Defense Task Force on Domestic Violence (DTFDV), especially regarding the military's prevention efforts and response to domestic violence. Implications for funding, and program changes will be identified and discussed. The discussion and presentation will address those areas that may affect Army Social Work along with other military health care providers. Updates on the potential impact of the DTFDV recommendations on professional training and program offerings will be provided. The presentation will provide a question and answer period.

Special Population Panel

Aviator Expectations About U.S. Army Mental Health Treatment A Challenge For Preventive Medicine

15 August 2001
1545-1645

CPT(P) John F. Leso, PH.D., Chief, Human Factors Section, U.S. Army School of Aviation Medicine (presenter)
Ms. Joanna L. Greig, M.H.S., Johns Hopkins University School of Hygiene and Public Health

Learning Objectives:

Participant will be able to:

1. Describe current aeromedical policy on the confidentiality of behavioral health services for aircrew
2. Describe the consequences of behavioral health treatment for flight status crew
3. Discuss aircrew expectations about the aeromedical consequences of seeking behavioral health services and the relationship of these expectations to the crew members' choices of whether to seek such services

Abstract:

Although the literature on aircrew behavioral health recognizes poor stress coping and other psychological problems as significant threats to aviation safety (Voge, 1989), there is currently no empirical evidence that aircrew with psychological problems seek out behavioral health treatment. In fact, it has been suggested that current practices for providing behavioral healthcare to aircrew (as prescribed by aeromedical regulations and policy), such as limited confidentiality and immediate removal from flight status, may decrease the likelihood that aircrew will self-refer for treatment when indicated (Leso, 2000). The present study examines beliefs about confidentiality in behavioral health treatment, beliefs about the effects of treatment on flight status, and self-assessments about the likelihood of actually seeking treatment when needed in a sample of over 100 Initial Entry Rotary Wing students at the U.S. Army Aviation Center. Subjects were administered a nine item questionnaire on a voluntary basis during the aeromedical phase of their training at the U.S. Army School of Aviation Medicine. Preliminary analyses of the data reveal that a significant percentage of the population studied would not seek behavioral health treatment despite undue stress and/or psychological problems. Results also indicate that a significant number of subjects were unfamiliar with the limits of confidentiality in aircrew behavioral health and did not understand the consequences of treatment for their flight status. Implications of the empirical findings for prevention education, treatment practices and healthcare policy will be discussed.

Special Population Panel

Classified Information in the Psychiatric Evaluation

15 August 2001
1545-1645

LTC Ricky Malone, MD MC, Chief Resident, Department of Psychiatry,
Walter Reed Army Medical Center, Washington, DC

Learning Objectives:

Participant will be able to:

1. Discuss military regulations governing the disclosure of classified material and their relevance to mental health care.
2. Describe common pitfalls encountered in the mental health evaluation of military intelligence personnel and strategies for handling them.
3. Describe the procedure for obtaining legal permission to discuss classified material as part of a mental health evaluation.

Abstract:

Psychiatrists, psychologists, and other therapists are presented with special challenges when their patients are involved in covert operations or other matters of national security that limit what may be disclosed during the evaluation. Such situations may be encountered with varying degrees of frequency by military mental health care providers or consultants to various federal or law enforcement agencies involved in classified activities. Addressing psychosocial stressors while avoiding prohibited disclosure, legal requirements to report potentially adverse information, or gaining legal permission to hear classified details may present novel challenges in such an evaluation. This paper will present a case report illustrating some of these issues, and review applicable regulations and public law governing the disclosure of classified information. Common pitfalls and strategies for handling them will also be discussed.

Special Populations Panel

Psychology in the Ranger Battalion

15 August 2001
1545-1645

CPT Craig Jenkins, PhD, Psychologist, HQ 75th Ranger Regt., Fort Benning, GA

Learning Objectives:

Participant will be able to:

1. To orient the participant to nature of the Ranger Unit
2. To describe the importance of establishing credibility in the unit.
3. Describe the mission and role of the psychologist in the Ranger regiment.

Abstract:

The 75th Rangers have had a storied past that has inspired greatness in the Army. Part of this tradition was been to embrace new ideas and tactics, many of which have been later adopted by the larger Army. The purpose of this presentation will be to outline the position of the Regimental Psychologist for the 75th Ranger Regiment. This is a new position in the Special Operations Community. The current concept of this position and the approaches used will likely have applications beyond the Special Operations Community. This psychology position is a hybrid of clinical and industrial/organizational psychologies. The facets of this position are: Assessment and Selection; Professional Development; Command Consultation; Operational Support; Research; and Delivery of Clinical Services.

Suicide Panel

Impact of "Buddy Watch" on Use of Inpatient Psychiatric Services

15 August 2001
1545-1645

MAJ Michael Doyle, MD, Chief, Inpatient Psychiatric Service, MAMC

Learning Objectives:

Participant will be able to:

1. Understand the impact of Buddy Watch on the use of Inpatient Psychiatric Services
2. Develop an SOP for a Buddy Watch
3. Discuss protocol, indicators, and measurement of impact on use of Buddy Watch

Abstract:

Introduction: "Buddy watch" remains a traditional method for Army units to observe soldier behavior and suicide risk potential under circumstances where inpatient psychiatric admission is not advisable. This study reviews the impact of instituting a "buddy watch" protocol (BWP) at Fort Lewis, WA. Methods: We compared the average admission rate of Fort Lewis soldiers to our Inpatient Psychiatry Service for the 5-year period prior to instituting the BWP to that admission rate during the calendar year (CY2000) during which we instituted the protocol. Results: The admission rate per thousand soldiers for CY2000 was 7.24. For the years 1995 through 1999 the average rate was 10.97 ± 1.34 per thousand soldiers. There were no suicides at Fort Lewis in 2000, 9 in 1999, 12 in 1998. Discussion: In 2000 the admission rate for Fort Lewis soldiers fell more than two standard deviations below the average for the previous 5 years. Suicide rates did not increase in 2000. There are many factors that influence admission rates including operational tempo, turnover of personnel, and changes in unit leadership, and these limit this study. There is no effective means to control for these variables. However, it does appear that at Fort Lewis, the "buddy watch" protocol reduced utilization of inpatient resources without compromising safety. Conclusions: "Buddy Watch" decreases utilization of psychiatric inpatient resources without compromising safety.

Suicide Panel

Profiles of Active Duty Soldiers Presenting to Division Mental Health with Suicidal Thoughts and Behaviors. Does Deployment Make a Difference?

15 August 2001
1545-1645

Michael McGhee, CPT; (Presenter)
Co-Authors: Alan Hines, MAJ; Scott Lawrence, M.A.; Denise Squire, CPT (P)

Learning Objectives:

Participant will be able to:

1. Identify risk factors for deploying active-duty service members.
2. Identify risk factors for family members of deploying active-duty service members.
3. Identify the difference between traditional and military risk factors.

Abstract:

Objective: Risk factors associated with complete suicides have been well described. Identifying early warning signs is key when crafting suicide prevention measures. Less known are the characteristics associated with active duty soldiers who express suicide thoughts and behaviors. This study specifically characterizes risk factors, including deployment, of active duty soldiers who present to a Division Mental Health clinic with suicidal thought and behaviors. Method: All new soldiers presenting to Division Mental Health self-reported thoughts and behaviors they had within the previous one month on an intake questionnaire. Four suicide questions, comprised of thoughts (death wish, suicide plan) and behaviors (suicide gestures [i.e., cut or burned self] and suicide attempts), were collapsed into one categorical variable—all questions denied or at least one question affirmed. This suicide variable was then analyzed with several factors: demographics, external stresses, maladaptive responses and referral patterns. Suicide risk factors of soldier associated with units deploying to JRTC and NTC were compared to units that were not deployed. Chi square and independent t-test were used to analyze the data as appropriate. Results: Thirty-nine percent of respondents endorsed suicidal thoughts or behaviors. Statistically significant factors ($p < .005$) associated with expressed suicidal thoughts and behaviors included: demographics (i.e., lower rank and age, single status, past suicide attempts), stresses (i.e., relationship break-up, excess debt), and personal responses (i.e., assaultive thoughts, acting out [multiple sex partners, binge eating, breaking valuables, driving recklessly, drinking alcohol excessively, going AWOL ($p < .02$)]). Deployments, recent receipt of negative counseling statements and Article 15s were not significantly associated with the suicide risk variable. Conclusion: Suicidal thoughts and behaviors are significantly associated with both static and dynamic factors: demographics, stresses, and personal responses. Deployments were not associated with increased suicide risk in this study. However, further research on the impact of deployment on suicide risk is needed.

Medical Corps Update

16 August 2001
0730-0830

COL George Weightman, MD, Chief, Medical Corps Branch, OTSG

Learning Objectives:

Participant will be able to:

1. Knowledgeably discuss the anticipated career development of AD MC officers
2. Be knowledgeable about current and potential future incentives to continue AD service
3. Be knowledgeable about non-clinical career opportunities

Abstract:

This presentation is a career update for medical corps officers. Topics will include 1) future career development such as military schooling, leadership positions and time on station/time in positions 2) current and future pay incentives such as 5 physician pay incentives (VSP, MASP, Bd Cert pay, ISP, MSP), current initiatives on the above pays critical Skills Retention Bonus and 3) Non-Clinical Career opportunities such as TOE positions, Administrative/60A positions, and Research/Academic positions

Workplace Violence Prevention Program Overview

16 August 2001
0845-1100

COL Linda Jellen, MSW, Chief, Social Work Services, TAMC
LTC Christine Piper, Director of Psychiatric Nursing, TAMC

Learning Objectives:

Participant will be able to:

1. Identify training program components for active Prevention/Intervention team.
2. Describe the role of the Team and the issues that should be addressed.
3. List 3 areas of concern when working a disciplinary action for behavioral problems with CPAC.

Abstract:

While most bases have a Workplace Violence Prevention Program (WVPP) that is the responsibility of the Provost Marshal few have fully integrated the program within the MTF. Because of several local incidents and the new co location with the VA, TAMC developed and instituted its own multi-focused program to meet the identified needs of the medical center. In addition to the rationale for such a program, this presentation will describe behavioral health role in relation to the programs components of policy, training and education, prevention response services (to include post incident de-briefing and team building) annual work-site safety assessment, and trend analysis.

U.S. Army Recruiting Center One

16 August 2001
1230-1330

MAJ Stephen V. Bowles, PhD USAREC Command Psychologist

Learning Objectives:

Participant will be able to:

1. Refer recruiters to wellness resources.
2. Incorporate Commanders environmental assessment factors into mental health interview of recruiter applicants.
3. Recognize important recruiter characteristics for screening recruiter applicants for recruiting.

Abstract:

Center One was developed in Spring 2000 as an institute to improve approaches to training/research, assessment, enhanced performance and wellness in Army recruiting. Center One has assisted the Recruiting and Retention School (RRS) in developing their Interpersonal Skills Scale for recruiter training. The training program has assessed inter-rater reliability and found statistical significance between instructors when examining their evaluation processes of recruiter candidates. Center One is also working in conjunction with ARI to conduct field research and testing at RRS to develop a screening tool to be employed prior to a candidate's entrance into RRS. Current selection of 35% of the volunteer recruiter candidates is done through USAREC, while the remainder is selected by PERSCOM. Mental Status Exams are requested for all recruiter candidates prior to their arrival at RRS. Complimenting the testing, the assessment program conducted at the RRS looks at the recruiter candidate's interpersonal and technical skills. The initial assessment process examines academic and telephonic sales skills. The overall assessment process looks at telephonic skills, sales skills, and multimedia skills, and a final assessment examines the combination of these technical skills along with interpersonal skills. The early results of the assessment process suggest that recruiter production has been significantly improved. The Wellness program is primarily web-based information on health and wellness, providing brief articles and links to various resources requested by support staff to assist the field force. The Enhanced Performance program information is technology that has been provided to RRS for entry-level recruiter classroom use, with continued further use for the field force.

Critical Incident Stress Debriefing: Could We Be Doing Harm?

16 August 2001
1230-1330

LTC Charles Engel, MD, Chief, Deployment Health Clinical Center, WRAMC

Learning Objectives:

Participant will be able to:

1. Describe the most scientifically sound method for evaluating the impact of interventions like CISD.
2. Provide a short summary of the empirical findings regarding CISD.
3. Outline the reasons why CISD could cause iatrogenic harm.
4. Describe two reasons why CISD is practiced in the absence of known efficacy.

Abstract:

Standard military medical doctrine calls for the extensive use of critical incident stress debriefing (CISD) of personnel who have deployed, particularly if they have experienced traumatic experiences. Controversy and polarized debate have occurred as to whether CISD is efficacious or perhaps even harmful. The purpose of this presentation is to review the current state of empirical evidence pertaining to CISD, whether or not it is theoretically reasonable to suspect CISD of producing more harm than benefit, and finally to contemplate the reasons why empirically unsupported or unstudied strategies like CISD are practiced and propagated. Are there valid reasons for practicing a potentially burdensome therapy such as CISD in the absence of clinical trial evidence of CISD efficacy?

The Past and Present Contributions of Dr. Kenneth Artiss

16 August 2001
1230-1330

LTC Charles Milliken, Dept of Psychiatry, WRAMC

Learning Objectives:

Participant will be able to:

1. Discuss the principals represented by the acronym "PIES"
2. Understand the context in which these principals were formulated.
3. Apply principals of social psychology to an understanding of cult psychology.

Abstract:

This presentation will cover the work of Dr. Kenneth Artiss. Topics to be reviewed include the principal of PIES and combat stress. Discussion will cover the context in which these principals were formulated, the application of these principals, and their use in the military. Additionally, concepts of social psychiatry will be reviewed to increase understanding of cult phenomenon.

Screening for Depression, Needs and Parental Comfort in a Military Obstetric Clinic: An analysis of frequency and correlates of depression among antenatal patients

16 August 2001
1230-1330

CPT Monica Douglas, MBA, Personnel Analyst, OTSG
CPT David Douglas, LCSW, Deputy Chief, SWS, TAMC

Learning Objectives:

Participant will be able to:

1. Understand the prevalence of depression among military beneficiaries seen in Tripler AMC's obstetric clinic.
2. Understand the sociodemographic characteristics of antenatal patients at risk for depression.
3. Understand the impact of antenatal depression on birth outcome, family functioning and readiness.

Abstract:

This presentation will focus the epidemiological aspects of Tripler's Maternal and Child Health Project. The Maternal and Child Health Survey Project has been underway for approximately two years. Recognizing the need to proactively identify the needs of the OB population, SWS developed a survey instrument designed to gather data pertaining to demographic characteristics of our patients, their interest in a variety of educational and healthcare activities, a self assessment of their parenting skills and lastly a screen for depression. This presentation will describe the prevalence and sociodemographic characteristics of antenatal patients who had a clinically significant score on the Zung Self Rating Depression Scale. We will also report correlates between patients self reported interest in a variety of activities and their SDS scores. This presentation will serve to improve providers understanding of the prevalence of depression among antenatal patients, and will aid them in conducting rapid and accurate screening for depression in primary care settings.

Information Technology Panel

From History to Case Descriptions, Interactive Video for the 'Everyday' Mental Health Practitioner.

16 August 2001
1230-1330

LCDR Brian J Grady, M.D. National Naval Medical Center
COL Swarnalatha Prassana, M.D. Walter Reed Army Medical Center

Learning Objectives:

Participant will be able to:

1. To cite the work of at least one pioneer in the developmental history of interactive telemental health.
2. To list at least two key developments in computer components or communications technology that led to the current boom in interactive video conferencing.
3. To identify one important limitation on the use of interactive video with deployed military units.
4. To identify at least one potential benefit of patient care that may not be realized without the availability of interactive videoconferencing.

Abstract:

The roots of utilizing interactive video for mental healthcare dates back over forty years. This presentation will provide a brief history of interactive telemental health and its growth with advances in computer and communications technology. Key concepts of interactive videoconferencing technology will be presented with the avid computer user and non-user in mind. Pertinent case examples demonstrating some of the unique aspects of providing mental healthcare via interactive videoconferencing will be discussed.

Information Technology Panel

Medical Information, the Internet, and the Law

16 August 2001
1230-1330

Scott Mann, JD, MPH, Legal Counsel, Department of Telemedicine, Walter Reed AMC
MAJ Anthony L. Cox, LMSW-ACP Social Work Fellow, Dept of Soc Wk, Walter Reed AMC
LCDR Brian J. Grady, MD, Navy

Learning Objectives:

Participant will be able to:

1. Identify the various information technologies currently online or on the horizon that will assist military mental health providers and policy makers.
2. Explain the legal and security concerns of utilizing information technologies (storage, transfer, and communication) in patient care.
3. Discuss the current laws, governmental/military regulations, and standards that govern the use of informatics in mental healthcare.

Abstract:

With the advent (and continued growth) of the World Wide Web, the possibility of communicating with peers and patients through various means (email, websites, web-based forms, case information transfer, etc.) is very tempting. Nevertheless, legal landmines exist in this brave new world. This presentation covers the various types of electronic communication that can enhance military behavioral health. Current technologies such as VTC, web-based education platforms, web-forms, and local PC applications are briefly discussed as potential ways to leverage technology to enhance supervision, clinical and operational education, research, and direct practice. An institutional example of the Navy's use of telepsychiatry (based at NNMCC) is provided to illustrate the capabilities and potential pitfalls of such services. Finally, the legal landmines - pertinent laws, regulations and court cases - will be presented and discussed. This includes the new Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

How to institute a Workplace Violence Prevention/Response Team

16 August 2001
1345-1515

COL Linda Jellen, MSW, Chief, Social Work Services, TAMC
LTC Christine Piper, Director of Psychiatric Nursing, TAMC

Learning Objectives:

Participant will be able to:

1. Identify the rationale for a medical facility to have a WVPP.
2. Describe the basic elements of the WVPP
3. Identify the military behavioral science professional's role in a MVPP

Abstract:

This workshop will provide more in-depth training on the educational and the prevention/response team aspects of the Workplace Violence Prevention Program. Two presentations-one for supervisors and one for employees will be provided and discussed focusing on skill building for defusing escalating behavior and addressing the behavior through the CPAC process. Integration of an education program into orientation of staff will be presented. Case studies will be used to discuss the role of the prevention/response team, lessons learned, etc. Websites with useful information for program models will also be provided

Army Neuropsychology - Current Applications of the ANAM

16 August 2001
1345-1515

LTC Gregory A. Gahm, PhD, Chief, Behavioral Health Clinic, MAMC
CPT Daniel Christensen, WRAMC
MAJ Mark Baggett, WRAMC
CDR Dennis Reeves, USN
LTC Gary Southwell, TAMC

Learning Objectives:

Participant will be able to:

1. Describe applications of ANAM to aeromedical psychology.
2. Describe how ANAM can be used to evaluate head injury.
3. Describe how ANAM can be used with VTC to evaluate patients remotely.
4. Describe new areas of development for computerized neuropsychological evaluation.

Abstract:

This presentation summarizes the work of 5 separate research projects utilizing the ANAM, a DOD developed computerized testing battery. Two aeromedical application studies are included. The first, presented by Dan Christensen, begins the development of a brief and uniform computerized neuropsychological assessment tool and database for use with Army aviators. This project conducted at Ft Rucker compares three computerized testing batteries Remote data transmission and data storage for disperse applications is initiated. The second, presented by Mark Baggett, conducted at Ft Campbell is designed to validate the ANAM as a tool for enhancing future selection of pilots to fly rotary wing aircraft under difficult and demanding conditions. This study compares ANAM performance to the current FAA standard computerized test utilizing some of the Army's top aviators. Gary Southwell will present on how TAMC, as part of an overall Army Psychology effort, is searching for ways to utilize advancing technology to accomplish the mission of providing both patient care functions and professional training experiences. Current studies are focusing on the evaluation of VTC as an alternative to live interviewing as well as the ANAM for patients in remote sites. Dennis Reeves will present on a study conducted at Ft Bragg, examining the utility of the ANAM in detecting the effects of subtle head injuries following parachute jumps. Data from ANAM subtests will be presented that demonstrates sensitivity to mild head injury impairment. Greg Gahm will present on studies that are applying the ANAM as a neuropsychological screening instrument that could be used for remote neuropsychological screening and some of the technical advances currently underway to make the ANAM more accessible to remote sites and on different operating platforms. Preliminary information on how it may be applied as a Force Health Protection Measure will also be presented.

Post-Deployment Evaluation and Management - Two New DoD-VA Clinical Practice Guidelines

16 August 2001
1345-1515

LTC Charles Engel, MD Chief, Deployment Health Clinical Center, WRAMC

Learning Objectives:

Participant will be able to:

1. Name two clinical practice guidelines developed to assist with health concerns after deployments and the rationales behind them.
2. Define "stepped care" and describe how it will be used to improve clinically based risk communication after deployments.
3. Recognize the four broad primary care patient subgroups with health concerns after deployment and know how to find the "tools" available to assist the clinician's care of each subgroup.
4. Name the two most effective therapies for medically unexplained symptoms as defined by the new VA-DoD clinical practice guidelines for explained pain and fatigue.

Abstract:

Following the Gulf War, many deployed veterans developed illness, health concerns, and medically unexplained symptoms related to their wartime service. Department of Defense responded by initiating the Comprehensive Clinical Evaluation Program. The CCEP medical evaluation was comprised of an extensive but often unnecessary and potentially harmful battery of diagnostic tests and specialty consultations. These consultations were motivated by the desire to leave no stone unturned in our efforts to assist ill veterans. The National Academy of Sciences reviewed the CCEP and the analogous VA clinical registry for Gulf War veterans and recommended the development of more clinically driven and evidence based clinical practice guidelines. The result has been an extensive DoD and VA collaborative guidelines development effort, yielding two clinical practice guidelines. These guidelines are the Postdeployment Evaluation and Management CPG and the Medically Unexplained Physical Symptoms CPG. These unique guidelines are expected to improve military relevant clinical practice, reveal gaps in our current body of clinical evidence, and focus attention on veterans concerns and symptoms rather than solely on disease centered care. Features of the guidelines will be discussed as well as the expected impact of these guidelines on future postdeployment health care.

Corrections Panel

Army Social Work in a Naval Consolidated Brig

16 August 2001
1345-1515

CPT John G. Sanchez, LCSW, BCD, Chief, Social Services Division, Naval Consolidated Brig Miramar, San Diego, CA

Learning Objectives:

Participant will be able to:

1. Understand the Army/Navy corrections philosophy.
2. Understand the Army Social Workers Role in a Navy Brig.
3. Have a better understanding of the various programs available in the military corrections facility.

Abstract:

The Naval Consolidated Brig located on Marine Corp Air Stations in San Diego, CA provides a wide variety of mental health services to prisoners confined there from all branches of service. The field of Army social work has now joined the team of mental health providers at the brig for the first time ever. The different programs offered to the inmate population include, Sex Offender Treatment, Substance Abuse Treatment, and Anger and Stress Management programs. The sex offender program is a 2+ year group, which utilizes innovative behavioral techniques while supplementing intensive group process that results in significantly low recidivism rates. The Substance Abuse Rehabilitation Program focuses on cognitive behavior skills and is relapse prevention based. This opportunity is a great follow-on assignment for anyone coming from the Disciplinary Barracks at FT Leavenworth or any of the other Army confinement facilities. There are definite PROS and CONS to this type of work, but I am confident in saying you will never have another experience like it in your career.

Corrections Panel

Mental Health Services in the Military Corrections

16 August 2001
1345-1515

LTC Carroll Diebold, MD, Chief, Dept of Psychiatry, TAMC
LTC Larry James, PhD Chief, Dept of Psychology, Walter Reed Army Medical Center

Learning Objectives:

Participant will be able to:

1. Be familiar with the overall structure of military corrections.
2. Be aware of behavioral health treatment programs in military corrections.
3. Recognize areas to be improved in the delivery of behavioral health services.

Abstract:

Mental health services are essential within any correctional system. The military correctional system consists of one maximum security facility (United States Disciplinary Barracks) and several regional confinement facilities (RCF's), each with its own organic mental health assets. The presenters comprise the MEDCOM task force appointed to assess the current state of mental health services within Army run facilities. Findings are based upon tours of CONUS Army correctional facilities (USDB; Ft Sill; FT Knox; Ft Lewis) and interviews of each mental health staff by the task force in December 2000. Tours of the Navy Brig at Miramar and the Kentucky State Prison at LaGrange were also conducted for comparison of mental health services. The USDB provides a comprehensive program of assessment and treatment services to include intervention with sex offenders, the major type of offender category in this facility. Such an extensive program needs to continue when the USDB moves into a new facility in late 2001 when only the most dangerous inmates (sentences greater than 20 years) will be incarcerated there. Such a shift will necessitate that the RCF's inherit a new inmate category (inmates with 5 to 20 year sentences) with a subsequent increase in demand for mental health services. Currently, mental health assets at these facilities are grossly understaffed to meet inmate needs and lack the staffing and scope of services offered at Miramar and in the Kentucky state prison system. The task force made several recommendations to improve the scope of services available to the inmate population at the USDB and the Army RCF's. At a minimum, mental health staffing at the USDB needs to remain at current level and staffing at the RCF's must be markedly upgraded to meet the mental health needs of that population.

Corrections Panel

Initiating Program Evaluation of Treatment Groups: Measuring Changes in Victim Empathy and Cognitive Distortions Among USDB Child Sex Offenders

16 August 2001
1345-1515

CPT Woolley, Kristin K. Ph.D. Staff Psychologist, DTP, USDB, FT Leavenworth
Carroll, Timothy K. LMSW, Social Worker, DTP, USDB, FT Leavenworth

Learning Objectives:

Participant will be able to:

1. apply Program Evaluation at lowest Level
2. collaborate more effectively with other mental health professionals
3. assess program evaluation at home facility

Abstract:

Program evaluation studies are far from easy, particularly in a prison setting. Additionally, research on treatment programs involving child sex offenders has been absent or poorly designed from correctional mental health organizations (Craissati & McClurg, 1997). As correctional institutions continue to expand and reorganize, there is a growing need to evaluate treatment programs and their efficacy. At the United States Disciplinary Barracks (USDB) the Directorate of Treatment Programs has the mission to attend to the mental health needs of all inmates. Our population is made up of 40% (approx. 185) child sex offenders, creating a unique opportunity for studies in this area. The primary treatment groups focus on various themes, but increasing victim empathy and decreasing cognitive distortions are common throughout treatment. These two constructs are the focus of the proposed program evaluation study. The purpose of this study is to measure victim empathy and cognitive distortions of approximately 75 child sex offenders over a 12 month period and to explore the possible trends that exist before and after some of the initial treatment groups offered at the USDB. The study will utilize two objective measures. The Bumby Cognitive Distortions Scales (Bumby, 1996) and The Empathy Scale (McGrath & Konopasky, 1995). The results of the proposed study will provide feedback to group facilitators and demonstrate a team approach to treatment by exploring the impact of specific programs on child sex offenders. Finally, the study is designed stimulate new ideas for program evaluations using empirical methods.

Forgiveness: An Awkward Issue in Psychotherapy

16 August 2001
1530-1630

Philip C. Lewis, COL, MC, Chief, Dept. of Psychiatry, USA MEDDAC, Wuerzberg, Germany

Learning Objectives:

Participant will be able to:

1. Define forgiveness as a therapeutic issue
2. Identify at least three benefits of forgiveness
3. Identify at least three obstacles to forgiveness
4. Describe the process of achieving/implementing forgiveness

Abstract:

Forgiveness is a topic that has been long neglected by Mental Health professionals. This is probably due, at least in part, to its close association with religious teachings. Nevertheless, many patients present for therapy with pent-up resentment and anger stemming from past victimization. Failure to deal adequately with past hurts leads to ongoing symptomatology and predisposes patients to further traumatization. Helping patients to forgive those who have hurt them is one way of dealing with past hurts. This paper will explore the concept of forgiveness, some of the issues that arise in connection with forgiveness in the course of therapy, and the results of forgiveness.

Strategies for Improving Pharmacological Treatment Outcome for Panic and Generalized Anxiety Disorder

16 August 2001
1530-1630

*COL Panakkal David, MC, USAR
Director, Psychopharmacology Course, Psychiatry Residency Training Program
Clinical Assistant Professor, Albany Medical College*

Learning Objectives:

Participant will be able to:

1. Recognize the clinical presentation of panic and generalized anxiety disorder in service members presenting for medical care especially in emergency rooms.
2. Review current biological theories for treatment of anxiety disorders.
3. Discuss current practice guidelines for pharmacological treatment of panic disorder.
4. Describe the pharmacological advances in treatment of generalized anxiety disorder.

Abstract:

The National Comorbidity study conducted in United States (n=8098) between 1990 and 1992 reported that anxiety disorder was the most commonly seen comorbid condition (58%) with depression. Among the group of anxiety disorders, Generalized Anxiety Disorder and Panic Disorder were comorbid at 17.2% and 9.9% respectively. The lifetime prevalence was 3.5% for panic disorder and 5% for generalized anxiety disorder. The prevalence of anxiety disorder as a broad category is similar in military and civilian population. The civilian population has a slightly higher rate of panic and generalized anxiety disorder. The age at first onset panic attack is usually in the 20s. Patients with panic disorder and comorbid depression are at higher risk for suicide attempts and substance abuse. Mental Health problems in Bosnia was studied in British troops and Panic disorder was reported as one of the common disorder. Early diagnosis and effective treatment of panic and generalized anxiety disorders will reduce the utilization of general medical and emergency visits. The extra cost of testing patients with chest pain associated with panic disorder is estimated at \$33million per year. Pharmacological strategies to improve treatment outcome with minimal use of benzodiazepines are likely to enhance military readiness.

ASVAB Data: An Under-utilized Resource in Military Psychology

16 August 2001
1530-1630

MA(P) Linda Ross, PsyD, Chief, Neuropsychology and Adult Assessment Service, Eisenhower Army Medical Center

Learning Objectives:

Participant will be able to:

1. Relate history of testing in the Army
2. Recognize subtest components of the ASVAB
3. Recognize the utility of using GT scores in determining premorbid functioning

Abstract:

The ASVAB is the most widely administered multiple-aptitude test in the United States. It has been estimated that about 900,000 students in 14,000 schools take the ASVAB annually (Defense Manpower Data Center, 1999). Unfortunately, although this information is collected, comprehensive and likely to be the most timely of data available, it is seldom utilized by neuropsychologists in their assessment of military members. There are several reasons for this. One reason may be the limited knowledge of what individual tests and composite scores on the ASVAB are actually measuring. Another area of confusion is the variability in emphasis on different composite scores between the services. The Army relies heavily on the GT score, while other services rely on the AFQT score. Knowledge about which subtests comprise the various composite scores and what each subtest measures would certainly make this objective data more usable to all neuropsychologists who evaluate military members. A third reason for the underutilization of the ASVAB data is the difficulty military psychologists may encounter in their attempt to obtain the information on a specific service member. The purpose of this paper is to increase the military psychologists knowledge regarding the development and components of the ASVAB, as well as addressing remaining obstacles that military psychologist continue to face in their attempts to utilize the ASVAB data. Finally, a suggestion for future research will be made which can make available ASVAB data more user friendly.

Sexual Trauma in the Military

16 August 2001
1530-1630

LTC Elspeth Cameron Ritchie, MD, Program Director, Mental Health Policy and Women's Issues, Dept. of Defense Health Affairs, Falls Church, VA

Learning Objectives:

Participant will be able to:

1. Discuss the recent history of sexual trauma in the military,
2. Discuss the basics of the military legal system,
3. Describe issues about disclosure in the military setting,
4. Identify areas in which the military is improving its procedures.

Abstract:

Sexual trauma in the military has become a well-publicized issue. The military has been recently criticized about its handling of victims of sexual crimes, in a report entitled *Adapting Military Sex Crime Investigations to Changing Times*, published in June of 1999. Congress has taken an active interest in this area, directing the Veterans Administration to improve the services available to women veterans, and querying the Services as to their procedures for handling sexual misconduct offenses. The number of court-martials for rape and attempted rape in the Army averaged 149 per year, between 1991 and 1999. The conviction rate was 55%. The number increased after Aberdeen to 205, but has subsequently declined again. Studies of women veterans surveyed after discharge indicate a rate of as high as 23% being sexually assaulted while in the military. Many women report being afraid to disclose that they were raped while on active duty. They expressed concerns about the effects on their careers. The majority of women who report sexual assault leave the military within a year.

Issues around disclosure of sexual assault, both in and out of the military will be outlined. Most often these cases fall into the "he said, she said category" and are difficult to prosecute. Experts may be brought in to assist the finders of fact. Sometimes the term "rape trauma syndrome" is used inappropriately. The author prefers to discuss common and uncommon reactions in the context of the alleged victims situation and personal history. Reasons to both conceal rape and to fabricate stories will be presented. The Army is actively attempting to improve the investigation, prosecution and provision of victim services concerning sexual misconduct offenses in the Army. In 1988-1999, the Department of Justice's Office for Victims of Crime provided the Army Victim-Witness Assistance Program a substantial grant. The military medical facilities have also developed new procedures for medical processing of sexual assault victims.

Psychiatry Medical Evaluation Board: Essentials of the Process

16 August 2001
1530-1630

COL Theodore Nam, MD Chief, Inpatient Psychiatry, WRAMC

Learning Objectives:

Participant will be able to:

1. Understand and more effectively handle physical disability evaluation system.
2. Understand the responsibilities of the medical board, PEBLO, PEB, PERSCOM, and PDES.
3. Describe essential components of the AR 40-501 & AR 635-40.

Abstract:

Psychiatry Medical Evaluation Board can be a daunting and feared process; especially for those in early years of military psychiatry residency program, for those not trained in the military psychiatry residency-training program, and for those who do not do medical evaluation boards frequently. Sometimes there are differing opinions amongst seasoned clinicians when a medical board is indicated. These challenges are further compounded by subtle differences between the Air Force, the Army, and the Navy. This workshop attempts to clarify the process by going to the source documents and providing actual clinical case vignettes to accentuate the learning objectives.

Medical Social Work: A Time & Motion Study

17 August 2001
0800-0930

Ms. Diane K. Debiec, MSW member NASW, Medical Social Work, MAMC

Learning Objectives:

Participant will be able to:

1. Identify direct and collateral contacts and ancillary processes as they relate to providing medical social work.
2. Identify how beneficiary status may impact amount of time spent related to providing medical social work services.
3. Discuss implications related to discharge planning and medical social work services.

Abstract:

Providing medical social work services to our active duty and retired population has changed significantly over the past 10 years. First, we moved to a managed care system with the implementation of the Tricare program. Next, selected facilities implemented Tricare Senior Prime, a Medicare HMO demonstration project for some retired beneficiaries 65 and over. With the recent Warner amendment and its October 2001 implementation date, military medical facilities will again see changes which may bring retired beneficiaries back to our medical facilities in order to honor the promises made to them for lifetime medical care. At the same time and in many places nurses are taking over the traditional "discharge planning" role which has been associated with medical social work. Looking critically at how medical social workers spend their time providing services to various categories of beneficiaries can give us data which may help in the development of business plans in military medical facilities. It also can help us as military social work leaders identify opportunities to improve the efficiency of our organizations and also to quantify what we do and how much time it takes to do it which is important information in these data-driven times. From January through March 2001, the Medical Social Work staff at Madigan Army Medical Center tracked the time spent providing direct and collateral contacts based on patient beneficiary status. This paper will discuss the results of that time-motion study, its conclusions and implications for future medical social work practice in the military setting.

Development of a Short-term Peer Counseling Unit

17 August 2001
0800-0930

*LTC Robert Byrne, PhD, Director, Center for Personal Development, West Point, NY MAJ
Lorenzo Luckie, Ph.D., Dept of Psychology, Brooke Army Medical Center, Ft Sam Houston, TX
Cadet 1st Class John A. Rowold, USMA Cadet Peer Counselor*

Learning Objectives:

Participant will be able to:

1. Describe the history, development, and implementation of the USMA Cadet Counseling Unit (CCU).
2. Describe the mental health curriculum, training, and supervision of USMA CCU.
3. Describe the role (I. E. functions, responsibilities, and "marketing") of the USMA Cadet Counselors.
4. Describe types of counseling cases seen as well as related satisfaction survey data.

Abstract:

Each summer, the US Military Academy admits a cohort of approximately 1100 young men and women between the ages of 17 and 23 years old. These New Cadets 47 month education begins in late June with six weeks of Cadet Basic Training (CBT) whereby they are integrated into the military academy culture while acquiring the fundamental soldier skills taught during Army Basic Training. For many, this introduction to military life can be challenging and stressful. As part of its commitment to ensuring the New Cadets successful transition, first line mental health support from upperclass cadet Peer Counselors is available to New Cadets who may struggle with this key initial adjustment. Immediately prior to the start of CBT, USMA psychologists along with faculty officers from the Department of Behavioral Sciences and Leadership (BS&L) provide an intensive 10 day train-up of basic mental health skills and services to eight highly selected cadets completing their sophomore year at the Academy. With the start of CBT, these cadet Peer Counselors provide short-term supportive counseling to the New Cadets as well as mental health consultation to the cadet chain of command. Blending their 10 day training with their own CBT experience from two summers before, the cadet Peer Counselors provide highly professional and credible service. These services are closely monitored by daily supervision from the psychologists and BS&L officers who trained them. This workshop will describe the 10 day curriculum and various teaching modalities (e.g., didactics, videotaped vignettes, etc.), services provided by the cadet Peer Counselors, and levels of clinical supervision. It will further describe the associated benefits the cadet Peer Counselors receive in their own military development and, finally, address the potential application to other military settings.

Wide Ranging Health and Social Effects of Childhood Abuse and Household Dysfunction: The Adverse Childhood Experiences (ACE) Study

17 August 2001
0800-0930

CPT Robert F. Anda, MD, MS

Learning Objectives:

Participant will be able to:

1. Identify the most common types of Adverse Childhood Experiences.
2. Understand the inter-relationships between Adverse Childhood Experiences.
3. Describe the variety of long-term health and Behavioral effects of these experiences.

Abstract:

The relationship of health risk behaviors and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described. A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number categories of these adverse childhood experiences were then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0-7) and risk factors for the leading causes of death in adult life. Results: More than half of respondents reported at least one, and one-fourth reported >2 categories of childhood exposures. Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for the leading causes of disease, social problems, and death in adults.

Improving JCAHO Readiness for a Department of Behavioral Health

17 August 2001
0800-0930

COL Lawrence M. Correnti, MD, Chief, Dept. of Behavioral Health, Martin Army Community Hospital, Fort Benning, GA

Learning Objectives:

Participant will be able to:

1. Describe how a Department of Behavioral Health prepares for a hospital JCAHO survey.
2. Review how JCAHO Behavioral Health standards are applied to policies and procedures specific to military health care settings.
3. Discuss the multidisciplinary nature of compliance with JCAHO standards through examples that apply to psychiatrists, psychologists, social workers, and behavioral health technicians.
4. Understand how the standards for JCAHO functional areas are applied across clinics and professional disciplines, using specific examples such as treatment planning, performance improvement, and documentation of staff competence.

Abstract:

Key elements required for a successful JCAHO accreditation survey are described. This includes review of 2001 Joint Commission standards, pre-survey consultation, and participation in the survey. While the Joint Commission establishes standards that cover a wide range of functional areas, these functions and standards are specifically applied to Behavioral Health services. Examples include: 1) Treatment Planning in Outpatient Mental Health, Inpatient Psychiatry, and the Family Advocacy Program. The treatment planning documents to be used in each of these settings are presented, along with approaches to make the treatment planning process multidisciplinary and patient-focused. 2) Hospital Restraint and Seclusion Policy. The great majority of hospital restraint episodes occur on medical and surgical services. A detailed hospital restraint policy is presented, with sections applicable to Behavioral Health and to medical/surgical treatment. Also described are procedures for educating hospital staff members, providing ongoing training, and monitoring compliance with documentation requirements. 3) Performance Improvement. Performance improvement initiatives that address patient outcomes and patient care processes are presented. Examples are projects that demonstrate favorable outcomes, improve access, and improve documentation of treatment plans, patient education, and patient condition. 4) Environment of Care. A detailed analysis of JCAHO standards governing the physical environment is presented. On an Inpatient Psychiatry ward, hardware and construction which pose patient risk are described. Potential problem areas with infection control, patient privacy, fire safety, security, and staff education are discussed. 5) Documentation of Current Competence. A program of gathering data, confirming job-specific and age-specific competencies, and documenting this proof of competence is described.

Overview of the Cytochrome P450 System for Medical Practice

17 August 2001
0945-1100

Kelly Cozza, MD, Staff Psychiatrist, Infectious Disease Service, Department of Medicine, WRAMC
Michael A. Cole, CPT, MC, USA, Medical-Psychiatry Resident, National Capital Area Military Psychiatry Residency Program

Learning Objectives:

Participant will be able to:

1. Name the P450 enzymes.
2. Name potent p450 inhibitors and inducers.
3. Predict P450 interactions

Abstract:

This course is designed for medical practitioners (M.D.s, Nurse Practitioners, Nurses, PAs) as an overview of the complicated literature and drug-interaction information in this era of polypharmacy. Polypharmacy includes prescribed, over-the-counter, illicit and herbal compounds that must compete in the body for metabolism and elimination. This workshop provides three discreet sections: I. Overview of basic pharmacology II. In-Depth study of seven P450 enzymes and the compounds metabolized/active there and III. Practical guidelines in reviewing the literature (in hard copy and on the internet) and for safely prescribing polypharmacy. Throughout the workshop, vignettes are used to make the topic clinically relevant and interesting. There is time for participation and questions from the audience.

The Ethics of Not Treating

17 August 2001
0945-1100

Donna L. Edison, D.O., Chief, Child and Adolescent Psychiatry Outpatient Clinic, WRAMC
MAJ Anthony L. Cox, LMSW-ACP, Social Work Fellow, Child and Family Fellowship

Learning Objectives:

Participant will be able to:

1. Identify the impact of pharmacologic and non-pharmacologic treatments on the continuously adapting brain.
2. Discuss the consequences of prolonged untreated vs. treated psychiatric illnesses in military members and/or their dependents.
3. Suggest an ethical framework within which to consider decisions to treat or not to treat.

Abstract:

Recently, there has been a backlash about the use of psychotropic medications in the popular press, particularly the use of stimulants with patients diagnosed with ADHD.

The presenters will briefly review normal neurodevelopment throughout the life cycle. They will examine the current hypotheses about the neurobiological correlates for certain diagnostic categories and the prognostic implications for the appearance of symptoms at different developmental stages. The presenters will then present the neurobiological and the psychosocial consequences of prolonged untreated psychiatric illnesses such as depression and psychosis. Utilizing current ethical theory, the presenters will examine an ethical framework upon which to ground thinking and decision-making about the potential risks of treatment vs. non-treatment. In this era of increasingly safe designer medications and significant gains in the understanding of neurobiology, we may need to reexamine the assumptions underlying the choices to offer or not offer particular treatments to particular populations.

Improving Safety In an Acute Care Setting Through Performance Improvement (using Root Cause Analysis)

17 August 2001
0945-1100

LTC Christine Piper, Director of Psychiatric Nursing, Tripler Army Medical Center
CPT Michael Watson, Psychiatric Staff Nurse 66C, Tripler Army Medical Center

Learning Objectives:

Participant will be able to:

1. Describe the elements of the Root Cause Analysis structure.
2. Identify the process of conducting the analysis and staff involvement in the process.
3. Describe how results of Root Cause Analysis can be integrated into performance improvement initiatives.

Abstract:

Insuring a safe environment is critical in a busy acute care setting. However, sometimes in spite of staff efforts, incidents occur that are serious in nature. The TAMC Inpatient Psychiatry service utilizes the Root Cause Analysis format to investigate and evaluate such incidents in order to establish clear performance improvement initiatives. Case studies will be utilized to discuss how this method has provided a vehicle for patient care improvement activities.

Psychological and Behavioral Responses to Weapons of Mass Destruction

Friday, 17 August 2001
0945-1100

COL Ann E. Norwood, MD Professor and Associate Chairman, Dept of Psychiatry, USUHS, Bethesda, MD

Learning Objectives:

Participant will be able to:

1. Compare and contrast responses expected to the different types of WMD agents.
2. To discuss some of the unique aspects of biological agents when used for terror.
3. Discuss the role of media in affecting the public's response.

Abstract:

This course will discuss preparation and response for chemical/biological/radiological/nuclear/explosive (CBRNE) terrorism. Psychological and behavioral responses to these incidents will be reviewed and contrasted among events. The interaction between the effectiveness of the government's response and the public's behavioral and psychological response will be discussed. The role of media and risk communication in such events will be examined.

POSTER SESSION
1730-1900
Monday, 13 August 2001

Buddhist Psychology and Meditation Tools and Perspectives for Psychiatry

MAJ Nancy B. Black, M.D. Walter Reed Army Medical Center

The Buddha's stated goal was to investigate the source of human suffering, and his subsequent teachings and attendant practices sought to fulfill that aim. The insights of the Buddha have psychological and practical importance in that Buddhist thought can offer the psychiatrist additional perspectives and tools for working with patients. As physicians and psychiatrists, we too are seeking to alleviate suffering. From the Buddhist perspective, three negative states of mind are highlighted as central to contributing to mental and physical suffering. These are ignorance (about the nature of reality), hatred and desire. One goal of meditation is to learn to observe the mind, and become more aware in subtle ways of those three negative states. This observation strengthens the ability to focus. Awareness and improved focus bring confidence in the ability to manage a wider range of emotion. Meditative practice also results in a lessening of the impact of the undesirable emotions, allowing room for more positive states of mind to emerge. One benefit of meditation by the psychiatrist is an increased capacity to tolerate affect with the patient. Another benefit is a growth in confidence in working with patients, assisting them with managing a wider range of affect. Buddhist thought is part of the cultural and spiritual heritage of the subcontinent of India, south, central and east Asia, and of Indonesia as well. This presentation offers the military practitioner an introduction to 1) an important spiritual tradition which is practiced in regions to which one might be assigned, 2) one of its core psychological teachings, and 3) the potential practical application of Buddhist thought to psychiatry.

Identification and Treatment of Army Impaired Healthcare Providers

LTC Karl Zeff, MD William Beaumont Army Medical Center
MAJ Eric Cipriano, MSW, William Beaumont Army Medical Center
MAJ Doreen Agin, BSN, William Beaumont Army Medical Center

Army regulations (AR 40-68) require all military treatment facilities (MTF) to have an Impaired Healthcare Provider Program. While this is a Quality Improvement regulation, mental health providers within the facility are frequently asked to oversee the program. Concerns have been raised about whether these programs are identifying and intervening with the appropriate population. This presentation seeks to review the requirements. The results of a survey assessing implementation of the AR across a variety of MTFs will be presented. Data suggesting the prevalence of impairment within one Army medical center will be examined. Recommendations about how to improve the Impaired Provider program will be discussed.

Proposal for Army Psychiatry Training Slots at BAMC for UTHSCSA/Wilford Hall Program

COL Joe Chozinski - Training Director for Psychiatry at Wilford Hall MC
Thomas Hardaway - Chief, Psychiatry at BAMC

The overall complexion of Army Psychiatry Training has undergone significant change in this last decade, with changes in overall Army missions, decrease in trainee recruitment, combining of military services such as at WRAMC, and closures of programs which previously provided geographical options. This paper will present and describe the training consortium between WHMC and UTHSCSA (U of Texas Health Science Center at San Antonio), and look at the possible effects of providing training for two Army residents at BAMC as part of this consortium, with the possible advantages being overall increase in recruitment pool. With WHMC being approved for two more open slots, this will allow the overall consortium program to function unaffected if BAMC Army slots do not fill any given year.

POSTERS

Family Consultation by Videoconference

Presenter: CPT Jeffrey V. Hill, MD Tripler Army Medical Center Department of Child and Adolescent Psychiatry

Due to the worldwide mission of the military, service members often find themselves isolated from their families and other important people in their lives. Historically, this has been especially problematic during periods of illness, as the isolation has precluded the meaningful involvement of families in patient care. The US Army uses telemedicine technology in many applications throughout the world. The Inpatient Psychiatry Unit at Tripler Army Medical Center (TAMC) in Honolulu Hawaii provides service to active duty military members and their families stationed or deployed in units throughout the Pacific Region. Notably, this includes 20% of all deployed US service members worldwide. Teleconferencing capability is of great interest to the Psychiatry Service as patients are often geographically isolated from their families, a factor that plays a role in many of their illnesses. In an effort to access the potential benefit of family support, treatment teams now utilize video teleconferencing (VTC) to bring family members into the therapeutic process. Theoretically, important benefits of conducting family meetings by VTC include the capacity to establish an interactive social presence and to facilitate an improved therapeutic alliance between the treatment team and family. There is little written about such VTCs. It is hoped the value of family teleconferencing for these patients will be reflected in decreased length of inpatient stay and improved prognosis, enabling a quicker return to duty.

Assessment and Selection of US army Special Operations Aviators

CPT John Via, PsyD 160th SOAR(A) Regiment Psychologist

The initial psychological test scores from three groups of Special Operations aviators were compared. The tests were administered when the pilots were first assessed for entry into the unit, and the scores were looked at retrospectively. The three groups were, 1 - pilots with a history of being on the controls during a class A, B, or C accident, 2 - pilots who later become flight leads and, 3 - pilots who neither became flight leads nor had an accident. Significant differences in these groups scores on the original MMPI and Jackson Personality Inventory will be presented.

WRAMC HIV Program, SOCIAL WORK IN HIV

Mr. Joseph Bowker, MSW, HIV Program Social Worker , WRAMC

This is a visual representation of the Social Work interventions from a clients initial diagnosis and entry into the HIV Program and the various services which may be needed by the client and family members while in, leaving the military or after retirement. This worker has over ten years experience at the WRAMC HIV Program and has worked in HIV since before it was named HIV.

Assessing and Treating Gambling Disorders

Lee Stevens, MD

Gambling disorders are often not recognized and contribute to treatment resistance in patients with emotional problems. This course will review pertinent and clinical information on gambling disorders including diagnostic definitions, epidemiology, screening instruments, and treatment and prevention approaches. Cognitive-behavioral approaches to treatment suitable for patients with chronic emotional problems will be emphasized. Health approaches focused on harm reduction in the soldier and his family will conclude the course.

Designing an Efficient "One-Write", Patient-Centered Problem Oriented Mental Health Record for Outcomes Management Throughout the Continuum of Care

COL Kenneth Hoffman, MD, MPH Colonel, Medical Corps, USA Drug and Alcohol Consultant, OTSG Medical Director, Military and Veterans Health Coordinating Board

The multi-modal, multidisciplinary approach of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) towards managing alcohol-related problems may serve as a model for other high risk problems that may progress to chronic illness. An unfortunate consequence of an integrated approach to alcohol-related problems has been a cumbersome documentation process that includes possible creation of an inpatient medical record, creation of a drug and alcohol specific outpatient record, placing sufficient documentation in the outpatient medical record, and putting information into medical and personnel electronic record systems. These records cannot document the very high treatment and occupational retention success rates reported in 1990. In 1994, current activities of seven Army ADAPCP clinics were modeled in terms of inputs, outputs, resources and regulations using DoD approved Integrated Definitions for activity and data modeling (IDEF0 and IDEF1X). Modelers developed idealized IDEF models focused on patient care, command consultation and support services, highlighting improvement opportunities and eliminating "wasteful" activities. ADAPCP clinical directors validated the optimized IDEF models. These were used to design a prototype patient record. A tri-service group of addiction treatment providers validated screen designs for a one-write, problem-oriented, patient-centered electronic record capable of tracking outcomes and generating required reports. The prototype received favorable reviews as an integrated medical record focused on serving the provider-patient interaction with analyzable data capable of being aggregated for reports and outcomes management. Military drug and alcohol treatment program success has been attributed to a continuum of care with integrated components of health promotion, occupational health, social support networks, traditional medical care, and military psychiatry. This is reflected in recommended documentation focused on the summary of health status related to biopsychosocial problems with associated interventions. Tracking associations over time provides capability for outcomes management and permits creation of clinical practice guidelines based upon the patient population served.

Developing & Implementing Clinical Care for the Victims of Terrorist Attack

Harold J. Wain, Ph.D., Chief, PCLS

MAJ John J. Stasinos, M.D. Director of Clinical Services, Psychiatry Consultation Liaison, WRAMC

Terrorist threats have been on the rise both overseas & on American soil, involving both civilians & military personnel. On 7 August 1998, the U.S. embassies in Kenya & Tanzania were attacked by terrorists, resulting in almost 2,000 casualties, including 81 fatalities. A dozen seriously injured patients, embassy personnel that included U.S. citizens & Kenyan nationals, were evacuated to WRAMC following the bombing for definitive medical intervention. This presentation will review the clinical & administrative principles that were applied to develop & implement a comprehensive & coordinated treatment plan to assess & manage trauma victims & their families. The principles of psychiatric intervention for trauma victims & their families will be highlighted. Administrative concerns & pitfalls will also be discussed.

POSTERS

The Use of ECT in Combination with Atypical Neuroleptics in Treating Acute Psychosis

CPT James Demer, MD, Psychiatry Resident, WRAMC

Joseph Dolansky, D.O., Attending

Tim Switaj, 2LT, MC, USA

This paper presents the case of a 20 year old male, AD U.S. Army with first break psychosis, refractory/intolerant to multiple trials of typical and atypical neuroleptics. This patient responded to a combination of ECT and 2 atypical neuroleptics. Unique diagnostic and treatment challenges are addressed. A detailed discussion of the combination of ECT-neuroleptics in treatment of schizophrenia is presented.

Vocal Cord Dyskinesia--A Biopsychosocial Model for Psychiatric Intervention

Harold J. Wain, Ph.D.

Geoffrey Gabriel, M.D.

George T. Brandt, M.D.

Charles Milliken, M.D.

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Many perplexing disorders bridge the gap between medicine & psychiatry. Unfortunately, when symptoms lack anatomical correlates, psychiatric diagnoses is often made by exclusion. One of the disorders that is often mistaken for asthma & where the symptoms appear to bridge the span between psychiatry & medicine is Vocal Cord Dyskinesia (VCD). The literature is muddled by a myriad of diagnoses. A historical perspective regarding the various labels applied to this particular disorder will be reviewed. The interaction of biological & psychological factors in the development & maintenance of VCD will be discussed. The somatization process, the role of dissociation, possible trauma & a biopsychosocial approach to the conceptualization & treatment of this disorder will be discussed. Emphasis on the evaluation & treatment process in the context of a consultation-liaison psychiatry model will be highlighted. Patient motivation & strategies employed to facilitate treatment & to respond to both primary & secondary gain issues will be explored. Case studies & videotapes will be employed to enhance the clinical hypotheses.

The abuse liability of dextromethorphan

William V. Bobo, M.D. LT, MC, USNR PGY-III NNMC

Dextromethorphan (DM) is a popular antitussive medication used in numerous over-the-counter cough remedies. Though adverse effects from the medication are rare at recommended dosages, well-established toxidromes with significant psychomimetic effects occur with ingestions far in excess of those for indicated usage. Indeed, both DM and its active metabolite, dextrophan (DOR), share pharmacologic properties similar to well-established drugs of abuse. As such, cases of DM abuse and, rarely, dependence have been long-reported. In this review, the current state of investigation into DMs rather complex neuropharmacology is presented from an addiction medicine viewpoint in order to support the contention that DM carries with it a significant abuse liability, along with a discussion of relevant social factors specific to DM and substances like it that may further contribute. Epidemiologic, diagnostic and treatment-related issues are also presented, along with identification of areas in need of further study.

POSTERS

Theory-Based Clinical Intake Questionnaires

MAJ Anthony L. Cox, LMSW-ACP (Social Work Fellow, Dept of Soc Wk, Walter Reed AMC)
Donna L. Edison, D.O. (Chief, Outpt Clinic, Child & Adolescent Psychiatry Service, Walter Reed AMC)

Nearly every military and civilian clinic utilizes some sort of intake questionnaire. Most of these forms have either been inherited from antiquity (i.e., the reasoning for asking certain questions and not asking others has been lost in the sands of time), or were theoretically put together (i.e., "cuz it felt right"). The presenters will examine the importance of utilizing conceptual frameworks, practice models and change theories in developing clinical intake (and other) questionnaires. Further, they will present the pitfalls and particulars of clinical intake questionnaire development. Electronic copies of questionnaires will be available (via email or diskette).

Restructuring Army Social Work Continuing Education

MAJ Anthony L. Cox, LMSW-ACP (Social Work Fellow, Dept of Soc Wk, Walter Reed AMC)
MAJ Kevin R. Stevenson, LMSW (Social Work Fellow, Dept of Soc Wk, Walter Reed AMC)

Currently, Army social work officers often come into the system with little experience, can be sent to remote assignments early in their careers, and often are not appropriately mentored. In addition, due to changes in DODD 6490.1, Army social workers must now obtain a clinical doctoral degree in order to be considered a "mental health provider." With only one new doctoral start and one new fellow start per year, how can Army Social Work provide a comprehensive training program that assists all social work officers from accession to retirement? The presenters will provide an overview of current Army social work training programs, the problems inherent in these programs, and "rules of thumb" for revising them. Finally, the presenters will outline an overarching program to provide early training, continuous mentoring, and the possibility for remote doctoral work. Three facets will be detailed: 1) a unique accredited distance learning and mentoring program that utilizes video teleconferencing as a primary vehicle for continuing education within Army Social Work. Curriculum content would be developed utilizing the Delphi Method, and senior social work officers and DOD civilians would provide the instruction and mentoring. 2) the Social Work Fellowship would be modified into a "social work CGSC" or a training base for advanced social work leadership practice. 3) various methods for obtaining a doctoral degree will be presented ? with one particular recommendation that could be merged into the distance learning/mentoring program above. Implementing this program will put Army Social work on the cutting edge of academic distance learning in the AMEDD. This clinical and technical training program is one way to ensure that social work officers are viewed as "force multipliers" within the Army community.

Personality and Stress Management in Trainees

CPT Matthew P. Novak, MA, MS

This project will examine the effect of a personality variable, Desire for Control, on the efficacy of a two-session stress management intervention in reducing anxiety. The sample will consist of approximately 400 IET students, half assigned to the intervention condition, and half to a control group. It is expected that Desire for Control will show an interaction with treatment/no-treatment. That is, trainees with high DC will show higher levels of anxiety when in the control condition versus the treatment condition, and trainees with low DC will show higher levels of anxiety when in the treatment versus control condition. Data will be analyzed using multiple regression. Data will be collected and analyzed by 31 Jul 01.

POSTERS

A Telephonic Home Program of Rehabilitation for Moderately Severe Traumatic Brain Injury Patients: Telephonic Mental Health Interventions

Deborah Warden, M.D.
Andres M. Salazar, MD
Elisabeth Moy- Martin, RNC, MA
Karen A. Schwab, Ph.D.
Mary Coyle, RN MS CS
Joan Walter, PA, JD
Laurie Ryan, Ph.D.
WRAMC Traumatic Brain Injury Program

The authors describe components of an eight week telephonic mental health intervention from WRAMC for rehabilitation following a moderate to severe TBI. The program was successful in returning an Active Duty soldier to military duty. Fifty-three (N=53/120) soldiers were randomized within 90 days of injury to an accompanied home leave after baseline multidisciplinary evaluation and medical stabilization. We describe the patient's gradual resumption of mental and physical activities, some of the difficulties encountered, and mental health interventions utilized allowing 51 patients to safely complete the Home Program. During weekly phone calls, patients reported that post concussive symptoms of headache, fatigue, depression, irritability, and memory problems were their main concerns. Nurses assessed the impact of symptoms on daily functioning and relationships in the home. Emotional reactions to anxiety, depression, and /or angry outbursts were explored. The development of a working alliance assisted with problem solving techniques. Situations provoking irritability, anxiety and depressive states were often talked through. This interactional process seemed to assist patients and families in the adjustment to the home and expectations of the community. Calls also promoted safety, medication compliance and support during the process of recovery. Patients increasingly self-monitored their behaviors during the home program. This included being able to discuss specific problematic or satisfying behaviors and the consequences. Telephonic mental health interventions were effective in monitoring patients after TBI in the home environment.

Can any Psychiatrist, Social Worker, Psychologist treat Substance Addiction? Should they!

Daniel E. Hendricks Ph.D., ADC, Director Eisenhower Substance Addictions Program, EAMC, Ft. Gordon GA 30905

Substance Addiction is recognized by many agencies as a specialized field requiring certification just as neuropsychology or child. This paper will explore some of the legal and ethical considerations of treating substance addiction in addition to reviewing some treatment standards.

Review of Psychological Autopsies to Improve Efforts of Suicide Awareness

Nancy Harpold, MD FT Riley, KS
Nicole Doyle, PhD. FT Riley, KS

Understanding the potential for increased risk of suicide in army communities is a responsibility of all installation commanders. During a 36-month period there were 11 completed suicides. Psychological autopsies at Fort Riley, Kansas were reviewed to identify characteristics associated with this period. This comprehensive review was undertaken to investigate existing efforts and to determine whether enhancements in mental health care would result in earlier recognition of trends to reduce successful suicides