

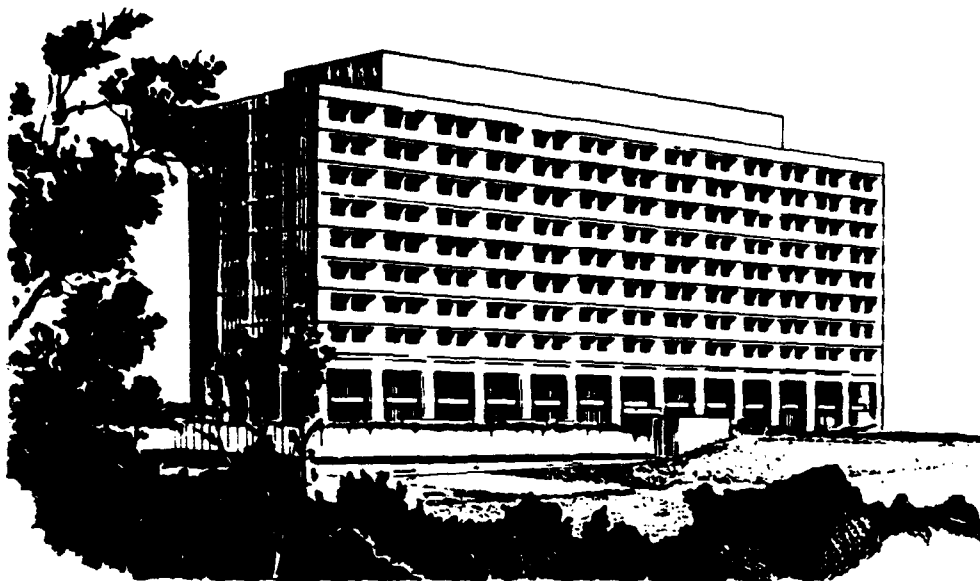
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1989 AMEDD
CLINICAL PSYCHOLOGY
SHORT COURSE



13 - 17 February 1989

EISENHOWER ARMY MEDICAL CENTER

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AMEDD CLINICAL PSYCHOLOGY SHORT COURSE

13 - 17 February 1989

EISENHOWER ARMY MEDICAL CENTER

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PROGRAM

Monday
13 February 1989

1000	Welcoming Remarks	COL Xenakis COL Imonen LTC Brooks COL Chermol
1045	Remarks by OTSG Psychology Consultant	
1300	Army Clinical Psychology into the 1990s	
1330	Aviation psychology	CPT O'Hara
	The administratively separate psychology service: current status and update	LTC Parker
	The administratively separate psychology service: evaluation	MAJ(P) Mangelsdorff
1430	Licensing and credentialing within HSC	LTC Grill
1515	Army clinical psychologists: factors affecting decision to remain in service	MAJ(P) Mangelsdorff
1545	Current status of Army psychology in Europe	LTC Hulsebus
1630	Association of Army psychologists	CPT Coleman CPT Storjohann

Tuesday
14 February 1989

0800	Neuropsychological assessment of HIV and AIDS patients	MAJ Beatty
0900	The effect of emotional state on neuropsychological test performance	MAJ Powell
0930	Workshop on the practical use of the California Verbal Learning Test for clinicians	MAJ Hollis LTC Zych
1045	Continuity-discontinuity in child-adult psychopathology	COL Xenakis Dr. Degroot
1300	Stress variables and patterns of alcohol consumption	Dr. Boyd Dr. Callen
1320	An experimental aversion therapy approach to treatment of cocaine abuse	Dr. Elkins
1345	The use of assessment instruments in marital counseling	Dr. Selby
1415	Update on dissociative disorders	Dr. Brandsma
1515	The seven deadly truths of caring (plus or minus two)	COL Logan
1615	Recent developments in treatment of post-traumatic stress with direct therapeutic exposure	Dr. Boudewyns
1900	Banquet	COL Xenakis

Wednesday
15 February 1989

0800	Families and anxiety disorders	Dr. Oppenheimer Dr. Frey
0900	American Board of Professional Psychology (ABPP) Examination Process	Dr. Frey Dr. Swanson
1000	Current practice of neuropsychology in the medical and psychiatric setting	Dr. Schear
1300	Psychiatry grand rounds presentation: The demographics of youth	Dr. Youniss

Thursday
16 February 1989

0800	Military forensic psychology	MAJ Crandell
0830	Forensic psychology: role of the military psychologist	CPT Gahm
0900	The psychologist's role in security evaluations	MAJ Roland MAJ Thomas
1030	The Army suicide prevention program	MAJ Thomas
1300	The role of the Army psychologist in psychological autopsies	MAJ(P) Younggren
1400	Dual relationships: legal and ethical dangers for therapists	LTC Laskow
1430	Intervention strategies for victims of terrorism/disasters: USAREUR scenario	MAJ Stephenson
1515	Psychological intervention in human catastrophe	

Friday
17 February 1989

0800	Corrective parenting	Dr. Anderson
0830	Peacetime stress casualties: characteristics and implications for Army psychology	CPT Hazlett
0900	Depression versus antisocial conduct disorder: differential diagnosis	Dr. Butler
0930	Cognitive treatment of depression	Dr. Riley
1015	Rehabilitation of chronic pain	Dr. Bruno
1045	Psychophysiological interventions for chronic phantom limb pain: preliminary findings	Dr. Arena Ms. Bruno Dr. Sherman
1130	Closing remarks	LTC Brooks

ARMY CLINICAL PSYCHOLOGY INTO THE 1990s

Brian H. Chermol, Ph.D.
Clinical Psychology Consultant
Office of The Surgeon General

Significant changes are occurring in the roles of clinical psychologists within the AMEDD. Within the next few years, Army psychologists will assume many of the roles presently restricted to psychiatrists. Some examples are admission of patients; membership on sanity, mental competency and selected medical boards; writing of temporary profiles and of prescriptions from a limited formulary; conduct of CPRP, NPRP and security evaluations; and performance of psychiatric discharge examinations. The future also holds special pay for licensure and ABPP certification, the creation of additional separate psychology services, and an increase in authorizations. Promotions will remain highly competitive until the 1990s, then become significantly easier, particularly for junior psychology officers. Significant changes are occurring in the CPIP, with obligated service being increased by one year, internships being extended by one to 12 months and graduation returned to the month of August. The 1990s will be rewarding both financially and professionally for those who remain on active duty.

Important changes are occurring in the Army Medical Department (AMEDD); they will substantially increase the scope of practice, patient responsibilities and professional liability of both military and civilian licensed psychologists. During 1988, the Surgeon General gave clinical psychologists the authority to (a) serve on sanity, mental competency and medical (i.e., psychiatric boards); (b) conduct Chemical and Nuclear Personnel Reliability Program (PRP) and security evaluations; (c) perform psychological autopsies in suicide cases; and (d) diagnose alcohol and drug related mental disorders. In 1989 this list should expand to include the diagnosis of personality disorders and homosexuality for discharge purposes, the issuance of temporary profiles (30 days maximum), and authority to conduct the psychiatric examination on SF 88 (Item 42).

In 1989, the number of separate Psychology Services should increase from one (WRAMC) to four, with the addition of Eisenhower Army Medical Center, Letterman Army Medical Center, and Madigan Army Medical Center.

As early as 1990, the Army may extend prescription writing privileges to licensed clinical psychologists on an optional basis, after they have completed formal course work followed by a period of supervised practice. The Physician's Assistant and Psychiatric Nurse Practitioner programs are being reviewed as possible models for the training of psychologists in this task. Also possible in 1990 are the start of a second psychology fellowship (EAMC, GA), the transfer of two psychology internships to MAMC, WA, and to TAMC, HI, special pay which could range from \$4,000-\$6,000 per year, and APA Continuing Education Credit for the Annual Short Course.

Internships will continue to be the focus of concern as sites continue to proliferate in the civilian community, but graduate student output remains static. More money and effort will be expended to recruit interns, the internship will be extended by one month, and the period of obligated service will be increased by one year (to three years post-internship). Military

specific instruction will increase during the internship to prepare interns for their new roles in the Army. In a related action, neuropsychology (NP) fellowships will also increase by one month in length and NP will become a recognized subspecialty through award of the 9Q suffix.

Recruitment of licensed psychologists and interns will necessitate (a) reinstatement of psychology graduate students in the Health Profession Scholarship Program (HPSP), (b) more psychology quotas in the LTCT for non-68 series officers, (c) more funds spent on advertising and direct recruitment efforts, (d) the provision of special pay for licensed psychologists (similar to that received by optometrists and veterinarians), and (e) the revision of US Code Title 10 to allow entry on active duty until age 40 for a full career.

The late 1980s will see a continued increase in the number of AOC 68S authorizations, with a significant number of 06 authorizations being created through the formation of separate Psychology Services and the interchangeability of key staff and divisional positions between AOCs 68R (social work) and 68S at the Academy of Health Sciences and major MEDCOMs. The only bad news on the horizon is that 1989 will see promotions being very competitive, a situation that should ease considerably as we enter the 1990s.

In summary, the 1990s appear to be a period of growth and increasing responsibility for Army psychology. It will also be a time of great financial and professional reward for those who proudly serve on active duty.

AVIATION PSYCHOLOGY

Charles P. O'Hara III, Ph.D.
160th Special Operations Aviation Group (ABN)

Aviation psychology is a new area of the discipline for the Army to incorporate into its professional ranks. Several Army psychologists are looking at what behavioral science has to offer aviators in the Army. The Army has the largest number of aircraft of any branch of service. Primarily, the Army has rotary wing aircraft which serve multiple functions: combat, troop movement, and cargo hauling to name but a few. The Army has only one psychologist who is dedicated solely to the support of aviation at this time. Another psychologist is currently receiving OJT at Fort Rucker, Alabama, the headquarters of Army aviation.

ENVIRONMENT

Why does the Army require specialized training for psychologists who support aviation? The answer lies in the environment, the equipment and the personnel. Current studies of aviation safety cite human error as the cause of 70-80% of the aviation accidents. Flying is an inherently dangerous business which has a small margin of error. The Army often flies at night to support the mission. This is the most hazardous environment for the pilot: night time, low level, rotary wing with night vision devices for visual input. The challenges for the aviator are increased dramatically from day time, above the trees flying that was the combat standard. For those who choose Army aviation as a line of work, it becomes critical that they receive support from all areas to ensure the mission is safely completed. This includes the support of the aviator by someone trained to understand human behavior.

EQUIPMENT MACHINES

Historically, accidents have been a means of understanding the limits of man's ability to master a new skill. The development of aviation has been no different; mishaps have provided the bulk of information concerning the safety of flight. Initially, mishap investigations focused on the machine malfunction as a profitable arena of study. Then, the study of human factors was introduced with the advent of the flight surgeon and his unique understanding of human physiology in the flying environment. The most recent areas under study have involved engineers to facilitate the design of equipment to complement human capacities and recognize human limitations of performance. Psychologists are in a position to investigate the large remaining area cited in mishaps: human error. What occurs in the cockpit is of critical concern to aviators, safety boards, and passengers.

HUMAN FACTORS

Far exceeding material or mechanical malfunctions, human error is listed as the cause of the majority of accidents. With the increasing sophistication of equipment and performance, the human is often pushed to the limits of his abilities. The behavioral scientist is trained to help others enhance their

performance. This is accomplished through being aware of subtle signals that would degrade cockpit effectiveness. The psychologist may function as the focal point in developing a curriculum to train instructor pilots and pilots in essential skills for cockpit resource management. How to help command to recognize this training as a mission enhancer is also the job for the behavioral scientist.

A goal of aviation psychology is to help aviators, commanders and family members recognize the number of human factors that contribute to accidents. Stress in the family, financial problems, working with someone who is difficult to approach with comments, all may be factors that inhibit the optimum performance of the crew and the safe completion of the mission.

CONCLUSION

Aviation psychology is a new concept for the Army that could become a high demand skill area. It is a recognized specialty in the civilian marketplace with most major airlines having behavioral scientists in their work force. The need for the Army is to utilize all the available resources to create the safest flight environment possible. One avenue of approach is to work from the lowest level of command up through the highest level. Another approach is to go in the opposite direction from the boss down to the lower levels of supervision. However it is done, the aviation psychologist will have to develop new theories, skills and applications of knowledge to fill a gap that exists now. Army psychology is in lean times; interested psychologists will have to be self starters, but, once going, they will discover that a network exists, and progress is possible.

THE ADMINISTRATIVELY SEPARATE PSYCHOLOGY SERVICE:
CURRENT STATUS AND UPDATE

Raymond A. Parker, Ph.D.
Director, Neuropsychology & Inpatient Section
Psychology Service
Walter Reed Army Medical Center
Washington, DC

As you may know, the Psychology Service became administratively separate from the Department of Psychiatry at WRAMC as of 1 May 1988 (See Figure 1). This separation was implemented as the result of a Congressionally-driven directive to establish and evaluate a separate "Department" of Psychology at an Army installation. WRAMC was chosen for this project. My purpose at this time is to update you on its status. It has truly been an interesting year thus far, successful in most respects, and there are many things I could discuss. However, in the time allotted, I want to discuss events in a number of functional areas which I feel will be most salient to those of you who become involved in a similar process. It is hoped that our experience can facilitate similar transitions still in the planning stages.

GENERAL ADMINISTRATIVE AND MANAGEMENT FUNCTIONS

The first area of interest is that of general administrative and management functions. As conceived by command, Psychology Service was to receive no additional resources for administrative support yet would actually incur additional requirements in the form of more personnel and new administrative responsibilities. It was hypothesized that the effects of this additional workload would be offset by having a shorter chain of command involved as well as having more direct control over our resources.

At this point in time, it is clear to all of us that we do have more administrative duties as a separate service and we must accomplish them ourselves. Many things which were the responsibility of the Department of Psychiatry now fall on our shoulders. We must manage more people since our TDA now includes all Center clinical psychologists previously assigned to other departments and services as well as newly established positions co-occurring with but unrelated to the separate service transition (See Table 1). Our new administrative responsibilities range from "nuts and bolts" issues such as obtaining parking permits, and updating telephone directories and signs (See Table 2) to more general activities such as budget management and quality assurance, both of which previously were embedded within the Department of Psychiatry's operations. We now sit on committees and attend center-wide meetings which heretofore were covered by psychiatry (See Table 3).

What, then, has been the impact of these changes and what do they imply? First, and foremost, our clinical workload does not appear to have been negatively affected by these increased administrative responsibilities. This is likely a result of several factors. First, careful division of additional responsibilities among staff members as well as effective delegation to subordinates appears to be a primary factor. No one has become overwhelmed with additional work. Second, having more staff members has meant having more people to get the administrative work done or to assume a greater clinical

workload so that other staff members could spend more time on administrative requirements. Third, having control over our resources and having more direct access to information have enabled us to "get it right the first time," thus obviating the need for time-consuming repetition or "back-tracking." Of course, getting this process set up has necessitated much expenditure of time in getting to know and talking with "key" people in other activities who make things happen for us and, by virtue of this communication, learning how the system works. Additionally, the parent organization administrative personnel, in our case Psychiatry, have been indispensable in filling our knowledge gaps. To be sure, you can expect to work harder and longer hours in such a transition phase. The results, however, are proving to be very satisfying thus far and the demands appear to be lessening as we get our system set up and operational.

FINANCIAL MANAGEMENT AND BUDGET

Since many of us are probably somewhat unfamiliar with administration and management issues, I would now like to use our experience with financial transition and the budget to underscore some of the foregoing points. As Financial Management Officer, I have had an opportunity to develop a detailed knowledge of procedures and formats necessary to insure proper fiscal support for the Psychology Service, and I am exceedingly pleased to report that we have been allotted a budget which meets all of our needs with the possible exception of TDY travel. Deficiencies in travel money, however, are uniform at WRAMC, and we were not deliberately slighted. We are very pleased with the total budget. Now, how did it come about?

Several factors have been important here. First, getting to know a number of individuals in our Directorate of Resources Management (DRM), particularly our financial manager in the Programming and Budget Division, has been invaluable. These people control and allocate the money and they have been very supportive and willing to teach us "the ropes." Second, development of a detailed budget in the areas of travel, contracts and supplies was essential in communicating our needs to the Programming and Budget Division. The level of detail here included a listing of each specific item of expenditure and its cost, such as planned TDYs (APA), visiting consultants, APA accreditation fee, etc. I cannot emphasize enough the need to have hard, defensible data in this regard. This budget request represented our "wish list." Third, since establishment of the separate service was to cost WRAMC no additional monies, we were directed by DRM to negotiate with the Department of Psychiatry to determine how much of its FY 89 budget would be given over to Psychology Service. In essence, we would be given our "fair share" of the Departmental budget as our own based on what, in fact, we had consumed in FYs 87 and 88 as a member of the department.

Well, you can probably see right away the source of some misgivings which arose on our part. We were faced with a task whose outcome would result in a decrease in FY 89 budget for the Department of Psychiatry. We did two key things here. First, a careful search of the departmental budget transaction records yielded a fair estimate of what we had actually spent. Second, and more important, several very constructive discussions between the Chief of the department and myself yielded extremely fruitful results. We both agreed that the funds should be allocated on a proportional basis, giving each of us the best chances of meeting our respective organizations' needs. In this manner, we all got what we needed.

At the PBAC Committee meeting in December, 1988, our fledgling budget was approved without discussion, and we became forthwith financially potent. We could now spend money without anyone's permission, so to speak. This situation has entailed development of a thorough understanding of an often vexing and complex financial management system. You see a graphic representation of the current state of our knowledge in Figure 2, entitled "The Big Chart." Don't worry if it is not crystal clear at first glance. I frequently stare at this thing to gain insight into my next financial adventure. You may notice a couple of things about this chart: First, names of specific individuals are prominent in the various blocks. Personal contacts are essential to success. Second, the flow of actions from one point to the next is comprehensible and, as a consequence, "glitch-points" can be more easily identified.

How is all of this going? I can tell you unequivocally that management of our own financial resources is a tremendous improvement over all other fiscal situations I have encountered in my Army career. We know exactly how much money we have at any given time in any given category, we can obligate it at will, and we have an understanding of the system such that we can quickly and efficiently spot and address problems. We are spending our money and enjoying it immensely.

INTERNSHIP PROGRAM AND TRAINING

I'd like to move now into the clinical areas affected, the first of which is the impact of the separate service transition on the internship and training programs. Overall, this change has not had a significant, direct impact on the internship program. Of course, potential indirect effects from the administrative and service areas are evident. One obvious example occurs with the funding for the interns' training outside WRAMC. With adequate budget resources, interns are able to attend one local conference of choice and have their registration fees reimbursed in full. An adequate budget also allows us to bring numerous consultants into WRAMC for training conferences. Clinically, the transition has given the interns a potential opportunity for a broader scope of involvement in clinical services. An example here would be providing treatment services psychiatric inpatients on the wards. Finally, an impact on training in general has been the requirement to establish and carry out our own grand rounds. We now do this once a month for one hour each time, bringing in invited speakers, either paid or unpaid. Recently, for example, Dr. Alex Martin, research neuropsychologist in the Department of Clinical Investigation, presented his work on HIV/AIDS. In sum, the impact of the transition on our training efforts and program appears uniformly positive.

CLINICAL SERVICES PROVISION

A final area to be covered involves the impact of the transition on clinical services provision. Referring again to Figure 1, I will address the effects on each clinical section in turn. First, the impact of the transition on the Behavioral Medicine Section has been minimal, with shifts of personnel to Psychology Service TDA occurring without material impact on their duties or location. Essentially, direct support of the HIV/AIDS program and Psychiatry Consultation Liaison Service has continued unaltered.

In the Outpatient and Pediatric Psychology Sections, a number of changes

have been driven by the transition. Interface with Outpatient Psychiatry Service was previously carried out as a subordinate element of that service. Psychotherapy with outpatients was entered into according to procedures established by Outpatient Psychiatry, and each case had to be initially reviewed by a psychiatrist or resident. Our present interface involves a reciprocal referral relationship in which we see therapy patients independently and decide when referral to an M.D. is necessary. We essentially run our clinic and follow our own procedures, which include some standard assessment on all intakes (i.e., MMPI, Shipley ILS). All of our intakes are scheduled; we are not an "emergency" service and, for that reason, all intake "emergencies" go to Psychiatry. This system has presented no reported quality of care problem of which I am aware.

Our pediatric psychology effort represents the reactivation of a previous mission, dormant for some time. Three new staff positions on our TDA and some "growing pains" in defining relationships with Child and Adolescent Psychiatry (CAPS) and with the Exceptional Family Member Department (EFMD) have presented some challenges. A major issue here has been precise clarification of command's intent for staff previously assigned to CAPS and EFMD to remain attached in direct support of those organizations. Thus, "business" in CAPS and EFMD continues as usual, and definition of roles, boundaries, divisions of labor, etc., among CAPS, EFMD, and our Pediatric sub-section proceeds with promising results. A major effort here is to establish a unique "niche" for the pediatric subsection, offering something not being offered in other pediatric organizations.

Some complex issues arising in the outpatient arena common to both adult and child practice are proving difficult to resolve quickly and easily. Officially mandated "independent" practice by non-physicians in a physician-oriented environment has generated some uneasiness about our ability to decide when to refer for medical workup as well as our ability to do the workup ourselves if need be. Also, the need to provide something "unique," to produce, to "sell ourselves" as it were, has to be met as much as possible without antagonizing our potential "competitors." At present, however, demand for our outpatient services has grown to the point that some limiting or regulating of availability is necessary. Also, I have heard no evidence of any disgruntlement among our potential competitors.

Neuropsychology and inpatient psychiatric services have been primarily assessment-oriented prior to the transition. Now, combined into one section, they still find assessments to be a major aspect of the workload. Requests for neuropsychological assessments have increased by 20% during October 1988 through January 1989 as compared to the same time period last year. This is probably not so much a function of the transition as it is a result of increasing popularity and usefulness of neuropsychological assessment, per se. As a rule, the transition has had minimal effect on neuropsychological services.

The same cannot be said for support to inpatient psychiatry. At present, we have been accorded much more leeway to define our role on the wards. We are being asked to provide training, treatment, and consultative services which were neither sought for nor provided prior to the transition. The danger herein is allowing ourselves to become committed to provide more than our resources can support. Careful planning and anticipation of the effects of an activity on our resources have prevented us from outstripping ourselves. Part

of this planning and management has involved continual liaison with the Inpatient Psychiatry Service by our inpatient coordinator. This individual now attends managerial-level inpatient psychiatry meetings as a voting member and is able to monitor the needs for and effectiveness of our service. Emphasis is being placed on the timely return of assessment consults (part of our unique role) as well as provision of some needed direct care in the form of group and family therapy. Care must be continually exercised, however, to avoid exceeding the resources we have available to meet the extensive needs here.

SUMMARY

This, then, brings our survey to a close. In general, the effects of the transition on administrative, training and service functions within our organization appear quite positive. At the same time, reports of adverse effects outside of Psychology Service have not materialized. In all, it appears that our continued efforts in "bustin' loose on Georgia Avenue" are quite successful.

FIGURE 1

PSYCHOLOGY SERVICE

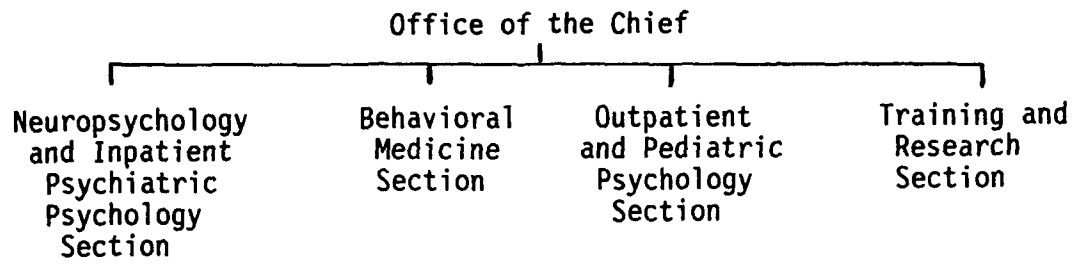


TABLE 1
STAFF CHANGES IN PSYCHOLOGY SERVICE

<u>POSITIONS</u>	<u>CHANGES</u>		<u>NEW</u>	<u>TOTAL</u>
	<u>PREVIOUS</u>	<u>IDA TRANSFER</u>		
Officer Staff	5	0	1	6
Civilian Staff	1	4*	2	7
Enlisted Staff	4	0	0	4
Administrative	1	0	0	1
Totals	11			18

* - 1 position currently unfilled - EFMD

TABLE 2

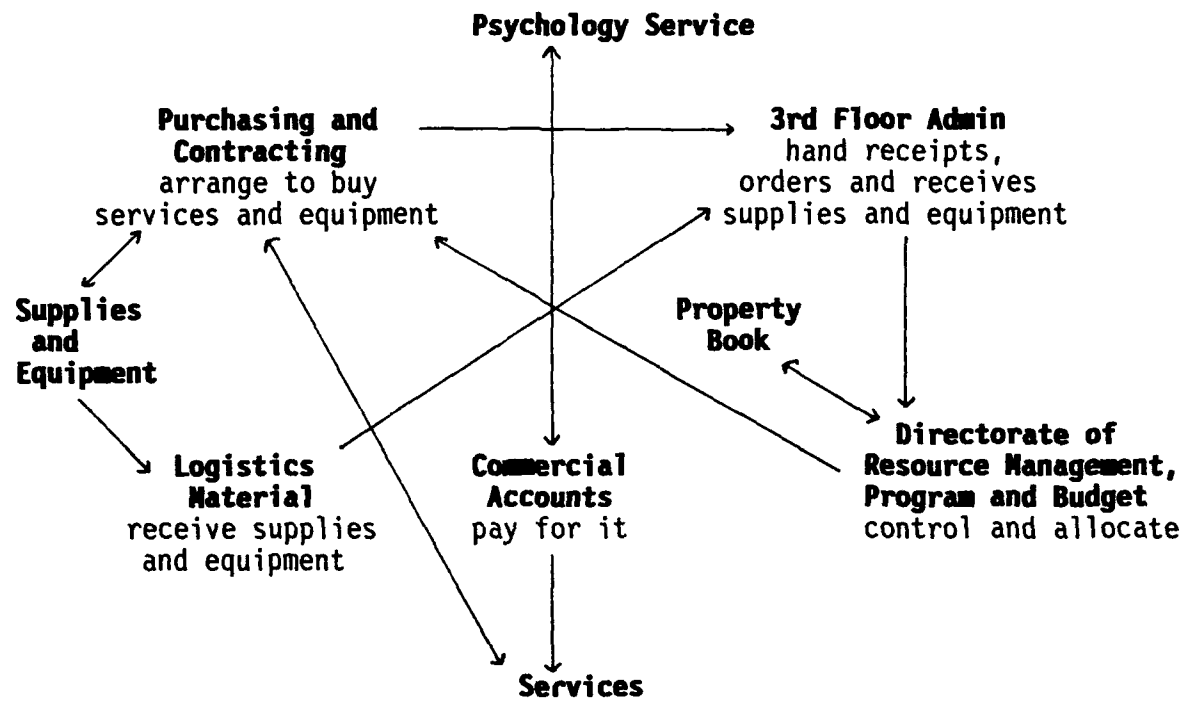
"NUTS AND BOLTS" - ADMINISTRATIVE RESPONSIBILITIES

- | | |
|------------------------------------|--------------------------------------|
| - obtain parking placards | - change signs in halls |
| - obtain name stamps | - change organizational chart |
| - new alert roster | - change telephone directories |
| - manage civilian time-cards | - separate psychology books & |
| - Establish OER and EER | journals from psychiatry listings in |
| rating schemes | library |
| - repetitive, continual efforts to | |
| "get the word out" | |

TABLE 3
NEW COMMITTEES AND MEETINGS

- Clinical Chiefs Meeting	1/mo.	1.5 hours
- Joint Staff Conference	1/mo.	1.5 hours
- Department Chief's Meeting	1/mo.	1.5 hours
- Chief of Staff Meeting	1/wk.	1.0 hours
- PBAC	PRN	varies
- QA/RM	1/mo.	2.0 hours
- Medical Library	PRN	varies
- Furniture Committee	PRN	varies

FIGURE 2
THE BIG CHART



ADMINISTRATIVELY SEPARATE PSYCHOLOGY SERVICE: CURRENT STATUS AND EVALUATION

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The National Defense Appropriations Act for Fiscal Year 1988 required the establishment and evaluation of a separate Department of Psychology at an Army installation. A separate psychology service was established at Walter Reed Army Medical Center on 1 May 1988. An implementation plan and evaluation program were required. This report will detail the evaluation of the separate psychology service.

Precedents for Separating Clinical Psychology From Departments of Psychiatry

Recognition of the range of contributions made by psychologists in the delivery of health services has resulted in the establishment of separate psychology departments or services in several medical schools and health care centers. The Department of Medical Psychology at the University of Oregon Health Sciences Center was established in 1961. Departments of Medical Psychology function well at the Uniformed Services University of the Health Sciences, the Veterans Administration, and at the University Medical Schools in Florida, U.C.L.A., and others (Lubin, Nathan, Matarazzo, 1978). A separate Psychology Department was established at the Naval Hospital, Bethesda, Maryland, in 1987; it continues to function well.

METHOD

Missions, personnel, and organizational structure were defined for the Walter Reed Army Medical Center (WRAMC) Psychology Service. Productivity measures were examined. Quality measures of complaints, staff satisfaction, patient satisfaction, access, and external/internal quality review were conducted.

Surveys were developed to determine (1) information about the clinic missions, personnel, and organization; (2) productivity measures of workload; (3) quality measures of staff satisfaction and patient satisfaction. The surveys were administered during each quarter. Open ended questions were used to compare retrospectively how the service operated before becoming separate and after establishment of the separate Psychology service. Psychiatry staff members were surveyed for comparison as well.

FINDINGS

PSYCHOLOGY MISSIONS, PERSONNEL, AND ORGANIZATION

The overall missions of the psychology service at Walter Reed Army Medical Center are (1) to provide and coordinate psychological services for all patients with the highest standards of quality patient care and (2) to conduct a clinical psychology internship training program and support the various medical residency and fellowship programs. These services include evaluation, diagnosis, treatment, consultation, referral, and disposition. The Psychology Service is one of 18 separate departments and services reporting directly to the Deputy Commander for Clinical Services.

Training Mission

The training mission of the psychology service is to train four psychology interns. Three to four full time Ph.D. equivalent personnel are required to support this training. The psychology internship training program is accredited by the American Psychological Association; the internship program accreditation was renewed in 1985. Other training programs supported by the Psychology Service include Psychiatry residencies; child Psychiatry fellowships; pediatric, neurology, and neurosurgery residencies; and USUHS medical students. Approximately 50% of staff time and service resources support the training mission.

The percentages of time spent in supervision of subordinates ranged from 10 to 50%, with a median of 25%. The percentage of time spent in formal teaching ranged from 5 to 30%, with a median of 10%.

Of the staff members, seven of eight are licensed as psychologists. There are two staff who are board certified diplomates in psychology.

Readiness Mission

The readiness mission involves one person. The resources are dedicated to the readiness mission 40-60% of the time.

Personnel and Organization

The psychology service is organized into several sections: Psychiatric Inpatient and Neuropsychology, Outpatient and Pediatric Psychology, Behavioral Medicine Consultation, and Training and Research. Workload is not broken down by section, but is summarized as Psychology Service. Figure 1 summarizes the organizational structure and personnel.

PRODUCTIVITY MEASURES

Patient Administration Systems and Biostatistics Activity, HSC (PASBA) extracted workload measures from the MED 302 reports for inpatient visits, outpatient visits, and psychological tests for calendar years 1987, 1988, and 1989. Table 1 reports the monthly productivity data extracted from the MED 302 reports. There is not a mechanism now available to track referrals and consultations to the Psychology Service from other clinics at WRAMC.

QUALITY MEASURES

Survey instruments were used to measure staff satisfaction and patient satisfaction. The staff satisfaction surveys were administered each quarter. Staff turnover was documented. On site interviews with staff and support personnel were conducted.

Psychology Staff Satisfaction

Responses to the 7-point Likert scale items showed that the Psychology staff was most satisfied with the "staff emphasis on providing quality patient care," "extent to which staff is encouraged to be self sufficient," "knowing what is expected of them daily," and having the support of their co-workers and supervisor. Issues of significant dissatisfaction included "the availability of adequate support personnel," "the availability of adequate equipment supporting my job," and "the extent the physical surroundings contribute to staff satisfaction with the work environment."

Comparisons were made between the responses of the Staff Psychologists, the Assistants/Administrative staff, and the Psychology Interns In Training on the Likert scale items. There were significant differences between the groups on "the availability of adequate equipment supporting my job," "obtaining licensure/certification while on active duty," "having opportunities available to work off duty," "the staff emphasis on providing quality patient care," and "the extent our staff receives cooperation from other departments." The Interns In Training were most dissatisfied with the "availability of adequate equipment supporting my job" and "having opportunities available to work off duty." The Assistants/Administrative staff were most satisfied with the "staff emphasis on providing quality patient care." The Assistants/Administrative staff were least satisfied with "the extent feel being utilized professionally," "the extent our staff receives cooperation from other departments" and "obtaining licensure/certification while on active duty."

Psychology Under Psychiatry

Responses to the open ended question retrospectively describing how the Psychology Service operated before becoming a separate service were quite revealing. The Staff Psychologists felt they were treated as second class personnel who were not accorded professional respect or recognition. Inequities were perceived in terms of the availability of support personnel, TDY funding, supplies and equipment the psychologists received, patient charting, and administrative procedures. Psychological services were not fully recognized or used. Psychiatry staff was not as supportive as they could have been. The Interns reported feeling little primary responsibility, as the patients were staffed through Psychiatry.

Separate Psychology Service

After the separation occurred, respondents from the Psychology Service felt they had significantly more control over their own resources, equipment, funds, and missions. The staff morale was perceived as greatly improved, particularly among those who had previously worked under Psychiatry. With successive surveys, the overall levels of staff morale were perceived to increase. Significant personnel turnover, lack of replacements, retirement of key personnel, and illnesses were notable during the test period.

As perceived by the Psychology staff, the relationship of the Psychology staff with Psychiatry remains good at the personal level, but cool at the organizational level. Professional cooperation continues, though some tension is present. More support staff are needed for both Psychology and Psychiatry.

The Psychology staff reports gaining confidence in its abilities. The positive effects of being able to control Psychology Service budgetary and manpower resources seem to be greater than the additional administrative workload and responsibilities incurred by being separate. Greater interdisciplinary cooperation on patient care is developing as more contacts with other departments are occurring. More interdisciplinary training opportunities are needed.

Department of Psychiatry Staff Perceptions

Psychiatry staff satisfaction surveys were administered by the Department of Psychiatry; the response rate was representative (6 of 11 officer staff, 14 of 27 trainees; 20 responses were used). The officer staff reported the most satisfaction with the issues of "The support of my supervisor," "Having colleagues available for professional growth and development," "My liking my

present position," and "The staff emphasis on providing quality patient care." The officer staff reported the least satisfaction with "The availability of adequate support personnel" and "Having opportunities available to work off duty (e.g. moonlight)."

The Psychiatry residents in training reported the most satisfaction with "The support of my coworkers," "Obtaining licensure/certification while on active duty," and "The amount of responsibility given to me." The trainees reported the least satisfaction with "The availability of adequate support personnel," "Having opportunities available to work off duty (e.g., moonlight)," "The availability of adequate equipment supporting my job," "Having a supportive duty environment," "The extent management is supportive of the staff," and "The extent our staff receives cooperation from other departments."

For the Psychiatry staff, the lack of support personnel and adequate equipment was a concern. With the establishment of the separate Psychology Service, psychological testing of patients was not as accessible nor were there as many referrals made to Psychiatry as previously. Psychiatrists were concerned whether psychologists could make appropriate assessments, particularly of organic conditions. Several staff psychiatrists expressed disapproval of the separate Psychology Service, believing the psychologists to be delusional in their euphoria. Many of the issues raised by the Psychiatry staff echoed concerns expressed by the American Psychiatric Association regarding the abilities of psychologists to function as independent practitioners.

As perceived by the Psychiatry staff, the relationship of Psychiatry with Psychology appears good at the personal level, but distant at other levels. Multidisciplinary patient care consultation continues. There was support from Psychiatry for the establishment of a Department of Mental Health which would foster multidisciplinary approaches and more comprehensive mental health care. Some physicians believed they should supervise, direct, rate, and command all professional staff. It was felt Psychology interns would not be exposed to as diverse a mixture of patients. Many Psychiatry staff members felt little had changed or were not aware of any differences since the separation.

Psychology and Psychiatry Staff Perceptions

ANOVAs were conducted between the staff satisfaction survey responses of Psychology and Psychiatry staff members. There were differences between Psychology and Psychiatry for "The availability of adequate support personnel," "The extent management is supportive of the staff," and "The extent our staff receives cooperation from other departments." There were differences between the types of staff members for "The extent the staff know what is expected of them daily." There were no significant interaction effects in the 2x3 ANOVAs.

One-way ANOVAs were conducted between selected groups of Psychology and Psychiatry staff. There were significant differences between the officer Staff members on "The availability of adequate support personnel" ($p = .026$), "The amount of responsibility given to me" ($p = .020$), "The extent to which staff is encouraged to be self sufficient" ($p = .049$), and "The extent our staff receives cooperation from other departments" ($p = .001$). There were significant differences between the In Training personnel with respect to "The extent our staff receives cooperation from other departments" ($p = .001$) and

"The extent management is supportive of the staff" ($p = .013$). The Psychology staff members were significantly more satisfied for all items reported.

Future Expectations for Separate Service

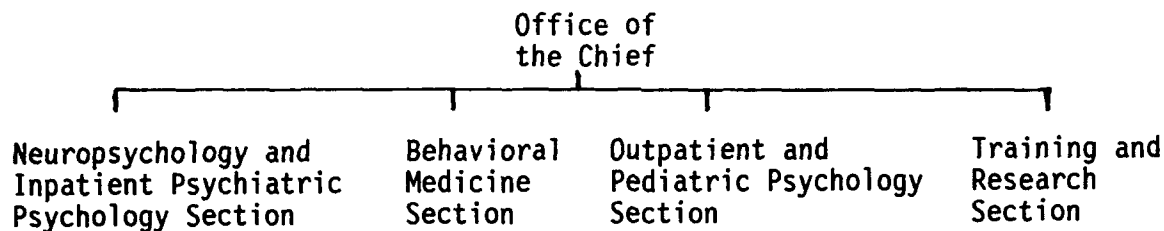
The open ended question for expectation in the future showed much optimism and hope. The Staff Psychologists expected to feel professionally respected and well utilized. Expectations were to have more timely fiscal support and control over support personnel, TDY funding, supplies and equipment, psychological treatment charts and procedures, continuing education programs, professional recognition, and respect. More psychological services were expected to be provided to enhance the quality of patient care. Professional health care services to referred patients were anticipated to be enhanced. The separate service was expected to enhance the psychologists' self image and professional pride. The autonomy should provide opportunities for creative leadership, self determination, professional growth, control over professional career, and more avenues for advancement. There was an expectation for more time being spent in administrative duties and hospital committee meetings. The Interns felt they would be more autonomous concerning patient care and be able to show more initiative in terms of patient care and research. The Assistants/Administrative staff were concerned about making future deadlines and requirements without additional support personnel. Work levels were projected to increase. Greater opportunities for professional give-and-take were expected. More research opportunities were deemed possible. Psychology staff cohesion and morale are expected to increase.

REFERENCE

Lubin, B., Nathan, R.G., & Matarazzo, J.D. (1978). Psychologists in medical education: 1976. American Psychologist, 33(4), 339-343.

FIGURE 1

ORGANIZATIONAL STRUCTURE OF WRAMC PSYCHOLOGY SERVICE



* * * * *

Psychology Service Table of Distribution and Allowances
Walter Reed Army Medical Center

PARA	LINE	DESCRIPTION	GR	MOS	BR	STRENGTH		ASSGN
						REQ	AUTH	
OFFICE OF THE CHIEF								
529A	01	C, PSYCHOLOGY	05	68S00	MS	1	1	1
529B	02	SECY (STENO)	06	00318	GS	1	1	1
PSY INP & NEUROPSY SECTION								
529B	01	DIR NEURO SVS	03	68S00	MS	1	1	1
529B	02	PSYCH IPS	03	68S00	MS	1	1	1
529B	03	BEH SCI NCO	E6	91G30	NC	1	1	1
529B	04	BEH SCI SP	E5	91G20	NC	1	1	1
529B	05	BEH SCI SP	E4	91G20	EN	1	1	1
529B	06	BEH SCI SP	E3	91G10	EN	1	1	1
529B	51	PSYCH TECH	09	00181	GS	0	0 *	0
529B	51	PSYCHOLOGIST	12	00180	GS	0	0 *	0
529B	51	CLIN NEURO PSYCH	13	00180	GS	0	0	0
BEH MEDICINE SECTION								
529C	01	SUP, CLIN PSYCH	14	00180	GS	1	1	1
529C	02	CLIN PSYCH	13	00180	GS	1	0	1
529C	03	PSYCH TECH	09	00621	GS	1	1	0
OUTPATIENT PSY SECTION								
529D	01	C, PSYCH (ADULT)	03	68S00	MS	1	1	1
529D	02	C, PSYCH (PEDS)	03	68S00	MS	1	0	1
529D	03	PSYCH (CHILD)	13	00180	GS	1	1	1
529D	04	PSYCH (CHILD)	11	00180	GS	1	1	1
529D	51	PSYCH (CHILD)	12	00180	GS	0	0	1
TRNG & RESEARCH SECTION								
529E	01	DIR OF TRNG	04	68S00	MS	1	1	0
529E	02	CLIN PSYCH INTERN	03	68U00	MS	[4	4	4]

Note:

* CHAMPUS recapture position

TABLE 1

MED 302 MONTHLY WORKLOAD PREPARED BY PASBA

<u>CY 1987</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	147	092	159	156	112	128	141	141	099	140	128	103
Outpt Vs	313	401	375	414	344	301	379	378	323	309	247	218

<u>CY 1988</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	131	167	128	192	227	180	167	280	172	164	327	389
Outpt Vs	391	611	655	478	577	552	502	416	451	258	915	765
Psy Test	257	314	489	519	496	540	479	670	489			

<u>CY 1989</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	319	398										
Outpt Vs	853	787										
Psy Test		675										

Note: Inpt Vs = Inpatient Visits
 Outpt Vs = Outpatient Visits
 Psy Test = Weighted Work Units/Psychological Tests

LICENSING AND CREDENTIALING WITHIN HSC

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Enclosed are excerpts from AR 40-66 (1 Apr 87) Medical Record & Quality Assurance Administration which are appropriate to credentialing and licensing of psychologists within HSC.

Section III

CREDENTIALING

9-10. General.

a. Individual clinical privileges will be delineated for all health care practitioners given the authority and responsibility for making independent decisions to initiate or alter a regimen of medical or dental care.

This will include physicians (less interns, residents, and fellows), podiatrists, nurse anesthetists, nurse practitioners, nurse midwives, physician assistants, optometrists, clinical psychologists, physical therapists performing primary neuromusculoskeletal, electroneuromyography (EMG), and nerve conduction velocity (NCV) evaluations, and occupational therapists performing primary upper extremity musculoskeletal evaluations.

When clinical social workers, clinical dietitians, clinical pharmacists, and speech pathologists meet the above criteria, they will be granted individual clinical privileges.

All other practitioners who function in a support role to the physician and exercise judgment within their areas of competence and participate directly in the medical care of patients will be categorically credentialed. When a practitioner who is categorically credentialed is deemed capable of performing duties beyond the scope or privileges defined for the professional category, his or her additional clinical privileges will be approved by the Credential Committee. However, any practitioner may be individually credentialed when deemed appropriate by the MTF or DENTAC commander.

In no instance may a person be assigned or credentialed to perform professional duties unless qualified by education, training, and experience to perform them. Where full performance of a civil service position requires the incumbent be individually or categorically credentialed, credentialing is a condition of employment (see also AR 40-48).

b. Each clinical department or discipline of the hospital will develop standards for granting clinical privileges in that department. Applications for clinical privileges will be routed to the appropriate chiefs of service for review and endorsement or recommendation concerning the privileges to be granted.

9-11. Explanation of Privileges.

a. Clinical Privileges. Those inpatient and ambulatory clinical activities permitted the practitioner after evaluation by the Credentials Committee and approval by the MTF or DENTAC commander.

b. Courtesy Privileges. Clinical privileges given to practitioners assigned to the MTF or dental clinic for short periods, i.e., TDY 180 days or less. . . . Courtesy privileges do not apply to ARNG or USAR practitioners.

c. Consulting Privileges. Clinical privileges given to military or civil service practitioners designated as consultants.

d. Temporary Privileges. Clinical privileges given military practitioners when reporting to a new duty station without a Professional Credentials File (PCF).

When an active duty military practitioner arrives on PCS without his or her PCF preceding him or her from the departed MTF and the practitioner requests clinical privileges (by letter) at the gaining MTF, the practitioner will be placed on temporary status by the commander on the recommendation of the chief of the applicable department or service or the chief, professional services.

Temporary privileges may be granted for a stated time not to exceed 30 days. A practitioner on temporary status will have a member of the MTF medical staff who is also of the same specialty area in which clinical privileges are requested (or any other member of the medical staff when a specialist in the same discipline is not available) designated and responsible for direct supervision of his or her activities.

Temporary status is to be used for active military practitioners only and will not be granted pending the processing of clinical privileges applications for Reserve Component or civilian practitioners.

e. Conditional (Provisional) Privileges. Clinical privileges given to practitioners when they first come on active duty or become employed by the AMEDD. These privileges are also extended to active duty practitioners or practitioner personnel already employed by the AMEDD who are listed below:

(1) For practitioners initially coming on active duty, the period for conditional privileges will be 365 days. . . .

(2) For practitioners already on active duty who complete a graduate education program in a different specialty, the period will be at least 90 days but no longer than 6 months. . . .

(3) For practitioners undergoing a period of remedial training or proctoring, there will be immediate and continual supervision for a period not to exceed 6 months. . . .

(4) For practitioners returning to clinical medicine or dentistry after serving in a nonclinical capacity for more than 1 year, the period will not exceed 1 year. . . .

(5) For practitioners changing duty stations or transferred employed civilian practitioners, the period will not exceed 90 days. . . .

f. Full privileges (Appointment Status). Clinical privileges given the practitioner after the conditional period.

g. Suspension of privileges. The action to withdraw a practitioner's clinical privileges temporarily.

h. Revocation of Privileges. The action to withdraw a practitioner's clinical privileges permanently.

9-12. Delineation of Privileges.

. . . The committee will evaluate and either reinstate or modify the privileges of all individually credentialed practitioners at least biennially. . . .

a. Medical and Dental Credentialing. . . .

(1) Determination of the initial (conditional) privileges will be based on training, experience, demonstrated competence, certifying examinations, professional conduct, and MTF or dental clinic resource availability. Evaluation and reinstatement or modification (extension or limitation) of privileges will be based on education, training, experience, thorough appraisals of clinical performance, privileges specifically requested in writing by the practitioner, professional conduct and health status. . . .

Note: Only currently competent practitioners will be granted clinical privileges. Further, actions to withdraw clinical privileges (para 9-17) will be taken promptly when a practitioner is found to be providing substandard care, no longer possessing required technical skills, or involved in improper or unethical conduct that affects the practitioner's ability to provide quality patient care.

(2) When a practitioner changes station, he or she will submit a letter of application to the receiving Credentials Committee. (A practitioner returning to clinical practice after serving in an administrative position must also submit a letter to the committee.). . . .

(3) Before an ARNG or USAR member assumes his or her duties, the responsible MEDDAC, MEDCEN, or DENTAC Credentials Committee will review the member's PCF. The privileges granted to him or her will be determined by this review. ARNG and USAR members as well as Reserve Component members of the other uniformed services will not be processed for duty at Active Army installations without a current PCF (para 9-23d(3)).

b. Musculoskeletal Manipulations. . . .

c. Categorical Credentialing.

In this kind of credentialing, personnel are granted privileges according to their professional category rather than as individuals.

For each category, the professional qualifications (i.e., education, training, and experience) and any other standards that must be met will be stated clearly.

The working relationships, clinical duties and responsibilities (scope of patient care services) granted will be spelled out in a written statement that can be expanded, modified, or canceled as needed.

The Credentials Committee will approve the professional qualification required and the scope of patient care services granted to a professional category. Each individual meeting the requirements of the category will be identified and evaluated at least biennially by the supervising physician or dentist in conjunction with the department or service chief to determine renewal of privileges. The department or service will keep a current listing of categorically credentialed individuals.

All categorically credentialed personnel will be under the supervision or direction of a physician or dentist for all medical or dental functions.

A PCF (para 9-20) will not be maintained for categorically credentialed personnel.

9-13. Initial Physician or Dentist Application for Privileges.

a. Military.

b. Civil Service. Before tentative selection is completed, the candidate will submit DA Form 4691-R with validating information to the MTF or DENTAC Credentials Committee.

Note: Civil service physicians or dentists appointed on or after the effective date of this regulation must maintain a current (full and unrestricted) license. The licensure requirement will be incorporated into position descriptions, performance standards, and placement announcements as a condition of employment.

c. Contract Practitioners. Civilian contract practitioners must meet the same requirements as civil service practitioners (b above). Validation of education, training, and experience may not be delegated to the contractor providing the practitioner.

9-14. Cross-Servicing of Practitioner's Credentials Files.

9-15. Evaluation of Privileges.

a. . . .

b. . . .

c. Evaluations on ARNG and USAR practitioners will be done during annual training and following each duty period for 12 or more days. For practitioners who do not participate in a consecutive 12-day duty period, evaluation will be made following the completion of 12 nonconsecutive duty days.

9-16. Total or Partial Withdrawal of Clinical Privileges.

a. The loss of clinical privileges of an AMEDD health care practitioner may be the basis for separation from military or civilian service. . . .

b. . . .

c. . . .

9-17. Actions to Limit, Suspend, or Revoke Privileges.

Information about the lack of professional conduct, substandard medical practice, or incompetence of any practitioner which is or may be detrimental to patient health or safety should be given by the chief of the department or service to the Credentials Committee for review and action. . . .

a. Summary Limitation or Suspension of Privileges. . . .

b. Routine Action to Limit, Suspend, or Revoke Privileges. . . .

Action taken may include the following:

(1) Investigation. . . .

(2) Committee Chairperson Action. . . .

c. Hearing Committee. . . .

9-18. Appeals Process.

a. Where the MTF or DENTAC commander has decided to limit, suspend, or revoke clinical privileges permanently, the practitioner will be granted 10 workdays (extendible by the commander) to give a written appeal by certified mail to the next higher headquarters. . . .

b. The appropriate commander will establish a committee of at least three senior physicians (MC officers) to act as an appeals committee. The other corps will each be represented when privileges in the respective disciplines are reviewed. . . .

c. . . .

d. . . .

e. . . .

9-19. Evaluation Follow-up Letter. . . .

9-20. Practitioner's Credentials File.

a. . . .

b. . . .

c. . . .

d. The file will be kept for the entire service career of the military practitioner to include active and inactive service in the Army, National Guard, or Reserves. For civilians, it will be kept the entire period they work within the AMEDD.

For nonunit USAR members, ARPERCEN will forward the file by certified mail to the MTF or DENTAC where the reservist will perform AT or ADT. On completion of training, the MTF or DENTAC will return the file by certified mail to ARPERCEN. . . .

If the practitioner changes station to an administrative position involving no clinical practice, the file will be sent to HQDA (DAPC-OPH-appropriate career branch), Washington, D. C. 20324-2000. These files will be held until the practitioner again enters clinical practice.

For all practitioners attending military graduate medical or dental education, the file will be forwarded to the military facility conducting the internship, residency, or fellowship training. The file may be requested by a co-located MTF or DENTAC if the individual practices medicine or dentistry while attending school.

For the active duty practitioner who joins the ARNG or USAR, the gaining Reserve Component control unit should request the file from the last MTF or DENTAC of appointment.

For disposition after a practitioner separates or retires from service, or if civilian, ends his or her employment within AMEDD, see File Number 912-04, AR 340-18.

e. The organizations of ARNG and USAR will initiate the PCF. . . .

Section V

PROFESSIONAL LICENSURE

9-25. Policy.

a. Active duty, Reserve Component, and civilian employee physicians, dentists, nurses, and clinical psychologists will maintain a valid, current professional license that meets the following criteria:

(1) The license must be one granted by the recognized licensing agency of a State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands. Foreign national employees in overseas areas may substitute a current, valid health care license from the country in which they are practicing. In addition a foreign medical graduate must also possess an Educational Commission for Foreign Medical Graduates certificate.

(2) Inactive or special licenses do not fulfill this licensure requirement. The license must be exactly the same as a license held by a private citizen for the practice of his or her discipline independently in the issuing agency's jurisdiction. Any concessions granted by the licensing agency in recognition of the non-resident or military status of the provider (i.e., waiver of fees or continuing education requirements) invalidate the license for the purpose of compliance with this regulation.

b. The requirements of this section also apply to physicians, dentists, nurses, and clinical psychologists who are not classifiable as employees of the Army, but are providing patient care services in an Army MTF.

c. All health care providers required to be licensed by this regulation must possess a license by 18 July 1988. Unlicensed providers assigned in CONUS who are eligible to take the necessary licensure examinations, and have not successfully passed them, will sit for the examination not later than 30 June 1987.

d. Physician graduates of GME I or II will obtain a license within 1 year of completion of GME. All physicians must successfully complete either the Federation Licensing Examination or the National Boards within 1 year of completion of GME I.

e. Unless specifically waived by the Surgeon General or the Assistant Secretary of Defense (Health Affairs), health care providers who fail to meet licensure requirements may be subject to adverse personnel actions or may be separated. They are also prohibited from providing patient care services unless under the direct supervision of an appropriate provider of the same discipline. Health care providers not subject to the UCMJ who provide health care in violation of this restriction are subject to a civil money penalty of not more than \$5,000 (10 U. S. C. 1094).

f. Licensure requirements apply to all physicians, dentists, nurses, and clinical psychologists regardless of whether they are performing clinical or administrative duties.

9-26. Payment of Fees Associated with Professional Licensure.

Appropriated funds cannot be used to pay the expenses for obtaining and maintaining a professional license. Permissive TDY (travel orders which show no entitlement to per diem or travel or lodging expenses) may be granted for the purpose of taking licensure examinations or for appearing for interviews required by the licensing agency as a condition for granting a license. Leave will not be charged for this purpose unless the provider already has a license that meets the requirements of this regulation.

Electronic Message
From HSC to MEDCENS & MEDDACs

Retyped by:
LTC Dennis Grill

Unclas

Oct 88

SUBJECT: Health Care Personnel Licensure Update

- A. 10 USC
- B. DOD Directive 6025.6, 6 Jun 88
- C. AR 40-66, Change 1, Apr 87
- D. LTG Becker sends MSG 112000Z Mar 86
- E. MSG DA WASHDC//SGPS-PSQ//DTD 241415Z JUN 88, SUBJ. as above
- F. Memorandum ASD (HA) DTD 14 Sep 88, SUBJ. Licensure of DOD Health Care Personnel

1. This message updates Reference E above in light of Reference F. This update applies to all "independently privileged" health care providers, military (active and reserve components) and civilian including personnel classified as employees of the Army but providing care in Army facilities.

2. Effective 8 November 1988 all physicians, dentists, clinical/counseling psychologists, registered nurses and civilian licensed practical nurses must be licensed in order to practice their specialty independently.

3. Major medical command (MACOM) commanders may utilize unlicensed GMOs as officers in charge (OICs) for smaller health clinics/dispensaries and dental clinics when no other reasonable alternative exists.

4. The following waiver provisions apply to "independently privileged" health care providers and have been incorporated into Army policy:

a. Health care professionals who have passed a licensure qualifying examination may be provided a temporary waiver until they can obtain a state license to practice. Requests will be forwarded through command channels to: HQDA, ATTN: SGPS-PSQ (PAB), 5109 Leesburg Pike, Falls Church, VA 22041-3258. Verification of examination results and proof of the application being received by a licensing authority must accompany the request for waiver.

b. Currently practicing health care professionals who have not previously failed a licensure exam nor failed to take an exam for which they were scheduled and that are scheduled to take an initial licensure examination within six (6) months of the date of this message may be issued a one-time waiver pending the results of that examination. In the event of unfavorable examination results, the individual shall not be permitted to provide health care to patients except under supervision of a licensed person of the same or similar discipline. Requests will be forwarded through command channels to this office as indicated above.

c. Health care providers in positions where all elements of their job could be performed by a non-health care provider and who are not practicing clinicians do not require a waiver. Their names and duty positions will be reported to HQDA (SGPS-PSQ). The majority of leadership and research positions currently filled by health care providers will not qualify. Unlicensed HCPS without waivers are not mobilization assets.

d. Commanders may submit requests for waiver for HCPS who have been prevented by unusual circumstances from obtaining a license. Requests should indicate as a minimum board certification status, years of active clinical military medical/dental service, and data from monitoring of clinical performance with full details on the circumstance to be considered.

5. Graduates of the Clinical Psychology Internship Program (CPIP) assigned to duty locations in the United States and to short tour areas outside of the U.S. will obtain a license within three (3) years of completion of their internship.

6. Requirements for CPIP graduates assigned to long tour areas after 8 Nov 88 are being coordinated with DOD and will be addressed in separate guidance from this office.

7. Foreign national physicians providing care outside the United States and its territories are not required to be certified by the Education Council for Foreign Medical Graduates (ECFMG) if they hold a valid, active license from the country in which they are practicing. In the absence of ECFMG or licensure by local authority, a waiver must be sought based on service evaluation of knowledge, skills, and performance in order for the HCP to practice independently.

8. Possession of a waiver of licensure should not be considered as placing recipients on an equal footing with their peers in terms of assignments, selections for schooling/training or retention.

9. HCPs without license or waiver will require supervision. Supervision requirements will be determined locally by commanders in consultation with appropriate staff but should ensure that:

a. A licensed supervisor or supervisors is/are formally designated in writing. Where more than one supervisor is named, a primary will be specified.

b. An individual written plan of supervision is on file in the provider credentials file of the MTF or DTF Quality Assurance (QA) Office and the QA Office of the major medical command headquarters.

c. The level of supervision is clearly more comprehensive than that for a similar licensed provider.

d. The individual's credentials will reflect less than fully credentialed status by the phrase: "Temporarily/Provisionally credentialed for practice in a supervised status (see enclosed supervision plan)." Normal credentialing time requirements shall remain in force for providers in this status.

10. Requests for retention of unlicensed health care providers (except recent and current graduates of the CPIP) after 1 October 1992 will be considered only on a case by case basis. Such requests will require the approval of the Surgeon General.

11. The provisions addressed in this and other messages pertaining to licensure will be included in subsequent revisions to applicable regulations. Point of contact in this office is LTC Reginald Ray. Autovon 289-8007.

Electronic Message
From HSC to MEDCENS & MEDDACs

Retyped by:
LTC Dennis Grill

Unclas

Nov 88

SUBJECT: Health Care Personnel Licensure Update

- A. MSG HQHSC HSCL-Q 031900Z Nov 88 SUBJ Health Care Personnel Licensure Update
- B. MSG HQDA SGPD-PSQ 141230Z Nov 88 SUBJ Health Care Personnel Licensure Update

- 1. This message retransmits Reference B verbatim.

Message: Subject: Health Care Personnel Licensure Update 141700z Oct 88

- 2. The following clarifications are provided:

a. Reference of Para 2: Doctorate prepared clinical psychologists are required to be licensed. Counselors who are not doctorate prepared clinical psychologists do not require licensure. Additionally, with respect to CPIP graduates assigned to overseas long tour areas after 8 Nov 88, these HCPs will require supervision for the duration of their tour if they remain in an unlicensed status following the completion of their 2 year mandatory pre-licensure supervision period. Upon return to the U.S. these individuals should request a waiver pending completion of administrative requirements for formal licensing. Requests for this waiver must be made through channels to the Office of the Surgeon General (ATTN: SGPS_PSQ) 5109 Leesburg Pike, Falls Church, VA 22041-3258.

b. No increased level of supervision is required for interns, residents or fellows since by definition all their work is supervised.

c. The "... (enclosed supervision plan) ..." referred to in Para 9.4 is the one developed by the commander in conjunction with his staff (Para 9.) and not a separate universal plan which was to be enclosed with message.

- 3. The following guidance is provided:

a. There is no one acceptable plan of supervision. In fact every plan may be unique. This is to allow commanders maximum latitude. As a minimum it is necessary to demonstrate good faith with the law by some measurable increase in the degree of oversight to which an unlicensed physician is subject. For example, if previously 5 records per week were subjected to peer review the plan may require an additional ten records per week be reviewed. Alternatively, the plan might direct that the supervisor actually observe a surgical case (a stress test, an endoscopy, etc.) once, twice per month and document the observation. Another possibility would be to utilize occurrence screening methodology and have PAD screen all cases of a particular type utilizing preset criteria (e.g. at least three items out of five present for diagnosis of acute cholecystitis, etc.). These screens would be changed at whatever frequency was desired.

b. Outside consultants both from military facilities and civilian consultants may be utilized as available. The above is only a very sketchy outline of the numerous possibilities available.

4. It is anticipated that unique situations may require consultation. The staffs at HSC, 7th MEDCOM and 18th MEDCOM as well as OTSG are ready to assist in any way they can. POC for this action is COL Jeffer, SGPS-PSQ, 756-0095 or AV 289-0095.

The point of contact for U.S. Army Health Services Command Medical Treatment Facilities and dental treatment facilities is COL Osvaldo Bustos, Chief, Quality Assurance Division, Office of the Chief of Staff for Clinical Services.

(Draft being staffed through HSC)

DEPARTMENT OF THE ARMY
Brooke Army Medical Center
Fort Sam Houston, Texas 78234

HSHE-SYM

26 Jan 89

MEMORANDUM FOR: Chief, Clinical Medical Division, Health Services Command,
Fort Sam Houston, Texas 78234

SUBJECT: SUPERVISION OF UNLICENSED PSYCHOLOGISTS

1. In accordance with DOD and OTSG directives and AR 40-66, all military psychologists must possess a valid state license or receive weekly supervision of their work that is "psychological in nature" from a qualified psychologist. Psychologists serving in non-clinical capacities are not relieved of the requirement to possess a valid and current state license.
2. A qualified psychologist is defined as an individual who has a doctorate in clinical or counseling psychology, has completed a one-year clinical internship, and is licensed to practice at the independent level in the United States.
3. Unlicensed military psychologists currently on active duty are typically recent graduates of the Army's Clinical Psychology Internship Program (CPIP) who serve in AOC 68U while they complete their eligibility for state licensure. To be eligible for licensure a psychologist must have one or two years (varies by state) of post-PhD experience under the supervision of a qualified licensed psychologist. Some states even require that the supervisor be licensed in the same state the psychologist is seeking licensure. While psychiatrists can provide general clinical supervision, this supervision will not satisfy state licensing requirements.
4. The following guidance is provided when an unlicensed military psychologist requires supervision as a prerequisite for state licensure:
 - a. Supervision should be provided by a qualified licensed military psychologist assigned to the MTF or to another unit or agency of the installation. Consideration should be given to utilizing qualified military psychologists assigned to FORSCOM units or to regional MEDCENS to provide the required supervision.
 - b. If a licensed military psychologist is unavailable, supervision should be provided by a qualified licensed DAC psychologist assigned to the MTF or to another unit or agency of the installation.
 - c. If a licensed military or DAC psychologist is unavailable, supervision should be provided by a qualified licensed USAR psychologist as part of his/her monthly drill.
 - d. As a last resort, supervision should be provided by a qualified licensed contract psychologist. Contracted supervision should not exceed two hours per week and every effort should be made to utilize a federal employee before contracting local practitioners. In accordance with state law, a

contracted supervisory psychologist must be licensed in the state in which he/she provides clinical supervision. The contract should be funded by the local MTF or unit to which the unlicensed military psychologist is assigned.

5. Questions can be addressed to the undersigned, telephone 221-7094/7095.

Dennis J. Grill
LTC, MS
HSC Psychology Staff Officer

ARMY CLINICAL PSYCHOLOGISTS: FACTORS AFFECTING DECISION TO REMAIN IN SERVICE

A. David Mangelsdorff, Ph.D., M.P.H.
Health Care Studies and Clinical Investigation Activity
Health Services Command
Fort Sam Houston, Texas

What factors affect the decision to remain in the military or to leave the service? The Division of Military Psychology (Division 19) of the American Psychological Association conducted a survey of all military psychologists on active duty in 1984. The purpose of this study was to document issues of concern to military psychologists.

Military health care providers need to be aware of what is expected of them; realistic expectations and information make a difference in retention (Mangelsdorff, 1978, 1984a, 1985; Mobley, Horner, and Meglino, 1980; Wanous, 1977; Wiskoff, 1976). Perceived control over decisions affecting one's life was a significant discriminator between psychologists who remained in the Army and those who left the service (Mangelsdorff, 1978). A longitudinal study of Army psychologists' perceptions in 1976 and 6-year follow-up (Mangelsdorff, 1984a) documented issues which predicted whether Army psychologists would remain in the service. In the 1976 Army study, a stepwise regression analysis was used to predict a 7-point criterion item; this behavioral intention item "Likelihood remain until eligible for retirement" was significantly related to whether the psychologist remained in the Army ($r = .453$, $p < .0001$). The methodology of using behavioral intentions to predict the likelihood psychologists would remain in the service was chosen for the present study.

METHOD

Subjects.

The survey instruments were mailed to 128 active duty Army clinical psychologists with the 68S identifier in 1984.

Procedure.

The current study was part of the 1984 survey of active duty military psychologists conducted by Division 19 of the American Psychological Association. The purpose was to document issues of concern to military psychologists. The survey instrument used was similar to that employed in the 1976 study of Army psychologists (Mangelsdorff, 1984a). Respondents were asked for demographic data, attitudes toward a military career, and attitudes toward a variety of issues. The issues were assessed from two perspectives: long term motivator factors and from the degree of satisfaction felt. Attitude statements were assessed using 7-point Likert scales (1 = minimum to 7 = maximum). Personalized follow-up letters were sent to encourage participation. All responses were analyzed together.

A regression equation was developed to predict the response to the 7-point criterion item "Likelihood remain until eligible for retirement" (scale endpoints were 1 = low probability and 7 = high probability). From the pool of demographic section responses and Long Term Motivators, items having content specifically dealing with military career, psychology, and/or military

identity were identified. Factor analyses were not performed. The items selected in the stepwise linear regression analyses reflected singular issues affecting the decision to remain in the service.

Responses from a 1976 Army sample and the 1984 sample were examined with respect to which psychologists who had left the service (LS) and who were still on active duty (AD/R) through June, 1988 (or until retired from the military). A stepwise regression equation was developed to predict the response to the criterion item (remain on active duty/retire AD/R). The equation developed for the 1976 Army sample was validated on the 1984 sample.

RESULTS

1976 Sample

The demographic characteristics of the 1976 Army clinical psychologists sample are displayed in Tables 1 and 2 for the LS and AD/R groups.

Regression Equation Development

The regression equation developed to predict the criterion AD/R of remaining on active duty was significant: $F = 9.60$, $df = 2/68$, $p < .0002$; multiple $r = .469$, $R^2 = .220$). The most salient issues for the Army clinicians in 1976 (with betas) were:

Total years active military service completed	(.283)
Likelihood extend beyond current obligation	(.268)

1984 Sample

The demographic characteristics of the 1984 Army clinical psychologists sample are displayed in Tables 3, 4, and 5 for the LS and AD/R groups.

Regression Equation Development

The regression equation developed to predict the criterion AD/R of remaining on active duty was significant: $F = 16.70$, $df = 4/86$, $p < .00001$; multiple $r = .661$, $R^2 = .437$). The most salient issues for the Army clinicians in 1984 (with betas) were:

Having retirement benefits available	(.341)
Likelihood remain until eligible to retire	(.264)
Having opportunity to change assignments frequently	(.236)
Availability of incentive pay	(-.176)

DISCUSSION

The regression equation to predict the criterion AD/R showed "Likelihood remain until eligible to retire" and "Total years of active military service completed" were significant predictors. The 1976 Army sample variables were cross-validated on the 1984 sample.

Comparisons made on the AD/R criterion showed company grade officers were more likely to have left the service than field grade respondents (see Table 5), and psychologists having 0 to 5 years of active duty completed were more likely to leave the service than psychologists with 6 or more years of active duty.

The issues of most concern in 1984 to the active duty psychologists dealt with the establishment of a professional career and a professional identity; these findings replicated those in the 1976 Army study (Mangelsdorff, 1984a). Though there were variations between the samples, the common themes focused on career development and progression, responsibility, the opportunities for self improvement, opportunities for independent thought and action, availability of retirement benefits, and professional experience. The promotion criteria, professional military education, and elements that might affect promotions or career progression were also of concern.

To retain its military psychologists, the armed services must offer means for continuing professional growth and development. For Army physicians, the availability of residencies and post-residency specialized fellowships has been noted as a significant factor in physician retention (Krause, 1978; Whelan, 1974). The Army offers opportunities for post-doctoral training on active duty (in child, community, or in neuropsychology) for its Army clinicians; a number of Army clinicians are remaining to take advantage of the Army fellowships.

The armed services can remain competitive in retaining their psychologists by offering: career progressions, opportunities for professional development and personal accomplishment, and options for the development of a professional identity. As more years of active military service are completed (either through training prior service officers as psychologists or through post-doctoral fellowship training on active duty), the probability increases that the military psychologist will remain in the service until eligible to retire.

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TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF 1976 RESPONDENTS

	GENDER		RANK	
	MALE	FEMALE	COMPANY GRADE	FIELD GRADE
LS	36	1	36	1
AD/R	39	0	25	14

$$\chi^2 = 7.02, df=1, p = ns$$

$$\chi^2 = 11.19, df=1, p = .0008$$

TABLE 2

MEAN CHARACTERISTICS OF 1976 RESPONDENTS

VARIABLE	AD/R (n=39)		LS (n=37)		Comparison p
	Mean	SD	Mean	SD	
Behavioral Intention: Likelihood remain until retirement	4.46	1.94	2.83	1.93	.0005
Demographics:					
Age	32.53	4.35	30.03	2.61	.0034
Total number of years active military service	8.51	5.30	4.67	3.22	.0003
Number years active military service prior to becoming a psychologist	3.35	4.73	1.27	2.76	.02
Attitude Statements:					
Sense of membership in Army	4.33	1.79	3.08	1.97	<.0001
Having retirement benefits available	6.07	1.28	4.89	2.01	.002

TABLE 3

1984 SAMPLE CHARACTERISTICS

	RANK	SURVEYED	RESPONDED
	03	86	60
	04	28	26
	05	12	10
	06	2	2
Totals		127	98
Moved/undeliverable			19

TABLE 4
MEAN CHARACTERISTICS OF 1984 RESPONDENTS

VARIABLE	AD/R (n=73)		LS (n=25)		Comparison p
	Mean	SD	Mean	SD	
Behavioral Intention: Likelihood remain until retirement	5.24	1.97	2.68	1.77	<.0001
Demographics:					
Age	36.68	4.71	34.08	3.76	.014
Total number of years active military service	10.04	6.24	4.96	3.36	.0002
Number years active military service prior to becoming a psychologist	3.09	4.40	1.24	2.24	.046
Attitude Statements:					
Sense of membership in Army	5.28	1.54	3.48	2.04	<.0001
Having retirement benefits available	6.64	0.67	5.04	1.92	<.0001

TABLE 5
DEMOGRAPHIC CHARACTERISTICS OF 1984 RESPONDENTS

	GENDER		RANK	
	MALE	FEMALE	COMPANY GRADE	FIELD GRADE
LS	21	4	22	3
AD/R	65	8	38	35

$$\chi^2 = 9.62, df=1, p = ns$$

$$\chi^2 = 8.67, df=1, p = .003$$

TABLE 6
APPLICATION OF 1976 WEIGHTS TO 1984 SAMPLE

	PROBABILITY OF REMAINING ON ACTIVE DUTY		
	LOW	MODERATE	HIGH
LS	0	19	6
AD/R	2	21	50

$$\chi^2 = 17.31, df = 2, p = .0002$$

TABLE 7
CORRELATION MATRIX OF VARIABLES
FOR 1984 SAMPLE

Variable	1	2	3	4	5
1					
2	505				
3	367	743			
4	426	562	376		
5	531	457	300	466	
6	316	657	853	335	263

Notes:

- 1 Criterion AD/R (where AD/R=1, LS=0)
- 2 Behavioral intention: Likelihood remain until eligible to retire
- 3 Total years active military service completed
- 4 Commitment to the military
- 5 Having retirement benefits available
- 6 Rank

NEUROPSYCHOLOGICAL ASSESSMENT OF HIV+ AND AIDS PATIENTS

E. Thatcher Beaty, Ph.D.
William Beaumont Army Medical Center
El Paso, Texas

A number of recent studies have indicated that impairment of higher cognitive functioning may be one of the earliest presenting symptoms in patients with AIDS, or those who are HIV+. There are confusing and conflicting opinions, however, about the prevalence of impaired brain functioning in these patients, and about which specific brain functions are most likely to be affected by the AIDS virus. These divergent opinions reflect differences between patient populations, nature and severity of the illness, methods of evaluation of cognitive deficits, and variable sensitivities of the measures used.

With increasing frequency, psychologists receive consultation requests to conduct baseline assessments, to monitor the course of the disease in a given patient over time, to evaluate the degree of occupational impairment for medical board purposes, and at times, to determine mental competency. As military psychologists, we may be called upon to conduct such evaluations, and make recommendations which frequently will have a direct and significant impact on the lives and careers of the affected individuals, their families, and their co-workers. We have a professional and ethical responsibility to these patients and the military to develop the knowledge and expertise necessary to detect either obvious or subtle impairments of brain functioning, and to make sound recommendations concerning their job abilities and case management.

Following a brief review of the pertinent literature on the neuropsychological effects of the AIDS virus, this paper presents a rationale and specific recommendations for conducting a neuropsychological evaluation of HIV+ and AIDS patients. What to look for, how, and which brain functions to assess, and how to predict specific aspects of job functioning are discussed. In addition, several case studies which illustrate particular points are presented.

REASONS FOR EVALUATION OF HIV+/AIDS PATIENTS

1. AIDS is a growing problem, and you are likely to be consulted for evaluation of these patients.
2. You can establish a baseline level of functioning in an individual patient for future comparisons.
3. You can monitor the course of the disease, and identify cognitive impairments if and when they occur.
4. Medical Evaluation Boards require an assessment of higher cognitive functioning in this patient population.
5. Questions of competency to manage personal/financial/legal affairs sometimes arise.
6. Assessment of a patient's ability to continue functioning on the job can be an important issue.

AIDS Dementia Complex (ADC):

- a neurological syndrome characterized by abnormalities in cognition, motor performance, and behavior.

- due to the direct effects of the AIDS virus on the CNS, rather than to opportunistic infection.

- the CNS is exposed to the virus early in the course of the illness, but ADC develops comparatively late (the virus is neurotropic, but not pathogenic in the absence of immunosuppression).

Early Symptoms of ADC:

- slowing and loss of precision in thinking and motor performance.

- in the motor system, a mild tremor, motor slowing, and gait unsteadiness may develop.

- mild memory impairments may be reported; patients may need to keep lists in order to carry out normal activities.

- complex, but formerly routine mental tasks take longer, and need to be consciously broken down into component steps.

- apathy (separate from depression) may develop, manifested by a loss of interest in work, social, and recreational activities.

- overt dementia is rare in the early stages of the disease.

Late Symptoms of ADC:

- predominance of symptoms is highly variable.

- intellectual impairment becomes more pervasive, affecting nearly all aspects of cognition, with further slowing and inaccuracy of performance.

- increasing apathy, slowing and slurring of speech, and severe cognitive impairments may lead to mutism and severe dementia.

- gait unsteadiness may progress to frank lower extremity weakness, general hypokinesia, and incontinence.

- a progressive paraparesis may develop.

- an agitated mental state with mania or other organic psychosis sometimes develops.

The Walter Reed Staging System

	Stage						
	WRO	WRI	WR2	WR3	WR4	WR5	WR6
<u>HIV Antibody</u>	=	±	±	±	±	±	±
<u>Chronic Lymphadenopathy</u>	=	=	±	±	±	±	±
<u>I Helper Cells/mm³</u>	>400	>400	>400	<400	<400	<400	<400
<u>Delayed Hypersensitivity*</u>	(N)	(N)	(N)	(N)	(P)	(C)	(P/C)
<u>Thrush</u>	=	=	=	=	=	±	+/-
<u>Opportunistic Infection</u>	=	=	=	=	=	=	±

* N = normal cutaneous response to two of four test antigens

P = response to one of four antigens

C = complete cutaneous anergy (no response to test antigens)

Findings of Published Neuropsychological Studies:

- some studies show high correlations between stage of disease and cognitive symptoms, others do not (sequential vs. referred pts).
- subtle differences between groups may be found, but these are generally not large enough to help in making decisions about an individual case (Statistical vs. clinical significance).

Characteristic abnormalities seen on early neuropsychological examination:

- deficits become more prominent under the following conditions:
- performance under time pressure (speeded cognitive processing)
- visual scanning
- visual-motor integration
- complex problem solving tasks
- choice reaction time tasks
- symptoms are similar to those seen in "subcortical dementia," i.e., cognitive slowing, inconsistent and variable performance
- impaired fine and rapid motor movement
- reduced verbal fluency, with relative sparing of other verbal abilities, such as vocabulary and object naming
- patients may complain of forgetfulness, or "losing their edge," but their memory abilities are relatively preserved on formal examination

Neuropsychological Screening Battery for HIV+ or AIDS Patients

1. Clinical interview
2. Attention/Concentration/Mental Speed
 - Digit Span (forward/backward)
 - Symbol-Digit Modalities Test
 - Trail Making Test
 - Paced Auditory Serial Addition Task (PASAT)
3. Memory
 - Wechsler Memory Scale (Russell Administration)
 - Rey Auditory Verbal Learning Test
 - Rey Complex Figure
4. Language and Language-Related
 - Aphasia Screening Test
 - Thurstone Verbal Fluency Test
 - Verbal Concept Attainment Test (if frontal lobe pathology suspected)
5. Motor
 - Hand Dynamometer
 - Grooved Pegboard
6. Sensory
 - Single-Double Simultaneous Stimulation Test (from Sensory-Perceptual Exam)
7. Visual-Spatial
 - Picture Arrangement
 - Block Design
 - Drawings from Aphasia Screening Test
8. Higher Intellectual/Complex Problem Solving
 - Wonderlic (for IQ estimate)
 - Short Category Test
9. Emotional/Personality Factors
 - MMPI Or MCMI
 - MBHI

Total Time Required: Average of 4 hours

Age and education adjusted norms are used in level of performance analysis of a patient's test performance. For the purpose of screening for impairment of brain functioning, the following ranges of performance are recommended:

normal: $Z > -1.5$ S.D.

borderline: $1.5 > Z > -2$ S.D.

impaired: $Z < -2$ S.D.

demented: impaired performance on measures of memory, problem solving, abstraction, concept formation

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THE EFFECT OF EMOTIONAL STATE UPON NEUROPSYCHOLOGICAL TEST PERFORMANCE

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The purpose of this paper is to survey briefly the literature on the results of neuropsychological testing of patients with emotional disorders, to identify consistent patterns of deficits attributable to affective disturbance, and to relate these findings to practical clinical concerns of assessment and interpretation. Conventional clinical wisdom may attribute a wide range of impaired performances to the impact of emotional distress. Unfortunately, there is little uniformity or consensus about how such factors can be reliably assessed, and even fewer guidelines on how to methodically distinguish the effects of neurobehavioral versus emotional impairment. This paper attempts to review the literature and describe the methodological difficulties encountered by researchers in this area, while arriving at some tentative conclusions about the probable effects of depression and anxiety upon test performance. The strengths and weaknesses of common assessment instruments used to evaluate affective state are addressed, and clinical recommendations are offered regarding the administration and interpretation of neuropsychological test batteries with emotionally distressed patients.

Making sense of the scores from neuropsychological tests relies heavily upon the training, experience, and clinical judgment of the neuropsychologist. Nowhere is this judgment more involved than in factoring out the influence of affective states upon obtained neuropsychological test performances. Conventional clinical wisdom may attribute a wide range of impaired performances to the impact of emotional distress. Unfortunately, there is little uniformity or consensus about how such factors can be reliably assessed, and even fewer guidelines on how to methodically distinguish the effects of neurobehavioral versus emotional impairment. The purpose of this paper is to briefly survey the literature on the results of neuropsychological testing of patients with emotional disorders, to identify consistent patterns of deficits attributable to affective disturbance, and to relate these findings to practical clinical concerns of assessment and interpretation. The primary focus of this paper will be on the impact of affective states; the complexities of assessing schizophrenia and the major affective disorders (which are likely to be organic disturbances in their own right) will not be addressed. The issue of pseudodementia also raises complex issues which will not be dealt with here.

The affective states of major concern to clinicians are those of anxiety and depression. It would be reasonable to assume that such common presenting problems would be thoroughly researched, and their effects on basic neuropsychological assessment instruments would be clearly defined and understood. Such is, in fact, far from the case. Although considerable research has been generated, the findings are often confusing and contradictory. This has been a result of two primary problem areas: inconsistency in operationally defining the emotional state of the target

population and poorly designed and controlled studies. Emotional problems have been defined in a variety of ways in different studies: by diagnosis (research diagnostic criteria DSM-II or III, psychiatrist; intake vs. discharge), by psychometric assessment (MMPI, Beck, Hamilton, Zung), or by population (inpatient, outpatient, psychiatric, medical, student). Such studies have also been plagued by methodological problems. In a review of 94 studies, Heaton et al. (1978) noted serious questions about research design: 68% of the studies did not specify how their populations were diagnosed; 84% did not specifically rule out organic problems in their psychiatric groups (a high risk population for undiagnosed neurological disorders); 54% did not specify the chronicity of the emotional problems; 38% did not mention the age of the patients in the different groups; and 11% matched groups on IQ rather than years of education (thereby relying on a measure which is sensitive itself to neurological impairment). In addition, trying to control for both past and present use of psychotropic medications has proved an almost insurmountable problem.

EFFECTS OF DEPRESSION

Considering these many difficult methodological issues, it is perhaps not surprising that the most consistent finding from all these studies is that there are few consistent findings. As a general rule in research with depression, however, patients with more severe emotional disturbance are more likely to demonstrate performance deficits on neuropsychological test instruments. There is also a tendency for patients to show improved performance as their depression resolves. Furthermore, despite contradictions, certain categories of impaired performances are observed with sufficient frequency to suggest a reliable association with depression. Table 1 offers a brief listing of some of the more commonly used neuropsychological measures on which depressed patients may do poorly.

In an attempt to characterize the impairments associated with depression, Caine (1986) identifies four major categories of deficits:

1. Impaired attention/concentration on tasks requiring sustained effort.
2. Poor initial acquisition/registration of information.
3. Difficulty with retrieval of information from memory.
4. Decreased psychomotor speed and strength.

He also notes that there are few indications that depression has any significant effect on higher level gnostic or praxic functions. Johnson and Magaro (1987) further point out the strong relationship between measures of effort and memory, and suggest that inability to sustain effort may be the central deficit underlying the poor performance of depressed patients on other tasks. Cohen et al. (1982) used motor strength as an indication of effort, thereby making a similar link between effort and the frequently observed deficits in psychomotor abilities.

It is possible, therefore, that the effects of depression are due not to specific functional impairment of cortical structures, but to a global pathology which interferes with the patient's ability to maintain effort or motivation. Caine (1986) reaches a similar conclusion, noting the sparing of cortically mediated intellectual functions, and the prominence of deficits dependent on arousal-attention-concentration. It would be ultimately

unsurprising to trace the deficit in affective disturbance back to the very subcortical structures most associated with the regulation of emotion and motivation (Schefft et al., 1985). It is notable that, like many other patients with subcortical lesions, depressed patients often produce fluctuating and inconsistent research findings.

In summary, depression may have an effect on a wide variety of neuropsychological measures. This effect may be due to an underlying global deficit in subcortical structures which regulate attention, concentration, and effort in cognitive processes. However, this effect may not be significant in milder forms of depression, where the clinician's efforts to ensure optimal performance should be sufficient to maximize effort. When confronted with a clinically obvious emotional disorder, more caution should be exercised in the interpretation of test results.

EFFECTS OF ANXIETY

Compared to the volumes of research on effects of depression, the impact of anxiety upon neuropsychological test results has gone almost completely ignored. Where anxiety has been studied most is in the education literature, where there has been interest in the effects of test anxiety on school performance. The reason for the neglect of this topic by clinicians can be traced to extensive earlier attempts to demonstrate effects of anxiety on intellectual measures; researchers consistently failed to demonstrate any significant impact. In a thorough review of this area, Matarazzo (1972) noted that virtually all of these studies relied upon the Taylor Anxiety Scale (TAS), a measure of trait anxiety. Different results were observed when researchers began studying state anxiety, either through self-report measures, or by experimentally inducing situation-specific anxiety. In these studies, state anxiety was found to have definite impact upon performance on the WAIS (Sarason & Minard, 1962). Effects were most commonly observed on the Digit Span subtest, although significant impairment was also observed on all the timed tests; in some studies, lower scores were also noted on the Information, Similarities, and Arithmetic subscales. An interesting interaction effect between trait and state anxiety also began to emerge: high TAS subjects ("worriers") performed worse on timed than untimed subtests on the WAIS, while low TAS subjects showed the opposite pattern. As the situational stress was increased, the high TAS subjects showed further impairments in performance on timed tests, while the low TAS subjects actually improved (Morris & Liebert, 1969).

Only a very small number of studies have looked at the effect of anxiety upon other neuropsychological measures. King et al. (1978) found that women (but not men) scoring high on trait anxiety did more poorly on the finger tapping test. Harris et al. (1981) also demonstrated decrement in finger tapping speed following negative performance feedback (similar to the induced state anxiety measures studied above). A study by Perkins (1974) showed no effect of anxiety on the Category Test score. Although not clearly related to anxiety, Newman & Silverstein (1987) found no difference in performance on the Luria-Nebraska Neurological Battery between agitated and nonagitated depressives.

In summary, trait anxiety does not appear to have any consistent impact upon neuropsychological test performance, and there is no reason to expect

patients with psychiatric diagnoses such as anxiety neurosis to show any particular deficits. However, the emotional state of the patient at the time of testing may have some influence. High state anxiety may be associated with lower performance on digit span, timed tests, and finger tapping speed, and possibly on verbal tests such as the Information, Arithmetic, and Similarities subtests of the WAIS. Individuals who are highly trait-anxious ("worriers") may be more sensitive to performance pressures or inferred negative feedback in the testing situation. The fact that "non-worriers" may actually improve their performance in the same circumstances is consistent with models of the impact of stress on task performance: as stress level increases, performance improves until it reaches a maximum level; further increases in stress level then result in a deterioration in performance. State anxiety might thus be construed as an internal expression of stress level, resulting in a generalized decrement in cognitive efficiency.

CLINICAL RECOMMENDATIONS

Affective state may produce impaired performances on a range of neuropsychological measures; therefore, it is important to thoroughly evaluate the patient's emotional functioning before attempting to interpret test scores. For those clinicians who espouse a blind, empirical approach to neuropsychological interpretation, it is suggested that there is a great risk of incorrect assessment of organic impairment in these patients.

Many of the commonly used psychometric instruments may not be highly reliable in diagnosis of emotional distress (Prusoff et al., 1972). The Depression Scale of the MMPI is often elevated by patients with multiple neurological or somatic symptoms, and may over-diagnose depression. However, more "pure" measures of depression, such as the Beck, are also thought to be more easily influenced by intentional distortion by the patient (Lambert et al., 1986). This is also likely to be true of the Wiggins Content Depression Scale, and the Weiner-Harmon Depression - Obvious Subscale, both from the MMPI, which correlate highly with the Beck Depression Scale. The Hamilton Depression Scale offers the advantage of being administered verbally by the clinician, which may generate a less distorted self-presentation by the patient and seems to be more sensitive to changes in level of depression (Lambert et al., 1986). For patients over age 65, the Geriatric Depression Scale is probably a more reliable measure of emotional functioning (Yesavage et al., 1983). The identification of state anxiety is more problematic. Most of the common psychometric measures assess trait anxiety, which does not correlate with deficits in test performance. Ultimately the clinician may need to rely on clinical skills and interpersonal sensitivity to assess the patient's anxiety level.

In addition to a thorough assessment of emotional functioning, the clinician needs to ensure the optimal performance of the patient. This requires greater sensitivity with emotionally distressed individuals, who are potentially more anxious, alert to negative feedback, or less motivated to perform. The traditional approach to testing, with maximum structure and minimum feedback to the patient, can produce a grossly distorted picture of their real capabilities. It may be necessary to offer considerable encouragement during testing, dealing with the patient in a warm and supportive manner. Sensitivity to increasing emotional distress during the evaluation sometimes requires an interruption of test procedures to deal with the patient's concerns.

Finally, caution should be employed in the interpretation of neuropsychological test results from emotionally disturbed patients. Level of performance indicators should be interpreted very conservatively. Organic deficits should be interpreted based upon pathognomonic indicators or expected patterns of known neurobehavioral pathology. Alternatively, emotional effects may be suspected if results fluctuate or appear inconsistent, or if the patient complains extensively of deficits that are not apparent on test results.

SUMMARY

Scores on neuropsychological measures are assumed to reflect optimal performance by the patient; any non-neurological factor which diminishes the patient's ability or motivation will confound the interpretation of those results. Emotional distress is one such factor, and its effects on the testing situation need to be better understood. Despite the confusion and inconsistency of research findings in the area, some tentative conclusions about how the neuropsychologist should approach this area may be warranted. Mild anxiety or depression may have minimal effects on testing if the clinician uses his clinical skills to ensure optimal performance. With more severe emotional disturbances, additional caution in the interpretation of results is necessary, and conservative standards for the assumption of neurological involvement are recommended. However, casual "adjustments" in interpretation based upon emotional factors are not justified, either in the direction of dismissing observed deficits as a result of emotional interference, or of discounting the possible impact of affective distress. A thorough, documented assessment of affective disturbance, including history, psychometrics, and clinical presentation, is a necessary part of every comprehensive neuropsychological evaluation.

TABLE 1
NEUROPSYCHOLOGICAL TESTS
POTENTIALLY AFFECTED BY DEPRESSION

WAIS/WAIS-R:

- Digit Span (Forward & Backward)
- Arithmetic
- Digit Symbol

Wechsler Memory Scale

(all subscales, except possibly Associate Memory)

Serial Learning Tests

(e.g., Rey Auditory Verbal Learning, Selective Reminding)

Signal Detection/Vigilance Tests

Psychomotor Tests

(e.g., Tapping Test, Grip Strength)

Trail Making Test

Stroop Test

Luria-Nebraska Neuropsychological Battery:

- Profile Evaluation Scale
- Impairment Scale
- Memory
- Arithmetic
- Intellectual Processes

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Note:

*Indicates a good summary/review article

STRESS VARIABLES AND PATTERNS OF ALCOHOL CONSUMPTION

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Traditional learning models have explained the development of alcoholism primarily through the stress-reducing, pharmacological effects of alcohol, yet stress-reduction models have not yielded consistent results. Utilizing a somewhat different theoretical framework, research will be presented from infrahuman subjects which investigates the potential interaction between stress and alcohol consumption. Specific attention will be directed to the role of excitatory and inhibitory conditioning mechanisms in the development and persistence of alcohol consummatory behavior. Two sets of data will be presented. First, evidence will be provided for the potential role of conditioned inhibition in the initial development of alcohol preference and increased consumption. Second, data will be presented suggesting a possible role of alcohol in the conservation of anxiety during extinction trials. Together these findings support a modified conditioning theory of the development and maintenance of alcohol consummatory behavior. The relevance for human alcoholism and potential treatments will be discussed.

THE USE OF ASSESSMENT INSTRUMENTS IN MARITAL COUNSELING

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Individuals doing research into the quality of marriage relationships have come up with a variety of procedures purported to measure relationship functioning. Some procedures look at information obtained from various observers including self, spouse, or trained others. Some procedures involve information obtained in different settings such as home or laboratory. Some procedures try to target in on crucial components of the relationship such as communication, companionship, sex, or affection. Finally, some procedures involve different methods of assessing the relationship such as global ratings, daily behavioral checklists, and behavioral coding systems. Another issue, and one of vital concern to clinicians, is what qualifications are most useful for characterizing marriages. It's not clear whether adjustment, satisfaction or happiness should be used to index the state of a marital relationship. If it were found that one treatment mode successfully changed adjustment scores and another changed happiness scores, which treatment should be used? Equally important is the issue of which one best predicts later distress and divorce. How do you measure specific components of marriages so that you can explain factors like happiness and adjustment? Orden and Bradburn (1968) developed a two factor theory which claimed that satisfactions and tensions are the two determinants of the overall evaluation of how happy a marriage is, and that these two factors are relatively independent. Marini (1976) expanded their work to include a third dimension, companionship. Kimmel and Vanderveen (1974) found that companionship, sexual compatibility, and closeness accounted for most of the adjustment score variance, as measured by the Locke-Wallace Marital Scale, which has been widely used as an overall or global measure of marital adjustment since its development in 1959. Spanier (1976) found that cohesion consensus, satisfaction and affectional expression were the crucial factors. Other investigators have included such factors as family expenditures and homemaking duties in their assessments of overall marital adjustment.

A social learning formulation of marital adjustment suggests that marital dysfunction is related to (a) a disproportionately high exchange of displeasing, as compared to pleasing, events between partners and (b) reliance on coercive rather than constructive methods to bring about change in problem areas.

In studying relationships among marital assessment procedures, Gayla Margolin used three types of measures including self-report data, spouse observer data, and trained observers. The self-report measures included the Locke-Wallace Marital Adjustment inventory, a traditional measure of marital adjustment, and the Areas of Change questionnaire, which assesses the changes that each spouse desires for self and spouse in 34 common problem areas (Birchler and Webb, 1977). Daily frequencies of pleasing and displeasing behaviors came from the spouse observation check list, a 400-item listing of relationship behaviors that spans 12 categories of dyadic functioning. Positive and negative communication behaviors were coded by a pair of trained observers using the Marital Interactions Coding System. They observed videotaped negotiation sessions between spouses and rated the behaviors according

to positive (approval, agree), negative (criticize, no response), or neutral (question). Margolin found that within method correlations were significant for two of the three methods investigated. That is, using the self-report data method, adjustment scores were inversely related to conflict scores, and using the trained observer Marital Interaction Coding System, positive communication scores were inversely related to negative communications behaviors. These observations seem rather straightforward and are not surprising. However, the only significant correlation across methods was between marital adjustment, as measured by the Locke-Wallace scale, and mean daily frequency of pleasing behaviors, as measured by the Spouse Observations Checklist. The results of this study illustrate the relative independence among several commonly used procedures to assess marital relationships. The lack of correspondence between Spouse Observation Checklists' pleasing and displeasing behaviors lends support to the repeated finding that these two dimensions vary independently. The overall lack of correspondence among measures used in this study is not an indication of invalid measurement procedures, but rather is an indication that marital adjustment is not a unitary dimension. If marital adjustment does imply a set of independent dimensions, a thorough assessment must take account of these different dimensions and provide a profile analysis for each couple's strengths and weaknesses. It appears necessary to use different data collection procedures to assess the various aspects of marital functioning.

Traditionally, behavioral marital therapists have gone on the assumption that a robust correlation exists between daily behavioral interactions and marital satisfaction. Going on this premise, their focus has been on changing daily behaviors in a distressed marriage and they have relied heavily on daily behavior checklists as a primary assessment device, both prior to therapy and as a process measure. However, while a significant correlation between behavior and marital satisfaction does exist, the research in general has found that only 25% of satisfaction variance had been accounted for by behavior. In fact, some researchers have found that only positive behaviors are highly correlated, others have found that only negative behaviors are highly correlated, and still others have found both positive and negative are important predictors. Nevertheless, a very significant portion of the variance in marital satisfaction or dissatisfaction has not been accounted for by behavioral measures. Consequently, the focus is now turning more toward the value of assessing affect and attitudes in the prediction of marital satisfaction. Love and jealousy have always been central affective concepts in novels, movies, etc., and attitudes regarding monogamy, sex roles, and divorce are grist for the mill in all forms of the media. Unfortunately, these constructs have, to a large extent, been avoided by researchers because their measurement is difficult. Since researchers have come to the conclusion that attitudinal and affective variables cannot be ignored, work is now proceeding with the measurement of these variables as correlates of marital satisfaction. Broderick and O'Leary (1986) proposed that the affective and attitudinal variables would substantially increase the amount of marital satisfaction variance accounted for by behavioral variables. In their research they selected positive feelings as the affective variable and exchange orientation and commitment as the attitudinal variables. Commitment to a relationship, such that one is willing to tolerate some adversity, seemed likely to be predictive of marital satisfaction, durability of the marital relationship, and the potential for change in therapy. It seems self-evident that love, or positive feelings toward a spouse, would be highly correlated with marital satisfaction, and in fact, Turkewitz and O'Leary found love to be

the most frequently endorsed affective component of a good marriage in a large sample of individuals whom they studied. However, the positive feelings that one has toward a spouse were predictive of positive therapeutic outcomes in women, though not in men.

Exchange orientation is based on the attitude that interpersonal relationships are valued on the basis of a fairly equal amount of give and take between partners. A person high in the exchange orientation attitude would be distressed if he or she felt that there was inequity in what was given or done for the spouse and what was received. However, the non-exchange oriented person would be much less affected by even moderate inequities because this individual's satisfaction depends less on what others do for them. In their research Turkewitz and O'Leary used the Locke-Wallace Marital Adjustment Test, and a feelings questionnaire, which was a 17-item inventory yielding a total score for positive affect or love an individual feels for his or her spouse. They also used the Broderick Commitment Scale, which involves rating on a 100-point scale the degree of commitment felt in the relationship and the Exchange Orientation Scale, which contains 49 items proposed to tap the degree of balance or equity an individual expected in the marital relationship.

In order to include a purely behavioral variable, they also used the Daily Checklist of Marital Activities, which contains 109 items selected from two different forms of the Spouse Observation Checklist. Half of the items are positive and the other half negative.

The results of the Turkewitz and O'Leary research indicated that attitudinal and affective variables accounted for a higher percentage of variance than did behavioral variables. They pointed out that affective, attitudinal, and marital satisfaction measures share a common method variance, which would lead one to expect a higher percentage of unique variance. Positive feelings, or love for one's spouse, is very highly correlated with a general measure of marital satisfaction, and has been found to predict marital therapy outcome. The component of commitment accounted for unique variance in marital satisfaction, and has also been found to predict marital therapy outcome for women. Exchange orientation was moderately correlated with marital dissatisfaction, and suggests that therapists should be cautioned against too great a behavioral emphasis on equity theory in therapy. It is clear that affective and attitudinal variables do play an important role in influencing both marital satisfaction and marital therapy outcome. Turkewitz and O'Leary conclude that the importance of the affective and attitudinal variables is not due to a comparatively poor performance of the behavioral variables but rather provides evidence that behavioral variables have an important but limited role in the explanation of marital satisfaction.

While on the subject of behavioral components of marital satisfaction, I would like to discuss briefly a study by Jacobson et al., which was done at the University of Washington in Seattle. Their goal was to predict who will benefit from behavioral marital therapy, and specifically, to look at the affiliation/independence variable. Their focus was on the extent to which each spouse derived gratification from interpersonal closeness and intimacy as opposed to independence and interpersonal distance. They distinguished between people who prefer interpersonal activities and intimate contact with those who prefer less intense interpersonal contact and, at the extreme, relatively autonomous and independent activities. When people who are

mismatched on this dimension marry, conflict is not only inevitable, but self-perpetuating; the more contact is sought by the affiliative partner, the more the autonomous partner withdraws; the more the autonomous partner withdraws, the more pressure the affiliative partner applies. Marital satisfaction was assessed using the dyadic adjustment scale developed by Spanier. This is a self-report questionnaire, completed by each spouse, yielding an overall score as well as a number of factor scores. Divorce potential was assessed by the marital status inventory developed by Weiss and Serretto. It is a 14-item scale, with each item reflecting a concrete behavioral step toward divorce.

Because of previous reports that wives who score high in femininity are more likely to report improved marital satisfaction following behavioral marital therapy, Jacobson et al. measured femininity using the femininity scale of the Bem Sex Role Inventory. They also included a measure of depressive symptoms which was obtained from a checklist of presenting problems used at the University of Washington Psychological Services and Training Center. Affiliative and independence preferences were measured using the affiliation and independence scale from the Edwards Personal Preference Schedule. These scales provide an assessment of the subject's preference for interpersonal-oriented versus independent or autonomous activities. They also used data from the Edwards Personal Preference Scale to generate a measure of traditionality. Traditional marriages are characterized by male instrumentality and female expressiveness, with women tending to be more relationship oriented and men tending to be more disengaged or to have a lower optimal level of intimacy. A traditionality score was obtained by summing the z scores for husband independence and wife affiliation.

The results of the study by Jacobson et al. provide evidence that a couple's affiliation-independence preferences may be important in understanding outcome and relapse in behavior marital therapy. Couples whose preference for intimacy versus autonomy follow traditional sex lines were less likely to benefit from behavioral marital therapy in their study, and this was particularly true at follow-up. They suggest that couples with a highly affiliative wife and a highly independent husband are also those in which spouses are differentially committed to therapy. Whereas wives in such relationships may be determined to enhance closeness and intimacy, husbands may be equally determined to maintain a degree of disengagement and autonomy. They make the assumption that the male independence/female affiliation constellation reflects sex roles in a relationship and that the pairing of a highly affiliative wife with a highly independent husband reflects a traditional marriage. Therefore, given that behavioral marital therapy tends to promote egalitarian relationships by emphasizing collaboration and compromise, it may be that couples with relatively traditional marriages are simply not likely to respond positively to the approach taken in behavior marital therapy. The other interesting finding that they report was that higher depression scores were associated with better outcome, even though they were also associated with greater marital distress prior to treatment. They posit that depressions associated with marital distress may be particularly responsive to behavioral interventions. Since behavior marital therapy often emphasizes increasing positive relationship behaviors, this may affect both depressive symptoms and marital satisfaction.

In a study by Barnett and Nietzel, which was published about 8 years ago, these researchers looked at a large number of variables including positive and negative companionship experiences, the impact of stereotyped sex roles, self-

esteem and traditionality. They used a number of the assessment instruments which have been discussed above, but also included an activity measure--the inventory of rewarding activities, developed by Birchler. This is a 100-item inventory designed to assess the frequency of recreational activities both desired and performed alone, with spouse, with family members, with spouse and other adults, and with non-family members. Sex role orientation and self-esteem measures were obtained from the PRF Andro Scale (Berzins, Welling, and Wetter, 1978).

The Barnett and Nietzel study is a very comprehensive and stimulating study which I think would be well worth the time spent reading the original publication. I will cite only a few of the results and will not go into the rather complex system of data analysis which they used, but I do recommend that anyone interested in research design would find it interesting. They found that the correlation of wife's self-esteem with the average rated couple adjustment was significantly greater than that of husband's self-esteem with couple adjustment. Also, whereas husband's self-esteem correlated only with their Locke-Wallace Marital Adjustment Score and the PRF Andro masculinity score, wife's self-esteem also correlated with a number of other variables including frequency of activities performed with spouse, with family members, and with spouse and other adults. Wife's self-esteem also correlated significantly with the distribution of time spent during the weekend on rewarding and nonrewarding tasks and the frequency of sexual activity. Another interesting observation made was that whereas the distribution of wife's sex role orientation was identical between distressed and nondistressed couples, a nearly inverse relationship existed between distressed and nondistressed husbands in terms of the indeterminate and masculine sex role categories. More than 50% of the males in the distressed group were in the category of indeterminate, while more than 60% of the males in the nondistressed group were typed "masculine."

As measured by the Inventory of Rewarding Activities, differences between individuals in the distressed and nondistressed groups were found for three categories. Nondistressed spouses performed significantly more rewarding activities alone than did the distressed spouses. Nondistressed spouses performed more activities with their spouses than did distressed spouses, and distressed spouses reported significantly fewer family activities than did nondistressed spouses. Analysis by sex revealed that the wives' reports accounted for the variance in these three categories. Across the three categories, when significant differences were obtained, nondistressed individuals both performed and desired significantly more rewarding activities than did their distressed counterparts. Not surprisingly, individuals in nondistressed marriages also performed significantly more rewarding activities in the spouse and other adults companionship category. In this instance however, analysis by sex revealed that the difference between groups was attributed to the greater number of activities performed and desired by the nondistressed husbands. As might be expected, nondistressed couples engaged in sexual intercourse significantly more frequently, with monthly means of 14.3 and 4.8 respectively. Their research also gave support for previous findings regarding the relatively greater importance of negative instrumental and affectional dimensions as determinants of satisfaction in marriage. The tendency was toward confirmation of the hypothesis that displeasurable events are weighted more heavily than pleasurable events, and reciprocated in a ratio far higher than the ratio at which pleasurable events are reciprocated. The importance of shared rewarding activities for marital satisfaction was also

confirmed by this study. The most significant finding was that there was a relationship between marital adjustment and the frequency of activities engaged in with the spouse only. This may be accounted for partially by the fact that nondistressed husbands and wives reported an average of three times as many sexual encounters over a 4-week period as did distressed couples.

One of the very significant findings in the Barnett and Nietzel study was that self-esteem differentiated distressed and nondistressed couples at a level exceeded only by the Locke-Wallace Marital Adjustment Test. This was true for both husbands and wives. These researchers posit that perhaps satisfied spouses have positive self-feelings because they are successfully filling their "proper" roles. On the other hand, their marriages may be successful because they are self-accepting, competent people who also happen to be husbands and wives. Or, another variable may exist that accounts for the shared variance of self-esteem and marital satisfaction which has not yet been delineated. They emphasize that a strictly behavioral account of marital happiness must be tempered by the fact that relatively enduring individual characteristics, like self-esteem, bear a substantial relationship to self-reported marital satisfaction, and these correlations are significantly higher for wives than for husbands. Historically, the literature on marital satisfaction has noted the critical importance of the male instrumental role in marital happiness and research indicating that factors pertaining to the husband appear crucial to marital success. They quote one study which commented that the adjusted wives may seem to better fit the traditional role of the submissive woman and the maladjusted wives the common stereotype of the castrating shrew. The results of the present study indicate that the contributions of wives to marital satisfaction are vitally important. They warn against being caught up in the circularity of defining adjustment for women as acceptance of the submissive role, selecting research participants on the basis of this adjustment, and then concluding that marriages that deprive one partner of a positive sense of self are successful. They do not agree that uppity wives should be admonished to be more submissive and self-subordinating. They advocate the investigation of marital happiness based, not on adjustment of the wife to a dependent role, but on the personal adjustment of both partners and the full expression of individual potential within the context of a mutually supportive relationship. If marriage is to be a source of individual benefit, then these must accrue to both individuals.

Finally, I would like to mention a study done by Joan Broderick at State University of New York at Stonybrook. This study expands upon factor-analytic and rational methods and introduces a third method for determining the important content areas to be assessed in marital relationships. Broderick collected data through the use of mailed questionnaires and direct contact in a shopping mall. The questionnaire was composed of a series of demographic questions which were followed by the instruction "please define what a 'good marriage' means to you." Each subject's definition, consisting of phrases and/or sentences, was broken down into individual thought units, that is, separate ideas. The thrust of the study was to examine the effects of basic demographic variables, specifically sex, marital status, age, religion and income on the type of content areas specified by respondents. It was hypothesized that men and women would ascribe different ratios of importance

to the content areas derived. The thought units were then categorized into 17 categories as follows:

Love	Children
Understanding	Living together
Individuality/growth	Fidelity
Sharing/agreement	Sexual interest
Trust	Financial security
Friendship/happiness	Religion
Exchange of information/honesty	Sense of humor
Respect	Noncategorizable
Resolution of conflict	

Broderick's group found surprisingly few significant differences between the demographic groupings. It was found that women included trust, sharing/agreement, and exchange of information/honesty in their definitions significantly more than men. Men noted living together significantly more often than women. Only individuality/growth showed a relationship to age, with the 18- to 27-year-old subjects including this content area in their definitions more frequently than older subjects.

Testing was conducted to determine differences among three education groups (graduate school, college, and elementary and high school combined). They found an effect for individuality/growth, with graduate educated subjects including this content area more frequently. Broderick was impressed with the number of derived content areas which were affectional in nature and seemed to address feelings residing within the individual as opposed to more overt, instrumental behaviors. Love, understanding, individuality/growth, trust/commitment, and respect are five areas which she felt have largely been ignored in formalized assessment endeavors thus far. She reported that these content areas received very high ratings of importance in this work. Fidelity was definitely a concept which was given significantly higher importance by women than by men.

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UPDATE ON MULTIPLE PERSONALITY DISORDER

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Multiple Personality Disorder is one of the most colorful and dramatic of all psychopathologies. In the diagnostic manual, it is now more appropriately classified as dissociative disorder and has the following two criteria: (a) the existence within the person of two or more distinct personalities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self; (b) at least two of these personalities or personality states recurrently take full control of the person's behavior.

Usually there is amnesia to the existence or actions of other personalities or alters. These persons "black-out" frequently, sometimes for weeks at a time. They wake in strange places in the midst of strange predicaments with no knowledge of their intervening behavior. They may fear that they have committed crimes in their periods of altered consciousness (and indeed may have). Strangers call them by names unfamiliar to them and attribute behavior to them that they cannot recall. They hear voices from within that they do not recognize, goading them into action that they find reprehensible. They likely have been to a multitude of doctors and psychologists who have labeled them schizophrenic, hysteric, or malingerers, while none has really helped them. Pharmacotherapy is unpredictable. Typically they regard themselves as mentally ill and feel ashamed but have no idea that they are multiple. In an attempt to live in what often seems to be a kaleidoscopic hell of a world, they resort to withdrawal and develop clever social skills to hide and reconstrue their odd behavior. For many this kind of existence becomes so hopeless that they resort to suicidal actions. Thus, multiple personality is a complex, polymorphous, polysymptomatic syndrome involving dissociative defenses and states.

Contrary to much thinking in the past and even today, it is not an artifact of or reducible to hypnosis. Hypnosis can produce superficial ego states in susceptible subjects, but this is nothing like a real personality found in MPD. Hypnotic phenomenon bear a resemblance because the trance states that these people get into are similar, but is not voluntary "auto hypnosis" or "self hypnosis" in the way that we understand those terms today. However, MPD does utilize automatic, involuntary, trance-like defenses, which is where the confusion seems to come in.

There will always remain questions of how best to conceive of the mind. One enduring question with regard to MPD is whether the mind is dipsychic, tripsychic, or polypsychic. How many "streams of consciousness" are there at any one time, and how separate are these from each other? Historically, the first school of dynamic psychiatry was formed by Pierre Janet, the great French neurologist. He gave us the term "dissociation" and conceived of the mind as having subconscious, fixed ideas or "complexes" which were unable to be integrated because of a weak ego. To him this process was always seen as unhealthy and often was the result of shock or trauma. Today we understand that there are many pervasive "silent processes" in the mind, and we see this as a more normal feature of mental activity that may be very useful in some of the more creative processes that are exhibited by humans. Following Janet in this

historical stream was the American psychologist, Morton Prince. As the result of an interesting case he had come upon, he wrote about a multiple personality and used the idea of "co-consciousness." He saw clearly the role of this pathology in binding strong emotions, and thought it necessary to resynthesize these parts into a whole.

All of these strong beginnings in the field were overshadowed, unfortunately, by the theoretical hegemony of Sigmund Freud, especially in American circles. Freud's concept was not dissociation, but rather repression. He did not emphasize so much the splitting of the mind and had one unconscious rather than several. Because of his experiences in therapy with Anna O., he discarded the diagnostic and therapeutic tool of hypnosis, opting instead for free association. He also abandoned his early theory which emphasized that the sexual trauma was real. While Freud had good reasons for all this from other points of view, his development turned out to be a fork in the road which led away from the concept of dissociation and thus away from an understanding of multiple personality disorder. In American psychological circles at approximately the same time, behaviorism came into its own, deemphasizing consciousness as an artifact, and not even dealing with the possibility of unconscious processes. Thus from around the turn of the century to about ten years ago, multiple personality cases were thought to be rare or iatrogenically created. The total number of articles or even case studies on MPD during that 70 years was under 15.

Within the last 10 years, MPD has become a considerable focus of interest in the literature, in diagnosis, and in treatment and research (Cf. Kluft, 1987). There have been three times as many cases reported in the past ten years as in the 150 years immediately preceding. Since 1974, 11 research groups have reported data with 10 or more patients; in two of these studies the numbers studied were over 100 cases and 300 cases. Between 1983 and 1985 five journals devoted special issues to MPD, and last year a new journal entitled "Dissociation" was begun. ISSMPD now has over 600 members after only 5 years of existence. Any change of this magnitude must be based on several factors and I shall try to iterate some of these. Many psychologists were aware of the laboratory results which showed certain subjects can create ephemeral "personalities" and therefore thought that all cases of MPD were iatrogenic. In psychiatry there was a broad reliance on schizophrenia as a category and Freudian ideas dominated theorizing. Then in the early 1970s there was a glimmer of interest as split brain research gave us some important findings, but this became largely used as a metaphor for a lot of unrelated phenomenon and faded as sort of a "fad." Meanwhile, Ernest Hilgard was doing hypnotic susceptibility research and discovered ego states and "hidden observers" (1977); there was some movement afoot for seeing dissociation as a more normal process. Then DSM III classed MPD with the Dissociative Disorders and not as a type of hysteria. It likewise tightened the definitions of schizophrenia and affective disorders. Also arising was a much greater awareness of child abuse as being a reality and not a client's fantasy. When patients were listened to in therapy about abuse, many cases of MPD emerged. Television dramas and the book Sybil created awareness in the popular culture of the possibility of MPD. There has lately also been a renewal in the interest of hypnosis thanks to the followers of Milton Erickson. Vietnam led to many PTSD phenomena which have remarkable similarities to MPD and important dissociative aspects. New psychophysiological findings have spurred interest; such things as average evoked potentials, topographic EEG, different allergies, handedness, and other anomalies have caused people to consider this a "real" disorder.

While there are, of course, instances of over-enthusiasm in diagnosis, in general it is my opinion that there have been many more legitimate cases in the past than have been diagnosed. Indeed, when 73 MPD clients were followed back to clinicians seeing their earliest presentation, 60% of clinicians admitted they disregarded data suggesting MPD (1984). This is the experience of many clinicians, not just a few. For example, a recent sample of 250 referred cases had 150 different referring physicians. While hypnosis can introduce some analogous phenomena, and iatrogenic technical errors may create fragments, there is no evidence that real MPD can be induced de Novo by hypnosis or misguided therapists. The rate of child abuse in several samples of MPD cases is 97%. Other kinds of trauma take up the other 3%, such things as death, war, illness, pain, and family chaos. It has been found that there is an average of 7 years between first contact with a psychiatrist and the true diagnosis of MPD being made, with an average of four other diagnoses being made before MPD. In 95% of cases, subjects admit to trying to hide and dissimulate their condition rather than dramatizing or exploiting it. Eighty percent of MPDs report substantial periods of harmony when the alters do not emerge, but rather influence the host personality without assuming executive control. DSM III was somewhat misleading in that it indicated that one personality must dominate. This has been changed in DSM III-R indicating that influence, sharing control, and contending for control, are all possibilities, and can now be classified under Dissociative Disorder N.O.S. Personalities may be fragmentary rather than complex, and the average number of personalities in various samples ranges between 8 and 14. These recent research studies have uncovered other interesting phenomenon. Seventy-five percent have child personalities under the age of 12. Fifty percent have personalities of the opposite sex. Thirty percent had changes in handedness. Fifty percent had the presence of an "internal self helper" or ISH. There seemed to be all gradations of awareness and control, and the strength of the dissociative barrier varies greatly from personality to personality. All share in certain core functions such as language and intelligence, but only some share certain memories, some are co-conscious, and some have amnesia for some, but not other personalities. They are all in systemic and systematic relationships, but the system, hierarchy, functions, and controls are unique to each person. Thus there is no common psychodynamic pattern across all cases.

All of this data and interest have led to a much better theoretical understanding of the etiology of this disorder. Four factors are involved: trance capacity, overwhelming stimuli, development, and lack of restorative experiences (Cf. Kluft, 1985). Let me go into each of these briefly.

1. Trance capacity refers to the well-documented fact that hypnotic susceptibility does not follow a normal distribution among the general population. It is rather a skewed distribution with 10% of the people being highly hypnotizable, another 15 to 20 percent being able to go into fairly deep trance, and the rest light to refractory in terms of hypnotic depth. While this is not proven to be much of an issue for hypnotherapy of the usual variety, it is thought that children who have high levels of trance capacity would naturally be more susceptible to using dissociative defenses.

2. The term "overwhelming stimuli" is a nice, sterile way of talking about traumatic experiences. Besides physical and sexual abuse, there are other forms of trauma, such as death of a parent figure, which rob a child of a crucial object needed for the integration of his sense of self. Certain

children are thought to be forced to substitute parts of themselves as transitional objects so that the object cannot be taken away from them. In the vast majority of cases, however, there are definable and documentable external events which are traumatic. In one sample, 50% of the subjects had Satanic cult involvement in their histories.

3. The understanding of early infant and child development continues to grow. Today this developmental psychology is not based on retrospective reports of adults in psychotherapy as it was with H. S. Sullivan, but on direct observation of infants and children as they develop. To the pioneering work of Margaret Mahler has now been added the important work of Daniel Stern who in 1985 wrote The Interpersonal World of the Infant. This book looks at the development of the four kinds of self organization which eventually cohere during the first 2 years into what is called the core self. These he calls the senses of agency, coherence, affectivity, and continuity. Also described are the ego states that the infant engages in during his developmental early life. The disorganization caused by trauma occurs differentially across these different spheres, and alters these ego states in early development before they cohere well. Now that we have these frames of reference to understand normal human development, we can see that early personality is naturally dissociated before a coherent sense of self is formed, and we understand better the subjective organizations through which experience is filtered. This is one reason why MPD is so heterogeneous, i.e., it happens at different stages of development and to different aspects of the core self. But there is no doubt that it radically changes the sense of self and the coherence of one's various senses of identity.

4. Once a child uses dissociative defenses he tends to achieve functional autonomy if there is no restorative experience or therapeutic input to reestablish normal development. Each fragment achieves autonomy and collects selective experiences which go into the building of that personality.

This theoretical understanding, which takes advantage of the more recent data, leads to better estimates of the scope of this problem. Dissociative problems are now seen to be on a spectrum of severity. The Continuum of Dissociation handout is useful to understand this spectrum of pathological states. Let us speculate logically and conservatively about the number of cases likely to be found in the population of the United States. Twenty-five percent of all children are excellent hypnotic subjects, therefore, one fifth of the population of children under 12 are at risk. It is estimated that there are 4 million abused children each year. Even if we only take the one fifth of these 4 million who are under age 5, that is 800,000; multiply this times the 25% of high trance capacity subjects, and we would get over 200,000 cases of dissociation each year. Even if other factors only yield a total of 10% from this at risk sample, we would still get 20,000 new cases a year, 12 times more than are currently being detected. Using similar kinds of assumptions, Richard Lowenstein from the Shepard and Enich Pratt Hospital has estimated that one percent of the population experiences some form of Dissociative pathology; Bliss' data suggest around 10% of the psychiatric population. Interestingly 92 out of 100 are women. Two reasons are given for this: (a) Women are subject to more abuse, particularly sexual abuse (it may also be that the ability to dissociate is sex-linked or that women have a different kind of developmental sequence, but this is unproven). (b) it is likely that males who dissociate tend to act out and get in trouble with the law. Indeed, in one sample of 33 randomly chosen male prisoners, 13 were seen

to have dissociative pathology. So it may be that dissociating women are finally diagnosed by psychiatrists, but men end up in prison.

Some believe that all this is "much ado about nothing" and the matter of diagnosis is not critical. This is not the case, since studies show that those who go untreated do not get better spontaneously, and those who leave treatment early experience severe relapse. Even though the treatment is almost always stormy, this disorder must be treated directly. When it is, the person has a good probability of becoming completely recovered. Secondly, the ability to diagnose this condition helps physicians deal with a number of secondary conditions which are found in almost all multiples. MPD is a superordinate condition which encompasses a plethora of manifestations such as anxiety, somatoform indications, phobias, borderline personality traits, depression, and "hallucinations." It really helps "make sense" out of a diversity of symptoms. As an example, one patient was treated for 22 years with medications and therapy for the diagnoses of schizophrenia, major depressive disorder, and partial seizures with no relief. After she was diagnosed for MPD and treated for such, she got considerably better, and her symptoms abated. The reality is that multiplicity can exist with many Axis I and Axis II diagnoses. The classic presentation is that of a depressed, compulsive person experiencing headaches and reluctant to acknowledge amnesic episodes. These patients have not responded to adequate treatment for other disorders and diagnoses in the past. The handout will list some of the important indicators of Multiple Personality in diagnosis. Please note that the elicitation of an alter personality is one of the clearest diagnostic signs, but is not infallible either. A diagnosis must be made clinically by an understanding of the history and all the presenting symptoms. There are two problems with regard to diagnosing schizophrenia versus MPD. The voices or revivifications are not classic hallucinations. They are experienced inside the persons head in MPD, and are identified as separate from the patient. It is suggested that one use the "four As" to diagnose true schizophrenia and not rely as much on the "first rank" symptoms, the latter being a conceptualization more likely to be encompassed by MPD.

The families that produce multiples are clearly unhealthy. MPD tends to run in families. MPD parents are abusive and deny it, and MPD children tend to identify with their strange parents. These families are characterized as having rigid religious beliefs, presenting a united front on keeping secrets from the community although there is great conflict within the family. They are isolated and resist assistance. Always at least one parent has serious psychopathology. Yet if this problem can be diagnosed in children, the treatment of them is much shorter, and the prognosis is excellent if they are not retraumatized. In the literature of late, a number of cases of child diagnosis and successful therapy even down to the age of three years old have been reported.

There have been great advances in the area of treatment. I would refer you to Bennett Braun's (1986) book where he lists 13 steps in the treatment of multiples. For the sake of this talk, however, I will collapse this into four categories important to describe treatment: (a) identification, (b) collaboration, (c) abreaction, and (d) integration. Each treatment must be highly individualized, and most of them are intense, psycho-dynamically oriented, and supportive treatments facilitated by hypnosis. Several apparent fusions usually collapse before the final one, but after the final one, the change in functioning level and consistency can be dramatic. An alliance must

be made with each part, and each must be treated equally. On an outpatient basis therapy must be at least twice per week with PRN hospitalization expected. Medications can be used (parenthetically a recent study suggested the use of clonazepam to be useful), but, in general, medication must be conservative and oriented towards symptoms. Good therapists are getting a 95% success rate at 2 years of follow-up. Both proper diagnosis and treatment are seen to be very critical.

Doing therapy with a multiple personality is an adventure that changes the therapist's life. Problems of boundary control and countertransference are usually large in the early cases, and supervision is a necessity. Therapy tends to drain the energy of the therapist, but it also teaches him much about the whole process of creating the surround of therapy and how the psychodynamics work. As Bennett Braun indicates, once you have treated a multiple, you will never be the same.

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APPENDIX

LIST OF SYMPTOMS WHICH RAISE SUSPICION OF MPD Jeffrey M. Brandsma, Ph.D. < C >

HISTORY

1. Child Abuse
2. Unjustly punished or accused of lying in childhood
3. Prior treatment failure
4. Three or more prior diagnoses
5. Unpredictable (non) response to psychoactive medications
6. Stormy relationships

CURRENT SYMPTOMS

1. Time distortions, lapses, or losses variously described by the patient as "blackouts," "fits," "seizures," "spells," or "blank times"
2. Severe headaches, often refractory to narcotics
3. Auditory hallucinations which are within the patients head and identified as separate from the patient
4. Fluctuating symptoms and an inconsistent level of functioning
5. Concurrent psychiatric and somatic symptoms
6. Easily hypnotizable
7. The elicitation of separate personalities with hypnosis or Amytal strongly suggests but does not confirm the disorder

SELF-REPORT

1. The patient having been told by others of complex behaviors that he/she has forgotten
2. The patient having been told by others of observable changes of his/her facies, voice, and behavioral style (smoking, handedness, aggression, dress, etc.)
3. Reports by the patient that strangers have called them by different names
4. The patient's discovery in his domicile, vehicle, or place of work of productions, possessions, or strange handwriting that he can neither account for nor recognize
5. The sense of "we" in a collective sense

CONTINUUM OF DISSOCIATIVE STATES

Normal Waking Attention
Generalized Reality Orientation*

Selective Inattention
Absent-mindedness
Parapraxis

Altered States of Consciousness
"Road hypnosis"
Reverie states
Partial amnesia
Experience of psychic phenomena

Loss of Consciousness
Blackouts
"Seizures"
"Fits"

Major Dissociative States
Fugue
Automatic writing
Psychogenic amnesia
Automatisms

Personality Fragments
Repeated fugue
Elements with low level of functional organization
Organized elements accessible by trance only

Multiple Personality
Elements with high level of functional organization
Elements with independent functioning
Irrepressible rotating elements

*After Shor et al. (1966). GRO may be defined as the organization of consciousness or the structural hierarchy of information processing which allows a person to be relatively stable in terms of perception and cognitive responding, that is, to maintain a stable frame of reference.

FAMILY THERAPY AND ANXIETY DISORDERS: A CLINICAL INVESTIGATION

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Clinical and empirical findings indicate a significant relationship between marital/family interaction and the development of anxiety disorders (Beech, 1978; Bland and Hallam, 1981; Chambless and Goldstein, 1982; Goldstein and Chambless, 1978; Hafner, 1982; Milton and Hafner, 1979; Turner, Beidel, and Costello, 1987). Unfortunately, literature regarding this relationship has remained outside of the family therapy field despite our capacity to contribute to both their assessment and treatment.

Perhaps the most significant mechanism through which family therapy has been informed about the relationship between the family and anxiety disorders is the case study. An example is Haley's (1976) presentation of "A Modern Little Hans" in which the therapy of a dog-phobic 8 year-old boy and his family is presented. Other examples of therapy with fears and anxiety are mentioned in Haley's work on Erikson (1973) and in Fisch, Weakland, and Segal's (1982) case of "The Anxious Violinist," and in Papp (1983). O'Connor (1983) and Dalton (1983) have presented case-oriented examples of problem-focused, strategic interventions in the treatment of obsessive symptoms in children. In general, all these case reports are somewhat vague in their interactional formulations of mother-patient enmeshment, a minimally involved, dispassionate father, and symptom-maintaining sequences around the patient.

Aside from these case studies, Fry (1962) used the communication/brief therapy paradigm to report on spouses of agoraphobics. His findings indicated that the spouses of these patients were similar in that they "typically are negativistic, anxious, compulsive, and show strong withdrawal tendencies" (p. 247). Other findings in Fry's study pertinent to a family/systems approach to the anxiety disorders included the following situations: spouses revealed, upon careful questioning, a history of symptoms that resembled those of the patient; the patient's symptoms coincided with an important change in the life of the spouse and were perpetuated by the ways in which they supported the spouse; the spouse and patient were locked in a hierarchically incongruous relationship; and the symptoms kept the couple united in a "distant and discontented" marriage.

Behavioral and biological approaches to treating anxiety disorders have been much more prevalent and clinical data indicate moderate success rates with their application. Despite specific differences in these two models, they do predominate the research and literature regarding state of the art treatment applications and etiological hypotheses. The relevance of marital and family interactional variables in the treatment and theory of anxiety-related disorders has been the subject of small, but not insignificant, investigations within components of this literature.

From an epidemiological viewpoint, Weissman, Leckman, Merikangas, Gammon and Presoff (1984) report significant familial patterns of increased psychopathology in anxiety-disordered patients, especially when panic attacks are present. Although Buglass, Clarke, Henderson, Krietman, and Presley (1977) found neither parents nor siblings of agoraphobics, for example, to have a higher incidence of psychopathology, their data were collected by patient self-report rather than through home/family visitation as in the study by Weissman et al. were. Family history via self-reporting has been shown to underestimate the familial presence of psychopathology, especially when non-psychotic disorders are involved (Andreasen, Rice, Endicott, Reich, and Coryell, 1986). Other authors researching agoraphobia present findings similar to those of Weissman et al. (e.g., Harris, Noyes, Crowe, and Chaudry, 1983; Crowe, Noyes, Pauls, and Slymen, 1983).

Parenting attitudes and behaviors also have been implicated in the emergence of anxiety disorder symptoms. The agoraphobia literature is instructive in regards to the conflicts and disagreements in these studies. Webster (1953) found agoraphobics to have more unstable relationships with their fathers when compared to anxiety neurotics and conversion hysterics. Webster reported that the agoraphobics' fathers were less available emotionally and/or physically than other fathers in the study.

Webster also found that agoraphobics' mothers were more overprotective than the two comparison groups. Methodological inadequacies such as data collection, classification into categories, and lack of a control group render these conclusions questionable. Nevertheless, Solyom, Silberfeld, and Solyom (1976), using an objective inventory, found that the mothers of agoraphobics were indeed overprotective, especially on subscales designed to measure maternal control and concern. Furthermore, they reported that these mothers' chronic anxiety scores were significantly correlated with the prevalence of fears in the agoraphobic and their degree of overprotectiveness.

The relevance of current marital and familial interactions and/or stressors on the etiology and course of the anxiety disorders has also been studied. Although husbands of agoraphobics have not been shown to have increased levels of psychopathology per se (Agulnik, 1970; Buglass, et al., 1977; Hafner, 1977), Hafner (1977) presents data that indicate that severe agoraphobic symptoms are typically accompanied by increased marital hostility and extrapunitive behavior, while less severe agoraphobic symptoms occur in relative isolation. Furthermore, he found that severely disabled patients who improved symptomatically experienced an increase in marital disharmony. More specifically, husbands of these wives reported an increase in anxiety symptoms, more overt hostility, less denial, and lowered self-esteem at treatment termination. At 12-month follow-up these husbands had effectively adjusted to their wives' improvement and changes within the marriage. On the other hand, wives in this category who achieved little in therapy or who lacked the determination to maintain changes outside of therapy had husbands who used increased levels of denial to cope with threats to their self-esteem. Thus, these women were in relationships that were less facilitating to change than before therapy. Moreover, their husbands were less in touch with their feelings about their wives' dependency on them than prior to treatment.

Further documentation regarding the presence of marital problems in agoraphobics is presented by Emmelkamp and Van der Hout (1983). In analyzing factors contributing to failure in the treatment of agoraphobia, they found

that secondary gain provided by partners of agoraphobics who refused treatment was a factor in the refusal. They also found that patients who complained about their partners during treatment were more likely to become treatment failures as compared with patients who did not complain. Bland and Hallam (1981) and Milton and Harner (1979) reported similar findings.

In a similar vein, Rasmussen and Tsuang (1986) have reported that epidemiological findings consistently demonstrate a significant degree of marital maladjustment with obsessive-compulsive disordered patients. They also reported a higher prevalence of marital maladjustment for the more severely disordered patient who is not able to isolate his/her rituals and/or beliefs from day-to-day family interactions.

To summarize, the majority of clinical findings and empirical research supports the hypothesis that, in fact, marital dissatisfaction, maladjustment, and denial occur in the context of agoraphobia, in particular, and that similar patterns are present in obsessive-compulsive disorders. With respect to generalized anxiety disorder and panic disorders (not associated with agoraphobia), the data from Weissman et al. suggest similar patterns may be present with them as well.

Although the above studies implicate family/systems issues as important in the anxiety disorders, they only address dyadic levels of interaction. An expanded family/systems approach would include observations and assessment beyond the two-person, same-generation subsystem reflecting the complex, multigenerational, multisubsystem, hierarchical arrangement of the family itself. Thus, opportunities to observe and inquire about the cross-generational interplay of boundary maintenance and subsystem functioning, points of collusion and triangulation, and developmental/life cycle transitions, and to delineate sequences of behaviors among family members, are entirely excluded from the field of vision. The importance of these issues is underscored by the positive findings even when the research scope is limited to two person interactions. That is, if we have identified dyadic sequences that are germane to the maintenance of anxiety disorder symptoms by looking only at the marriage of the patient, it is eminently reasonable to hypothesize that wider aspects of family/system functioning are also contributory to the maintenance and expression of anxiety symptoms.

To this end, a clinically-oriented investigation was begun with anxiety disordered patients who were moderately to severely refractory to standard behavioral and biological interventions. A system-wide approach was employed to gather marital and family data at three systems-oriented levels of analysis: the structural (Minuchin, 1974); the developmental/life cycle (Combrinck-Graham, 1985; Haley, 1973); and systemic/strategic (Haley, 1973; Madanes, 1981).

A semistructured interview was conducted with five families of anxiety-disordered patients (four with agoraphobia with panic attacks, one with obsessive-compulsive disorder). These families had agreed to participate in the interview for research, as opposed to clinical, purposes. The interview followed an outlined procedure that sequentially gathered information regarding family structure and subsystem functioning, family mood and attitude regarding the anxiety symptoms, current life cycle stages, transitions, family nodal events, and interactional patterns and sequences around the symptom. All interviews were conducted by the author. In addition, data from six

clinical families (two with agoraphobia with panic attacks, four with obsessive-compulsive disorder) seen over the last two years were collected in the course of therapy. The data were organized around the semi-structured interview.

THE FAMILY STRUCTURE AND MOOD

From a structural family therapy framework, the focus was on assessing subsystem functioning in marital, parental, and sibling subsystems with respect to both the patient's current family, and, when appropriate and available, his/her family of origin. Data that emerged from both clinical and interview settings were consistent with each other, as well as with previously mentioned findings. Nevertheless, whereas the dyadic focus of earlier studies correctly identified mother-patient and spouse-patient boundaries as being enmeshed, current data extend the loci of dysfunctional boundaries across other subsystems in both the current family and the family-of-origin.

With respect to family of origin issues, anxiety-disordered patients, male and female, were as likely to be enmeshed with a father or a grandparent as with a mother. In fact, initially being guided by maternal overprotectiveness findings, functionally significant clinical data regarding patient-father or patient-grandparent subsystems were missed on several occasions until later in the therapy. Most commonly it was found that patients were enmeshed in family-of-origin conflicts, issues, and/or commitments, with only perfunctory involvement in marital affairs. If family-of-origin conflicts were not salient, this was typically due to the death of these family members, their incapacitation due to illness or age, or the distance they lived from the patient's current family. In these situations the conflicts tended to center on adult children of the patient and mirrored the issues between patient and parents. Idealization of and enmeshment in family-of-origin issues, as well as the resulting disengagement from the spouse subsystem, appeared to contribute to both the patient's and other family members' capacity to deny the presence of conflict. Nevertheless, politely persistent questioning regarding subsystem functioning typically revealed long histories of dysfunctional boundary problems.

With respect to current subsystem functioning, the lack of involvement in marital affairs by both patient and spouse typically invited participation in the regulation of marital distance by first or third generation members. With the patient in the middle position of this triangulation process, accepting and acting on advice from one party regarding the third party resulted in what amounted to split loyalties (Boszormenyi-Nagy and Ulrich, 1981), the negotiation of which was avoided by the patient and family members alike. With younger anxiety disordered patients the conflicts more often had to do with loyalties to parents versus loyalties to spouse or children; in older patients the conflict was more apt to have to do with older children who were moving into adulthood and who had been triangulated into either parental or grandparent-parent conflicts.

Enmeshment in the intense loyalty binds appeared also to diminish the patient's emotional availability to children. As a result, one of the children typically had assumed a parental child function (Minuchin, 1974) in the process of growing up, thus becoming very sensitized to and protective of the patient's feelings and status within the family. Moreover, with obsessive-compulsive

young adults, the symptoms actually seemed to function to allow the patient to remain in a parental child role with respect to one parent, while his/her "sickness" precluded resolution of issues with the other parent.

The protectiveness of one child towards the patient, the lack of parental availability, and loyalty conflicts in other generation(s) all contributed to fragmented sibling relationships. The dichotomy of overfunctioning and underfunctioning siblings, so often seen in other symptomatic families, was applicable in these families as well. In fact, it was often in response to questioning regarding the functioning of the patient's siblings and/or sibling children of the identified patient that the interviews revealed family dysfunction. For example, in one interview with a young adult patient, his spouse, and his parents, family life was depicted as idyllic--free from conflict, strife, and disappointments. Nevertheless, questioning about the patient's siblings revealed, down to each of the five, a history of legal, occupational, and emotional problems that were "no-longer-a-problem" problems. The last nonproblem addressed by this very religious family was the 2-month-old marriage of the patient's 16-year-old sister because she had become pregnant.

Two paradoxical aspects of the family's mood revealed themselves during initial interviews. First, the level of denial was rather intense but present with a pseudomutual atmosphere of pleasantness and warmth. However, an outright expression of desperation was often quickly revealed, usually by the spouse or overinvolved parent of the patient. Desperation in this population has also been noted by Grayson, Foa, and Steketee (1985). This desperation has clinical implications that will be addressed later. More to the point here is the observation that the desperation seemed to represent the family's organization around the symptom, and also was the only affective outlet family members may have felt safe expressing. In addition, the desperation may play a factor in the maintenance of the symptoms, especially if it has organized the therapist to respond in accord with what family members want for the patient (e.g., medication changes, referral to another center, more therapy, re-hospitalization, etc.). Nevertheless, desperation represents the opposite side of the coin from denial, and both seem to be clinical features of these families' moods.

LIFE CYCLE ISSUES - TRANSITIONS

Several studies have reported significant life stresses at or around the time of the development of agoraphobic symptoms (Buglass, et al., 1977; Solyom, Beck, Solyom, and Hugel, 1974). Rather than focusing on recalled events per se, this study focused on themes and patterns that emerged from questions regarding current family and family-of-origin issues and life cycle events. In order to gather data regarding these issues and events, family relationship data were used as an entree to identify coping strategies around transition points, conflicts, life cycle issues, and personal problems. The emphasis was thus not on a history of pathological behavior or traumatic loss per se in previous generations, but the processes by which these conflicts, issues and events were handled. What emerged from all six clinical and five research/interview families was a strong pattern of poorly negotiated transition points, family trauma, intra- and intergenerational conflict and individual psychiatric difficulties.

Moreover, in general these families had each experienced most of these problems, not just one or two. Even more salient were the efforts made by these families to normalize, minimize, or deny the occurrence of ongoing transactions around failed developmental tasks. Unresolved issues from the past were thus a prominent feature of these families, along with their capacity to "act normal" in response to these issues. This finding is consistent with individual styles of denial seen elsewhere in the family systems of these patients (Chambless and Goldstein, 1982). In fact, in several clinical families, major life cycle happenings had been "overlooked" by the patient for one or two years of individual therapy. Much to the chagrin of these patients, such happenings emerged (albeit reluctantly) in family sessions and significantly impacted the course of therapy. Examples of this pattern of family denial included parents who have never visited their daughter's grave or ever mentioned her death in conversation, a mother who has never discussed with her only child, a 28-year-old obsessive-compulsive man, the father's abandonment of them, a wife who will not confront her agoraphobic husband and mother-in-law with her bitterness over 15 years of past wrongs, and a father who will not talk to his obsessive-compulsive son about his own history of obsessive-compulsive behaviors and alcohol abuse. Usually, rudimentary genogram data reveals the transgenerational nature of these unresolved issues and their normalization.

FAMILY SEQUENCES AND THEMES

To expand the picture, recursive family sequences such as those described by Haley (1976), Madanes (1981), and Breunlin and Schwartz (1986) are generated around the patient and maintained by family members. Breunlin and Schwartz (1986) define a recursive sequence "as a set of acts (s₁, s₂, s₃, s_n) that repeat over time in some predictable fashion" (p. 71). Although it is not possible to capture the complexity of all sequences of any given family, for anxiety-disordered families there appear to be several thematic sequences that do commonly emerge.

The first theme is that the patient tends to draw attention via his symptoms onto himself, and family members complement this by focusing on the patient when given cues. For example, one patient agreed to an interview with his mother present only if he could screen out the questions first. After several rounds of negotiation he agreed to the interview and that his mother could decide for herself whether or not to answer questions. Nevertheless, during the interview, he repeatedly attempted to intervene in questions revealing the nature of his relationship with his mother by discoursing on the intrapsychic nature of his problems. His mother actually cued his discourses with eye contact, nods, and questions requesting his commentary. Straying from the symptoms may incur either the patient's wrath or that of another family member.

Second, this symptom-focused centrality seems to draw affect away from painful emotions and leaves interactions within the family containing little or no intensity unless they are about the symptom. The stilted politeness and pseudointellectualized atmosphere that remains may leave a therapist's best therapy flat and stale, like yesterday's news. Thus, family sequences not related to symptoms contain only superficial emotionality (positive and negative). Furthermore, high levels of emotional intensity are routinely digested and easily absorbed into the family system. For example it has been

noted that divorced parents of an anxiety-disordered patient can maintain equanimity in the same room with each other despite bitter divorce proceedings.

The third thematic sequence noted to emerge with these families is that the patient plays a central role in the overall management of family boundary problems and life cycle transitions within and across generations. The patients seen in this study have had family roles such as secret-keepers, parental protectors, or mediators between parents and grandparents, mother and father, or wife/husband and children. The recurrent theme of these sequences thus seems to be one of the patient assuming responsibility for balancing the variety of emotionally charged inter- and intragenerational issues on behalf of the family.

These sequences accomplish the task of keeping the patient central to family functioning, with other family members being "protected" (in a systemic sense) from having to deal with their own boundary and developmental family issues. Painful affect arising from such issues is thus avoided by all family members. Although some family members may appear peripheral by virtue of physical or emotional distance, often the distance is predicated on avoiding close contact with the family and/or patient and usually belies their actual level of emotional involvement. Two examples of how these sequences appear to function in general are

1. A 31-year-old agoraphobic with panic attacks holds all the secrets surrounding the death of her 21-year-old sister five years ago in an automobile accident. Her parents do not know that the sister stole wine and beer from the father and left with friends to attend an off-limits concert; she was killed on the way. The parents have maintained her room as if she were coming home, have never been to the grave site, and do not speak her name. The patient's agoraphobia began within six months of the accident. Although they live 75 miles from her, the parents remain preoccupied with the patient's psychological status, her symptoms, and her children, and thus avoid dealing with their loss.
2. A 30-year-old obsessive-compulsive man lives on a farm in rural Georgia. He has had two dates in his lifetime, and despite attempts by mother to push him out of the nest, his symptoms keep him firmly entrenched at home. Although he has been in treatment for several years and had several hospitalizations, his therapists are surprised to learn in the fifth family therapy session that a brain-damaged younger brother of mother's lives with them and that mother is frightened by this man's aggressiveness and unpredictability. Were the patient to leave home, mother would be confronted with having to institutionalize her brother in a nursing home. She feels she was at fault for the accident that disabled this man some 40 years ago, and reneging on her vow to her mother to care for him until his death would clearly disturb her emotional state. The sequences generated by her son allow her to focus on his problems instead and reduce the risk of her facing the feared scenario.

CLINICAL GUIDELINES

The interventions offered here were used with patients for whom traditional treatment had produced minimal results and were primarily aimed at interrupting the family sequences in such a way that the patient could return to a more appropriate level of functioning. With such patients, in general, the modest therapeutic goal is to lessen the importance of the symptoms in balancing family issues, thereby facilitating an increase in the patient's level of functioning. Enmeshment across generations, the intensity of unresolved past hurts and disappointments, and the rigidity of the repetitive sequences may limit setting goals such as "self-differentiation" or family reorganization around appropriate issues and transitions. Also, attempts to expose unresolved family issues, to uncover unconscious or repressed emotions in family members towards each other, or to promote direct confrontation between patient and family members are generally avoided. Work on these substantial issues is only indicated if and when other relevant family members become committed to the relatedness of their behaviors to the patient's symptom. This process appears to be the exception rather than the rule in these cases.

The first therapy guideline is that collaborating with non-family oriented colleagues is essential. The clinical cases seen in this study were routinely complex, but usually some attenuation of symptoms had been achieved through medication, behavioral therapies, or both. Often the therapist has been triangulated by the patient's controlling and demanding posture and this should be looked at and addressed prior to seeing the patient if possible.

Second, when convening the family, convene at least three family members (including the patient) across at least two, preferably three, generations. Family pressures may operate to keep the sessions initially limited to as few people as possible; nevertheless, the therapist should use his/her influence to convene other generations and members as early on as possible. Often a critical family member will be, or will be said to be, unavailable for family sessions. Although agreeing to convene sessions when a crucial member is excluded for whatever reason helps the therapist to maintain cordial collegial relationships, it is wise to limit such sessions to a one-time event per family. Such sessions tend to leave the family therapist questioning his/her judgment regarding involving the family in the first place, and may justify to the family their reasons not to participate in further sessions.

Third, to reiterate, a focus on gathering structural and subsystem data is recommended. However, also recommended is the use of circular-type questioning in gathering the data in order to maximize information regarding relationships, family members' frames of reference, differences in opinion, and issues which activate family differences. Following the recommendations outlined by the Milan group regarding neutrality, hypothesizing, and circularity, (Selvini-Palazzoli, Boscolo, Cecchin, and Prata, 1980) has been particularly helpful.

The final recommendation has to do with the progression of therapy. Clinical experience suggests that within 3-5 sessions the therapist needs to be prepared to confront the family with the hypothesized systemic function of the symptom. This guideline seems to be especially important in cases that have extensive histories of prior interventions. As stated previously, these families display a great deal of desperation around the symptoms. They tend

not to hear therapist refrains regarding how long it took for the patient to get this way. Often the first family session is the first time they have convened as a family around the problem and they are expecting the therapist to respond to what they each think should be done. It is appropriate to affirm the importance of their concerns, but it is even more important to use them as a rationale to ask questions regarding family life and issues related to the symptoms rather than to answer them outright. Thus family members' desperation becomes an entree into gathering information about family subsystems, history, and family of origin relationships. If all relevant family members attend the sessions regularly, hidden conflicts will emerge despite persistent denial of their presence.

It is important that hurtful conflicts and issues be reframed as neutrally as possible. This helps the therapist to "speak" the family's language and reduces the perceived threat to the system. One frame that has been particularly useful in this respect has been "the safety of family stability." This speaks specifically to repeating family sequences and gives the therapist the opportunity to pull together structural and developmental information to prescribe aspects of these sequences. Thus, family stability is seen as "in delicate balance," and the assumption of responsibility that symptom removal would make available "could backfire and put family and patient under more pressure than they are now experiencing." Typically, one entree into this frame of family stability is by way of trying to understand what individual family members stand to lose if the symptoms disappear or if the patient resumes functioning.

Another important strategy is to tie symptom maintenance to patient functioning. The usual reframe here, especially with young adults, has to do with the difficulties associated with assuming adult levels of responsibility, loss of parental support, and moving out of the middle position of the family. For older patients, such as agoraphobic housewives, the therapist maintains these themes but gives variations on them as appropriate.

Case Example 2

Tom was referred for outpatient follow-up following a two-month hospitalization for obsessive-compulsive disorder, the onset of which was four years prior. He was 21-years old at the time of referral, and had been served divorce papers by his wife the day following admission to the inpatient unit and 3 days following the birth of their first child. At the time of follow-up, Tom was living with his mother, not working, and deeply in debt. Neither Tom nor his wife expressed any interest in seeing each other or reconciling during hospitalization, and within 30 days the divorce was final. No further contact between him and his wife occurred except around visitation with the child. Prior to hospitalization, Tom had lost a variety of jobs because of his unexplainedly feeling compelled to return home while at work. At the time of follow-up, a variety of obsessive thoughts, mainly doubts, were under fair control, having been treated with behavioral interventions and medication. Nevertheless, Tom claimed he was still unable to work, but for a different reason: he did not like being told what to do. Because Tom resided with his mother, his individual therapist suspected their relationship was enmeshed and overprotective, and began a shift to family therapy. Although Tom's parents had been divorced for 6 years, the therapist invited both in for the first two family sessions, since Tom had volunteered that he was very close to his father and step-mother as well as his mother. During these interviews, and

throughout the therapy, mother and father were very cordial with each other, despite the admitted bitterness of the divorce. Father further admitted to a history of alcoholism and obsessive-compulsive behaviors throughout his marriage to Tom's mother, but stated he was better now and had been working steadily the last 5 years. During these sessions, the hypothesis that Tom's symptoms were related to an enmeshed mother-son relationship was not corroborated; also, a subsequent hypothesis relating to father-son enmeshment and overprotectiveness was discarded. Nevertheless, information gathered during the hypothesis testing suggested another area to explore. It was discovered that the father's parents lived in a house virtually in the backyard of Tom's mother's house, and that any time Tom had left his job, he had gone to visit, check-up on, or eat a meal with his grandparents. Tom further revealed that wondering and worrying about his grandparents occupied a good deal of his time. Tom's father agreed to get his parents in and they willingly came to the third session in order to help Tom. Their attendance quickly placed the problem in perspective: parents and grandparents each had a different agenda for Tom and he apparently was caught in the middle, trying to please both. Specifically, Tom's parents wanted him to work, while his grandparents, who both said they wanted him to work, frequently negated this by stating, "But he doesn't have to work if he can't." Tom's response to this situation was to maintain that he was "his" own person and could do whatever he wanted.

The fourth session was with Tom alone for two reasons: (a) the second session with grandparents present had moved very fast and had made Tom uncomfortable; (b) we were afraid that grandmother was resistant, and so we did not want to press for weekly attendance. In this individual session Tom stated he was going to terminate therapy if he did not get better. By way of sympathizing with him, we got him to commit to several more sessions with his parents and grandparents. With all five in attendance at the fifth session, three therapeutic positions were taken: (a) in response to father's increasing desperation to help Tom, his permission and the permission of mother and grandparents was obtained to "say some things that might make Tom angry"; (b) Tom was informed that we did not think he was his own person; and (c) Tom was told that "We are starting to see things through the eyes of your grandmother." This last statement referred to what we thought both grandparents would lose in the event Tom became more autonomous--Tom's closeness to and dependence on them--but fell short of exposing the hypothesized systemic function of the symptom (that is, that Tom's symptoms functioned to stabilize a variety of cross-generational conflicts in the extended family, the most specific being his loyalty to his parents versus his grandparents which functioned to keep the family "in delicate balance"). Therapy broke up for a one-month Christmas break. Prior to convening the next session the therapist and supervisor prepared to confront the family with several reframes drawn from the preceding hypothesis. However, the family began the session by exclaiming that Tom had been working since 2 days after the last session. Grandmother had directed one of her daughters who managed a convenience store to hire Tom to work the 12 a.m. - 8 a.m. shift, and had directed Tom to accept the job. It is worthy of noting that the job had been available to Tom for quite some time, and had been a source of intense frustration for parents and therapist because he had refused to take it. Father beamed proudly as his son described the nuances of the modern-day cash register, while Tom described being able to see his grandparents several times throughout the day. Follow-ups at six-, 12-, and 18-months indicate a continued remission of symptoms with job advancement in the franchise. Thus

symptoms were resolved without awareness of their significance, major family reorganization, or confrontation of repressed emotions.

Of the five families who have completed therapy, all five patients (three obsessive-compulsives and two agoraphobics) have returned to adequate levels of functioning. None have been hospitalized since family therapy was begun. One is no longer in therapy, and a follow-up after six-months indicates the patient has assumed stable and productive levels of functioning. Four others maintain symptom remission but continue with some level of individual therapy.

REFERENCE NOTES

- 1 A copy of this interview is available from the author upon request.
- 2 Max Rojas, M.D. was the therapist in this case.

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THE ABPP EXAMINATION

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I. For information and an application form, write to

Nicholas Palo, Executive Officer
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Columbia, MO 65201-6082

(314) 875-1267

II. Eligibility

- A. Ph.D. from an APA approved program or its equivalent
- B. Graduate training must include core areas of graduate study (e.g., physiological, learning, social, motivation, perception)
- C. Five years experience, 4 of which must be postdoctoral
- D. Presently engaged in professional work in the field of specialization

III. Areas of specialty

- A. Clinical
- B. Counseling
- C. School
- D. Industrial/Organizational
- E. Neuropsychology
- F. Forensic
- G. Possible future areas in psychoanalysis and in family therapy

IV. Application procedure

A. Initial application

1. Documents that candidate has met qualifications for candidacy
2. Provides references
3. Includes check for outstanding ethical complaints against the candidate
4. Transcripts, etc.
5. Fee (\$300)
6. For \$50, a potential candidate can have a review of credentials to ascertain whether he or she is eligible to apply for candidacy

B. If initial application is approved

1. The candidate has one year to prepare and to submit his or her work sample along with fee (\$400)
2. In clinical or counseling, once the work sample has been screened by area coordinator, a committee is assigned with:
 - a. Three voting members
 - b. A nonvoting senior Chair
3. The examination is scheduled
4. In neuropsychology, the work sample is first either passed or failed. If it passes, the candidate goes to a centralized location, with other candidates, to take the oral examination

V. Work sample

A. Assessment

1. Consistent with candidate's usual methods
2. Must include raw data, but with confidentiality preserved
3. Must include theoretical rationale for methods used
4. Candidate should be prepared to discuss relevant research

B. Intervention

1. Consistent with candidate's orientation
2. Includes tape plus transcript

3. Must include theoretical rationale
 4. Candidate should be prepared to discuss relevant research
 - C. Current vita, including continuing education activities
 - D. Brief vita, one page, including breakdown of time spent in various activities
- VI. The examination process
- A. Interview with patient
 - B. Discussion of interview with ABPP committee
 - C. Discussion of work sample
 - D. Discussion of research in candidate's area of expertise
 - E. Discussion of ethics
 - F. Discussion of professional issues
- VII. Areas of evaluation
- A. Assessment (evaluative skills)
 - B. Constructive intervention (intervention skills)
 - C. Psychology as a profession (professional commitment)
 - D. Research (depth and currency of scientific and professional knowledge)
 - E. Ethical practices (ethics and social responsibility)
- VIII. Preparation for the examination
- A. Practice a mock examination with colleagues
 - B. Get feedback on your work sample from colleagues
 - C. Read the APA Monitor to be current on professional issues
 - D. Read current journals in your area of interest. Also, be familiar with recent issues of the Professional Psychologist
 - E. Read articles on ethics in the American Psychologist. Also, familiarize yourself with the Casebook on ethics and with other relevant publications on ethics put out by APA.

F. Consider

1. Reviewing sections of a licensing preparation package
 - a. Ethics
 - b. Professional issues
 - c. Psychotherapy research
 - d. Special populations
 - e. Assessment
2. Dr. Norman Ables' workshop, "Preparing for the ABPP Examination," which is offered during the time of the APA annual meeting.

MILITARY FORENSIC PSYCHOLOGY

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As a result of the publication of Executive Order 12586, Amendments to the Manual for Courts-Martial, United States, military clinical psychologists have become more involved in the mental examination/sanity board process. This paper discusses the issues confronted by clinicians in assessing competency to stand trial and mental state at the time of the offense. The application of military law as it pertains to forensic psychology is reviewed. Traditional psychological assessment techniques as well as more recently developed methods of assessing criminal responsibility, for example, Rogers Criminal Responsibility Assessment Scales, are examined within the context of a four stage evaluation process. Ethical issues involved in forensic practice are presented and a bibliography of selected references in forensic psychology is provided.

Blau (1984) has noted the increasing involvement of psychology in the American judicial system. The utilization of expert psychological testimony in cases of the insanity defense and competency to stand trial are two of the areas of interface between psychology and the law in the civilian community. As a result of Executive Order 12586, Amendments to the Manual for Courts-Martial, United States, 1984, military clinical psychologists are serving on sanity boards when evaluations are requested to determine the mental capacity or responsibility of the accused. The participation in the mental examination/sanity board process creates new responsibilities and opportunities for psychologists who wish to engage in forensic practice.

Forensic psychology requires the clinician to confront issues which are not usually involved in other types of clinical practice. This paper addresses some of the factors involved in conducting psychological evaluations as a part of a sanity board. Points of military law pertinent to psychology are reviewed. A four step procedure which includes testing and methods of assessing competency and mental responsibility based on current forensic literature is proposed. Ethical issues of forensic practice are discussed.

MILITARY LAW AND PSYCHOLOGY

Due process of law is the constitutional right of every citizen regardless of his mental condition. The courts have traditionally recognized that in order to be tried for an offense the accused must be mentally competent or "sane." Although the final decision regarding competency is a legal one, the United States judicial system has relied on the expert opinion of psychologists and psychiatrists in determining competency and mental responsibility. Within the U. S. Army, the Manual for Courts-Martial identifies the rules and procedures for evaluating competency to stand trial and mental responsibility. A full review of the Uniform Code of Military Justice and constitutional law relevant to the insanity defense is beyond the scope of this paper. However, it is important to understand some fundamentals of military and civilian law in order to practice forensic psychology.

Melton, Petrila, Poythress, and Slobogin (1984) noted that the historical basis of the insanity defense dates back to ancient Greek and Hebrew civilizations. English common law, which served as the basis for much of the American judicial system, recognized the need for a clear definition of what constituted insanity. Based on public outcry over the acquittal due to insanity of Daniel M'Naghten who murdered a secretary to the British prime minister, the parliament promulgated a definition of insanity. The M'Naghten Rule stated that if at the time of committing an illegal act, an individual was suffering from a mental disease or defect which resulted in the inability to know what one was doing and/or know that it was wrong, a defense by reason of insanity may be established. The key to applying this rule was the presence of an inability to know, that is, a cognitive test. The concept of mens rea or knowing the wrongfulness of one's actions became an essential component of mental responsibility determinations. In addition to the M'Naghten Rule, U. S. courts have applied the irresistible impulse test and product test to the insanity defense (Melton et al., 1987). These purported "tests" of insanity address volitional control and the fact that the illegal act was a product of a mental defect. Each of these attempts to define insanity has met with numerous criticisms from both the legal and medical professions. Among these criticisms was the opinion that one would have to be totally incapacitated in order to be declared insane under the strict interpretation of the M'Naghten Rule.

On 25 July 1977, the Court of Military Appeals in the case of U. S. vs. Frederick adopted the test of insanity developed by the American Law Institute (ALI) which stated:

A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. (P.230)

The ALI criteria specifically excluded any pattern of repeated criminal or antisocial behavior from being considered a mental disease or defect. This standard employed both cognitive and volitional tests of insanity while eliminating the requirement for total incapacitation. It was this standard which was used by military courts until the incorporation of the Insanity Defense Reform Act (1986) into the Manual for Courts-Martial (MCM).

The Insanity Defense Reform Act of 1986 specifies that at the time of the offense the accused, as the result of a severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of his actions. Excepting these conditions, mental disease or defect does not constitute a defense in military courts. The provisions of this act are applicable to crimes committed since 1986. The significant changes from the ALI criteria include (a) the requirement for a "severe" mental disease or defect, (b) the requirement for complete impairment ("unable" versus "substantial capacity"), (c) elimination of the requirement for volitional control, and (d) the use of the term "wrongfulness" instead of "criminality." The problems with the definitions of mental disease or defect remain. However, antisocial behavior continues to be excluded from the category of mental disease. The basis for considering a defense by reason of insanity rests on these legal precedents.

The procedures by which the forensic mental health professional becomes involved in a case are contained in the Manual for Courts-Martial. Rule 706 of the MCM states that the accused's commander, the trial counsel, the defense counsel, the judge, the investigating officer, or any court member who doubts the accused's mental responsibility should report that concern to the authority empowered to order a sanity board. The convening authority for the court-martial orders the sanity board at the request of the defense counsel. Rule 706 specifies that the board will consist of one or more persons with each member being either a physician or a clinical psychologist. One board member should be a psychiatrist or a clinical psychologist. Typically the convening authority will request that the board answer the following questions:

1. At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects.)
2. What is the clinical psychiatric diagnosis?
3. Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his or her conduct?
4. Does the accused have sufficient mental capacity to understand the nature of the proceedings and to conduct or cooperate intelligently in the defense? (P. II-83, MCM)

Questions one and three reflect the changes in the MCM as a result of the Insanity Defense Reform Act. Based on the findings of the sanity board, the court-martial convening authority will decide to proceed with the trial, dismiss the charges, or take other administrative action. It is important to remember that the purpose of the board is to determine the mental state of the defendant. Opinions about guilt or innocence are not relevant.

In addition to questions about the accused's mental status at the time of the offense (MSO), the sanity board will be asked to comment on the accused's capacity to stand trial. Rule 909 of the MCM states:

No person may be brought to trial by court-martial if that person is presently suffering from a mental disease or defect rendering him or her mentally incompetent to the extent that he or she is unable to understand the nature of the proceedings against that person or to conduct or cooperate intelligently in the defense of the case. (P. II-117)

The capacity to stand trial is presumptive. The burden of proof is on the defense counsel to show that the accused is unable to cooperate with his/her own defense.

This review of military law and procedures regarding the insanity defense is not intended to be definitive. It is designed to serve as an introduction to the legal issues involved in serving as a member of a sanity board. The military forensic professional should consult the applicable military and civilian legal references and the Manual for Courts-Martial in order to better understand the interface between the law and behavioral science.

FORENSIC PSYCHOLOGICAL EVALUATION

A four step process is proposed for forensic psychological evaluations in order to answer the questions of competency to stand trial and mental state at the time of the offense. The evaluation process consists of (a) obtaining a multi-source database of third party information, (b) clinical evaluation to include psychological testing and specific methods of assessing competency and mental responsibility, (c) assessment of distortion, and (d) establishing the relevance of the clinical findings to the forensic referral issues.

Although similar to the evaluation process in nonforensic settings, the present procedure seeks to continually translate the clinical data into findings which will address the legal questions of mental capacity and mental responsibility. In addition to organizing the evaluation, this four step process is easily understood by lawyers, judges, and juries. Relying solely on clinical opinion without providing objective evidence and the methodology used to reach the conclusions will decrease professional credibility and reduce the value of expert witness testimony. As Ziskin (1981) has noted, psychological testimony must be both believable and understandable to be useful in forensic settings.

A database of information from multiple sources is an essential first step in conducting a forensic evaluation. The report of the Article 32 investigating officer, a copy of the charges, and copies of all statements should be reviewed. Melton et al. (1987) considered third party information to be an essential element of forensic assessment. In addition to this legal database, useful information can be found in the accused's military records which contain reports of duty performance, entrance test scores, and previous disciplinary actions. The sanity board is asked to respond to the four questions described under Rule 706 of the MCM as well as other questions requested by the defense counsel. Discussion of any additional questions with the defense counsel prior to formal submission may avoid the tendency of counsel to go on a "fishing expedition."

The second step in the forensic evaluation process consists of the initial interview of the accused and the use of psychological tests and procedures designed to answer the questions posed by the court. Based on the forensic database and the clinical history obtained during the initial interview, a plan is developed to assess the accused using psychological tests and procedures. The psychologist's investment in quantification through the use of tests and other forms of measurement has been reported to distinguish forensic psychological evaluations from evaluations done by most other forensic experts (Grisso, 1986). The specific tests to be used will depend on the questions to be answered and the background, training, and experience of the psychologist.

The psychometric portion of the forensic psychological evaluation usually consists of measures of intelligence, personality, academic achievement, and neuropsychological status. When used for forensic purposes, the interpretation of these tests requires the establishment of a link between test findings and the criminal offense. It has been argued that psychological testing has limited value in the determination of the accused's mental state at the time of the offense (Melton et al., 1987). This argument assumed that psychological tests provided information about current functioning but not prior mental state. It was also noted that the general nature of test results and the time interval between the testing and the offense served to relegate testing to a

limited or nonexistent role in forensic mental evaluations. These arguments offer a circumscribed view of psychological testing. Testing is only a part of the broad scope of psychological assessment consisting of problem definition, history, testing, and the integration of findings with other data. In assessing the quality of forensic evaluations it has been noted that reports which were primarily opinion oriented and lacked corroborative data were rated lower in quality by legal experts (Petrella & Poythress, 1983). Blau (1984) has been a proponent of psychological testing in forensic evaluations and has recommended a battery consisting of tests of intelligence, personality, reading skills, and neuropsychological status.

In addition to traditional clinical measures, a number of assessment procedures have been developed to answer the legal questions of competency to stand trial and mental state at the time of the offense. Two attempts to measure competency to stand trial, the Competency Screening Test (CST) and the Competency to Stand Trial Assessment Instrument (CSTAI), have been proposed. Lipsitt, Lelos, and McGarry (1971) developed the CST and CSTAI to screen and evaluate the defendant's capability to cooperate and participate in his/her defense. The CST consists of 22 incomplete sentences pertaining to court personnel and procedures. The accused is instructed to complete each sentence which is then scored 0 (incompetent), 1 (marginal), or 2 (competent). An arbitrary cutoff score of 20 was used to determine competency to stand trial. Studies of the CST have concluded that low scores may be due to factors other than competency such as ideological differences with the legal system, feelings of powerlessness, and secondary gain (Grisso, 1986). The Competency to Stand Trial Assessment Instrument is an attempt to overcome the deficiencies of the CST.

Lipsitt and Lelos (1983) reported that the CSTAI presents clinical opinion to the court in language, form, and substance which are common to both behavioral science and the law. It is probably more accurate to describe the CSTAI as an interview guide. Thirteen functions dealing with the accused's ability to understand and participate in a trial are presented. These functions include ability to plan legal strategy, knowledge of court personnel, and awareness of defense options. Each item is rated by the clinician using a 5-point Likert scale ranging from 1 (total incapacity) to 5 (no incapacity). The authors emphasize that the court has the ultimate decision regarding which areas of competency are most relevant to the case. The CSTAI is a means of organizing and rating the competency data collected during the clinical interview.

Having formed an opinion regarding competency to stand trial, it is necessary to assess the accused's mental state at the time of the offense. The Rogers Criminal Responsibility Assessment Scales (R-CRAS) (Rogers, 1981) are designed "...to provide a systematic and empirically based approach to evaluations of criminal responsibility" (Rogers, 1981, p. 1). The R-CRAS consists of 25 variables which are assigned a rating (0-6) to indicate severity. These ratings are then grouped into six psycholegal criteria designed to answer the question of criminal responsibility using the ALI standard. The criteria are (a) malingering, (b) organicity, (c) major psychiatric disorder, (d) loss of cognitive control, (e) loss of behavioral control, and (f) loss of cognitive or behavioral control over criminal conduct due to a major psychiatric disorder. Various combinations of the criteria may be applied to other legal standards of insanity. In order to meet the ALI standard, criterion a must be absent, criteria b and/or c must be present,

criteria d and/or e must be present, and a direct relationship must be shown on criterion f.

A critique of the R-CRAS has suggested that the weaknesses in the instrument result from its reliance on quantification of impairment by assigning ordinal ratings and attempting to quantify factors which may be logical or intuitive (Melton et al., 1987). The R-CRAS can provide a valuable aid to the forensic professional in the organization and presentation of findings. It also ensures that the major substantive issues in the evaluation of criminal responsibility have been addressed. For these reasons it should be included in the second phase of the forensic evaluation process.

The third step in conducting a forensic evaluation is to account for deliberate and nondeliberate distortion by the accused. Hall (1986) has proposed a set of procedures designed to analyze and report the presence of misrepresentation by a defendant. The forensic distortion analysis employs a decision tree in which nondeliberate distortion, deliberate distortion, and response style are examined using a broad forensic database. The first step in the process is to rule out or account for nondeliberate distortion. Hall (1986) noted that although deliberate distortion is the typical focus of the forensic evaluation, factors may be present within the individual, the events, or the evaluation which result in an unintentional misrepresentation. Circumstances such as impaired physical condition, stress, presence of environmental interference, and invalid assessment methods should be considered in determining if nondeliberate distortion is present. Deliberate distortion is assessed next. One method of assessing deliberate distortion is to examine the accused's misrepresentation on psychological tests. Analysis of MMPI validity configurations and subtle-obvious scales as well as the use of parallel test forms and illusorily difficult items can identify intentional faking. Finally, an analysis of distortion should state which of the following response styles was present: (a) no distortion, (b) faking good, (c) faking bad, (d) results invalid, (e) mixed or unknown. If the evaluator believes that distortion was due to a mental disorder, this finding should also be reported.

The forensic evaluation differs from its clinical counterpart in that the evaluator must do more than diagnose and treat. The fourth step in the forensic evaluation process relates the findings to the presence of a mental disorder and the presence of a deficit in behavior as a result of that disorder. At this stage, the evaluation should answer the four questions asked by the military court-martial convening authority. In answering these questions, the evaluation must demonstrate a clear relationship between the findings and the lack of competency to stand trial and/or criminal responsibility.

A particular diagnosis will not suffice because the law does not attempt to relate diagnosis to criminal responsibility or competency. No psychological test or procedure will substitute for the forensic clinician's ability to formulate meaningful opinions from the database obtained during the previous three steps of the evaluation.

The written report of a military forensic evaluation is prepared in accordance with the guidance provided by Rule 706 of the MCM. The full report of the evaluation is usually provided only to the defense attorney although the accused's commander may request a copy. The court-martial convening authority, trial counsel, and commander receive a statement containing only the sanity

board's answers to the questions contained in the examination order. If a board member nonconcurs with the opinion of the board, a minority report explaining the nonconcurrence should be submitted.

ETHICAL ISSUES

An ethical code designed especially for forensic psychology does not exist. Curran (1986) has presented the ethical perspectives of the American Bar Association and the American Academy of Forensic Sciences with regard to mental health expertise in the courts. The ABA standards address the allowable limits of expert psychiatric and psychological testimony in a conservative manner. The standards state that the expert should not be asked to render opinions concerning questions of law, moral or social value, predictions of dangerousness (with some exceptions), or the mental condition of someone whom the expert has not examined. The American Academy of Forensic Sciences emphasizes accurate and complete statements of qualifications, technical and scientific accuracy in reporting findings, and impartiality with regard to the outcome of the case. The recommended standards of these groups are not binding for psychologists. However, they do illustrate the value and need for ethical conduct by forensic professionals.

The Ethical Principles of Psychologists (APA, 1981) provides general guidance which may be applied to the ethical issues of forensic work. Among the foremost ethical issues in forensic practice are privileged communication and confidentiality. As Blau (1984) noted, these concepts are often confused and may contradict one another. Confidentiality assumes that release of information will occur only with the written permission of the patient or in cases of dangerousness. Privileged communication is granted by legal statute and defines the limits and conditions of confidential patient communication. An APA task force on the role of psychology in the criminal justice system recommended that the psychologist clearly advise the accused, in writing, of any limitations in confidentiality which exist in the forensic evaluation (APA, 1978). Such action would be in accordance with principle 5, confidentiality, of the Ethical Principles of Psychologists.

Jeffrey (1987) has reviewed the ethical conflicts associated with the fact that privileged communication between psychologist and patient does not exist in the military. Clearly this issue becomes more significant when the patient stands accused of a crime and is undergoing an evaluation which may produce incriminating evidence. Rule 302 of the Military Rules of Evidence affords military psychologists some relief from this dilemma.

Rule 302 states that the accused has the privilege to prevent any statement made during a mental examination or any derivative evidence from being used to determine guilt or during sentencing. This privilege does not exist when the statements or evidence were previously introduced by other sources. Notwithstanding this exception it is recommended that the accused be fully informed about the lack of privileged communication in order to be consistent with principle 5. A sample written format for this purpose was provided by Jeffrey (1987).

CONCLUSION

This paper is a review of some of the basic issues relevant to the conduct of forensic psychological evaluations in the military. By providing a rationale for the role of forensic psychological evaluation, it is hoped that military clinical psychologists will become actively involved in sanity board proceedings. Each clinician will approach this professional activity utilizing a unique set of skills and abilities. Careful attention to applicable military law and the use of scientific methods of inquiry will ensure high standards of professionalism for those who serve on sanity boards.

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FORENSIC PSYCHOLOGY: THE ROLE OF THE MILITARY PSYCHOLOGIST

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Military forensic psychology encompasses primarily four areas: prison consultation, forensic evaluations, expert testimony, and sanity boards. These general areas have much in common with civilian forensic psychology, but in addition involve considerations specific to the military. This paper will review these areas of forensic psychology with an emphasis on aspects unique to the military.

Prison consultation requires many of the skills needed for any form of consultation: communication skills, definition of roles and boundaries, and establishing credibility. In addition, care must be taken to separate manipulation from pathology. The area of forensic evaluations requires consideration of the legal as well as psychological aspects of the case: patient rights, limits to confidentiality, and provision of clear, jargon-free responses to legal questions. Expert testimony is reviewed in terms of the technical proficiency required, the presentation skills needed, and potential difficulties that may be encountered. It is in the use of Sanity Boards that the military is most unique, with specifications for the boards outlined in the Manual for Courts-Martial. The role of this board is to determine competence, responsibility, and severity of mental disorder, and to make a determination for legal disposition. All psychologists in the military will find themselves involved at some time in at least one of these major areas of forensic work.

This paper is intended to review briefly some of the major forensic issues that psychologists in the military may face. It is not intended to present the authoritative opinion on these issues nor will this information be sufficient to prepare a person with no forensic training for forensic work. Rather, the goal is to highlight some of the most important points for consideration and to provide the reader with some of the primary documents and resources pertaining to this area of psychology. The primary focus of this paper is on sanity boards because this is the area in which military psychologists are most likely to be involved.

PRISON PSYCHOLOGY

Generally a military psychologist will interact with a prison in the role of consultant. The USDB has the Army's only authorized position for clinical psychologists in a prison setting, and even in this environment the role can be primarily consultative. As a psychologist at a given post, you will most likely be requested to provide evaluation of certain prisoners identified as problematic. This may include signs of mental disturbance and/or suicide threats/attempts. Your recommendation may range from a generally clear mental status evaluation to segregation to hospitalization. An isolated evaluation may be adequate to address an individual problem; however, a pattern of referrals likely reflects institutional misperceptions

and/or lack of training in proper management of cases. In that case, staff consultation may facilitate appropriate case dispositions and result in both improved care for the prisoners and decreased workload for yourself. Care must be taken to avoid being pulled into the trap of predicting future violence or criminal behavior unless you are able to clearly document that the method you use to determine these actions has validity for the stated purpose.

Research is also a viable option in a prison setting. While strict standards must be followed when conducting research with prisoners, they are generally available at specific times and can provide a wide range of options for study. Both basic and applied research are possible.

FORENSIC EVALUATIONS

When conducting an evaluation that is requested for legal reasons or that you can reasonably expect will be used in a legal case, it is extremely important that you clarify the limits of confidentiality. When a lawyer requests an evaluation, the report of what transpires is available to both sides of a case and may be introduced as evidence in the legal arena. Generally an attorney will ask specific questions which need to be clearly and unequivocally answered. As much as possible, jargon should be avoided keeping in mind that the consumers of the report will not generally be other medical personnel, but rather persons unskilled in psychological or medical jargon.

The report should be organized in a logical format and include basic information included on all reports such as identification, evaluation procedure, and behavioral observation. In addition, the report should include a statement of the individual's competence to understand and participate in legal procedures and his competence at the time of the alleged offense. A diagnosis should be provided, if appropriate, as well as an estimate of the impact of this diagnosis on the alleged offense. The report is generally submitted to the lawyers and, as stated earlier, may be introduced as evidence in court.

EXPERT TESTIMONY

Expert testimony may be requested under a variety of circumstances. The request may be based on your particular qualifications in a given area (e.g., neuropsychological deficits, child sex offense), position you hold at a given time (e.g., Chief of Community Mental Health, Psychologist at the United States Disciplinary Barracks), or because you provided evaluation for the case. The reason the expert testimony is requested will determine what qualifications will be required and how closely these qualifications may be challenged. Certainly the position you hold is not open for much dispute; however, your expertise in a given area may be challenged, particularly if you are presenting strongly pointed testimony or controversial opinions.

Regardless of the reason you are requested to provide expert testimony, it is important to clarify why you are testifying and whom you represent. The person who calls you as the witness (i.e., defense or prosecution) will generally define the side for which you are expected to testify. However, the defense may initially ask you to evaluate an individual, and if your evaluation does not support the defense position, the prosecution may call you

to testify. Your role must be to present impartial testimony and not to succumb to the lawyer's agenda which may involve distorting factual information to support a position that you are personally disposed towards. In addition, if you have been called to testify based on your institutional affiliation (e.g., USDB), it is imperative that you clarify that you are not stating the official policy of that organization (unless, of course, you are), but rather your professional opinion. It may even be the case that two witnesses testify with conflicting opinions from the same institution.

If you intend to testify based on test results or specific assessment information, you must be prepared to support the reliability and validity of the instrument and defend its use in the manner you used it.

SANITY BOARDS

There are three likely situations when a sanity board may be requested. By far the most likely is when a person is accused of a crime and the issue of mental competence or responsibility is raised. A sanity board may also be required for a person who has been convicted and is now appealing the case or is pending a rehearing. A case may not be finalized if the issues of competence and responsibility have not been resolved. The third situation in which a sanity board may be required is for a person awaiting execution. In this case it is necessary to determine that the person understands "the punishment to be suffered and the reason therefore."

Clinical psychologists are authorized board members by Rule of Court Martial (R.C.M.) 706 which describes the process and content of sanity boards. Paragraph (c) (1) which defines who may serve on the boards, was amended in 1986 (Change 3) to allow clinical psychologists on the board (See Appendix A). This rule applies to offenses committed after November, 1986. If the offenses occurred prior to this date, the previous version of this rule applies allowing only physicians to serve as board members. The previous rule stated:

"(1) By who conducted. When a mental examination is ordered under subsection (b) of this rule, the matter shall be referred to a board of one or more physicians for their observation and report as to the mental capacity or mental responsibility, or both of the accused. Ordinarily at least one member of the board shall be a psychiatrist."

If a person is charged with offenses that occurred both before and after November 14, 1986, both rules must be considered and separate boards may be held.

Prior to beginning a board, there are several steps you must take to insure that the board findings are upheld. These include the following:

1. Advise the patient of his Article 31 rights which include the right not to participate in the board and the right to refuse to answer any or all questions.
2. Insure the patient has consulted with a lawyer and has been advised of his charges, his rights, and the function/purpose of the board.
3. Inform the patient that the proceedings/findings of the board are not confidential.
4. Inform the patient of the purpose of the board and discuss the process that will be followed (e.g., 1-2 hours, many questions).

Other appropriate questions may also be included. Essentially this requires a determination of whether at the time of the alleged offense the patient had a severe mental disorder or defect. While not clearly outlined in diagnostic terms, this would certainly include psychotic diagnoses, organic diagnoses (Alzheimer's), and affective diagnoses. Clearly ruled out are antisocial personality disorder or other compulsive behaviors that only involve criminal conduct. There is still a large area left open for interpretation. If a diagnosis is made this must be clearly stated and should not, if at all possible, include qualifying terms such as "may, possibly, or rule out."

If the patient is found to have a severe mental disorder or defect, it is next necessary to determine if, as a result of this mental disease or defect, the patient was unable to appreciate the nature and quality or wrongfulness of the action. It is clearly possible that a person meets the diagnostic criteria for severe disorder and yet this disorder does not impact on his alleged criminal behavior.

The board must also determine if the accused has the mental capacity to understand the criminal proceedings and to assist in his own defense. If a person is not found to be competent to proceed with the judicial proceedings then an accurate determination of responsibility generally can not be made and the responsibility question should be deferred.

Your job as a member of the board is not to determine if a person is lying, and the results should be stated in terms that make it clear that your findings are based on the patient's report (e.g., according to the patient). You also are not required to answer any questions other than those specified in R.C.M. 706 (c)(2) or ordered by the judge. The defense and/or prosecuting attorneys may request (in terms that resemble an order) that you answer other questions such as what was the role of childhood abuse in the crime. These questions do not need to be answered unless the judge subsequently orders them to be. Additionally, attorneys can not require that specific assessment measures be administered or that any specific assessment be conducted.

The information that has been presented provides an introduction to some of the factors that need to be considered when conducting sanity boards. I have included as Appendices three sample sanity board reports (Appendix A) and excerpted sections from the Manual for Courts-Martial (Appendix B) that are relevant to forensic military psychology.

Appendices

A 1-3 Sample Sanity Board Write-Ups

B 1-9 Excerpts from the Manual for Courts-Martial

APPENDIX A-1

ATZL-DBM

Sanity Board - Inmate

TDS, USDB DMH
Field Office

15 Jan 88

CPT Gahm/jmb/4096

1. Sanity Board was conducted on Inmate _____ on 17 December 1987. The evaluation lasted for 1 1/2 hours.
2. The Sanity Board consisted of CPT Gregory Gahm, MS, and LTC Michael B. Vandewalle, MC.
3. At the time of the alleged offenses, Inmate _____ did have a severe mental disease.
4. Inmate _____ does not have sufficient mental capacity to understand the nature of the proceedings and to conduct or cooperate intelligently in the defense.
5. Unable to address responsibility issue at this time.

MICHAEL B. VANDEWALLE
LTC, MC
Chief, Psychiatry Division

GREGORY A. GAHM
CPT, MS
Chief, Clinical/Research
Psychology Division

APPENDIX A-2

SANITY BOARD

SSAN:

DATE:

Inmate Name:

Register:

1. A Sanity Board was convened and held for _____ on 21 April 1988. The Sanity Board consisted of Gregory A. Gahm, CPT, MS, Clinical Psychologist and Michael B. Vandewalle, LTC, MC, Psychiatrist, as per request from the Third Judicial Circuit, signed by F.A. Gates, COL, JA, Circuit Judge.

2. In accomplishing the Sanity Board, the inmate was informed that this evaluation was not confidential and that he had the right to talk with his attorney. He informed us that he had talked with his attorney and he was willing to have this Sanity Board. All available records on his charges and his DMH file were reviewed. In addition, the individual was given a full psychiatric interview.

3. Findings:

- a. At the time of the alleged criminal conduct, the accused did not have a mental disease or defect.
- b. No psychiatric diagnosis at the time of the alleged criminal conduct.
- c. The accused at the time of the alleged criminal conduct did not have a mental disease or defect; therefore, he also did not lack substantial capacity to appreciate the criminality of his conduct.
- d. The accused at the time of the alleged criminal conduct did not lack substantial capacity to conform his conduct to the requirements of the law.
- e. The accused has sufficient mental capacity to understand the nature of his court-martial proceedings and to conduct and cooperate intelligently in his defense.

MICHAEL B. VANDEWALLE
LTC, MC
Chief, Psychiatry Division, DMH

GREGORY A. GAHM
CPT, MS
Chief, Clinical and Research
Psychology Division

APPENDIX A-3

FINDINGS OF THE SANITY BOARD ON
SSG _____

1. At the time of the alleged criminal conduct, the accused did not have a severe mental disease or defect.
2. Diagnosis: DSM-III-R
 - Axis I. 305.00 Alcohol Abuse, Chronic, Severe
 - Axis II. 301.90 Personality Disorder, Not otherwise specified (formerly called Mixed Personality Disorder)
 - Axis III. (1) Chronic Low Back Pain
(2) Recurrent Urticaria
(3) Probable Hyperacidity
3. The accused did not suffer from a severe mental disease or defect at the time of the alleged criminal conduct and was able to appreciate the nature and quality or wrongfulness of his conduct.
4. The accused has the mental capacity to understand the nature of the proceeding and to conduct or cooperate intelligently in the defense.

COL, MC
C, Community Mental Health Service

Discussion

See also R.C.M. 910(f) (plea agreement inquiry).

Rule 706. Inquiry into the mental capacity or mental responsibility of the accused

(a) Initial action. If it appears to any commander who considers the disposition of charges, or to any investigating officer, trial counsel, defense counsel, military judge, or member that there is reason to believe that the accused lacked mental responsibility for any offense charged or lacks capacity to stand trial, that fact and the basis of the belief or observation shall be transmitted through appropriate channels to the officer authorized to order an inquiry into the mental condition of the accused. The submission may be accompanied by an application for a mental examination under this rule.

Discussion

See R.C.M. 909 concerning the capacity of the accused to stand trial and R.C.M. 916(k) concerning mental responsibility of the accused.

(b) Ordering an inquiry.

(1) Before referral. Before referral of charges, an inquiry into the mental capacity or mental responsibility of the accused may be ordered by the convening authority before whom the charges are pending for disposition.

(2) After referral. After referral of charges, an inquiry into the mental capacity or mental responsibility of the accused may be ordered by the military judge. The convening authority may order such an inquiry after referral of charges but before beginning of the first session of the court-martial (including any Article 39(a) session) when the military judge is not reasonably available. The military judge may order a mental examination of the accused regardless of any earlier determination by the convening authority.

(c) Inquiry.

*(1) By whom conducted. When a mental examination is ordered under subsection (b) of this rule, the matter shall be referred to a board consisting of one or more persons. Each member of the board shall be either a physician or a clinical psychologist. Normally, at least one member of the board shall be either a psychiatrist or a clinical psychologist. The board shall report as to the mental capacity or mental responsibility or both of the accused.

(2) Matters in inquiry. When a mental examination is ordered under this rule, the order shall contain the reasons for doubting the mental capacity or mental responsibility, or both, of the accused, or other reasons for requesting the examination. In addition to other requirements, the order shall require the board to make separate and distinct findings as to each of the following questions:

- * (A) At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects.)
- (B) What is the clinical psychiatric diagnosis?
- * (C) Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his or her conduct?
- (D) Does the accused have sufficient mental capacity to understand the nature of the proceedings and to conduct or cooperate intelligently in the defense?

Other appropriate questions may also be included.

(3) Directions to the board. In addition to the requirements specified in subsection (c)(2) of this rule, the order to the board shall specify

- (A) That upon completion of the board's investigation, a statement consisting only of the board's ultimate conclusions as to all questions specified in the order shall be submitted to the officer ordering the examination, the accused's commanding officer, the investigating officer, if any, appointed pursuant to Article 32 and to all counsel in the case, the convening authority, and, after referral, to the military judge;
- (B) That the full report of the board may be released by the board or other medical personnel only to other medical personnel for medical purposes, unless otherwise authorized by the convening authority or, after referral of charges, by the military judge, except that a copy of the full report shall be furnished to the defense and, upon request, to the commanding officer of the accused; and
- (C) That neither the contents of the full report nor any matter considered by the board during its investigation shall be released by the board or other medical personnel to any person not authorized to receive the full report, except pursuant to an order by the military judge.

Discussion

Based on the report, further action in the case may be suspended, the charges may be dismissed by the convening authority, administrative action may be taken to discharge the accused from the service or, subject to Mil. R. Evid. 302, the charges may be tried by court-martial.

(4) Additional examinations. Additional examinations may be directed under this rule at any stage of the proceedings as circumstances may require.

(5) Disclosure to trial counsel. No person, other than the defense counsel, accused, or, after referral of charges, the military judge may disclose to the trial counsel any statement made by the accused to the board or any evidence derived from such statement.

Discussion

See Mil. R. Evid. 302.

Rule 909. Capacity of the accused to stand trial by court-martial.

(a) In general. No person may be brought to trial by court-martial if that person is presently suffering from a mental disease or defect rendering him or her mentally incompetent to the extent that he or she is unable to understand the nature of the proceedings against that person or to conduct or cooperate intelligently in the defense of the case.

Discussion

See also R.C.M. 916(k).

(b) Presumption of capacity. A person is presumed to have the capacity to stand trial unless the contrary is established.

(c) Determination at trial.

(1) Nature of issue. The mental capacity of the accused is an *interlocutory question of fact*.

Discussion

The military judge rules finally on the mental capacity of the accused. The president of a special court-martial without a military judge rules on the matter subject to objection by any member. See R.C.M. 801(e).

*(2) Standard. Trial may proceed unless it is established by a preponderance of the evidence that the accused is presently suffering from a mental disease or defect rendering him or her mentally incompetent to the extent that he or she is unable to understand the nature of the proceedings against the accused or to conduct or cooperate intelligently in the defense of the case.

Discussion

If the accused is not found to possess sufficient mental capacity to stand trial, the proceedings should be suspended. Depending on the nature and potential of the accused's incapacity, the case may be continued or charges withdrawn or dismissed. When appropriate, administrative action may be taken to discharge the accused from the service on grounds of mental disability. Additional mental examinations may be directed at any stage of the proceedings as circumstances may require.

*(k) lack of mental responsibility.

(1) Lack of mental responsibility. It is an affirmative defense to any offense that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his or her acts. Mental disease or defect does not otherwise constitute a defense.

Discussion

See R.C.M. 706 concerning sanity inquiries. See also R.C.M. 909 concerning the capacity of the accused to stand trial.

(2) Partial mental responsibility. A mental condition not amounting to a lack of mental responsibility under subsection (k)(1) of this rule is not a defense, nor is evidence of such a mental condition admissible as to whether the accused entertained a state of mind necessary to be proven as an element of the offense.

(3) Procedure.

(A) Presumption. The accused is presumed to have been mentally responsible at the time of the alleged offense. This presumption continues until the accused establishes, by clear and convincing evidence, that he or she was not mentally responsible at the time of the alleged offense.

Discussion

The accused is presumed to be mentally responsible, and this presumption continues throughout the proceedings unless the finder of fact determines that the accused has proven lack of mental responsibility by clear and convincing evidence. See subsection (b) of this rule.

(B) Inquiry. If a question is raised concerning the mental responsibility of the accused, the military judge shall rule finally whether to direct an inquiry under R.C.M. 706. In a special court-martial without a military judge, the president shall rule finally except to the extent that the question is one of fact, in which case the president rules subject to objection by any member.

Discussion

See R.C.M. 801(e)(3) for the procedures for voting on rulings of the president of a special court-martial without a military judge. If an inquiry is directed, priority should be given to it.

(C) Determination. The issue of mental responsibility shall not be considered as an interlocutory question.

(1) Not defenses generally.

(1) Ignorance or mistake of law. Ignorance or mistake of law, including general orders or regulations, ordinarily is not a defense.

Discussion

For example, ignorance that it is a crime to possess marijuana is not a defense to wrongful possession of marijuana.

Ignorance or mistake of law may be a defense in some limited circumstances. If the accused, because of a mistake as to a separate nonpenal law, lacks the criminal intent or state of mind necessary to establish guilt, this may be a defense. For example, if the accused, under mistaken belief that the accused is entitled to take an item under property law, takes an item, this mistake of law (as to the accused's legal right) would, if genuine, be a defense to larceny. On the other hand, if the accused disobeyed an order, under the actual but mistaken belief that the order was unlawful, this would not be a defense because the accused's mistake was as to the order itself, and not as to a separate nonpenal law. Also, mistake of law may be a defense when the mistake results from reliance on the decision or pronouncement of an authorized public official or agency. For example, if an accused, acting on the advice of an official responsible for administering benefits that the accused is entitled to those benefits, applies for and receives those benefits, the accused may have a defense even though the accused was not legally eligible for the benefits. On the other hand, reliance on the advice of counsel that a certain course of conduct is legal is not, of itself, a defense.

(2) Voluntary intoxication. Voluntary intoxication, whether caused by alcohol or drugs, is not a defense. However, evidence of any degree of voluntary intoxication may be introduced for the purpose of raising a reasonable doubt as to the existence of actual knowledge, specific intent, willfulness, or premeditated design to kill, if actual knowledge, specific intent, willfulness, or premeditated design to kill is an element of the offense.

Discussion

Voluntary intoxication may reduce premeditated murder to unpremeditated murder, but it will not reduce murder to manslaughter or any other lesser offense. See paragraph 43c(2)(c), Part IV.

Although voluntary intoxication is not a defense, evidence of voluntary intoxication may be admitted in extenuation.

Rule 615. Exclusion of witnesses

At the request of the prosecution or defense the military judge shall order witnesses excluded so that they cannot hear the testimony of other witnesses, and the military judge may make the order sua sponte. This rule does not authorize exclusion of (1) the accused, or (2) a member of an armed service or an employee of the United States designated as representative of the United States by the trial counsel, or (3) a person whose presence is shown by a party to be essential to the presentation of the party's case.

Section VII. OPINIONS AND EXPERT TESTIMONY

Rule 701. Opinion testimony by lay witnesses

If the witness is not testifying as an expert, the testimony of the witness in the form of opinions or inference is limited to those opinions or inferences which are (a) rationally based on the perception of the witness and (b) helpful to a clear understanding of the testimony of the witness of the determination of a fact in issue.

Rule 702. Testimony by experts

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

Rule 703. Bases of opinion testimony by experts

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert, at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

Rule 704. Opinion on ultimate issue

Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

Rule 705. Disclosure of facts or data underlying expert opinion

The expert may testify in terms of opinion or inference and give the expert's reasons therefore without prior disclosure of the underlying facts or data, unless the military judge requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination.

Rule 706. Court appointed experts

(a) Appointment and compensation. The trial counsel, the defense counsel, and the court-martial have equal opportunity to obtain expert witnesses under Article 46. The employment and compensation of expert witnesses is governed by R.C.M. 703.

(b) Disclosure of employment. In the exercise of discretion, the military judge may authorize disclosure to the members of the fact that the military judge called an expert witness.

(c) Accused's experts on own selection. Nothing in this rule limits the accused in calling expert witnesses of the accused's own selection and at the accused's own expense.

Sec 850a. Art. 50a. Defense of lack of mental responsibility

(a) It is an affirmative defense in a trial by court-martial that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of the acts. Mental disease or defect does not otherwise constitute a defense.

(b) The accused has the burden of proving the defense of lack of mental responsibility by clear and convincing evidence.

(c) Whenever lack of mental responsibility of the accused with respect to an offense is properly at issue, the military judge or the president of a court-martial without a military judge, shall instruct the members of the court as to the defense of lack of mental responsibility under this section and shall charge them to find the accused -

(1) guilty;

(2) not guilty; or

(3) not guilty by reason of lack of mental responsibility.

(d) Subsection (c) does not apply to a court-martial composed of a military judge only. In the case of a court-martial composed of a military judge only, whenever lack of mental responsibility of the accused with respect to an offense is properly at issue, the military judge shall find the accused -

(1) guilty;

(2) not guilty; or

(3) not guilty by reason of lack of mental responsibility.

(e) Notwithstanding the provisions of section 852 of this title (article 52), the accused shall be found not guilty only by reason of lack of mental responsibility if -

(1) a majority of the members of the court-martial present at the time the vote is taken determines that the defense of lack of mental responsibility has been established; or

(2) in the case of court-martial composed of a military judge only, the military judge determines that the defense of lack of mental responsibility has been established.

* (5) Action when accused lacks mental responsibility. An appellate authority may not affirm the proceedings while the accused lacks mental capacity to understand and to conduct or cooperate intelligently in the appellate proceedings. In the absence of substantial evidence to the contrary, the accused is presumed to have the capacity to understand and to conduct or cooperate intelligently in the appellate proceedings. If a substantial question is raised as to the requisite mental capacity of the accused, the appellate authority may direct that the record be forwarded to an appropriate

authority for an examination of the accused in accordance with R.C.M. 706, but the examination may be limited to determining the accused's present capacity to understand and cooperate in the appellate proceedings. The order of the appellate authority will instruct the appropriate authority as to permissible actions that may be taken to dispose of the matter. If the record is thereafter returned to the appellate authority, the appellate authority may affirm part or all of the findings or sentence unless it is established, by a preponderance of the evidence - including matters outside the record of the trial- that the accused does not have the requisite mental capacity. If the accused does not have the requisite mental capacity, the appellate authority shall stay the proceedings until the accused regains appropriate capacity, or take other appropriate action. Nothing in this subsection shall prohibit the appellate authority from making a determination in favor of the accused which will result in the setting aside of a conviction.

THE PSYCHOLOGIST'S ROLE IN SECURITY EVALUATIONS

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An important and expanded role for the military psychologist is expected to be created by an increase in the number of evaluations conducted for security clearances. This role takes on added significance in light of the reduced number of mental health professionals in the military. Psychologists in the Army will also see more requests for assessments as a result of new regulatory requirements.

The very real potential for inaccurate or incomplete evaluation to result in a serious breach of national security is evident from recent news reports. Balancing these concerns with the ethical, legal, and regulatory guidelines of the professional psychologist can often result in contradictory guidance.

This article addresses several considerations which are important in conducting evaluations and reporting results. Current regulatory guidance is reviewed and suggestions made for collection of demographic, performance, and psychological testing data. Sample assessment formats and reports and abstracts from current regulations are provided. Case examples are used to highlight the discussion of these materials.

IMPORTANCE

Walker, Whitworth, Richardson, Conrad--these are names that would not be immediately recognizable except when they are subsumed under the category of American service members engaged in espionage against their own country (Miles, 1989; Spolar & LaFraniere, 1985). Sadly, we are still unable to calculate the vast damage these informants, and others like them, may have caused to our national security and military forces. The spies apprehended by our intelligence and law enforcement organizations may represent only a portion of those who are currently active. Overcoming this internal threat requires the cooperation of many agencies and professions.

Mental health specialists are being tasked more frequently than ever before to assist in the evaluation of persons with and those seeking access to classified materials. This tasking is partially due to the surprising number of individuals who have documented behavioral problems (Flyer, 1985) and who are seeking security clearances. Other considerations include the need for periodic reviews, clearance upgrades, and access removal.

Psychologists working in the field continue to make significant contributions to our understanding of the pertinent issues, regulatory requirements, and practical considerations of the assessment process (Hibler, 1985; Gupton & DiMarco, 1985). As the stakes increase and the technological sophistication of organizations spirals, the need for principles in the measurement of personnel risk becomes more acute. It is no longer acceptable

to depend upon standard mental status evaluations to screen populations with access to our national and military secrets. A proactive stance is required in the collection of local norms in various agencies and in the accumulation of specific information when faced with a request for an evaluation of an individual (Kowal, 1985; Roland, 1988).

ETHICAL IMPLICATIONS

Is it possible for mental health experts to maintain their professional and ethical standards while assuming a more proactive role in the evaluation of individuals for positions of great responsibility? It is clear from recent surveys conducted by Jeffrey (1987, p. 259) that many military psychologists are confused about their respective roles as client advocate and/or agent of the system. This confusion is not peculiar to the military (Haas, L.J., Malouf, J.L., & Mayerson, N.H., 1986) and has wide implications for the practitioner. The wise clinician is directed to the current literature on the issues of confidentiality in the military (Gillooly, 1985; Jeffrey, 1989).

The duty of the psychologist to inform the person being evaluated of the implications of the assessment is not abrogated by the psychologist's function as organizational consultant. In practice, there is seldom a problem if all parties agree to the evaluation and the disposition of the findings. A statement like those included in Appendix 1 (Limits on Confidentiality of Psychological Information) along with the standard Privacy Act Statement - Health Care Records (DD Form 2005) will satisfy current Department of Defense and AMEDD requirements.

The standards of disclosure of information outlined by The American Psychological Association may be at variance with those specified by the military (APA, 1983). This is a cautionary note for all practicing psychologists to bear in mind. Although alleged cases of ethical violations resulting from information provided to commanders in security clearance evaluations have not been adjudicated as of yet by The APA, this is not a remote possibility. APA reprimands are documented wherein military psychologists followed DOD guidance in contravention of APA guidelines and principles (Jeffrey, 1987).

The popular press continues to report on issues related to the testing and psychological screening of job applicants and the use of assessment for promotions (Dentzer, 1988). These practices are largely viewed with skepticism by employees even if they are accepted by organizations. As all consumers of psychological services become more knowledgeable, the likelihood of an APA ethics case arising as the result of a security clearance evaluation increases. These contradictions have been addressed to various divisions of the APA as well as to the standing ethics committee. They are still awaiting resolution.

THE REFERRAL PROCESS

Unquestionably, the most appropriate starting point in any evaluation is with the referral source. Take the time to conduct a thorough assessment and your expectations of appropriate background information. This process should commence when you receive the first evaluation request or prior to that if

possible. A personal visit with the security officer and commander at the unit is advisable. This foundation can pay considerable dividends in the future by saving inestimable time and energy on your part and that of the referring agency.

The psychologist needs to become conversant enough with the supported organization so that the data sources, regulatory, legal and command affiliations are understood. Comprehend these basic issues first before any evaluation is conducted. Use them as a cognitive template to weigh what the individual will be asked to do for the agency against what you learn about his strengths and weaknesses. Job descriptions can be helpful but these data cannot always be provided. In that case, ask for a general behavioral description of the work standards without the specifics.

When the referral source and the expectations of the agency are understood, it is comparably easier to get more specific and varied information. At the same time, the unspoken standards of the unit become evident as do the requirements for a new person to "measure-up" in the system. As an example, a first-line supervisor may have a far different opinion of an individual than a commander while the "unit" may not know the person well. These contradictions are not unusual in many organizations especially those with compartmented missions.

Completing an evaluation for a source that is unwilling to cooperate in this mutual exchange of information is, at best, a dangerous process. Sometimes this resistance occurs because the unit is only trying to conform to regulatory requirements. Usually the security manager or referral source has not done the homework required to provide needed and readily available information. Asking that referral sources use a standard or specially developed Request for Consultation Form like the sample at Appendix 2 can help to overcome this problem. Support the requesting agencies as fully as possible while making clear the data requirements for a comprehensive assessment.

THE EVALUATION PROCESS

The evaluation process involves the collection of much important data prior to any interview or testing. In addition to reviewing the materials supplied by the agency, review medical records as a basic starting point. This review should include the entire record and any current physical examinations, notes, consults, and labs. Make a note of PRP or Flight Status and any previous suspensions. The file should appear reasonable for the time-in-service and the general content can usually be an indication of unusual discrepancies. A check of the Clinical Case Files in the mental health section can help to eliminate an embarrassing omission in the assessment and should always be done. This entire process usually takes less than 10 minutes and is well worth the effort, for it often generates questions for the interview.

As a standard part of the inprocessing for the interview, obtain a release form and any other documents that may be required in order to complete the evaluation and forward the results. Be specific about your role in the assessment as an agent of the system and the limits of confidentiality. Document this explanation in the record and detail to the person being

interviewed what he will be required to do during this visit. Arrange for subsequent feedback sessions as needed and expect appropriate anxiety, as a job may be depending upon the outcome. Ask if the subject is clear about the purpose of the evaluation and what the job at his agency will require of him. Confirm some simple data that you have gleaned from records and be aware of any questionable memory gaps. Make sure to note any unusual physical appearance or disabilities that may be readily detectable.

Psychometric testing data and the use of an appropriate battery will be dependent upon information from the interview but may be specified by the agency. Often the careful evaluation of historic behavior patterns is the discriminating factor in these evaluations, as many of these individuals have similar personality profiles and intelligence levels. Two important considerations in testing are (a) Is this testing to be used for exclusion or inclusion? and (b) Is a degree of pathology a positive or a negative trait?

Assessment results should be compared with facts that are already known (i.e., a Shipley score with a GT score, WAIS-R with education). This comparison can reveal important information regarding the approach and intention of the examinee. "Test only" or "blind" interpretations of data without extensive demographic performance details can result in disaster. Don't do them.

THE EVALUATION REPORT

Sample formats of evaluation reports are found at Appendix 3 (Grill, 1988; Roland, 1988). Usually a single page is sufficient to convey the results of the evaluation because few referral sources will be acquainted with the meaning of psychometric data. The facts should be stated clearly along with the meaning of any pertinent results. Listing information about an individual that the unit may be unfamiliar with is usually enough to communicate that the assessment was meticulously done. Your impressions and diagnoses (if appropriate) should be supported. Make a clear recommendation in simple terms as the bottom line. Attaching a DA Form 3822-R (Report of Mental Status Evaluation) can eliminate repetitious material in the body of your report. If the DA Form 3822-R is used, make sure to note it as an attachment to your report and in the remarks block of the form. A sample sheet of Comments and Recommendations is included as Appendix 4.

There may be an occasion when the referral agency expresses great urgency in having the assessment completed in a short time. In these cases, do not write an interim report or give preliminary telephonic results. Units may be inclined to take action based on your verbal or incomplete data which may not reveal the entire picture. Take appropriate time to do a good job while assisting the organization whenever possible. In the process, be aware of any special safeguards that may be necessary for your report and evaluation data. If you have any questions, clarify them with the unit. Guidelines abstracted from appropriate regulations are at Appendix 5.

Organizations that require assistance from psychologists in security evaluations vary widely. Each presents a unique set of factors for consideration which becomes part of the evaluation stratagem. A general checklist is provided as Appendix 6 as a generic outline for use in these contexts.

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APPENDIX 1

LIMITS ON CONFIDENTIALITY OF PSYCHOLOGICAL INFORMATION

It is important that you know the limits of confidentiality and privileged communication regarding psychological information. Military health care records are the property of the United States Government. The same controls apply to these records as other Government documents. Information disclosed by you (patients) to military medical department health care personnel is not confidential. This means that access to information in your file is allowed when required by law, regulation, judicial proceedings, hospital accreditation, or when authorized by you. A written summary of each of your visits with us will be maintained in your medical record and/or a separate Psychology clinical case file.

Military lawyers and chaplains have more complete confidentiality than medical department physicians or psychologists.

Examples where limits on confidentiality may apply follow:

1. If you are on active duty, your commander or higher chain of command will have access to information contained within your health record or any locally maintained clinical record. Your commander can request (make referral for) a psychological evaluation. This means that we will evaluate the status of your psychological health and provide a written and/or verbal report to your commander. Participation in the personnel reliability or nuclear surety programs may require review of the status of your health at any time. The information is normally disclosed on a need-to-know basis. There is no patient-provider basis for privileged communication in the military. Release of such information is required by regulation.
2. Requests for information from sources, i.e., civilian lawyers, spouses, lawyers, etc.) outside the Department of Defense (Department of Transportation for U.S. Coast Guard personnel) will normally not be honored unless you have first given permission (in writing) for the release of the information).
3. If you are involved in any legal action/proceedings your records may be subject to subpoena when ordered by a judge.
4. If you should state that you intend to harm yourself or someone else, or if we believe you intend to harm yourself or someone else, it is our duty to disclose that information.
5. In situations of suspected child abuse, it is our duty to notify medical, legal, or other authorities.

APPENDIX 1

6. If you tell us of a situation that involves violation of military regulations, the Uniformed Code of Military Justice, or civil law, we may be required to divulge that information to the chain of command or other authorities.

7. You may have been referred by another health care provider. If so, a report summarizing the results of your consultation with us will be sent to the referral source.

8. Other members of the hospital/clinic professional staff associated with your health care may, when appropriate, have access to psychological information on record without your written consent.

9. You may be seen in group therapy. If so, you and every other member of the group will be advised that anything discussed which could be considered personal is private information. This includes the names of the group members or any problems that they present. This is not to be talked about with anyone outside the group or clinic. At the same time you must realize that there is no way that the confidentiality of any group member can be guaranteed. Confidentiality will exist to the extent that each patient trusts and respects every other member of the group.

10. All clinical case files are routinely reviewed to ensure quality of care.

11. All psychology intern and other categorically credentialed providers' cases are reviewed after each patient visit to ensure quality of care.

12. Qualified persons with official approval may have access to your record for clinical investigation (research) purposes.

There is no confidentiality or privileged communication in the military. At the same time, we are bound by the code of ethics of psychologists. We will strive to safeguard information obtained from you and insure that only authorized sources have access IAW the above guidelines.

Ask us if you have questions about the limits of confidentiality or privileged communication. You may also inquire at the Patient Administration Division/Patient Affairs Office.

APPENDIX 1

STATEMENT OF UNDERSTANDING

I have read the above and understand that psychological information about me will be safeguarded within the limitations of confidentiality mentioned above and the Privacy Act (DD Form 2005).

Patient Signature

Date

I have reviewed the above limits of confidentiality with the above identified patient to insure that he/she understands them.

Health Care Provider's Signature

Date

(Jeffrey, 1987)

APPENDIX 1

LIMITS ON CONFIDENTIALITY OF PSYCHOLOGICAL INFORMATION

It is important for you to know the limits of confidentiality of psychological information. Army medical records are the property of the Government, thus the same controls that apply to other Government documents apply to them. Information disclosed by patients to Army Medical Department health personnel is not privileged communication.

Access to information in your psychology case file is allowed when required by law, regulation, or judicial proceedings; when needed for hospital accreditation; or when authorized by you.

Examples of the limits on confidentiality follow:

1. If a provider of psychological services believes you intend to harm yourself or someone else, it may be the duty of the provider to disclose that information.
2. In situations of suspected child abuse, it is the duty of the provider to notify medical, legal, or other authorities.
3. If you are involved in any legal action/proceedings your records may be subject to subpoena.
4. Other members of the WBAMC professional staff associated with your health care may have access to psychological information on record without your written consent.
5. If you are on active duty, your commander/chain of command could have access to certain information authorized by regulation, e.g., a command directed referral, a line of duty investigation, or participation in the nuclear surety program.
6. Qualified persons may have access to your record for clinical investigation purposes.

If you have questions about the limits of confidentiality you may ask us or inquire at the Patient Administration Division (PAD) of the MEDCEN.

STATEMENT OF UNDERSTANDING

I have read the above and understand that psychological information about me will be safeguarded within the limitations of confidentiality mentioned above and in the Privacy Act Statement (DD Form 2005).

Patient Signature

Date

APPENDIX 2

REQUEST FOR CONSULTATION (Sample Format)

FROM: Include at a minimum, Headquarters address, Phone, Requestors Name and their command relationship.

PURPOSE OF EVALUATION: Two copies with any supplementary reports, job descriptions or requirements.

PERSONAL DATA:

Name:	Grade:	SSN:
Unit:	Phone:	GT & Ed.:
Age:	T.I.S.	MOS:
Months in Unit:	Duty Assignment:	
ETS:	Marital Status:	
Dependents:	Other:	

BEHAVIOR REPORT:

1. Conduct and efficiency ratings, last report results, promotions, awards, etc.
2. General appearance, attitude, PT score.
3. Work Attitude, toward others, superiors.
4. List actions pending or previous.
5. Personal/family circumstances +/-.

OTHER REMARKS OR SPECIAL CONSIDERATIONS:

APPENDIX 3



DEPARTMENT OF THE ARMY
UNITED STATES MILITARY ACADEMY PREPARATORY SCHOOL
FORT MONMOUTH, NEW JERSEY 07703

REPLY TO
ATTENTION OF:
Dr. Roland

5 May 1988

COMMANDER
____ Brigade ____
ATTN: LTC ____
SPECIAL ACTIONS OFFICE

SUBJECT: Command referral of CPT GARY L. ____ for position of Commander,
Special Reaction Team (SRT).

1. As per your Command request dated 2 May 1988 the following report is submitted. This 34 year old male active duty Infantry Officer is being evaluated for selection as Commander SRT. Unit records, Medical records, Officer Record Brief, Command endorsements and detailed job description of the SRT were reviewed in conjunction with an extensive testing battery. Interviews were conducted on 2 and 4 May 1988. Cpt ____ signed appropriate releases.

2. Pertinent Results: Cpt ____ has been on station 4 months. He is a 1978 graduate of the United States Military Academy who came through the enlisted ranks through the USMA Preparatory School. He has had one prior command experience in Korea of 7 months duration for which he received no military award. He has a break in service to attend a Graduate Business School where he completed 13 semester hours in 2 years. He states that a divorce from his first wife resulted in financial difficulties and his return to active duty. His Medical records contain several annotations of note; specifically 2 injuries treated in Emergency Rooms without follow-up and a lab slip with a high Blood Alcohol and no corresponding treatment record. There is a current active case file in the Family Advocacy Program and he is separated from his 2nd spouse.

3. Testing: Psychological Assessment reveals above average intelligence with predominantly concrete thinking patterns. Interpersonal adjustment difficulties are suggested as are nonconformity and impulsiveness. He leaves an excellent first impression which is superficial. He can be hostile and aggressive with no remorse. This is a stable profile indicating a long-standing behavior pattern that is supported by his records.

4. Recommendations: Cpt ____ is ill-suited for the sort of position described in the SRT Commander job description. I recommend that he not be placed in this position. DA Form 3822-R (Report of Mental Status Evaluation) is attached.

1 Encl.

ROBERT R. ROLAND
MAJOR, MS
CLINICAL PSYCHOLOGIST

APPENDIX 3

REPORT OF MENTAL STATUS EVALUATION For use of this form, see AR 635-200; the proponent agency is MILPERCEN		
NAME Gary L.	GRADE CPT/O-3	SOCIAL SECURITY NUMBER
REASON FOR EVALUATION		
1. REQUEST A MENTAL STATUS EVALUATION FOR THE ABOVE NAMED SERVICE MEMBER WHO IS BEING CONSIDERED FOR DISCHARGE BECAUSE OF ☐ PERSONALITY DISORDER ☐ MISCONDUCT ☐ REQUEST FOR DISCHARGE FOR GOOD OF SERVICE ☒ OTHER (See Remarks)		
NOTE: IF NECESSARY, INCLUDE SPECIFIC REASONS IN REMARKS		
EVALUATION (Check all that apply) During Interviews		
2. BEHAVIOR ☐ HYPERACTIVE ☒ NORMAL ☐ PASSIVE ☐ AGGRESSIVE ☐ HOSTILE ☐ SUSPICIOUS ☐ BIZARRE		
3. LEVEL OF ALERTNESS ☒ FULLY ALERT ☐ DULL ☐ SOMNOLENT		
4. LEVEL OF ORIENTATION ☒ FULLY ORIENTED ☐ PARTIAL ☐ DISORIENTED		
5. MOOD OR AFFECT ☐ ANXIOUS ☐ FLAT ☒ UNREMARKABLE ☐ DEPRESSED ☐ LABILE ☐ MANIC OR HYPOMANIC		
6. THINKING PROCESS ☒ CLEAR ☐ CONFUSED ☐ BIZARRE ☐ LOOSELY CONNECTED		
7. THOUGHT CONTENT ☒ NORMAL ☐ ABNORMAL ☐ HALLUCINATIONS ☐ PARANOID IDEATION ☐ DELUSIONS		
8. MEMORY ☒ GOOD ☐ FAIR ☐ POOR		
IMPRESSIONS (Check all that apply)		
9. IN MY OPINION, THIS SERVICE MEMBER ☒ HAS THE MENTAL CAPACITY TO UNDERSTAND AND PARTICIPATE IN THE PROCEEDINGS ☐ WAS MENTALLY RESPONSIBLE ☒ MEETS THE RETENTION REQUIREMENTS OF CHAPTER 3, AR 40-501 ☐ NEEDS FURTHER EXAMINATION (See remarks) ☒ OTHER (See Remarks)		
REMARKS 1. This report is based upon a Brigade Command request to screen applicants for command of a Special Reaction Team. 2. Complete narrative is attached. 3. Mental status is within normal limits (grossly) on examination. 4. Contact the undersigned if further evaluation or information is needed. 5. This report consists of 2 pages.		
DATE 5/5/88	SIGNATURE Robert R. Roland, Major MS	



APPENDIX 3

DEPARTMENT OF THE ARMY
LETTERMAN ARMY MEDICAL CENTER
PRESIDIO OF SAN FRANCISCO, CALIFORNIA 94129-6700

REPLY TO
ATTENTION OF:

HS HH-YCP

13 Jun 88

MEMORANDUM FOR: Commander, 980th Military Police Company,
Sierra Army Depot, Herlong, CA 94129

SUBJECT: Psychological Evaluation
RE: Snuffl, Joseph E., PVT, 123-45-6789

1. IDENTIFYING DATA: This paragraph should include complete identifying data for the individual, the date of the evaluation, the administrative purpose for which the evaluation is required or recommended, and the requesting source of the evaluation.
2. PERTINENT HISTORY: This paragraph should contain a concise summary of the individual's present problems, situations, illness, etc., pertinent to this specific request for evaluation (include any pertinent past social/medical history, as necessary).
3. MENTAL STATUS EXAMINATION: This paragraph should contain a concise summary of the individual's mental status. The words used should be those understandable to the commander.
4. IMPRESSION: This paragraph should contain a diagnosis using DSM-III-R nomenclature. In the absence of a diagnosis, "No psychiatric disorder (V71.09)" should be used.
5. COMMENTS/RECOMMENDATIONS: This paragraph should contain all the necessary statements, as sub-items, that convey the evaluator's findings and recommendations. The statements should relate sufficient information to the commander for him to make an informed decision regarding a soldier's PRP status. Sample statements are attached as another appendix.

DENNIS J. GRILL
LTC, MS
Clinical Psychologist

APPENDIX 4

COMMENTS
AND
RECOMMENDATIONS

1. This individual meets the retention standards prescribed in Chapter 3, AR 40-501, and there is no psychiatric disease or defect which warrants disposition through medical channels.
2. This soldier suffers from a mental illness or condition (to include personality disorder) that may cause significant defects in his judgement or reliability.
3. This soldier does not suffer from a mental illness or condition that would cause significant defects in his judgement or reliability.
4. This soldier did suffer from a mental illness or condition that caused significant defects in his judgement or reliability, however, this condition is now in full remission and there is no residual defect which impairs his judgement or reliability.
5. This soldier is undergoing evaluation at this time and a statement addressing possible significant defects in judgement and reliability would be premature.
6. This condition and the problems presented by this individual are not, in the opinion of this examiner, amenable to hospitalization, treatment, transfer, disciplinary action, training, or reclassification to another type of duty within the military. It is unlikely that efforts to rehabilitate or develop this individual into a satisfactory member of the military will be successful.
7. Based solely upon this evaluation, it is difficult to make a definite statement regarding the rehabilitative potential of this soldier. Such determination must be made by command on the basis of this soldier's ability to adjust to his/her unit and his/her performance on the job. It is likely, however, that further rehabilitative efforts will not be effective (or will be effective).
8. From a psychiatric/psychological point of view, this soldier demonstrates motivation for continued service, and there appears to be sufficient basis to warrant further rehabilitative efforts by command.
9. This soldier is psychiatrically cleared for any administrative (or judicial) action deemed appropriate by command.
10. Based solely on clinical evidence, the need for specific rehabilitative measures has not been demonstrated, and, from a psychiatric/psychological point of view, the soldier is considered to have the capacity for functioning effectively.

APPENDIX 5

AR 50-5 -- Nuclear Surety Chapter 3 -- Personnel Reliability Program Section III -- Screening & Evaluation Procedures

3-11. Qualifying Factors. In the absence of disqualifying evidence, selection of personnel for training and assignment to nuclear duty positions will be based on the following desirable qualifications:

(a) Evidence of physical competence, mental alertness, and technical proficiency or aptitude commensurate with duty or training requirements.

(b) Evidence of dependability in accepting and exercising responsibility and effectively accomplishing duties in an approved manner, and evidence of flexibility in adjusting to changes in a working environment.

(c) Evidence of social adjustment, emotional stability, and the ability to exercise sound judgement when confronted with adverse or emergency situations.

(d) Evidence of a positive attitude toward duties involving nuclear weapons and the objective of the PRP.

3-12. Disqualifying Factors.

(a) Any of the medical conditions, abuse of drugs and/or alcohol, traits, or behavioral characteristics listed below will be considered disqualifying for nuclear duty training or assignment unless overriding evidence of reliable duty performance exists.

(1) Alcohol abuse.

(a) Any irresponsible use of an alcoholic beverage leading to misconduct; unacceptable social behavior; or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships.

(b) Persons who are medically diagnosed as dependent upon alcohol will neither be selected for nor retained in the PRP and are not eligible for requalification until satisfactory completion of the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) rehabilitation (Track III residential treatment and followup).

(2) Drug Abuse.

(a) Drug abuse is the illegal, wrongful, or improper use of any narcotic substance or its derivative, cannabis or its derivatives, or other controlled substance or the illegal or wrongful possession, transfer, or sale of these substances. When any drugs have been prescribed by authorized medical personnel for medicinal purposes, their proper use by the patient is not drug abuse. It is not intended that isolated or experimental use of cannabis or its derivatives be automatically disqualifying. The certifying official must decide whether such experimental or isolated use has adversely affected the individual's reliability.

(b) Persons who are medically diagnosed as dependent on any narcotic substance or its derivatives, cannabis or its derivatives, or other controlled substance will neither be selected for nor retained in the PRP and are not eligible for requalification until satisfactory completion of ADAPCP rehabilitation (Track III residential treatment and followup).

(c) Persons who have used a hallucinogenic drug with a potential for flashback (to include LSD, PCP or its derivatives, psilocybin, mescaline, or any other substances with similar properties) will neither be selected for nor retained in the PRP under any circumstances.

(3) Negligence or delinquency in performance of duty.

(4) Nonjudicial punishment.

(5) Conviction(s) by a military or civil court of a serious offense.

(6) A pattern of behavior or actions that is reasonably indicative of a contemptuous attitude toward the law or other duly constituted authority.

(7) Any significant physical or mental condition substantiated by competent medical authority, or any characteristic or aberrant behavior that in the judgement of the certifying official is prejudicial to reliable performance of nuclear duties.

(8) Poor attitude or lack of motivation.

(b) When an individual is not disqualified because of overriding evidence of reliable duty performance, the certifying official may make the circumstances a matter of record if deemed necessary.

APPENDIX 5

(1) Information that the certifying official believes should be brought to the attention of future certifying officials may be noted on the reverse of the DA Form 3180. Notations made must not be in violation of AR 600-37.

(2) Adverse information that the certifying official considers to be potentially disqualifying and that is not a matter of official record may be placed in the soldier's file in accordance with AR 600-37. The servicing civilian personnel officer (CPO) should be requested to document adverse information on civil service personnel in accordance with applicable Federal Personnel Manuals. Appropriate adverse information will also be reported to CCF, using DA Form 5248-R (Report of Unfavorable Information for Security Determination) in accordance with AR 604-5.

APPENDIX 6

INFORMATION AND SOURCES CHECKLIST

1. The Referral:

- A. Educate the referral source.
- B. What data is available?
- C. Exactly what are they asking you to do?
- D. On what basis, ie Regulation, Legal, Medical.
- E. Do they have the authority to ask? Who wants to know?
- F. Can you legally do the consultation?
- G. Is the task clear to you and behaviorally defined?

2. Unit Information:

- A. What do you know about the referral source, unit, person?
- B. How are they judging the person, how well are they known?
- C. What does the first-line supervisor think?
- D. Any Administrative actions, Art 15s, counselings?
- E. Request copies of all pertinent documents.

3. Medical Records:

- A. Records must accompany individual.
- B. NEVER do an evaluation without medical records.
- C. Review the whole record, labs, physicals, notes.
- D. Check PRP or Flight status, note suspensions.
- E. General content, reasonable for T.I.S.?
- F. Any unusual problems or discrepancies?
- G. Check for a Mental Health file.

4. Interview:

- A. Get a release form, Specify confidentiality issues.
- B. Be clear about your role as agent of the system.
- C. Do they understand the purpose of this evaluation?
- D. Do they know the job requirements?
- E. Explain what you will be doing, expect anxiety.
- F. Check physical appearance.
- G. Confirm some simple data, check memory gaps.

5. Testing Data:

- A. Selection of tests, criterion referenced.
- B. Is past history a better discriminator?
- C. Inclusion or exclusion? Is pathology a + or - ?
- D. How do results square with background data?
- E. Never do "Test only" or "blind" interpretations.
- F. Confirm, Confirm, Confirm all data.

6. Feedback:

- A. Can the individual have access to the results?
- B. Inform them of the disposition of the report.
- C. Defer any feedback until you look at all the results.
- D. Think about it, collect more data if needed.
- E. Your recommendation may or may not effect the outcome.

7. The report:

- A. State the facts, keep it brief.
- B. State the results, keep it brief.
- C. Give conclusions and how they are verified.
- D. Make a clear recommendation in simple terms.
- E. No interim reports.
- F. Note any special safegaurds for the data and files.
- G. Ask the referral source immediately as questions arise.

SUICIDE PREVENTION IN THE U.S. ARMY:
A PROGRAM COMES OF AGE

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During 1984, the rising concern in the United States over the apparent increase in the number of young people attempting and completing suicide prompted the Army to form a panel of experts to review existing suicide prevention efforts and to determine what additional steps could be taken to reduce both attempts and actual suicides in the Army. The panel was convened in December, 1984, and included experts from the civilian and military sectors as well as representatives from several Department of the Army agencies responsible for programs or policies affecting suicide prevention, reporting and investigation.

The review conducted during this and several subsequent meetings produced a number of observations about suicide and the status of suicide prevention efforts in the Army. First, the rate of suicide in the Army was not significantly different from that of the general population of the United States. During the previous 5 years, the Army suicide rate had averaged just over 11 per 100,000, while the national suicide rate had been just over 12 per 100,000. While this favorable comparison prompted some to question the need for a specific suicide program, others noted that the active duty force is composed of a young, healthy, fully employed population from which severely impaired persons have been eliminated. Therefore, the Army should have a much lower suicide rate than the national population.

Next, it was recognized that leadership is the key to any successful program in the Army. Suicide prevention would be accomplished through command policy and action. Beginning with the senior leadership of the Army, the entire chain of command must make suicide prevention a top priority. Commanders at all levels are required by Army Regulation to "initiate proactive measures to prevent loss of life due to suicide within their unit and to reduce the impact on survivors if a suicide takes place."

In developing the Army Suicide Prevention Program, certain essential tasks were identified. First, leaders and supervisors at all levels needed to be taught to recognize warning signs of personal crisis and know where to refer someone for help. To this end, an education awareness program was begun to train every officer, NCO, and civilian supervisor how to spot personnel who may be at increased risk of suicide. Second, the data gathering mechanisms in place at that time were not giving an accurate picture of the magnitude of the problem and needed to be improved. Third, because not much was known about the circumstances of persons committing suicide in the Army, psychological autopsies were needed so that prevention programs could be targeted on the real causes. These three tasks became the basis of the program.

Implementation of an effective suicide prevention program in the Army proved to be a lengthy process. A comprehensive action plan was published in February, 1985. Among the actions outlined in this plan was the publication of a model installation suicide prevention program. The model was to provide specific operational guidance on how to establish local suicide prevention programs. The model was approved and distributed to the field in November, 1985. Experience gained from the use of this model in the field was used to write the final program which was ready for publication in October, 1986. The decision to incorporate suicide prevention into a larger effort known as the Army Health Promotion Program delayed publication of the final suicide prevention program as a regulation until November 1987. However, information gathered from field commanders suggests that by November, 1986, most Army installations and units had begun a suicide prevention program of some sort. Thus 1987 may be considered the first full year of implementation of an Army wide suicide prevention program.

During the 3 years in which the Army Suicide Prevention Program was being developed, much was learned about suicide in the Army. The most serious problem in terms of numbers of deaths was in the 20-24 year age group. The most frequently occurring age (mode) for soldier suicides was 21. However, when suicides were studied by military rank, it was learned that suicides occur in the various enlisted ranks in proportion to the strength of each in the Army. Because rank is highly correlated with age, it may be seen that the majority of Army suicides occur in the 20 to 24 year age group because most of the Army is in the 20 to 24 year age group.

It was learned in earlier studies that disruptions in heterosexual relationships seemed to be the trigger for up to 80% of all active duty suicides. An analysis of the past 3 years experience confirms that problems in romantic relationships, marital and family problems seem to be the root cause of most Army suicides. There was a striking absence of suicides resulting from problems within the Army work environment. The few "job related" suicides which were reported followed some criminal activity by the victim.

The results of the Army Suicide Prevention Program have been dramatic. In the 7 years prior to 1987 (1980-1986), there were 643 active Army suicides. There were an average of just under 92 suicides per year or 7.65 suicides per month. The average suicide rate for this period was 11.8 per 100,000 soldiers. By contrast, in 1987 there were 70 soldier suicides for an average of 5.8 per month and an annual rate of 9.2 per 100,000.

When compared to the peak year of 1985, the results are even more dramatic. During 1985 there were 115 suicides with a monthly average of 9.7 and an annual rate of 14.3. During 1987, the Army experienced only 61 per cent as many suicides as 1985.

As a result of strong command support, an effective suicide prevention program has been implemented in the Army. While it cannot be proven that the program caused the reduction in suicide deaths, the Army has experienced about 40 percent fewer suicides during the first year of full program implementation.

DUAL RELATIONSHIPS:
LEGAL AND ETHICAL DANGERS FOR PSYCHOTHERAPISTS

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Over the past decade there has been increasing interest on the part of psychologists and others regarding professional standards of practice and ethics. Interest has been focused on dual relationship violations with specific emphasis on sexual intimacy. While this topic has been the subject of much debate and definition, the overall area of dual relationship violations has not received as much attention. The American Psychological Association has begun work on this type of violation, but much more work needs to be done, and significant confusion still exists. This article suggests a model that would help the psychologist avoid such violations and thereby assist the profession in more accurately defining this very complex area.

During the past decade, psychologists have been called upon to define and be accountable for what is both appropriate and inappropriate therapeutic practice. While the psychotherapeutic setting continues to be viewed as a safe place for self exploration and behavior change, psychologists and other health care professionals are being required to demonstrate increasing care for how they behave in and use that setting for their own benefit. Historically, the rules for conduct were set down in professional codes of ethics and professional standards, but in many areas the regulations and limitations were not clearly spelled out and thus became mere statements regarding the "spirit" of appropriate professional behavior.

Because of concern over the lack of clarity about how a therapist should behave in the therapy setting, professional associations and state licensing boards have recently been called upon to more accurately define appropriate therapeutic practice on the part of those that they regulate. Yet, the continued difficulty in accurately defining appropriate professional conduct is clearly evident in the struggle to develop laws and ethics codes that allow professional flexibility and still guarantee protection to those that use therapy services. This trend is most apparent in the actions taken by the Ethics Committee of the American Psychological Association to define sexual intimacies with patients as being unethical (1981). These problems and the general level of confusion in this area are only compounded by the differences that exist between legal and ethical violations, since many ethical violations are not violations of state licensing laws. Psychotherapists continue to be confused by these regulatory discrepancies and use this confusion as a defense for errors in professional conduct.

Early ethics codes gave a clearly negative, yet, loose definition to unprofessional and unproductive patient relationships. The spirit of these rules stemmed from the early belief that health care providers should not contribute to a patient's problems. Thus, the professional should not enter into a treatment relationship that is in the long run destructive to the individual that he or she is being called upon to treat. Again, increased awareness of these types of problems is clearly evident in the growing concern over the sexual conduct of therapists with clients. This interest has resulted in many valuable publications on this topic over the past few years

(Pope and Bouhoutsos, 1986; Pope, Keith-Spiegel, and Tabachnick, 1986; Pope, 1987; Bates & Brodsky, 1988). This work has demonstrated how serious the negative impact of sexual intimacies is to one's patients with the end result of this work being a series of clear regulations regarding this type of behavior on the part of licensed and professional psychologists. Yet, while we have successfully defined sexual intimacies with patients as unethical, and in many states illegal, we continue to have difficulty in accurately defining other areas of relationship violations.

It is quite clear how psychology professionals feel about appropriate professional relationships. Principle 6a of the most recent Ethical Principles of Psychologists (1981) clearly states:

Psychologists are continually cognizant of their own needs and of their potential influential position vis-a-vis persons such as clients, student, and subordinates. They avoid exploiting the trust and dependency of such persons. Psychologists make every effort to avoid dual relationships that could impair their professional judgment or increase risk of exploitation. Examples of such dual relationships include, but are not limited to, research with and treatment of employees, student, supervisees, close friends or relatives. Sexual intimacies with clients are unethical. (p. 636)

With this statement, psychologists clearly have taken a position that exploitive and dual relationships with patients and others are unethical. Yet, in areas other than that of sexual intimacies, very little has been done to define exactly what those unethical relationships are and many of the supporting publications in this area have been theoretical or general in nature. As it is written, the current code raises some significant and not so easily answered questions. Is a sexual intimacy with a client more serious than one with a supervisee or student? When does a close therapeutic alliance become a dual relationship? When does a dual relationship become unethical? Is there a difference between unethical and illegal dual relationships? Are some types of dual relationships more serious than others? When does kindness from a client become a dual relationship? And, are all dual relationships detrimental to the client and therefore unethical? These questions are not easily answered when one reviews the relevant literature.

The current Code also creates a substantial problem in a legal sense where courtroom and administrative proceedings demand precise definitions and professional psychologists are called upon to testify regarding what is and what isn't competent professional practice. The general lack of specificity in this area makes the task of the expert or ethics committee member much more difficult in deciding what is or is not ethical and acceptable professional practice. Additionally, this confusion makes it easier for violators to use the lack of clarity as a defense in and of itself. The position becomes, "How can something that is unethical or illegal be so poorly defined, and where is the data to support this contention?"

Kitchener (1988) reviewed the topic of dual relationships and arrived at the conclusion that in general these relationships are "ethically problematic" and that the area is less well defined than it should be. She has taken the position that as the inequity between the two roles increases so does the opportunity for exploitation. Thus, when the demands of the roles differ widely, the situation becomes much more problematic than when roles are not

highly divergent. To exemplify, there are fewer problems when a dual relationship exists between the roles of a professor and supervisor than when the professor also serves as therapist. Also, problems come from the incompatibility of expectations and loss of objectivity by the therapist because of divided loyalties that come from the two roles. Her final area of concern lies with the loss of protective objectivity on the part of the client when confronted with the power and prestige of the professional's role. In essence the client loses some degree of concern about his or her own best interests by being placed in the client role. She clearly states that "when the conflict of interests is great, the power differential large, and the role expectations incompatible, the potential for harm is so great that the relationship should be considered a priori unethical" (p. 220).

In essence, while the profession clearly has been adequate in defining sexual intimacies with clients as unethical other types of dual relationship violations clearly need definition. Leaving this area poorly defined only increases the likelihood of confusion over this topic and leaves the area open for exploitation.

Individuals in academic settings might feel that the constraints on sexual intimacies are limited to the actual therapy setting, yet there is a growing body of evidence on the effect of sexual exploitation outside of the therapy setting. As an example, research conducted by Robinson and Reid (1985) has shown that there is a substantial amount of sexual exploitation that occurs in the educational environment. Over 48% of female graduate students in their study reported that they have been subjected to sexual seduction by faculty members and 13.6% reported actual sexual contact. Work by Glaser and Thorpe (1986) reports that 36% of the women who engaged in sexual relationships with faculty felt that the experience was destructive to them. This type of behavior on the part of faculty members lends support to the contention that if a female student will produce in an intimate way the faculty member will be more likely to produce in an academic one.

The licensing laws of states like California do not necessarily define exploitation of a student by a faculty member as illegal, and many university faculty members are not licensed providers and are not regulated by the state anyway. The American Psychological Association, though, has made its position on one aspect of this matter perfectly clear by stating that sexual relationships between clinical supervisors and supervisees are violations of the ethics code and therefore are unethical (APA Monitor, 1988). Yet, this position does not clearly protect other types of academic relationships such as business relationships from being exploited.

The rapid growth seen in these types of violations requires the attention of the profession at large. Reports from the American Psychological Association (1988) indicate that dual relationship violations constitute the most frequent type of violation found by the Ethics Committee. While a large number of these violations are sexual intimacy violations the Ethics Committee expressed clear concern over the dangers of nonsexual dual relationships and how the development of this type of relationship increases the likelihood that the relationship will become sexual (Borys, 1988). Regardless of whether the relationship becomes sexual, the data coming from dual relationships research indicates that such relationships are destructive to the patient (Pope & Bouhoutsos, 1986; Borys, 1988).

The problems and confusion with the concept of dual relationship become much clearer when they are applied to the general therapeutic setting. While psychotherapy is supposed to be a "pure," one way relationship, in reality, therapy creates, or has the potential for creating, a setting for the development of very complex relationships. In actuality, nothing is pure or ideal, and while there can be little doubt about a therapist's responsibility to avoid damage to a client, one would find it quite difficult to create a pure, one way psychotherapeutic relationship in today's complex office or clinic practice. At times, it becomes confusing to separate concepts of bonding from friendship. Is it a dual relationship violation when a client wants to do a favor for or give a gift to his or her therapist? In a theoretical sense, the rejection of such a gift could create as much difficulty therapeutically as allowing the client to express his or her feelings of kindness and appreciation. Is it not possible that a client could feel rejected by a therapist who always set limits and refused an extension of personal appreciation from a client? If a therapist were to accept a gift with full recognition of the fact that it would not detract from the therapeutic process, would such an action be an ethics or legal violation? It is clearly arguable that the acceptance of such a gift would not be unethical since something that is not harmful should not be unethical or illegal. Yet allowing such actions to occur clearly sets up a potential for patient exploitation. Thus, it becomes very evident that the therapist must be given clear and realistic guidelines about patient exploitation and dual relationships that also allow some degree of professional judgment as to what might and might not be destructive to the patient.

Recent articles in Newsweek (1988) and the Los Angeles Times (1988) have brought popular attention to the problem of dual relationships in psychotherapy. These publications discuss the case of Brian Wilson, the creative genius of the Beach Boys, and how his psychologist, Eugene Landy, may have misused the power of his role as a therapist to benefit himself beyond normal compensation for professional services. The articles state Landy used his professional position to develop new and unrelated roles with Wilson outside of the psychotherapy relationship and that this resulted in increased personal income to him. As an example, Landy is credited as the executive producer of Brian Wilson's newest album and has written the lyrics to a number of the songs in it. Because of these allegations and other unrelated ones, the State of California early in 1988 filed licensure violation charges against Landy. In 1989, a settlement was reached in which he voluntarily surrendered his license for 2 years only agreeing that he prescribed medications illegally to Brian Wilson. After that period of time Dr. Landy will be able to reapply to the Psychology Examining Committee for licensure. No agreement as to dual relationship violations came out of this settlement, and Brian Wilson continues to contend that Dr. Landy was responsible for his recovery from years of psychological disability. The question as to whether Dr. Landy in fact "exploited" Brian Wilson in essence remains unanswered.

A possible solution to some of the problems in this area might be found if the American Psychological Association applied the following standard to psychologist-patient and psychologist-student psychologist relationships. A dual relationship should be considered unethical if it in any way harms the patient. This harm could be defined in psychological, physical, and material terms. Additionally, relationships that result in any opportunities to the psychologist that would not have been available without the original therapy contact or outside of the educational setting would also be considered

unethical. Thus, gain that is beyond compensation for professional services or educational remuneration would be a violation unless it could be established that the same opportunity was available to all. The proof for this equal opportunity provision should rest with the psychologist in question and not with the profession. It would also appear helpful to set some limit on gift giving that allows the professional some degree of flexibility in accepting extensions of kindness from clients or students and yet sets clear monetary limits.

In the world of professional regulation we must create a rule system that carries the spirit of the ideal; yet, in fact, it is one that we can apply realistically in both a professional and legal sense. The position of the American Psychological Association must allow flexibility to the professional and yet give clear guidelines regarding what is and what is not accepted practice. The American Psychological Association must proceed to more clearly define what is and what is not a dual relationship violation. While we cannot realistically expect perfection in this area, just as we have defined sexual intimacies as unethical, we should begin to define other types of unacceptable practice as unethical as well. To avoid doing so only lends confusion to this overall area and renders the subject vulnerable to constant debate. While this move is clearly underway the continued confusion points out the need for more work to be done. If we as a profession do not define this area better, there exists a distinct possibility that others will do it for us.

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UNDERSTANDING FAMILY AND COMMUNITY VIOLENCE

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Violence induced trauma has become a more frequently occurring phenomenon in communities. In order to initiate an effective intervention program on behalf of victims, survivors, and the community, one must understand and consider the characteristics of the people involved in the incident, the recovery stages usually experienced, and the progression of symptoms over time. The purpose of this paper is to provide information about these issues for the individual concerned with helping the family and/or community cope effectively with violence induced trauma.

PEOPLE CHARACTERISTICS

Victims/Survivors

The victims and survivors of violence induced trauma are typically normal people attempting to cope with an abnormal crisis or life situation. The recovery from violence induced trauma by normal people may be facilitated with the provision of necessary skills and knowledge to cope and through effective use of existing support systems. In some instances, work may be necessary to reconstitute the existing support systems because the violent incident may have fragmented the support system. Hence, intervention efforts should include (a) provision of psychoeducational skills and knowledge about "normal" reactions and adaptation to violence and (b) efforts to utilize and/or reconstitute support systems which were in place before the violence experience.

Experience factors with community and family violence suggest that about 5% of a violence-experienced group are "at risk" for severe psychiatric responses to the violence event and experience. Some especially vulnerable individuals are (a) people with a history of clinically significant psychiatric disorders, (b) people with no or only limited support systems in their lives, (c) people who experienced eye-to-eye contact with the perpetrator during the violence episode, and (d) "heroes" whose heroic roles do not encourage "working through" experiences with others.

A hierarchy of victims/survivors may be conceptualized in three concentric circles (see Figure 1). Victims and survivors in the innermost circle are all individuals who were exposed or potentially exposed to the violence, especially life or death events.

Individuals in the middle circle are members of the victims' or survivors' households and other very intimate family members or significant others. In other words, these are the people most likely to be a part of critical support systems.

Chris Hatcher, Ph.D., is acknowledged as the consulting director of this program. His contributions of time, knowledge, and skills were invaluable.

Finally, individuals in the outer circle are friends and acquaintances of the victims and survivors. In rural and smaller communities, schools will probably warrant special attention. This is especially true if victims/survivors are children, parents of school children, or faculty/staff of the school.

This conceptual hierarchy of victims/survivors provides triage guidelines for community assistance efforts, especially in terms of intervention focus and timing.

One survivor of special interest is the "phantom" survivor. This is an individual who is a usual member of the environment in which the violence occurred. However, due to some circumstance, the individual was not present at the time of the violence episode. This person experiences many of the responses of the affected group, but is unable to completely appreciate the victims' responses due to not being present. Hence, the "phantom" survivor's group membership is disrupted. The individual often experiences considerable guilt or uneasiness (left out?) feelings. Simultaneously, he/she may feel relieved to have been spared the experience. In any event, this person will need to be included in work with the victims.

Any victim of a violent episode that had an experience that is remarkably different from other victims will probably need to be monitored closely. For example, solitary hostages, heroes, individuals given special treatment by the perpetrator, individuals who made eye to eye contact with the perpetrator, etc. often find reintegration into the pre-existing support structure difficult at some point in the recovery process.

Perpetrators

Although very little conclusive knowledge exists about the characteristics of perpetrators of family or mass murder, some information is known about family perpetrators. For example, they tend to be middle aged, white males and reclusive. They also tend to believe their families belong to them and will continue to belong to them after death. Hence, the perpetrators will not lose their family attachments and may, in fact, spare family members pain of living through death. Interestingly, one or more members of the perpetrator's family often have prior knowledge of plans for the murder (often for long periods of time). The reasons for family members not taking preventive action are many, varied, and open to conjecture.

PROCESS CHARACTERISTICS

Victim Response Stages

The victims of violence typically have an initial response to a violent situation with "recoil." This stage may last from a few hours to several days. Its main characteristic is a sense of unreality accompanied by feelings of horror, shock, numbness, confusion, and vulnerability. During this period, people tend to be hypervigilant, experience sleep problems, experience phobic avoidance or uncontrolled attraction to reminders of the event, and often fear they are "going crazy."

The second stage of victim response is "behavioral search." During this period of recovery, the individual is beginning to attempt to regain some sense of control and impact over his/her experiences with violence. They cannot deny or control the fact of the violence, the reality of the injuries or death of other victims, or the existence and harmful intent of the perpetrator. However, during this time, they can obtain some sense of mastery of the concrete events and behavioral responses that occurred during the violent episode. During this time, intervention may focus beneficially on "knowing more" about the events, experiences of others (especially, their knowledge of events), and behavioral realities of the situation.

After survivors have a satisfactory understanding of the events in the violent episode, they begin a "cognitive search" to develop a cognitive understanding and control of the incident. During this time, the survivors are attempting to understand "why" events and behaviors occurred. It is important that any intervention permit a variety of understandings that best fits the individuals' needs in order for the victim to cope and recover more effectively.

After the victims have developed satisfactory, general understandings of the violence events, they begin a more personal evaluation and understanding of the violent event. They evaluate their behaviors in the incident and begin to formulate how they might have handled the situation differently. These strategies often are heroic, involving behaviors that prevent death or injuries to others. This phase of recovery may be beneficial in terms of providing an effective coping behavior for future violent situations. It also often results in changes in everyday life patterns that are more cautious and safety oriented.

The next stage is often referred to as "revenge." The victim often begins to experience a sense of guilt and has a strong need to overcome the guilt. During this stage, the victim often becomes quite agitated and has a strong need to take action. This is probably the first time the victim has genuine rage and vengeance feelings towards the perpetrator. The nature of the individuals' plans or fantasies for revenge may often be quite violent and cruel. However, again, the intervention should facilitate movement through this stage rather than being judgmental.

The "revenge" stage may produce some family interaction problems because it comes rather late in the recovery phase of the victim but almost immediately after the violent incident for family and community members. Victims will often feign rage earlier in the recovery phase in order to meet the expectations of significant others (e.g., family) and/or to be "normal" (believing their responses and feelings are somehow "crazy"). When the rage and agitation finally do occur for the victims, others may be surprised because the time since the violence episode was "so long ago."

In the final phase, the victims have developed a behavioral, cognitive, and emotional understanding of the event that is acceptable to themselves. In this "integration stage" the victims are developing a "moral handle" on the situation and integrating the experiences and knowledge from the violence episode into their value systems. It is not unusual for victims in this stage to recall that they had a sense of the violence experience occurring to someone else. It was almost as if they were watching the events occur in a movie or outside their body. During this stage, they begin to integrate the experience

and acknowledge the psychological experiences as their own. For the first time, many of the victims will report their disgust and revulsion with their behaviors in the violence episode and how their behaviors had somehow violated their basic sense of who they were as human beings.

It is essential that victims, family members, and significant members of support groups understand this recovery sequence. Often individuals are in different places in the recovery sequence and, therefore, need to understand the process and inevitability of people being in "different places." This understanding of the process should also help people understand an individual's (especially the victim's) possible change in life emphases (e.g., family becomes more important, mortality becomes more of a reality, previous priorities suddenly seem less important).

Progression of Time

The first one or two weeks are a "peak period" during which victims experience being totally out of control. The individuals experience terror, hypervigilance, and a concern about "will this ever end?"

At about two weeks, victims often experience some sense of relief. However, individuals typically continue to have flashbacks, intruding thoughts, and inability to totally "put the experience behind them."

Generally, life returns to "normal" after about six months. However, the victims must be reminded that their lives will never be the same again, that they will never forget the experience, and that their lives will be full again. In fact, somehow they will probably be stronger and wiser for the experience.

When discussing the time line for recovery, debriefing personnel must be cautious about the varied recovery times for different people. This caution is necessary for at least two reasons. One, victims may assume time will heal the problems and, therefore, not invest themselves in the recovery process. Two, these time lines are only guidelines. Many victims may believe that, if they have not recovered according to the time lines, they are emotionally weak or going "crazy."

INFORMATION REFERRAL SOURCES

Several agencies are available to provide information and consultation for individuals, agencies, and communities concerned with managing or planning for violent incidents. These agencies include

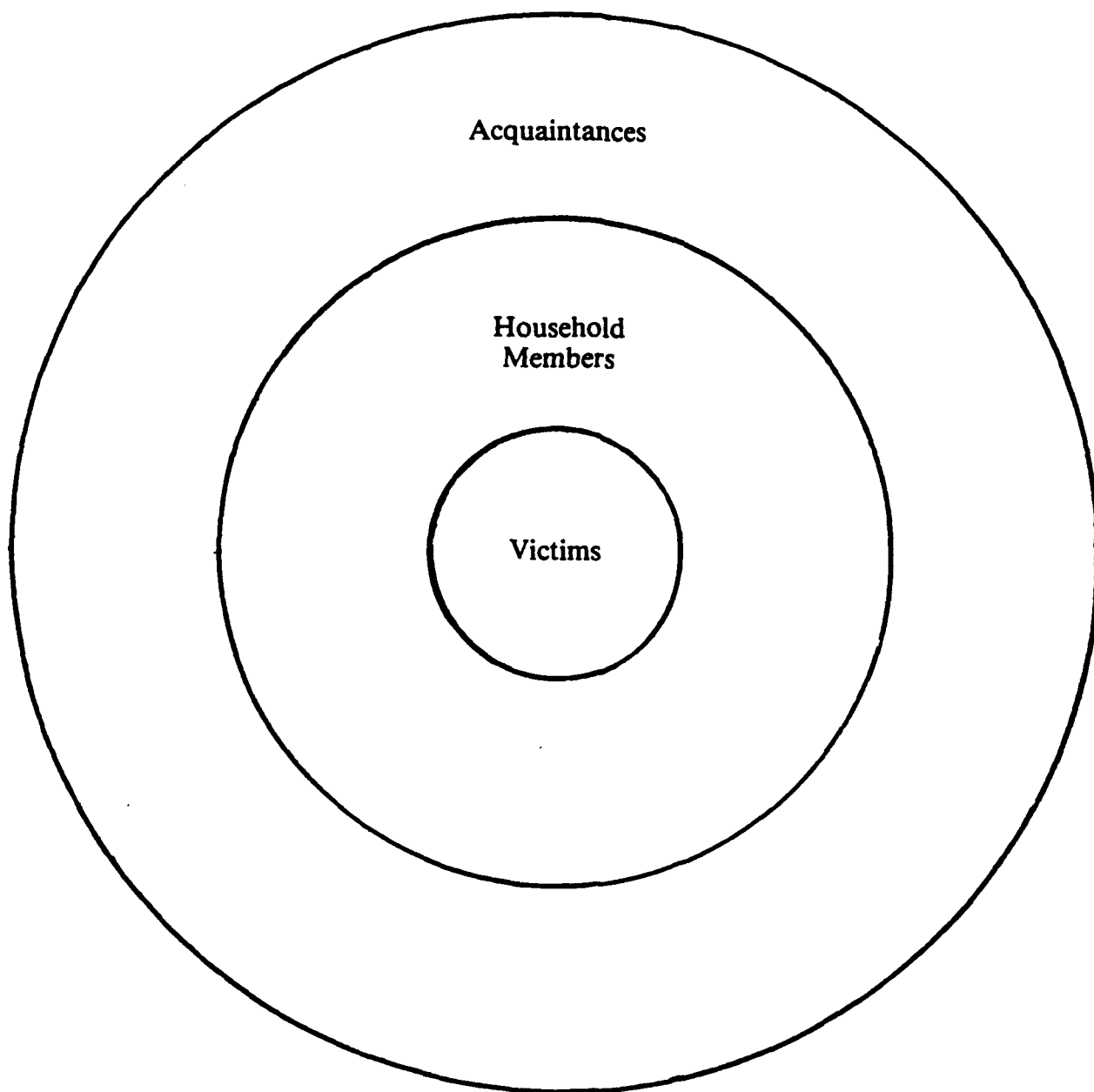
1. Federal Emergency Management Agency (FEMA)
2. Organization of Emergency Services (state OES)
3. National Institute of Mental Health (Disaster Section)
4. National Organization for Victim Assistance (NOVA).

In the opinion of the writer, communities need to manage as many violent aspects of violent crises as possible. Resources outside of the community should be in as limited consultant roles as possible. This will allow the community to continue to manage situations as the recovery process continues and after outside agencies have withdrawn. This will also help the community be prepared for future crises. The judgment about the extent to which outside assistance will be utilized is critical!

CONCLUSION

Violence and catastrophic disasters are "abnormal" events that occasionally occur to "normal" people. These people often have not had the opportunity to cope with such traumatic episodes. Therefore, they often lack the skills and information to optimally cope with the traumatic situations and their personal responses to the situations. Fortunately, most of these people will "recover" and return to productive lives. However, the "recovery" can be facilitated with provisions of basic information and skills by trained professionals in violence/disaster intervention. This paper has attempted to provide some basic knowledge about the characteristics of the people and processes typically involved in violence/disaster situations. It is hoped this information can be used by professionals to plan intervention strategies and by victims to understand and cope with violence/disasters more effectively.

FIGURE 1
IMPACT EFFECT OF VIOLENCE/DISASTER



PEACETIME STRESS CASUALTIES:
CHARACTERISTICS AND IMPLICATIONS FOR ARMY PSYCHOLOGY

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A review of clinical records closed over a six-month period at two mental health activities was conducted. Data representing 21 variables were obtained from 659 individual case files closed between 1 January 1988 and 30 June 1988 at the Division Mental Health Activity at Fort Stewart, Georgia, and the Community Mental Health Activity at Fort Gordon, Georgia. The intent of the record review was to obtain data regarding the number of individuals seen in each setting for treatment during that time period and the services received. In addition, the diagnoses of each individual and other factors such as presence of suicidal ideation/intent at intake, prior and subsequent hospitalizations, discharges from the Army, treatment outcome, and selected patient demographic data were also collected and analyzed.

The experiences of western military forces during this century have indicated that psychiatric/combat stress casualties represent a significant proportion of the total troops lost to forces engaged in conflict. Changing patterns of warfare and technological developments have challenged military psychology and psychiatry to develop more effective responses to combat-related stress reactions. Current American military doctrine for dealing effectively with combat stress casualties has been primarily developed from the experiences of United States forces in twentieth century conflicts (Gabriel, 1986). Our knowledge of and approach to dealing with the casualties of mid- to high-intensity conflict have also been enhanced by the experiences of the Israeli Defense Force in the Middle East. Currently, the Army is considering the creation of Combat Stress Control Units as one means of meeting the challenge of combat stress casualties (AHS, 1988). Although approval of the Combat Stress Control unit has not been made, the proposal is illustrative of the Army's serious concern with the problem posed by wartime psychiatric casualties. However, it appears that even in the absence of combat-related stressors, the Army experiences significant losses of available manpower during peacetime as a result of psychiatric/psychological problems.

This research project is part of a proposed larger study to be continued at additional sites in the future. The long range goals of the study would be to increase knowledge and understanding of the types of patients seen in Army mental health activities and the level of services provided to those patients. In addition, this project was undertaken with the purpose of obtaining a better picture of soldiers lost to the Army, at least in part, due to psychological difficulties. These "peacetime psychiatric casualties" represent a constant drain on Army manpower and resources. In addition, how this problem is being dealt with may have significant implications for the role of Army psychologists.

METHOD

Subjects

Project workers reviewed the case files of active duty soldiers whose clinical records were closed between 1 January 1988 and 30 June 1988 at the Division Mental Health Activity at Fort Stewart, Georgia, and the Community Mental Health Activity at Fort Gordon, Georgia. During the 6 month time period, 412 case files were closed at the Fort Gordon CMHA, and 247 records were closed at the Fort Stewart DMHA, making a total of 659 records reviewed in this study. Only records of soldiers who were being seen in treatment were included in the study. Case files opened on individuals for purposes other than treatment (e.g., drill instructor applicants, personnel reliability programs) were not included.

Procedure

A review of clinical records closed over a 6-month period at two mental health activities was conducted. Data representing 21 variables were obtained including the diagnoses of each individual, factors such as presence of suicidal ideation/intent at intake, prior and subsequent hospitalizations, discharge from the Army, treatment outcome, and selected patient demographic data. The data collection was facilitated using a simple protocol available from the author.

RESULTS AND DISCUSSION

Discharged vs. Retained Soldiers

Of the 659 soldiers treated at the two mental health facilities, 139 (21.1%) were discharged from the military. The ratio of males to females for the discharged group was about 2 to 1 compared to a 3 to 1 ratio in the retained group. The mean number of treatment/evaluation sessions discharged and non-discharged soldiers received was 4.2 and 3.6, respectively. The discharged and retained groups differed somewhat in terms of marital status in the following respective percentages: single, 60% versus 40.1%; married, 31.6% versus 48.9%; divorced, 6.5% versus 8.7%; separated, 2.9% versus 8.8%.

Although there was considerable variability, discharged soldiers tended to have spent less time in the service compared to retained soldiers. Specifically, retained soldiers averaged about 50 months active duty service compared to about 20 months active duty service for discharged individuals. Among soldiers who were discharged, the majority tended to have less than 12 months active duty prior to being seen for evaluation/treatment. There did not appear to be much difference between the groups in terms of history of previous outpatient treatment, with 18.9% of the discharged group and 14.0% of the retained group reporting outpatient therapy experiences prior to the date of intake. Referral patterns for the two groups also differed with discharged soldiers being more likely to have been a command referral (51.8% vs. 32.6%), and less likely to be either a self referral (19.4% vs. 29.7%) or a hospital referral (10.8% vs. 16.3%).

Differences Between Duty Stations

The differential discharge rate for the two posts was reviewed to determine if there was a difference in regards to their particular "casualty rate." This analysis was further broken down into subgroups based on rank (i.e., E-1 through E-3 and E-4 through E-6). Of all the soldiers between the

grades of E-1 and E-3 seen at Fort Gordon, 36.3% obtained a discharge from the Army. The same group of soldiers at Fort Stewart obtained discharges at about half that rate (15.5%). Among soldiers grade E-4 to E-6 seen at Fort Gordon, about 8.2% were listed as discharged. At Fort Stewart, this same group of mid-level enlisted soldiers was discharged at about twice that rate, 16.5% listed as discharged.

Suicidal Ideation, Behavior, and Hospitalization

Approximately 21.0% of all the soldiers involved in the study expressed some degree of suicidal ideation around the time of the intake. Of these 135 soldiers, about one-third also made some type of suicidal gesture. Discharges were awarded to approximately one-third of the soldiers expressing suicidal ideation (35.5%). When partitioned by duty station, it appears that 43.3% of the soldiers expressing suicidal ideation at Fort Gordon were discharged compared to about a 15.8% discharge rate among Fort Stewart soldiers. Regardless of duty station, about one-third of all soldiers expressing suicidal thoughts also made some type of suicidal gesture. Among all individuals who received a discharge from the military, 37.0% had been hospitalized prior to or soon after the intake interview due to their psychological difficulties.

Treatment Outcome

Of the 659 case files reviewed, it appeared that about one-third (37.7% of cases with known outcome) of the interventions resulted in some improvement or positive resolution of the presenting problem. For another third of the sample (32.8%), the condition of the individual appeared to be largely unchanged at the time services were terminated. It is important to consider that these individuals may not represent treatment failures. The fact that they were returned to duty suggests that they were capable of functioning as soldiers, and as such probably represent a treatment success for the purposes of the military. Among cases with a discernible outcome, about one-fourth were discharged from the service (24.8%). Whether or not the discharge was part of a negative or positive treatment outcome was not addressed.

Diagnostic Practices

Overall, the diagnoses awarded to individuals in the samples examined tended to be relatively "mild" Axis I disorders. Axis II diagnoses were utilized rather sparingly. There appeared to be few differences between retained soldiers and discharged soldiers in terms of the diagnoses awarded. On Axis I, the two groups differed only in that fewer V-codes were applied to discharged soldiers (29.5% vs. 48.6%) and substance abuse/dependence disorders were about twice as common (14.7% vs. 7.6%). In addition, while a diagnosis of Antisocial Personality Disorder was predictive of discharge in every case where it occurred, other Axis II diagnoses did not appear to discriminate between the retained and discharged groups. Appendix A contains a breakdown of the frequency with which various diagnostic categories were assigned to discharged versus retained soldiers.

The predominance of V-Codes and Adjustment Disorders would seem to be expected. However, it is interesting to note that a diagnosis of Dysthymia occurred very rarely although the DSM-III-R suggests that this is a relatively common disorder. It may be that clinicians are tending to choose diagnoses of lesser "severity" in order to minimize potential labeling effects or for some other reason. Regardless, it may be important to consider whether these diagnostic practices are accurate and representative of ideal standards of

professional practice. An alternative hypothesis suggested by the data may be that the military may be eliminating many soldiers who may have been salvageable. It would appear that considerations of the cost-benefit of retention versus elimination of such soldiers from the service may be useful in determining the relative utility to the Army of retaining or discharging soldiers with potentially treatable condition.

General Summary of Findings

From the findings obtained thus far in this project, it appears that psychological/psychiatric services are utilized by soldiers of all ranks. Most individuals appear to be seen for relatively brief interventions, with about three-fourths of soldiers being returned to duty rather than being released from the military. Soldiers who were discharged from the military tended to be younger soldiers with limited active duty service. These individuals generally were diagnosed as suffering from some form of Adjustment Disorder or had their difficulties described in the form of a V-Code. However, there were few overall differences between the diagnoses given to discharged and retained soldiers. A prior history of outpatient treatment did not appear to distinguish retained from discharged personnel, but a significant percentage of individuals who were discharged did have a history of inpatient treatment. Race and marital status did not appear to be related to outcome; female soldiers did tend to be discharged at a somewhat greater rate than male soldiers.

Analogies to Combat Stress Syndrome

It is given that there is some constant rate of psychologically disordered soldiers that can be expected regardless of whether the Army is involved in actual conflict or not. The challenge to Army mental health may be to determine to what length we should go to retain personnel given the relative costs of replacing the soldier.

How much of the problem that we see clinically could be attributable to the "new guy" syndrome in which new additions to units are not adequately integrated into obtaining units? The "new guy" syndrome can arise when soldiers are brought into units with few social supports and put under high pressure to perform. The associated lack of social supports, estrangement from others, and sense of isolation could be predisposing factors in precipitating a higher rate of casualties from new unit additions. There are certainly historical precedents to indicate the chances for survival of new replacements in combat units are significantly poorer than for individuals who have been with a particular unit for some time. It is hypothesized that many of these wartime casualties among newcomers are at least in part attributable to an impaired defensive posture due to high stress. This stress is not attenuated by unit/personnel cohesive forces that serve to protect "veteran" members of units. If this analogy can be applied to the present pattern of peacetime casualties, it may indicate that at present too little is being done to integrate new soldiers into units and that a proactive stance on this matter may be helpful in retaining a greater percentage of soldiers through some "critical period" of adjustment.

Is what we are seeing in both combat-related and peacetime casualties the same basic process, involving a general failure to adapt to new, stressful situations? Are the two types of casualties to be differentiated only by the relative severity of symptoms and a more obvious causal relationship with an easily identifiable stressor? If so, then we may need to try to conceptualize

cases as varying degrees of the same problem. In such a case, given known success rates during combat situations, we may be better off adhering to a similar treatment paradigm when dealing with these individuals in order to increase retention.

FUTURE RESEARCH/CRITICISMS OF CURRENT RESEARCH

A number of areas for improvement and questions for future study became apparent. For one, is there a differential fallout rate (loss through discharge) for different types of units? Hopefully, as additional posts are sampled, some answers will be produced. A better study would include an analysis of TMC's to determine the level of stress related disorders that are seen and treated there (or in the hospital) in order to obtain a better estimate of the true level of stress-related casualties. In the context of this study, gathering such data would be problematic. As such, the obtained results are likely to represent a rather conservative estimate of peacetime casualties. However, it can be argued that similar types of casualties have probably not been appropriately represented in research into wartime psychiatric casualty rates either.

One of the greater problems encountered in gathering this data related to the differential quality of information available about patients from the case files, especially within the intake report/notes. As a means of increasing the quality of service while facilitating research some consideration may be needed toward developing standard methods of information reporting so that the data routinely gathered as part of normal clinical practice can be more easily gathered.

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APPENDIX A

PERCENTAGE FREQUENCY OF DIAGNOSES FOR DISCHARGED AND NONDISCHARGED SOLDIERS

Axis I		Axis II	
DC (n=122)	NDC (n=458)	DC (n=38)	NDC (n=18)
V-Code 29.5	V-Code 48.6	PD NOS 55.3	PD NOS 44.4
AD DM 21.3	AD DM 21.3	ANTI 18.4	BORDER 22.2
ETOH/D 14.7	ETOH/D 7.6	BORDER 15.8	DEPEND 11.1
AD MEF 13.1	AD NOS 5.9	SCHIZD 2.6	SCHZTP 5.5
MAJ D 4.1	MAJ D 4.8	SCHZTP 2.6	HISTRI 5.5
AD DOC 4.1	AD MEF 4.6	HISTRI 2.6	NARCIS 5.5
AD AM 3.3	AD AM 3.3	NARCIS 2.2	AVOID 5.5
ANX D 2.4	ANX D 2.2		
DYSTH 1.6	PTSD 1.9		
PTSD 1.6	AD DOC 1.3		
SCHZ .8	DYSTH .9		
O/PSY .8	O/PSY .6		
BIPOL .8	SCHZ .2		
AD PC .8	DISS D .2		
AD NOS .8			

AD = Adjustment Disorder

PD NOS = Personality Disorder Not
Otherwise Specified

DM = Depressed Mood
MEF = Mixed Emotional Features
DOC = Disturbance of Conduct
AM = Anxious Mood
PC = Physical Complaints
NOS = Not Otherwise Specified
ETOH/D = Substance Abuse/Dependence
MAJ D = Major Depression
ANX D = Anxiety Disorder
DYSTH = Dysthymia
PTSD = Post Traumatic Stress Disorder
SCHZ = Schizophrenia
O/Psy = Other Psychotic Disorder
BIPOL = Bipolar
DISS D = Dissociative Disorder

ANTI = Antisocial
BORDER = Borderline
SCHIZD = Schizoid
SCHZTP = Schizotypal
HISTRI = Histrionic
NARCIS = Narcissistic
DEPEND = Dependent
AVOID = Avoidant

CMHA QUALITY ASSURANCE STUDY OF STRESS MANAGEMENT GROUP

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The purpose of this study was to evaluate the effectiveness of the stress management group offered at CMHA, Fort Gordon, and to compare its effectiveness with two alternative group formats and a control group. The first of four groups involved continuing the group as it had existed before and collecting data on its effectiveness. The patients in this group ("existing group") were invited to participate in weekly, one hour groups as many times and as often as they chose. The patients in a second group ("commitment group") were asked to commit to attending four consecutive weeks of group. The patients in the third group ("closed group") were assigned to a four week stress group that was closed to new members. A fourth group ("control group") was offered individual treatment for stress on an as-needed basis. At the time of this writing, the first three groups mentioned above had been completed. The results suggest the presence of a significant Hawthorn Effect (attendance increased markedly just by initiating the study). Patients reported significant symptom reduction in all three groups. This reduction in symptoms was greatest for the existing and closed groups. Another significant finding was the difference in patient and staff behavior as the result of participating in quality assurance research. This study was discussed as a useful tool for improving and measuring the effectiveness of stress group treatment. As such, results can be shared by different Army facilities and can be part of a larger research contribution made by Army psychologists.

The treatment of stress is an important service offered by Community Mental Health Activities. This is because of the large number of patients whose presenting problem is stress or stress related. Stress patients are generally treated in stress management groups. This allows CMHA personnel to effectively treat large numbers of patients. The utilization of this treatment modality is supported by research (Meichenbaum, 1977) which demonstrates its effectiveness to be at least equal to the individual treatment of stress.

The success of stress management groups is related to the primary goals of treatment: education about stress, the teaching and practicing of stress management techniques, and support. The group format is well-suited to accomplishing these treatment goals. The group format assists the educational component of the treatment because of the many real-life examples that can be shared and demonstrated. Newly acquired stress management skills (RET, assertion) can be practiced in the group. The group format allows members to realize that they are not alone in suffering from stress. They can benefit from the success and support of the other group members.

The purpose of this study was to evaluate the effectiveness of the stress management group at CMHA, FT Gordon, and to compare it to two alternative stress group formats. The existing stress management group invited patients to participate in the group as many times and as often as they chose. Patients were offered weekly, one-hour group sessions.

Although this open format appeared satisfactory, a review of the attendance records for October, November, and December 1987 indicated that the average number of meetings attended by patients was 1.6 (the mode was 1.0). This raised the question as to what produced this attendance pattern. Three explanations appeared most likely. The first explanation was that stress patients who came to CMHA, FT Gordon, recovered with little or no treatment. The second explanation was that the stress group provided patients with the information and experience necessary to stabilize and improve their stress level in one or two sessions. The third explanation was that patients dropped out of the group prematurely because of demanding schedules, some marginal relief from symptoms, and a desire not to fall even further behind in their duties.

The goal of this study was to collect data that would shed light on which of these explanations appeared most accurate at CMHA, FT Gordon. If either of the first two explanations was correct, then the existing stress management group would remain sufficient. However, if the third explanation was correct, then it may be argued that the patients were not receiving adequate treatment. If the treatment was inadequate, then it may have resulted in more serious problems for some patients and in chronic stress and stress-related symptoms in others. The possibility of chronic stress and recurring stress raises an issue about prevention of future stress. Ideally, treatment for stress management would provide an individual with the tools to manage future stress more effectively. It is doubtful that this goal of stress treatment was accomplished in one or two group sessions.

Since it was believed that the existing group structure was at least inadequate for stress inoculation, it was decided that a group format that encouraged a commitment to a minimum of four group sessions would be employed in this study to determine if it led to greater improvement in reported stress. Most studies reported in the literature appear to use a closed group format. However, the existing group in this study has an open group structure. In selecting a format (open or closed) for the four session group to be employed in this study, researchers found that little information exists about whether different results are obtained from groups with open and closed formats. It was decided that a closed group structure would allow a better comparison between this study and other studies reported in the literature. In addition, an open group with four week attendance commitment was also included to permit a separate analysis of the effects of an attendance commitment and open versus closed group format.

This study involved four groups designed to test the effectiveness of the existing stress management group and to compare its effectiveness with two alternative group formats and a control. The first comparison group asked subjects to make a commitment to four consecutive weeks of group. This group permitted an analysis of the effect of commitment to treatment (four weeks) and increased exposure to stress management treatment.

The second comparison group assigned subjects to a four week stress group that was closed to new members and started and ended on the same day for all members. This group permitted an analysis of the effect of stable group membership on variables such as development of trust, group support, and a shared treatment experience.

The patients assigned to the control group were invited to follow-up as needed for weekly, individual stress management counseling. It was similar to the existing group format, but the treatment was administered individually.

The effectiveness of all treatments was determined by two measures. The first was a 60-item questionnaire developed for the purpose of this study. The questionnaire consisted of all 21 items from the Beck Depression Inventory, the 20 items from the state anxiety portion of the State-Trait Anxiety Inventory, 15 items from the Hopkins Stress Inventory, and 4 general questions about the patients' satisfaction with the treatment provided them. The questionnaire was given to patients before and after treatment to determine the difference in their expressed stress and symptomatology. The second measure of the treatment effectiveness was the graduation rate of the Signal Corps students from their AIT training.

Hypotheses

1. Patients who participate in the open group with no attendance commitment, "existing group," will experience some moderate improvement in their reported complaint as measured by the questionnaire. Their graduation rates will be slightly higher than the "control group."
2. Patients who participate in the open group with a four week attendance commitment, "commitment group," will experience moderate improvement in their reported complaints. Their improvement will be superior to the "existing group." Their graduation rate will also be higher than the existing group.
3. Patients who participate in the closed group with a four week attendance commitment, "closed group," will experience the greatest improvement in their reported complaints. The closed group will also have the highest graduation rate.
4. Patients who participate in the open-ended individual treatment condition with no attendance commitment, "control group," will experience the least improvement in their reported complaints. The control group will also have the lowest graduation rate.

METHOD AND PROCEDURES

Participants

The participants were 26 adult soldiers who came to CMHA for treatment or evaluation. Patients were selected as appropriate for the study if their primary diagnosis was stress or stress-related based on clinical judgment. It had been proposed that the MMPI operate as an additional screening device, but it was not uniformly administered or utilized. The purpose of screening patients was to exclude those patients who were inappropriate for the stress management groups either because of the type or extent of their problems. For example, psychotic patients were not included in the study as their primary diagnosis was not stress and their problems were more appropriately treated using other modalities.

Participants were asked to give informed consent. They were told that the group was being evaluated for its effectiveness. Therefore, their participation would require that they complete a questionnaire before and after the group for evaluation purposes.

Procedure

If the intake clinician's primary diagnosis was stress and the treatment plan included the stress management group, then the patient was told about the study and asked to give informed consent. All 26 subjects gave informed consent and were included in the study. Many patients were asked to take the MMPI at this time (11 participants took the MMPI, 15 did not). No patients were excluded based on their MMPI results. The patients were then asked to arrive one hour early on the day of their first group session to fill out the questionnaire. Patients were assigned to groups based on the order in which they were referred to the study. The first 10 were assigned to the existing group, the next 10 to the commitment group, and the last 6 to the closed group. Posttest questionnaires (the same instrument as the pretest) were administered four weeks after the patients' first group meeting following the scheduled group session. If a subject failed to attend the final group session, he was contacted and asked to complete the poststudy questionnaire as soon as possible.

RESULTS AND DISCUSSION

The results reported in this paper represent the preliminary findings of this study. As the project is not completed, not all of the hypotheses can be addressed. While the final results of this study will be computed using a 2 x 4 MANOVA with one repeated measure, these preliminary findings were based on t-tests. As 18 t-tests were conducted, significance levels of $p < .01$ were used to reduce the probability of obtaining statistical significance by chance alone. The results of graduation rates and patient satisfaction with treatment were analyzed separately.

The pretest-posttest comparison was significant for all three of the completed groups (existing group, $t = 12.25$, $df = 9$, $p < .001$; commitment group, $t = 7.82$, $df = 9$, $p < .001$; and closed group, $t = 14.92$, $df = 5$, $p < .001$). This indicates that all three groups reported improvement in their condition as a result of the treatment.

A comparison of the three treatment groups on the pretest indicates that there were no significant differences. However, the existing group and the closed group both reported greater relief from symptoms than the commitment group (existing X commitment, $t = 7.04$, $df = 5$, $p < .001$). There was not a statistically significant difference in symptom reduction reported by subjects in the existing group and the closed group.

While improvement in condition was reported for all three measures of stress, the greatest amount reported on the Beck Depression Inventory (BDI) and the State-Trait Anxiety Index (STAI). Both of these measures yielded greater reduction in symptoms than 15 items from the Hopkins Symptom Check List - 90 (BDI X Hopkins, $t = 4.31$, $df = 25$, $p < .001$; STAI X Hopkins, $t = 6.49$, $df = 25$, $p < .001$). There was not a statistically significant difference in symptom reduction reported on the BDI and the STAI.

The graduation rate for all three groups was 69%. There were no significant differences between groups on this variable.

Patient satisfaction as measured by the questionnaire was moderate to high. The highest patient satisfaction was reported by the closed group; the lowest satisfaction was reported by the commitment group. The difference in reported satisfaction between these group was significant ($t = 4.85$, $df = 9$, $p < .001$).

One additional finding which seems relevant to the results of this study was the average number of meetings attended by members of the three groups. The average number of meetings attended for each group was as follows: (a) existing group 4.9, (b) commitment group 4.6, and (c) closed group 2.3. This finding was quite unexpected. Historically, the existing group was attending only an average of 1.6 meetings. When the study was initiated, this number jumped to 4.9.

It appears that participating in the study had a significant effect on the attendance pattern of the patients in the existing group. In fact it appeared that this study had a significant impact on the entire clinic. The stress management group facilitators developed for the study group a four session protocol which clarified their weekly treatment goals and provided a logical and thorough treatment regimen. In addition, CMHA clinicians reviewed their assumptions regarding the proper role and utilization of the group.

The Hawthorne effect may account for some of the observed differences noted before and after the initiation of this study. For example, the subjects may have responded to their roles as subjects in the study by being more compliant and attending more sessions. In addition, the patients may have developed a greater commitment to their treatment as a result of completing the questionnaire and, in some cases, taking the MMPI. It is also likely that the group facilitators and the CMHA staff were affected by the knowledge that they were participating in quality assurance research. The staff may have developed a greater commitment to the stress management group.

While it is difficult to tease out which factors accounted for the increased attendance of the existing group, it is likely that this increased attendance resulted in better treatment outcomes and greater patient satisfaction with treatment. This is especially true considering that the average number of meetings attended in the existing group (and the commitment group) was greater than the length of their participation in the study.

The reason for the lower attendance rate in the closed group was that two patients were unexpectedly discharged from the Army after attending a combined total of one meeting. The group started with six members because referrals at that time of year were slow and there was concern about making patients wait too long before administering treatment. After the two patients mentioned above were discharged, the group was left with four members. As data had been obtained for the two discharged members, they were included in the group for statistical analysis. Despite their brief attendance in the group, the group still reported the greatest improvement in their condition. It is likely that if this group were run again with a full complement of patients and subjects attending four treatment sessions, that this group would score even higher than the other two groups.

As hypothesized, all three groups led to improvement in the reported condition of the patients. Also, as hypothesized, the closed group reported the greatest improvement in their reported complaints (though this difference was only statistically significant when compared to the commitment group). The existing group also reported greater reduction of symptoms than the commitment group. This finding, inconsistent with the hypotheses, appears to be at least partially due to the Hawthorne effect which probably accounts for the observation that subjects attended three times as many meetings as had been expected from the stress management group's history.

Also inconsistent with the hypotheses was the finding that there were no statistical differences between groups in their graduation rates. However, it should be noted that the two subjects who failed to graduate from the closed group were discharged from the Army after attending a combined total of one meeting.

While all three measures of stress produced data that were statistically significant, the BDI and the STAI both yielded statistically greater pretest-posttest scores than the Hopkins. This could suggest that the BDI and the STAI are more sensitive to differences in patient condition when patients are exposed to stress management treatment. However, only 15 items from the Hopkins were selected for the study. The use of additional carefully selected items from the Hopkins might yield better results.

This study is incomplete and, when finished, best qualifies as a pilot study. A major lesson learned from this study is the potential significance of the Hawthorne effect. By itself, the apparent magnitude of the Hawthorne effect alone in this study argues in favor of conducting studies similar to this one. It appeared that the study improved the services rendered and patient satisfaction with their treatment. It was reassuring that all forms of the stress management group led to improvement in patient condition. Further study in this area could help determine whether significant differences exist for various group formats and whether these reported improvements are greater than would be reported by a control group. Given the relative importance of stress management groups throughout the US Army, it would appear that Army psychologists have much to contribute by conducting studies of this nature.

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TABLE 1

CMHA QUALITY ASSURANCE STUDY GROUP MEANS ON BDI, STAI, AND HOPKINS

	Pretest	Posttest
Existing Group		
BDI	18.1	6.9
STAI	54.3	43.0
Hopkins	23.8	18.0
Commitment Group		
BDI	17.1	8.2
STAI	52.0	46.0
Hopkins	25.7	23.3
Closed Group		
BDI	16.7	5.7
STAI	57.2	42.2
Hopkins	21.0	13.0
Control Group		
BDI	NA	NA
STAI	NA	NA
Hopkins	NA	NA

TABLE 2

CMHA QUALITY ASSURANCE STUDY GROUP MEAN DIFFERENCE SCORES BETWEEN
PRETEST AND POSTTEST MEASURES

	Mean Difference Scores	Mean Meetings Attended	Graduation Rates
Existing Group	28.3	4.9	.60
Commitment Group	17.3	4.6	.80
Closed Group	34.0	2.3	.67
Control Group	NA	NA	NA

THE ARMY HEALTH PSYCHOLOGY FELLOWSHIP

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The Health Psychology Fellowship at William Beaumont Army Medical Center is described. The historical basis for this training program, the evolution to the current structure, and the key professional developments in the speciality area of Health Psychology within the Army are described. As the APA and APIC move toward formalizing accreditation standards for post-doctoral fellowships, the Army needs to be prepared to meet these professional standards and continue to train mid-career psychologists in speciality areas.

HISTORY

An early call for a training program in behavioral medicine was voiced by COL Harris (1980) at the Walter Reed Psychology conference. The purpose stated for the proposed fellowship was to provide a mid-career retention incentive, and to move Army psychology in the same direction that civilian psychology was moving in terms of professional specialization. After initially attempting to organize the fellowship at the Uniformed Services University of Health Sciences, the OTSG approved the mission of the Health Psychology Fellowship for William Beaumont Army Medical Center (WBAMC) in 1982. Military psychologists have been training at WBAMC since 1983. This program was originally described by Jeffrey (1982) and has been reviewed in previous AMEDD proceedings by Greenfield, Greuling, and Rankin (1984). The mission for the Health Psychology Fellowship is

Comprehensive training in behavioral programs designed to promote and maintain health, prevent and treat illness, and identify etiological and diagnostic correlates of health and illness (Matarazzo, 1980).

Experienced Army psychologists are aware that the current Health Psychology Fellowship was largely shaped by the personal efforts of LTC (Ret) Tim Jeffrey who was the mentor for the program from 1983 until his retirement in 1988. In his role as fellowship director Dr. Jeffrey sought to mold the fellowship into a valuable training experience within the bureaucratic limitations imposed by limited personnel and resources. It is largely from the unpublished notes, schedules, and descriptions left by Dr. Jeffrey that this paper is drawn. The health fellowship (perhaps all AMEDD psychology fellowships) was developed and implemented without any additional personnel or resources being committed by the AMEDD. The challenges to provide meaningful training in the absence of tangible support dictated that resources outside of the WBAMC Psychology Service be utilized to the maximum extent possible. This trend toward the use of external resources can perhaps best be illustrated by comparing the description of the 1982 fellowship (Jeffrey, 1982) with the curriculum described later in this paper. The general trend has been toward a more structured sequence of training experiences and less work within Psychology Service.

During its existence, the WBAMC fellowship has trained Drs. Greenfield and Chesnutt, both of whom have been promoted to positions of greater responsibility within the Army. Dr. Robert Rankin was also a graduate who, despite being on the Army promotion list, promoted himself into private practice. Drs. Jeffrey and Rankin trained staff until their departures in 1988. During one year the fellowship was vacant; although this was a source of concern at the time, it actually provided an opportunity for review and improvement of the program. I am the most recent graduate and mentor for the current fellow, Dr. Bob Roland. The selected 1989-1990 fellow is Dr. Dwayne Marrott.

CURRENT STRUCTURE

The current fellowship uses a preceptor model and is designed with sufficient flexibility to satisfy diverse training needs and interests while concurrently providing core training in a wide variety of health issues with behavioral components. The fellowship is structured around 8 required monthly rotations and 4 elective rotations. The 8 required rotations are: readings and research projects (2 months), internal medicine (2 months), cardiology, hematology/oncology, neurology, and gynecology. These required rotations ensure that the fellow is exposed to a wide variety of behaviors and diseases within the field of health psychology. Elective rotations can be scheduled in any department in the hospital. The purpose of the elective rotations is to provide the fellow with the opportunity to develop mastery in one or more areas. Some electives that have been selected are the trauma unit, orthopaedics, and emergency medicine. During the rotations, the fellow is under the control of the physician trainer. Psychology fellows participate fully in training seminars, rounds, case presentations, and treatment procedures within the medical clinic to which they are assigned during the first 2 weeks of each rotation. During the second 2 weeks the fellow and the physician negotiate a training schedule to target specific activities which will maximize the training experience. Most physicians expect the fellow to be involved in teaching medical interns and residents about the behavioral and psychological components of various disease processes. The fellowship director maintains daily contact with the fellow to insure that adequate psychological supervision is maintained. Fellows also take anatomy and physiology, pathophysiology, or other appropriate science courses at the University of Texas at El Paso. Every effort is made to insure that the fellow not become entangled in long term patient contact within Psychology Service. Most of the patient contact that is provided occurs outside of Psychology Service during medical rounds or clinic conferences.

The fellow also has the opportunity to participate in the teaching and supervision of psychology interns in areas related to behavioral medicine. The fellow is individually credentialed in the hospital and is fully qualified to supervise the work of interns. Because the internship brings in consultants the fellow is exposed to additional sources of training by nationally prominent psychologists. The WBAMC staff has programmed one fully funded training conference for each fellow; past fellows have attended training conferences in clinical hypnosis, although this is only one of many possibilities.

PROGRAM REVIEWS

Dr. Jeffrey saw the need for the fellowship to be evaluated and reviewed. Both the APIC post-doctoral committee and the APA were beginning to discuss the development of accreditation standards for fellowships. A group organized under the National Working Conference on Education and Training in Health Psychology was also formulating plans to formalize fellowship standards. In March 1987 the program was reviewed during a 2-day visit by LTC Gillooly, HSC Psychology consultant. Another 2-day external review of the program was conducted by Dr. Tom Boll in July 1987. Dr. Boll is the director of the medical psychology program at the University of Alabama at Birmingham. Both of these reviewers investigated the program's mission, budget, organizational ties, history, description, and selection criteria. Dr. Boll had the advantage of reading Dr. Gillooly's report, and their findings and conclusions were quite similar. The key findings of the reviews emphasized the following points:

1. Dr. Jeffrey was praised for his leadership in developing and sustaining the fellowship. Concern was expressed that because the fellowship had not been institutionally supported by added personnel or resources the loss of Dr. Jeffrey might end the fellowship.
2. The program was seen as well designed and a suitable model for both civilian and military fellowship programs.
3. The clerical support for Psychology Service was seen as inadequate.
4. Additional professional staff were seen as necessary.
5. The total lack of staff involvement in the selection of fellows was criticized.
6. The WBAMC medical library is inadequate. Even the journals that are carried have missing volumes due to inconsistent renewal priorities.
7. The fellowship should spend more effort on preventive or health maintenance issues.
8. The formal standard for health psychology fellowships is likely to be for a 2-year program. The Army needs to prepare to accept this standard when formalized and realize the effect this will have on already limited resources.

The originals of the reports by Drs. Gillooly and Boll are on file at WBAMC. Training directors or prospective fellows can request this information by mail.

FUTURE TRENDS

ABPP certification for Health Psychology is currently being negotiated and developed by a national committee. Dr. Tim Jeffrey and Dr. Tom Boll are both involved in this effort. The negotiations are aimed to allow consummation and announcement of the diplomate agreement at the 1989 APA convention.

APIC published generic criteria (Appendix A) for fellowships in November 1988. These criteria must be met for any fellowship to be listed in the APIC guide. While the benefit to the Army of listing a fellowship in the APIC guide

is questionable, it does seem to represent the first step toward development of formal accreditation criteria for fellowships. By meeting the APIC standards, the Army will be in position to have its post-doctoral training programs "grandfathered" as more explicit accreditation criteria are developed. While it appears that the WBAMC fellowship currently meets the APIC standards, the proposed transfer of the WBAMC internship would reduce the size of the WBAMC psychology staff to one or two positions. This would eliminate the fellowship from meeting the APIC standards since size and availability of staff are important accreditation criteria.

The acquisition of a computerized biofeedback system and office automation are being pursued at WBAMC. While you might expect the health fellowship to have model biofeedback program, it doesn't. In fact, the Fort Huachuca MEDDAC has a biofeedback system that is much superior to the equipment at WBAMC. While many psychologists may have Zenith or Apple computer systems on their desks, the WBAMC clinic has one TRS 80. Both of these problems are being addressed and should help reduce the impact of inadequate clerical help.

CONCLUSION

The Health Psychology Fellowship is a valuable training experience for psychologists interested in preventing, diagnosing, and treating behavioral medical problems. The structured rotations in medical clinics provide a unique opportunity to observe, participate in, and improve the military medical system. The fellowship has proven to be a useful (though not guaranteed) mid-career retention incentive. Previous reviews by Greenfield and Rankin (1984) are informative personalized descriptions of what was learned during the fellowship.

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APIC

association of psychology internship centers

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POST-DOCTORAL CRITERIA

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1. A post-doctoral training program is an organized experience which, in contrast to on-the-job training, is designed to provide the Fellow with a planned, programmed sequence of supervised training experiences. The primary focus and purpose is advanced training in some area or areas of professional psychology.

2. The post-doctoral program has a clearly designated staff psychologist who is responsible for the integrity and quality of the training program and who is currently licensed/certified by the State Board of Examiners in Psychology in the state in which the program exists.

3. The sponsoring institution has two or more psychologists on the staff as supervisors, at least one of whom is currently licensed/certified as a psychologist by the State Board of Examiners in Psychology in the state in which the program exists.

4. Clinical supervision is provided by a staff member of the sponsoring institution who carries clinical responsibility for the cases being supervised. At least half of the clinical supervision is provided by one or more licensed/certified psychologists.

5. At least 25% of the Fellow's time is in direct patient contact.

6. The postdoctoral program includes a minimum of two hours per week of regularly schedules, face-to-face individual supervision with the specific intent of dealing with psychological services rendered directly by the Fellow. There must also be at least two additional hours per week in learning activities, such as: case conferences, involving cases in which the Fellow is actively involved; seminars dealing with clinical issues; co-therapy with a staff person, including discussion; group supervision; additional individual supervision.

7. Postdoctoral training follows completion of doctoral degree requirements and predoctoral internship meeting APIC standards. APA guidelines on specialty change are followed. Fellows having completed doctoral studies in fields other than clinical or counseling psychology have received a certificate of equivalency from an APA-approved university program attesting to their having met APA standards, including the internship.

POSTDOCTORAL CRITERIA

Page 2.

8. Postdoctoral trainees have a title, such as "Intern", "Resident", "Fellow", or other designation of trainee status.
9. The sponsoring institution has a written statement or brochure which describes the goals and content of the program, states clear expectations regarding the Fellow's work, and is made available to prospective Fellows.
10. The postdoctoral training program must be at least one-half time and last at least one year.

* * * * *



DEPARTMENT OF THE ARMY
HEADQUARTERS DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON GEORGIA 30905-5650



HSHF-PN

11 April 1989

MEMORANDUM FOR Commander, USAHPSA, ATTN: SGPS-EDT, 5109 Leesburg Pike,
Falls Church, VA 22041-3258

SUBJECT: After-Action Report - 1989 AMEDD Clinical Psychology Short
Course

1. All actions pertaining to the conduct of the 1989 AMEDD Clinical Psychology Short Course at Augusta, Georgia during the period 13-17 February 1989 have been completed. This report constitutes a summary of all available materials pertaining to the course, to include critiques of individual attendees:

a. Course Overview: The purpose of the 1989 Short Course was to prepare clinical psychologists for the new roles they will assume during the next 1-5 years. To this end, topics presented included forensic psychology (sanity boards, security evaluations, psychological autopsies), licensing and credentialing, preparation for ABPP, legal and ethical issues, and presentations centered on child and family issues. In addition, presentations were given in more traditional clinical areas such as Neuropsychology and Psychotherapy.

b. Course Content: (See attached course program). In keeping with the course objectives, approximately 60 percent of the training hours were devoted to military unique subject matter. Of particular interest were the presentations on the administratively separate Psychology Service.

c. Faculty/Guest Speakers: The faculty consisted of 20 military psychologists, both active and reserve, and 17 civilian psychologists. The 17 civilian guest speakers were drawn mostly from the local Medical College of Georgia and the Veterans Administration Hospital and made a significant contribution to the conference. They were able to provide information as to the current research on a variety of relevant topics. Our primary civilian guest speaker, Dr. James Youniss, Ph.D., Professor of Psychology, The Catholic University of America, Washington, DC, was especially well received. He would make a valuable contribution to any future conference. A complete listing of the faculty/guest speakers is provided at the back of the attached course program.

d. Course Attendees: There were 48 active Army and 8 reserve component psychologists in attendance. See attached list of course attendees.

e. Attached is a copy of the course critique for a tally of all responses.

(1) A review of the distribution of responses and weighted averages for the first three questions reveals that attendees viewed the

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SUBJECT: After-Action Report - 1989 AMEDD Clinical Psychology Short Course

administrative processing as excellent to superior. They rated the course as excellent compared to other similar courses. However, they rated the facility only as good. We were unable to learn the source of this dissatisfaction.

(2) The cumulative ratings of the course content suggests that the course content was seen as useful, met the stated objectives, and was useful. The overall educational experience was rated 4.78 on a 5 point scale, indicating a very positive response.

(3) With respect to the methods of presentation, participants wanted to see more demonstrations. Lectures were seen by some as excessive, but the majority felt that this method was used appropriately.

(4) The presentations by Dr. James Youniss, MAJ Ed Crandell and MAJ Tom Stephenson were rated 1, 2, and 3 as the most interesting. The presentation by Dr. Rosemary Selby was seen as the least interesting.

f. Course Administration: The perception of the administrative handling of the course by those who responded to the critique was very favorable (3.4 on a 4 point scale). The task of handling the administrative details was greatly simplified due to the assistance of the Fort Gordon Special Projects Office (SPO). The SPO helped in all aspects of the course including transportation, registration and printing as well as providing all of the audio-visual support. The hotel staff and the Augusta-Richmond County Convention and Visitors' Bureau also lent invaluable assistance. The somewhat negative rating of the hotel facility given by some is puzzling. Some individuals did complain of poor heat regulation in their rooms. A careful inspection of available facilities in Augusta which would accommodate a meeting of this size was conducted. The Landmark Hotel was best suited for our purposes and clearly superior to our second choice. New convention facilities are under construction in Augusta and should be available in time for our next turn at hosting this conference.

2. Recommendations for future conferences.

a. February is probably a bad month for any national conference as weather could have been a serious problem.

b. In the final analysis, the funding level of \$31,000 proved adequate for TDY expenses. All individuals who requested funds were

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SUBJECT: After-Action Report - 1989 AMEDD Clinical Psychology Short Course

funded. However, if nationally known speakers are to be obtained, an additional \$5,000 would be needed. When the conference is held in higher cost areas such as San Francisco, \$10,000 to 15,000 additional funding will be necessary for the anticipated attendance.

3 Encls

1. Course Program
2. List of Attendees
3. Course Critique



FRANKLIN R. BROOKS
Lieutenant Colonel, MS
Chief, Psychology Service
Course Director

AMEDD CLINICAL PSYCHOLOGY SHORT COURSE
AUGUSTA, GEORGIA
13-17 February 1989

CONFERENCE ATTENDANCE

<u>NAME</u>	<u>PRESENTING</u>	<u>FUNDING STATUS</u>
MAJ Raymond Anderson, MS, USAR	No	USAR
CPT Dean Aufderheide, MS	No	CENTRAL
CPT Donald Azevedo, MS	No	CENTRAL
MAJ E. Thatcher Beaty, MS	Yes	CENTRAL
MAJ Donald R. Birmingham, MS, USAR	No	USAR
LTC Franklin Brooks, MS	No	NONE
COL Brian H. Chermol, MS	Yes	LOCAL FUNDS
CPT Jerry Ching-Brouwers, MS	No	PCS
CPT Daniel W. Clark, MS	No	NONE
CPT Lang K. Coleman, MS	Yes	CENTRAL
MAJ Edward O. Crandell, MS	Yes	CENTRAL
CPT Shirley A. Corsbie, MS	No	NONE
CPT Bruce Crow, MS	No	CENTRAL
CPT James F. DeGroot, MS, USAR	Yes	NONE
CPT Kenneth A. Delano, MS	Yes	PCS
CPT Carl Dickens, MS	No	CENTRAL
CPT David Ferguson, MS	No	CENTRAL
MAJ Terrence Fullerton, MS	No	CENTRAL
CPT Gregory A. Gahn, MS	Yes	CENTRAL
MAJ Fred Garland, MS	NO	NONE
CPT Hodges Glenn, MS	No	LOCAL FUNDS
LTC Dennis J. Grill, MS	Yes	CENTRAL
CPT Herbert M. Gupton, MS	No	LOCAL FUNDS

<u>NAME</u>	<u>PRESENTING</u>	<u>FUNDING STATUS</u>
CPT Eileen M. Gupton, MS	No	LOCAL FUNDS
CPT Gary A. Hazlett, MS	Yes	CENTRAL
MAJ Daniel Hendrichs, MS, USAR	No	NONE
MAJ Gregory P. Hollis, MS	Yes	CENTRAL
LTC Robert C. Hulsebus, MS	Yes	CENTRAL
CPT John M. Jameson, MS	No	NONE
CPT Petti Johnson, MS	No	CENTRAL
CPT William Kea, MS	No	CENTRAL
LTC Gregory B. Laskow, MS	Yes	CENTRAL
COL Ernest Lenz, MS	Yes	CENTRAL
CPT Vern E. Lewis, MS	No	CENTRAL
MAJ A. David Mangelsdorff, MS, USAR	Yes	USAR
CPT Kenneth Miles, MS	No	CENTRAL
COL Stanley Mintz, MS, USAR	No	USAR
CPT Charles O'Hara, MS	Yes	LOCAL FUNDS
LTC Raymond Parker, MS	Yes	CENTRAL
MAJ John B. Poewll, MS	Yes	CENTRAL
CPT Carlton Pyant, MS	No	CENTRAL
MAJ Robert R. Roland, MS	Yes	CENTRAL
MAJ Kenneth D. Rollins, MS	No	CENTRAL
CPT Michael Russell, MS	No	CENTRAL
CPT Martin L. Seitz, MS	No	CENTRAL
CPT Scott Smith, MS	No	CENTRAL
MAJ Thomas Stephenson, MS, USAR	Yes	USAR
MAJ Gregory Swanson, MS, USAR	No	NONE

<u>NAME</u>	<u>PRESENTING</u>	<u>FUNDING STATUS</u>
MAJ(P) Federico Tamayo, MS	No	NONE
CPT Walter F. Teachout, MS	No	CENTRAL
MAJ Robert W. Thomas, MS	Yes	NONE
CPT Jane E. Vogel, MS	No	CENTRAL
CPT James D. Warren, MS	No	NONE
CPT Mark D. Winborn, MS	No	CENTRAL
MAJ(P) Jeffrey N. Younggren, MS, USAR	Yes	USAR
LTC Kenneth A. Zych, MS	Yes	CENTRAL

SUMMARY

YES - 24
NO - 32

TOTAL

56

CENTRAL FUNDS	32	ACTIVE ARMY	48
USAR FUNDS	6	RESERVE COMPONENT	8
TDY IN ROUTE	2	TOTAL	56
LOCAL FUNDS	5		
NON-FUNDED	11		
<u>TOTAL</u>	56		

AMEDD PROFESSIONAL POSTGRADUATE SHORT COURSE CRITIQUE

The following questions have been designed to help us improve future courses conducted under the AMEDD Central Training Program. Your thoughtful consideration to each question (front and back) will be most appreciated.

TITLE OF COURSE:

DATES:

1. How did you rate this course compared to other similar courses? (Check one)

4. 6 Superior 3. 17 Excellent 2. 6 Good 1. 0 Fair 0. 0 Poor

5 I have not attended one

Weighted Average = 3.0

2. In your opinion, how was the administrative processing handled? (Check one)

4. 17 Superior 3. 15 Excellent 2. 1 Good 1. 1 Fair 0. 0 Poor Weighted Average = 3.4

3. What did you think of the facilities? (Check one) Weighted Average = 2.3

4. 5 Superior 3. 9 Excellent 2. 12 Good 1. 8 Fair 0. 0 Poor

COURSE CONTENT

4. Listed below are statements concerning the course you attended. Please circle the number which best describes your feeling on each statement. The ratings are:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

- | | | |
|---|-----------|------|
| a. The course outcomes or objectives were clearly communicated. | 1 2 3 4 5 | 3.94 |
| b. The course met the communicated outcomes or objectives. | 1 2 3 4 5 | 4.00 |
| c. The materials presented were relevant to the objectives of the course. | 1 2 3 4 5 | 4.00 |
| d. The materials and techniques presented during the course will better prepare me to perform my professional duties. | 1 2 3 4 5 | 4.39 |
| e. The professional experiences and associations developed during this course will assist me in making meaningful contributions to the AMEDD. | 1 2 3 4 5 | 4.67 |
| f. This educational experience is worth the associated expenditure of funds and time. | | 4.78 |

METHOD OF PRESENTATION

5. I would have preferred	More	Less	Same	Remarks
a. Slides	9	1	21	
b. Films	11	1	16	
c. Demonstrations	19	0	10	
d. Lectures	1	13	17	
e. Clinics	10	0	16	
f. Field trips	3	0	27	