
COMBAT AND OPERATIONAL BEHAVIORAL HEALTH



The Coat of Arms
1818
Medical Department of the Army

A 1976 etching by Vassil Ekimov of an original color print that appeared in *The Military Surgeon*, Vol XLI, No 2, 1917

This book is dedicated to the many professionals committed to diagnosing and treating combat and operational stress casualties. These include our predecessors—Doctors Frank Jones, Kenneth Artiss, and Albert Glass—as well as the many who worked on this project, and those who will no doubt labor many years from now on the next volume in this series. All of these caregivers pursue this effort not just to conserve the nation’s fighting strength. They also believe, as do all military personnel, that we take care of our own—the service members who face the difficulties of combat and the families who support them.

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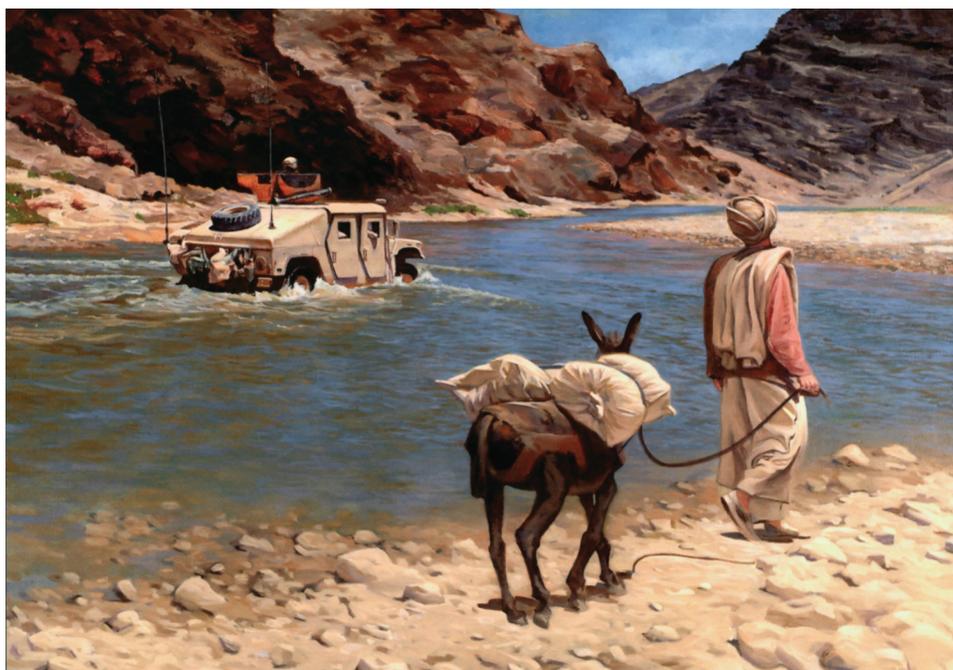
*Office of The Surgeon General
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*US Army Medical Department Center and School
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Editor in Chief

Martha K. Lenhart, MD, PhD
Colonel, MC, US Army
*Director, Borden Institute
Assistant Professor of Surgery
F. Edward Hébert School of Medicine
Uniformed Services University of the Health Sciences*



Tracking Bin Laden, by Sergeant First Class Elzie Golden, oil on canvas, 2002. First place winner of the DINFOS MILGRAPH 2002 Military Graphic Competition, fine art category.

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COMBAT AND OPERATIONAL BEHAVIORAL HEALTH

Senior Editor

ELSPETH CAMERON RITCHIE, MD, MPH
Colonel, Medical Corps, US Army (Retired)
Chief Clinical Officer, District of Columbia Department of Mental Health
Former Psychiatry Consultant to The Army Surgeon General and Director,
Behavioral Health Proponency, Office of The Surgeon General

Office of The Surgeon General
United States Army
Falls Church, Virginia

Borden Institute
Fort Detrick, Maryland

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Editorial Staff: Linette Sparacino
Volume Editor

Ronda Lindsay
Technical Editor

Douglas Wise
Illustrator

Joan Redding
Senior Production Editor

Bruce Maston
Illustrator

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Contents

Contributors	xiii
Foreword by The Surgeon General	xxi
Preface	xxiii
Section I: Setting the Stage	1
1. Combat and Operational Behavioral Health: An Update to an Old History Elspeth Cameron Ritchie and Christopher G. Ivany	3
2. US Army Psychiatry Legacies of the Vietnam War Norman M. Camp	9
3. Preparation for Deployment: Improving Resilience Patricia Watson, Brett Litz, Steven Southwick, and Elspeth Cameron Ritchie	43
4. Combat and Operational Stress Control Edward A. Brusher	59
5. Walter Reed Army Institute of Research Contributions During Operations Iraqi Freedom and Enduring Freedom: From Research to Public Health Policy Charles W. Hoge, Amy B. Adler, Kathleen M. Wright, Paul D. Bliese, Anthony Cox, Dennis McGurk, Charles Milliken, and Carl A. Castro	75
Section II: In Theater	87
6. The Division Psychiatrist and Brigade Behavioral Health Officers Christopher H. Warner, George N. Appenzeller, Todd Yosick, Matthew J. Barry, Anthony J. Morton, Jill E. Breitbach, Gabrielle Bryen, Angela Mobbs, Amanda Robbins, Jessica Parker, and Thomas Grieger	89
7. US Marine Corps and Navy Combat and Operational Stress Continuum Model: A Tool for Leaders William P. Nash	107
8. Expeditionary Operational Stress Control in the US Navy Robert L. Koffman, Richard D. Bergthold, Justin S. Campbell, Richard J. Westphal, Paul Hammer, Thomas A. Gaskin, John Ralph, Edward Simmer, and William P. Nash	121
9. Provision of Mental Health Services in Operation Iraqi Freedom 05–07 Marc A. Cooper, Sharon M. Newton, and Jeffrey S. Yarvis	137
10. Psychiatric Medications in Military Operations Brett J. Schneider, John C. Bradley, Christopher H. Warner, and David M. Benedek	151
11. The Role of Chaplains in the Operational Army Peter Frederich, Thomas C. Waynick, Jason E. Duckworth, and Jeff Voyles	163
12. Psychiatric Consultation to Command Christopher H. Warner, George N. Appenzeller, Jill E. Breitbach, Jennifer T. Lange, Angela Mobbs, and Elspeth Cameron Ritchie	171
Section III: The Road Home	189
13. The Aeromedical Evacuation Alan L. Peterson, Kelly R. McCarthy, Daniel J. Busheme, Rick L. Campise, and Monty T. Baker	191

14.	Behavioral Healthcare at Landstuhl Regional Medical Center Jeffrey V. Hill, David Reynolds, and Ronald Campbell	209
15.	Traumatic Brain Injury in the Military Population Louis M. French, Katherine H. Taber, Kathy Helmick, Robin A. Hurley, and Deborah L. Warden	225
16.	Psychiatric Intervention for the Battle-Injured Medical and Surgical Patient Following Traumatic Injuries Harold J. Wain, Scott C. Moran, Marvin Oleshansky, Andree Bouterie, and Christopher L. Lange	243
17.	Oral Health Effects of Combat Stress Georgia dela Cruz and Paul Colthirst	259
Section IV: Reunion and Reintegration		273
18.	Resetting the Force: Reentry and Redeployment Kris A. Peterson and Michael E. Doyle	275
19.	Treatment of Deployment-Related Posttraumatic Stress Disorder Josef I. Ruzek, Jeffrey S. Yarvis, and Steven Lindley	297
20.	The Continuum of Care for New Combat Veterans and Their Families: A Public Health Approach Harold Kudler, Alfonso R. Batres, Charles M. Flora, Terry C. Washam, Marshall J. Goby, and Laurent S. Lehmann	325
21.	Pain Management Frederick J. Stoddard, Robert L. Sheridan, Jeevendra Martyn, James E. Czarnik, and Virgil T. Deal	339
22.	US Army Occupational Therapy: Promoting Optimal Performance Mary W. Erickson, Teresa L. Brininger, Sharon M. Newton, Amy M. Mattila, and James P. Burns	357
23.	Provider Fatigue and Provider Resiliency Training Mary Ann Pechacek, Graeme C. Bicknell, and Lisa Landry	375
Section V: Surveillance and Intervention		391
24.	Army Suicide Surveillance: A Prerequisite to Suicide Prevention Gregory A. Gahm and Mark A. Reger	393
25.	Suicide Prevention in the Army: Lessons Learned and Future Directions Elspeth Cameron Ritchie, Walter Morales, Michael Russell, Bruce Crow, Wayne Boyd, Kelly Forys, and Steven Brewster	403
26.	Suicide and Homicide Risk Management: Rationale and Suggestions for the Use of Unit Watch in Garrison and Deployed Settings Samuel E. Payne, Jeffrey V. Hill, and David E. Johnson	423
27.	Severe Psychiatric Illness in the Military Healthcare System Geoffrey Grammer	441
28.	Eating Disorders Gail H. Manos, Janis Carlton, and Aileen Kim	449
29.	Substance Use and Abuse in the Military R. Gregory Lande, Barbara A. Marin, James J. Staudenmeier, and Daryl Hawkins	473
Section VI. Military Children and Families		485
30.	The Impact of Deployment on Military Families and Children Simon Pincus, Barbara Leiner, Nancy Black, and Tangeneare Ward Singh	487

31.	The Children and Families of Combat-Injured Service Members Stephen J. Cozza, Ryo S. Chun, and Corina Miller	503
32.	Family Maltreatment and Military Deployment René J. Robichaux and James E. McCarroll	535
33.	The Families and Children of Fallen Military Service Members Douglas H. Lehman and Stephen J. Cozza	543
34.	Establishing an Integrated Behavioral Health System of Care at Schofield Barracks Michael E. Faran, Albert Y. Saito, Eileen U. Godinez, Wendi M. Waits, Victoria W. Olson, Christine M. Piper, Margaret A. McNulty, and Christopher G. Ivany	563
Section VII. Operational Behavioral Health		577
35.	Disaster Psychiatry Artin Terhakopian, David M. Benedek, and Elspeth Cameron Ritchie	579
36.	Terrorism and Chemical, Biological, Radiological, Nuclear, and Explosive Weapons Ross H. Pastel and Elspeth Cameron Ritchie	593
37.	Operation Iraqi Freedom 05–07 Medical Civil-Military Operations: Lessons Learned in Humanitarian Assistance Jeffrey S. Yarvis	609
38.	Behavioral Health Issues in Humanitarian and Military Relief Operations: The Special Problem of Complex Emergencies Thomas F. Ditzler	619
39.	Population-Based Programs and Health Diplomacy Approaches of the US Public Health Service Jon T. Perez, Jeffrey Coady, Kevin McGuinness, and Merritt Schreiber	633
40.	Behavioral Health Issues and Detained Individuals Richard Toye and Marshall Smith	645
41.	Mental Healthcare in the United Kingdom Armed Forces Neil Greenberg, Jamie Hacker Hughes, Mark Earnshaw, and Simon Wessely	657
Section VIII. Other Military Issues		667
42.	Military Psychiatry Graduate Medical Education Carroll J. Diebold, Wendi M. Waits, Millard D. Brown, and David M. Benedek	669
43.	Military Forensic Mental Health Elspeth Cameron Ritchie	693
44.	Women, Mental Health, and the Military Deborah Crowley, Trisha Bender, Ashley Chatigny, Tina Trudel, and Elspeth Cameron Ritchie	703
45.	Mental Health Support to Operations Involving Death and the Dead James E. McCarroll and Robert J. Ursano	717
46.	Ethics and Military Medicine: Core Contemporary Questions Edmund G. Howe, Robert C. McKenzie, and Chad Bradford	727
47.	Combat and Operational Behavioral Health: Final Thoughts and Next Steps Elspeth Cameron Ritchie and Michael Doyle	747
Appendix 1: Provision of Behavioral Health Services During Operation Iraqi Freedom One Robert D. Forsten, Brett J. Schneider, Sharette Kirsten Gray, Colin Daniels, and Gary J. Drouillard		751

Appendix 2: Operational Psychiatry in Operation Enduring Freedom Bryan L. Bacon, Matthew J. Barry, and James Demer	767
Appendix 3: Good or Bad News? Media Coverage of Soldiers: Focus on Behavioral Health in Iraq During Operation Iraqi Freedom 05-07 Jeffrey S. Yarvis and Elspeth Cameron Ritchie	775
Abbreviations and Acronyms	xxv
Index	xxxii

Contributors

AMY B. ADLER, PhD

Research Psychologist, US Army Research Unit—Europe, Walter Reed Army Institute of Research, CMR 442, APO AE 09042-1030

GEORGE N. APPENZELLER, MD

Lieutenant Colonel, Medical Corps, US Army; Commander, US Army Medical Activity, Alaska, 1060 Gaffney Road #7400, Fort Wainwright, Alaska 99703-7400; formerly, Deputy Commander for Clinical Services, Command Group, Winn Army Community Hospital, Fort Stewart, Georgia

BRYAN L. BACON, DO

Major, Medical Corps, US Army; Disaster Psychiatry Fellow, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814; formerly, Chief, Behavioral Health, Bavaria Medical Department, Vilseck, Germany

MONTY T. BAKER, PhD

Major, Biomedical Sciences Corps, US Air Force; Director of Clinical Research, Warrior Resiliency Program, San Antonio Military Medical Center, 2200 Bergquist Drive, Suite 1, Lackland Air Force Base, Texas 78236; formerly, Element Leader, Mental Health Clinic, 59th Military Health System, Lackland Air Force Base, Texas

MATTHEW J. BARRY, DO

Major, Medical Corps, US Army Reserve; Staff Psychiatrist, Department of Behavioral Health, Rochester Veterans Affairs Outpatient Clinic, 465 Westfall Road, Rochester, New York 14620; formerly, Major, Medical Corps, US Army; Chief of Psychiatric Service USA MEDDAC and 10th Mountain Division Psychiatrist, Fort Drum, New York

ALFONSO R. BATRES, PhD

Chief Officer and Director, Readjustment Counseling Service, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420

TRISHA BENDER, MD

Major, Medical Corps, US Army; Division Psychiatrist, 25th Infantry Division Headquarters, Building 580, DIVSURG CELL, Schofield Barracks, Hawaii 95857-6000; formerly, Child and Adolescent Fellow, Tripler Army Medical Center, Honolulu, Hawaii

DAVID M. BENEDEK, MD

Colonel, Medical Corps, US Army; Professor and Deputy Chair, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

RICHARD D. BERGTHOLD, PsyD

Commander, Medical Service Corps, US Navy; Chief of Staff, Wounded, Ill and Injured, Bureau of Medicine and Surgery, 2300 E Street NW, Washington, DC 20372

GRAEME C. BICKNELL, PhD, LISW

Lieutenant Colonel, Medical Service Corps, US Army; Deputy Chief, Behavioral Health Division, US Medical Command, Building 2792, Room 112, 2050 Worth Road, Fort Sam Houston, San Antonio, Texas 78234-6010

NANCY BLACK, MD

Colonel, Medical Corps, US Army; Training and Program Director, National Capital Consortium of Child and Adolescent Psychiatry Fellowships, Department of Psychiatry, Walter Reed Army Medical Center, Borden Pavilion, 6900 Georgia Avenue NW, Washington, DC 20307-5001

PAUL D. BLIESE, PhD

Colonel, Medical Service Corps, US Army; Director, Psychiatry and Neuroscience, Walter Reed Army Institute of Research, 503 Robert Grant Avenue, Silver Spring, Maryland 20910

ANDREE BOUTERIE, MD

Staff Psychiatrist, Psychiatry Consultation Liaison Service, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5100

WAYNE BOYD, MDIV

Colonel, Chaplain Corps, US Army; Staff Officer, Comprehensive Soldier Fitness, Headquarters, Department of the Army, Zachary Taylor Building (NC3), 2530 Crystal Drive, Room 512B, Arlington, Virginia 22202; formerly, Program Manager, Directorate of Health Promotion and Wellness, US Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, Maryland

CHAD BRADFORD, MD

Commander, Medical Corps, US Navy; Division Psychiatrist, 2nd Marine Division, Division Surgeon's Office, Attn: Division Psychiatry, HQBN 2MAR DIV, Camp Lejeune, North Carolina 28547; formerly, Forensic Psychiatry Fellow, National Capital Consortium, Washington, DC

JOHN C. BRADLEY, MD

Colonel, Medical Corps, US Army; Chair, Department of Psychiatry, Borden Pavilion, Room 2022, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; Psychiatry Consultant, North Atlantic Regional Medical Command and Vice Chair, Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland

JILL E. BREITBACH, PsyD

Major, Medical Service Corps, US Army; Neuropsychologist, Department of Psychology, Evans Army Community Hospital, USAMEDDAC, 1650 Cochrane Circle, Fort Carson, Colorado 80913; formerly, Group Psychologist, 1st Special Warfare Training Group, Fort Bragg, North Carolina

STEVEN BREWSTER, MD, MPH

Colonel, Medical Corps, US Army; Commander, US Army Medical Activity—Bavaria, Vilseck, Germany, Unit 28038, APO AE 09112; formerly, Director, Epidemiology and Disease Surveillance, US Army Center for Health Promotion and Preventive Medicine, Public Health Command, Aberdeen Proving Ground, Maryland

SUSAN MILLER BRIGGS, MD, MPH

Associate Professor of Surgery, Harvard Medical School, Director, International Trauma and Disaster Institute, Massachusetts General Hospital, 55 Fruit Street, White 506, Boston, Massachusetts 02114

TERESA L. BRININGER, PhD, CHT, OTR/L

Lieutenant Colonel, Medical Specialist Corps, US Army; Deputy for Rehabilitation and Reintegration, Telemedicine and Advanced Technology Research Center, Medical Research and Materiel Command, 504 Scott Street, Building 722, Room 30, Fort Detrick, Maryland 21702

MILLARD D. BROWN, MD

Major, Medical Corps, US Army; Psychiatry Residency Director, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859

EDWARD A. BRUSHER, LCSW, BCD

Lieutenant Colonel, Medical Service Corps, US Army; Deputy Director, Behavioral Health Proponency, Office of The Surgeon General, 5109 Leesburg Pike, Skyline 6, Suite 693, Falls Church, Virginia 22041-3258; formerly, Combat Operational Stress Control Program Manager, US Army Medical Command, Fort Sam Houston, Texas

GABRIELLE BRYEN, MSW, LCSW

Major, Medical Service Corps, US Army; Deputy Chief, Department of Social Work, Womack Army Medical Center, Stop A, Fort Bragg, North Carolina 28310; formerly, Brigade Behavioral Health Officer, 3rd Brigade Combat Team, 4th Infantry Division, Fort Carson, Colorado

JAMES P. BURNS, OTR/L, MOT

Major, Medical Specialist Corps, US Army; Occupational Therapist, Department of Orthopaedics and Rehabilitation, Building 2, Room 3J04, Walter Reed Army Medical Center, 6900 Georgia Avenue, NW, Washington, DC 20307-5001; formerly, Chief Occupational Therapist, Department of Surgery, Fort Jackson, South Carolina

DANIEL J. BUSHME, MA, LCDC

Lieutenant Colonel, Nurse Corps, US Air Force; Chief, Mental Health Nursing, US Air Force Medical Operations Agency, 485 Quentin Roosevelt Road, Suite 400, San Antonio, Texas 78226-2017; formerly, Deputy Squadron Commander and Inpatient Mental Health Flight Commander, Travis Air Force Base, California

NORMAN M. CAMP, MD

Colonel, US Army (Retired); 3105-D Stony Point Road, Richmond, Virginia 23235; Clinical Professor of Psychiatry, Department of Psychiatry, Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia 23298

JUSTIN S. CAMPBELL, PhD

Lieutenant, Medical Service Corps, US Navy; Deployment Health Senior Analyst, Department of the Navy, Bureau of Medicine and Surgery, Deployment Health (M3C3), 2300 E Street NW, Washington, DC 20372

RONALD CAMPBELL, MD

Chief, Inpatient Psychiatry Service, Department of Behavioral Health, Landstuhl Regional Medical Center, CMR 462, APO AE 09180

RICK L. CAMPISE, PhD, ABPP

Colonel, Biomedical Sciences Corps, US Air Force; Commander, 559th Medical Group, 1920 Biggs Avenue, Lackland Air Force Base, Texas 78236; formerly, Commander, 1st Medical Operations Squadron, Langley Air Force Base, Virginia

JANIS CARLTON, MD, PhD

Commander, Medical Corps, US Navy; Department Head, Psychological Health and Traumatic Brain Injury, Building 7, Room 600, National Naval Medical Center, 8901 Wisconsin Avenue, Bethesda, Maryland 20889; formerly, Department Head, Mental Health, Naval Hospital, Camp Lejeune, North Carolina

CARL A. CASTRO, PhD

Colonel, Medical Service Corps, US Army; Director, Military Operational Medicine Research Program, US Army Medical Research and Materiel Command, 504 Scott Street, Fort Detrick, Maryland 21702-5012; formerly, Chief, Department of Military Psychiatry and Chief, Soldier and Family Readiness, Walter Reed Army Institute of Research, Silver Spring, Maryland

ASHLEY CHATIGNY, DO

Captain, Medical Corps, US Army; Fellow, Department of Child and Adolescent Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859-5000

RYO S. CHUN, MD

Colonel, US Army (Retired); Clinical Director, Child and Adolescent Psychiatry Service, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; formerly, Chief, Child and Adolescent Psychiatry Service, Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC

JEFFREY COADY, PsyD

Commander, Scientist Corps, US Public Health Service; Deputy Team Leader, US Public Health Service Disaster Mental Health Team II, Department of Health and Human Services, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601

PAUL COLTHIRST, DDS, MS

Major, Dental Corps, US Army; Dental Public Health, Department of Leadership Development, US Army Medical Department Center and School, 2250 Stanley Road, Fort Sam Houston, Texas 78234-6100; formerly, Staff Officer, Dental Command Headquarters, Fort Sam Houston, Texas

MARC A. COOPER, MD

Chief, Community Mental Health Service, Moncrief Army Community Hospital, 4500 Stuart Street, Fort Jackson, South Carolina 29207; formerly, Major, Medical Corps, US Army; OIF 05-07 Theater Mental Health Consultant, Task Force 30th Medical Brigade, Baghdad, Iraq

ANTHONY COX, MSW

Lieutenant Colonel, Medical Service Corps, US Army; Social Work Consultant, Great Plains Regional Medical Command; Chief, Social Work, Brooke Army Medical Center, 3851 Roger Brooke Drive, Fort Sam Houston, Texas 78234

STEPHEN J. COZZA, MD

Colonel, US Army (Retired); Associate Director, Center for the Study of Traumatic Stress, and Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814; formerly, Chief, Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC

BRUCE E. CROW, PsyD

Colonel, Medical Service Corps, US Army; Clinical Psychology Consultant to The Surgeon General, US Army, and Director, Warrior Resiliency Program, Southern Regional Medical Command, Brooke Army Medical Center, Fort Sam Houston, Texas 78234

DEBORAH CROWLEY, MD

Captain, Medical Corps, US Army; Child Psychiatry Fellow, Department of Psychiatry, 1 Jarrett White Road, Tripler Army Medical Center, Hawaii 96859

JAMES E. CZARNIK, MD

Colonel, Medical Corps, US Army; Command Surgeon, Joint Special Operations Command, PO Box 70239, Fort Bragg, North Carolina 28307-5000; formerly, Deputy Command Surgeon, US Army Special Operations Command, Fort Bragg, North Carolina

COLIN DANIELS, MD, MBA

Lieutenant Colonel, Medical Corps, US Army; Psychiatrist, Department of Psychiatry, Madigan Army Medical Center, 9040 Fitzsimmons Drive, 7BLM, Tacoma, Washington 98431; formerly, Chief, Behavioral Health Services, 28th Combat Support Hospital, Operation Iraqi Freedom 2003

VIRGIL T. DEAL, MD

Colonel, Medical Corps, US Army; Surgeon, United States Special Operations Command, 7701 Tampa Point Boulevard, MacDill Air Force Base, Florida 33621-5323; formerly, Commander, Walter Reed Health Care System, Washington, DC

GEORGIA DELA CRUZ, DMD, MPH

Lieutenant Colonel, Dental Corps, US Army; Dental Staff Officer, Dental Corps Office, Office of The Surgeon General, US Army, 5109 Leesburg Pike, Suite 682, Falls Church, Virginia 22041; formerly, Army Dental Representative, TriService Center for Oral Health Studies, Uniformed Services University of the Health Sciences, Bethesda, Maryland

JAMES DEMER, MD

Attending Child Psychiatrist, Inpatient Child Psychiatry Service, Hutchings Psychiatric Center, 7682 Warrior's Path, Baldwinsville, New York 13027; formerly, Major, Medical Corps, US Army; Division Psychiatrist, 10th Mountain Division, Fort Drum, New York

CARROLL J. DIEBOLD, MD

Colonel, Medical Corps, US Army; Chief, Department of Psychiatry, 1 Jarrett White Road, Tripler Army Medical Center, Honolulu, Hawaii 96859

THOMAS F. DITZLER, PhD

Director of Research, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859

MICHAEL E. DOYLE, MD

Lieutenant Colonel, Medical Corps, US Army; Deputy Commander for Clinical Services, USAMEDDAC West Point, 900 Washington Road, West Point, New York 10996; formerly, Commander, US Army Health Clinic, Wiesbaden, Germany

GARY J. DROUILLARD, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Chemical Addiction Treatment Service, Department of Psychiatry 1 Jarrett White Road, Tripler Army Medical Center, Hawaii 96859; formerly, Chief, Consultation Liaison Psychiatry, Tripler Army Medical Center, Honolulu, Hawaii

JASON E. DUCKWORTH, DMIn, MDiv

Lieutenant Colonel, Chaplain Corps, US Army; Garrison Chaplain, Religious Support Office, US Army Garrison, Heidelberg, Germany, CMR 419 Box 1876, APO AE 09102; formerly, Training Developer, Chaplain Basic Officer Leader Course, US Army Chaplain Center and School, Fort Jackson, South Carolina

MARK EARNSHAW, BA(HONS), MSc

Lieutenant Colonel, QARANC, Ministry of Defence, St Georges Court, Bloomsbury Way, London, WC1A 2SH, United Kingdom; formerly, Research Fellow, Academic Centre for Defence Mental Health, London, United Kingdom

MARY W. ERICKSON, MAOL, OTR/L

Colonel, US Army (Retired); formerly, Reintegration Branch Chief, Proponency Office for Rehabilitation and Reintegration, The Office of The Surgeon General, US Army, 5109 Leesburg Pike, Suite 684, Falls Church, Virginia

MICHAEL E. FARAN, MD, PhD

Colonel, US Army (Retired); Director, Child, Adolescent, and Family Behavior Health Proponency, Madigan Army Medical Center, Madigan Annex Building 9913A, Ramp 2, McKinnley Road, Tacoma, Washington 98431; Director, School Based Mental Health, Child and Adolescent Psychiatry Service, Department of Psychiatry, Tripler Army Medical Center, Honolulu, Hawaii

CHARLES M. FLORA, MSW

Associate Director, Readjustment Counseling Service, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420

ROBERT D. FORSTEN, DO

Colonel, Medical Corps, US Army; Command Psychiatrist, US Army Special Operations Command (AOMD), 2929 Desert Storm Drive (Stop A), Fort Bragg, North Carolina 28310-9110; formerly, Staff Psychiatrist, Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC

KELLY FORYS, PhD

Psychologist, Department of Outpatient Behavioral Health, Landstuhl Regional Medical Center, CMR 402, Box 1045, APO AE 09180; formerly, Psychologist, US Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, Maryland

PETER FREDERICH, MDiv

Lieutenant Colonel, Chaplain Corps, US Army; Family Ministries Officer, Directorate of Ministry Initiatives, US Army Chief of Chaplains Office, 1421 Jefferson Davis Highway, Suite 10600, Arlington, Virginia 22202; formerly, Director, US Army Family Life Chaplain Training Center, Fort Benning, Georgia

LOUIS M. FRENCH, PsyD

Director, Traumatic Brain Injury Service, Defense and Veterans Brain Injury Center and Department of Orthopaedics and Rehabilitation, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; Department of Neurology, Uniformed Services University of the Health Sciences, Bethesda, Maryland

GREGORY A. GAHM, PhD

Colonel, Medical Service Corps, US Army; Chief, Department of Psychology, Madigan Army Medical Center, 9933C West Hayes Street, Fort Lewis, Washington 98431

THOMAS A. GASKIN, PhD

Commander, US Navy (Retired); Director of Combat Operational Stress Control, US Marine Corps, Manpower and Reserve Affairs, Personal and Family Readiness Division, 3280 Russell Road, Quantico, Virginia 22134; formerly, Head, Combat and Operational Stress Control Program, Headquarters, US Marine Corps, Quantico, Virginia

MARSHALL J. GOBY, PhD

Colonel, US Army (Retired); Team Leader/Supervisory Psychologist, Veterans Affairs Readjustment Counseling Service, Palm Beach Veterans Center, 2311 10th Avenue North, #13, Lake Worth, Florida 33461; formerly, Reserve Psychology Consultant, Office of The Surgeon General, US Army, Falls Church, Virginia

EILEEN U. GODINEZ, PhD

Inspector General Chief, Inspections and Outreach Branch, US European Command, CMR 480, Box 1865, APO AE 09128; formerly, Chief, Plans Analysis and Integration Office, US Army Garrison, Hawaii

GEOFFREY GRAMMER, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Inpatient Psychiatry, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307

SHARETTE KIRSTEN GRAY, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Hospital and Administrative Psychiatry Services, Department of Behavioral Health, Carl R. Darnell Army Medical Center, Building 36000, Darnell Loop, Fort Hood, Texas 76544; formerly, Division Psychiatrist, 4th Infantry Division, Fort Hood, Texas

NEIL GREENBERG, MD

Commander, Medical Corps, United Kingdom Armed Forces; Defence Professor of Mental Health, King's College, London, Weston Education Centre, Cutcombe Road, London SE5 9RJ; formerly, Senior Lecturer in Military Psychiatry, Academic Center for Defence Mental Health, King's College, London

THOMAS GRIEGER, MD

Captain, US Navy (Retired); Associate Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

PAUL HAMMER, MD

Captain, Medical Corps, US Navy; Director, Naval Center for Combat and Operational Stress Control, 34960 Bob Wilson Drive, Suite 400, San Diego, California 92134-6400

DARYL HAWKINS, PhD

Alcohol and Drug Control Officer, Army Substance Abuse Program, Building 6, Room 2066, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5001

KATHY HELMICK, MS, CNRN, CRNP

Senior Executive Director, Traumatic Brain Injury, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, 1335 East-West Highway, 9th Floor, Suite 700, Silver Spring, MD 20910; formerly, Deputy Director, Defense and Veterans Brain Injury Center, Walter Reed Army Medical Center, Washington, DC

JEFFREY V. HILL, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Child and Adolescent Psychiatry, Landstuhl Regional Medical Center, CMR 402 Box 1356, APO AE 09180; formerly, Chief, Outpatient Psychiatry, Landstuhl Regional Medical Center, Landstuhl, Germany

CHARLES W. HOGE, MD

Colonel, US Army (Retired); formerly, Director, Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, 503 Robert Grant Avenue, Silver Spring, Maryland 20910

EDMUND G. HOWE, MD, JD

Professor of Psychiatry, Associate Professor of Medicine, and Director, Programs in Medical Ethics, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814; and Senior Scientist, Center for the Study of Traumatic Stress, Bethesda, Maryland; formerly, Major, Medical Corps, US Army

JAMIE HACKER HUGHES, PSYCHD

Head of Defence Clinical Psychology, Ministry of Defence, Joint Medical Command, Coltman House, Whittington Barracks, Lichfield, United Kingdom WS14 9PY; formerly, Senior Lecturer in Military Psychology, Academic Center for Defence Mental Health, London, United Kingdom

ROBIN A. HURLEY, MD

Associate Director, Education, WG Hefner Veterans Affairs Medical Center (Mailcode 11F), 1601 Brenner Avenue, Salisbury, North Carolina 28144; formerly, Associate Director, Mental Health, WG Hefner Veterans Affairs Medical Center, Salisbury, North Carolina

CHRISTOPHER G. IVANY, MD

Major, Medical Corps, US Army; Psychiatrist, Department of Behavioral Health, Evans Army Community Hospital, Building 7500, 1650 Cochrane Circle, Fort Carson, Colorado 80913; formerly, Division Psychiatrist, 4th Infantry Division, Fort Hood, Texas

DAVID E. JOHNSON, MD

Major, Medical Corps, US Army; Chief, Behavioral Health, Department of Psychiatry, US Army MEDDAC Bavaria, IMEU-SFT-DHR, ATTN: OMDC Schweinfurt, Unit 25850, APO AE 09033

AILEEN KIM, MD

Lieutenant Commander, Medical Corps, US Navy; Staff Psychiatrist, Department of Behavioral Health, Building 7, 3rd Floor, National Naval Medical Center, 8901 Wisconsin Avenue, Bethesda, Maryland 20889; formerly, Chief Resident, Department of Psychiatry, Naval Medical Center Portsmouth, Portsmouth, Virginia

ROBERT L. KOFFMAN, MD, MPH

Captain, Medical Corps, US Navy; Director of Deployment Health, Department of the Navy, Bureau of Medicine and Surgery, Deployment Health, 2300 E Street NW, Washington, DC, 20372

HAROLD KUDLER, MD

Associate Clinical Professor, Department of Psychiatry, Duke University Medical Center, Durham, North Carolina; Associate Director, Mental Illness Research, Education and Clinical Center, Mid-Atlantic Veterans Integrated Service Network (VISN 6), VA Medical Center, 508 Fulton Street, #166A, Durham, North Carolina 27705

R. GREGORY LANDE, DO

Chief, Psychiatry Continuity Service, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Building 2, Room 5343, Washington, DC 20307; Clinical Consultant, Walter Reed Army Medical Center Substance Abuse Program, Washington, DC

LISA LANDRY, PhD

Instructor/Writer, Department of Behavioral Health Sciences, Army Medical Department Center and School, 3151 Scott Road, Building 2840, Office 32, Fort Sam Houston, Texas 78234

CHRISTOPHER L. LANGE, MD

Lieutenant Colonel, Medical Corps, US Army; Program Director, National Capital Consortium Forensic Psychiatry Fellowship Program, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Building 6, Room 3038, Washington, DC 20307; formerly, Staff Psychiatrist, Psychiatry Consultation Liaison Service, Walter Reed Army Medical Center, Washington, DC

JENNIFER T. LANGE, MD

Lieutenant Colonel, Medical Corps, US Army; Medical Director, Behavioral Health Clinic, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5001

DOUGLAS H. LEHMAN, MSW, LCSW

Treatment Provider, Department of Behavioral Health and Family Advocacy, Evans Army Community Hospital, 7500 Cochrane Circle, Fort Carson, Colorado 80913

LAURENT S. LEHMANN, MD

Associate Chief Consultant in Mental Health, Office of Mental Health Services, Department of Veterans Affairs, 810 Vermont Avenue NW, Room 966, Washington, DC 20420

BARBARA LEINER, MSW, LCSW-C

Psychiatric Social Worker, Department of Child Psychiatry, Walter Reed Army Medical Center, Borden Pavilion, 6900 Georgia Avenue NW, Washington, DC 20307-5001; formerly, Clinical Case Manager, Department of Child Psychiatry, Kaiser Permanente Mid-Atlantic States, Rockville, Maryland

STEVEN LINDLEY, MD, PhD

Director of Outpatient Mental Health, Department of Veterans Affairs Palo Alto Health Care System, 795 Willow Road, 116R/MHC, Menlo Park, California 94025; and, Associate Professor, Department of Psychiatry, Stanford University, Palo Alto, California

BRETT LITZ, PhD

Professor, Department of Psychiatry, Boston University School of Medicine, 77 East Concord Street, Boston, Massachusetts 02118; Associate Director, Behavioral Sciences Division, Department of Veterans Affairs National Center for Posttraumatic Stress Disorder, White River Junction, Vermont

GAIL H. MANOS, MD

Captain, Medical Corps, US Navy; Navy Psychiatry Specialty Leader and Senior Medical Officer, Director of Mental Health, Naval Medical Center Portsmouth, 620 John Paul Jones Road, Portsmouth, Virginia 23708; formerly, Psychiatry Residency Training Director, Department of Psychiatry, Naval Medical Center Portsmouth, Portsmouth, Virginia

BARBARA A. MARIN, PhD

Integrated Chief, Department of Addictions Treatment and Clinical Director, Army Substance Abuse Program, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5001

JEEVENDRA MARTYN, MD

Professor/Chief, Department of Anesthesiology and Critical Care, Harvard Medical School/Shriners Hospital for Children, 51 Blossom Street, Room 206, Boston, Massachusetts 02114

AMY M. MATTILA, MS, MBA

Captain, Medical Specialist Corps, US Army; Chief, Department of Occupational Therapy, Reynolds Army Community Hospital, 4301 Wilson Street, Fort Sill, Oklahoma 73503; formerly, Chief, Occupational Therapy, 254th Medical Detachment (Combat Operational Stress Control), Germany

JAMES E. McCARROLL, PhD, MPH

Colonel, US Army (Retired); Psychologist, Center for the Study of Traumatic Stress and Department of Psychiatry, Room B3068, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814; formerly, Psychologist, Walter Reed Army Institute of Research, Silver Spring, Maryland

KELLY R. McCARTHY, MA

Captain, Nurse Corps, US Air Force; Historian, Peterson Air Force Base, 150 Vandenberg, Suite 1105, Peterson Air Force Base, Colorado 80914; formerly, Chief, Behavioral Health Nursing Management, Life Skills Center, United States Air Force Academy, Colorado Springs, Colorado

KEVIN M. McGUINNESS, PhD

Captain, Scientist Corps, US Public Health Service; Director and Medical Psychologist, HRSA/BCRS National Health Service Corps, Ready Responder Program, Department of Health and Human Services, c/o La Clinica de Familia, 510 East Lisa Drive, Chaparral, New Mexico 88081; formerly, Senior Clinical Scientist, Health and Human Services, US Department of Justice, Bureau of Prisons, Federal Correctional Institution La Tuna, New Mexico

DENNIS McGURK, PhD

Major, Medical Service Corps, US Army; Commander, US Army Medical Research Unit—Europe, Walter Reed Army Institute of Research, CMR 442, Box 777, APO AE 09042

ROBERT C. McKENZIE, DO

Lieutenant Colonel, Medical Corps, US Army; Department of Behavioral Health, US Army Health Clinic-Vicenza, Caserma Ederle, Italy, Unit 31401, Box 13, APO AE 09042

MARGARET A. McNULTY, DrPH

Captain, US Navy (Retired); Assistant Professor, Department of Nursing, Kapiolani Community College, 4303 Diamond Head Road, Honolulu, Hawaii 96816

CORINA MILLER, MSW

Clinical Social Worker, Department of Psychiatry, Walter Reed Army Medical Center, Building 2, Office #6317, 6900 Georgia Avenue NW, Washington, DC 20307-5001; formerly, Clinical Social Worker, National Naval Medical Center, Bethesda, Maryland

CHARLES MILLIKEN, MD

Colonel, Medical Corps, US Army; Program Director, National Capital Consortium Psychosomatic Medicine/Geriatric Psychiatry Fellowship, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC; formerly, Principal Investigator, Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, 503 Grant Avenue, Silver Spring, Maryland

ANGELA MOBBS, PsyD

Captain, Medical Service Corps, US Army; Special Forces Assignment and Selection Psychologist, Special Warfare Center and School, Rowe Training Facility, Building T-5167, 1500 Camp Mackall Place, Marston, North Carolina 28363; formerly, Brigade Psychologist, 3rd Brigade Combat Team, 3rd Infantry Division, Fort Benning, Georgia

WALTER MORALES, MSA

Sergeant Major, US Army (Retired); Program Manager, Army Suicide Prevention Program, Army G-1, Headquarters, Department of the Army, 300 Army Pentagon, ATTN: Army G-1 (DAPE-HR), Washington, DC 20310-0300

SCOTT C. MORAN, MD

Major (P), Medical Corps, US Army; Psychiatry Residency Training Program Director, Psychiatry Consultation Liaison Service, Department of Psychiatry, Building 6, Room 2060, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5100

ANTHONY J. MORTON, MD

Major, Medical Corps, US Army; Medical Director, Department of Behavioral Health, Moncrief Army Community Hospital, 4500 Stuart Street, Fort Jackson, South Carolina 29207-5720; formerly, Division Psychiatrist, 1st Armored Division, Wiesbaden, Germany

WILLIAM P. NASH, MD

Captain, US Navy (Retired); Assistant Clinical Professor, Department of Psychiatry, University of California at San Diego, 6326 Timarron Cove Lane, Burke, Virginia 22015; formerly, Senior Consultant, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Rosslyn, Virginia

SHARON M. NEWTON, OTR/L, MHS

Lieutenant Colonel, Medical Specialist Corps, US Army; Command Inspector General, 30th Medical Command, CMR 442, APO AE 09042; formerly, Theater Consultant for Combat and Operational Stress Control, Iraq

MARVIN OLESHANSKY, MD

Colonel, US Army (Retired); Staff Psychiatrist, Psychiatric Outpatient Service, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96822; formerly, Staff Psychiatrist, Psychiatry Consultation Liaison Service, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC

VICTORIA W. OLSON, MBA

Executive Director, Hawai'i Army Museum Society, Post Office Box 8064, Honolulu, Hawaii 96830-0064

JESSICA PARKER, PsyD

Captain, Medical Service Corps, US Army; Chief, Warrior Restoration Center, Department of Behavioral Medicine, Winn Army Community Hospital, 541 East 9th Street, Building 359, Fort Stewart, Georgia 31314-5674; formerly, Psychology Resident, Traumatic Brain Injury, Brooke Army Medical Center, San Antonio, Texas

ROSS H. PASTEL, PhD

Lieutenant Colonel, Medical Service Corps, US Army; Chief, Division of Traumatic Brain Injury, Research Directorate, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, 1335 East-West Highway, Suite 900, Silver Spring, Maryland 20910; formerly, Assistant Professor, Department of Medical and Clinical Psychology, Uniformed Services University of the Health Sciences, Bethesda, Maryland

SAMUEL E. PAYNE, MD

Colonel, Medical Corps, US Army; Chief, Outpatient Behavioral Health Services, Dwight D. Eisenhower Army Medical Center, Building 300, Room 13A-15, 300 South Hospital Road, Fort Gordon, Georgia 30905

MARY ANN PECHACEK, PsyD, LMFT

Psychologist and Instructor/Writer, Department of Behavioral Health Sciences, Special Subjects Branch, Army Medical Department Center and School, 3151 Scott Road, Building 2840, Office #033-B9, Fort Sam Houston, Texas 78234; formerly, Psychologist and Instructor/Writer, Soldier and Family Support Branch/Special Subjects, Fort Sam Houston, Texas

JON T. PEREZ, PhD

Captain, Scientist Corps, US Public Health Service; Team Leader, US Public Health Service Disaster Mental Health Team II, Department of Health and Human Services, Indian Health Service Headquarters, 801 Thompson Avenue, Suite 300, Rockville, Maryland 20852

ALAN L. PETERSON, PhD, ABPP

Professor, Department of Psychiatry, Mail Code 7792, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, Texas 78229; formerly, Chair, Department of Psychology, Wilford Hall Medical Center, San Antonio, Texas

KRIS A. PETERSON, MD

Colonel, Medical Corps, US Army; Chief, Department of Psychiatry, Madigan Army Medical Center, Building 9040, Fitzsimmons Drive, Tacoma, Washington 98431; formerly, Child and Adolescent Psychiatry Consultant to The Surgeon General, US Army

SIMON PINCUS, MD

Colonel, US Army (Retired); Clinical Director, Department of Mental Health, McChord Medical Clinic, 690 Barnes Boulevard, Joint Base Lewis-McChord (McChord Field), Washington 98438; formerly, Chief, Inpatient Psychiatry, Madigan Army Medical Center, Tacoma, Washington

CHRISTINE M. PIPER, APRN, BC

Colonel, US Army (Retired); Coaching Trainer/Instructor, LivingWorks, Inc.; formerly, Chief, Soldier and Family Assistance Center, Schofield Barracks, Hawaii

JOHN RALPH, PhD

Commander, Medical Service Corps, US Navy; Director, Department of Mental Health, National Naval Medical Center, 8901 Wisconsin Avenue, Bethesda, Maryland 20889; formerly, Officer-in-Command, Presidential Support Program, Marine Barracks, Washington, DC

MARK A. REGER, PhD

Research Psychologist, Department of Psychology, Madigan Army Medical Center, 9933C West Hayes Street, Fort Lewis, Washington 98431; and Affiliate Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, 1925 NE Pacific Street, Seattle, Washington 98195-6340

DAVID REYNOLDS, PhD

Major, Biomedical Sciences Corps, US Air Force; Mental Health Element Leader, Department of Psychology, Malcolm Grow Medical Center, 1050 West Perimeter Road, 779 MDOS/SGOH, Andrews Air Force Base, Maryland 20762; formerly, Chief, Department of Health Psychology, Landstuhl Regional Medical Center, Landstuhl, Germany

ELSPETH CAMERON RITCHIE, MD, MPH

Colonel, US Army (Retired); formerly, Psychiatry Consultant to The Surgeon General, US Army, and Director, Behavioral Health Proponency, Office of The Surgeon General, Falls Church, Virginia; currently, Chief Clinical Officer, District of Columbia Department of Mental Health, 64 New York Avenue NE, 4th Floor, Washington, DC 20002

AMANDA ROBBINS, PsyD

Captain, Medical Service Corps, US Army; Brigade Combat Team Behavioral Health Officer, 4th Brigade Combat Team, 10th Mountain Division, Fort Polk, Louisiana 71459

RENÉ J. ROBICHAUX, PhD, LCSW

Colonel, US Army (Retired); Social Work Programs Manager, Behavioral Health Division, US Army Medical Command, 2050 Worth Road, Suite 10, Fort Sam Houston, Texas 78234; formerly, Chief, Department of Social Work, Brooke Army Medical Center, Fort Sam Houston, Texas

MICHAEL RUSSELL, PhD

Lieutenant Colonel, Medical Service Corps, US Army; Army Medical Department Neuropsychology Consultant, Warrior Resiliency Program, Lincoln Center, Suite 300, 7800 Interstate 10 West, San Antonio, Texas 78230

JOSEF I. RUZEK, PhD

Director, Dissemination and Training Division, National Center for Posttraumatic Stress Disorder, Veterans Affairs Palo Alto Health Care System, 795 Willow Road, Menlo Park, California 94025

ALBERT Y. SAITO, MD

Clinical Director, Child and Adolescent Psychiatry Service, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, Hawaii 96859-5000; formerly, Staff Psychiatrist, Department of Child Psychiatry, Tripler Army Medical Center, Honolulu, Hawaii

BRETT J. SCHNEIDER, MD

Lieutenant Colonel, Medical Corps, US Army; Deputy Chief, Department of Psychiatry, Building 61, Child and Adolescent Psychiatry Clinic, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307

MERRITT SCHREIBER, PhD

Captain, Scientist Corps, US Public Health Service (Inactive Reserve Corps); Senior Program Manager, Center for Public Health and Disasters, University of California at Los Angeles Center for the Health Sciences, 1145 Gayley Avenue, Suite 304, Los Angeles, California 90024; and Operations Lead, USPHS Mental Health Team II

ROBERT L. SHERIDAN, MD

Associate Director, Department of Surgery, Harvard Medical School at the Massachusetts General Hospital; Assistant Chief of Staff, Shriners Burn Hospital, 51 Blossom Street, Boston, Massachusetts 02114; formerly, Lieutenant Colonel, Medical Corps, US Army; US Army Institute of Surgical Research, Brooke Army Medical Center, San Antonio, Texas

EDWARD SIMMER, MD, MPH

Captain, Medical Corps, US Navy; Executive Officer, Naval Hospital, 1 Pinckney, Beaufort, South Carolina 29902; formerly, Senior Executive Director for Psychological Health, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Silver Spring, Maryland

TANGENEARE WARD SINGH, MD

Major, Medical Corps, US Army; Chief, Department of Behavioral Health, Blanchfield Army Community Hospital, 650 Joel Drive, Fort Campbell, Kentucky 42223

MARSHALL SMITH, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Behavioral Health, Landstuhl Regional Medical Center, CMR 402, Box 1357, APO AE 09180; formerly, Chief, Outpatient Behavioral Health, Landstuhl Regional Medical Center, Landstuhl, Germany

STEVEN SOUTHWICK, MD

Professor, Department of Psychiatry, Yale University School of Medicine and Yale Child Study Center, 333 Cedar Street, New Haven, Connecticut 06510; Adjunct Professor, Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, New York 10029; Deputy Director, Clinical Neurosciences Division, Department of Veterans Affairs National Center for Posttraumatic Stress Disorder, White River Junction, Vermont

JAMES J. STAUDENMEIER, MD, MPH

Colonel, Medical Corps, US Army; Consultant, Army Substance Abuse Program, Department of Psychiatry, USAMEDDAC, 11050 Mount Belvedere Boulevard, BMD (Wilcox), Fort Drum, New York 13602; formerly, Fellow in Geriatric Psychiatry, Walter Reed Army Medical Center, Washington, DC

FREDERICK J. STODDARD JR, MD

Associate Clinical Professor, Department of Psychiatry, Harvard Medical School at the Massachusetts General Hospital; and Chief of Psychiatry, Shriners Burn Hospital, 51 Blossom Street, Boston, Massachusetts 02114; formerly, Senior Surgeon, US Public Health Service

KATHERINE H. TABER, PhD

Research Health Scientist, Department of Research and Education, WG Hefner Veterans Affairs Medical Center, Mailstation 11M, 1601 Brenner Avenue, Salisbury, North Carolina 28144; formerly, Research Fellow, School of Health Information Sciences, University of Texas at Houston

ARTIN TERHAKOPIAN, MD, MPH

Major, Medical Corps, US Army; Chief, Inpatient Psychiatry, Department of Behavioral Health, William Beaumont Army Medical Center, 5005 North Piedras Street, El Paso, Texas 79920; formerly, Chief, Behavioral Health, 10th Combat Support Hospital, Baghdad, Iraq

RICHARD TOYE, PhD

Lieutenant Colonel, Medical Service Corps, US Army Reserve; Company Commander, 883rd Medical Company (Combat Stress Control), 495 Summer Street, Boston, Massachusetts 02210; formerly, Brigade Behavioral Health Consultant, 804th Medical Brigade, Fort Devens, Massachusetts

TINA TRUDEL, PhD

Site Director, Defense and Veterans Brain Injury Center at Virginia NeuroCare, 1101-B East High Street, Charlottesville, Virginia 22902; Assistant Clinical Professor of Psychiatry and Behavioral Neurobehavioral Sciences, University of Virginia Medical School, Charlottesville, Virginia 22902; formerly, Executive Director, Lakeview NeuroRehabilitation Center, Effingham Falls, New Hampshire

ROBERT J. URSANO, MD

Colonel, US Air Force (Retired); Director, Center for the Study of Traumatic Stress, and Chair, Department of Psychiatry, Room B3068, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

JEFFREY L. VOYLES, MDiv

Lieutenant Colonel, Chaplain Corps, US Army; Director and Clinical Supervisor, Chaplain Family Life Training Program, Building 2606 Collins Loop, Fort Benning, Georgia 31905

HAROLD J. WAIN, PhD

Chief, Psychiatry Consultation Liaison Service, Department of Psychiatry, Building 2, Room 6238, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5100

WENDI M. WAITS, MD

Lieutenant Colonel, Medical Corps, US Army; Chief, Inpatient Psychiatry Service, Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Room 4B106, Honolulu, Hawaii 96859-5000; formerly, Child and Adolescent Psychiatry Fellow, Tripler Army Medical Center, Honolulu, Hawaii

DEBORAH L. WARDEN, MD

Formerly, National Director, Defense and Veterans Brain Injury Center Headquarters; Departments of Neurology and Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; Departments of Neurology and Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5001

CHRISTOPHER H. WARNER, MD

Major, Medical Corps, US Army; Chief, Department of Behavioral Medicine, Winn Army Community Hospital, Building 9242, Room 20, 1083 Worcester Drive, Fort Stewart, Georgia 31324; formerly, Division Psychiatrist, 3rd Infantry Division, Fort Stewart, Georgia

TERRY C. WASHAM, MSSA, LISW

Colonel, Medical Service Corps, US Army Reserve; Military Liaison Coordinator, Office of Seamless Transition, Department of Veterans Affairs, VA Medical Center, 10000 Brecksville Road, Brecksville, Ohio 44141

PATRICIA WATSON, PhD

Assistant Professor, Dartmouth Medical School, 1 Rope Ferry Road, Hanover, New Hampshire 03755-1404; Senior Educational Specialist, Executive Division, Department of Veterans Affairs National Center for Posttraumatic Stress Disorder, White River Junction, Vermont

THOMAS C. WAYNICK, MDiv

Lieutenant Colonel, Chaplain Corps, US Army; Command Chaplain, Family, Morale, Welfare, and Recreation Command, 4700 King Street, Alexandria, Virginia 22301; formerly, Director and Clinical Supervisor, US Army Family Life Chaplain Training Program, Fort Benning, Georgia

SIMON WESSELY, MD

Department Head, Department of Psychological Medicine, King's Centre for Military Health Research, King's College, Weston Education Centre, 10 Cutcombe Road, London SE5 9RJ United Kingdom; formerly, Honorary Lecturer in Forensic Psychiatry, Institute of Psychiatry, London, United Kingdom

RICHARD J. WESTPHAL, PhD, RN

Captain, Nurse Corps, US Navy; Psychological Health Promotion Programs, Department of the Navy, Bureau of Medicine and Surgery, Deployment Health, 2300 E Street NW, Washington, DC 20372

KATHLEEN M. WRIGHT, PhD

Research Psychologist, US Army Medical Research-Europe, Walter Reed Army Institute of Research, CMR 442, Box 94, APO AE 09042; formerly, Deputy Chief, Department of Military Psychiatry, Walter Reed Army Institute of Research, Silver Spring, Maryland

JEFFREY S. YARVIS, MSW, PhD

Lieutenant Colonel, Medical Service Corps, US Army; Chief, Behavioral Health, Department of Psychiatry, Borden Pavilion, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307; formerly, Director of Social Work, Uniformed Services University of the Health Sciences, Bethesda, Maryland

TODD YOSICK, LISW

Major, Medical Service Corps, US Army; Deputy Director, Resilience and Prevention Directorate, Office of the Assistant Secretary of Defense for Health Affairs, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, 1335 East-West Highway, Silver Spring, Maryland 20910; formerly, Chief, Battlemind Training Office / Chief, Combat and Operational Stress Control, Army Medical Department Center and School, Fort Sam Houston, Texas

Foreword

Military healthcare has the unique opportunity of truly addressing the full continuum of illness, injury, disease, and health. Just as military healthcare professionals have made significant contributions to the improvement of physical health and lessening of injury and disease over the history of the United States, we are now a leading proponent of changes in prevention, recognition, and treatment in multiple areas of behavioral health.

Essential to progress in this arena is developing awareness of behavioral health needs and educating our beneficiaries about the appropriateness of receiving care for what are often “invisible” diseases or injuries. The need for this education and developing a toolkit of successful skills, techniques, and strategies for resilience have never been more apparent than during what has become a persistent state of conflict. We are committed to leading the Nation in eliminating the stigma of behavioral health problems. Men and women within our militaries and across America must learn that it is just as acceptable and appropriate to seek behavioral healthcare as it is to seek treatment for a broken bone.

Since the publication of the two *Textbooks of Military Medicine* psychiatry volumes—*Military Psychiatry: Preparing in Peace for War* (1994) and *War Psychiatry* (1995)—we have made tremendous strides. This volume, *Combat and Operational Behavioral Health*, expands on these previous two volumes, covering the full breadth of the psychological and behavioral health continuum. Important contributions include preparation for deployment and resiliency training; the provision of services in theater; recovery after physical or emotional injury due to combat; reunion and reintegration; military children and families; operational psychiatry; and the daunting challenge to prevent suicide.

I see our effect on social attitudes toward behavioral and/or psychological health as potentially substantial. Our prospects are good for a better understanding of the neurochemistry and basic pathophysiology of many common stress-related problems, and our grasp and management of millennia-old problems of armed conflict are much improved. However, major challenges remain. One may think the diagnosis of posttraumatic stress disorder (PTSD), for example, would be straightforward. On the contrary, it varies widely among different stakeholders. The more complex issues of the etiology of PTSD and traumatic brain injury, and effective treatments for these conditions, as well as their interaction with age, gender, and other medical issues, are far more daunting.

This new textbook is an excellent resource for all healthcare professionals as they strive to provide the finest quality and most compassionate care of the men and women in uniform and their spouses, significant others, and children. Every person who is in contact with a military member struggling to cope with the emotional trauma of war, disease, or injury needs our support and best efforts.

The contributions of the exceptional civilian and military professionals in this outstanding text can raise the quality of behavioral healthcare across our land and help eliminate the stigma of requesting this care. Although we talk a lot about the reduction of stigma, to actually reduce it and improve Soldiers’ willingness to seek treatment is a Herculean task. Therefore, let us all participate in this essential step forward for the health and well-being of those who have often suffered in silence and alone.

Lieutenant General Eric B. Schoomaker, MD, PhD
The Surgeon General and
Commanding General, US Army Medical Command

Washington, DC
February 2010

Preface

This book was begun in 2005 when it became apparent that an update to the previous volumes on military psychiatry—*Military Psychiatry: Preparing in Peace for War* (1994) and *War Psychiatry* (1995)—was needed. In the almost 20 years since the chapters in those two volumes were drafted, enormous changes and advancements in classification, diagnosis, and treatment of combat stress have occurred. The pace of change has accelerated with the wars in Afghanistan and Iraq. These wars have become known by many names: Operations Enduring Freedom and Iraqi Freedom, the Long War, and continuous overseas contingency operations, among others.

In the early years of the operations in Afghanistan (2001) and Iraq (2003), changes in operational tempo and resulting extended deployments were extremely taxing for military families. What was problematic in these early years (tempo and deployment) because of the change from past experience has now become problematic because it is the norm. The murders and murder/suicides at Fort Bragg, North Carolina, in 2002 highlighted the perils of soldiers' rapid return from Afghanistan battlefields to civilian life. The investigations at Fort Bragg and other installations revealed continuing problems with access to care, as well as reluctance of career-minded soldiers to seek treatment.

In response to these and other events, training and systems were put into place to prepare soldiers for "redeployment" (return to garrison). One of the earlier approaches, "Battlemind," was designed to help reintegrate service members and families. Battlemind recently evolved into the Comprehensive Soldier Fitness program, which is focused on enhancing resiliency. Despite these various new programs, many soldiers remain reluctant to seek behavioral healthcare for many reasons, perhaps the greatest of which is worry about its effects on their careers. Stigma is a persistent problem, despite numerous efforts to reduce its prevalence. Often it is the soldiers' families who try to get these service members in for treatment. To improve access to care, the Army and other services have dramatically increased their number of mental health providers, up about 70% between 2007 and 2010.

To assist this growing population of service members, the military behavioral health community has added many new systems of evaluation and care. The Post-Deployment Health Assessment (PDHA), which screens soldiers on return from theater, was implemented after the Persian Gulf War (1990–1991). However, soldiers often did not admit to symptoms after deployment because they wanted to get home as soon as possible. Beginning in 2005, the PDHA was joined by the Post-Deployment Health Re-Assessment (PDHRA), administered at 3 to 6 months after return. It was designed to connect with service members after "the honeymoon" of returning home was over.

Family programs have been expanded to help with issues that arise during both deployment and redeployment. There are specialized programs at Walter Reed Army Medical Center and other facilities for families of the wounded that attempt to prepare children to see parents missing a limb or disfigured from a blast. Another difficult area has been support to families of the deceased. US military families have not faced these numbers of service-connected fatalities since the Vietnam War. In the past, spouses and children were required to leave base housing and service-centered support systems relatively soon after their loved one's death. This policy has changed over time, with longer access to housing and healthcare afforded these families.

Traumatic brain injury (TBI) is another major concern and affects families as well as service members. The sources of these injuries are varied: blasts, gunshot wounds, accidents. TBI can present with many symptoms, some similar to posttraumatic stress disorder, including irritability, impulsiveness, and personality changes.

The rising suicide rate has been a major concern for all in the Army. The combination of unit and individual risk factors include high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. Consistent and high-profile attempts have been made to reduce suicide with numerous training programs for service members, focusing on buddy aid and gatekeepers. However, thus far these efforts have been only partially successful. The prolonged effects of exposure to violence and death are not easy to change.

New efforts to assist service members continue. The Defense Center of Excellence was stood up in November 2007, with a focus on best practices and reducing stigma. Other programs are the Comprehensive Behavioral Health Campaign Plan, the Department of Defense–Department of Veterans Affairs Integrated Mental Health Plan, and the National Intrepid Center of Excellence.

An ongoing concern is the long-term effects of the Long War, for the next 20, 30, or 50 years. After the Viet-

nam War, far too many veterans ended up on the streets—unemployed, homeless, and addicted. By examining the potential causes of combat stress and emotional trauma, the various approaches to diagnosis and treatment, the roles of providers (and their own resiliency), and the many programs available to help, this volume seeks to reduce the difficulties faced by veterans as they reenter civilian life. However, success in this area will require a concerted effort by all on the home front, including the Army, other branches of the military, the Department of Veterans Affairs, other federal agencies, and state and local agencies, as well as civilian and private organizations. It is hoped that the interventions described in this volume will contribute to that effort by informing and guiding military and civilian healthcare providers, the public, and both active duty service members and veterans of these most recent conflicts.

Elsbeth Cameron Ritchie, MD, MPH, Colonel, US Army (Retired)
Chief Clinical Officer, District of Columbia Department of Mental Health
Formerly, Psychiatry Consultant to The Army Surgeon General, and Director, Behavioral Health Proponency,
Office of The Surgeon General

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