Military Health as Part of Emergency Responding

MEASURING DEPLOYMENT RISK AND RESILIENCE IN MILITARY PERSONNEL AND VETERANS
By Rachel A. Vaughn, Dawne Vogt, Daniel W. King, Lynda A. King, Brian N. Smith, Joyce M. Wang, and Brooke A. L. Di Leone

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Military Mental Health as Part of Emergency Responding

Colonel Robert Morecook, Lieutenant Colonel J. Ray Hays, Colonel James L. Greenstone, and Major Richard Chaumier

Psychology is a helping profession, and psychologists want to help people who are in need. When disaster strikes, natural or manmade, people whose lives are disrupted or who must leave their homes have many needs. At times during disasters, there is a public request for professionals to give their expertise, their time and energy to help those who are experiencing a wide variety of difficulties. What we have learned about volunteer efforts is that help by individuals can be useful, but organized group efforts offer better, faster, more consistent, and more effective results. There are a number of groups, some more organized than others, specially trained to respond to both health and mental health concerns when disaster strikes in Texas. These include the Texas State Guard, the American Red Cross, the Salvation Army, Disaster Medical Assistance Teams from the U.S. Department of Health and Human Services, the civilian Medical Reserve Corps of U.S. Surgeon General’s Office, and Civilian Emergency Response Teams. Disasters for which these groups train include natural disasters, such as hurricanes and floods, and manmade disasters, such as mass casualty accidents or terrorist attacks.

Texas psychologists have found a new and organized way of serving Texans who are struggling with mental health problems or stress related issues during Texas disasters. These psychologists, as members of the Texas State Guard of the Texas Military Forces, provide crisis intervention, supportive counseling, and referrals in evacuation shelters or temporary public health clinics. State Guard members have been used as surge responders in Hurricanes Katrina and Rita in 2005, Gustav and Ike in 2008, and Alex in 2010.

What is the Texas State Guard?

The Texas State Guard is one of the three branches of the Texas Military Forces. The Texas Military Forces are composed of the Texas Army National Guard, the Texas Air National Guard, and the Texas State Guard. The mission of the Texas State Guard is to provide mission-ready military forces to assist
state and local authorities in times of state emergencies under the umbrella of Defense Support to Civil Authorities. A principle role within that mission of the Texas State Guard is to set up and staff evacuation shelters during times of disaster. The Texas State Guard has units distributed throughout the state with six army regiments, one maritime regiment, two air wings, and one Medical Brigade. Psychological services are found in the medical brigade. The mission of the Medical Brigade is to provide licensed health support personnel and expertise in response to natural and manmade disasters. As surge responders, the Texas State Guard supplements and supports local public health authorities when assigned to do so by the Texas Adjutant General and the Governor of the State of Texas. Besides psychologists, other health professionals serve in the Texas State Guard. These include physicians, nurses, pharmacists, dentists, paramedics and other allied health personnel. Behavioral health professionals include psychologists, psychiatrists, clinical social workers, psychiatric nurses, marriage and family counselors, licensed professional counselors, and certified drug and alcohol abuse counselors.

Over a two week period in 2010, the Texas State Guard, working with the Department of State Health Services and the Texas Army National Guard, provided care for approximately 13,000 patients with medical problems. Unlike personnel in the Texas National Guard or U.S. Army Reserve, members of the Texas State Guard serve under the direction of the Governor of Texas and cannot be federalized or deployed outside of Texas. Thus, the Texas State Guard serves only in Texas, or with special agreement by the Governor of Texas and with the members’ permission, in neighboring states. When deployed, Texas State Guard personnel are paid a standard daily stipend, regardless of military rank. As part time employees of the State of Texas, Guardsmen receive workmen’s compensation insurance coverage when on duty and selected other benefits.

Need for Mental Health Services in disasters

The importance of mental health services after emergencies has been underscored by a number of findings in recent years. For example, during Hurricanes Katrina and Rita, behavioral health problems were the second most frequently cited problems occurring at the Federal Medical Stations in Waco and Marlin, Texas, and the Naval Air Station in Meridian, Mississippi (Davis, 2006). These federal shelters provided temporary, non-acute inpatient medical care when disaster overwhelmed local medical resources. At these three evacuation sites, among evacuees (N = 258), hypertension was the most frequently cited presenting problem (41%), followed by behavioral health issues (37%), diabetes (24%), heart disease (16%), and asthma (15%). Depression was most commonly seen behavioral issue (27%), followed by schizophrenia and other psychoses (20%), anxiety disorders (15%), bipolar disorder (12%), Alzheimer and other dementias (9%), and unspecified conditions (13%). Many of these patients presented co-morbid physical health and behavioral health problems (26%), and a lesser number presented behavioral health issues alone (4%).

Another data set provided evidence that mental health problems in such settings are significant. Operation Lone Star (OLS) is an annual medical training exercise of the Texas Military Forces, led by the Texas State Guard. OLS is designed to set up and provide free public health clinics for the medically underserved population in the Rio Grande Valley of Texas. These clinics simulate the creation and provision of medical care in disaster evacuation clinics. Over a two week period in 2010, the Texas State Guard, working with the Department of State Health Services and the Texas Army National Guard, provided care for approximately 13,000 patients with medical problems. The first author of this article (Morecook, 2010) obtained a convenience sample of patients (N = 75) at one clinic site. Patients were requested to complete the Modified Mini Screen (Dartmouth Psychiatric Research Center, 2010) prior to a physician visit. Twelve percent of the sample were identified as being at a significant risk of mental health problems, with an additional 9% at moderate risk, using published cut-off scores (Morecook, Greenstone, & Hays, 2010).

Maj. Richard Chaumier, a Texas State Guard, Medical Brigade psychologist, recently noted that as well as providing services to evacuees, one of the responsibilities of the Medical Brigade is to provide supportive care to Texas military personnel during and after disasters. He remarked that military personnel leave behind their families when called to active duty to assist others. Thus, Texas State Guardsmen experience stress associated with being separated from their families as well as experiencing stress from caring for evacuees who are housed in disaster shelters.

In ordinary evacuation shelters, when compared to Federal Medical Stations, Maj. Chaumier said most evacuees that he saw were dealing with the confusion of being separated from their homes, their loved ones, and a very uncertain future. Many of these evacuees had pre-existing pathologies made worse by fears for personal and family safety during the disaster.

Mental health skills in evacuation shelters

There are specific skills that can be developed for offering services in shelter situations. Specifically, psychological first aid (MRC, 2010) is an evidence-based approach that can be ef-
Deployment-related experiences have consistently demonstrated effects on health and well-being in service members returning from deployment (e.g., King, King, Foy, Keane, & Fairbank, 1999; Lee, Vaillant, Torrey, & Elder, 1995; Vogt, Pless, King, & King, 2005; Wells et al., 2010). To adequately assess factors that may impact health following military deployment, valid instruments are needed. The Deployment Risk and Resilience Inventory (DRRI; King, King, & Vogt, 2003) is a suite of scales that can be used to measure psychometric risk and resilience factors prior to, during, and after military deployment.

The original DRRI includes 14 scales that assess 2 pre-deployment, 10 deployment, and 2 post-deployment risk and resilience factors. They may be administered as a single suite of scales or as stand-alone measures. (For more information on instrument construction, instructions for use, and scoring guidelines, see King et al., 2003, and King, King, Vogt, Knight, and Samper, 2006).

### Original DRRI Scales

<table>
<thead>
<tr>
<th>Pre-deployment Factors</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Life Stressors</td>
<td>Exposure to highly stressful or traumatic life events before deployment.</td>
</tr>
<tr>
<td>Childhood Family Functioning</td>
<td>Quality of family relationships in early life in terms of discord, cohesion, and closeness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deployment Factors</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Preparedness for Deployment</td>
<td>Extent to which service members felt prepared for deployment in terms of equipment, supplies, and training.</td>
</tr>
<tr>
<td>Difficult Living and Working Environment</td>
<td>Exposure to circumstances or events representing day-to-day irritations or pressures related to life in the war-zone.</td>
</tr>
<tr>
<td>Concerns about Life and Family Disruptions</td>
<td>Concerns that deployment will negatively affect important life and family domains.</td>
</tr>
<tr>
<td>Deployment Social Support from Unit Members and Leaders</td>
<td>Support and encouragement provided by the military in general, unit leaders, and fellow unit members during deployment.</td>
</tr>
<tr>
<td>Sexual Harassment</td>
<td>Exposure to unwanted sexual conduct from fellow unit members, unit leaders, or civilians in the war zone.</td>
</tr>
<tr>
<td>General Harassment</td>
<td>Exposure to non-sexual harassment that may occur in relation to biological sex, gender roles, race/ethnicity, or other personal characteristics.</td>
</tr>
<tr>
<td>Perceived Threat</td>
<td>Fear for safety and well-being during deployment, especially as a response to potential combat exposure. These cognitive and emotional appraisals may or may not accurately reflect factual or objective reality.</td>
</tr>
<tr>
<td>Combat Experiences</td>
<td>Objective exposure to traditional combat experiences and events such as firing a weapon, going on combat patrols or missions, or receiving incoming fire.</td>
</tr>
<tr>
<td>Exposure to the Aftermath of Battle</td>
<td>Exposure to the consequences of combat including handling human remains and exposure to devastated communities and refugees.</td>
</tr>
<tr>
<td>Self-reports of Nuclear/Biological/Chemical Exposures</td>
<td>Exposure to nuclear, biological or chemical agents that service members believe they encountered in the war zone.</td>
</tr>
</tbody>
</table>
Post-deployment Factors
Post-deployment Social Support
Post-deployment Life Stressors

Descriptions
Emotional support and instrumental assistance from family, friends, and the community more generally.
Exposure to highly stressful or traumatic life events after returning from deployment.

Uses of the DRRI

The DRRI is designed for administration to military and veteran populations. The broad scope of the DRRI scales allows for an assessment of deployment experiences that goes beyond simply measuring exposure to traditional combat and addresses a network of events and circumstances occurring before, during, and after a military deployment. The DRRI is suitable for use across a variety of deployment circumstances (e.g., combat deployment, peace-keeping missions) and different subsets of deployed service members (e.g., combat arms and service support roles, men and women, Active Duty and National Guard/Reserve members, veterans of different deployment cohorts, U.S. veterans and those from other countries). While this set of scales was developed as a research tool, the DRRI may also be used by clinicians to obtain information about deployment experiences that can inform the application of diagnostic tools and interventions. The DRRI has demonstrated acceptable psychometric properties: Internal consistency and test-retest reliability have been found to be quite satisfactory, and validity has been supported by meaningful group differences and expected associations with external variables (e.g., Fikretoglu, Brunet, Schmitz, Guay, & Pedlar, 2006; King et al., 2006; Vogt, Proctor, King, King, & Vasterling, 2008).

There has been significant interest in the DRRI within the deployment stress field. Large-scale studies that have used or plan to use DRRI scales include the VA Neurocognition Deployment Health Study (Brailey, Vasterling, Proctor, Constans, & Friedman, 2007), the Readiness and Resilience in National Guard Soldiers (RINGS) cohort study by Polusny and colleagues (Polusny et al., 2009), and the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience (STRONG STAR). The DRRI is included as part of the core battery of assessment measures for all treatment studies conducted under this network, such as Resick and colleagues’ examination of the efficacy of Cognitive Processing Therapy for combat-related PTSD in active duty military personnel. From 2004-2010, 37 publications appeared in peer-reviewed psychological journals reporting use of DRRI scales. For example, scales have been implemented in studies examining the effect of deployment experiences on post-deployment health and

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functioning (Fikretoglu et al., 2006; Marx et al., 2009; Vasterling et al., 2010), the influence of pre-deployment factors on post-deployment health and functioning (Carter-Visscher et al., 2010; Marx, Doron-Lamarca, Proctor, & Vasterling, 2009; Wilson et al., 2008), and the impact of interpersonal relationships and support during and following deployment on post-deployment health and readjustment (Bailey et al., 2007; Pietrzak et al., 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Ongoing Attention to the Psychometric Quality of the DRRI

While ample evidence is available for the reliability and validity of the DRRI, and initial evidence suggests that DRRI scales are valid for use in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans (Vogt et al., 2008), maintaining the psychometric quality of a set of scales is an ongoing process that involves updating the language and content to ensure psychometric properties do not degrade over time. The original DRRI measures were constructed and validated in veterans of the 1990s Gulf War, and some of the items and language may pertain more expressly to that conflict than to current and potential future deployment operations. Additionally, there has been a call for additional content focus on family functioning and relationships surrounding the phases of deployment, as well as shorter scales for abbreviated assessments. To address these issues and ensure that the DRRI is relevant and applicable to current and future cohorts of military service members and veterans, a large-scale project to update the DRRI and validate new and updated scales in a sample of OEF/OIF veterans was funded by the VA Health Services Research & Development Service (VA HSR&D Grant DH1 09-086-2). This project is currently underway.

Development and Validation of DRRI-2

The primary aims for the project are to revise the DRRI by updating the language and content of existing items as appropriate, expanding the assessment of combat-related stressors, and developing new scales to assess family-related risk and resilience factors across deployment phases. To facilitate these goals, focus groups were conducted with veterans who served in OEF/OIF. Veterans were asked to identify missing content domains within the DRRI.

For more information on the contributions of focus group methodology to measure development, see Vogt, King, and King (2004). Revisions to the DRRI were also informed by an updated literature review and feedback from experts in the field. Revised and new items for each DRRI scale were administered along with the original items to a national sample of OEF/OIF veterans to evaluate the psychometric impact of changes to the DRRI.

Upon completion of data collection, Classical Test Theory (CTT) analyses were conducted to examine dispersion of responses, internal consistency reliability, incremental validity, and criterion-related validity. Item Response Theory (IRT) analyses were conducted to identify gaps in content and to identify overlapping or redundant item content. Analyses from the first wave of data collection revealed that revised and new DRRI scales demonstrated high internal consistency reliability (alpha coefficients averaging .85) and strong relationships with post-traumatic stress symptomatology (correlations averaging .37), suggesting that revisions did not result in decrements to the psychometric quality of the DRRI. Based on the CTT and IRT results, recommendations from the literature, and consultation with content and psychometric experts, revised versions of each scale were then prepared for administration to a second national sample of OEF/OIF veterans, along with several mental and physical health measures. The objective of this next phase of data collection is to examine and document the scales’ discriminant validity, criterion-related validity, and discriminative validity. Analyses from the second wave of data collection will result in the finalization of the DRRI-2, which is expected to be completed by summer of 2011.

Strengths of the DRRI-2

The DRRI-2 improves upon the original suite of scales in several ways. The content and language of items has been updated to ensure applicability and relevance across a variety of deployment circumstances and military cohorts. There is a greater focus on family functioning and family-related stressors during and after deployment. Finally, while new scales have been added, many of the existing scales are shorter in length.

Development Factors
Deployment Social Support from Friends and Family
Family Stressors
Post-deployment Factors
Post-deployment Family Functioning

<table>
<thead>
<tr>
<th>New DRRI Scales</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional support from family members and friends back home during deployment.</td>
<td></td>
</tr>
<tr>
<td>Exposure to objective family stressors during deployment, including financial problems, family adjustment issues, and conflicts.</td>
<td></td>
</tr>
<tr>
<td>Quality of relationships in current family (discord, cohesion, and closeness).</td>
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</tbody>
</table>

In conclusion, the DRRI-2 and its predecessor, the DRRI, provide psychometrically sound scales that can be used to assess deployment-related experiences with documented implications for the post-deployment health of service members and veterans. Ongoing attention to ensure the relevance and psychometric quality of the DRRI represents a major strength of this inventory of scales.

1VA Boston Healthcare System, National Center for PTSD, Women’s Health Sciences Division
2VA Boston Healthcare System, National Center for PTSD, Behavioral Science Division
3Boston University, Department of Psychiatry
4Boston University, Department of Psychology
The question of questions for mankind---the problem which underlies all others, and is more deeply interesting than any other---is the ascertainment of the place which Man occupies in nature and of his relations to the universe of things. ~ Huxley

The photoplay tells us the human story by overcoming the forms of the outer worlds, namely, space, time, and causality, and by adjusting the events to the forms of the inner world, namely, attention, memory, imagination, and emotion. ~ Munsterberg

That is happiness; to be dissolved into something complete and great. When it comes to one, it comes as naturally as sleep. ~ Cather

But we were built for more. As a species, humans evolved a most uniquely advanced and specialized neurological and bodily apparatus. The distinguishing feature of this remarkable strategy was self-awareness, to bestow anxiety about mortality, the meaning of self, and destiny in relation to the Universe. In a clan of social animals, we recognized that the spirit to sustain survival had to be fortified with the realm of the mind for exploring and rehearsing scenario options. There was dream work by night and narrative imagination by day, in stories and artistic expression that is now the province of the Arts, Religion, Politics and the other blending social enterprises. This bringing us all together into a story creates solidarity in mood, membership, and might. This is a good thing. But the routinizing demands of dogmatic cultural beliefs and practices, tribal identities, and bureaucracy can be costly and self-defeating when they impose rigidities that stifle creativity and foster divisions, depleting energy and morale.

The vehicles of the revered sacred texts and religious art expressions are, for many, not sufficient. In the pervasively disenchanted World of Secular Modernity, we search for guidance and renewal of the human spirit as much as ever before---just not all in the same places as ever before. The century of cinema and other storytelling electronic media from TV to video gaming have realized the McLuhanesque prediction for our progressively interconnected polycultural Global Village.
Today’s multiplex theater is a moviegoer’s Holy Sanctuary, insulated from everyday trials and tribulations. It is a hallowed Temple for renewal of Faith in our intrinsic bonds, for the pursuit of Truth, for contemplation together among co-acting others of Meaning in our shared human predicament, and for confirming our mutual capacities for joy, suffering and the full range of connective Human Emotion. 

As we sit quietly together, the “sermons” come to life. Each moviegoer dwells there in respectful silent meditative awe (no cell phones, texting, or idle chatter, if you please) among fellow souls of congregants in their rows. The spectacle of the iconic stories and characters reveals lessons amidst drama, unfolding special effects, marvelous costumes and elaborate set embellishments, with a power akin to the fantastic Biblical fables that captivated pre-cinematic cultures. The language of film is Universal. The majestic stories grip us in rapt attention as we suspend disbelief, indulge fantasy, examine our worst fears and reflect on our deepest hopes. The underlying mythologies miraculously spring forth and Doubt is momentarily vanquished. Communal, we savor sustenance and renewal from the refreshment stand’s popcorn and coke. Most of all, we savor sustenance and renewal, as we sit and consider together, often during or at the dawn of Sabbath, the Mysteries of Life.

Narrative sells. It always has. Once upon a time it was only the Holy Scriptures, with the Bible as our bestselling book of all time. Now we have the Hollywood Scriptures too. But what is it about storyline that compels us? And what difference does it make to us as individuals and as a culture that this about us is so? The forthcoming Hollywood Scriptures: Why we go to the movies, What happens to us while we are there, and How it matters more than we may think will dazzle its readers with film critique, as it brings to life our love of story from the dawn of time to what lies ahead for the narrative creatures that we are.
ffecti ve in aiding evacuees to deal with the stress involved from experiencing a disaster and displacement from their normal environment. There are training materials that offer guidance for techniques to use and behaviors to avoid in working with evacuees. (Greenstone, 2008, and Greenstone and Leviton, 2011). Another such training manual developed for the United States Public Health Service Medical Reserve Corps (2010) can be used as a curriculum for psychological first aid or studied independently by individuals who want to add to their skill set.

Psychologists involved in the Texas State Guard
Three Texas psychologists in the Texas State Guard, Col. Robert Morecook, Maj. Richard Chaumier, and Maj. Kristin Anderson, have provided mental health services in evacuation shelters after Texas hurricanes. Others have since joined in preparation for future disasters. These include Lt Col. J. Ray Hays and Capt. Ross Keiser.

What you can do
Texas psychologists have the opportunity to play an important role in support of the public health of disaster evacuees and for the persons who care for them. Medical Brigade units of the Texas State Guard are found throughout Texas and welcome applications from prospective members. More information about the Medical Brigade is available at its website http://tmb.txsg.state.tx.us/
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