Structured Clinical Interview Guide for Psychological Screening Programs at Post-Deployment

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Structured clinical interviews are a key component of the US Army Medical Research Unit – Europe (USAMRU-E) psychological screening program. Such interviews are critical for establishing valid research outcomes and for guiding the training and implementation of psychological screening. To standardize the interview process, USAMRU-E developed a structured interview guide. The current interview guide was designed in response to both clinical requirements and research findings. The guide includes sections on depression, suicidality, post-traumatic stress disorder, anger, relationship problems, alcohol problems, and sleep problems. In addition, there is an open-ended section on other problems and a section for case dispositions. Data from a 2005 blind validation study with troops returned from a year-long combat deployment are included to demonstrate the utility of the structured interview. Possible guidelines and implementation considerations for adapting this structured interview are discussed.

• Psychological Screening Background

Psychological screening provides military mental health professionals with an effective method of assessing the mental health needs of military personnel recently returned from deployment. The original US Department of Defense (DOD) psychological screening program was initiated by OSD Health Affairs in February 1996 for military personnel returning from the Bosnia Area of Operations. At that time the US Army Medical Research Unit-Europe (USAMRU-E) was tasked with providing analytical support for the program (e.g., Adler, Huffman, Bliese, & Castro, 2005; Adler, Wright, Huffman, Thomas, & Castro, 2002). Subsequently, the screening program underwent a series of changes as it continued to be implemented in peacekeeping deployments. For a detailed historical review of the screening program, see Wright, Huffman, Adler, and Castro (2002).

In 2002, USAMRU-E began systematically assessing the validity of the psychological screening instrument. To-date the research program has included three blind validation studies conducted with US Army, Europe military personnel preparing to and returning from deployment to Iraq (Bliese, Wright, Adler, & Thomas, 2004; Ployhart, 2004).

Although aspects of the screening program have changed over time, throughout its development, the

psychological screening program has consisted of a primary screen. This primary screen is a survey that assesses a range of clinical dimensions. The dimensions used in the current version of the screen were selected based on content validation research conducted in 2002 and 2004 (Wright, Thomas, Adler, Ness, Hoge, & Castro, 2005). The dimensions include depression, post-traumatic stress disorder, relationship problems, alcohol problems, and sleep problems. In addition, suicidal and homicidal ideation were included to assess need for immediate referral. Table 1 summarizes the scales and related references for the items on the screening survey. The items and cut-offs associated with elevated scores on these dimensions were selected based on sensitivity and specificity analyses conducted using data from the 2004 blind validation studies (Bliese, et al., 2004; Ployhart, 2004).

Table 1. Primary Screen Survey

Clinical Dimensions	Scale
Depression	Patient Health Questionnaire - Depression (PHQ-D) (Spitzer, Kroenke, & Williams, 1999).
Suicide Risk	Item 9 of PHQ-D (Spitzer, Kroenke, & Williams, 1999).
PTSD	Post Traumatic Stress Disorder (DD2796, Post-Deployment Health Assessment, 2003).
Anger	Modified items from open literature (USAMRU-E, 2004).
Relationship Problems	Quality of Marriage Index (Norton, 1983).
Alcohol Problems	The Alcohol Use Disorders Identification Test (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Two-Item Conjoint Screen (TICS) (Brown, Leonard, Saunders, & Papasouliotis, 2001).
Sleep Problems	Insomnia Severity Index (Morin, & Espie, 2003).

The procedure for psychological screening has been relatively consistent across studies. In general, after the primary screen is completed, it is scored on-site by screening staff. Individuals scoring above cut-off criteria, as well as a random selection of 20% of those scoring below criteria, are then briefly interviewed using a structured clinical interview guide to determine referral need. This structured clinical interview is the focus of the present research report.

• Structured Clinical Interview Background

The concept of developing a structured clinical interview following administration of the primary screen originated in the field. Specifically, military mental health care providers screening personnel returning from the Bosnia Area of Operations developed a one-page case disposition sheet to track referrals. In parallel, USAMRU-E developed a Standard Operating Procedure (SOP) for guiding interviewers. Variations in the recommended interview procedure evolved over the course of the screening program. When the first validation study was conducted in 2002, a semi-structured clinical interview guide was designed. With the implementation of blind validation studies in 2004, this guide was redesigned, using an established structured interview format as its basis.

Rationale. There were two major reasons for establishing a structured interview format. First, a structured interview was required in order to execute blind validation studies. That is, some kind of clinical "gold standard" was required to assess the validity of the clinical dimensions of the primary screen survey. Second, military mental health providers in operational units requested detailed guidance on how to conduct the follow-up clinical interviews. Over the years, USAMRU-E has received multiple requests for training clinical interviewing staff. These requests came from units in garrison (the US and in Europe), peacekeeping and combat operations.

Ultimately, the goal of developing a structured clinical interview is to complete the psychological screening package being delivered to the US Department of Defense. This package ideally will consist of a short, validated primary screening survey, a structured clinical interview guide that can be adapted for easy administration in operational units, and a screening procedure that can be flexibly applied to large scale screening efforts.

Research data. As part of this long-term goal, the structured clinical interview presented here reflects both recommendations for clinical practice accompanied by results from applications of the interview in a 2005 blind validation study. This study was conducted with Soldiers three to four months following a one year combat deployment to Iraq. Although participation in the post-deployment screening program was command-directed, all of the Soldiers included in this analysis consented to having their data used for research purposes. In the 2005 study, 780 Soldiers were screened and 724 (or 92.8%) consented to have their data analyzed. Of these 724 Soldiers, 18.6% (n=135) were referred for follow-up assessment with mental health. The data presented here are based on the 135 Soldiers who were referred using the structured clinical interview[1]. The interviewers and the Soldiers did not know the results of the primary screen or the cut-off status on the clinical dimensions.

The rates of referral for the various clinical dimensions reported here reflect the prevalence of mental health problems in this population. The prevalence rate was determined by examining the number of referrals as a percentage of all Soldiers screened. This rate can be used to project referrals in a population of Soldiers who have returned from a combat deployment. Using the gold standard structured interview guide as a confirmatory test, allows greater precision in tailoring follow-up programs and services. There are several key principles that must be considered when developing a structured interview guide that serves as a gold standard.

- **Key Principles**

[1] Of the 724 Soldiers, 29.1% (n=211) exceeded criteria on the primary screen and were interviewed and 70.9% (n=513) did not exceed criteria on the primary screen. Of these 513, 30.4% (or n=156) were randomly selected for a brief clinical interview. Thus, a total of 367 Soldiers were interviewed using the structured clinical interview, 211 (57.5%) of whom exceeded criteria on the primary screen and 156 (42.5%) of whom did not.

Areas of clinical relevance vs. clinical diagnoses. Traditionally, structured clinical interviews address the complete list of diagnostic categories that appear in the Diagnostic and Statistical Manual of Mental Disorders (APA, 4th edition, 1994). Based on our content validation work with military personnel, we selected only the most pertinent clinical areas for inclusion in the structured clinical interview guide. Furthermore, we also included areas that may not have direct counterparts in terms of diagnostic criteria but which are nevertheless highly relevant for military populations. These areas, including anger problems, marital conflict, and sleep problems, are considered to be global symptom areas that should be assessed in some capacity by clinicians interviewing military personnel post-deployment. Whether symptom areas such as sleep or anger are indicative of additional co-morbid problems, are early warning signs of emerging problems, or represent problem areas in their own right, they are worthy of further assessment should they be reported by military personnel.

Triage vs. Intake. By definition, the screening process is designed to be short and easily administered. With these goals in mind, any structured interview should be geared to triaging large numbers of military personnel in a short amount of time. Such an interview should target the most common symptom areas and assess them quickly and efficiently. Thus, although excellent structured diagnostic interview schedules are available, they are time consuming and not appropriate for the needs of this particular population. In response to the requirement to screen literally thousands of soldiers in a matter of weeks, a short, targeted interview was developed.

Stringent criteria vs. clinical guide. In establishing any structured clinical interview, there is a balance needed between developing questions that match every possible clinical diagnostic category and developing questions that serve as a guide for clinical decision-making. In the

interview format presented here, we try to maintain this balance by presenting varying decision points for clinicians to use. In addition, when applicable, we have opted for including a range of relevant questions about particular clinical dimensions rather than relying exclusively on stringent diagnostic criteria that result in a series of decision points in which a line of interview questions is discontinued. In addition, for those individuals scoring high but not being recommended for follow-up, a place to record the rationale for this decision is included.

Semi-structured vs. structured interview. For research purposes the structured interview was followed very closely with the majority of follow-up questions reserved for the end of the interview. The questions were also asked verbatim in the research studies. In an applied clinical setting, the interview is probably best regarded as a semi-structured format, although using the original language makes the interviews consistent across clinical providers.

• Clinical Dimensions

Depression

Overview. The structured interview module for depression primarily taps symptoms of Major Depressive Disorder (MDD). It is adapted directly from the MINI International Neuropsychiatric Interview (MINI; Sheehan et al., 1998).[2] There are a total of nine symptom questions and two additional background questions. In the original MINI, endorsement of at least one of the first two symptom questions is required to proceed with the rest of the module. These two questions reflect the diagnostic criteria for MDD.

In adapting this module for clinical purposes, we broadened possible response options to the symptom questions to include not only "nearly every day for the past two weeks" but also "more than half the days for the past two weeks." This adaptation is consistent with the same adjustment used by Spitzer, Kroenke, and Williams (1999) in their validation of the Patient Health Questionnaire for Depression. Lowering the frequency threshold may help identify military personnel with significant symptoms of depression and not just those who meet stringent criteria for MDD. That is, we are interested in identifying those who may meet criteria for other depression diagnoses such as Depressive Disorder Not Otherwise Specified and Adjustment Disorder with Depressed Mood. Despite this interest in including other depression-related diagnoses, we do not want an exhaustive intake interview at this stage in the screening process.

That said, the interview module for depression still provides cut-offs that can be used to guide clinical decision making. For example, if an individual endorses at least five of the 9 symptoms, then they are likely to need referral for follow-up. However, if an individual does not meet these criteria, the clinician can ask additional questions, and consider the overall symptom picture and the individual's resources before assessing the need for follow-up.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 54 (7.5%) were referred for depression-related problems. Of these 54 Soldiers, 57.4% (n=31) met criteria for MDD using the stringent criteria in the original MINI. An additional 24.1% (n=13) met revised criteria for depression symptoms. Finally, 18.5% (n=10) were referred by clinicians for follow-up related to depression symptoms although they did not meet strict or revised criteria on the structured guide. Individuals in this group reported multiple problems and most of them specifically requested to see a counselor. Thus, the majority of

[2] While the MINI is copyrighted, a note on the front of the manual states that researchers and clinicians working in nonprofit organizations may use the MINI for clinical and research purposes.

Soldiers referred for depression-related problems were identified by the structured interview module.

Suicide Risk

Overview. In assessing risk for self-harm, we used the MINI module on suicidality. The module consists of six questions about suicide thoughts, plans, and attempts with assigned point values for each question. The cut-offs provided by Sheehan, et al. (1998) determine the type of follow-up recommended which ranges from no follow-up to immediate follow-up.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 11 (1.5%) were referred for suicidality. Of these 11 Soldiers, 100% exceeded the original MINI cut-offs on the suicide module. None were referred who scored low on the MINI cut-offs.

Post-Traumatic Stress Disorder

Overview. The questions regarding symptoms of Post-Traumatic Stress Disorder (PTSD) were adapted from the MINI module on PTSD. The differences between the MINI version and the one used in the interview guide essentially reflect differences in how symptoms are counted rather than the questions themselves. In all, there were two initial questions reflecting Criterion A from DSM-IV (exposure to a traumatic event and an emotional response of fear, helplessness or horror). In the clinical interview, only exposure to a traumatic event was required to warrant continuation with this module.

The decision to limit the initial criterion to one item (i.e. exposure to a traumatic event) was based on a previous blind validation study conducted with re-deploying Soldiers (Bliese, et al., 2004). Anecdotal results from the clinical interviews indicated that Soldiers did not endorse the second question in Criteria A (feeling helpless, horrified or afraid) in relation to a deployment-related event. However, they did endorse PTSD symptoms. Soldiers frequently told interviewers that their reaction to the traumatic event was to do as they were trained. We are examining this issue more closely in a follow-up study but at this point it seems premature to require both items in Criterion A for continuation of the PTSD assessment.

Beyond the Criterion A requirements, there were also differences in how Criteria B, C and D were addressed in the clinical interview. In the original MINI, items from Criteria B (re-experiencing symptoms) are combined into one question. For our purposes, we created individual questions for each of these items to reflect DSM-IV more closely. Thus, there was a total of 17 questions reflecting each of the 17 symptoms listed in the DSM-IV. Furthermore, in the original MINI individuals must meet criteria for each of three symptom categories (re-experiencing, avoidance and hyper-arousal) before continuing on with the module. For our purposes, the interviewers asked all 17 questions to assess PTSD-related problems more inclusively. Those endorsing at least six of these symptoms (regardless of symptom category) were considered to meet revised symptom criteria.

Significant distress and functional impairment were maintained as stringent criteria for PTSD. For the clinical interview, revised criteria included endorsing at least six symptoms without the requirement of functional impairment. The third category was being referred for PTSD—related symptoms based on a constellation of symptoms and informed clinical judgment.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 81 (11.2%) were referred for post-traumatic stress. Of these 81 Soldiers, 6.2% (n=5) met criteria for PTSD using the stringent criteria in the modified MINI (exposure, number of symptoms corresponding to each of the three categories as listed in DSM-IV, and functional impairment). An additional 11.1% (n=9) met the exposure criterion and the required symptoms per

category but without functional impairment. An additional 72.8% (n=59) met revised criteria for PTSD (exposure, any 6 of 17 symptoms). Finally, 9.9% (n=8) were referred by clinicians for follow-up related to general PTSD symptoms in combination with multiple problem areas, and half of them requested to see a counselor. Thus, the majority of Soldiers referred for post-traumatic stress were identified using revised criteria.

Anger Problems

Overview. Five questions were used to assess significant anger problems. The first two questions involved whether there was a risk for loss of control (i.e. 'Have you felt that you could not control your urge to harm others…' and 'Were you on the verge of losing control of your anger?'). If at least one of these items was endorsed, then three additional questions regarding plans to harm others and a history of harming others were asked. If at least one of these three items was endorsed, then the individual would be referred for further assessment (barring other information). These questions incorporated results from violence prediction studies that demonstrate previous history of violence to be the primary predictor of current risk of violence (e.g., Broidy, et al., 2003).

Although anger problems were not directly linked to a diagnostic category, they have the potential to affect military job performance, unit cohesion, safety of others and co-morbid symptoms. Previous research with re-deploying military personnel has linked exposure to deployment-related events with increased aggression (Adler, Dolan, & Castro, 2000) and severe family abuse (McCarroll et al., 2003). Therefore, we felt it was imperative to assess levels of anger in re-deploying military personnel with a particular emphasis on the overlap between the potential for lack of self-control and harming others.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 28 (3.9%) were referred for anger problems. Of these 28 Soldiers, 75.0% (n=21) met criteria for anger problems using the structured interview. An additional 25.0% (n=7) were referred for anger problems based on clinical judgment, although they did not meet strict criteria for the structured interview module on anger. Six of these seven Soldiers requested help for anger problems.

Relationship Problems

Overview. Four questions were used to assess serious relationship problems. The first two questions established whether the service member was in a significant relationship. The remaining two questions established whether there was serious conflict or potential conflict in the relationship. These criteria relate broadly to v-codes on relationship problems found in the DSM-IV. The questions are included as an interview module because of research results regarding the risk of severe spouse abuse among re-deploying military personnel (McCarroll et al., 2003). In addition, content validation screening studies have confirmed the need to include relationship problems as a clinical area for assessment.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 16 (2.2%) were referred for relationship problems. Of these 16 Soldiers, 87.5% (n=14) met criteria for relationship problems using the criteria in the structured interview. An additional 12.5% (n=2) service members were referred for relationship problems who did not meet criteria for the structured interview module on relationship problems. One of them was already in treatment and the other requested to see a counselor. The majority of those referred for relationship problems were married (14 out of 16).

Alcohol Problems

Overview. Although the MINI has an alcohol module that assesses alcohol abuse and dependence, we selected the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001), for use on the clinical interview because it has been recommended for military populations (Allen, Cross, Fertig, & Litten (1998). In addition, the AUDIT yields a continuous score which can identify a range of alcohol-related problems and not only alcohol dependence or abuse.

The 10-item AUDIT scale includes items such as "How often do you have a drink containing alcohol?" and "How often do you have six or more drinks on one occasion?" Scale scores were derived using the standard scoring procedure (Babor et al., 2001). The cut-off of 16 was selected for the screening procedure to determine Soldiers with clinically significant symptoms of alcohol abuse. According to the scale authors, scores starting in this range indicate harmful or hazardous drinking that requires brief counseling and monitoring. This cut-off was selected rather than the typical cut-off of 8 because we were interested in identifying Soldiers requiring follow-up evaluation and clinical services, and not only basic education about drinking that Soldiers receive in required training programs (see Babor et al., 2001, for a discussion of appropriate AUDIT cut-offs depending on the population).

In addition, the directions for the AUDIT had to be slightly adjusted. Typically, individuals are instructed to consider the questions as they apply to the past year. Given that military personnel were deployed to an alcohol-free environment, these directions were inappropriate. Instead, individuals were asked about alcohol use in the past four weeks.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 24 (3.3%) were referred for alcohol problems. Of these 24 Soldiers, 87.5% (n=21) met criteria for alcohol problems using the criteria in the structured interview. An additional 12.5% (n=3) were referred for alcohol problems, but did not meet criteria for the structured interview module on alcohol. One was already in an alcohol program, and the other two had additional clinical problems.

Sleep Problems

Overview. Sleep problems were specifically added to the psychological screen in 2005 because of findings from a content validity analysis of screening data collected from military personnel at re-deployment (Bliese, et al., 2004). In addition, follow-up analyses of sleep data from surveys conducted with military personnel three to four months post-deployment demonstrated the link between sleep problems and combat exposure (U.S. Army Medical Research Unit-Europe, 2005).

It is unknown whether sleep problems are a unique response to combat stress. Regardless, sleep problems have the potential to affect functioning and levels of distress and also may be an early indication of some other clinical dimension (Levine, et al., 2003). Sleep problems may also carry less stigma than other mental health problems and can serve as a socially acceptable conduit to mental health services. Consequently, sleep problems were added to the primary screen and the clinical interview. However, these items are considered exploratory at this stage because they have not yet undergone a thorough analysis.

The module on sleep problems was developed specifically for the clinical interview and is based on DSM-IV criteria for primary insomnia. It includes two items assessing sleep difficulties (e.g., 'difficulty falling or staying asleep' or 'restless or fragmented sleep'). For those endorsing either symptom, six other questions are asked to clarify the context of those symptoms. These additional items assess the degree to which sleep problems are related to distress, medications, a medical

condition, or an environmental distraction. Two final questions ask whether the sleep problem is related to feeling stressed and whether the individual wants a referral.

Research Results. In the 2005 blind validation study conducted with Soldiers at post-deployment, 66 (9.1%) were referred for sleep problems. Of the overall total of 66 service members referred for sleep problems, 64.6% (n=42) thought their sleep problems were related to feeling stressed, being upset, or worried. Interestingly, 73.8% (n=48) answered "yes" to "Would you like help dealing with the sleep problem." Given the exploratory nature of the interview module, there were no strict or broad definitions used for comparison.

Other Problems

Overview. The final module includes four questions that assess interest in clinical services. The first question asks about any additional problems that might be of concern. The second asks about current mental health treatment. The third asks about mental health treatment during deployment. The final question asks whether the individual would like to receive counseling. Other clarifying questions can be asked during this stage to help the interviewer make a final assessment of clinical areas in need of follow-up. [Note: Of the 16 service members referred for other problems, 14 of them were also referred based on another clinical dimension. The other 2 were referred for evaluation of Attention Deficit Hyperactivity Disorder].

Interview Outcome Status

Overview. This final section provides the interviewer an opportunity to summarize the outcome status for each of the clinical modules. The outcome categories in this section include: no follow-up necessary, immediate follow-up necessary, standard follow-up, already in treatment, and sub-clinical/moderate symptoms.

The outcome status section can be simplified depending on the clinical context and the need for administrative oversight. For research purposes, we required that each module be assessed using the entire range of outcome categories. Clinical applications of this section may vary by including for example, information that would direct follow-up recommendations (e.g., agency to be contacted, service required). Following the outcome summary, an open-ended section is included for interviewer notes. The complete Structured Clinical Interview Guide is provided in Appendix A.

- **Psychological Screening: Practical Issues**

The clinical interview is one key component of the psychological screening process. This section describes several alternatives for implementing a screening program. These options have been developed and tested over time as units have adapted the program to their particular context. We raise them here to lay out a series of decisions that could be considered when developing a psychological screening program. Such considerations include who should conduct the interviews, when structured clinical interviews should occur, whether the interviews should include the complete set of modules, and how referrals should be documented. Furthermore, broader issues regarding timing, location, infrastructure, and resources for implementing psychological screening are reviewed.

Screening staff. Historically, the psychological screening program has been implemented by a combination of medical professionals, including military mental health officers, physician assistants, enlisted mental health specialists (e.g., 91X), and other available mental health assets in the local community (e.g., social work staff, care managers, local clinic resources). The clinical interviews can be conducted by trained enlisted mental health specialists under the direction of credentialed providers. Given the potential for psychological screening to identify an immediate need for referral

because of risk of harm to self or others, a credentialed provider should be either directly on site or on call.

The structured clinical interview guide in Appendix A can be used as a training tool to focus interviewers on brief assessments of key clinical dimensions. Typically, mental health and other health providers are not trained to conduct triage mental health interviews. To that end, the clinical interview guide is designed to provide the structure for a brief interview. The need to develop rapport and ask appropriate follow-up questions are part of general clinical training that should transfer easily to this task.

Screening process. There are two major models for implementing the screening program that have been used in the past year. The first involves conducting both the primary screening survey and screening interview at the same time and on-site.

The advantage of this model is that those service members who require immediate follow-up can be easily identified and referred to behavioral health services. Also, all of the individuals who need an interview based on their responses to the primary screen can be easily located and provided one. There is no additional staff time required to track down these military personnel and schedule a follow-up interview. The final benefit is that the procedure of interviewing a random selection of those scoring below cut-off criteria can be implemented. Thus, there is the potential benefit of reducing stigma by interviewing a range of military personnel. The disadvantage of this model is that it is resource intensive and requires a sizeable screening staff in order to prevent military personnel from having to wait for an interview. Typically, a company of 120 soldiers can be screened and 20-30% interviewed on-site using the entire interview guide in about three hours with a team of one credentialed provider, two mental health specialists (e.g., 91X), and one person to score the survey.

The second model for implementing the psychological screening program is to conduct the primary survey screen and only interview those on-site who indicate on the survey potential for harm to self or others. Within two weeks following the screening, service members scoring above cut-off on the clinical dimensions should be contacted by telephone and an appointment for a clinical interview scheduled. These interviews can be conducted either on the telephone or in person.

The advantage of this model is that it requires a small on-site clinical staff and because the interviews are spread out over a two week period, fewer interviewers are needed. The interviews are also conducted under more private conditions potentially reducing stigma. The disadvantage of this model is that service members must be contacted by telephone which can be difficult. Service members may be on temporary duty, emergency leave, have left the unit, or be otherwise unavailable. In addition, telephone interviews, while convenient, do not provide the face-to-face contact which might benefit the interview process.

Adapting the modules. There are two options for adapting the clinical interview guide for screening implementation. The first option is to use the entire guide and review each section with the service member. The advantage of this option is that it checks a range of key symptom areas known to be relevant to service members at post-deployment. In addition, because some symptom areas are likely to be co-morbid with others (e.g., anger and sleep), the context of these symptoms can be more thoroughly evaluated. For those screening procedures incorporating a randomized group of low scoring service members, the entire interview guide would be recommended because there is no reason to select one module over another. The disadvantage of this approach is that it is more time consuming and does not target the symptom area already identified by the primary screen.

The second option for adapting the clinical interview guide is to use only the modules that correspond to the clinical dimensions the service member endorsed on the primary screen as well as the module that assesses other problem areas. The advantage of this method is that it is short, avoids redundancy, and is targeted to explore the identified symptom area. The potential disadvantage of this method is that other symptom areas may be overlooked and the full symptom picture missed.

The implementation of the screening interview modules should be based on an analysis of the advantages and disadvantages of the two methods taking into account available resources.

Following up. The psychological screening program is designed to give service members the opportunity to self-refer. It is not designed to catch those "faking good" or otherwise unwilling to report symptoms. If it is determined (i.e. from the brief clinical interview) that a service member should receive follow-up care, a list of services members is generated. Historically, this list has been provided to Division Mental Health or its equivalent. It is a confidential list that is used to ensure follow-up to the appropriate service such as social work, substance abuse, or behavioral health. Interestingly, in a recent implementation of psychological screening, many referred service members requested that Division Mental Health contact them rather than have them contact Division Mental Health.

Timing. One key consideration is when to conduct post-deployment psychological screening. There are two points at which screening may be conducted. First, at immediate reintegration, after the service member has returned to home station but has not yet gone on block leave. This option is currently mandated by the US Department of Defense. Research has found that this early screening option may be most useful for identifying service members with serious symptoms but that many others will not report symptoms until three to four months later (Bliese et al., 2004; Bliese et al., 2005). The second target of screening opportunity is after military personnel return from block leave and have settled back into their garrison routine. Applying the lessons learned from the Bliese et al. study (2004), the US Department of Defense has issued a policy requiring post-deployment screening be conducted between three to six months following redeployment from combat (Assistant Secretary of Defense for Health Affairs, 2005).

Location. Implementation of psychological screening requires minimal physical infrastructure. Psychological screening typically occurs at a location convenient to the operational units such as unit day rooms, aircraft hangars, community movie theaters, classrooms, and large tents. The screening team is designed to be mobile, flexible, and able to go out to the unit to conduct efficient large-scale screening.

Leveraging existing requirements. Psychological screening can be implemented in conjunction with existing unit requirements. For example, psychological screening has been conducted during pre-deployment processing (PDP) as one of many required stations or as part of a week-long reintegration program. It has also been conducted as part of post-deployment medical screening (e.g., when military personnel had to have results from their TB tests recorded). Psychological screening can also be conducted independently from existing unit requirements, at the convenience of the company.

- **Future Work**

Several areas remain to be developed in future versions of the structured clinical interview guide. Some of these changes will result from the ongoing validation studies with the primary screen. These processes are intricately linked given that the primary screen will drive the inclusion of items for the clinical interview. Nevertheless, certain areas of the clinical interview have already been identified for follow-up analysis and review.

Depression and PTSD. One issue for both the Depression and PTSD modules is the effectiveness of broadening the interview questions to assess symptoms related to these two clinical dimensions. Results from upcoming sensitivity and specificity analyses will address the implications of these revisions to the two modules.

Anger. There may be two aspects to the anger dimension: homicidal ideation and heightened irritability. Should these two dimensions prove reliable, then the clinical interview questions may need to be adapted to reflect this change. Further analyses are being conducted to determine the factor structure and constructs of this dimension.

Sleep. Results from using the recently developed sleep module are still being analyzed. The degree to which sleep problems provide unique information that does not overlap with other clinical dimensions will determine whether this module is ultimately recommended for continued inclusion in the interview.

Pre-Deployment Screen. Much of the research conducted up to this point has focused on post-deployment psychological screening. Some validation work has been conducted with pre-deployment samples but additional work should address the effective adaptation of the clinical interview for a pre-deployment context.

- **Conclusion**

Deployment-related psychological screening was mandated by the Department of Defense as early as 1996 and requested by commanders across a range of military operations since that time. In response to this real-world demand, the psychological screening research program has targeted developing a valid screening instrument and delivering an effective set of procedures for psychological screening.

The systematic program of psychological screening research continues by focusing on re-validation of the short screening instrument, determining optimal items and cut-offs for the clinical dimensions, and program evaluation. Integrating lessons learned from the implementation of screening with research results reinforces the continued development and refinement of the psychological screening program to ensure service members receive optimal support across the deployment cycle.

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OPERATION IRAQI FREEDOM
POST-DEPLOYMENT PSYCHOLOGICAL SCREENING STRUCTURED INTERVIEW

v. June 2005

Date of Interview: _____

Date Soldier returned from deployment: _____

Soldier's Name: _____

Interviewer's Name: _____

Social Security Number

_____ - _____ - _____

Points to address: (Do NOT read verbatim)

- Point of Screening – proactive attempt for early identification and follow-up
- Point of Interview – to make sure the screening survey is not missing anything

INTRODUCTION:

"I am (name & MOS) and a part of the screening team. I am going to ask you some questions that may sound similar to some of the survey questions that you just completed. These are structured questions that we are asking all service members who are being interviewed. We're asking these questions so that we can check to see if the screening survey is doing its job. And now I'd like to begin with the first question."

NOTE:

Shaded areas of interview guide are instructions to the clinical interviewer and should NOT be read to the Soldier.

Arrows (⟶) are decision points for the clinical interviewer.

MODULE 1 – Depression

	YES	NO
1a. Have you been consistently depressed or down, most of the day, **NEARLY EVERY DAY**, for the past two weeks?	O	O
→ IS QUESTION **1a.** CODED **YES**? IF **YES** CONTINUE WITH ITEM **2**. IF **NO** CONTINUE WITH ITEM **1b**, directly below.		
1b. Have you been consistently depressed or down, most of the day, **MORE THAN HALF THE DAYS**, for the past two weeks?	O	O
2. In the past two weeks, have you been much less interested or lost pleasure in most things?	O	O
→ IF QUESTION 1 **OR** 2 IS CODED **YES** CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE 2 ON THE NEXT PAGE.	O	O

Over the past two weeks, when you felt depressed or uninterested:	**YES**	**NO**	**If NO, "More than half the Days?" YES**	**NO**
3. Was your appetite decreased or increased nearly every day?	O	O	O	O
4. Did you have difficulty sleeping nearly every night, such as difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively?	O	O	O	O
5. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	O	O	O	O
6. Did you feel tired or without energy almost every day?	O	O	O	O
7. Did you feel worthless or guilty almost every day?	O	O	O	O
8. Did you have difficulty concentrating or making decisions almost every day?	O	O	O	O
			If NO, "Occasionally?" YES	**NO**
9. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?	O	O	O	O

ADDITIONAL QUESTIONS FOR BACKGROUND INFORMATION:	**YES**	**NO**	**If NO, "Somewhat?"**
- Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?	O	O	O
- During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about?	O	O	
→ ARE **5** OR MORE ANSWERS (**1-9**) CODED **YES (on either scale)**? IF **YES** CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE 2 ON THE NEXT PAGE.	O	O	

→ DETERMINE TYPE OF FOLLOW-UP REQUIRED BELOW (ASSESS INTENSITY OF PROBLEM):

- O FOLLOW-UP NOT NECESSARY, REASON_____
- O STANDARD FOLLOW-UP
- O IMMEDIATE FOLLOW-UP

GO TO MODULE ON THE NEXT PAGE

MODULE 2 - Suicidality

	NO	YES	Points
In the past month did you:			
Think that you would be better off dead or wish you were dead?	O	O	1
Want to harm yourself?	O	O	2
Think about suicide?	O	O	6
Have a suicide plan?	O	O	10
Attempt suicide?	O	O	10
In your lifetime, did you ever make a suicide attempt?	O	O	4
→ IS AT LEAST **1** OF THE ABOVE CODED **YES**? IF **YES** CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE 3 ON THE NEXT PAGE.	O	O	

ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS IN THIS MODULE

→ AND SPECIFY LEVEL OF SUICIDE RISK AS FOLLOWS: TOTAL: _____

- O 1-5 POINTS **LOW** – STANDARD FOLLOW-UP
- O ≥ 6 POINTS **MODERATE TO HIGH** - IMMEDIATE FOLLOW-UP

→ DETERMINE TYPE OF FOLLOW-UP REQUIRED:

- O FOLLOW-UP NOT NECESSARY, REASON:_____

  _____
- O STANDARD FOLLOW-UP
- O IMMEDIATE FOLLOW-UP

GO TO MODULE ON THE NEXT PAGE

MODULE 3 - PTSD

	NO	YES
A. Have you **EVER** experienced or witnessed or had to deal with an extremely traumatic event, (for example, actual or threatened death or serious injury to you or to someone else)?	O	O
→ IF **NO** SKIP TO MODULE 4 ON THE NEXT PAGE. IF **YES** CONTINUE TO THE ITEMS BELOW AND ASK ALL QUESTIONS.		
B. Did you respond with intense fear, helplessness, or horror?	O	O

In the past month, have you re-experienced the event in a distressing way, such as:	**NO**	**YES**
1. Intense recollections? (e.g., images or thoughts of the event)	O	O
2. Dreams?	O	O
3. Flashbacks? (e.g., acting or feeling as if the event were happening again)	O	O
4. Intense distress in reaction to something that reminds you of the event?	O	O
5. Physical reactions? (e.g., increased heart rate)	O	O
In the past month:	**NO**	**YES**
6. Have you avoided thinking about the event?	O	O
7. Have you avoided things that remind you of the event?	O	O
8. Have you had trouble recalling some important part of what happened?	O	O
9. Have you become less interested in being with your friends?	O	O
10. Have you felt detached or estranged from others?	O	O
11. Have you noticed that your feelings are numbed? (e.g., that you have less ability to feel emotions?)	O	O
12. Have you felt that your life will be shortened or that you will die sooner than other people?	O	O
In the past month:	**NO**	**YES**
13. Have you had more difficulty sleeping?	O	O
14. Were you especially irritable or did you have outbursts of anger?	O	O
15. Have you had difficulty concentrating?	O	O
16. Were you nervous or constantly on your guard?	O	O
17. Were you easily startled?	O	O

During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	**NO**	**YES**
	O	O

→ ARE 6 OR MORE ANSWERS **(1-17)** CODED **YES**? IF YES, CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE **4**.	**NO**	**YES**
	O	O

DETERMINE TYPE OF FOLLOW-UP REQUIRED BELOW (ASSESS INTENSITY OF PROBLEM).

- O FOLLOW-UP NOT NECESSARY, REASON_____
- O STANDARD FOLLOW-UP
- O IMMEDIATE FOLLOW-UP

GO TO MODULE ON THE NEXT PAGE

MODULE 4 - Anger

	NO	YES
During the past month and up to today:		
1. Have you felt that you could not control your urge to harm others, such as a unit member or friend?	O	O
2. Were you on the verge of losing control of your anger?	O	O
→ IS AT LEAST **1** OF THE ABOVE ITEMS CODED **YES**? IF **YES** CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE 5 BELOW.	O	O

	NO	YES
1. In the past month did you have a plan to physically harm others?	O	O
2. In the past month did you try to physically harm others?	O	O
3. Other than on combat missions, have you physically harmed others in the past?	O	O
→ IS AT LEAST **1** OF THE ABOVE ITEMS CODED **YES**? IF **YES,** determine type of follow-up required. IF **NO** SKIP TO MODULE 5 BELOW.	O	O

→ DETERMINE TYPE OF FOLLOW-UP REQUIRED:

- O FOLLOW-UP NOT NECESSARY, REASON: _____
- O STANDARD FOLLOW-UP
- O IMMEDIATE FOLLOW-UP

GO TO MODULE BELOW

MODULE 5 - Relationship Problems

	NO	YES
1. Are you married or in a relationship with a significant other?	O	O
2. Are you currently going through a separation or divorce?	O	O
→ IS AT LEAST **1** OF THE ABOVE ITEMS CODED **YES**?	O	O

IF **YES** CONTINUE TO THE ITEMS BELOW. IF **NO** SKIP TO MODULE 6 ON THE NEXT PAGE.

	NO	YES
1. Have you been having any serious problems in your marriage (or relationship with your significant other), such as serious conflict, abuse, infidelity, substance abuse, and/or serious financial problems?	O	O
2. Do you anticipate having serious conflict with your spouse or significant other in the next few months? IF **YES**, REASON: _____	O	O

→ IF **YES** TO **EITHER #1 OR #2**, ASSESS INTENSITY OF PROBLEM AND IF FOLLOW-UP IS NECESSARY INDICATE BELOW. IF **NO** SKIP TO MODULE 6 ON THE NEXT PAGE.

- O FOLLOW-UP NOT NECESSARY, REASON:_____
- O STANDARD FOLLOW-UP
- O IMMEDIATE FOLLOW-UP

GO TO MODULE ON THE NEXT PAGE

MODULE 6 – Alcohol Use Disorders Identification Test

BEGIN BY SAYING "Now I am going to ask you some questions about your use of alcoholic beverages during the **PAST 4 WEEKS**. READ THE QUESTIONS AS WRITTEN AND RECORD THE SCORE (0-4) CORRESPONDING TO THE RESPONSE IN THE SPACE PROVIDED.

1. How often do you have a drink containing alcohol? **Score**

Never (SKIP TO #9-10)	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
⓪	①	②	③	④

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7, 8 or 9	10 or more
⓪	①	②	③	④

3. How often do you have six or more drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

→ **Skip to Questions 9 and 10 if total score for questions 2 and 3 = 0**

4. How often during the last 4 weeks have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

5. How often during the last 4 weeks have you failed to do what was normally expected from you because of drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

6. How often during the last 4 weeks have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

7. How often during the last 4 weeks have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

8. How often during the last 4 weeks have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⓪	①	②	③	④

9. Have you or someone else been injured as a result of your drinking?

No	Yes, but <u>not</u> in the last year	Yes, during the last year
⓪	②	④

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

No	Yes, but <u>not</u> in the last year	Yes, during the last year
⓪	②	④

RECORD TOTAL OF RESPONSE SCORES HERE

MODULE 6 (CONTINUED) – Alcohol Use Disorders Identification Test

RECORD TOTAL OF RESPONSE SCORES HERE _____

→ 1. IF TOTAL SCORE IS **15 OR LOWER**, SKIP TO MODULE 7.

→ 2. IF TOTAL SCORE IS **BETWEEN 16 AND 19** EVALUATE FOR FOLLOW-UP AND INDICATE BELOW.

- o FOLLOW-UP NOT NECESSARY, REASON:_____
  _____
- o STANDARD FOLLOW-UP
- o IMMEDIATE FOLLOW-UP

→ 3. IF TOTAL SCORE IS **20 OR HIGHER**, REFER FOR FURTHER EVALUATION.

- o FOLLOW-UP NOT NECESSARY, REASON:_____
  _____
- o STANDARD FOLLOW-UP
- o IMMEDIATE FOLLOW-UP

GO TO MODULE BELOW

MODULE 7 – Sleep Problems

	NO	YES
During the past month and up to today:		
1. Have you had difficulty falling or staying asleep?	o	o
2. Have you had restless or fragmented sleep?	o	o
→ IF **YES** TO **EITHER** QUESTION, CONTINUE WITH THE FOLLOWING: IF **NO** SKIP TO MODULE 8	o	o

	NO	YES
3. Has the sleep problem led to significant distress or impairment in social, occupational or other important areas of functioning?	o	o
4. Is the sleep problem related to medication, over the counter medicines, or excessive use of caffeine?	o	o
5. Is the sleep problem related to a medical condition such as back pain?	o	o
6. Is the sleep problem related to an outside factor like small children in the home, noisy neighbors, or telephone calls?	o	o
7. Do you think the sleep problem is related to feeling stressed, being upset or worried?	o	o
8. Would you like help dealing with the sleep problem?	o	o

→ ASK ANY QUESTIONS NEEDED TO CLARIFY SYMPTOM PICTURE OR DISPOSITION. ASSESS NEED FOR FURTHER EVALUATION.

EVALUATE FOR FOLLOW-UP AND INDICATE BELOW.

- o FOLLOW-UP NOT NECESSARY, REASON: _____
- o STANDARD FOLLOW-UP, REASON: _____
- o IMMEDIATE FOLLOW-UP, EXPLAIN: _____

GO TO MODULE ON THE NEXT PAGE

MODULE 8 – Other Problems

	NO	YES
ASK ANY QUESTIONS NEEDED TO CLARIFY SYMPTOM PICTURE OR DISPOSITION. ASSESS NEED FOR FURTHER EVALUATION REGARDLESS OF MEETING STRUCTURED INTERVIEW CRITERIA.		
1. Is anything bothering you that we have not already discussed? IF **YES**, PROBLEM: _____ _____	O	O
2. Are you currently in treatment for behavioral or emotional problems? If **YES**, REASON: _____ _____	O	O
3. Were you in treatment for behavioral or emotional problems while you were deployed? If **YES**, REASON: _____ _____	O	O
4. Do you want to see a counselor? If **YES**, REASON: _____ _____	O	O

IF **YES** TO **ANY** ITEM ABOVE – EVALUATE FOR FOLLOW-UP AND INDICATE BELOW.

- O FOLLOW-UP NOT NECESSARY, REASON: _____
- O STANDARD FOLLOW-UP, REASON: _____
- O IMMEDIATE FOLLOW-UP, EXPLAIN: _____

SECTION I & II TO BE COMPLETED BY INTERVIEWER

I. INTERVIEW OUTCOME STATUS

DIRECTIONS: Indicate Interview Outcome Status for EACH Module	**No Follow-up Necessary**	**Immediate Follow-up Necessary**	**Standard Follow-up**	**Already in Treatment** (Module 8.2)	**Sub-clinical Moderate Symptoms***
Module					
1 - Depression	O	O	O	O	O
2 - Suicidality	O	O	O	O	O
3 - PTSD	O	O	O	O	O
4 - Anger	O	O	O	O	O
5 - Relationship Problems	O	O	O	O	O
6 - Alcohol Problems	O	O	O	O	O
7 - Sleep Problems	O	O	O	O	O
8.1 - Other Problems	O	O	O	O	O
8.4 - See Counselor	O	O	O	O	O

***** Based on Interviewer's clinical judgment that service member has a problem but does not need follow-up.

NOTES