

# PERSONNEL LOSS IN THE U.S. NAVY

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## IMPACT OF MENTAL HEALTH DISORDERS

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After learning that such disorders are the second leading cause of medical separation from the U.S. Navy, these researchers took a closer look at the epidemiology of these conditions among personnel referred to the Physical Evaluation Board.

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**W**ith multiple deployments supporting the ongoing operations in Iraq and Afghanistan, the recruitment and retention of service members have become highly prominent issues for the U.S. armed forces. In such a situation, it is critical to understand the various sources of personnel loss and to prevent these losses to the extent possible.

One reason for separation from active duty is medical unfitness or psychiatric unsuitability. In the U.S.

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Navy, the process of evaluating a service member's fitness for duty includes the Physical Evaluation Board (PEB) system, which has both medical and administrative components. An analysis of the PEB's activities between 1998 and 2000 revealed that mental health disorders were the second leading diagnostic category, after musculoskeletal conditions.<sup>1</sup> Although not every PEB diagnosis results in a service member's separation from active duty, this finding suggests that mental health disorders represent a leading cause of personnel loss in the U.S. Navy.

In order to expand our understanding of the specific psychiatric disorders that are contributing to this personnel loss, our team conducted a descriptive epidemiologic study of the mental health diag-

noses made by the PEB during the aforementioned time period. This study analyzed the frequency of various diagnoses for the entire sample and for gender and age subgroups. Here, we present our results and discuss their implications for military medical practice and future research.

### MENTAL HEALTH AND THE PEB

The PEB process is initiated by health care providers once they have diagnosed a service member with a condition they believe precludes continued military service. If the condition is a mental health disorder, it is the military mental health provider who must set the PEB process in motion.<sup>2</sup>

Mental health conditions—such as depression, psychosis, bipolar disorder, and anxiety disorders—

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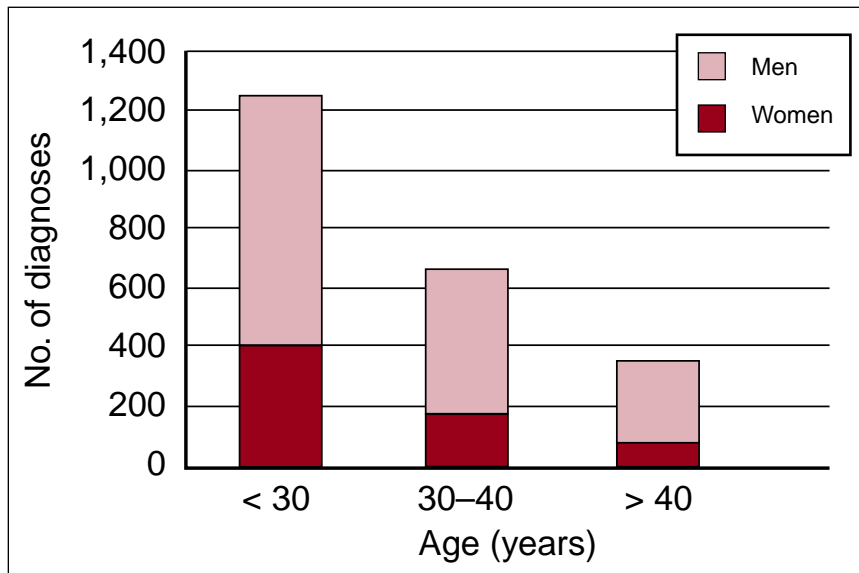


Figure. U.S. Navy Physical Evaluation Board mental health diagnoses (1998–2000) by age group and gender.

may preclude a service member's continued military service. In those cases, the provider initiates the PEB process by writing a report of the condition and forwarding this report to the Central PEB in Washington, DC. This board (which includes medical and line officers) examines the report, determines the service member's fitness for continued active duty, and assigns a disability rating if applicable.

Certain conditions that fall under the responsibility of mental health providers—such as adjustment disorders, personality disorders, and the so-called “V-code” diagnoses (which include occupational problems and partner relationship problems)<sup>3</sup>—do not constitute a physical disability according to the *U.S. Department of the Navy Disability Evaluation Manual* and, thus, are not processed through the PEB system.<sup>4</sup> If a service member's primary diagnosis is one of these disorders, and the disorder is consid-

ered severe enough to preclude continued military service, the service member undergoes a process of administrative review and separation.<sup>5</sup>

### MATERIALS AND METHODS

We obtained PEB records for calendar years 1998 through 2000 from the computerized database maintained by the U.S. Navy Medical Information Management Command (NMIMC) in Bethesda, MD. The diagnoses were stored using codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*.<sup>6</sup> The data set included all mental health diagnoses (*ICD-9-CM* codes 290 through 310) but did not provide individual patient identifiers, so multiple diagnoses per patient were possible. This would allow one patient to be represented several times in the analysis.

Using demographic data for the entire U.S. Navy population from

the Army Medical Surveillance Activity in 2000, we generated frequency rates of PEB mental health diagnoses for each gender and age group.<sup>7</sup> We performed statistical analyses using the software Epi Info 6.0 (Centers for Disease Control and Prevention, Atlanta, GA) and SPSS (SPSS Inc., Chicago, IL). The study was approved by the institutional review board of Naval Medical Center Portsmouth, VA (CIP# P03-051:A).

For simplification, some diagnoses were combined into larger categories using *ICD-9-CM* criteria. For example, all major depression diagnoses were grouped together regardless of subtype—though we did distinguish between single episodes and recurrent disease. Likewise, all diagnoses of type I bipolar disorder were grouped together irrespective of whether the most recent episode was manic or depressive or included psychotic features. We did not consolidate the anxiety disorders—including post-traumatic stress disorder (PTSD), generalized anxiety disorder, specific phobias, and panic disorder—because the diagnostic criteria for each are considerably different.

The diagnoses were analyzed by gender and age groups. The age groups used in this study (less than 30 years, 30 to 40 years, and greater than 40 years) were the same ones used in the previous study that had analyzed all PEB diagnoses between 1998 and 2000. These age groups generally correlate with U.S. Navy career phases: Personnel younger than 30 are probably in their first or second enlistment, those aged 30 to 40 are likely to be considered career personnel; and those over age 40 are likely eligible for military retirement. These factors might be expected to

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affect the evaluation and referral processes in the PEB system.

## OUR FINDINGS

The NMIMC PEB database contained a total of 2,283 records with mental health diagnoses between 1998 and 2000. Men constituted 1,609 (70%) of the diagnoses, while women comprised 674 (30%). The breakdown by age group was: 1,252 (55%) in the under-30 group, 675 (30%) in the 30-to-40 group, and 333 (15%) in the over-40 group (Figure). A total of 23 records (1%) had no age listed.

Using the 2000 demographic data, we found that women had significantly higher frequency rates of PEB mental health diagnoses than did men—both in the total group and in the individual age groups (Table 1). For both women and men, the frequency rate of PEB mental health diagnoses increased significantly with age: Among women, the chi square for trend (1df) was 29.1 ( $P < .001$ ); among men, it was 29.4 ( $P < .001$ ).

### Diagnoses by gender

Regardless of age, 20 conditions accounted for about 80% of all diag-

noses in both women and men (Tables 2 and 3). Major depressive disorder—single episode and recurrent—accounted for about 20% of the diagnoses in both groups (18.6% in men and 23.9% in women).

Women were more than three times as likely as men to be diagnosed with PTSD (risk ratio, 3.49; 95% confidence interval, 2.97 to 4.10;  $P < .001$ ). Of interest, the rank percentage for PTSD did not change significantly with age for either men or women.

Rank percentages for alcohol dependence were slightly higher for men than for women (5.5% versus 3%). The psychotic disorders (including schizophrenia, schizophreniform disorder, and psychotic disorder not otherwise specified [NOS]) accounted for approximately 10% of diagnoses in men and 4% in women.

Eating disorders (including bulimia nervosa and eating disorder NOS) accounted for nearly 4% of diagnoses in women and less than 1% in men. Borderline personality disorder accounted for 2.4% of diagnoses in women and less than 1% in men. (Because personality disorders usually are handled by

administrative processes rather than the PEB system, the presence of these diagnoses in the PEB records likely represents service members who had other PEB diagnoses that led to the initiation of the PEB process. The same is true for personnel with substance abuse disorders.) The rates of bipolar disorder, anxiety disorders other than PTSD, and personality disorders were about the same for men and women.

### Diagnoses by age

For the under-30 age group (both genders), the depressive disorders—major depressive disorder, single episode; major depressive disorder, recurrent; dysthymic disorder; and depressive disorder NOS—were the first, third, fourth, and eighth most frequent diagnoses, respectively, collectively accounting for 26.2% of the diagnoses (Table 4). PTSD was the second most common at 7.8%. The psychotic disorders together accounted for 10% of the diagnoses.

For 30- to 40-year-olds, the depressive disorders were also the most common (34.3%) (Table 5). PTSD accounted for 4.9% of the di-

**Table 1. Frequency rates\* and risk ratio of U.S. Navy Physical Evaluation Board mental health diagnoses for women compared with men (1998 through 2000)**

Group	Frequency rates (per 100,000 people per year)		Risk ratio (women to men)	95% confidence interval	P value
	Men	Women			
All ages	167.7	428.9	2.54	2.32–2.78	< .0001
< 30	155.2	371.2	2.38	2.11–2.68	< .001
30–40	166.0	525.9	3.13	2.65–3.71	< .001
> 40	239.4	640.6	2.64	2.07–3.38	< .001

\*Frequency rates were calculated using 2000 demographic data on the entire U.S. Navy population from the Army Medical Surveillance Activity.<sup>7</sup>

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**Table 2. Rank order of U.S. Navy Physical Evaluation Board mental health diagnoses for men (1998–2000)**

Rank	Diagnosis	ICD-9-CM* code	No. of diagnoses (n = 1,609)	Percentage
1	Major depressive disorder, single episode	2962	200	12.4
2	Major depressive disorder, recurrent	2963	99	6.2
3	Bipolar I disorder, most recent episode	2967	92	5.7
4	Alcohol dependence	30390	88	5.5
5	Depressive disorder NOS <sup>†</sup>	311	87	5.4
6	Posttraumatic stress disorder	30981	78	4.8
7	Dysthymic disorder	3004	74	4.6
8	Schizophrenia	295	67	4.2
9	Specific phobia	30029	62	3.9
10	Schizophreniform disorder	29540	47	2.9
11	Personality disorder NOS	3019	43	2.7
12	Bipolar II disorder	29689	41	2.5
13	Psychotic disorder NOS	2989	38	2.4
14	Tension headache	30781	38	2.4
15	Postconcussion syndrome	3102	37	2.3
16	Anxiety disorder NOS	30000	29	1.8
17	Panic disorder without agoraphobia	30001	26	1.6
18	Obsessive-compulsive disorder	3003	23	1.4
19	Alcohol abuse	30500	22	1.4
20	Nicotine dependence	30510	22	1.4

\*ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.<sup>6</sup> †NOS = not otherwise specified.

agnoses, and the psychotic disorders accounted for 4.7%.

For personnel older than 40 years, depressive disorders accounted for 38.4% of the diagnoses (Table 6). Alcohol dependence was much more common in this age group, accounting for 7.2% of the diagnoses. PTSD accounted for 5.1%, while the psychotic disorders did not rank in the top 20.

**PUTTING THE RESULTS IN CONTEXT**

This study analyzed nearly 2,300 U.S. Navy PEB mental health diagnoses for the years 1998 through 2000. It is important to note that PEB assessments are appropriate for personnel with severe mental health conditions that preclude continued military service. The frequency of PEB diagnoses, therefore, does not equate with overall

disease prevalence in the U.S. Navy population since some patients may have conditions that are not sufficiently occupationally impairing to warrant separation or have improved enough with treatment to allow the member to return to full active duty.

Mental health issues in the military have been studied by a number of authors. Comparing data

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**Table 3. Rank order of U.S. Navy Physical Evaluation Board mental health diagnoses for women (1998–2000)**

Rank	Diagnosis	ICD-9-CM* code	No. of diagnoses (n = 674)	Percentage
1	Major depressive disorder, single episode	2962	91	13.5
2	Posttraumatic stress disorder	30981	75	11.1
3	Major depressive disorder, recurrent	2963	70	10.4
4	Depressive disorder NOS <sup>†</sup>	311	40	5.9
5	Dysthymic disorder	3004	33	4.9
6	Bipolar I disorder, most recent episode	2967	22	3.3
7	Alcohol dependence	30390	20	3.0
8	Personality disorder NOS	3019	19	2.8
9	Specific phobia	30029	17	2.5
10	Panic disorder without agoraphobia	30001	16	2.4
11	Borderline personality disorder	30183	16	2.4
12	Tension headache	30781	16	2.4
13	Anxiety disorder NOS	30000	14	2.1
14	Panic disorder with agoraphobia	30021	14	2.1
15	Bulimia nervosa	30751	14	2.1
16	Bipolar II disorder	29689	13	1.9
17	Schizophrenia	295	11	1.6
18	Eating disorder NOS	30750	11	1.6
19	Alcohol abuse	30500	10	1.5
20	Bipolar I disorder, single episode	29600	9	1.3

\*ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.<sup>6</sup> †NOS = not otherwise specified.

from the 1994–1995 DoD Health Beneficiary Survey with national benchmarks, Constantian found that, while active duty service members' mental health status was indistinguishable from that of the general U.S. population, their rates of outpatient mental health service utilization were far lower.<sup>8</sup> Other studies have examined demographic and referral patterns to

military outpatient mental health clinics.<sup>9,10</sup> And Kilbourne and colleagues analyzed PEB records from 1,450 enlisted patients with a primary mental health diagnosis.<sup>11</sup> They found that severity of diagnosis and the length of military service were significant predictors of the type of medical discharge awarded by Navy PEB evaluations. To our knowledge, however, ours is

the first study to evaluate both demographic and diagnostic patterns of PEB evaluations for mental health disorders.

According to data from the National Comorbidity Survey (NCS), approximately 30% of the general population has at least one mental health diagnosis, with depressive disorders being the most common of these.<sup>12</sup> Although our

findings do not represent U.S. Navy prevalence figures, the fact that we also found depression to be the most frequent across all age groups and genders suggests consistency between the military and general U.S. populations. The NCS findings for alcohol dependence in men also were similar to our results.

In our study, alcohol dependence occurred more frequently in patients over age 40 than in younger patients. By contrast, survey data from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) Program showed a stable trend with age.<sup>13</sup> It may be that U.S. Navy personnel who are identified as having a dependence on alcohol at a younger age are more likely than those who are identified later in life to receive an administrative separation. It's

also possible that older men with alcohol dependence may have been able to conceal their dependence while they were younger—or may not have developed the condition until they were older and thus had a less debilitating case than those identified and separated from service at a younger age.

More surprising was the high frequency (seventh in rank) of alcohol dependence in women in our study. The U.S. national ratio of alcohol dependence in men and women is around 5:1, though this disparity may decline with age.<sup>14</sup>

The ECA survey data also showed a constant prevalence of psychotic disorders across age, though the incidence of symptom onset varied with diagnosis.<sup>13</sup> Similarly, a recent article from the Schizophrenia Research Unit in

Mannheim, Germany cited findings that psychotic disorders such as schizophrenia have a 1% prevalence across the population.<sup>15</sup> Our results demonstrated that psychotic disorders were much more common in younger patients who underwent the PEB process than in their older counterparts. This is not entirely unexpected in a military population, given that many of these diagnoses would represent incident cases of conditions that are incompatible with continued military service.

In general population studies, eating disorders and borderline personality disorder were more common in women,<sup>16,17</sup> which is consistent with our results. McNulty studied the prevalence of eating disorders in active duty women (from all branches of service) and

**Table 4. Rank order of U.S. Navy Physical Evaluation Board mental health diagnoses for patients younger than 30 years (1998–2000)**

Rank	Diagnosis	ICD-9-CM* code	No. of diagnoses (n = 1,252)	Percentage
1	Major depressive disorder, single episode	2962	149	11.9
2	Posttraumatic stress disorder	30981	98	7.8
3	Major depressive disorder, recurrent	2963	71	5.7
4	Dysthymic disorder	3004	60	4.8
5	Specific phobia	30029	58	4.6
6	Bipolar I disorder, most recent episode	2967	57	4.6
7	Alcohol dependence	30390	54	4.3
8	Depressive disorder NOS <sup>†</sup>	311	48	3.8
9	Schizophreniform disorder	29540	47	3.8
10	Schizophrenia	295	41	3.3
11	Personality disorder NOS	3019	38	3.0
12	Psychotic disorder NOS	2989	36	2.9

\*ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.<sup>6</sup> †NOS = not otherwise specified.

**Table 5. Rank order of U.S. Navy Physical Evaluation Board mental health diagnosis for patients aged 30 to 40 years (1998–2000)**

Rank	Diagnosis	ICD-9-CM* code	No. of diagnoses (n = 675)	Percentage
1	Major depressive disorder, single episode	2962	90	13.3
2	Major depressive disorder, recurrent	2963	61	9.0
3	Depressive disorder NOS <sup>†</sup>	311	49	7.3
4	Bipolar I disorder, most recent episode	2967	44	6.5
5	Posttraumatic stress disorder	30981	33	4.9
6	Schizophrenia	295	32	4.7
7	Dysthymic disorder	3004	32	4.7
8	Alcohol dependence	30390	28	4.1
9	Anxiety disorder NOS	30000	18	2.7
10	Panic disorder without agoraphobia	30001	18	2.7
11	Personality disorder NOS	3019	18	2.7
12	Tension headache	30781	18	2.7

\*ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.<sup>6</sup> <sup>†</sup>NOS = not otherwise specified.

found rates of anorexia and bulimia that were similar to those in civilian studies.<sup>18</sup> Abnormal eating behaviors that did not fulfill the criteria for anorexia or bulimia (eating disorder NOS), however, were much more prevalent among military women. Furthermore, women in the U.S. Marine Corps had much higher rates of all eating disorders compared with civilian women. Surprisingly, when McNulty examined the same eating disorders in U.S. Navy men, the prevalence of anorexia and bulimia (2.5% and 6.8%, respectively) was similar to that for military women.<sup>19</sup> This contrasts to civilian studies that found men were diagnosed with eating disorders at one tenth the rate of women.<sup>20</sup>

There are several possible reasons for the much lower rates of

eating disorders in our study. For one, only those cases in which the eating disorders were occupationally impairing would have led to a PEB. Moreover, these conditions often involve covert eating patterns and behaviors that are not volunteered by the individual unless specifically asked, while comorbid conditions such as major depression may be more readily apparent.

The occurrence of PTSD in the under-30 group was nearly double that of the other two age groups. One possible explanation would be that some service members have a history of PTSD prior to entering the military and are released from service early in their careers. As the data in this study were collected prior to recent combat operations in the Middle East, it's likely that many of the service members diag-

nosed with PTSD had childhood trauma or other trauma unrelated to combat. A study of 1,887 female recruits found that 57% of them had a history of childhood physical or sexual abuse, and 35% had been sexually assaulted as an adult.<sup>21</sup>

Overall, our PTSD rate was similar to that of community samples.<sup>22</sup> The rate of PTSD in women was nearly two and a half times that found in men, which is also consistent with findings from civilian studies.<sup>22</sup>

**STUDY LIMITATIONS**

The study design and data set have several limitations. The analysis was performed by diagnosis rather than by individual, so some individuals may have been represented multiple times within the study. There was no way to assess the co-

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**Table 6. Rank order of U.S. Navy Physical Evaluation Board mental health diagnoses in patients older than 40 years (1998–2000)**

Rank	Diagnosis	ICD-9-CM* code	No. of diagnoses (n = 333)	Percentage
1	Major depressive disorder, single episode	2962	49	14.7
2	Major depressive disorder, recurrent	2963	37	11.1
3	Depressive disorder NOS <sup>†</sup>	311	28	8.4
4	Alcohol dependence	30390	24	7.2
5	Posttraumatic stress disorder	30981	17	5.1
6	Dysthymic disorder	3004	14	4.2
7	Bipolar I disorder, most recent episode	2967	13	3.9
8	Nicotine dependence	30510	11	3.3
9	Bipolar II disorder	29689	10	3.0
10	Anxiety disorder NOS	30000	10	3.0
11	Cognitive disorder NOS	2949	9	2.7
12	Panic disorder without agoraphobia	30001	7	2.1

\*ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification.<sup>6</sup> †NOS = not otherwise specified.

morbidity of conditions that are common in many psychiatric diagnoses. It would be interesting to have the patient identifiers (Social Security numbers) available for further analysis. In addition, the PEB database included all diagnoses—some of which may be less important than others—in order to document fully the level of disability involved for the individual. The most critical diagnoses for an individual, however, could not be determined from the data set, so we could not identify those conditions.

**IMPLICATIONS FOR PRACTICE**

While military psychiatric practice involves many areas beyond the scope of the PEB, this analysis illustrates one important aspect of expected clinical practice. It identifies common conditions with which military psychiatrists should be

well experienced and for which military psychiatric residencies should provide a solid background. These findings also support the need for military primary care providers to develop mental health expertise since they are likely to perform the initial evaluation and make the referral for specialty care.

In addition, the study highlights several areas for future analysis. Because separations for certain conditions (such as personality disorders) are considered administrative and are not handled through the PEB, they are not captured by the data source we used. Therefore, these data do not fully represent mental health losses in the service. It would be interesting and useful to study these other mental health losses as well. The analysis also identified a number of people who underwent a PEB for recur-

rent depressive disease. The data set, however, does not include factors associated with people whose recovery from their initial depressive episode allowed career completion; this certainly would be worth further investigation. Lastly, the fact that the PEB process leads to significant personnel loss from the U.S. Navy suggests that annual analysis of PEB data for trending would be valuable.

**CONCLUSIONS**

Mental health conditions represent a substantial source of personnel loss in the military, as evidenced by the fact that such conditions were the second leading diagnostic category in the U.S. Navy's PEB during the years 1998 through 2000. Major depressive disorder was the most common diagnosis across age and gender groups. PTSD and alcohol

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dependence also were encountered frequently. Women were more likely than men to be diagnosed with PTSD within the PEB process. ●

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