



Avoiding the Walker Dip in the Advancement of Military Psychology and Psychiatry Research

Alan L. Peterson^{1,2*}

¹Department of Psychiatry & Behavioral Sciences and Department of Psychology, The University of Texas at San Antonio, San Antonio, TX 78249, USA

²South Texas Veterans Health Care System, San Antonio, TX 78229, USA.

*Corresponding author: Alan L. Peterson, PhD, Department of Psychiatry and Behavioral Sciences, The University of Texas at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900, USA. Email: PetersonA3@uthscsa.edu

Keywords: The Walker Dip, posttraumatic stress disorder, PTSD, traumatic brain injury, TBI, research funding, Congressionally Directed Medical Research Program, CDMRP, Large-Scale Combat Operations, LSCO.

Many of the greatest discoveries in science and medicine have come from the military battlefield. Unfortunately, many of these advancements dwindle and are sometimes lost or forgotten during peacetime with reductions in overall military personnel force strength and research funding. *The Walker Dip* [1] is a term that has become popular over the past decade within the military medical community [2,3]. The term is credited to Surgeon Vice Admiral Alasdair James Walker, who served as the Surgeon General of the British Armed Forces from 2015-2019. As described by Admiral Walker, there has been a pattern in recent history whereby significant advancements in military medicine that are made during wartime are followed by periods of limited advancements during peacetime [1].

The same concerns about The Walker Dip and the associated cyclical advancements and declines in military medical research, skills, and capabilities can also be applied to military psychology and psychiatry research. For example, the diagnosis of posttraumatic stress disorder (PTSD) was first included in 1980 in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [4]. This addition was the result of clinical research with Vietnam Veterans that occurred during and soon after the Vietnam War [5]. Unfortunately, in the two and a half decades between the end of the U.S. military conflict in Vietnam in 1975 and the start of the Global War on Terrorism in 2001, very little research occurred focused on the assessment and treatment of PTSD in military personnel [6]. The first clinical case report of treating combat-related PTSD in active duty military personnel was not published until 2005 [7], 30 years after the end of the Vietnam War.

Soon after the start of the Global War on Terrorism, three seminal publications highlighted the significant clinical and research gaps that existed in deployment-related military

psychology and psychiatry research. These publications helped stimulate U.S. federal research funding to address these gaps. The first publication was a *New England Journal of Medicine* publication in 2004 which focused on the mental health problems reported by U.S. military personnel completing combat duties in Iraq and Afghanistan [8].

The second seminal publication was the 2007 Institute of Medicine report of an assessment of the evidence for the treatment of PTSD [9]. The report was commissioned by the Department of Veterans Affairs (VA), and it reviewed the scientific and medical literature on the diagnosis, assessment, and treatment of PTSD. The report indicated that the only treatments for PTSD with sufficient scientific evidence for their efficacy were exposure-based cognitive behavioral therapies. The report served as a foundational document for the identification of research gaps by providing a comprehensive review of the scientific and medical literature on PTSD in service members and veterans.

The third seminal publication was the 2008 RAND report edited by Tanielian and Jaycox titled the *Invisible Wounds of War* [10]. This influential publication assessed post deployment health-related needs in U.S. military personnel associated with PTSD, major depression, and TBI. It also highlighted the limited treatment capacity of the existing

Received: August 21, 2026; **Revised:** August 24, 2026; **Accepted:** August 25, 2026

Citation: Peterson AL. (2026) Avoiding the Walker Dip in the Advancement of Military Psychology and Psychiatry Research. *J Psychol Psychiatry Res*, 3(1): 1-4.

Copyright: ©2026 Peterson AL. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Department of Defense (DoD) and VA health care systems and estimated the costs of providing quality health care to all military members in need.

In response to this emerging national public health crisis, the U.S. Congress approved a \$900 million appropriation in 2007. This DoD appropriation was to enhance clinical and research efforts targeting PTSD and TBI in U.S. military personnel. Two-thirds of this funding (\$600 million) was targeted for increased clinical activities (e.g., hiring more clinicians). One-third (\$300 million) was allocated for clinical research to be managed by the Congressionally Directed Medical Research Program (CDMRP). The research funding was divided equally between PTSD (\$150 million) and TBI (\$150 million).

This initial bolus of research funding led to the establishment of the CDMRP's PTSD and TBI Research Program. This resulted in the funding of multiple investigator-initiated research projects in 2008 as well as funding to support three research consortia focused on PTSD, TBI, and a clinical consortium focused on PTSD and TBI clinical trials. The DoD-funded PTSD research consortium was called the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience (STRONG STAR) Multidisciplinary PTSD Research Consortium headquartered at the University of Texas at San Antonio [11]. Funding of the DoD's PTSD and TBI Research Program resulted in the first wave of research focused on PTSD, TBI, and other psychological and psychiatric health conditions in post-9/11 service members and veterans.

The second bolus of DoD PTSD and TBI research funding was part of an Executive Order by President Obama in 2012 to establish a National Research Action Plan focused on PTSD, TBI, suicide prevention, and other mental health conditions in military service members and veterans [11]. This included \$46 million in joint funding from the DoD and VA to establish the Consortium to Alleviate PTSD to further advance research targeting PTSD in military personnel and veterans. This funding supported a second wave of research projects with post-9/11 service members and veterans to further extend the research by the STRONG STAR Consortium focused on PTSD and other psychological and psychiatric conditions. Additional research emphases of the STRONG STAR Consortium to Alleviate PTSD as guided by the National Research Action Plan included a focus on biomarkers of PTSD, the establishment of Common Data Elements (CDEs) for the assessment of PTSD in DoD and VA research studies, and studies focused on the mechanisms of action in the prevention and treatment of PTSD [11].

The third bolus of DoD PTSD and TBI research funding was in 2021 with the initial funding of the TBI and Psychological Health Research Program through the CDMRP. The program was funded for 4 years between 2021-2024 for \$175 million per year. This funded a third wave of nationwide PTSD, TBI, suicide prevention, and other psychology and psychiatry

research projects with post-9/11 service members and veterans.

The results of the research funding by the DoD and VA targeting PTSD and other psychological and psychiatric conditions between 2008-2025 have resulted in substantial advancements in the assessment, diagnosis, and treatment of PTSD in active duty military personnel and veterans [11]. The initial wave of DoD-funded clinical trials focused on treating PTSD in active duty military personnel demonstrated that cognitive behavioral therapy treatments originally developed for civilians, such as Prolonged Exposure Therapy and Cognitive Processing Therapy, were also efficacious for the treatment of combat-related PTSD. However, the effect sizes for treating military personnel were smaller than found in previous civilian studies. The second wave of DoD- and VA-funded research evaluated methods to improve treatment outcomes by adding military-relevant components. Some of these modifications included compressed or intensive (e.g., daily) treatment formats, variable-length treatments, shared decision making, treatment shifting, and combined treatments that also focused on the most common PTSD comorbidities such as TBI, sleep disorders, substance use disorders, chronic pain, tinnitus, and suicide prevention. The results of these PTSD clinical trials have demonstrated that up to 75% of service members and veterans can achieve clinically significant reductions in their symptoms and 40-50% no longer meet diagnostic criteria for PTSD [11]. The third wave of DoD- and VA-funded clinical trials that are currently ongoing are focused on how to further enhance the efficacy of evidence-based cognitive behavioral therapies by systematically combining them with medications (e.g., ketamine, psychedelics, stellate ganglion blocks, etc.) and medical devices (e.g., transcranial magnetic stimulation, transcranial direct current stimulation, vagus nerve stimulators, etc.). These scientific and clinical advancements will help maintain military operational readiness by significantly increasing the proportion of active duty service members seeking treatment for PTSD and other psychological and psychiatric conditions who can be treated into remission, remain fit for duty, and be prepared to support future military deployments.

Unfortunately, with changes in the U.S. government administration in 2025 resulting in significant budget reductions, the TBI and Psychological Health Research Program received no budget allocation in Fiscal Year 2025 and only limited research funding in Fiscal Year 2026. Research funding by the DoD was continued for other topics with less direct military relevance, such as cancer research. Whether or not the TBI and Psychological Health Research Program with significant military operational readiness implications will be reinstated in future years is currently unknown. Elimination of this critical research program may be the start of a Walker Dip that could result in significant decreases in the advancement of military psychology and psychiatry research.

Sustained military research funding is vital to keep pace with the changing landscape of warfare and to be prepared for the next war. The recent military conflicts in Ukraine, Israel, and Iran are excellent examples, where drone warfare has been the leading cause of injury, death, and destruction [12]. Recent concerns have also been expressed by U.S. military leaders about the potential for future Large-Scale Combat Operations (LSCO), such as a widespread war in the Indo-Pacific region including China, Russia, and North Korea [13]. These concerns include the conditions and implications of modern LSCO that the U.S. military would have to face. To prepare for future warfare, military leaders must understand various aspects of LSCO, the impact on military operations, and the planning and execution of training that will be required to successfully execute national security objectives. In addition, the psychological preparation of military personnel for LSCO is essential.

The psychological health of U.S. military personnel is one of the most significant factors contributing to military operational readiness. Human performance optimization, the enhancement of psychological resilience, and the prevention of psychological and psychiatric conditions in military personnel are additional research gaps directly related to military readiness. Sustained research funding is vital to continue scientific advancements on the enhancement of psychological health and resilience in U.S. military personnel. This is particularly relevant in the preparation of military personnel for deployment.

One of the most important missions in a service member's military career is to deploy to an active combat theater or other operational environment. The successful completion of a military deployment is often the highlight of a military career. Unfortunately, not all service members are able to successfully complete military deployments. During the height of post-9/11 U.S. military combat operation in Iraq, Afghanistan, and surrounding locations, the majority of casualties that required aeromedical evacuations from the Central Command (CENTCOM) were for battle-related physical injuries [14]. However, with the decreases in military combat operation over the past decade, mental health conditions have emerged as the leading cause of aeromedical evacuations. As of 2023, mental health conditions accounted for 27.5% of all aeromedical evacuations from CENTCOM as compared to only 1.9% for battle injuries. Additional military research is needed focusing on the enhancement of psychological resilience [15] and the development and evaluation of psychological and psychiatric interventions that can be delivered in far-forward locations [7] to prevent the need for aeromedical evacuations and sustain military operational capabilities.

In summary, during a time of limited military operational deployments, we must avoid The Walker Dip related to military psychological and psychiatric research. The significant advancements in military psychology and

psychiatry research that were made during the Global War on Terrorism must not be allowed to dwindle or be lost during peacetime. Continued public advocacy is essential to support psychological and psychiatric research funding by the DoD (renamed Department of War [DoW] in September 2025). The sustained funding of research to avoid The Walker Dip is critical to continue the advancement of military psychology and psychiatry research, maintain military operational readiness, and enhance warfighter lethality.

REFERENCES

1. Walker AJ. (2018) The 'Walker dip'. *J R Nav Med Serv*.104(3):173–176.
<https://doi.org/10.1136/jrnms-104-173>
2. Coppack RJ, Ladlow P, Cassidy RP, Egginton N, Barker-Davies R., et al. (2024) Academic Department of Military Rehabilitation (ADMR): avoiding the pitfalls of 'the Walker Dip'. *BMJ Mil Health*. 170(1):4-8. Published 2024 Jan 25. doi:10.1136/military-2023-002469
3. Panarello NM, McCarthy CF, Harrington CJ, Stinner DJ, Renninger CH. (2025) Recent Orthopedic Trauma Volume in the United States Military Health System. *Mil Med*. 190(5-6):e1206-e1210. doi:10.1093/milmed/usae576
4. American Psychiatric Association. (1980) *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. Washington, DC: American Psychiatric Association.
5. Kolb LC. (1986) Post-traumatic stress disorder in Vietnam veterans. *N Engl J Med*. 314(10):641-642. doi:10.1056/NEJM198603063141009
6. Peterson AL. (2022) General Perspective on the U.S. Military Conflicts in Iraq and Afghanistan After 20 Years. *Mil Med*. 187(9-10):248-251. doi:10.1093/milmed/usab496
7. Cigrang JA, Peterson AL, Schobitz RP. (2005) Three American troops in Iraq: Evaluation of a brief exposure therapy treatment for the secondary prevention of combat-related PTSD. *Pragmat Case Stud Psychother*. 1(2).
<http://dx.doi.org/10.14713/pcsp.v1i2.857>
8. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, et al. (2004) Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med*. 351(1):13-22. doi:10.1056/NEJMoa040603
9. Institute of Medicine. (2007) *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*. Washington, DC: The National Academies Press.
10. Tanielian T, Jaycox LH, eds. (2008) *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: RAND Corporation;

- <https://www.rand.org/pubs/monographs/MG720.html>.
11. Peterson AL, Young-McCaughan S, Roache JD, Mintz J, Litz BT, et al. STRONG STAR and the Consortium to Alleviate PTSD: Shaping the future of combat PTSD and related conditions in military and veteran populations. (2021) *Contemp Clin Trials*. 110:106583. doi:10.1016/j.cct.2021.106583
 12. The Lancet. (2025) Understanding the health threats of drone warfare. *Lancet*. 406(10516):2191. doi:10.1016/S0140-6736(25)02261-5
 13. Department of the Army. (2024) *The Operational Environment 2024-2034: Large-Scale Combat Operations*. TRADIC Pamphlet 525-92. <https://oe.tradoc.army.mil/product/the-operational-environment-2024-2034-large-scale-combat-operations/>
 14. Cowser MA, Gomes KD, Straud CL, Young-McCaughan S, Raps SJ., et al. (2026) Longitudinal trends in aeromedical evacuations for mental health disorders and battle injuries from Central Command between 2001 and 2023. *Mil Med*. 191(5-6):e993-e1000. doi:10.1093/milmed/usaf513
 15. Peterson AL, Moore BA, Evans WR, Young-McCaughan S, Blankenship AE, et al. (2024) Enhancing resiliency and optimizing readiness in military personnel through psychological flexibility training: design and methodology of a randomized controlled trial. *Front Psychiatry*. 14:1299532. Published 2024 Jan 5. doi:10.3389/fpsyt.2023.1299532