VOLUME 4 ISSUE 1

The Navy Psychologist

March 2012

Inside This Issue

From the Editor

Greetings! As your new editor, I am honored to be the current steward of The Navy Psychologist (TNP). TNP enhances communication, provides information and helps us stay connected to our fellow Navy clinical psychologists stationed around the world. The current issue offers a number of announcements related to outstanding psychologists and news from Navy psychology.

In this issue psychologists continue to share their unique experiences in a variety of capacities. Our Specialty Leader and Training Director provide updates on the community, bonuses and the training program. CDR Robin Lewis relates her experiences doing disaster relief in Haiti. LT Jason Duff provides an update on our billets in Okinawa. LT James (aka Matt) Keener provides an ethics case from Iraq. CAPT Scott Johnston and colleagues examine psychological health and operational stress in military guards serving in Guantanamo Bay. And find out which psychologist received a MCMAP Brown Belt!

Finally, TNP is always looking for ideas for future editions. Please submit your ideas or short manuscripts to carrie.kennedy@usmc.mil for the next issue, anticipated in September 2012. If you've been somewhere interesting, been involved in a unique operation, want to pass on some information to the rest of the community or if you have an ethics case, please let me know.

CDR Carrie H. Kennedy

Clinical Psychology Specialty Leader
CAPT John Ralph

Message from the Specialty Leader

Dear Colleagues,

Earlier this month the USS Bataan completed her latest 6-month deployment. Along for the ride was LCDR Sam Stephens, the first clinical psychologist to deploy with an Amphibious Readiness Group. In his After Action Report, the ARG commander noted that the presence of a psychologist "had a dramatic positive effect on the mental health [of the crew] and resulted in significant financial savings." From March to mid August of 2011, the ship averaged 3.4 mental health evacuations per month, at a cost of over $142,000 and nearly 11,000 lost man hours. From late August of 2011 to January of 2012, with LCDR Stephens onboard, mental health evacuations were reduced to 0.5 per month, saving the command $132,000 and about 9,300 man hours.

To those who remember when psychologists were first deployed on aircraft carriers, these numbers seem eerily familiar. In fact, whenever psychologists have deployed in operational settings, they have proven without exception that the presence of a clinical psychologist not only benefits the mental health of those who seek treatment, but improves the actual operational readiness of the unit in clear, measurable ways. That is why, as we enter 2012, our community has more billets than we've ever had before. We now have 188 billets, up from 138 in 2009. By October we'll have 194 billets, and I don't expect the demand to stop there. In fact, I predict that in a few short years, we'll have 9 additional billets to fill aboard large amphibs like the Bataan. At a time when the Navy is shrinking and the DoD is looking for any possible way to save money, our community is unequivocally growing.

(Continued on page 6)

From the National Training Director

By CAPT Eric Getka (Retired)

Naval Medical Center Portsmouth (NMCP) Training Programs Earn Dual Accreditation

Accreditation
An enthusiastic Bravo Zulu* to the psychology training faculty at NMCP for being awarded the American Psychological Association's highest level of accreditation for their Clinical Psychology Post-Doctoral Fellowship and their pre-doctoral internship. Both programs received full seven-year accreditations after their first years and were lauded by the APA representatives who conducted the site visits. Anyone who has been involved in the APA accreditation process appreciates that earning one accreditation is an impressive feat. To earn two accreditations in consecutive years during one of the busiest times ever for Navy psychology is simply astonishing. Dr. Tom Kupke (Training Director), CAPT Kevin Kennedy, CAPT David Jones, CDR Greg Caron, LCDR Ingrid Pauli and the entire training staff at Portsmouth have achieved a goal that is unprecedented in the history of Navy Medicine. With a capacity for nine trainees per year (seven interns and two post-docs), Portsmouth is currently the largest of our three training sites.

NMCP Internship
The NMCP internship has a unique mission compared to our internships in San Diego and Bethesda. The Portsmouth internship was created to insure, to the maximum extent possible, that Uniformed Service University (USU) students and students in the Health Professions Scholarship Program (HPSP) would be able to attend a Navy internship and acquire the Navy-specific knowledge required to function effectively in their first assignments. This objective cannot be achieved through the national Match process which prohibits internships from reserving internship positions for pre-selected students. For this reason, the Portsmouth program does not participate in the APPIC Match and accepts applications only from USU and HPSP students. (Participation in the Match and accreditation are entirely separate from one another). There is no guarantee that a USU or HPSP student will be accepted at Portsmouth. APA accreditation rules require that internships have a defined application process and that the Training Director have the prerogative to accept or disqualify an applicant. In order to be accepted into the Portsmouth internship, USU and HPSP students must demonstrate that they are adequately prepared based on their academic performance and practicum experiences. The Portsmouth internship will be accepting up to five scholarship students and two USU students per year.

NMCP Post-Doctoral Fellowship
The NMCP post-doctoral fellowship accepts two fellows per year. The mission of the fellowship program is to develop advanced competencies in the assessment and treatment of posttraumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), chronic pain, family issues, substance/alcohol abuse and severe mental health conditions requiring inpatient psychiatric treatment. Fellows gain experience in the practice of clinical psychology in operational settings— spending several days aboard a major Navy combatant vessel working with the ship's psychologist and visiting a Marine or Navy SEAL base where Navy psychologists practice. Training is also provided in clinical leadership, preparing fellows to evaluate existing clinical programs, develop new programs, provide effective supervision of other practitioners, and organize resources to meet clinical and administrative objectives. Applications for the fellowship are open to civilians, under 42 years of age, who have completed, or are nearing completion, their predoctoral internship. Selectees are commissioned as Lieutenants, attend Officer Development School prior to the fellowship, and incur a three-year service obligation.

Two Internships Under One Roof
The last issue of *The Navy Psychologist* included a look-ahead to the merger of Walter Reed Army Medical Center and the National Naval Medical Center, Bethesda (NNMC). At this writing, the former Walter Reed has closed, the Bethesda campus has been transformed by nearly one billion dollars of construction, and the Walter Reed National Military Medical Center has been christened. The new facility is the home of two APA-accredited internships, the Army internship formerly located at "the old Walter Reed" and the Navy internship long-housed at the fondly-remembered NNMC. For the first time, two separately-accredited military internships are operating jointly under one roof. Long and careful planning by the Army and Navy training directors preceded the merger and the arrival of twelve interns in October. (The start of the internship class was delayed to let the dust settle after the August merger). Continued on Page 13.

*Bravo Zulu is a Naval signal, conveyed by flaghoist or voice radio, meaning "Well Done."

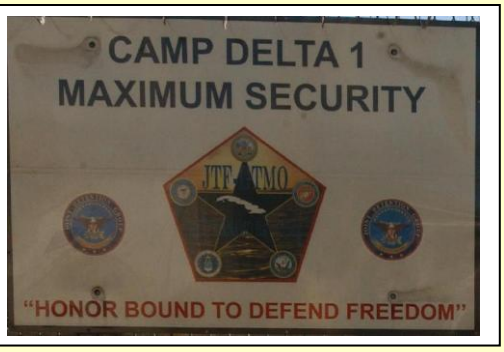
The bravo and zulu signal flags

OPERATIONAL STRESS IN DETAINEE OPERATIONS AT JOINT TASK FORCE GUANTANAMO BAY, CUBA

By CAPT Scott Johnston, Jennifer Webb-Murphy, Stephanie Raducha, Elizabeth Abou
Naval Center for Combat & Operational Stress Control

The Joint Task Force Guantanamo Bay (GTMO) detention facility was established in 2002 to retain unlawful combatants of the Global War on Terror (GWOT). Due to allegations of aggressive interrogation techniques, prisoner abuse, and reports of detainee self-injurious behavior the detention facility has received a controversial reputation. Environmental stressors not only impact detainees, but also the guards serving at GTMO. It has been well established that correctional officers and service members are at risk of developing Posttraumatic Stress Disorder (PTSD) and other operational stress injuries due to the nature of their work, however, little is known about the guards who work at GTMO.

In order to better understand the relationship between psychological health and occupational stress among the guards, the population was surveyed between the months of August 2009-November 2009. The surveys included measures of PTSD, depression, perceived stress, resilience, beliefs about mental health and alcohol use. The sample (N= 297) was largely male (84%), ranking between E1-E9 (98.3%), in the Navy (67.9%) or Army (32.1%) with an average age of 27. Three noteworthy findings are described below.



First, we found that guards do experience elevated levels of operational stress injuries. Approximately 25.3% of the guards met criteria for depression (PHQ-9 score of 10 or greater) and 15.2% met criteria for PTSD, based on a PCL-M score of 50 or greater and meeting DSM-IV diagnostic criteria for clusters B-D. Furthermore, rates of depression were higher in GTMO guards compared to Operation Iraq Freedom (OIF) soldiers sampled in the Millennium Cohort study (Wells et al. 2010). Fewer than 10% of service members in the Millennium Cohort study, who deployed in support of GWOT, and who had combat experience met the same criteria for depression. The increased rates of depression and high rates of PTSD among the guards may be due to the cumulative effects of both the stressors associated with deploying and those specific to working at GTMO, such as, relations with inmates, relations with superiors, political pressures, public spotlight, administrative problems and lack of participation in decision-making. All of this creates an environment that may feel constrictive to the guards as compared to combat personnel. Combat personnel, even though they are serving in stressful areas, may benefit from small unit autonomy. This level of control and freedom experienced by combat personnel may protect them against feelings of helplessness and depression. Warfare at GTMO is more psychological in nature, compared to the more "kinetic" warfare experienced in traditional combat deployments. For example, guards serving at GTMO commonly report being impacted by the continuous taunts of prisoners and threats of violence without the ability to react. An additional, important consideration is the duration of stress faced by the guards. The stress and threats are typically chronic since they are dealing with inmates on a daily basis with little relief. While those involved in combat deployments may experience intense and even traumatic moments, they are often fleeting and coupled with periods of reprieve. In summary, detainee operations are stressful, factors uniquely associated with work at GTMO may put service members at higher risk for depression.

Continued on Page 7

For an excellent reference on operational stress, see the Naval Center Combat & Operational Stress Control Website at http://www.med.navy.mil/sites/nmcsd/nccosc/Pages/welcome.aspx?slider2=1 as well as their quarterly newsletter, MINDLINES at http://bit.ly/fUdVNW

Disaster Relief in Haiti

By CDR Robin Lewis (pictured in the middle aboard the USNS Comfort)

What has become known as The Haiti Earthquake happened over two years ago, I still have a hard time talking about it. Not because of the devastation and trauma, but because of the magnitude of the experience. I have a difficult time finding an appropriate starting and stopping point in discussing my time on the USNS Comfort. I am having the same difficulty now. So I will start at the point of a repeated question, that being "who were your patients?" My answer, "everyone was a patient". The majority of consultations were for the Haitians. However, the patient behind the consultation was often the provider in pain. A typical consultation went something like this: "Patient in bed 23 with a tib/fib fracture and multiple lacerations/burns. Found under rubble 5 days post earthquake. Several family members dead including two children. Whereabouts of other family members unknown. Please assess for PTSD." REALLY? And oh, BTW, 80 – 90% of the Haitians on the ship could have had the same consult with only a few changes. I responded to every consult by spending hours on end hearing stories and talking with the Haitians about life, beauty, pain, chaos, destruction and their religious beliefs/meaning behind what had happened. Were people sad and in distress – absolutely. Yet, they were hopeful, thankful and filled with praise – at a level that humbled me over and over again. I am thankful for what the Haitians taught me.

I am not so narcissistic to think that another psychologist could not have provided the same or better care for the Haitians and staff of the Comfort as I did. I am thankful I was there. Haitians are a deeply religious group of people. I have a strong faith and feel that there is an inseparable connection between our spiritual and psychological self. When a Haitian "freaked a provider out" when talking about "spirits or crying out to God" it did not bother me and I was able to tease out "normal" beliefs and delusions. It was not uncommon for me to approach a bedside and find the person singing a hymn or a song of praise. If I knew the song in English, I would join in. What smiles were received and immediate bonds made. I quickly learned that given their beliefs I had to change my standard interview with the Haitians in one significant way. If I asked about suicidal thoughts they would shut down. At first I was concerned - then I learned. They were deeply offended that I asked. As an early patient taught me in an angry response, "Ma'am I don't know what you are saying. If I wanted to die I would not have yelled out for help. I was just stuck under a building and tasted death. I don't want to die. I want to live! God saved me for a reason." He had one arm and one leg amputated. And had lost several people in his family. And had no place to live. So, I learned to ask about future plans and hopefulness vs. directly about suicide.

After talking with the patients and assessing how they were coping, I would talk with the person that referred that patient. I would start with: "I just spent some time with so and so. But before we go there, how are you doing?" More often than not, the referral was based on the referrer's anxiety, stress and difficulty with the tragedy of it all. I talked, held, cried and laughed with the amazing providers and staff on the Comfort. I would eventually brief the referrer on the patient, but only after their emotions were acknowledged and felt in the presence of another.

I am often asked, "How did you take care of yourself?" In truth, I cried – a lot. After tears flow and flow and there are no more tears left, a sense of peace would take over which allowed me to move on. I prayed – a lot too. I cannot over-emphasize the importance of belief and understanding of God in bringing a true Peace that passes all understanding (because things are not fair – but really, who promised that they ever would be?). I practiced as much self-care as possible (regular treadmill time, evening meals I would sit next to people that I was developing friendships with and if there was an option between laughing about a situation or crying – I would try to laugh as there were plenty of reasons to cry).

I am also asked, "What were some of the challenges?" There were numerous challenges that were faced daily on the Comfort. Working with/through a translator with the majority of Haitian patients was a new experience. Providing psychological care in a disaster challenged every APA ethics/HIPAA code and law that has been pounded into my head. From the moment I introduced myself (I quickly learned that I could be saying I was a voodoo doctor if I used the term "psychologist") to what I said in wrapping up the "session", to diagnosis (really, what good is the DSM is such a situation?) to charting, to what I told the referrer – all actions were steeped in ethical conflicts. Helping outside of my scope of comfort/competence was a new experience. I would often chuckle as I approached a naked Haitian male to conduct an interview and think, "what would APA say about this?" I learned about wound care, changing bedpans, changing sheets, mopping up and other duties on the fly. When I explain the "collateral duties" I often get the response of "you emptied bed pans?" Oh yeah. Lots. What else does one do when you go to talk with a patient and realize they are sitting on a full bedpan? Call the corpsmen over?

Continued on Page 10.

Service in Okinawa

By LT Jason Duff

Dr. Logue, LT Clark, LT Caraveo, LT Domery, LT Duff

Duff. Domery. Udell. Caraveo. Clark. Logue. These are the names of the motivated and capable providers representing Navy Psychology at USNH Okinawa, Japan. LT Udell just happens to be representing from JTF GTMO as an Individual Augmentee. Yes, people do deploy out of Okinawa. I am currently the Division Officer of the Deployment Health Center, while the other psychologists are assigned to Outpatient Mental Health. Dr. Mary Beth Logue has been our civilian child psychologist since May 2004. OSCAR does not currently have any psychologists, but is manned by two psychiatrists, one psychiatric nurse practitioner and one licensed clinical social worker. There are various GS workers and contractors also providing invaluable support as licensed professional counselors, psychiatrists, and social workers.

Though we are on a small island, Okinawa hosts about two-thirds of the 40,000 American forces in Japan. Okinawa allows for frequent joint service collaboration as the Army and Air Force are here along with the Navy and Marines. Psychologists have admitting privileges here at USNH Okinawa. This provides a sense of autonomy that might not be experienced at other commands. The new Naval hospital is set to open in early 2013. It is always exciting and motivating to have new workspaces and it is an exceptionally exciting time here in Okinawa for mental health. USNH Okinawa has recognized the unique needs of the mental health community and recently stood up its first Directorate for Mental Health. CAPT Catherine MacDonald, a psychiatric nurse practitioner will be the first to assume the Director role.

There are myriad collateral duties for both junior and senior psychologists to contribute and grow both personally and professionally. I am currently heading up the Caregiver Occupational Stress Control Team and I am the Program Director for Tele-behavioral health services. I also sit on the TBI Treatment Team, Patient and Family Centered Care Council, Suicide Prevention Committee and the Continuous Readiness Posture Work Group. Other collaterals for psychologists have included sitting on the Bio-ethics committee and the Overseas Screening Committee. Additionally, psychologists have served as Customer Relations Representatives, Department Peer Review Coordinators, and Department Process Improvement Coordinators.

Additionally, I am excited to be getting back on the radio when I take over for LT Domery as the host of Okinawa's mental health radio program. Mike has done a great job while addressing such important topics as stress management, mindfulness, and the effective use of leisure time.

Being stationed in Okinawa is analogous to an exotic vacation that lasts 2-3 years. Even though home may be far away there is incredible amount of support here and the sense of family is abundant. Okinawa is known as a "two baby tour". In fact, our first-born is due in April. Some people, like the Caraveos, try to speed up the process…their twins are due in May.

There are numerous activities from snorkeling and scuba diving to clay sculpturing and language lessons. Big name entertainers frequent the island thanks to groups such as the USO, MCCS, and MWR. Okinawa offers countless one of a kind cultural and historical experiences. For example, the Battle of Okinawa tours, the many castles and ruins that are available for exploration, the markets and souvenir shops on Kokusai Street, or even just going out for dinner or walking down the street can provide a novel cultural encounter. The food menus on Okinawa include more than just sushi. From foodies to gourmets, everyone will enjoy the endless variety of food choices on this small island.

Okinawa is an ideal place for working on that Travel Bucket List. In December, my wife and I spent eight amazing days in China. Other psychologists and their families have traveled to Hawaii, Cambodia, and Vietnam. Thailand, mainland Japan and Australia are just a few of the potential travel sites over the course of our tour. Space A flights are always available to a great number of exciting destinations. Overall the advice for anyone headed overseas is, "be open minded and have fun." Anyone thinking of PCSing to Okinawa or just wanting to reminisce about their "happy time" please feel free contact me: Jason.duff@med.navy.mil; www.facebook.com/jasonduffusn Ψ

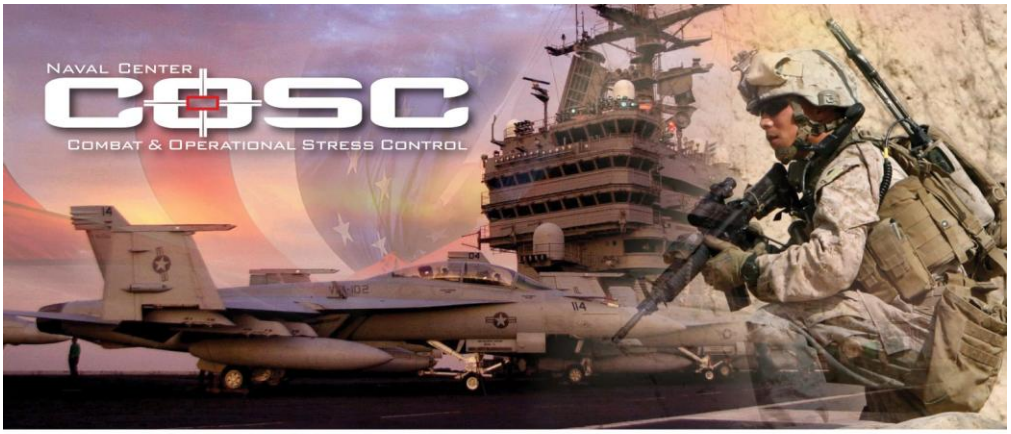
Message from the Specialty Leader, continued from Page 1

In fact, we're growing so fast we're having trouble meeting demand. In 2010 we had 132 people in our community and were 90% manned. Now we have 160 people, but we're only 84% manned. If you subtract trainees, we're at 78%. These figures illustrate the primary issue facing our community these days; the more successful we are, the more that is asked of us. While this is a challenge, it's a great challenge, much like a successful small business is challenged when sales go through the roof. The roles we're being asked to fill, and the responsibilities we're being asked to shoulder, are the direct result of hard work, skillful communication, exceptional care, and unqualified success at what we do.

I know that many of those in our community are feeling the pressure that comes with such success. We have many folks who feel like they're out on a limb, having to shoulder responsibilities beyond what they previously thought they could handle. For those in this position, remember that increased responsibility and stress as a result of one's success is rightfully a tremendous source of pride. Be proud of what you do and what you've accomplished. I know without a doubt that our line colleagues value your efforts a great deal. Also, don't be afraid to reach out to others in our community who have been through similar experiences. As we work together to meet our current challenges, I'm certain that our successes will continue to multiply. Thanks to you all for the fine work you're doing. As always, I'm extremely proud to be a member of the Navy Clinical Psychology community.

Very respectfully,

CAPT Ralph



JOINING FORCES TO STRENGTHEN RESILIENCE

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Check our website for more information and updates:
www.nccosc.navy.mil

Email NCCOSC at:
nmcsd.nccosc@med.navy.mil

Who Should Attend:
- Line Leaders
- Chaplains
- Researchers
- Medical Personnel
- Therapists
- Case Managers
- Military Family Members

Conference Tracks:
- Navy
- Marine Corps
- Research
- Clinical
- Family

NAVY AND MARINE CORPS COMBAT & OPERATIONAL STRESS CONTROL CONFERENCE 2012

REGISTRATION OPENS FEBRUARY 8
AT WWW.NCCOSC.NAVY.MIL

Conference Dates: May 22 - 24
Pre-conference Workshops: May 21
Town & Country Resort and Convention Center, San Diego

NAVAL CENTER COSC COMBAT & OPERATIONAL STRESS CONTROL

Follow us on:

This activity is jointly sponsored/co-provided by the Naval Center for Combat & Operational Stress Control and The Postgraduate Institute for Medicine and has been designed to meet the educational needs of providers involved in the care of patients with combat and operational stress injuries and illnesses.

AMA Credit Designation - This activity has been approved for AMA PRA Category Credit(s)™. The number of credits are pending; see future activity announcement for specific details.
Psychologist Credit - This activity is eligible for APA credit; see future activity announcement for specific details.
Nursing Credit Designation - This activity is eligible for ANCC credit; see future CNE activity announcement for specific details.
Social Worker and Marriage and Family Therapist Credit Designation - This activity is eligible for both Social Worker and Marriage and Family therapist credit; see future activity announcement for details.
Case Managers - This activity is eligible for CCMC credit; see future activity announcement for details.

Navy Psychologists of the Year 2011

Junior Psychologist

LT Mat Rariden

Senior Psychologist

LCDR Ray Nairn

Civilian Psychologist

Tom Kupke

OPERATIONAL STRESS IN DETAINEE OPERATIONS AT JOINT TASK FORCE GUANTANAMO BAY CUBA, (continued from Page 3)

Second, it was found that those working within their Military Occupational Specialty (MOS) had significantly higher scores on depression and alcohol use compared to those working outside their MOS. Since those working inside their MOS have been trained for security operations and may have had previous experiences as guards, coming in with expectations may prove to be a risk factor for increased stress due to the unique and challenging environment at GTMO. Thus, working outside your MOS may be a protective factor as there is no basis for comparison.

Third, we found evidence of salient stigma in this population. Unfortunately, those that are likely to need professional help the most, such as those meeting criteria for PTSD, were less likely to agree to seeking professional help if they believed that they had a mental health problem (31.4%) compared to those that did not meet criteria (71.6%). A similar pattern was observed in those who met criteria for depression. Additionally, when asked if they believed they had a mental health problem if they would seek professional help, 32% of the sample said they would not for themselves but would refer a trooper under their leadership. These striking statistics highlight the presence of stigma in this population and challenges associated with delivering mental health care in the military. It also supports the current efforts underway to make operational stress control a leadership function, as guards are more likely to refer a shipmate before referring themselves.

These findings reveal that detainee operations are stressful, that guards are especially at risk of developing depression, that guards working within their MOS are at an even higher risk for mental health problems and that stigma is a real barrier to care. There is a clear need for the ability to identify service members suffering from occupational stress and to develop programs to mitigate stress injuries for GTMO guards. Ψ

CONGRATULATIONS TO LT ANGELA CORIANO (USNH Guam), MCMAP BROWN BELT!

Bonuses: Clear as Mud

CAPT John Ralph, Navy Psychology Specialty Leader

There has been a lot of confusion about our bonus situation over the past few years. In an attempt to clarify things, here are the important facts about our available bonuses:

We now have 3 types of bonuses for licensed clinical psychologists on active duty. These include Incentive Pay, a multiyear Retention Bonus, and Board Certification Pay.

Incentive Pay (IP) is a $5,000/year bonus for all psychologists who maintain an active license. This bonus is paid in monthly increments. Accepting this bonus commits you to remaining on active duty for a year after the bonus begins. Since most people are already committed to remaining on station longer than a year, there is usually no reason not to apply for IP. To continue receiving this bonus every year, each officer must submit a request for IP on every anniversary date. If you fail to submit a request, IP could be stopped and any overpayment recouped. The one exception to this rule is for those who are receiving a retention bonus as well as IP. In these cases, it is not necessary to apply annually for IP, since it is already known that these officers will remain on active duty through the duration of their retention bonus.

There are 3 alternatives for the Retention Bonus (RB). Individuals can commit to two additional years on active duty in exchange for a $10,000/year RB. They can also commit to 3 years to receive $15,000/year, or 4 years in exchange for $20,000/year. These bonuses can be terminated and renegotiated at any time, as long as the commitment on active duty is not less than what was already owed for the previous agreement, and provided the officer still meets all eligibility criteria. For instance, suppose you are on a 4-year bonus, and after 3 years you calculate that you will retire 4 years in the future. At that point you can terminate and renegotiate your bonus, allowing you to receive $20,000 per year over the next 4 years. This would be a more lucrative alternative than waiting for your 4-year period to expire, than signing on for the 3-year bonus option.

To be eligible for the RB, an officer either has to be free of any education or training obligation, or if they do have an obligation, they must have at least 8 years of creditable service. So, for those new to the Navy, you typically have to wait until your initial service obligation is up before you can apply for the RB. Also, some fully licensed psychologists might be restricted in the number of years for which they can apply, based on the timing of their promotion board. For instance, if you are coming into zone for O-4, it would have to be taken into account that you might fail to select, and therefore would be unable to fulfill the full obligation requirement for the RB. Failure to select twice for O-4 requires a mandatory separation. Therefore, you can't be given an RB requiring you to remain on active duty beyond the time you might have to be separated. Once you are selected for O-4, you become eligible for the full 4-year RB, and can submit your request once the NAVADMIN that indicates your selection has been released.

For those considering HPLRP (loan repayment): The HPLRP is considered an education obligation. Therefore, if you have an HPLRP obligation you must have 8 years creditable service to be eligible for the RB. However, if you are already receiving the RB, this does not prevent you from applying for and accepting HPLRP funding. It is important to note, however, that the paybacks for the RB and HPRLP are consecutive. In other words, they are additive; accepting both requires you to complete both paybacks. One point of confusion is that if an officer takes an RB prior to entering a training program, then those paybacks are concurrent. So if you are getting an RB and apply for DUINS training, as long as you are getting the RB prior to entering your training program, your DUINS obligation can be served concurrently with your RB obligation. Such concurrent paybacks are not the case with HPLRP.

Board Certified Pay (BCP) is an additional $6,000 for getting ABPP qualified. Like IP, this is paid in equal monthly installments, and requires you to remain on active duty for a year from the time you start receiving funds. To apply for BCP, you must forward to BUMED proof of board certification along with an initial one-time request that obligates you for a minimum of 1 year of service.

Above all, when applying for any special pays, it is extremely important that you work closely with your command special pay coordinator or administrative office. If they cannot answer your questions, have them contact the BUMED Special Pays staff. Their information can be found on the website below. This website is also a very good source of information on special pays, so you should periodically refamiliarize yourself with its contents. If you have any questions, don't hesitate to contact me as well. Ψ

http://www.med.navy.mil/bumed/Special_Pay/Pages/default.aspx

Spotlight on Ethics

By LT Matt Keener and CDR Carrie Kennedy

LT Matt Keener

CDR Carrie Kennedy

The Case of the Unsecured MMPI-2

The Case

The psychologist, a Lieutenant, was deployed to a combat zone. One evening the psychologist was approached by an 0-5 of a different medical specialty. After a brief and friendly conversation, the CDR got up to leave and told the psychologist that he had an MMPI-2 that he needed her to interpret. When the CDR returned he had a completed MMPI-2 with a computer printed interpretation report. Handing the interpretation report to the psychologist, the CDR stated "I need a wet read on this doc, and I need it today." When the psychologist queried the CDR as to why the MMPI-2 had been administered, who administered it and whose it was, the CDR informed the psychologist that he had completed the MMPI-2 on himself.

The Conflicts

There are a wide variety of ethical conflicts and pitfalls represented by this case; primarily 3.05 Multiple Relationships, 3.10 Informed Consent, and 9.11 Maintaining Test Security. This analysis will focus on the latter, namely the security of psychological testing materials in the combat zone, since if the test had been secured, the CDR would have been unable to obtain the MMPI-2 without first discussing it with the psychologist. This would have enabled the psychologist to avoid the problematic dual relationship and the lack of informed consent, as well as potential career pitfalls in the LT now having to discuss these problems with the CDR.

The Ethical Analysis

APA Standard 9.11, states "psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations." This is an interesting issue in the combat zone where many psychologists continue to work out of tents which may go unmanned during parts of the day and few medical supplies of any kind are behind lock and key. Even if a door has been installed to make it easier to enter and egress a tent, a lock is powerless when all one needs to do is unzip any of a number of flaps to gain entry. In some locations non-mental health providers share spaces with a number of other providers and technicians, who do not understand issues related to psychometric testing and test security. There are a number of solutions which have been developed by psychologists in both Iraq and Afghanistan; construction of locked cabinets out of plywood, training of technicians and development of SOPs related to psychometric testing. These are relatively simple solutions to avoid this type of breach of test security, as well as other problems related to unsecured psychometric testing.

However this does little for the LT who still has a CDR who wants to know how he did on the MMPI-2.

The Outcome

The psychologist realized that she could not accommodate the CDRs request. She informed him of her concerns regarding entering into a multiple relationship and attempted to brainstorm possible solutions. Recognizing that she was unaware of his motivation to want some kind of psychological evaluation and concerned that there may be a problem, she discussed his concerns with him and ultimately recommended that he undergo psychological evaluation with another provider in theater who was from a separate unit or upon his return home (which was imminent). The CDR was agreeable to the latter option. Continued on Page 10.

A recent publication on ethics and psychology is strongly recommended for all departmental libraries where Navy Psychologists work:

APA Handbook of Ethics in Psychology (Knapp, 2011)

Read more here: http://www.apa.org/pubs/books/4311504.aspx

Haiti, Continued from Page 4

Which brings me to another area that I cannot speak enough about: the providers and staff. They were all amazing. The entire crew worked together, each playing their part tirelessly for hours on end, day after day. It was amazing. For every 30ish critically injured you would have one doc, two nurses and a few corpsmen. That is all. The ward staff was going non-stop. The resiliency among the staff was amazing. Daily I would catch someone tired, exhausted, spent, and crying as they worked. I would pull them aside and talk. One standard question I asked was "do you need to leave, do we need to get you off the ship?" Not one wanted to leave. They were tired, but still providing care in an amazing fashion. We all worked non-stop in whatever way we could.

One of the first nights on the ship I was doing rounds in the evening. I asked a nurse on one of the wards how I could help her as she had tears running down her cheeks. She said, "oh, thank you. Can you go get the IV going on bed 4?" My response, "oh, I don't know how to do that." Is there anything else I asked? "The kid in bed 9 keeps screaming can you go give him his pain medication (via injection)." My response "I can't do that." Her response, "never mind, you are no use to me." She did not need to process, talk, reflect, and learn about provider burn out or self care. She needed help. Several hours later I was in my rack thinking about the situation. My heart went out to all of the pediatric patients and staff. The other wards seemed to quiet down a bit for several hours during the night. Not so much with peds. I put my PT gear on, and returned to the ward. Nothing grates on ones nerves and gives one a sense of helplessness like crying children. I could be of help to the nurse, I could comfort the children. From that evening on, I was "moonlighting" as "Dr. Mama" (as several of the children called me). I roved from bed to bed with a photo of my boys. I stopped by bedsides and said, "I miss my boys, you miss your mama, and maybe we can miss them together." I would then sing songs quietly to the child while petting their foreheads (in the same way I do to my boys) till they fell asleep. I was able to help the nurse. I was able to bring comfort in the midst of chaos – and for that I give thanks. Ψ

Join APA and Division 19 – Military Psychology

It is best to be a full member of APA so that you can vote, take advantage of all of the benefits of APA and better get your voice heard. However, if this is not an option, please consider joining Division 19.

One can be an exclusive member of Division 19 without having to join APA. You can join the division on the web by going to the following link (http://memforms.apa.org/apa/cli/divapp/). If you do not have an account, you will need to create one to submit the application. Once you are inside the portal you can complete the application and select "affiliate member" which is $27.

Existing members of Division 19 – Don't forget to join the Division 19 facebook page: APA Division 19 – Military Psychology.

Spotlight on Ethics (continued from Page 9)

For further information related to the various approaches for solving military-specific ethical dilemmas, please see the following resources:

American Psychological Association (2010). Ethical principles of psychologists and code of conduct. Available at: http://www.apa.org/ethics/code/index.aspx#

Barnett, J. E. & Johnson, W. B. (2008). *Ethics Desk Reference for Psychologists*. Washington, DC: American Psychological Association.

Kennedy, C. H., & Moore, B. A. (2008). Special issue: Clinical military psychology ethics. *Military Psychology*, 20.

In each issue of the Navy Psychologist, a case, taken from the fleet, is highlighted which displays one of the primary ethical conflicts of military psychologists. Please contact CDR Carrie Kennedy at carrie.kennedy@usmc.mil if you have a case which would be educational for the rest of the community or if you would like an opportunity to write an ethics case as practice for your ABPP board. Ψ

Bravo Zulu Everyone!

Meritorious Service Medals

CDR Michael Basso
LCDR Erin Simmons

Elected APA Fellow (Division 19)

CDR Carrie Kennedy

Division 19 Officers

LCDR Eve Weber – Member at Large
LCDR Kathryn Lindsey - Treasurer

Latina Style Meritorious Service Award

LT Lisseth Calvio
Read more about this at:
http://navylive.dodlive.mil/index.php/tag/distinguished-military-service-award/

LT Calvio with Rear Adm. (select) Raquel Cruz Bono

2011 Navy ABPPs

LCDR Melissa Hiller-Lauby
LT Matt Keener
LT Yaron Rabinowitz
LT Mat Rariden

Fleet Marine Force Qualified Officers

LT Angela Coriano
LT Christopher Ecklund
LT Eric Kloeppel
LT Scottie Knox
CDR Walter LaBrie
LT Erin McKee
LT Claudia A. Rojas

Surface Warfare Medical Department Officers

LCDR Jonathan Locke
LT Daren Norris

Force Protection Military Medical Hero

CDR Robin Lewis
Read more about this at
http://www.charlestonbusiness.com/events/HealthCareHeroes

Pictured with Lieutenant General Livingston, Medal of Honor Winner

Publications

Armistead-Jehle, P., Johnston, S.L., Wade, N.G., & **Ecklund, C.J.** (2011). Posttraumatic stress in U.S. Marines: The role of unit cohesion and combat exposure. *Journal of Counseling & Development*, 89, 81-88.

Ballenger-Browning K.K., Schmitz K.J., Rothacker J.A., Hammer P.S., **Webb-Murphy J.A. & Johnson D.C.** (2011). Predictors of burnout among military mental health providers. *Military Medicine*, 176 (3), 253-60.

Conway, T. L., Hammer, P. S., **Galarneau, M. R., Larson, G. E.,** Edwards, N. K., Schmied, E. A., Ly, H. L., Schmitz, K. J., **Webb-Murphy, J. A., Boucher, Wayne C., Johnson, D. C., & Ghaed, S. G.** (2011). Theater mental health encounter data (TMHED): Overview of study design and methods. *Military Medicine*, 176, 1243-1252.

Fleischmann, D., Michalewicz, B., Stedje-Larsen, E., Neff, J., **Murphy, J.**, Browning, K., Nebeker, B., Cronin, A., Sauve, W., Stetler, C., Herriman, L., & McLay, R. (2011). Surf medicine: Surfing as a means of therapy for combat-related polytrauma. *Journal of Prosthetics and Orthotics*, 23(1), 27-29.

Hayes, J., Gelso, C., & **Hummel, A. M**. (2011). Managing countertransference. *Psychotherapy*, 48(1), 88-97.

Hayes, J., Gelso, C., & **Hummel, A.M.** (2011). Managing countertransference. In J. Norcross (Ed.). *Psychotherapy Relationships that Work*, 2nd ed. New York, NY: Oxford University Press.

Kennedy, C. H. (2011). Establishing rapport with an "enemy combatant": Cultural competence in Guantanamo Bay. In **W. B. Johnson** & G. P. Koocher (Eds.). *Ethical Conundrums, Quandaries, and Predicaments in Mental Health Practice: A Casebook from the Files of Experts* (pp. 183-188). New York: Oxford.

Kennedy, C. H., & Williams, T. J. (2011). *Ethical Practice in Operational Psychology: Military and National Intelligence Applications*. Washington, DC: American Psychological Association.

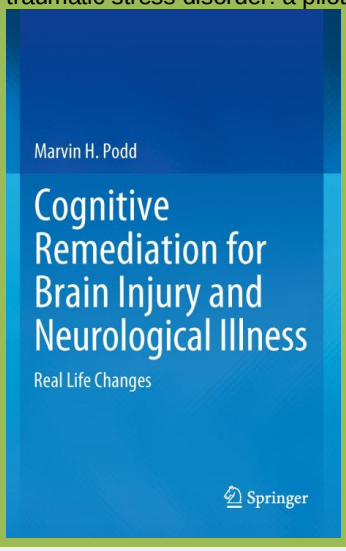
Larson G.E., Hammer P.S., **Conway T.L.,** Schmied E.A., **Galarneau M.R.,** Konoske P., **Webb-Murphy J.A.,** Schmitz K.J., Edwards N., **& Johnson D.C.** (2011). Predeployment and in-theater diagnoses of American military personnel serving in Iraq. *Psychiatric Services*, 62 (1), 15-21.

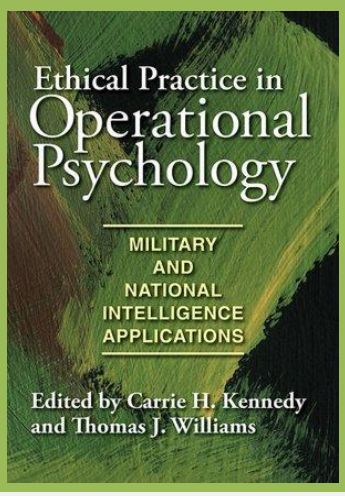
McLay, R.N., **Wood, D.P., Webb-Murphy, J.A., Spira, J.L.,** Wiederhold, M.D., Pyne, J.M. & **Wiederhold, B.K.** (2011). A randomized, controlled trial of virtual reality-graded exposure therapy for post-traumatic stress disorder in active duty service members with combat-related post-traumatic stress disorder. *Cyberpsychology, Behavior and Social Networking*, 14 (4), 223-9.

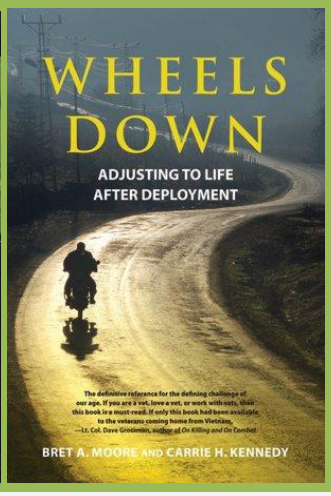
Moore, B. A., & **Kennedy, C. H**. (2011). *Wheels Down: Adjusting to Life After Deployment*. Washington, DC: American Psychological Association.

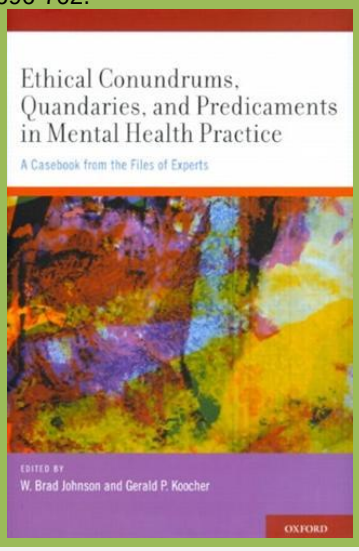
Podd, Marvin H. (2011). *Cognitive Remediation for Brain Injury and Neurological Illness: Real Life Changes*. New York: Springer.

Wood, D.P., Webb-Murphy, J., McLay, R.N., **Wiederhold, B.K., Spira, J.L., Johnston, S.,** Koffman, R.L., Wiederhold, M.D., & Pyne, J. (2011). Virtual reality graded exposure therapy with physiological monitoring for the treatment of combat related post traumatic stress disorder: a pilot study. *Studies in Health Technologies and Informatics*, 163, 696-702.









Message from the National Training Director, continued from Page 2

The joint training program is built around four major rotations (Outpatient, Primary Care/Health Psych, Psychological Assessment, and Neuropsych) and capitalizes on the combined talents of the Army and Navy supervisors. Interns are intermingled (Army and Navy) as they progress through the rotations and are only separated for occasional service-specific training (e.g., one week aboard a carrier and at Camp LeJeune for the Navy interns and a week at Fort Bragg for the Army interns). Clinical training reflects the diverse military population served by the new joint hospital, exposing the interns to patients and family members from the full spectrum of the DoD. All indications are that the careful planning for the joint internship has paid off and that both programs are well-prepared for re-accreditation site visits expected in the Fall of 2012.

SPOTLIGHT: THE PSYCHOLOGY HEALTH PROFESSIONS SCHOLARSHIP PROGRAM (HPSP)
The newest of Navy psychology's training options is the Health Professions Scholarship Program (also known as HPSP). HPSP should not be confused with "HSCP" (the Navy's Health Services Collegiate Program). The latter is a scholarship program for Environmental Health, Health Care Administration, Industrial Hygiene, Optometry, and Pharmacy.

After a 30-year hiatus, the psychology HPSP was re-introduced in 2010 and has grown to its maximum number of five scholarships per year since that time. The program provides scholarships to students who are enrolled in APA-accredited doctoral programs in clinical or counseling psychology. They receive extensive coverage of their academic expenses including full tuition, books, and fees as well as a monthly stipend of $2,100. Scholarship students incur a three-year service obligation that begins at the end of the internship.

All of the psychology scholarships are three years in length, covering years 2-4 in the doctoral program. (The standard three-year length of the scholarships was needed to insure that the maximum capacity of the Portsmouth internship of seven interns per year (5 HPSP; 2 USU) was not exceeded). Scholarship awardees are chosen annually by a Professional Review Board consisting of senior Navy psychologists and training directors. Students who are selected for a scholarship, and cleared for commissioning, start receiving scholarship support at the beginning of their second year. During their fourth year in graduate school, students apply for the pre-doctoral internship at Naval Medical Center, Portsmouth as described earlier in this article. While in school, scholarship students are in the Individual Ready Reserve. They transition to active duty as Lieutenants during the summer before the internship. Scholarship students may attend Officer Development School while they are on the scholarship or during the summer prior to internship. Detailed information about the Navy psychology scholarship program can be found at the Navy Medical Department Accessions website:
http://www.med.navy.mil/Sites/navmedmpte/Accessions/Pages/default.aspx

Our future colleagues in Navy psychology, brought to us through HPSP, are listed below:

Scholarship Student	Doctoral Program	Internship Start Date
D'Andria Jackson	Argosy U. Washington, D.C.	(Currently an intern at NMC, Portsmouth)
Emily Mulvey	Catholic University Washington, D.C.	2012
Stephanie Gaines	Argosy U. Washington, D.C.	2013
James Larsen	U. of Hawaii (Manoa)	2013
Greg Matos	Massachusetts School of Professional Psychology	2013
Daniel Northington	Loma Linda University	2014
Trinity Parker	George Fox University	2014
Michael Morin	Biola University (Rosemead School of Psychology)	2014
Eren Roubal	Illinois Institute of Technology	2014
Matthew Johnson	Pennsylvania State University	2014

The next issue is already underway! If you want to write an article about your duty station, a unique experience or opportunity, or take on the next ethics case, please let me know. We will also be introducing a clinical case in the next issue. As always if you received an award, a MCMAP belt, warfare device or attained another accomplishment, please let me know.

CDR Carrie Kennedy