



September 2012

From the Editor

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Once again, I offer you this snapshot of the Navy clinical psychology community. I am gratified that so many people are motivated to participate in this newsletter. In this issue we have an unprecedented array of contributions, from updates on billets, research, deployments and earning wings to experiences rebuilding a mental health department and sage advice on getting good ideas implemented in the military medical system. Read on to find out which Navy clinical psychologist was elected President-Elect of the American Psychological Association's Division 19!

We are dedicating our next issue to our specialty communities. We will update each subspecialty and provide focused articles and news targeted towards those communities and billets. As always, we will be looking for news about awards, publications and other accomplishments by the active duty, reserve and civilian components of our Navy clinical psychology community. Please submit your information and ideas to carrie.kennedy@usmc.mil for the next issue, anticipated in March 2013. Good reading!

Very respectfully,

CDR Carrie H. Kennedy

Message from the Specialty Leader

Dear Colleagues,

Greetings all, and welcome to another edition of *The Navy Psychologist*.

The Navy Clinical Psychology Community is still growing, both in numbers and prestige, and our members are continuing to have a significant impact on the clinical care and operational readiness of our fighting forces.

Here's a brief snapshot of our community as of this summer. We have 156 members, 40 more than we had in 2009. 28 people are in a training status. This includes 6 interns at Bethesda, 6 interns at San Diego, 4 interns and 2 postdocs at Portsmouth, 8 USUHS students in various stages of their doctoral programs, and 2 postdoctoral fellows in neuropsychology. Not counted against these numbers are 2 MSC officers enrolled in DUINS programs to become clinical psychologists, and 9 scholarship students who will be joining our internship programs in the coming years.

Of the 128 members of our community who are not in training, 11 are stationed aboard our nation's aircraft carriers and 7 (soon to be 8) are assigned to Marine Corps regiments as OSCAR providers. We have 2 psychologists at our SERE schools, 3 with Marine Corps Special Operations, and 6 with Navy Special Warfare. We have psychologists responsible for the selection and monitoring of all Marine Corps Embassy Security Guards, as well as all Marines on Presidential Support Duty, including those stationed at Camp David, Marine Helicopter Squadron 1, and the White House Communications

(Continued on page 10)



Clinical Psychology Specialty Leader
CAPT John Ralph

MARSOC: Marine Special Operations School Psychology

LT Tony Kraemer, MSOS Psychologist



LT Tony Kraemer

The Marine Special Operations Command (MARSOC) was founded in 2006. As a service component of U.S. Special Operations Command (USSOCOM), MARSOC is tasked to train, organize and when directed deploy U.S. Marine Corps Special Operations Forces worldwide in support of combatant commanders. MARSOC has been directed to conduct Foreign Internal Defense (FID), Counter Insurgency Operations (COIN), Special Reconnaissance, and Direct Action missions.

Currently at MARSOC, there are 3 active duty Navy psychologists, and 3 GS psychologists. One of the uniformed psychologists is assigned to the 1st Marine Special Operations Battalion (MSOB), and another to 2nd MSOB. The third Navy Psychologist is assigned to the Marine Special Operations School (MSOS) and is involved in the selection and training of Critical Skills Operators (CSO) as well as the training of support personnel.

The MSOS Psychologist is responsible for psychological testing, interpretation and interviews for candidates at Assessment and Selection (A&S), as well as evaluating candidate performance during role-play scenarios at A&S. The MSOS Psychologist advises the Selection Board at A&S regarding matters of psychological strengths and areas of weakness in particular CSO candidates. Assessments and recommendations for Advanced Skills Operators (ASO) and Combat Support Teams (CST) are also often completed by the MSOS Psychologist.

The MSOS Psychologist is responsible for providing training for the various classes offered through the Schoolhouse. Training includes classes in Mental Toughness, Resiliency and Leadership for the Individual Training Course (ITC) for CSO's, Support Training Course (STC) for support personnel, and Mental Toughness for A&S Preparatory and Orientation Course (ASPOC).

A third area of responsibility for the MSOS Psychologist is Survival, Evasion, Resistance and Escape (SERE) and Personnel Recovery (PR). As such, the psychologist must be SERE Level C certified. The SERE Psychologist insures that students are ready to handle this high stress training and intervenes if appropriate to coach during student performance problems. Since student performance is often unpredictable, the SERE psychologist may also work with the SERE instructors to adjust the problem scenario for the optimum student learning results. The focus is on safety, achievement of student learning objectives and proper stress inoculation effects. The observation periods include detention periods, as well as training periods, to assure student safety and provide support to and advise staff. In line with these responsibilities, the MSOS Psychologist debriefs SERE students to insure their safety and emphasize the positive developmental impact of this uniquely effective training.

The MSOS Psychologist also provides support and training in the interpersonal influence and listening skills useful in military intelligence and Irregular Warfare (IW). These skills are particularly important for those CSO's who will serve a critical role in IW missions. These CSO students are tested in training culmination exercises and are expected to conduct FID missions with a "foreign power," collaborating and coordinating with their counterparts. The MSOS Psychologist consults on these interactions and works with instructors to optimize student learning outcomes.

These duties are in addition to the personal stress, leadership and individual performance issues that pop up in any command. The MSOS Psychologist does not provide treatment, but may refer service members to staff at local clinics and the Camp LeJeune Naval Hospital, to assure proper mental health care of MSOS personnel.

Working in MARSOC has provided many challenges, and as the command grows and changes, the challenges continue to match. The needs of the organization, along with the continual demands of the Marine Corps and USSOCOM, means that the MSOS Psychologist participates in several committees in addition to operational duties. I am a presenter for the Safety Officer, provide consultation to the Human Factors board, contribute to the Performance Resilience (PERRES) program, and have helped to implement Suicide Prevention Trainings to the command. In addition, I have conducted several Command Directed Evaluations since reporting.

While this is a fast-paced and busy community, it has been extraordinarily rewarding. Working with professionals from various disciplines to help choose and train Marine Critical Skills Operators has been one of the highlights of my professional career. I have learned a great deal from these Marines, especially their idea of *Spiritus Invictus* (Unconquerable Spirit) from the MARSOC Creed, "I will never quit, I will never surrender, I will never fail. I will adapt to the situation. I will gain and maintain the initiative. I will always go a little farther, and carry more than my share." As I have discovered, this is more than words, it is an expectation of all who work here. Ψ

Mental Health Treatment Preferences of U. S. Navy Submariners: Stigma, Confidentiality, and Risks

LT Anthony Smithson, Intern, Naval Medical Center San Diego

I began my Naval career as an enlisted submariner in 2000, separated after eight years of active duty as a Navy Chief, and am thrilled to be returning for my pre-doctoral internship in San Diego. Hoo-rah!

Because of my background, one of my research interests is the issue of stigma and other barriers to care as related to submariners. To investigate this issue, I evaluated the idea that each formal, informal, and civilian-based resource available for coping with distress presents with unique stigma, confidentiality, and risks that serve as potential barriers to care. An additional area of research was to observe the rate with which submariners wanted help versus actually sought help. Overall, the aim was to shed light on these treatment preferences and factors in submariners, as it appeared that prior research on these topics was limited to Army infantry and Marine populations.

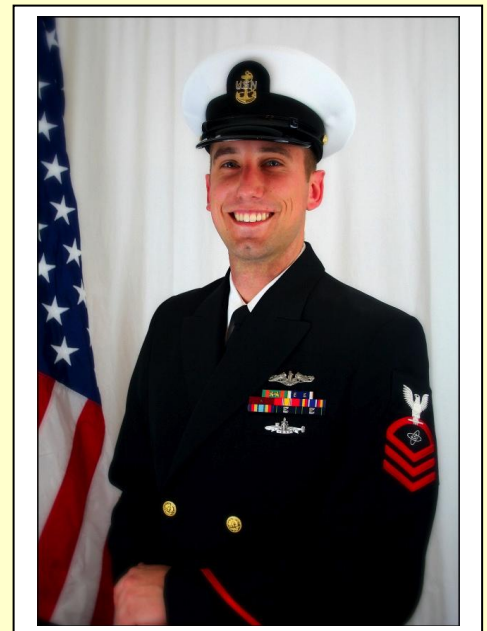
A survey was created to assess sailors' 1) history of treatment seeking, 2) likeliness to utilize a list of resources (e.g., family member, Navy psychologist, civilian psychiatrist, etc.), 3) the degree to which stigma, confidentiality, and risks affected their willingness to use each resource, and 4) their ranked preferences for each resource across varying degrees of stress (e.g., mild, moderate, and severe). The list of resources included friends, family, religion; internet or social media; chain of command; military primary care; military mental health; military chaplain; fleet and family support; ombudsman; civilian mental health; and civilian primary care.

Twenty-four sailors at Trident Training Facility King's Bay completed the survey. Questions about their history of treatment seeking revealed that of those who wanted help for distress at some point during their military career, fifty-percent had not sought care due to perceived barriers to care. As far as likeliness to utilize each resource, sailors were most likely to use friends, family, and or religion, and they were least likely to use internet and social media resources and the ombudsman. When asked to what degree stigma, confidentiality, and risks affected their preferences for care, stigma and risks were observed as the most perceived barriers to care, especially toward utilizing the ombudsman, chain of command, internet and social media resources. When sailors were forced to rank their preferences for each resource on the pre-determined list, internet and social media resources and the ombudsman were least preferred while friends, family, and or religion were most preferred. Meanwhile, most formal military and civilian resources were ranked neutrally, indicating that these professional resources were neither least nor most preferred on average. In addition, these ranked preferences showed almost no change when the degree of distress (e.g., minimal, moderate, and severe distress) varied, suggesting that these sailors may not see the need to modify their care resource when the severity of stress becomes worse.

Barriers to care are significant issues, mediate treatment engagement, and therefore affect sailors' wellness and operational readiness. Even though based on a small sample it seems that submariners have preferences for care as well as strong perceptions about stigma, confidentiality, and risks toward seeking help. In particular, internet and social media resources and ombudsman programs may be tailored to reduce these heightened concerns. Future research directions include examining whether these barriers also vary among branch of service, warfare community, or those in special duties. I am ecstatic to re-join all of you in the fleet! Ψ



After Photo:
LT Anthony Smithson



Before Photo: Chief Anthony Smithson (Where are the beer gut and cup of coffee?)

Earning Navy Psychology Wings of Gold

LCDR Arlene "Top Shrink" Saitzyk, Naval Aerospace Medical Institute

What's it like to earn the "Wings of Gold"? Exhilarating! And humbling. In July 2011, I reported to Naval Aerospace Medical Institute (NAMI) in Pensacola, FL. NAMI is a detachment of Navy Medicine Operational Training Center (NMOTC) and our mission is to support Navy and Marine Corps aviation units through expert aeromedical consultation, application of aeromedical standards, and training of aeromedical personnel for operational assignments. But before consulting and applying, I needed to experience first-hand this training, and so there I was ... surrounded by baby pilots and navigators - also known as Student Naval Aviators (SNAs) and Student Naval Flight Officers (SNFOs), fellow Medical Service Corps officers (aerospace physiologists, experimental psychologists, optometrists), and Medical Officers (most fresh out of internship and in training now to become flight surgeons). We were Aviation Preflight Indoctrination (API) Class 4111. That's us after our "six week deployment" to API.



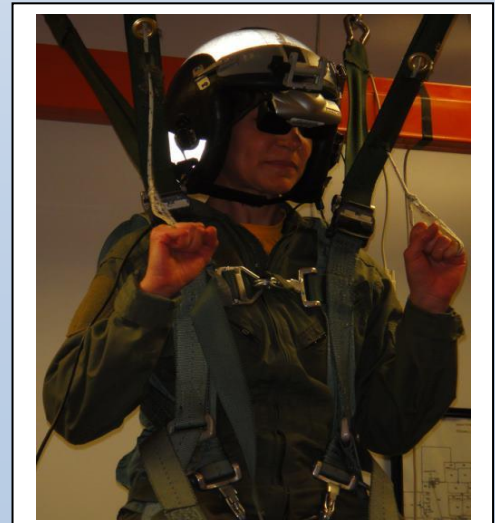
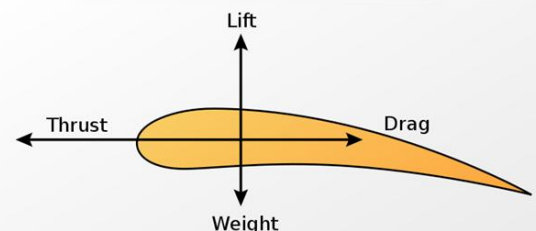
API was a mentally and physically challenging, yet fascinating journey that all started for me on the trip out to Pensacola. I figured I ought to try to read ahead in the syllabus, and by page three I was trying to make sense of this equation: $L = \frac{1}{2} \rho V^2 S C_L$. After hitting the "I believe" button a few times during subsequent classes and study groups for Aerodynamics I and II, I soon came to see the exquisite nature of $\frac{1}{2}$ density times velocity squared times surface area times the coefficient of lift, you know, the lift equation! I probably owe this epiphany to my study group. Notably, the Commanding Officer at API had warned our class that those with "hippy liberal arts degrees" are generally the ones who attrite, and since I figured Psychology might fall into that category, I quickly formed a study group with four "kids" about $\frac{1}{2}$ my age. I was also quickly humbled by their dedication, intelligence, diligence, maturity, and total confidence. Together, we hit the "I believe" button much less frequently, and successfully navigated our way through classes, gouge, and exams for Engines & Systems, Navigation, Weather, and Flight Rules & Regulations (FR&R).

The bonds amongst my study buddies and with the rest of API Class 4111 only deepened as we completed land and water survival evolutions, endured the multi-station spatial disorientation device (who's got an empty barf bag?), rode the rails on the ejection seat trainer, practiced emergency egress, played "patty-cake" as we learned to recognize the signs of hypoxia in the hypobaric chamber, virtually negotiated fixing a twisted parachute ... and learned not to twist our ankles or injure our knees during real reality Parachute Landing Falls (PLFs) - yeah, that was fun (not!) - jumping off five foot ledges onto a bed of rocks (well, actually, it was kind of fun, though not as exciting as learning to survive in the water in full gear) ...

(Google helo dunker Pensacola for some really good footage).

API - check! Now on to four weeks of Primary.

Continued on Page 10.



Building a Department: The Rebirth of Mental Health at Cherry Point

LCDR Erin Simmons, Naval Health Clinic Cherry Point



Left to right, back row: Laura Toot (Psych Tech), Kim Glover (Clerk), Emmanuel Finney (Psychologist), Ron Howes (Psychologist), Steve Zuchowski (Psychiatrist), Kwasi Foluke (Psychiatrist), LCDR Erin Simmons (Psychologist, DH), Pearly Walker-Gibbs (Psych Nurse), Pattie Bierswirth (Behavioral Health Coordinator), Sharon Irving (Psych Nurse Practitioner), Katie Rickabaugh (Psych Tech), Meghan Kelley (Psych Tech), Latonia Curtiss (Psych Tech)

Seated: LT Juliana Simmons (Psychologist/DivO), LT Chelsey Jones (LCSW), LT Julie Barbour (LCSW)

On the floor: HN Joseph Norton (Psych Tech), HN Alan Lyles (Psych Tech), HM3 Adam Harvey (ALPO)

On my first deployment to Iraq in 2004, I learned 2 important lessons: 1. Semper Gumby—that's a play on the Marine Corps motto of Semper Fidelis, meaning Always Flexible—and 2. Don't Sweat the Small Stuff. During my tour at Naval Health Clinic Cherry Point I used both lessons—but not in the ways I expected.

When I arrived at NHCCP, the Mental Health Department did not exist. Literally. Mental Health was a division of Military Readiness, which also included Military Medicine (Primary Care for Active Duty) and Optometry. Division leadership was a Nurse Clinic Manager (who was PCSing) and a recently licensed Navy Psychologist Division Officer (also PCSing). Other providers included another recently licensed Navy Psychologist (who was deploying), a half-time contractor psychologist (who stayed for only 6 more months) and a retired Navy Psychiatrist who worked 2 days a week. Support staff included a civilian clerk (new to the department), and 2 HN Psychiatric Technicians. Because of challenges with access, up to 80% of active duty referrals were being deferred to the network.

The problems had not gone unnoticed by the command, and my arrival accompanied the restructuring of the Naval Health Clinic so that Mental Health and Optometry were their own departments, and the hiring of 2 new GS providers—a psychologist and a clinical social worker. So I was able to take leadership of a

tiny, but evolving Department rather than a faltering Division. Nevertheless, there were immediate challenges. Because of gaps, active duty deployments, staff turnover, and problems with hiring, the start was rocky. Other problems involved figuring out how this new Department would address issues of access, productivity, and maintaining good care. The command felt strongly that to capture referrals and keep up RVUs, 36 hours of direct clinical care per week was required from every provider, which required some creative template manipulation in order to meet that standard with 6-7 patient encounters a day. Despite Cherry Point's reputation as a small, relaxed, Wing environment, the high level of trauma, acuity, and serious mental illness present rivaled my experiences in Okinawa, Camp Lejeune, and Iraq. Significant change was needed.

I have identified 4 simultaneous and continuous steps that made this change happen. The 1st step was simply to accept that recovery was possible, especially when everything—staff, metrics, coding guidelines—seemed to change every month. That was Lesson 1: Semper Gumby. So we kept up hiring processes and requests for Wounded Ill and Injured money for contracts until, 18 months after my arrival, the department has 2.5 prescribers, 4 psychologists, 2 clinical social workers, a psychiatric nurse, and 7 psychiatric technicians. The command also successfully renovated an entire wing of the building for the new, improved Mental Health Department, and our Ribbon Cutting succeeded in increasing awareness of our services throughout the base. Outreach and monthly interservice meetings continued that process. The Department was reborn.

The 2nd step was to consult the subject matter experts in all aspects of running a department. That was Lesson 2: Figure out which "small stuff" to sweat. I spoke at length to the Access Manager, the Comptroller, the Referral Manager, the Coding Manager, OPMAN, Materials Management, and the Director about the business plan for the Department, required appointment types and access standards, standards of care and how to maximize RVUs, the strategic goals of NHCCP and the SG, the needs of the patient population, the needs of the Mental Health staff—it seemed never ending, and I had to accept that small things (how many ROUT appointments to template) were not always "small things." Continued on Page 7.

mTBI/Concussion Care Team: From Clinic to Warrior Recovery Center

CDR Greg Caron, Kandahar Air Field, Afghanistan



CDR Greg Caron and LCDR Octavian Adam, Neurologist

We arrived at Fort Dix in June 2011 from distant lands with a similar yet vague mission. An occupational therapist (OT) with a specialty in hand therapy from Okinawa, a physical therapist from Minnesota, a neurologist with a specialty in movement disorders from NMCP, and (moi) a psychologist with generalist training and CBT orientation, were to be assigned to the mTBI/concussion care clinic at NATO Role 3 MMU, Kandahar, Afghanistan. We had familiarized ourselves with the DTM 0933 and I visited NCCOSC, and explored the internet sites of DVBIC, DCoE, and MHS Learn for resources to understand more fully the nature of blast concussion. The billet to which I was assigned was given the title "Neuropsychologist" as it was filled initially by a neuropsychologist. Unfortunately, the continuous deployment of a neuropsychologist to this billet could not be maintained at the time as we had only 3 neuropsychologists in the Navy. This position was also influenced by the algorithm in DTM 0933, which required any service member who suffered a third

concussion within a 12 month period to undergo a neuropsychological assessment. As is the typical nature of a theater environment, the scenario and focus were about to change...

Once settled into our barracks and offices at Role 3 MMU at the end of July 2011, we began providing Level III assessment which included a neurological examination, a psychological and occasional cognitive screening, and a functional assessment by the OT. Our services were joined by a Level II rehabilitation program, located about a mile away, providing a 3-7 day milieu for concussion recovery, a combat stress and behavioral health program in a building adjacent to the hospital, and the hospital's emergency and outpatient behavioral health services. Thus in Kandahar, Level II and Level III concussion care programs as well as combat stress and behavioral health care programs were operating on a daily basis and addressing the needs of the wounded warriors. BUT – such services were being provided in separate locations.

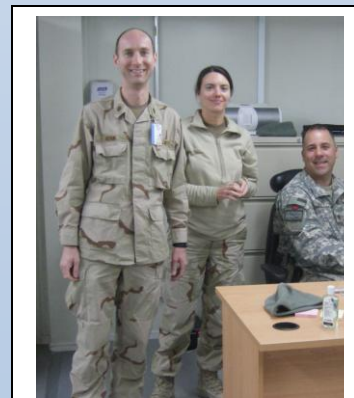
In an effort to consolidate care and as the result of an overall military effort to standardize in theater care, KAF, under the leadership of TF MED South Commander (CAPT Meneley), conceptualized the Warrior Recovery Center (WRC) in September 2011. The WRC project, which included a reconfiguration and preparation of a Canadian clinic and compound, was accomplished within an unprecedented three month period through the efforts of numerous personnel and commands and integrated the mTBI/Concussion Care Program, Combat Stress Control (CSC) Restorative Care Program, Wounded Warrior (Musculoskeletal) Care Program, and Behavioral Health Assessment, Prevention, and short-term treatment. The WRC was officially opened in February 2012. Our team moved into our new spaces during late January and following the Grand Opening Ceremony we redeployed (i.e. came home!) several days later. From the experience I described above, I would like to offer the following suggestions to psychologists who are preparing for deployment to a theater Concussion Care Center:

Take time to prepare and request such time from your Director or Department Head. If possible, attend the Army's TBI for Deploying Providers Course. Explore the web and take advantage of resources available on such web sites as DVBIC, DCoE, and MHS Learn. Familiarize yourself with the current literature on blast concussion and the interrelationship of concussion and psychiatric conditions. Rely upon and develop your generalist skills rather than focus on cognitive assessment.

Collaborate closely with the other disciplines. Consult with the neurologist, OTs and PTs on a daily basis. Explore the areas in which the disciplines overlap and develop an appreciation for what each discipline brings to the table. Both patient and provider benefit from such collegial efforts. Anecdotally, the neurologist and OTs, with whom I worked closely, told me that what they valued most from my contribution was insight about the psychological factors and dynamics that might influence the persistence of symptoms.

Participate in interdisciplinary and mentorship face-to-face and via telephone and video conferences with peers in CONUS and in theater whenever possible. In theater concussion care continues to be a burgeoning field, which lends itself to putting military psychologists in a situation in which they are asked to perform services for which most are not trained, i.e., neuropsychology. Furthermore, many disciplines contribute to the successful assessment and management of concussion and becoming more aware of what other disciplines can offer allows us to work more effectively in conjunction with each other.

Immediately upon entering the theater, develop circles of professional and social support and develop your own personal routine. The theater environment is unpredictable, traumatic, politically charged, and often disorganized. War is a profoundly sad, chaotic, and unexplainable event. We, as medical professionals, are embedded in such circumstances to help give some structure, meaning, and healing. Such a milieu necessitates that we take care of each other and ourselves. Ψ



LCDR Adam, LCDR Lisa Bogan (OT), LCDR Chad Tabatt (PT)

Cherry Point (continued from Page 5)

The 3rd step was to educate the chain of command about what needed to be changed and why. I argued for the need for longer templated appointment times, in order to meet the 36-hour standard while still leaving time for handling acute issues, writing MEBs and specialty evaluations, supervising new psychologists, proctoring new government employees, liaising with flight surgeons and command personnel, and, of course, completing required training. I informed the command that templates would change periodically as we searched for the balance between how many new and established appointments were needed while maintaining the MHS requirements of appointment types and access standards.

The 4th step was to keep the staff informed of new procedures and priorities—and the idea of Semper Gumby! I encouraged innovation and creativity to improve care and increase productivity. We implemented a sacrosanct weekly, all-hands staff meeting where word is passed, problems discussed, and new ideas presented; and a weekly Case Conference for providers and psychiatric technicians, included in the 36-hour requirement, which provides a much-needed outlet for discussion and peer support. We started a weekly training program to enhance knowledge of mental health issues, military culture, and Navy Medicine. And I have an open door policy to address concerns, questions, venting, negotiations, and confusion!

As a result of this 2-year process, the NHCCP Mental Health Clinic can now boast 100% capture of active duty referrals, and we are ahead of almost every department in meeting our Business Plan goals. We offer 9 psychotherapy groups and 2 intensive outpatient programs. We are known as one of the Command's successes, and I am very proud of the Department that now exists. As a first-time Department Head, my newest lesson, and frustration, is that sometimes Business Plans are more important in the here-and-now than Vision...BUT, if small stuff—those hateful metrics—can be accepted as necessary evils to be managed, then the larger purpose—that of helping our Marines and Sailors—can be sweated with pride. Ψ



CONGRATULATIONS TO LCDR William Johnson, promoted by CAPT Robert McCullah!

Navy Interns go to sea on the USS Stennis! Pictured left to right: LT Manny Gonzalez, LT Dave Broderick, LT Allison Whitesell, and CDR Mark Heim



LCDR Robert Lippy trades his SWO pin for his SWMDO!

Mental Health at Naval Hospital Jacksonville

LT Kristin Somar, Naval Hospital Jacksonville

Change. At present, that sums up what is happening at the Mental Health Clinic at Naval Hospital Jacksonville. In Jacksonville proper, we currently have five active duty psychologists (LT Kianimanesh, LT Fernandez, LT Myers, LT Jimenez, and LT Somar), two civilian psychologists (Dr. Harwood and Dr. Mullins), two licensed clinical social workers (LT Brenner and Ms. Griswold), one neuropsychologist (Dr. Pollick), and two psychiatrists (CAPT True and CAPT Bowers). At our Mayport Clinic we have Dr. Hart (retired Navy Psychologist) and at the Deployment Health Clinic we have Dr. Hejmanowski (former active duty Navy Psychologist). While this Sounds like A LOT of staff, our catchment area spans Georgia and a large portion of Florida and many of our staff are scheduled to leave us soon!



LT Jimenez, Dr. Harwood, Dr. Pollick, Dr. Mullins, LT Somar, and LT Myers

NH Jacksonville provides care for all active duty (to include all military branches), dependents, and retired service members from Albany, Georgia to Key West, Florida (though I've even seen patients from as far north as Atlanta, GA!). Mental health services are only available in Kings Bay, GA, Mayport, FL, and Jacksonville, FL. As such, we send all dependents and retirees to the TRICARE network (with the exception of TDRL evaluations). The position at Kings Bay, GA, which is home to submariners and a small installation of Marines, is currently vacant and LT Jimenez has graciously been driving to that clinic 2 days per week to help fill the gap for over a year. Additionally, there is one open position in Mayport, FL, where our small fleet is located; Dr. Hart has been covering this clinic by himself for several months. (If you have any psychology friends looking for jobs, send them our way!!)

In Jacksonville, we are losing our two psychiatrists and one social worker (Ms. Griswold) to retirement this fall; thankfully the Navy has already filled the psychiatry positions. Additionally, LT Kianimanesh will be leaving the USN in August and LT Fernandez has received orders to the USS Eisenhower and will be leaving in September. (Current Bethesda intern, LT Libby Peachey, has been identified as his replacement.)

The Jacksonville Mental Health Clinic and the Deployment Health Clinic are located on the NAS Jacksonville base. We treat patients from nearly every community the Navy has: sailors from ships, those with flight status, and submariners. We also see a number of Marines, Army, National Guard, Coast Guardsmen, and Air Force. The main clinic (in Jacksonville) offers an Intensive Outpatient Program and various other groups that many service members from all over the area take advantage of. Additionally, Dr. Pollick just came to us (from the Army) and has started a TBI program.

There are many opportunities to deploy from NH JAX. In fact, we have the highest number of deployments in all of Navy Medicine. Additionally, NH JAX is attempting to lead the Navy with process improvement. Our program, Jacksonville Kaizen Production System, is slowly rolling out to other commands within Navy Medicine East as a way of improving patient care, eliminating waste, and decreasing cost.

Jacksonville is the biggest city (in terms of land mass) in the United States. We are also lucky to have amazing vacation destinations nearby, such as Amelia Island, Daytona Beach, St. Augustine, and Savannah, GA. There is a great deal of history in Northern Florida/Southern Georgia. And coming from San Diego, I'm shocked by how warm the Atlantic Ocean is!

Overall, NH Jacksonville is a great place to be as a junior officer – it is small enough and ever changing so it allows for opportunities to “stand out” and challenge one’s abilities as a leader. Yet, it is large enough that we have many resources to provide exceptional care to our patients. If you have questions about NH Jacksonville, please feel free to contact me at Kristin.Somar@med.navy.mil. Ψ

To learn more about NH Jacksonville, please visit <http://www.med.navy.mil/SITES/NAVALHOSPITALJAX>.

Spotlight on Ethics

LCDR Porter Evans and CDR Carrie Kennedy

The Case of The Harmful Treatment



LCDR Porter Evans

The Case

A newly licensed military psychologist (MP) is stationed at a stateside mental health clinic serving a Marine Corps base. The MP notices that members of a combat stress group are requiring psychiatric hospitalization at a much higher rate than other patients in treatment. The group is co-led by a licensed professional counselor (LPC) who is supervised by a senior civilian psychologist. Notably, the LPC is credentialed to practice only under supervision. The MP has an individual therapy patient in the group, and the MP's patient reports that the group focuses on retelling combat experiences. The patient also informs the MP, that the supervising psychologist rarely attends the group. The patient feels that group members compete to see who can tell the most "gruesome" or "intense" story. It does not appear that group members are provided therapeutic tools to cope with emotions and behaviors that often accompany exposure based treatments. The MP is unaware of and unable to find any empirical literature supporting the group's approach. Complicating matters, both the LPC and supervising psychologist have been at the command for a long time and are well respected within the department.



CDR Carrie Kennedy

The Conflicts

Numerous ethical principles apply in this situation. However, the primary focus is: Principle A: Beneficence and Nonmaleficence; and ethical standards: 2.04 Bases for Scientific and Professional Judgments; 2.05 Delegation of Work to Others; 2.01 Boundaries of Competence; and 1.04 Informal Resolution of Ethical Violations. Adding an additional challenge, the LPC does not fall under the APA ethics code.

Principle A: states that psychologists strive to benefit those with whom they work and take care to do no harm. It appears very possible, if not probable, that the patients are being harmed by the group. Ethical standard 2.04 states that psychologists' work is based upon established scientific and professional knowledge of the discipline. While there are many group-based exposure therapies for combat stress, all supported approaches contain a component that helps the patient cope with the exposure. Ethical standard 2.05 states that supervising psychologists authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training or experience, either independently or with the level of supervision being provided; and see that such persons perform these services competently (American Psychological Association, 2010). Given the complex nature of the combat stress and co-morbid diagnoses (substance abuse, personality disorders, etc.), a provider requires significant training to independently manage treatment with this population. Furthermore, it does not appear that the supervising civilian psychologist is closely monitoring the group.

The Outcome

Consistent with ethical standard 1.04 (Informal Resolution of Ethical Violations), the MP initially addressed his concerns with the LPC who became defensive and dismissive of the concerns. Consistent with ethical standards and the military chain of command, the MP then brought the concerns to the clinical psychologist responsible for supervising the LPC. The supervising psychologist listened intently and agreed to take corrective actions. However, it became clear after a few weeks that no corrective actions were taken. The MP again addressed concerns with the supervising psychologist, and again the supervising psychologist agreed to take corrective actions. Unfortunately after several more weeks, no corrective actions were taken. The MP then brought the issue to the attention of the department head who investigated and took appropriate action.

Unfortunately, scenarios in which a junior psychologist feels reluctant to come forward with a concern due to perceived inexperience are common. Fortunately, the APA ethics code provides us with a standard to evaluate and address concerns and the Navy psychology community provides us with senior psychologists with whom to consult. Any psychologist can consult any of our training directors, our Specialty Leader, and any senior/peer active duty or civilian Navy psychologist. Ethical dilemmas can be painful, particularly when interpersonal relationships at the work place are affected and no one has to experience these alone.

For more information, please see the American Psychological Association's (2010) Ethical Principles of Psychologists and Code of Conduct, available at: <http://www.apa.org/ethics/code/index.aspx#>. In each issue of the Navy Psychologist, a case, taken from the fleet, is highlighted which displays a primary ethical conflict 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

Wings of Gold, Continued from Page 4

First, another week of ground school, alongside SNFOs, and with the major task of learning everything about our specific aircraft-to-be. We were presented with a book that put all editions of the DSM to shame in terms of its density – that is, the Naval Air Training and Operating Standardization (NATOPS) for the T-6A Texan II, a single-engine, two seat aircraft designed to train Joint Primary Pilot Training (JPPT) students in basic flying skills common to U.S. Air Force, Coast Guard, Navy, and Marine Corps pilots. We knew our aircraft limits, ranges, and boldface Emergency Procedures (EPs) cold, completed the blindfold cockpit check, and then went on to test some briefing, navigating, and flying skills in the flight simulators. And then, FINALLY, the chance to bring it all together in a series of familiarization flights, starting with aerobatics, followed by formation flights, and a night flight. WOW! It was an incredible experience – a rollercoaster ride on steroids. Loops, rolls, spins, chases – what a rush! And coming in for landing was the perfect finale - rumor had it the Instructor Pilots (IPs) liked to pull 5Gs at the break to best “familiarize” the docs. All good (and guess who still has an empty barf bag?).

And it got even better when our next training evolution took us just north of Pensacola to learn rotary wing aircraft – the TH-57B Bell Jet Ranger (that’s helos to you, and pure magic to me). The next three weeks included more classes, one exceedingly painful day of computer-assisted instruction (CAIs), and a “workshop” on night vision goggles, all culminating in some pretty amazing day and night flights.

Then it was back to being a doc for the next three months. While the flight surgeons were learning important medical issues (internal medicine, ophthalmology, neurology, psychiatry, etc.) from an aeromedical perspective, and the aerospace physiologists were learning how to run all that fancy training equipment, the two other aerospace experimental psychologists and I learned about “human factors” in aviation including the human-machine interface, aviation personnel selection and evaluation, and acquisition of resources for research and development. And since I was a special breed of aerospace experimental psychologist (i.e., aerospace clinical psychologist) I began to learn how mental health conditions, maladaptive personality traits, and disorders may particularly impact safety of flight, air crew coordination, and mission accomplishment. And that is why it was wild, fun, and *necessary* to begin to get a sense of what our population experiences, via this six month training experience, enroute to those wings of gold. On some level now, albeit not the full extent, I “get” what our aviation personnel go through – the thrills and the stressors, and not to mention the fear of getting a down chit from medical! This is a very special population, and I feel honored to support and train them. Despite the word on the street about the “NAMI whammy,” I know I’m working with a group now who does their best to “keep ‘em flying.” Ψ



For a video synopsis of the survival aspects of Aviation Preflight Indoctrination, check out this video:

<http://www.youtube.com/watch?v=e9tpLvMZCqQ&feature=related>

Message from the Specialty Leader (continued from Page 1)

Agency. Four of our members (soon to be 5 I hope) are assigned as instructors or clinicians at the US Naval Academy, and 17 are serving proudly at our MTFs overseas, including those in Naples, Sigonella, Rota, Guam, and several bases throughout Japan.

We have psychologists running programs at BUPERS and BUMED. We have one Commanding Officer in our ranks, as well as several directors, department heads, and OICs. These include CAPT Richard Stoltz, CO of Naval Hospital Guantanamo Bay; CAPT Dave Jones, who was recently selected as the Director of Mental Health at Naval Medical Center Portsmouth; CAPT Scott Johnston, Director of the Navy Center for Combat and Operational Stress Control; and CAPT Rich Berghold, Chief of Staff of the National Intrepid Center of Excellence for psychological health and traumatic brain injury.

Of those stationed at our many MTFs throughout the United States, almost everyone with a license has deployed at least once in support of OIF, OEF, or some other contingency operation. Currently we have 2 psychologists at the Role III in Kandahar, 4 serving with the Marine Corps at Camps Leatherneck and Dwyer, and 2 in Guantanamo Bay.

In short, we are serving throughout the world in a military where mental health utilization is going up, the stigma associated with mental health care is going down, and where we are seen as playing a vital role in the readiness of the force. I hope you are proud of the work you do and the organization in which you play an important part. We are definitely making a difference.

Very respectfully,

CAPT Ralph

Innovation and Program Development: Putting your Good Ideas to Work

CAPT David Jones, Naval Medical Center Portsmouth



So you have a good idea for innovation in a clinical service or program at your command. What do you need to know and do to put that idea to work in serving your patients, command, and/or community? Across my 19 years in the Navy at 7 commands (CONUS and OCONUS) involving 3 deployments, I've had the opportunity to design and/or implement a variety of programs, including a service-wide suicide prevention training video, an intensive outpatient service for forward-deployed troops, Psychology Fellowship and Internship training programs, distribution of new combat stress teams in theater, and regional tele-health services. These efforts have been implemented through very different chains of command, including Headquarters Marine Corps, an OCONUS MTF, MEDCEN (see the example on Page 15), the Army/NATO, and Navy Medicine East. In this article, I'm going to draw on lessons learned on pushing innovation through a bureaucratic structure like Military Medicine. Our organization is looking for innovative programs and services--you need to be clear-eyed though on what it takes to bring such innovation about. What follows are 4 ideas to help put your good ideas to work.

1. Electrons and paper rule.

Remember that a good idea in our system does not “really” exist until you write it down. Just as with our medical documentation (“if it’s not in the chart, it didn’t happen”), if you don’t write it up, your idea doesn’t exist. You breathe life into your ideas by putting them down in writing. Early in my career, I benefitted from a tour at Headquarters Marine Corps where I learned the discipline of quickly translating ideas into Point Papers, Talking Points, Memos, Proposals, Briefings, and Policy Statements. Our bureaucracy feeds on electrons and paper. If you have a good idea, you need to write it up in a way the system can use, to include any of the documents above, but also SOPs, clinical treatment guides, and instructions. Familiarity with Naval Correspondence will only serve you in the future.

2. Gotta know the M-Codes.

Just crafting a good idea onto paper will only get you so far. You have to push that idea through the system whether at the local level or region. Your command is organized around certain functions or Directorates. A place like BUMED is organized around certain offices or codes. Each code has a number. It’s useful to know the codes or functional areas at your command in order to think through the areas that your new idea or program will likely touch. Thinking through the codes will save you lots of trouble in the future; just knowing the codes, however, will not save you from all hassles. We DO operate within a bureaucracy and it can be crazy-making to run into hurdles and obstacles you did not even know existed. Almost any program you might develop will have implications for manning, clinical services, facilities/space allocation, Information Technology support, and funding. Programs involving direct troop support for conditions such as TBI and PTSD will likely also connect with Wounded, Ill, and Injured services. BUMED has published guidance on the format for submitting proposals for consideration of funding. Here are the codes or functions that you need to know to put your good ideas to work within our system.

M-1	M-2	M-3	M-4	M-5	M-6	M-7	M-8	M-9
Manpower Total Force	Research and Development	Clinical Operations	Installations/ Facilities Logistics	Futures	Information Management /Technology	Training and Education	Resource Management Comptroller	Wounded, Ill and Injured

3. It’s tough to face, but the Navy does expect you to function like an MBA.

Virtually every uniformed psychologist I know above 0-3, has uttered some variation on the following theme: “I can’t believe this organization expects me to know all this business stuff...I trained to be a clinician, and now I have act like an MBA too.” Once you embrace this hard truth, you can translate frustration into something productive like solving a problem. There are not enough MSC healthcare administrators (HCAs) to go around and there are certainly not enough Psychologists to fill all the billets we have. In order to put your good ideas to work, you do need to understand how to make a business case analysis for your program and get acquainted with funding streams at the command level, the region, and the enterprise. If you choose to try to obtain funding for your new program, the table below describes the process in which new proposals are reviewed. Many allies exist up and down the organization and within our sister services and the VA to help with understanding healthcare business issues (e.g., return on investment, sustainment, and contracting) pertinent to your new program. Within Navy Psychology there are mentors who can help you understand the business side of our operations to help you keep your program ideas/innovations moving along. Continued on Page 14.

Bravo Zulu Everyone!

Graduates of the University of Virginia's 2-Year Navy Neuropsychology Fellowship

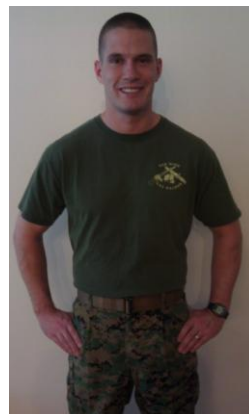
LCDR Porter Evans
LCDR Shawna Lynch-Chee

MCMAP
Brown Belt Instructor

ENS Marcus VanSickle

California Lutheran
University
2011 Outstanding Alumni

CDR Mary Vieten



ENS Marcus VanSickle



"The vast majority of Mary's career focuses on the care of veterans. Her private practice provides pro-bono or low-cost treatment in an effort to bridge the gap for veterans who are suffering from hard core PTSD and have not been helped by other programs, are not well enough to navigate the complexity of VA services, or have no health insurance or means to pay."

Read more about her accomplishments here:

<http://www.callutheran.edu/alumni/awards/CallutheranAlumniAssociation-AwardWinners.php#a0>

New Navy ABPPs

LT Heather Anson
LCDR Chris Blair
LT Brandon Heck
LCDR Shawna Lynch-Chee

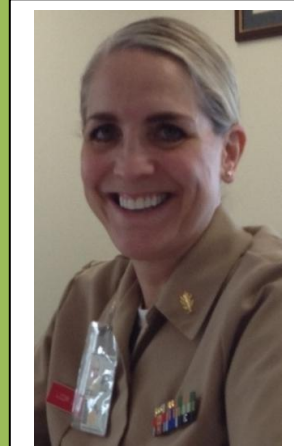
APA DIVISION 19 AWARDS

PRESIDENT-ELECT

**LCDR Kathryn
Lindsey**

Charles S. Gersoni
Military Psychology
Award

**CDR Carrie
Kennedy**



LCDR Lindsey, USNA

WARFARE DEVICES

Aerospace Experimental Psychologist



LCDR Arlene Saitzyk

Surface Warfare Medical Department Officer



LCDR Robert Lippy

Men's Health Interview
Military Fitness: On a Mission to Save You

CDR Eric Potterat

From the article: The SEALs are trying to figure out ways to rewire the brain to avoid soup sandwiches. "If you can control the stress response, both physical and cognitive, then you can optimize performance in any environment," says Commander Eric Potterat, Ph.D., command psychologist for the Naval Special War Group One. "It boils down to handling stress: Can you do your best when the pressure is highest?"

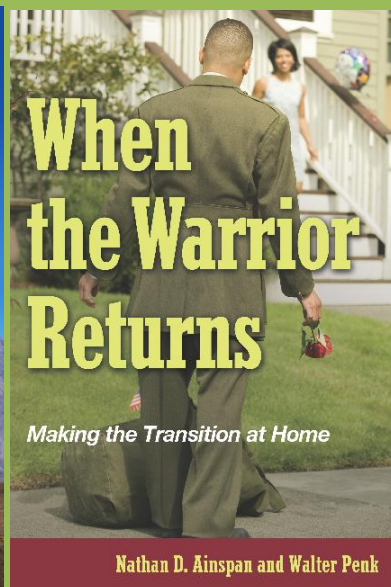
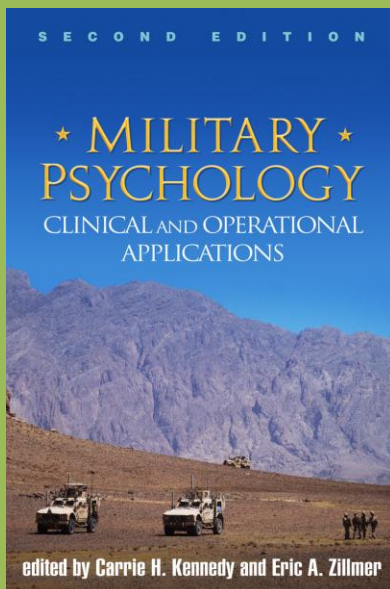
Read the entire interview with CDR Potterat:

<http://www.menshealth.com/best-life/mission-save-you/page/5>

The end of the year is approaching. Keep in mind those outstanding psychologists that you want to nominate for 2012 Junior, Senior and Civilian Navy Psychologist of the Year!

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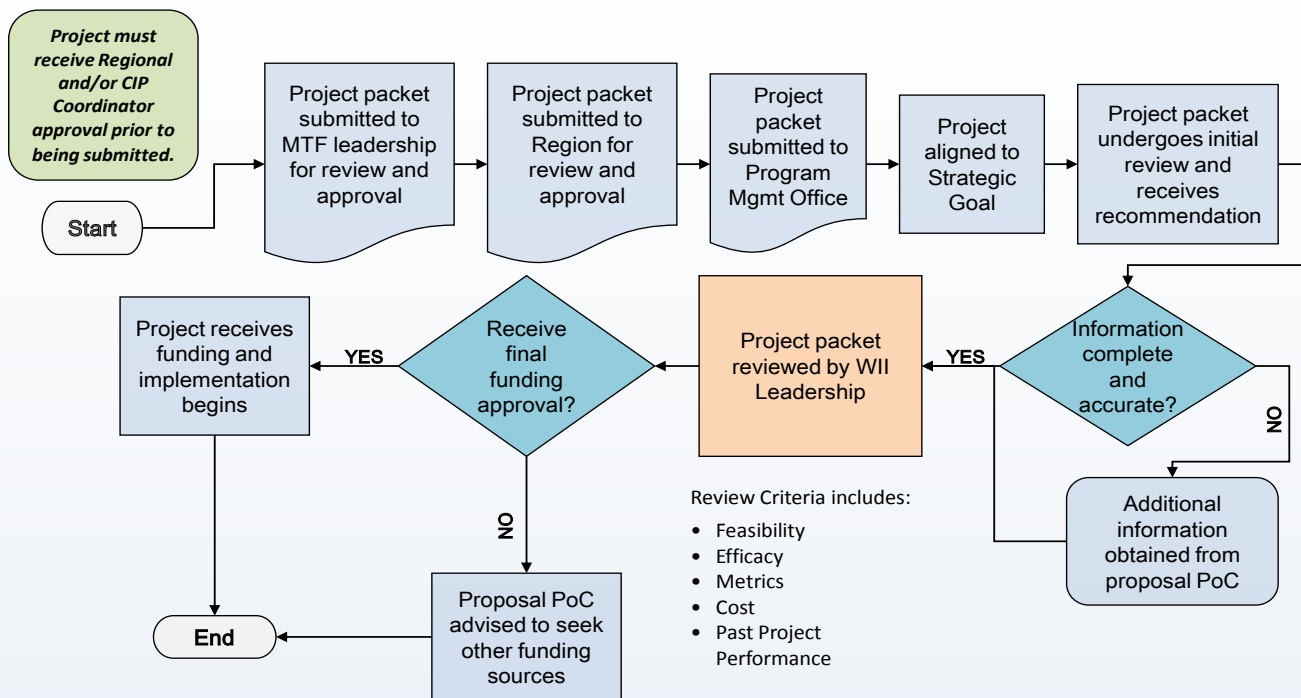


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Putting your Good Ideas to Work (continued from Page 11)

Proposal Review and Approval



7/17/2012

1

4. Fortune favors the brave—or at least those brave enough to be the dumbest guy or gal in the room.

You simply can't know everything. Keep a listening ear and a humble attitude and you can glean a lot of good gouge to get your ideas/proposals/and projects off the ground. Let me use tele-health as an example. I graduated from High School in 1977---a year not notable for a lot of high tech innovation (at least that I'm aware of). I used a CD player on workouts during my last deployment (2010), not an MP3 or iPod (yeah, I think I was the only one doing that in the gym). I get on Facebook primarily when I look over my teenage daughter's shoulder and see who she is writing to---so you get my tech credentials. So how is it that I got involved in pushing a tele-health initiative that will link Navy hospitals together with joint service and VA partners to provide remote specialty care to our beneficiaries? Obviously not because I'm some sort of technology guru. Rank may have a little bit to do with it, but keeping my ear close to the ground and learning from a lot of people who are experts has put me into a position to work with Navy Medicine Information Systems Support Activity (NAVMISSA, San Antonio) to create a pilot proposal for Navy Medicine East with implications for the entire enterprise. Over the course of the past year in developing this tele-health proposal, I sat in many meetings where if I wasn't the dumbest guy the room, I was close to it. An attitude of collaboration and a willingness to chase down as many leads as I can and engage as many experts as possible, has provided me a foundation on which to build the tele-health project. It's been a continual learning process. The Navy needs innovators and if you have good ideas and want to put those ideas to work---we need you to get into the game and help the organization meet our challenges for the future. Let me know how I can help you---david.jones4@med.navy.mil. Ψ

Please see Page 15 for an example of integrating senior level guidance into program development.

Example of Integration of Senior-Level Guidance to Inform Program Development at the MEDCEN-Level

CAPT David Jones, Naval Medical Center Portsmouth

Introduction

VADM Nathan has stated that in planning for the future of Navy Medicine, “leaders need to skate to where the puck will be, not to where it is now.” His intent is to push Navy Medical leaders to anticipate needs in the future and take steps now to make that future a reality. In shaping that future for NMCP and the NME region, we have guidance from key sources, including MHS, the SG’s Guidance, the NMCP Pillars, and RMDL Wagner’s Priorities (see Table 1 below). These perspectives complement each other and give direction to leaders involved in planning DMH activities for the next year, next 5 years, and next 10 years. This Strategy Statement is a follow-on to the NME CONOPs on Wounded, Ill, and Injured Care published by Commander NME in AUG 2011. The 7 Advances that follow reflect an integration and application of senior level guidance to the daily work of the DMH in supporting NMCP’s mission.

Table 1. Complementary Guidance in Planning DMH Advances in the Future

MHS Focus: Healthcare to Health			
Quadruple Aim	SG’s Guidance	NMCP Pillars	RMDL Wagner’s Priorities
Experience of Care Population Health Readiness Per Capita Cost	Support the War Fighter Readiness Value Healthcare Informatics Jointness Global Engagement	Readiness Customer Service Quality Healthcare Professional Development Research Medical Education	Readiness Quality Productivity Growth Financials Satisfaction

7 Advances for the MH Mission of NMCP

1. (Integrated Services) Support war fighters and their families through a Joint DoD/VA multi-market collaboration that integrates Federal Healthcare assets in Hampton Roads to improve readiness, quality, value, and continuity of care. The focus of effort will be on improving coordination and case management related to treatment and rehabilitation services to facilitate effective transitions within and between centers of care. Partnerships will also be encouraged with Universities and state agencies as appropriate in support of military members and their families.
2. (Technology) Use telehealth and telemedicine technologies to improve access to primary and specialty care services within the local area and region with a focus on interoperability between DoD/VA clinical services/programs related to Depression, PTSD, TBI, and Substance Abuse.
3. (Pathways) Establish well-defined clinical pathways for a full spectrum of care for service members and their families from psycho-educational services to managing severe/chronic mental illness. Communicate the range of services with beneficiaries and enhance linkages to support recapture of care with other NME MTFs--with NMCP serving as the regional hub.
4. (Academics) Prepare trainees in all DMH programs and uniformed staff members with skills necessary to adapt and thrive in future global deployment arenas, including combat, disaster relief and humanitarian missions.
5. (Business Focus) Employ daily real time business metrics/outcome measures that inform clinical operations across the multi-market arena and NME region and guide personnel allocation based on definable needs.
6. (Prevention/Wellness) Integrate proven prevention/wellness and population health strategies into the daily clinical care of patients at NMCP and outlying branch clinics, especially through Medical Homeports and interdisciplinary care teams within the Medical Center. Encourage DMH staff to actively pursue improvements in their own health.
7. (Interdisciplinary Care) Go all in to assist other medical specialties within NMCP to provide population health support for the 4 most costly behavior related diagnostic groups: namely, diabetes, obesity, cancer, and cardiac problems so that DMH is fully engaged in moving from healthcare to health.

The views presented in this newsletter are those of the authors and do not necessarily represent the opinions or policies of the U.S. Navy, U.S. Marine Corps, Department of Defense or the U.S. Government.