



## September 2013

## From the Editor

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Welcome to *The Navy Psychologist*, the newsletter devoted to the Navy clinical psychology community. In this issue we introduce a Reserve column, a clinical case and a mentorship segment. Our Specialty Leader provides an update on the community, Navy psychologists stationed around the world update us on news from the fleet, and the spotlight on ethics segment dissects an ethical dilemma unique to military psychologists.

Many thanks to all who contributed ideas and material for this issue! For the next edition, we will divert from the usual format to focus on Mentorship and Professional Development. Senior psychologists – expect to hear from me! Plus, as in every issue, TNP wants to hear from everyone. Send word of publications, photos, awards, accomplishments, and news regarding the great work our active duty, reserve and civilian components are doing in the fleet. Submit your information and ideas to [carrie.kennedy@usmc.mil](mailto:carrie.kennedy@usmc.mil) for the next issue, anticipated in March 2014. Good reading!

Very respectfully,  
CDR Carrie H. Kennedy

## Message from the Specialty Leader

Hello friends of Navy Psychology, and welcome to another installment of TNP.

I recently hit the 4-year mark as Specialty Leader, and as I approach the end of my tenure, I find myself thinking about some of the “big picture” issues in Navy Psychology. This is particularly true as we approach the expected drawdown in Afghanistan. What have we learned from the past ten years and what can we expect for the future?

These years have transformed our community in dramatic ways. We’ve learned a lot about deployments on dry land. We know much more about how to treat PTSD and other combat related conditions. We know what CPGs are, and that we’re supposed to be guided by them. In fact, most of us have sat through formal training on CPGs and EBTs for PTSD at the CDP (and we don’t need a translator to know what that means). We also understand more about TBI and how to treat it. In short we have a much greater understanding of the role of mental health providers in assisting combat-deployed units, ensuring that they are ready to fight, and ready to return home.

We have been transformed on an individual level as well. Those who were around in 2003 and 2004 remember the exodus of psychologists from the military during this time. Those who left were replaced by a new kind of psychologist, including many of you, who joined the Navy because of the deployments, not in spite of them. Many of you joined because you specifically didn’t want to do what psychologists have done for years – hang your diploma on the office wall, create a template of appointments and see those patients who traveled to your clinic. One reason this traditional model seems to be on the decline is because of the kind of people who now make up this community.

When I started in this job, one of my challenges was having many deployments to fill and not enough qualified psychologists who were eager or ready to fill them. I don’t have that problem anymore. In fact, I get a lot of calls from people reminding me that they are waiting to deploy. “Don’t forget about me,” I’ll hear. (Continued on page 13)



Clinical Psychology Specialty Leader  
CAPT John Ralph

## Message from the Reserve Assistant Specialty Leader

CAPT Victor Huertas, Outgoing Navy Reserve Psychology Assistant Specialty Leader



Three generations of MCESG psychologists:  
CAPT Margaret Lluy, CAPT Victor Huertas and  
CDR Carrie Kennedy

Greetings fellow psychologists,

I am writing to provide a snapshot of the state of reserve psychology. For all of you who may not know, CDR Michael Basso is the new Assistant Specialty Leader for Clinical Psychology. He began his tenure in May 2013 ([michael-basso@utulsa.edu](mailto:michael-basso@utulsa.edu)). I have completed an exciting three year tour as the Assistant Specialty Leader for Clinical Psychology. Unlike the Active Component (AC) Clinical Psychology Specialty Leader, all of the Reserve Component (RC) Allied Health Specialty Leaders fall under the MSC Specialty Leader and are considered Assistants. As with the AC Specialty Leader, the position is a collateral duty.

It may surprise many of you that we only have 16 billets for Reserve Clinical Psychology. It is surprising given the great need there is for our services. As many of you may be aware, obtaining additional billets is a long and uphill battle, especially in the current fiscal environment. Nevertheless, we currently have 19 Reserve Psychologists. In the next year three reserve psychologists will be leaving reserve service. Despite the fact that we will be losing three psychologists, it does not mean we can gain three more. The reason is that not all of our

psychologists fill the 16 billets we have available. Some are outside the billet structure which does not count against our 16 formal billets. For example, I am in a 2XXX (executive medicine) billet as the Director for Administration (DFA) at Operational Health Support Unit (OHSU) Portsmouth, Va. This billet allows for others to occupy one of the 16 Clinical Psychology billets. Other psychologists are in what we call the Voluntary Training Unit (VTU) and are in non-pay billets which again do not count against our 16 billets. The breakdown of where each psychologist is located is as follows: 4 Psychologists with 4<sup>th</sup> Medical BN, 2 Psychologists OHSU Bethesda, 1 Psychologist OHSU Bremerton, 1 Psychologist at Camp Pendleton, 1 Psychologist Dallas, 1 Psychologist at Great Lakes, 2 Psychologists at OHSU Pensacola, 3 at OHSU Portsmouth, and 1 Psychologist at OHSU San Diego. We also have one psychologist who is currently deployed to Djibouti and who will be returning in December 2013.

In the past we have had Psychologists obtain positions as DFA and XO which helps with the ability to provide paid billets for other psychologists who may be in the VTU or have just recently moved from the AC to the RC. However, we cannot always rely on that due to the billet selection process that is too cumbersome to explain in this forum presently. Currently we have billets for one CAPT, 2 Billets for CDR, 4 billets for LCDR and the rest are for LT's.

We will generally have more psychologists than we have billets. The reason for this is that Psychologists are constantly leaving Active Duty through natural attrition, but have reserve time obligations. However, most will be placed in the VTU, which again are non-pay billets with no obligation to drill once a month or perform Active Training two weeks a FY. There are some caveats however. A service member placed in the VTU may elect to drill monthly and earn retirement points, a type of deferred pay plan. While you may not earn active drilling reserve pay, you may earn points towards retirement which will increase the amount of pay one would receive if the service member elected to retire from the Reserves. The rules currently indicate that a service member may retire from the Navy Reserves if they have earned enough time (the equivalent of 20 years or more of service) in the Navy with pay and benefits at age 60. More precisely, the Reserve Service Member may retire before age 60, but s/he may not collect benefits and pay until the Retiree reaches the age of 60. In any case, if you are lucky enough to obtain a paid billet, it is a great part time job and a great way to continue serving the country.

I realize this is probably a lot of information short on details in a short forum, but if you have more questions, please don't hesitate to contact me ([victor.mario.huertas@gmail.com](mailto:victor.mario.huertas@gmail.com)) or CDR Basso ([Michael-Basso@utulsa.edu](mailto:Michael-Basso@utulsa.edu)) about Navy Reserve Clinical Psychology. Being a reserve Clinical Psychologist is an incredibly rewarding experience. Ψ

For more information:

<http://www.navyreserve.com/careers/healthcare/clinical-care.html>



CDR Michael Basso, new Assistant Specialty  
Leader for Reserve Psychology

## USNH Guam: Supporting Psychological Health and Resiliency Where America's Day Begins

LT Jay Morrison, Psychologist, USNH Guam

The island of Guam has been and continues to be a key strategic epicenter in the Pacific Ocean. Located at the intersection of the East-West Axis between the Hawaiian Islands and Asia, and the North-South Axis between Japan and Australia, it is the largest in the Marianas island chain and the only regional landmass with both a protected harbor and sufficient space for major airports. US Naval Hospital Guam plays an important role in the Navy and Marine Corps missions to operate forward, and engage globally.

Psychology and the Department of Mental Health are continuously working in support of these missions as well, in both traditional and innovative ways within the hospital. A small but dedicated staff of psychologists, psychiatrists, social workers, and nurses provide contemporary evidence-based treatments for the full range of mental health conditions, including PTSD and substance use disorders, to service members on Guam. These service members include not only sailors, but airmen stationed on-island at Anderson Air Force Base, as well as Army Reservists, Army National Guard, and deployed units from Hawaii and elsewhere in the continental US. Effectively meeting some of the unique challenges of service

members on Guam, particularly those of special groups such as those in the submarine and EOD communities, requires close collaboration with medical departments throughout the hospital. Undersea Medical Officer LT Ryan Snow notes that "demanding schedules, limited port time, austere living environments, and strict medical standards make treating submariners much more difficult, but this department has been creative and flexible in developing treatment plans, and when appropriate, getting sailors back out to sea."

In addition to special service populations, the Department of Mental Health faces many of the same challenges as other far-forward, isolated environments. Psychiatric services on the island are limited, particularly the capacity for inpatient treatment. This limitation occasionally necessitates finding creative solutions to support service members until they can receive care at an appropriate Military Treatment Facility elsewhere. Despite the limited resources, the staff continue to provide care to dependents as well. Psychologist Shallimar Jones, the only pediatric psychologist on the island, is kept busy with the assessment and treatment of behavioral functioning as well as health conditions in dependent minors, helping greatly in bringing our families peace-of-mind for wellness and mission readiness.

In addition to direct care for active-duty service members, the department is proud to play a role in staff professional development at all levels of the command. LT Kay Harris, in collaboration with CO CAPT Plummer, continues to assist in hospital-wide leadership development through personality and vocational assessment. Using tools such as the Meyers-Briggs, she and others use psychological measures to generate greater understanding of individual differences in communication and leadership styles to build more cohesive and efficient teams. Psychological expertise in qualitative research methods is being used to conduct command climate surveys, to ensure that hospital employees feel supported and empowered in their provision of care. The department also plays an important role in building resilience to stress and trauma exposure in medical personnel.

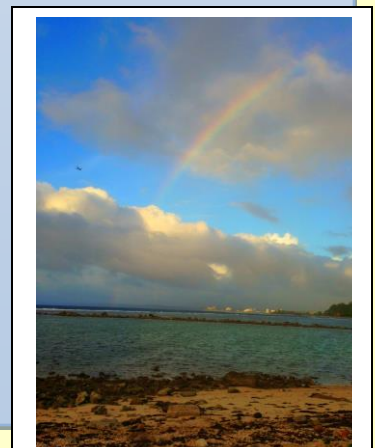
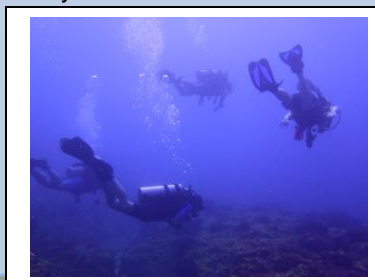
"The amazing thing about working in Guam is that you never know what is going to come through the door next, it's challenging and you have to think on your feet," says LT Mark Peugeot. "I am amazed at the incredible diversity of cases that we handle." Whether working with forward-deployed EOD or submariners, or providing assistance to fill needs unmet in the community and engaging with the native Chamorro culture, Guam provides rich soil for innovation in Navy psychological service delivery. The department looks forward to continued growth within the command, which is scheduled to move into a new, LEED-certified state-of-the-art facility at the close of the calendar year. Ψ

For more on USNH Guam:

<http://www.med.navy.mil/sites/usnhguam/Pages/default.aspx>



From left to right: LT Mark Peugeot, psychology, LT Kay Harris, psychologist, CDR Robert O'Byrne, nurse practitioner, HM2/LPO Tijani Bah, LCDR Michael Kim, psychiatrist, Ms. Rosita Mahony, LCSW, LT Jay Morrison, psychologist



## Spotlight on Ethics: The Case of the Purple Heart Motivation

LCDR Shawna Chee, Concussion Restoration Care Center and  
CDR Carrie Kennedy, Marine Corps Embassy Security Group

### The Case

Two senior enlisted members of a National Guard unit, serving on a forward operating base in Afghanistan, were indoors, approximately 30-meters from an incoming mortar round that exploded just outside their trailer-like building. They experienced no shrapnel or other injuries and both denied any loss or alteration of consciousness, or any other symptoms consistent with blast concussion. Following the explosion they assisted in evacuating civilian contractors from the building, got to the safety of a bunker for the required period of time and then completed their work shift that night. 48-hours later they reported headaches, dizziness, mental grogginess and difficulty sleeping. They were referred for concussion evaluation 7-days post blast. Both noted that they had been submitted for a Purple Heart based on their medical problems post-blast. As was standard protocol, written informed consent was obtained which included explanation of the regulations which apply to providing medical information to commands and possible outcomes of the evaluation.

During their evaluations, both service members reported forgetting the alphabet, forgetting their spouses' names, retrograde amnesia lasting one week, periodic disorientation, and numbness/tingling of extremities. Both exhibited a normal neurological examination and vestibular testing, but performed poorly on their Automated Neuropsychological Assessment Metrics (ANAM) test as compared to their predeployment testing. (The ANAM is a cognitive test which is given to every service member prior to deployment and then again in theater following concussion.) Due to their poor performance on the ANAM, they underwent traditional neurocognitive evaluation. Both performed well below established cut-offs on multiple effort measures.

### The Conflict

Given that neither service met criteria for a concussion at the time of the blast, both endorsed improbable neurological and neurocognitive symptoms and both performed well below empirically-based cut-offs on formal effort testing, the clinical conclusion was that neither experienced a concussion. The complication here presents in that the neuropsychologist in this case has the knowledge that neither has experienced a concussion and that both are motivated to receive a Purple Heart. Does the psychologist have a duty to the command to provide any of this information AND/OR does the psychologist have a duty to preserve the privacy of the two service members?

Multiple ethical standards apply here but we will focus on Ethical Standard 9.03 Informed Consent in Assessment which states "informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits to confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers." Informed consent is critical for all evaluations but in this case it ensured that both service members knew that the information would be documented in their medical record and could be shared with their command on a need-to-know basis. (In the case of Purple Hearts, the medical record is a source document used to establish that specific criteria have been met.)

In addition, there are multiple military regulations and laws to consider to include the Uniformed Code of Military Justice (UCMJ) Article 115 regarding malingering, which carry very stiff penalties during a time of war, as well as each services individual guidelines regarding the Purple Heart for concussion. In this case Army Directive 2011-07 states "the chain of command will ensure that the criteria in paragraph 2.a are met (wound, injury or death must have been the result of an enemy or hostile act, international terrorist attack, or friendly fire; and the wound for which the award is made must have required treatment, not merely examination, by a medical officer) and that both diagnostic and treatment factors are present and documented in the Soldier's medical record."

### The Outcome

Given the complications in this case, not the least of which was the possibility of legal charges due to malingering, the neuropsychologist met with each patient individually regarding all of the variables involved. A frank talk ensued regarding the impression that each may not have given sufficient effort and that their symptom development and course was not consistent with a diagnosis of blast concussion/mild traumatic brain injury. Their command was informed that both service members were fit for full duty and that a diagnosis of concussion/mild traumatic brain injury had been ruled out. Subsequent ANAM administration revealed test scores consistent with predeployment testing and denial of all symptoms.  $\Psi$



LCDR Chee



CDR Kennedy

## The Concepts of NPQ and NAA in the Context of Alcohol Disorders in the Aviation Population

LT Annie Reader Murray, NMCS Psychology Intern; Former USMC Helicopter Pilot and CDR Arlene Saitzyk, NAMI, Aerospace Clinical Psychologist

In the film "Flight," Denzel Washington is a commercial pilot who needs a few drinks (and a line of cocaine) before takeoff. Among military aviators, alcoholism is less common, but alcohol plays a key role in military aviation culture, and in turn has relevance in military psychology.

During my (A.R.M.) years as a carrier-based pilot, I considered myself fairly worldly regarding aviation and alcohol, especially after completing two OEF/OIF carrier deployments, Air Wing detachments, and a Tailhook trip. During all of those events, alcohol was omnipresent - port calls were a chance to catch up on drinking missed while underway, and debriefings and squadron functions were held at local watering holes or ready-room bars. Yet regulations require that Naval aircrew abstain from alcohol a minimum of 12 hours before pre-flight mission planning. Alcohol misuse is a hazard due to acute and chronic cognitive and physical effects, such as slowed reaction time, impaired G-tolerance, and difficulties with multisensory inputs. Deficiencies can persist many hours after the blood alcohol level returns to zero, well beyond the 12 hour "bottle to brief" guide. Many military pilot friends have commented, "It only took one hangover to realize I never wanted to fly feeling that badly again." Aviators are risk-takers by nature, and they may push the boundaries as they try to find their own limits with alcohol and flying. As military psychologists working with aviators it may be helpful to remember that while most are responsible, they may be only one late night away from trouble.

Assessment and selection of applicants, and monitoring designated personnel (pilots, naval flight officers, aircrew, air traffic controllers) are key tasks of flight surgeons and consulting mental health professionals, as most accidents are the result of human factors. Most mental health disorders are disqualifying, rendering an individual Not Physically Qualified, or NPQ (those without such conditions are Physically Qualified or PQ). If NPQ, a waiver may be requested once the illness is in complete remission without the use of medication or therapy for a specified amount of time (depending on the diagnosis) per the Aeromedical Reference and Waiver Guide (ARWG). Those with an alcohol diagnosis are NPQ, require treatment and abstinence per BUMEDINST 5300.8, and may request a waiver 90 days after they complete treatment (Level 1-3 *not* .5), express unqualified acknowledgement of the disorder, have the CO's endorsement, remain abstinent without medication, and complete aftercare requirements (e.g., attend Alcoholics Anonymous, undergo annual psychological evaluations).

In my (A.S.) experience, the "unqualified acknowledgement" criterion has occasionally presented a dilemma, highlighting the importance of the annual evaluation by the local psychologist in the waiver continuation process. As military psychologists working with aviators, your ability to discern any denial ("I'll follow the guidelines because I want to fly but I really don't think I have a problem") or "dry drunk" behaviors (may have stopped drinking but have problems with emotional regulation) is of utmost importance. As well, once the alcohol use disorder is treated, you may recognize a previously masked personality disorder or maladaptive personality traits. Personality disorders or personality traits that interfere with safety of flight, crew coordination, or mission completion are also disqualifying, but are discussed in terms of Aeronautical Adaptability (AA), and generally are not waivable. Those who show such problems are NAA - Not Aeronautically Adaptable (candidates) or Not Aeronautically Adapted (designated personnel). Since the birth of Aviation Medicine, we've known that psychological fitness of aviation personnel is critical in order to "keep 'em flying *safely*." Your role in this process is critical - if you have any questions, feel free to give us a call! Ψ

For questions about specific medical and mental health conditions in Navy and Marine Corps flight personnel, start here:

<http://www.med.navy.mil/sites/nmotc/nami/arwg/Pages/AeromedicalReferenceandWaiverGuide.aspx>

Do you have a mental health question about a Naval or Marine Corps member with flight status? Talk to any of the NAMI staff members pictured to the right. Call 850-452-2783.

Right to left: CAPT (Ret) Tony McDonald, Aerospace and Addiction Psychiatrist; CDR (Ret) Shirley Ellis, Clinical Psychologist and Former Marine; (seated on floor) CDR Chris Alfonzo, Aerospace Psychiatrist; CDR Saitzyk; Mrs. Laroice Keligond, Secretary, (i.e., NAMI Psychiatry would sink or burst into flames without her)



LT Murray



CDR Saitzyk



## Mentorship Corner: Farewell and Vision Building

CAPT David Jones



The following is a condensed version of remarks made by CAPT Jones to NMCP Mental Health leaders on the occasion of his PCS enroute to his new job as XO at FHCC Great Lakes.

I'd like to take you on a personal and intellectual journey of what I have learned about leadership during my nearly 7 years here at Naval Medical Center Portsmouth, the First and Finest. Let me start by emphasizing that it's the people you work with whose energy, dedication, and compassion are displayed everyday who are the foundation of what makes Navy Medicine and Navy Psychology great. I was very aware as Director that I had a unique role at the nexus between the Directorate, the Front Office and the region. I've likened it to being part of a neural pathway that linked me daily to the best minds around—so at 54 while I can't run like I'm 24, I can think faster, clearer, and more complexly than at any time in my life. Putting yourself out there in leadership and finding ways to draw the best in thinking and motivation from others by caring for others makes you better at everything you do.

When I came to Portsmouth in 2006, we had already been at war for 5 years. I had completed my internship here in 1993 and stayed on for my first tour of duty from 1994-1997. So coming back, was like coming home. Here are a series of observations about leadership that I have made:

1. **Prolonged war has changed us—we may try to act like it hasn't, but the reality is this war has not only changed our patients, it has changed us.** We need to talk with each other on how serving during this time of war has changed us both professionally and personally. I know that seeing 18 and 20 year olds in body bags—young people the ages of my girls, has affected me. One important way this war has changed my thinking is this: we have looked at Primary Care with its short-term, symptom focused treatments as perhaps our closest medical kin; the reality is that for some of our patients, we may have more in common with oncology. The co-morbidities for some of our patients (e.g., TBI, PTSD, Major Depression, Substance Abuse) take such a toll that it may end up costing them their lives, despite our best efforts. Oncologists accept that they will lose patients, while they as providers do their best to alleviate suffering related to chronic and life-threatening diseases. Our own beliefs and institutional pressures push us to think that resilience can inoculate people from the horrors of war or problems that people bring into the military—of course, we should try to build resilience, but we need to be clear-eyed on the challenges we face and be good with each other as we care for others.
2. **Major on the majors.** Your emotional energy is a resource that you have to manage; you have to save it for the things that count. It's too easy to get distracted by things that drain you of energy, but don't contribute to the reason why we are here—which is to be ready ourselves and serve our patients. We swim in a sea of complexity every day, disagreement and dissent are part of the process—we can always agree that taking care of America's most deserving patients is a good thing and the reason we exist.
3. **Accountability is your friend; welcome scrutiny, seek difficult, unfiltered feedback.** You really don't control much of anything, especially as a leader, but you can choose to be open to all kinds of input. Actually, the higher you go, the less control you have. Seeking only supportive information and correspondingly devaluing or not seeking negative feedback only sets you up for hubris, self-deception, and way more pain and trouble than any negative feedback might have caused you in the first place. You can get out in front on difficult issues by being willing to put yourself and your team under a microscope—you can buy goodwill by asking hard questions of yourself first.
4. **Opportunity comes to prepared people.** Such "preparation" doesn't mean you have to be exactly prepared for the next job or situation, but it does mean that you have to be prepared enough to be flexible and not blinded by ego and worrying about who gets the credit. I found an ancient Proverb to be true: "Do you see a man (or woman) skilled in his work; he will serve before kings; he will not serve before obscure men." We have "kings" at many levels. As close to anything in our country, the military functions like a meritocracy. I'm not saying that biases don't exist, I am saying that people who get really good at their jobs find new opportunities that are often in plain sight and allow them to excel even more.
5. **Your service reputation builds from doing hard things.** If you want to get into Executive Medicine, namely becoming an XO or CO, then you need to be a Director. Period. That's Admiral Nathan's bottom line requirement. There is no better preparation for XO than leading a group of people as a Director and dealing with all the joys, frustrations, and you-can't-make-this-stuff-up realities of day to day mission and personnel concerns. If you want to be in leadership, but you're not sure about being an XO and CO, there are still many other opportunities in leadership and Executive Medicine. We need Executives and we need senior clinicians. You have to be real honest with yourself about what you want and where you are willing to go and what your husband, wife or significant other wants as well.

## Clinical Case: Mild Traumatic Brain Injury vs. PTSD

LCDR J. Porter Evans, Neuropsychologist and Deputy Director for Research and Robin H. Logan, Neuropsychologist, Naval Hospital Camp Lejeune



Dr. Logan and LCDR Evans

**The Case:** A 38-year-old Master Sergeant presented with complaints of two years of worsening short-term memory, poor sleep quality, irritability, and misplacing important items. History is significant for four combat deployments (most recent in 2008) with exposure to multiple blasts with brief alteration of consciousness (AOC) and an incident of a one-minute loss of consciousness (LOC). There were no periods of posttraumatic amnesia.

He stated that he requires multiple compensatory devices to manage at work. He denies counselings regarding his work performance, but he feels that he is failing to meet the mission. His marriage is under strain secondary to his irritability and forgetfulness. He attributes his current problems to an incident in 2008 when his vehicle hit a buried IED resulting in brief LOC. He denies a history of mental health treatment, and he states that he knows that he does not have posttraumatic stress disorder (PTSD) as that is “for people that cannot handle it.” However, he reports weekly nightmares, hypervigilance, emotional numbing, and avoidance behaviors (crowds, restaurants and loud noises). He reports severe headaches with light and sound sensitivity, which he treats with over-the-counter medications. His family medical and developmental histories are unremarkable. There is no history of substance abuse. Neuroimaging is unremarkable.

Recent neuropsychological testing indicated average intellectual functioning with a strength in processing speed and a weakness in working memory. Notably, this finding is uncommon in acute concussion where processing speed is generally not a strength. His free recall is slightly below expectations, but recognition memory is intact. His executive functioning and attention are at or above expectations. Personality measures indicate a self-evaluation style with a high degree of self-criticism, hypervigilance, ruminative worry, affective instability, and discomfort in social relationships.

**Diagnostic Dilemma:** He believes that he has residual effects of concussion, but clinical data suggests otherwise. The typical recovery course of concussion based on the sports medicine literature is 7 to 14 days for most people, and within three to six months for almost everyone. Multiple concussive events can result in a delayed recovery. Additionally, in mild to moderate traumatic brain injury, it is expected, that at best, functioning gradually improves over time, and at worst, functioning remains static. Additionally, it would be atypical for onset of memory problems to occur two years post injury. In the military population, there is emerging evidence that recovery can be much longer compared to the sports concussion literature. In contrast with athletic contests, the deployed service member is in an environment where their life is at risk and they frequently witness death and serious injury of their peers. Furthermore, many comorbid effects (e.g. orthopedic injuries, tinnitus) of a blast injury persist long after the direct impact of a concussion has resolved.

**Course of treatment:** The primary etiology for his subjective complaints is likely PTSD, headache, and poor sleep quality. Treatment recommendations involve psychotherapy, sleep medicine, headache treatment, and cognitive rehabilitation. Notably, PTSD and the acute symptoms of concussion often result in similar subjective reports of memory and attentional dysfunction. Additionally, chronic use of over-the-counter analgesics such as ibuprofen and acetaminophen can cause headaches (referred to as rebound headaches). He would benefit from cognitive rehabilitation to gain more effective memory strategies as his forgetfulness is a considerable source of frustration, which may worsen memory performance. Poor sleep quality is linked with decreased cognitive functioning.

**Summary:** With so much emphasis on concussion in the military, this injury is often misattributed as the primary etiology for mild cognitive dysfunction. This case presents additional challenges for the clinician as the service member’s objective functioning contrasts with his subjective reports. Also, neuropsychological test norms are collected in a distraction free environment. There is a tendency for all individuals to perform better in a distraction free environment compared to their real world environment. However, in military members with environmental hypervigilance this discrepancy is likely greater as they allocate a significant amount of cognitive resources towards evaluating their environment for threats. Thus, while neuropsychological testing indicates intact capabilities, the service member may not be able to fully utilize these capabilities in their “real world” environment secondary to the cognitive demands of environmental hypervigilance. Finally, a logical approach would indicate that most individuals would rather have a treatable condition rather than a permanent or untreatable condition such as a severe brain injury. However, in the military culture there may be less stigma associated with a physical injury than a mental health condition. Ψ

For more on concussion and brain injury in the military, start with the Defense and Veterans Brain Injury Center:

<http://www.dvbic.org/about/tbi-military>

## The Integrated Clinical Management and Risk Mitigation System (ICM-RMS): A Mental Health and Force Preservation Tool

LT Yaron G. Rabinowitz, LT Russell P. Balmer, LT Darren Norris, HM3 Justin Seabrook, HM2 Stephen Windle, and HN Samuel Malone



2D Marine Regiment, 2D Marine Division OSCAR TEAM: From left to right, LT Rabinowitz, Psychologist, LT Balmer, Psychiatrist, LT Norris, Psychologist, HM2 Windle, FMF, HM3 Seabrook, FMF, HN Malone, FMF

Of the numerous challenges facing embedded mental health providers, mitigating suicide risk is one of the most important. Recent experience has demonstrated that traditional paradigms of mental health treatment are not sufficient to attenuate the escalating numbers of suicides and adverse outcomes in operational commands. Rather, effective risk surveillance practices must be adopted to enhance communication, coordination, and detection of at risk service members. At 2d Marines, the OSCAR Team (Operational Stress Control and Readiness) developed and implemented a novel force preservation tool designed to proactively identify risk and support the unit's Force Preservation program.

The Integrated Clinical Management and Risk Mitigation System (ICM-RMS, pronounced: "I.C.M. – Rams") is a networked and interactive data management system with dedicated portals for key force preservation players. Each portal has capabilities and access to information specific to that individual's position and unit (e.g., differing levels of accessibility to protect HIPPA, PHI, and patient data). From a Force Preservation perspective, ICM-RMS was designed to capture risk factors for individuals assigned to a unit's Force Preservation program, produce an empirical risk score, and allow sustained coordination and communication between "need to know" entities (Medical, Command, and Mental Health). It enables key players to independently input risk factors into a single repository, and provides medical and mental health capabilities such as automated alerts and controlled medication tracking.

Risk scores are generated using an original algorithm of known risk factors, and automated alerts make specific recommendations to commanders based on the risk score. If a risk score supersedes a predetermined threshold, an alert is sent to all individuals involved in force preservation for that service member. This alert is generated irrespective of whether that individual is a current mental health patient, which permits mental health providers to identify those in need prior to referral to mental health. Lastly, users can easily generate reports for a selected unit delineating risk scores and contributing factors. ICM-RMS allows for more informed command decisions and risk management plans, and helps facilitate the transition from reactive to proactive mental health treatment. By leveraging objective data, ICM-RMS focuses attention on key variables, helps quantify and elucidate force preservation information, and minimizes the degree to which decisions are made on emotion or "gut instinct". Moreover, it lessens the impact of human error by automating alerts and generating modifiable cross sectional reports.

ICM-RMS was initially developed by 2d Marines OSCAR mental health professionals to help manage front desk and administrative responsibilities when the OSCAR team was without psych tech support during their first year. Thus, in addition to its force preservation capabilities, ICM-RMS includes a full suite of clinical management tools to include the ability to track appointments, schedules, biographical data, intake data, vitals, medication, and psychological testing. It also includes auto note generation and remote data entry via laptop for all appointments.

ICM-RMS has been embraced by both the 2d Marine Division and 2d Marine Expeditionary Force Commanding Generals, and Headquarters Marine Corps has begun development of an enterprise, web-based, CAC enabled version. The initial release is anticipated to be late fall and will include broader connectivity to key entities such as the unit Substance Abuse Control Officers, Substance Abuse Rehabilitation Program, and Marine Corps Community Services providers. The overarching intent of development is to provide local commanders with a viable Force Preservation solution that bridges the gap between command and medical. Ψ

To read the OSCAR MARADMIN (MARADMIN 597/11) go to:

<http://www.marines.mil/News/Messages/MessagesDisplay/tabid/13286/Article/110997/operational-stress-control-and-readiness-training-guidance.aspx>



## Value and Readiness: Behavioral Health Consultation Services within the Sleep Medicine Clinic

LT Jeremiah D. Ford, Psychologist, Naval Medical Center Portsmouth



At the onset of FY2013, leadership within Naval Medical Center Portsmouth (NMCP) reported an estimate of \$80,000,000 in revenue lost to patient network deferrals. A call was put forth to all NMCP directorates to brainstorm means of recovering this lost revenue. One significant source of network deferrals was Pulmonary/Sleep Medicine with approximately 10% (or \$8,000,000) of the total. In reviewing deferrals from Sleep Medicine, it was noted that as many as forty to sixty referrals each month involved patients solely with insomnia or patients with both insomnia and a potential medically-based sleep disorder (e.g., Sleep Apnea, Restless Leg Syndrome, etc). These referrals were part of the reason that an already undermanned Sleep Clinic was deferring cases to the network. In some cases, network providers were not accepting insomnia-related consults due to insomnia being a non-reimbursable condition. In other cases, patients were requiring more than one sleep study because of inability to fall/stay asleep during the study.

To address these problems an Insomnia/Sleep Hygiene Clinic was created in February 2013 as part of the treatment pathway within Pulmonary/Sleep Medicine. Patient referrals primarily involving insomnia were sent to this clinic to receive a 4-session behavioral health intervention for insomnia. Patient's insomnia symptom severity was monitored at each weekly session via the Insomnia Severity Index (ISI) as well as at 30 days post-treatment and 60 days post-treatment. Following treatment completion, patients without satisfactory resolution of symptoms then have the option of returning to their PCM to coordinate additional evaluation in Pulmonary/Sleep Medicine.

The four sessions involve education, skill building, and cognitive-behavioral interventions. In the first of the four sessions, patients receive education about sleep disorders and common sleep problems and select specific sleep behaviors to target. The second and third sessions focus on relaxation training and cognitive distortions involving sleep, while patients continue making behavioral changes to increase and improve sleep. The final session summarizes gains and provides techniques for maintenance of new behaviors. Motivational interviewing techniques are utilized to improve patient adherence to behavior change throughout this intervention.

As of July 2013, a total of 125 patients attended the 4-session intervention within the Insomnia/Sleep Hygiene Clinic. This 4-session intervention has a treatment completion rate of nearly 80% and data analysis of treatment completers shows a decrease in insomnia symptom severity from pre-treatment to 60 days post-treatment, based on mean ISI scores. Specifically, scores changed from *severe* to *moderate* pre-treatment to *subthreshold* after the 4-session intervention. In addition to the clinical gains made by patients, the treatment protocol has reduced NMCP network deferral losses by as much as \$360,000 over the first 6 months of the program. Even a minor expansion within this program (e.g., one additional 10 person group each week) could further increase recovery of network deferral losses substantially. Not too shabby considering only one psychologist and one psychiatric technician currently provide this service within NMCP. Ψ

For more on sleep and sleep resources in the military, check out the Human Performance and Research Center:

<http://hprc-online.org/mind-tactics/sleep-optimization>

In the deployed environment, service members tend to sleep whenever and wherever they can.



The end of the year is nearing fast! Keep in mind those junior (O-3), senior (O-4 to O-6), and civilian Navy psychologists deserving of Navy Psychologist of the Year awards for 2013. Submissions will be due at the end of the year. Gather bullets and start your drafts now!

## Caring for the Caregiver Starts With You

CDR Carrie Kennedy, Marine Corps Embassy Security Group, LT Mary (Dr. No) Cava, Naval Medical Center Portsmouth, and LT Adam (Spicy) Tomlinson, Naval Medical Center Portsmouth



CDR Kennedy, LT Cava and  
LT Tomlinson

Military Psychologists are supposed to be impervious to stress. We deal with everyone else's "stuff" and never have any of our own – right? That would be great, because an overt display of personal problems can undermine the psychologist's credibility and consequent ability to assist others in an embedded command or military treatment facility. No pressure there.

Let's face it, being a psychologist in the military is fraught with pitfalls. A standard day involves vicarious traumatization, breaking the bad news to service members who have a disqualifying condition that their career hopes are ended, managing unscrupulous individuals who try to use you to meet selfish goals, and just

generally dealing with other people's crises. RVUs and other bean counting techniques exacerbate the problem. Unique ethical issues are thrown in just to make things more interesting. The belief that psychologists should be impervious to stress and problems compounds the dilemma. Repeated deployments top it all off. This sounds bad, but the reality is that this is the normal course of business that we all signed up for and it is manageable. But, managing this lifestyle is not effortless. The following is some guidance to stay healthy, professionally satisfied and in the game.

**MANAGE EXPECTATIONS FOR BOTH YOU AND YOUR FAMILY:** Okay – you know you've chosen the more difficult path. You won't be sitting in an office 100% of the time with all of the amenities that go along with that type of psychological practice. You will get dirty. You will get exposed to some danger. You will have to be creative to meet the needs of service members. You will work more than 40 hours a week and some of these hours WILL be unexpected and at 0-dark-30. You will have to stay in shape. You will deploy. You and your family will move, a lot. Your life will be unpredictable at times. And thus, it is imperative that you learn, as all successful service members and their families do, to "embrace the suck." The reality is that everything that was just listed keeps life and work pretty d\*\*\* interesting, you will save lives and careers on a regular basis and very few people get to do this job! It's all a matter of perspective, management of expectations and putting supports in place such that the professional satisfaction and variety of experiences outweigh the stress.

**GET CONNECTED:** If you are going to accomplish the mission, you can't do it alone. No military psychologist can succeed without a team of peers, mentors, consultants and social supports and you alone are responsible for assembling your own team. Your network needs to consist of: peers from each of the services, a JAG, one or two senior members of the community, an ethics consultant, one or two senior MSCs, the specialty leader and detailer, and any clinical, research and operational specialty consultants that you may need. Where to find these people? The Navy Psychologist distribution list, moderated by the Specialty Leader is one way to send out a call for assistance to the community. The Navy Clinical Psychology Facebook page exists only for psychologists serving in the Navy or in Navy facilities and is a great way to reach out to psychologists all over the world. APA Divisions 18 and 19 provide excellent network resources for military psychologists working with both active duty and veterans. Get involved, always participate in military psychology activities and training opportunities and your network will expand rapidly.

**PLAN AHEAD:** Waiting until there is a problem is a recipe for disaster. Don't wait until you are in over your head before reaching out to others or engaging in restorative activities. If you see something at your command that you know is going to result in a problem in the future, fix it now. Staying organized is another way to easily manage unexpected obstacles. We all know that taking care of Sailors, Marines and ourselves is an ongoing evolution that takes planning, consistent implementation and forethought.

**PRACTICE WHAT YOU PREACH:** In all of this, remember the basic interventions we provide our clients as well as the competencies our specialty espouses. We teach them because they work! Self-awareness, advocacy, pacing, good friends and family relations, a sense of humor, physical fitness, responsible personal behavior, and maintenance of personal and professional boundaries are key as we navigate the competing demands from our personal lives, commands, and patients. And use your leave whenever you are presented with the opportunity!

**GET FORMAL HELP IF YOU NEED IT:** There are times when even the best planning and prevention strategies are not enough. When this happens, follow your own guidance. GO GET HELP! You don't have to go to the clinic that you work in or where you already know all of the providers personally. Go to a neighboring base or get a civilian referral. If you work with your command and PCM for these resources you can make this happen. Ψ

LT Cava, LT Maid and LT Tomlinson with Lucca, a retired Marine working dog, who lost her left front leg to an IED in 2012. She now spends time motivating others, to include this completely stress free (at least while Lucca is around) group of Navy psychologists.



## Navy and Marine Corps Achievement Medals

**LT Anthony Kraemer**  
**LT Chrissy Supervielle**

## Navy and Marine Corps Commendation Medals

**LCDR Melissa Hiller Lauby**  
**LT Stephanie Long**

## Meritorious Service Medals

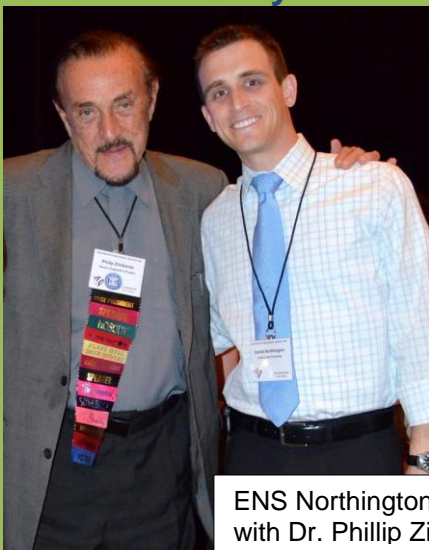
**CAPT David Jones**  
**LCDR Kathryn Lindsey**



LCDR Lindsey receives her MSM from the Commandant of Midshipmen, CAPT Robert Clark III.

## Zimbardo-Maslach Research Award in Social Psychology

**ENS Daniel Northington, HPSP, Loma Linda University**



ENS Northington (right) pictured with Dr. Phillip Zimbardo

## Newest Navy ABPP

**LCDR Robert Lippy**

## Graduate of the University of Virginia's 2-year Neuropsychology Fellowship

**LCDR Efland Amerson**

## Elected Treasurer Division 19

**CAPT Scott Johnston**

## **WARFARE DEVICES**

## Surface Warfare Medical Department Officer

**LT Anthony Kraemer**



## Fleet Marine Force Qualified Officer

**LCDR Shawna Chee**



## Meritorious Student Award, 4<sup>th</sup> Annual Meeting of the Society of Behavioral Medicine

**LT Chantal Meloscia, USUHS**



Congratulations to **LTJG Marcus VanSickle** who survived the MCMAP Tan Belt instruction of **LT Mary Cava**, **CDR Carrie Kennedy** and **LT Stephanie Long**.



## **Publications and Presentations (bolded names are Navy Psychologists)**

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Billingsley-Marshall, R.L., **Basso, M.R.**, Lund, B.C., Hernandez, E.R., Johnson, C.L., Drevets, W.C. McKee, P.A., & Yates, W.R. (2013). Executive function in eating disorders: The role of state anxiety. *International Journal of Eating Disorders*, 46, 316-321.

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Hill, C.E., Gelso, C.J., Chui, H., Spangler, P., **Hummel, A.M.**, Huang, T., Jackson, J., Jones, R., Palma, B., Bhatia, A., Gupta, S., Ain, S., Klingaman, B., Lim, R.H., Liu, J., Hui, K., Jezzi, M.M., & Miles, J. (in press). To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. *Psychotherapy Research*.

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McLay, R.N., Graap, K., **Spira, J.**, **Perlman, K.**, **Johnston, S.**, **Rothbaum, B.O.**, **Difede, J.**, **Deal, W.**, Oliver, D., **Baird, A.**, **Bordnick, P.S.**, **Spitalnick, J.**, **Pyne, J.M.**, & **Rizzo, A.** (2012). Development and testing of virtual reality exposure therapy for post-traumatic stress disorder in active duty service members who served in Iraq and Afghanistan. *Military Medicine*, 177(6), 635-42.

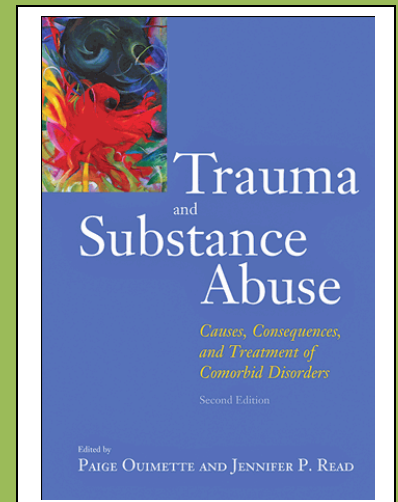
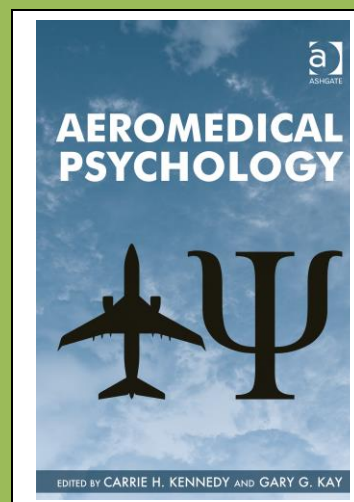
**Meloscia, C.** (2013, March). *Ratings of Puff Liking During Cigarette Smoking are Associated with Nicotine Dependence and Subsequent Relapse to Smoking*. Poster presented at the 34<sup>th</sup> Annual Meeting and Scientific Sessions of the Society of Behavioral Medicine, San Francisco, CA.

**Morrison, J.A.**, Berenz, E.C., & Coffey, S.F. (in press). Exposure –based, trauma-focused treatment for comorbid posttraumatic stress disorder and substance abuse disorder. In P. Ouimette and J. Read (Eds.), *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders* (2<sup>nd</sup> Ed). Washington, DC: American Psychological Association.

**Phillips, H.L.**, **Walker, P.B.**, **Kennedy, C.H.**, Carmichael, O., & Davidson, I.N. (2013, July). *Guided Learning Algorithms: An Application of Constrained Spectral Partitioning to Functional Magnetic Resonance Imaging (fMRI)*. Paper presented at the 15<sup>th</sup> international conference on Human-Computer Interaction, Las Vegas, NV.

**Saitzyk, A.R.**, Alfonzo, C.A., Greydanus, T.P., Reaume, J.R., & Parsa, B.B. (2013). US military standards and aeromedical waivers for psychiatric conditions and treatments. In C.H. Kennedy and G.G. Kay (Eds.) *Aeromedical Psychology* (pp. 125-158). Aldershot: Ashgate.

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## Message from the Specialty Leader, Continued from Page 1

“I haven’t deployed in a while, so when can I go back?” or “I passed the EPPP, can I go now?” Our junior psychologists really want to deploy. They understand why we have uniformed psychologists - so we can work alongside those we serve, no matter where they happen to be. I think that if there’s one thing that will last from these years of war, it will be that this new model of care will continue to take root. The new breed of expeditionary-minded psychologists will continue to work where the action is, providing care on the deckplates or in the field, meeting service members where they are, reaching out rather than waiting to be asked for help.

About a third of our billets are now in expeditionary settings, and all indications are that this will increase. As I’ve said in the past, I suspect we’ll soon have more billets on the larger Amphibs. The Marines are asking why only their ground combat elements have OSCAR providers (probably no good reason truthfully). In both the Marine Corps and Specialty Operations communities, there is a general sentiment that units need “their own” mental health providers – someone to whom they can relate and who understands them. In fact, one of the primary recommendations of a recent VCNO task force on resilience was to increase the number of embedded mental health providers in the Navy.

So I think that one of the enduring legacies of these conflicts will be this – that the presence of mental health providers in forward deployed settings is a requirement. More and more, units of all types will travel with their own psychologists, because of an increasing sense that they need these providers to function optimally. This is of course due to each one of you, who through your own efforts have helped prove to line commanders the inherent value of the services we provide.

This is exciting to watch. For the junior members of our community, I urge you to continue this trend, not only because it matches your skills and reasons for joining the Navy, but because it is the right thing to do for this unique population we serve. I have no doubt that these lessons-learned from the past ten years will continue to transform the military into a more ready force, and an organization that will serve as a model for how mental health prevention and treatment can enhance the wellness and readiness of its members.

As always, it is an honor to serve with each of you. Keep up the great work. Ψ

## Mentorship Corner, Continued from Page 6

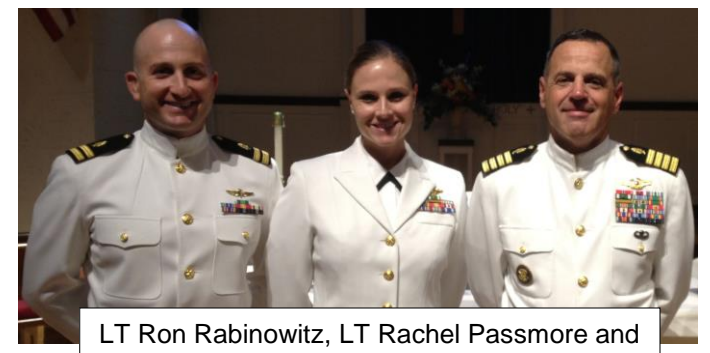
- You can gauge your growth as a leader by your willingness to tell others (including yourself) the truth.** Truth-telling doesn’t have to be done in a demeaning way, but can be done in a straightforward, this-is-where-things-stand way—rate yourself on 0-5 scale on your comfort level over the past month in saying exactly what needed to be said. Is there a frank conversation that you’ve put off having in the past week? Now, I don’t wake up in the morning and say, whose parade can I rain on today?—but, I have accepted the fact that I have been entrusted with a leadership position and the exercise of that position requires honesty, and getting people to see the part that they need to play and to see when they are not, and praise them when they are.
- Keep your job as a leader in perspective. Can you name your best day in the Navy?** I know that going to my XO job is a high privilege and I’m honored to have been selected. I also know that my best day in the Navy occurred in Wednesday 28 October, 2009 when I was heloed in with two psych techs to take care of a Stryker unit out of FT Lewis, WA that had just lost 7 soldiers and an Afghan interpreter to an IED blast. All my training and experiences culminated in being ready to do my job on that day, when it counted most, under the most arduous circumstances. The reality is that for all of our efforts, we only have a defined time in the Navy. We may invest our careers with a higher meaning, but this is still just a job. The jobs we do in the Navy while incredibly important don’t define us as people; my wife knows me as Dave, my girls know me as Dad; you may know me as Captain, but that’s a role I play here. I do know I’ve had my best day and I will work to help create others like it, but exercising good leadership means that we’re not imprisoned by unreasonable expectations of success. In short, we have a serious job, but can’t take ourselves too seriously. Ψ

# Fair Winds and Following Seas

## CAPT Andy Davidson

CAPT Davidson completed his graduate studies at Indiana State University and was commissioned as a Lieutenant in 1992. He did his internship at National Naval Medical Center, Bethesda, MD and completed his first tour as a Navy psychologist at Naval Hospital Camp Lejeune. In 1995 he became Mental Health Department Head at Roosevelt Roads, Puerto Rico and was then selected to serve as the first Navy psychologist for Presidential Support Duty at 8<sup>th</sup> & I, Washington DC from 1998-2001. Following this tour he served as the Deputy Command Psychologist at Naval Special Warfare Development Group. He then enjoyed a stint as an Assistant Professor at the US Naval Academy before assignment to Marine Forces Special Operations Command from 2007-2011. He completed his 21 years of Naval service as the 8<sup>th</sup> Regiment Operational Stress Control and Readiness Psychologist at Camp Lejeune. During his career he deployed four times; once to Guantanamo, once to Iraq and twice to Afghanistan.

His personal awards include: Bronze Star, Meritorious Service Medal with Gold Star, Joint Commendation Medal, Navy and Marine Corps Commendation Medal with Gold Star and Navy Achievement Medal. Additionally, he was awarded the Presidential Support Badge, Fleet Marine Force Badge and Airborne Silver Wings.



LT Ron Rabinowitz, LT Rachel Passmore and CAPT Andy Davidson



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## Fair Winds and Following Seas

### CDR Mark Heim



CDR Mark Heim enlisted in the Navy at age 17 in 1982 and served for 6 years as an Electronics Technician. Following his first period of active duty service, he worked as a realtor, owned a pizza shop, worked as a counselor in an outdoor therapy school for troubled teens and was employed at the International Paper Company. During this time he received a BA from Penn State University and then his PhD from Michigan State.

CDR Heim was commissioned in 1998 when he began his internship training at the National Naval Medical Center in Bethesda, MD and then was assigned to Naval Hospital Camp Lejeune. He then completed his first carrier tour aboard the USS George Washington followed by a teaching assignment at the United States Naval Academy. He then served as the Group Psychologist for Marine Corps Embassy Security Group followed by a second carrier tour, this time aboard the USS John C. Stennis.

Throughout the course of his career he completed 5 shipboard deployments and has over 7 years of sea duty. He completes 21 years of active service this fall and has planned an arduous schedule of touring the US by bicycle and hiking the Pacific Northwest. Ψ



Pictured with NNMCM Training Director, Dr. Marvin Podd

## Mentorship Parting Shot, LTs: Don't Leave Money on the Table

### CAPT David Jones

LTs - If you are fretting about getting promoted but haven't taken the time to get your ABPP, you just might have your priorities misplaced.

Every month you don't get your ABPP, you leave 5 Benjamins on the table – that's \$500 bucks each month - \$6000 each year. If you're an **L T**, that's like leaving the equivalent of your next pay grade's increase on the table – EACH month. OUCH! LTs, you can get paid like an O-4 right now if you get your ABPP. You don't control your promotion chances nearly to the extent that you can control your ABPP plans. There are mentors and pathways to help you get to where you need to be in working toward your ABPP. Don't leave money on the table – let Uncle Sam pay you at the speed of light each month for your advanced professional skills. Yes, it takes work to get your ABPP but listen to that cha-ching – that's money in your pocket.

For more on board certification and military psychologists, start here:

<http://www.apadivisions.org/division-19/publications/newsletters/military/2012/04/military-psychologists-certification.aspx>

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.