



September 2014

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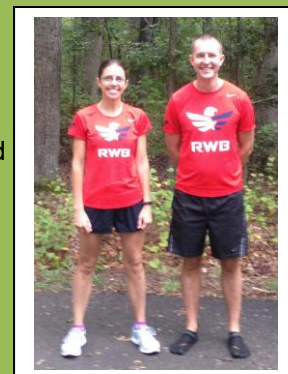
From the Editor

Welcome to the newest issue of *The Navy Psychologist*, the only newsletter devoted to Navy Psychologists © I am pleased to introduce everyone to LT Jay Morrison, currently stationed in Guam (where America's day begins!) and the new Co-Editor of TNP. LT Morrison has not yet learned the true meaning of NAVY (Never Again Volunteer Yourself) but this experience should do it!

For our first combined effort, the next issue will focus on Navy psychology deployments and we will begin sending out calls for information very soon (see page 10). As always, send word of publications, photos, awards, retirements, accomplishments, and news regarding the great work our active duty, reserve and civilian components are doing in the fleet. Submit your information to carrie.kennedy@usmc.mil **AND** jay.morrison77@gmail.com for the next issue. Good reading!

Very respectfully,

CDR Carrie H. Kennedy and LT Jay A. Morrison



Message from the Specialty Leader

Hello Navy Clinical Psychology Community,

The American Psychological Association convention has recently concluded and it was highly successful. It was wonderful to see so many of you there connecting with colleagues from across the globe. I want to use this Specialty Leader column to recap the important points shared about our community at Navy Day.

I am proud to report that the health of Clinical Psychology within the Navy continues to be strong. While many specialties, and the overall Navy, are shrinking in size, the Clinical Psychology community is growing. This is clear validation of the vital contributions you all make to the mission of the Navy every day. We currently have 197 billets, up from 137 in 2009. We have 174 personnel onboard, leading to an overall manning of 88%. If you factor out the 31 training billets, our manning is 86%. Our community brings in about 20 accessions and loses about 10 psychologists each year. With this net gain of about 10 per year, we are still on a growth trajectory and I believe we will be near full manning in 3-5 years.

Routine Individual Augmentee deployments are on the decline as our combat footing overseas decreases. Currently, LT John Knorek and LCDR Porter Evans are deployed, and LT Claudia Rojas, LT Anthony Smithson, and LT Jay Morrison are scheduled to deploy over the next few months. Bottom line: we may soon have more people who want to deploy than we have spots. If you want to deploy, please contact me quickly when I send out requests for volunteers. Of course, many of you will have an opportunity to deploy in your organic role with OSCAR, NSW, carriers, etc.

We have four psychologists entering DUINS fellowships this Summer and Fall. LTs Christofer Ecklund and George Stegeman in neuropsychology, LT Michael Domery in child psychology and LT Matthew Schumacher in operational psychology.

The Psychological Health Advisory Board (PHAB) is comprised of all the Specialty Leaders in the mental health professions and we are working on a variety of

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Clinical Psychology Specialty Leader
CAPT Scott Johnston

Navy Prescribing Psychology

LT Yaron G. Rabinowitz, OSCAR Psychologist, 2nd Marine Division



Since the Defense Demonstration Project (DDP), which produced the first prescribing psychologists in the 1990s, Navy psychologists have played a prominent role in the prescriptive authority movement (RxP). We produced more DDP graduates than any other branch, and one of the original prescribing psychologists in Louisiana (the first state to pass RxP legislation) is a senior member of our community, CAPT Robert Younger. Navy psychologists, such as CAPT Morgan Sammons (Ret., former Specialty Leader and current Executive Officer of National Register of Health Service Psychologists), routinely contribute to national RxP advocacy efforts. Presently, we have 2 active duty prescribers, 4 in training, and 12 other Navy psychologists in the early stages of RxP.

In the past, Navy psychologists became credentialed to prescribe through either the Defense Demonstration Project, or later, via a health psychology fellowship at Tripler Army Medical Center. Although the Navy's formal training program is currently in flux, Navy psychologists can still obtain RxP training independently, and then be credentialed to prescribe in any military treatment facility. The requirements in the DoD and in all states and territories with RxP legislation (LA, NM, IL, and Guam) include completion of a

Master's degree in Psychopharmacology, the cost of which can be defrayed by the GI Bill, passing the Psychopharmacology Exam for Psychologists (PEP), and completion of a supervised practicum (the Navy requires 100 patients).

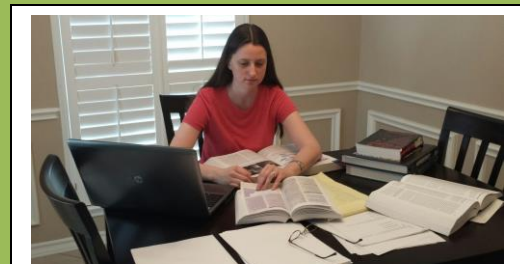
Prescribing psychologists provide a uniquely valuable skillset in military mental health. With extensive training in both psychopharmacology and psychotherapy, they can develop treatment plans that leverage combined modalities. This allows them to make medication decisions in the context of an integrated mental health care treatment strategy, using considerably more data than available with medication management alone. The result is more incisive decision-making, fewer failed medication trials, and because of the synergistic benefit of medication combined with psychotherapy, better outcomes with less medication. Moreover, by providing both psychotherapy and medication management, prescribing Navy psychologists can offer patients a level of timeliness and responsiveness not otherwise possible. Not only do many patients prefer "one-stop shopping", but reducing numbers of visits has important organizational implications. Overburdened mental health departments can reduce necessary patient contacts by using a prescribing psychologist for both psychotherapy and medication management, allowing psychiatrists to focus exclusively on patients who do not require psychotherapeutic intervention.

Navy prescribing psychologists also facilitate increased access to care in expeditionary settings in which prescribing mental health providers are scarce. For example, in Operational Stress Control and Readiness (OSCAR) settings, prescribing psychologists have relieved the prescribing burden from primary care managers who prescribe the preponderance of psychotropic medications. Likewise, prescribing psychologists provide improved command consultation in force preservation councils by using their expertise to clarify complex medical treatment dynamics and duty limitations. Finally, prescribing psychologists, who work with special duty populations in which psychotropic medication use is incompatible with full duty status, play a critical role in determining whether individuals can be adequately treated without medication.

Prescribing Navy psychologists study the dynamic interplay between medical conditions, pharmacological interventions, and psychological symptomatology. Consequently, they are attuned to contributory medical factors and psychological overlays. Their enhanced skillset incorporates psychotherapy, psychopharmacology and advanced differential diagnosis. Indeed, Navy psychologists have successfully identified esoteric physiological problems, like pheochromocytoma, and intervened to mitigate adverse medication events like serotonin syndrome.

Critics contend that prescribing psychologists blur the important distinction between psychology and psychiatry. However, the literature suggests that prescribing psychologists prescribe at a lower rate than psychiatrists and primarily use psychotherapeutic interventions. Furthermore, the ability to prescribe is also the ability to un-prescribe. Navy prescribing psychologists utilize their skills for the vitally important purpose of minimizing or discontinuing unnecessary medications. Helping patients improve without an overreliance on medications can increase the speed with which they are returned to full duty, an advantage for patients and command alike.

Navy psychologists have historically played a significant role in the RxP movement and continue to utilize RxP to improve delivery of care and expand command consultation capabilities. There is definite interest in RxP across the Navy, and those who have pursued RxP have realized significant personal and professional benefits. Prescribing Navy psychologists are positioned to assume a variety of billets and can help address organizational issues of limited resources and prescribers. They are also ideally suited, by virtue of their education and training, to perform well in other advanced areas that require a knowledge of physiological and neurologic processes (e.g., neuropsychology). Although their path is challenging, Navy psychologists with prescriptive authority are significant assets to their patients, commands, and more broadly, to the Navy Psychology community. Ψ



LT Mary Cava studies for an exam for her Psychopharmacology Master's program at Fairleigh Dickinson University.

Pre-Service Trauma: A Case Study

LT Ashley Clark, OSCAR Psychologist, 1st Marine Division

LT Clark is currently serving as the first female OSCAR psychologist.

Perhaps one of the greatest advantages in embedded psychology is the flexibility for creative treatment planning. Recently, a PFC was referred to me by his Battalion Surgeon after he was observed shaking, crying, and likely having a flashback on the rifle range. When he arrived to his initial evaluation, he brought along his Corporal and Corpsman for courage; he needed proof that I was trustworthy before they would relieve their overwatch.

This Marine disclosed that he was a child soldier, kidnapped in Africa at age nine and forced to “serve” until age 16 when he escaped and returned to his village. Shortly thereafter, his mother sent him to live with his father and brothers in New York so that he would be safe from further harm. He enlisted at age 24. When he came to my office, he had a salty ten months of active duty under his belt.

According to the Marine, his most frightening memory happened six months after being kidnapped. He was deprived of food and water, marched with other children for six miles at night, and forced to experience inconceivable events.

It is not hard to imagine that this Marine suffered from nightmares until approximately two years ago, is generally fearful of developing close relationships with others, and is triggered by the smell of barbecue or burning meat, the sight of blood or smoke, and the sound of screaming. Throughout his experiences as a soldier, he recalled that his eyes remained closed because he could not tolerate what was happening. However, I was surprised to learn that as a Marine rifleman, he had actually failed to complete nighttime range exercises in boot camp and the School of Infantry because he was too frightened to conduct the course of fire. The Marine described that when he held his rifle on the nighttime shoots, he would experience tunnel vision and it was though he could not hear anything. The day he was found shaking on the range, he remembers firing five to ten rounds before experiencing a self-described black-out.

As the case unfolded, the Marine and his command had a burning question: can he chop to the MEU in a few weeks? The obvious answer was no. The complicated answer that I gave his Commander was more similar to, “Give me eight weeks and I will have him ready for deployment. In the meantime, I recommend pulling his weapons card.” The eight week timeframe could not be accommodated. Telling this Marine that he could not deploy stunk. He is incredibly bright, talented, charismatic, and best of all-desperate to be a Marine. I would have his full commitment.

With the Corporal, the Corpsman, and the patient, we started with a group deep breathing exercise. Once the PFC mastered this, I sent him back to work to practice four times daily and prepared him for imaginal exposure at our next session. The final goal would be successful completion of in vivo exposure to nighttime range exercises and his related triggers.

The fire team diligently reassembled in my office the next week. The Marine reported significant improvement in his sleep when using the deep breathing technique. His Corporal asked him four times daily to complete his homework. In that second session, I asked him to recount memories of that horrific night with as much detail as possible. We paused several times to describe the sights, smells, and sounds; he was visibly anxious and refused to close his eyes or turn off the lights to simulate portions of the scenario. After the first recitation of the story, he appeared fatigued and timid. I instructed him to continue re-telling his story and imagining the events when he was in a safe, secure place; he took his own initiative to lay in bed nightly doing imaginal exposure coupled with deep breathing.

Before our third session, the patient attended a raid package with his company, unbeknownst to me. His Corporal was there, keeping him grounded to the task and reassuring him. When he returned to therapy, he pleaded with me to be found fit for deployment. I could not agree just yet. We carried on with imaginal exposure during this session; he was able to close his eyes and tell the story twice- in English and French- one of his native languages. Around this time, I spoke with the Battalion Commander about our treatment and alternatives to the MEU deployment. I should have expected what came next.

The Marine returned to his fourth session without his Corporal or his Corpsman; they had already chopped to the MEU. He reported that on his own accord, he attended a barbecue around strangers and smoke without having to leave. He also held his own barbecue and grilled the meat. Soon thereafter, the Battalion Sergeant Major called my cell phone, “Ma’am, I heard you want to take our Marine to a nighttime shoot. When can I make that happen for you?” Heck yeah. The Sergeant Major of a primarily infantry battalion is trying to pull strings for a female wizard? Count me in.

A few weeks later, the Marine was in high spirits, enjoying his new company more than expected, sleeping an easy eight hours per night, and exposing himself to his triggers without incident. I remained cautious in the event he was just telling me what I needed to hear. He was thrilled at the possibility of going on a nighttime shoot; within two weeks, we had a spot on a Copeland assault package with recruits. As the sun set, we perched on some bleachers and talked through the scenario one more time. He was calm. The Marine performed the obstacle course with his rifle in hand, under a cloud of

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Not Always Fair Winds and Following Seas? Self-directed Violence on U.S. Navy Aircraft Carriers

CDR Arlene Saitzyk, NAMI Psychologist and LTJG Eric Vorm (Aerospace Experimental Psychologist)

Research has shown that over the past decade the suicide rate among military personnel has notably increased, in some cases surpassing the civilian rate. Because military shipboard personnel may represent a unique subset of this population, we might expect differences in the prevalence of self-directed violence (SDV) between this group and other active duty personnel, signifying a distinct operational impact. Last year, the Carrier Psychologists joined to examine SDV among personnel assigned or deployed to U.S. Navy aircraft carriers to see whether occurrences varied by descriptors commonly identified in the literature (e.g., age, gender, marital status, pay grade). We were also interested in looking at characteristics specific to life aboard aircraft carriers, such as deployment cycle stage and occupational specialty, in order to better understand issues particular to this population.

The project, approved by the Portsmouth Naval Hospital IRB, utilized data from May 2012 to October 2013 gathered by the Carrier Psychologists stationed on board seven of the 11 carriers. We looked at all forms of SDV, unlike the DoDSER, which only examines suicides and attempts. That is, in our study, SDV included suicide, suicidal ideation with and without intent, suicidal preparatory behaviors (attempts with and without harm), and non-suicidal self-directed violence. Relative Risk (R/R) measures were used by comparing SDV occurrences by department and rate to the Enlisted (and Officer) Distribution and Verification Report which provides current manning of the ship. $R/R=1$ means there is no difference in risk between groups. $R/R>1$ means an event is more likely to occur, and $R/R<1$ means an event is less likely to occur.

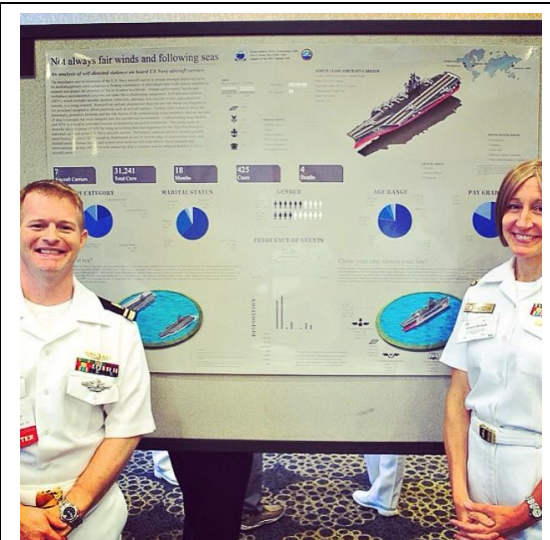
Our findings for the demographic variables of age, gender, and pay grade were similar to DoDSER results, though marital status differed between the two. In both groups (i.e., across the military as reported in DoDSER and in our study), young (< 25 years old), lower pay grade (E1-E4), and male service members were more likely to experience SDV. However, whereas the DoDSER showed married individuals with a greater number of suicides and attempts, in our study, “never married” were at higher risk.

Second, we looked at characteristics specific to life aboard aircraft carriers. Would there be more “trouble at sea?” No - individuals underway were almost 20% less likely to experience SDV than those in port. While we know shipboard duty is grueling, it also provides good routine, camaraderie, and other forms of support, which may not be as robust while on shore. As well, access to other stressors and to alcohol may heighten risk while in port.

Finally, what about that saying, “Choose your rate, choose your fate?” Which departments and rates were most at risk? Service members in Deck and Reactor were over three times as likely to experience SDV than other departments (controlling for size), with R/R's of 3.90 and 3.02, respectively. In third place was Air Department (not Air Wing) with R/R of 1.71, and then Supply with R/R of 1.35. The rates particularly at risk were Culinary Specialist (R/R=2.83), Airman (R/R=2.8), Aviation Ordnanceman (R/R=1.5), and Aviation Boatswain Mate (R/R=1.4). We believe these are some of the hardest working departments and individuals (think “five and dimes” for Reactor, long shifts in the heat for Air Department, and hard work/little glory for Deck Department). These are preliminary findings. Further investigation is needed to determine what organizational, environmental, and interpersonal factors may contribute to this increased risk, in order to best design intervention strategies. Ψ

We would like to recognize and thank the following for their dedication and support:

CVN-65: USS Enterprise - LCDR Amar Purewal, LT Vahe Sarkissian
 CVN-68: USS Nimitz - Dr. Angel Lugo-Steidel, LT Lara Myers
 CVN-69: USS Eisenhower – CAPT Aaron Werbel, LT Anthony Kraemer
 CVN-70: USS Carl Vinson - LCDR Robert Lippy, LCDR David Loomis
 CVN-71: USS Roosevelt - LCDR Matthew Rariden
 CVN-72: USS Lincoln – Dr. Gregory Asgaard, LT Anna Sparks
 CVN-73: USS Washington – LCDR Michael Domery, LT Nausheen Momen
 CVN-74: USS Stennis – CDR (ret) Mark Heim, LT David Elkins
 CVN-75: USS Truman – LT Christofer Ecklund, LT Stephanie Long
 CVN-76: USS Reagan – Dr. Charmaine Lowe, LT Jennifer Thompson
 CVN-77: USS Bush – LCDR Lisseth Calvio, LT Jeremiah Ford



LTJG Vorm and CDR Saitzyk presenting their research at the 2014 Aerospace Medical Association Annual Meeting.

For more on military suicide rates, start with this website:

<http://www.suicideoutreach.org/Docs/Reports/DoD%20Quarterly%20Suicide%20Report%20CY2013%20Q4.pdf>

Embedded Psychology with the 31st Marine Expeditionary Unit

LT Luis Concepcion, OSCAR Psychologist, 3rd Marine Division

Work as a Navy psychologist is never dull and there are assignments which can challenge and fulfill you professionally. One such challenge was meeting the mission on a MEU. Officially I was the first greenside psychologist assigned to the 31st Marine Expeditionary Unit (MEU), a Marine Air-Ground Task Force specializing in amphibious operations in the Asia-Pacific region, for their Spring 2014 float to South Korea. Unofficially, I was the *only* psychologist for the 31st MEU and the Amphibious Readiness Group (ARG), including the crews, blueside and greenside, of the USS Bonhomme Richard (BHR), the USS Ashland, and the USS Denver, roughly totaling six-thousand active duty service members. The BHR CO, XO, and Senior Medical Officer did not have advance notice of my presence; they heard that the greenside brought along a psychologist the first day of the float. To increase my “opportunities” to problem solve, no office space had been designated, there was no available Psych Tech onboard, I had no computer access, and no process for referring patients had been established. The first few days were full of “opportunities.”

My TAD Orders arrived approximately six weeks before the float, and during that time I quickly initiated a mental health screening process for patients from MEU commands not usually covered under the Okinawa 3rd Marine Division's Operational Stress Control and Readiness (OSCAR) team—my permanent duty station. Preventing greenside medical evacuations during the deployment for mental health reasons was my goal. The Command Logistics Battalion (CLB), Aviation Combat Element (ACE), and Battalion Landing Team (BLT) also needed predeployment evaluations so within days of reporting to the MEU, calls and emails streamed in for evaluations of a variety of mental health issues, many of them chronic and serious. Although no process had previously existed for referring patients, my presence became known quickly, and the work flowed-in. Unfortunately, due to the short-fused nature of my orders, I was unable to screen everyone, but those deemed unable to deploy were left off of the deployment in order to receive appropriate treatment or administrative action.

Cooperation of the various commands was the key to mission success. Getting “buy in” from the various commands took time and evolved throughout the deployment. At times Marine commands argued in favor of deploying the Marines that they were particularly concerned about in order to “keep an eye on them,” instead of sending them to the rear or to a medical command. Marines have a tendency to want to take care of their own and could be hesitant to leave Marines behind who needed help. Fortunately I was able to work with the commanders and was successful in preventing Marines who needed treatment from deploying.

I grew more conscious of the importance of developing close relationships with the various commands with each passing day. While onboard the BHR I conducted two Professional Military Education (PME) Trainings with the Chief's Mess (about fifty total) and about twenty USMC Staff NCOs. Cooperation from middle management was never wholehearted, despite the strong support of the MEU Commanding Officer. Ultimately, frank face-to-face meetings with the various command staffs and enlisted leadership proved invaluable in building their trust in my skills, my judgment, and my value as a force multiplier.

The results of the mental health screenings and evaluations were apparent within the first week of the float. Most of the service members with significant problems were those who were not screened prior to the deployment, reinforcing the success and importance of the screening initiative. Meetings with the blueside Commanding Officer, Executive



Enjoying the view off the coast of South Korea, with Dr. Kelly Peng, Fleet Surgical Team-7, and Dr. Gabe Valerio, Battalion Landing Team 3/5 Medical Officer. LT Concepcion is pictured far right.

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Deployment Lessons Learned

LCDR Mathew Rariden, Carrier Psychologist, USS Theodore Roosevelt (CVN 71)



Transitioning from an MTF to a deployed environment for the first time is an exciting but anxiety-provoking endeavor, filled with challenges and potential pitfalls. You may be the only mental health provider; you will be out of the country in an unfamiliar place; there will be challenges to provision of care; you will need excellent officer skills; and you will need to take care of yourself. Since completing a deployment to Afghanistan, I thought it might be useful to share some lessons learned with a focus on uncertainty/ambiguity, credibility as a professional, and burnout/compassion fatigue.

When I arrived in Afghanistan, the Regimental Combat Team that had been there for one year had just left, so the new Regimental Combat Team had no existing system for the delivery of mental health care (aka: Combat & Operational Stress Control). While my predecessor had done a phenomenal job, all of his hard work, corporate knowledge and dedication went home with him and we found ourselves in a “reinvent the wheel” situation. Consequently, business was initially slow as the commands were unfamiliar with what we had to offer. During that time I had to figure out a way to create a system that worked for the Medical Battalion that the psychologist technically belonged to, the

Regimental Combat Team where I was assigned, and the Marine Corps units spread throughout the southern portion of Helmand Province. However, Navy psychologists have handled this dilemma previously in novel ways and these challenges were overcome through some ingenuity and much consultation. Just remember, when you deploy, you will run into varying degrees of ambiguity, but you will figure out what to do and in the process develop critical management and leadership skills; but don't forget to ask for help when you need to!

Credibility was another hurdle that had to be surmounted with senior USMC officers and enlisted personnel. Too many interactions predictably began with some dig about mental health providers (e.g., “I don't really like you people.”). I was very conscious about such moments because I was all too aware that I was being felt out in some way. So, I made a decision to primarily handle such moments with humor (e.g., “Well, we don't really like you either ☺.”). A means had to be found to use these instances to increase credibility, rather than watch it erode in real time (e.g., noticeably get upset or offended as opposed to laughing, smiling, or telling a joke). I worked hard to see and be seen, to become part of the unit wherever I was. Ironically, the less they saw me primarily as a psychologist the more effective, individually and unit wide, I became. Success in the credibility department had been attained once everyone started calling me “Doc.”

Lastly, burnout is a real thing; compassion fatigue will follow if you don't take care of yourself. It is imperative that you develop social relationships on deployment and that you engage in continuous self-care activities (e.g., exercise, fun events, game night, near-beer and cigars, etc.). Such events should never be viewed as optional. They must be included in your daily and weekly schedule and exercise is a must (see Page 12)! Nonetheless, it is normal to be mentally exhausted by the end of the deployment and to be grateful to be surrounded once more by psychologists, psychiatrists, psychiatric nurse practitioners, LCSWs, LMFTs, and anyone who can speak mental health; how relieving it was to be among like-minded professionals.

In summary, be prepared to cope with highly ambiguous situations, to defend your credibility in an endearing way, and to guard against the ever present threat of burnout. Good luck! Ψ

Preventing burnout in Helmand Province. Exercise and social interactions are a must to successfully make it through a deployment.



Bravo Zulu Everyone!

Navy and Marine Corps Achievement Medal

LT Anthony Kraemer 

LT Stephanie Long 

LT Adrienne Manasco 

Navy and Marine Corps Commendation Medal

LT Lindsay Gleason 

LT Kristin Somar 

Joint Service Commendation Medal

LT Linda Havens 

Navy Pistol Qualification

LT Michelle Mahone (E)

LT Adrienne Manasco (S)

LT Jay Morrison (E)

LT Alexandra Perkins (E)

LT Claudia Rojas (E)

LTJG Aaron Weisbrod (E)



LTs Mahone and Perkins embarrass a bunch of Marines (seriously, they got yelled out when outshot by a couple of psychs...).

Navy Rifle Qualification

LT Adrienne Manasco (S)

LT Jay Morrison (M)

LT Claudia Rojas (E)

LTJG Aaron Weisbrod (S)

Marine Corps Martial Arts Program (MCMAP)

Tan Belt

LT Jesse Locke

WARFARE DEVICES

Surface Warfare Medical Department Officer

LT Christofer Ecklund 

LT Anthony Kraemer 

Fleet Marine Force Qualified Officer

LT Jesse Locke 

LT Adrienne Manasco 



LTs Manasco (left) and Locke on Camp Leatherneck, Afghanistan.

Congratulations to **LT Stephanie Long**, Naval Medical Center Portsmouth, Junior Medical Service Corps Officer of the Year 2013 and Junior Medical Service Corps Officer of the Quarter, First Quarter 2014!

Congratulations to **Dr. Amy Isaiah**, Branch Health Clinic Fort Worth, Civilian of the Quarter, Second Quarter 2014!



Publications and Presentations (bolded names are Navy Psychologists)

Kennedy, C. H. (2014). What's in a name? The controversy of being denoted The Wizard. *The Military Psychologist*, 29, 15. <http://www.apadivisions.org/division-19/publications/newsletters/military/2014/07/wizard.aspx>

Morgan, C.A., **Rabinowitz, Y.G.**, Leidy, R., Coric, V. (2014). Efficacy of combining interview techniques in detecting deception related to bio-threat issues. *Behavioral Sciences and the Law*, 32, 269-285.

Saitzyk, A.R. (2014, May). The doctor is in: aerospace clinical psychology. In P. Souvestre & J. Pickard (Chairs), *Clinical Aviation Medicine*. Symposium conducted at the 85th Annual Scientific Meeting of the Aerospace Medical Association, San Diego, CA.

Saitzyk, A.R., Vorm, E.S., & LaVan, J.T. (2014). Not always fair winds and following seas: An analysis of self-directed violence on board U.S. Navy aircraft carriers. Poster session presented at the 85th Annual Scientific Meeting of the Aerospace Medical Association, San Diego, CA.

Taylor, M.K., Laurent, H.K., Larson, G.E., Rauh, M.J., **Hiller Lauby, M.D.**, & Granger, D.A. (2014). Salivary nerve growth factor response to intense stress: Effect of sex and body mass index. *Psychoneuroendocrinology*, 43, 90-94.

Taylor, M.K., Larson, G.E., **Hiller Lauby, M.D.**, Padilla, G.A., Wilson, I., Schmied, E.A., McRoy, R., Morgan, C.A. III. (2014). Sex differences in cardiovascular and subjective stress reactions: Prospective evidence in a realistic military setting. *Stress*, 17, 70-78.

Navy Medicine Blogs

Collaborative Leadership and an Evolving Military by **LT Jay Morrison**

<http://navymedicine.navylive.dodlive.mil/archives/6483>

The Ballistic Missile of Behavioral Health Prevention by **LT John Knorek**

<http://navymedicine.navylive.dodlive.mil/archives/6428>

Preventing a Vicious Cycle by **CAPT Scott Johnston**

<http://navymedicine.navylive.dodlive.mil/archives/6378>

Corpsmen: Meeting the Medical Needs of Marine Embassy Security Guards by **CDR Carrie Kennedy**

<http://navymedicine.navylive.dodlive.mil/archives/6345>

Psychological Health Research Leads to Readiness and Resilience by **CAPT Scott Johnston**

<http://navymedicine.navylive.dodlive.mil/archives/6189>

Understanding Traumatic Brain Injury by **LT Ana Soper**

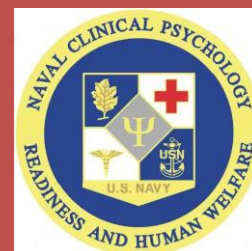
<http://navymedicine.navylive.dodlive.mil/archives/6096>

Navy Neuropsychology and TBI in Afghanistan by **LT Ana Soper**

<http://navymedicine.navylive.dodlive.mil/archives/6063>

It's that time of year already!

Start getting your nominations for Navy Junior, Senior and Civilian Psychologists of the Year together.



Message from the Specialty Leader, Continued from Page 1

issues effecting all our professions. Current initiatives include looking at compliance with Clinical Practice Guidelines related to PTSD and Major Depressive Disorder. Thank you to the many of you who have been involved in chart reviews. I recently sent results out on the Listserve displaying how we are doing. Other PHAB initiatives include the review of stigmatizing policies, workload recommendations, and MOUs relating to peripheral mental health staff being hired across the enterprise. If you have any initiatives that you think the PHAB should address, please contact me.

The Naval Center for Combat & Operational Stress Control (NCCOSC) is hosting a symposium on 25 September that provides 6 free CEUs. Attendance can be in person at NMCSO or virtually via DCO. You can find more information and register at www.med.navy.mil/sites/nmcsd/nccosc. NCCOSC just published its most recent version of Research Quarterly that catches you up on all the newest literature in an easy to digest format. Read online or download at www.med.navy.mil/sites/nmcsd/nccosc/healthProfessionalsV2/researchQuarterly/Documents/Summer2014ResearchQuarterly.pdf.

NCCOSC also compiled preliminary results from the Navy Psychology Needs Assessment Survey. Thank you to all of you who completed the survey. These results indicated that our community has experienced low levels of trauma and low rates of PTSD. Stress levels were average, although 20% experienced significant stress. Job and life satisfaction were high. Regarding burnout, our community endorsed high levels of emotional exhaustion, but average levels of depersonalization and personal achievement. Work/family conflict was high with work more negatively impacting family than vice versa. Retention rates have increased since the last survey. I will send out all the preliminary results on the Listserve. If you are not on the Navy Psychology Listserve, please email me and I will add you.

Last, but certainly not least, it is wonderful to welcome CDR Shannon Johnson onboard as our Assistant Specialty Leader. We are planning many exciting new initiatives to help support this stellar community. If you have any questions, ideas or would like to help volunteer, please contact us. As always, thank you for your dedication and compassion as you work tirelessly every day executing the Navy's mission and helping improve the lives and psychological well-being of our Sailors and Marines. Ψ

Very Respectfully,

CAPT Scott Johnston

CDR Shannon Johnson, Navy
Psychology Assistant Specialty Leader

Navy Psychologists annual
meeting at Navy Day 2014
during the APA Convention.



Embedded Psychology, Continued from Page 5

Officer, and Command Master Chief were frequent, and I was spending my time in meetings, conferring with patients' commands, and on paperwork. My inner battery was fading, luckily with just a few weeks left before homeport. Nevertheless, where previously there had been no established structure for this type of mental health engagement, I was now fully embedded in the commands, extremely busy with frequent consultations, and familiar with all the players I needed to know to get things done.

Despite the workload I was able to qualify for the Fleet Marine Force (FMF) pin, spend a few days in the field (Pohang, South Korea), and experience a large amphibious assault exercise. The deployment was unforgettable and I walked away with new knowledge and skills, and with one overarching insight. The experiment answered the question, "What is the most important job of a forward deployed mental health provider?" Screening! Ψ

Next Issue: TNP Deployment Edition

As CAPT Johnston noted earlier in this issue, while the number of deployments overall may be decreasing, deploying remains an important aspect of life for Navy Psychologists. And since the Co-Editor will be deployed during preparation of the next issue...for the next issue of TNP, we'll be focusing on deploying.

Our goals are to share experiences, reminisce, distill wisdom and have a little fun. Toward that end, we'll be polling you about your experiences on deployments soon. For those of you who have deployed, this will be an opportunity to reflect on your experiences and share some of your hard-earned wisdom with all of us. For those of you who have not, this will be an opportunity to get some gouge. We'll be sending something out in the next couple of months.

**Join APA Division 19,
Society for Military
Psychology!**

<http://www.apadivisions.org/division-19/membership/index.aspx>

**Navy Psychologists,
join the Navy Clinical
Psychology Facebook
group:**

<https://www.facebook.com/groups/115996937866/>

**NEWEST ABPP Board
Certified Psychologists!**

**LT Lindsay Gleason
LT Ana Soper**

****LT Soper is the FIRST active duty
Navy Psychologist to be boarded in
Clinical Neuropsychology!**

Case Study: Continued from Page 3

artificial smoke, simulated mortar and gunfire, and obnoxiously loud Drill Instructors. He executed flawlessly. Later he admitted that when the smoke began to fill the air, he felt slightly nervous. When he heard the loudspeakers and the Drill Instructors, he repeatedly told himself, "I can do this, I got this."

As we loaded up and returned to the cars, he stopped and remarked that no one had ever helped him before. He had no idea that treatment was available for his psychological distress and figured he would live with it forever. Given his excellent compliance with the treatment plan, observable improvement in mood and anxiety symptoms, and his performance on the range, I cleared him for full duty. Six weeks after his company chopped, he was granted his wish to deploy with the MEU. Perhaps the best reward of all was when he said, "I can't wait to tell my mom."

Footnote: Since treatment, the Marine put on Lance Corporal and completed work-up phases for the MEU. He has now been underway for one month, feeling saltier than ever. Ψ



LT Clark gets indoctrinated into 1st Marine Division.



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Mentorship Parting Shot: GET/STAY IN SHAPE!

CDR Carrie H. Kennedy

In the same vein as practice what you preach, get out and PT! You'll feel better; you'll look better; and your IQ will jump up at least 20 points... What??

Alright – let's start with you'll feel better...literally. Recent studies have found cardiovascular exercise to be as effective as antidepressant medications... You are all psychologists and already know about the increases in self-confidence, energy, stress resilience and the decreases in a variety of health risk factors, all due to the simple act of regular exercise. What else is there to say?

You'll look better. Got a couple of bumps under that uniform? Want to lose a couple of pounds or just restructure your physique? Go to the nearest base gym, take advantage of the personal training services and work out a plan to take care of yourself and your own personal fitness goals. Anything from losing 5 pounds to gaining 20 pull-ups is fair game. (Oh yeah and LT Michelle Mahone, Navy psychology fellow at Portsmouth is a Personal Trainer and she will hook you up! Look her up on Facebook or the global...).

Raise your IQ 20 points ☺ Give an enlisted Marine the choice between an out of shape, but clinically amazing psychologist, and an in shape clinically terrible psychologist and who will they choose to see? Yep – the in shape but subpar provider. Let's face it, in a lot of military populations, physical fitness equates to psychological health, leadership abilities and professional competency. I know most of you have had some variant of this conversation with a commander: "Sir, I am calling to let you know that we need to put Sgt Drinks-Until-He-Blacks-Out-Every-Night into a residential treatment program." "Wizard, what are you talking about, he has a 300 PFT!" Assumptions about physically fit people run deep in the military, so use it to your advantage! Your military patients and staff will assume you are amazing.

PT doesn't need to be excruciating, boring or even too terribly time intensive. Navy Psychologists are known for thinking outside of the box – there's no reason you can't apply this to PT. Check out some of the many options below. Everyone is obviously happy, gorgeous and brilliant! Ψ



LCDR Saacha Hake snowboarding in Mammoth.

LT Anthony Kraemer changes a tire...



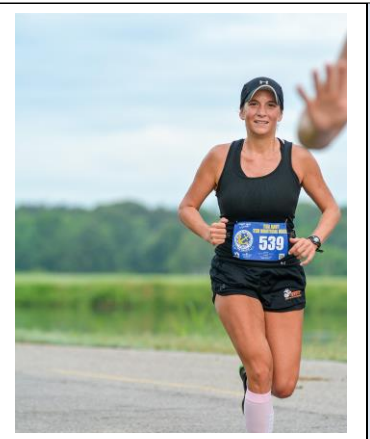
LT Chris Heath doing a little light lifting.



LT Anthony Smithson playing goalie in Greenville, NC.



LT Katie Pierce indoctrinating her 3-year old daughter into regular and fun exercise in Rota, Spain.



LT Sandra Pahl takes the woman's 3rd place overall in the Nautical 10-miler!

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.