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DIVISION 19 OFFICERS

President        Eric Surface E: esurface@alpssols.com
President-Elect  Maurice Sipos E: Maurice.sipos@gmail.com
Past President   Stephen Bowles E: lifewellbeing@gmail.com
Secretary        Angela Legner E: angelalegner@gmail.com
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Members-at-Large Paul Bartone E: bartonep@gmail.com
                          Bruce Crow E: bruce.crow@gmail.com
                          Scott Johnston E: scott.johnston@socom.mil
Representative to APA Council Carrie Kennedy E: carriehillkennedy@gmail.com
                                          Becky Blais E: rbblais@gmail.com

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vacant
Stephen Bowles E: lifewellbeing@gmail.com
Kristin Saboe E: Kristin.saboe@gmail.com
Maurice Sipos E: Maurice.sipos@gmail.com
Armando Estrada E: military.psychology.journal@gmail.com
Shawna Chee E: shawnna.m.chee.mil@mail.mil
Hannah Tyler E: div19conventionchair@gmail.com
Paul Gade E: paulgade39@gmail.com
Erin Moezer-Whittle E: erinmoesz@gmail.com
Carl Castro E: cacastro@usc.edu
Kate McGraw E: Kate.mcgraw.div19@gmail.com
Alex Wind E: alexander.p.wind.civ@mail.mil
Jeremy Jinkerson E: div19list@gmail.com
Ethan Bannar E: ethan.bannar@du.edu
Scott Edwards E: scott.a.edwards60.mil@mail.mil
Neil Shortland E: Neil_Shortland@uml.edu
Freddy Paniagua E: faguapan@aol.com
vacant

THE MILITARY PSYCHOLOGIST: The Military Psychologist is the official newsletter of the Society for Military Psychology, Division 19 of the American Psychological Association. The Military Psychologist provides news, reports, and noncommercial information that serves to (1) advance the science and practice of psychology within military organizations; (2) foster professional development of psychologists and other professionals interested in the psychological study of the military through education, research, and training; and (3) support efforts to disseminate and apply scientific knowledge and state of the art advances in areas relevant to military psychology. The Military Psychologist is published three times per year: Spring (submission deadline January 20), Summer (submission deadline May 20), and Fall (submission deadline September 20). Instructions for Contributors appear on the back cover.

EDITORIAL BOARD OF THE MILITARY PSYCHOLOGIST

Editor in Chief        Shawwna Chee shawnna.m.chee.mil@mail.mil
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Editor’s Column
Shawnna Chee

The Summer 2020 Issue of The Military Psychologist (TMP) Newsletter was written in a very different time than that of the previous Spring 2020 issue. Given the global COVID-19 pandemic, the Editors of TMP Newsletter agreed to devote the entire Summer 2020 Issue to a "Special COVID-19 Issue" with articles from the membership highlighting how the practice and delivery of military psychology was modified to accommodate the stay at home orders, social distancing, virtual tele-health opportunities and anything else relevant to Military Psychology and the Division 19 Membership. With this request, the Membership did not disappoint. We received more articles than any previous issue, all with information from how the healthcare delivery, training programs, clinic operations and person lives were impacted.

Take time to read through each article as they discuss how COVID-19 can impact our mental health, how behavioral health clinics responded to meet the needs of not only patients but staff members, how traditional in-person programs became telehealth focused and how psychology training platforms were altered to meet the recommendations for infection control. There are articles devoted to how behavioral healthcare technicians were utilized in an Air Force clinic as well as how the Navy deployed its mental health care teams aboard both of its hospital ships as a rapid response mission to assist our civilian counterparts during the height of the pandemic at home. We even received updates from our international colleagues in the United Kingdom on how they altered their psychological services.

We also hear from our Division 19 President, Eric Surface, as he helps guide and direct us through these changing times as well as sets the records straight regarding the Division’s Zero-Tolerance Policy for discrimination and racism. We are all encouraged to speak up when we see racism and discrimination within our clinical practice and in our personal lives as well.

This issue also includes updates from relevant Committees, as well as renewed emphasis on budget goals and fiscal responsibility, a shift toward utilizing virtual platforms for communications and how the student affairs committee is supporting training opportunities. These changes are timely and valuable to push the Division into a new, sustainable future.

Lastly, please note that all newsletters will be in a virtual, online format, with archived issues available online at https://www.militarypsych.org/the-military-psychologist.html. Until the Fall Issue, may you be well, stay clean and ever be surrounded by “blue skies”!
June 5, 2020

Dear Society Members,

When I wrote my first presidential column back in January—which seems like an eternity ago—a global pandemic was not in my thoughts for 2020, and I could not have imagined how COVID-19 would reshape our world and our Division’s plans for 2020. Many of our plans for 2020 are adapting or have changed. As you know, one of the strengths of the military community is its ability to adapt and face challenges. I thank all our Division 19 volunteers who are working to pivot our programming and activities in response to the global pandemic. My presidential theme for 2020 is Stronger Together. This seems even more appropriate as we look back on the first half of 2020 and look forward to the remainder of the year.

I know COVID-19 has impacted many of our members and their families directly. Some of our members have been working on the frontlines, such as Shawna Chee, and I appreciate the work she and others are doing to fight this pandemic and/or care for the ill and our medical personnel and other first responders. Others are working to prepare their organizations and personnel to operate in the COVID-19 world. Others are applying their expertise to COVID-19 response in other ways. Most are continuing to show up and do their jobs, serving Military members, Veterans and their families. Many are working from home. Some are without work right now. All of you have been in my thoughts daily. I appreciate the efforts of all our members.

Division 19 members understand what it means to volunteer, to act, and to put themselves in harm’s way for others when called. I want to recognize our members who have and are continuing to step up during the COVID-19 pandemic. There are two ways in which we plan to do this.

- We want to highlight and promote the work Division 19 members have been doing in response to the global pandemic, as well as highlight resources developed by Division 19 members that can be helpful in military and non-military contexts. To do this, we need to know what you are doing. Please reach out to our communications committee (jeremy.jinkerson@gmail.com) or me (esurface@alpssols.com) directly and let us know.

- Last year, Past President Stephen Bowles started issuing Division 19 Presidential Citations. Given the COVID-19 pandemic, I’m explicitly asking for nominations of Division 19 members who have gone above and beyond providing response, service and/or expertise during the COVID-19 pandemic. We will be taking nominations throughout the year. Nominations for service to Division 19 and military psychology are also accepted. Please contact our Secretary Angela Legner (angelalegner@gmail.com) or me if you would like to nominate someone.

We are Stronger Together.

I want to provide you with few updates on the Division’s activities since my last president’s column:

- 62nd International Military Testing Association (IMTA) Conference. Division 19 had planned to host IMTA in Raleigh, NC, in October 2020. Given the COVID-19 pandemic and the uncertainty of hosting a conference in October, the IMTA Management Board decided to postpone the 62nd Annual Conference until 25-28 October 2021. The conference will still take place in Raleigh and will retain the same format with workshops, meetings and the opening reception on 25 October, the main conference 26-28 October, and optional excursions on 29 October. Division 19 is still hosting and committed to making IMTA a success.

- APA Convention. APA 2020 is now virtual. The Division recently received guidance from APA on the parameters for a virtual convention. Hannah Tyler, our program chair, and the committee are working diligently to adapt our program and activities to the constraints of the virtual format. Information will be distributed to members as available. I look forward to seeing you during Division 19’s virtual events.

- Military Psychology Foundation. Establishing a foundation for military psychology is one of my top priorities. COVID-19 delayed the launch of the taskforce but work has started under the leadership of Scott Johnston.

- Midyear Meeting. In February, the EXCOM met at HumRRO’s offices in Alexandria, Va. I appreciate all the efforts of our officers and committee chairs in making the meeting a success. We accomplished all
Even though COVID-19 has forced some changes and delayed some activities, we will continue to move forward with the Division’s business, while promoting the interests of our members.

On a final note, as I was writing this column, the murder of George Floyd happened and protests all over the world followed. I share the feelings of outrage and heartbreak expressed over the senseless killings of George Floyd, Ahmaud Arbery, Breonna Taylor, and many other Black men and women before them. I also share the hopefulness inspired by a broad base of Americans coming together to condemn these horrific acts and exercise their First Amendment rights to protest for change. George Floyd’s death is a tipping point. We must all say, “NO MORE”, and we must all act.

Over the past week, I devoted many hours to listening, learning and reflecting about race and privilege and about systemic racism, discrimination, marginalization, and brutality against People of Color in America. I have participated in conversations with other leaders. I do not have any answers. I cannot tell others how to feel or to think. But, as a leader, I can set an example. I can listen. I can learn, reflect and change. I can be an ally. I can create a safe space for People of Color. I can provide resources. I can encourage listening and dialogue. I can support and encourage change. I can set a zero-tolerance policy for racism. I can speak up against racism and discrimination when I see it. I can give people grace as we discuss these issues and their solutions. I encourage each of you to think about what you can do.

Currently, our Diversity Committee is working on an official statement from Division 19 and on developing resources for our members, including a podcast series. More information will follow from the committee. My hope is that our Division will be a beacon, as it always has been, heralding the values of respect, service, integrity, and unity.

I know the past weeks and months have been emotionally and physically exhausting for many of you. Please engage in self-care as you perform your duties and take care of others. I wish you all the best!

We are Stronger Together!

Best Regards,

Eric A. Surface, PhD
2020 President
Fellow
Society for Military Psychology (Division 19, APA)
Active duty service members are no strangers to isolation, decreased contact with friends and family, frequent schedule changes, numerous moves, long work hours, and deployments (with limited access to resources). This makes us flexible. We know how to live and work with uncertainty. When it comes to a global pandemic there are added levels of anxiety due to fears of the virus itself and the potential for unplanned deployment while on shore duty. There are significant changes currently underway in telehealth practices, and this could have a lasting impact on medicine and mental health in the military.

**Challenges in Mental Health Due to COVID-19**

Under normal circumstances, behavioral health is a fluid field with a large spectrum in how patients experience symptoms and respond to treatment. As a result of COVID-19, a number of new and unique stressors have been added to the typical behavioral health concerns, including social distancing, isolation, unemployment and financial difficulties, and fear of direct morbidity and mortality from the virus itself (including the loss of loved ones). In addition, there are now tremendous challenges in delivering high quality patient care, providing adequate access to care, and administering early intervention for patients experiencing behavioral health crises.

During times of national emergencies, significant administrative confusion in the healthcare system may be created for both patients and providers which can severely impair communication/scheduling, treatment, and aftercare plans. This type of confusion is a well-known phenomenon in battle for years, called the “fog of war” (Lieberman, 2005), and can be mitigated through preparation by preemptively planning and remaining flexible throughout the crisis (Cronin, 2008). Similarly, in the battle and “fog of war” of COVID-19, the medical and mental health community has needed to respond and adjust accordingly to ever-changing guidelines. This includes developing formal plans and guidelines, preparing for potential worsening of the crisis, and maintaining flexibility and adaptability for deviation from normal “standard practices,” in order to meet the evolving and dynamic needs of mental health patients during exigent circumstances. To best facilitate this process, discussion and guidance on how to address these factors are needed, and the intention of this document is to add to this effort.

**Use of Telehealth and Impact on Patient Care**

Virtual visits (including mental health visits) were already offered before the pandemic hit as an option to patients at the parent command of one of our clinics (Naval Branch Health Clinic Kings Bay) via the Navy Care app. Our clinic began virtual visits in response to COVID-19 to maintain mission readiness. A full range of options (virtual visits with both audio and live video capability, telephone consultations, and face-to-face visits), and technical troubleshooting, were implemented to address the complex needs of the situation. As with any change, there were hurdles to overcome, and these included the need for patients to create a virtual profile and obtain internet connectivity.

Patients have demonstrated a wide range of responses to the use of virtual telehealth. While many patients were open to virtual visits, a minority of patients demonstrated a preference for in-person visits. Patients that prefer in-person visits noted the importance of being in the therapeutic environment as a safe space outside of their home and work settings to discuss their stressors. Consultations by telephone and new precautions for in-person sessions (i.e., required cloth face coverings) have anecdotally negatively impacted providers’ ability to observe and engage in non-verbal communications. In contrast, many patients using the virtual platform have reported satisfaction with treatment, as it seems to support a more goal-oriented and solution-oriented focus. Some have noted they enjoy experiencing therapy from the comfort of their homes. Seeing a patient in his or her home during a virtual visit can bring a new level of openness and humanity to the treatment session that is difficult to develop in the traditional clinic setting. The potential for these benefits (increased solution-focused therapy and a deeper clinical connection) via telehealth is a potential future area of study.

The DoD’s Psychological Health Center of Excellence (PHCoE) recent article on “Going Virtual” (Pruitt, 2020) addresses safety planning and safety concerns given the use of new virtual platforms. Dr. Pruitt suggests the elements of an effective plan include the desire for the plan to work and accessibility of said plan. He also notes that simplicity and flexibility are vital. Finally, ownership and timing of implementation of the plan allow for the most efficient strategy. Additional suggestions for virtually engaging in safety planning include using the patient’s chain of command and command chaplain for support, accessing the Sailor Assistance and Intercept for Life (SAIL)
program, and engaging the patient’s primary supports (i.e., spouse, parent, and best friend).

**Psychological Impact of COVID-19 on Patients**

A review of the psychological impact of quarantine (Brooks et al., 2020) outlines several stressors during pandemics: duration, fear of infection, frustration and boredom, inadequate supplies, inaccurate information, finances, and stigma associated with being infected. Boredom has been the primary concern for those in our clinic, and the leading secondary concerns have been frustration related to a lack of information and decreased finances. Inability to engage in previously utilized self-care strategies (i.e., visiting the gym or beach, engaging in social gatherings) serves to further perpetuate frustration. Pandemic information that is incorrect or incomplete (from unreliable sources) increases individuals’ stress and anxiety.

Providers must be mindful of the current situation’s impact on self-harm risk, given the added stressors of quarantine, fear of illness, and lack of interpersonal interactions (Brooks et al., 2020). The current situation could increase depressive symptoms, and might also decrease social phobic symptoms (Brooks et al., 2020). Clinical considerations relevant for all patients include evaluating the impact of such events as social isolation and social distancing, quarantine, the loss of major milestones (e.g., promotions, graduations, weddings, funerals), the transition to telework (which decreases interpersonal interactions), and the fear of infection among self and others. Creating new ways to engage in these life-changing events could potentially mitigate the negative impact. People across the country and the world have found ways to virtually participate in community (using a number of easily-accessed commercial products) which has reportedly decreased feelings of loneliness and sadness and provided connection that would otherwise have been lost (Brooks et al., 2020).

**Impact of COVID-19 on Providers**

Burnout, or compassion fatigue is a psychological syndrome consisting of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment that can be experienced by those who do “people work,” (Maslach, 2016). Compassion fatigue can emerge among behavioral health providers rapidly during normal circumstances if not addressed, and the many stressors of the pandemic can increase the potential for burnout. This highlights the importance of awareness, psychoeducation, and concern for our colleagues, shipmates, and loved ones to provide support and intervention during this uncertain period.

How can we take care of ourselves and our colleagues before burnout/compassion fatigue sets in? Several strategies are recommended for mental health providers (Norcross, 2000) beginning with the need to be able to recognize signs and implications of burnout. Providers must be equipped to recognize and address vicarious trauma swiftly and should preemptively develop problem-solving strategies and self-awareness. Providers must practice what they preach, such as being willing to disconnect from work to engage in healthy meals and time with family. The ability to emphasize the humanity in delivering psychological care and the emotional impact it can have on providers optimizes empathy and provides invaluable support. Providers should be encouraged to seek their own personal therapy if feasible. Finally, providers should be encouraged to seek to diversify treatment modalities and be reminded of the rewards of working in the field.

A review of literature from the 2003 severe acute respiratory syndrome (SARS) outbreak provides us some context for the impact of a global pandemic on healthcare workers. A study of healthcare staff who were quarantined after treating patients during the 2003 SARS outbreak reported they began to feel “increased exhaustion, detachment from others, anxiety when dealing with febrile patients, irritability, insomnia, poor concentration, and indecisiveness, deteriorating work performance, and reluctance to work and consideration of resignation” during their mandatory quarantine following contact with SARS patients (as cited in Brooks et al., 2020). SARS research suggests that people continue to engage in avoidance behaviors after the end of an outbreak (as cited in Brooks et al., 2020). To help mitigate the psychological effects of quarantine, literature suggests that individuals gain information from reliable sources to prevent increased anxiety. It is also crucial that reducing boredom and improving communication helps people feel empowered to prevent idle time to persevere on the pandemic. As a result of their jobs, healthcare workers require special notice, and must be provided with empathy and added support in order to prevent burnout and loneliness. Finally, recognizing altruism, doing good for others, rather than focusing on oneself can help alleviate isolation and anxiety (Brooks et al., 2020).

Finally, it is recommended that behavioral health providers engage in self-care. First, meditation techniques serve to strengthen the ability to cope in a healthy manner. Second, assertiveness techniques (such as respectfully saying “no” when needed) create appropriate boundaries allowing for the provider to cope in a manner that is most aligned with his or her needs. Third, cognitive restructuring (making our own use of treatment tools such as thought records) challenge dysfunctional thoughts and allow for a more realistic reframe. Lastly, exercise provides a healthy outlet for the discharge of excess negative emotions and energy. Of note, there is additionally the need for healthy relationships with colleagues and peers (those on whom we can rely for suggestions and guidance). Performing “check-up from the neck up” visits with our own staff offers an outlet to share resources with our entire clinic team to minimize mental health symptoms and loneliness.

**Conclusion**

It feels as though we are transitioning into a new normal as healthcare providers, and further work is undoubtedly ahead regarding the future of virtual psychological healthcare. As members of the military services, we are no strangers to change and uncertainty and we “don’t give up the ship,” (Touba, 2013). We are learning to adapt to new means of care delivery during COVID-19. Much like providing therapy in a deployed or operational setting, we
are assisting patients with thinking outside of the box in terms of treatment and self-care. Whether it be telephonic, virtual, or in-person visits, providers are given new opportunities to contribute and model positive behavior change for our patients and remain steadfast in meeting patients’ individual treatment goals. There’s little uncertainty that in the coming weeks and months we will continue to evolve our practice patterns and develop a catalog of lessons learned that we can employ to improve care.

The military is one team, one fight, all working together to support the mission and each other. All of us, including mental health providers, need to practice good self-care and regularly check-in with our colleagues in order to mitigate the risk of burnout. While the challenges of the COVID-19 era may be daunting, therein lies tremendous opportunities, including improving self-care, fostering healthier connections, and innovating process improvements. With the right perspective, motivation, and follow through, we have the potential to come through on the other side of this crisis stronger, wiser, and more effective than ever before.

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The material included in the present document has not been published and is not currently under consideration for publication elsewhere. For further information, please contact:

LT Ashley Shenberger-Hess: Ashley.m.shenbergerhess.mil@mail.mil

References available upon request

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**Madigan Fight with COVID-19:**
Department of Behavioral Health Response to the Pandemic

Marat V. Zanov, Kimberly Genkov, Douglas Taylor, Christina Hein, Bret Crittenden, & Kathryn Eklund

Madigan Army Medical Center

The first officially identified case of the 2019 Novel Coronavirus (COVID-19) in the United States happened to be in our home state. The announcement by Centers for Disease Control and Prevention (CDC) and Washington State Department of Health was made on January 21, 2020, and mere three months later the number of confirmed cases skyrocketed to 12,753 statewide¹ and 828,441 nationwide². With death rate statistics rising, comparisons to this being a war-like situation have been made by the media and various officials. On the front lines, the Madigan Army Medical Center (henceforth “MTF” or “Madigan”) valiantly faced this adversary. What follows is an overview of the Madigan Department of Behavioral Health (DBH) response, including the immediate steps taken, specific operational transitions of DBH subunits, general challenges encountered, and the resulting lessons learned along with a look to the future.


**Initial response**
Readiness is at the core of the Army mission, and it is the fundamental guiding principle for Madigan. It is probably fair to say that our entire Nation was under-prepared for such a pandemic as COVID-19. The transmission rate and it rapidly becoming a global problem unquestionably tested every organization’s disaster response plans. At that, guided by the priorities of safeguarding the wellbeing of our patients and staff, Madigan DBH took a series of timely steps in response to the rapidly deteriorating situation, readily reinforcing the hospital response efforts as well as smartly adapting its own operational capabilities in this fight.

The DBH provides direct support to the Madigan Emergency Operations center (EOC) to manage acute psychiatric needs during significant events (e.g., MASCAL). An important element of this response is attending to the behavioral health needs of the Madigan staff. While the pandemic did not necessitate the emergency operations plan activation, DBH stepped in to offer support to their healthcare teammates and colleagues. The hospital com-
mander and staff were given psychoeducational materials on self-care and provider wellness, so these could be distributed to subordinate units through the command communication channels. A special team of behavioral health professionals was then assembled to provide tactical support to the leadership. To buttress the resiliency of staff on the front lines, this team began working closely with the leadership and staff of nursing units who were directly treating COVID-19 patients. They then engaged with the Emergency Department (ED) and delivered psychoeducation and psychological first aid briefings to medical professionals on both the day and night shifts. In addition, the team was instrumental in establishing a support program aimed to create generous space for individual and group peer support.

Specific to its own operations, one of the first steps that DBH took was identifying and consequently preventively removing select staff from the physical footprint of its clinics. This was accomplished to minimize the risk of exposure to the virus by our most vulnerable employees. Among others, those with health conditions and jeopardized immune systems were encouraged to take leave or work from home. The next step was to virtualize as much of DBH operations as was possible. Given the nature of behavioral health work, this task was largely the function of having laptops, appropriate software, network connectivity, staff training, and development of virtual clinic infrastructure. However, full virtualization of behavioral health could not be anticipated because some operations had to remain face to face (F2F).

In addition to the inpatient psychiatric unit operations remaining intact (as described below), it was clear that some physical presence for outpatient behavioral health services was still necessary. Thus, DBH stood up the Madigan Behavioral Health Triage Clinic, which was housed within the MTF footprint and staffed with a limited number of active duty and civilian providers and support staff. The clinic’s intent was to assist in limiting the spread of COVID-19 while continuing to provide service members and their families with high quality, ethical, evidence-based behavioral health care. Its primary tasks included risk assessment and treatment planning upon patients’ discharge from a higher level of care (i.e., ED or inpatient facility), carrying out emergency command directed behavioral health evaluations, as well as providing services in situations constituting imminent risk to the patient or others.

Specific transitions

Inpatient psychiatry unit

Madigan Army Medical Center maintains the ability to expand its inpatient psychiatric unit capacity in support of AEROVAC / MEDEVAC (aero/medical evacuations) admissions, should the need arise. While this is a non-medical unit, all incoming patients require medical clearance prior to admission. During the pandemic, this medical clearance also included screening for the presence of COVID-19 symptoms as well as self-reported history of exposure to the virus. The screening was conducted in accordance with the specifically structured Madigan protocol. Due to the inherent limitations in this process, it is possible that some asymptomatic yet COVID-19 positive patients (i.e., ostensibly feeling well and not being aware of prior exposure) may have been admitted to the unit.

The initial stage response planning focused on the ability to maintain inpatient psychiatric bed capacity and patient care operations during a possible surge. To ensure that, outpatient psychiatric prescribers were identified as inpatient reserve staff, to be utilized on the unit in the event of illness or COVID-19 exposure by the primary staff. These individuals were placed on telework status and instructed to follow the CDC guidelines in order to limit their exposure to the virus. Due to an increase in psychiatric care utilization and the rapid reduction of bed capacity in the network facilities, Madigan inpatient psychiatric unit was now unable to maintain single occupancy rooms. As a result, nursing leadership devised a contingency plan for use of isolation rooms on the psychiatric unit to house medically non-compromised, COVID-19 positive behavioral health patients. Should the medical floors become overwhelmed with medical patients and unable to maintain psychiatric patients, the above plan would be put in action. Otherwise, patients would remain hospitalized on the medical floor with a safety attendant for patient observation provided by the inpatient psychiatric team.

In preparation for the necessity to manage COVID-19 positive behavioral health patients and maintain ability to support other treatment areas during staff shortages, the inpatient psychiatric staff were provided with training on use of personal protective equipment (PPE). Eventually, the use of surgical masks when unable to maintain six feet of distance between individuals (i.e., either staff or patients) was enforced. However, the outpatient clinics and many other areas of the hospital were already enforcing use of PPE when engaged in patient care. This timing disparity in deployment of PPE measures among MTF subunits resulted in uncertainty among the staff as well as contributed to their general sense of organization’s insufficient preparation. Another observation was that the social distancing efforts were difficult to enforce on the inpatient unit to its physically tight quarters. Lastly, because the ED behavioral health staff at increased risk (i.e., those with personal or family health concerns) were approved to complete telephonic mental health assessment of acute psychiatric patients presenting to the ED the rate of admissions to the inpatient unit increased. It is thought that the loss of F2F assessment advantage directly correlated with the decrease in accuracy of assessment, ultimately leading to the false positives of admissions.

Outpatient psychiatry services

Several challenges unique to psychiatric prescribing were identified during this time. In the resulting virtual operations, a prescriber was now compelled to balance such safety issues as risk of COVID-19 exposure for the patient and self versus risk to the patient’s wellbeing due to insufficient monitoring of their physiological response to medications. Many psychiatric drugs can increase blood pressure, heighten the risk of metabolic syndrome, and introduce other undesirable and at times quite dangerous consequences. Therefore, taking vital signs to monitor patient’s response to medications is im-
important. Likewise, lab studies are a crucial element of safe psychiatric prescribing. Thus, the first prominent challenge for DBH prescriber was obtaining lab data and vital signs readings at the time when many facilities within Madigan provided limited range of services. Moreover, losing the F2F aspect of psychiatric evaluation reduced the amount of helpful information that a prescriber would typically derive from observation. In fact, several prescribers openly expressed their discomfort not only due to the necessity of utilizing new to them technology (i.e., virtual behavioral health, VBH) as well as lack of lab and vital signs data, but also due to the loss of the information normally ascertained from a F2F interaction with a patient. The latter challenge extended to clinics whose primary mode of intervention is a group format. In light of safety considerations, discomfort with VBH, and insufficient administrative support, all group appointments were initially suspended. Nevertheless, some positive observations were also made during this time. For instance, it has been noted that transition to VBH obviated the logistical challenges inherent to booking patients with providers who are assigned to other clinics (e.g., utilizing an alternate should the patient’s primary prescriber not be available). Furthermore, the flexibility of VBH format was found to be more preferred by some patients who did not have to significantly alter their daily routines (e.g., arrange for childcare, etc.), and therefore generally positively affecting access to care.

**Child and Family Behavioral Health**

At Madigan, the Child and Family Behavioral Health lane consists of the Family Advocacy Program (FAP) and Child and Family Behavioral Health Services (CAFBHS) clinic. FAP maintained a limited physical footprint with a rotating staff schedule in order to provide coverage for walk-ins, select sensitive assessments, and support such functions as incident determination committees, which continued throughout the pandemic. Precautions were maintained to limit exposure, and FAP providers with supervisor oversight collaboratively determined which assessments absolutely had to be conducted in person.

CAFBHS mission is unique to the Army and is structured around consultative and collaborative care model of behavioral health service delivery for children and families served by MTFs.\(^3\) The pandemic vividly highlighted some of the challenges unique to this population. For instance, a number of military spouses may have lost their jobs or otherwise experienced a reduction in income, causing a ripple effect stress to the entire family. In addition, given that most schools have closed, and many service members had to stay home, families were compelled to remain homebound, often housed in a limited amount of space. These and many other challenges tested the resilience the military families and raised the risk for behavioral health problems\(^3\). Much like the rest of DBH, CAFBHS operations became virtualized, with normal operating procedures, such as staff supervision and accountability, clinic administrative management, staff meetings (to include tracking of high risk patients), triage of patients, and case management continuing via virtual platforms and email.

Integral part of CAFBHS, the School Behavioral Health program (SBH) staff ensured continued communication with the local school district to maintain uninterrupted availability of SBH services. They took part in the virtual triage and prevention activities as well as individual educational plan meetings with the corresponding schools. It was observed that the biggest challenge inherent to this process was the loss of direct observation of patients in their milieu (i.e., the school), though it was not prohibitive of otherwise care delivery.

**Graduate Medical Education**

Madigan behavioral health training programs include the Psychology Internship, Psychology Residency, and Social Work Internship. During the outbreak, patients’ and trainees’ wellbeing had to be balanced with the respective program’s training requirements and the broader needs of the Army. One significant area of focus was fulfilling the need for trainees’ direct contact hours. As DBH transitioned to virtual operations, it was recognized that trainees would not have immediate access to F2F supervision. This was particularly problematic in cases where clinical emergency may arise. For that reason, trainees’ engagement in VBH was not prioritized. Instead, opportunities for obtaining F2F clinical hours were leveraged through their participation in the Behavioral Health Triage Clinic as well as the inpatient psychiatric unit. Each of these undertakings also provided extraordinary training opportunities in supervised management of higher acuity cases. The second major task was arranging for appropriate supervision. While tele-supervision is acceptable by the American Psychological Association, the practical transition to videoconference-based supervision called for navigating both the technical as well as procedural (e.g. HIPAA compliance) issues. Additionally, preemptive planning of potential future directions for modifying the training programs (e.g., shortening rotations) had to be also considered, in case of prolonged operational curtailment.

**General challenges**

In addition to the specific transitions outlined above, across all services within DBH a number of common challenges were identified. Some were overcome quickly, others took more time to address, and others still have yet to be fully resolved. We believe that there is value in itemizing these issues below because they may not only serve as excellent learning opportunities for us but also represent experiential variables to be accounted for in future response planning at multiple organizational levels.

To begin with, there were a number of administrative challenges. For example, in the first days of transition, a lot of telework agreements had to be rapidly signed, but many employees already left the physical footprint of the hospital to minimize COVID-19 exposure. This presented a logistical dilemma. Specific to patient care, some appointments weren’t cancelled in time or patients had not

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received or noticed the corresponding notifications and therefore still showed up to the closed clinics. Moreover, the greetings on clinics’ front desk phones were very difficult to change in order to notify callers of the current status of operations. Conversely, the automated appointment reminders sent to patients scheduled for VBH still instructed patients to present to the clinic. No straightforward option of changing these reminders was available. Due to system capabilities, staff could not check the clinics’ front desk phone voice messages from any other location than the front desk itself, compelling sending a staff member back to the clinic from home to triage voicemails.

Other technology-specific challenges were also observed. For instance, the organization did not have enough laptops for immediate use, and it was difficult to quickly acquire the necessary hardware in the first weeks. There were far too few official cell phones, forcing admin staff to use personal devices for scheduling/rescheduling appointments, etc., knowing full well that “**67” does not protect privacy as it can be “cracked” with a freely available app. The network connectivity was inconsistent, and many VPN issues have been reported, resulting in interruptions of VBH services. More than a few staff members’ common access cards were unexplainably locked out, forcing them to come to the hospital for a reset and thereby increasing the risk of interpersonal exposure to COVID-19.

The Adobe Connect software for VBH was difficult to sign up for, and it did not function well for several weeks. In addition, patients and providers reported difficulties with its navigation and user interface. While there were alternatives to Adobe Connect programs (i.e., Google Duo, Facetime, and Skype), for several weeks there was some confusion due to conflicting guidance on their utilization. It was also discovered that not all patients had sufficient network bandwidth at home to support VBH sessions.

In terms of the human aspect, initially there was observed a significant increase in anxiety among the staff because many employees were fearful of contracting the virus, yet they still came to work before the official guidance on telework came out. The timing for annual credentialing and performance evaluations couldn’t be worse as both came due at once, placing additional burden on the already overworked supervisors. Many staff members were not tech savvy enough to quickly master VBH, and the task of remotely teaching fell on the shoulders of supervisors who themselves were overburdened with other newly-emerged responsibilities. There was initial confusion regarding the various platforms used for VTC calls/meetings as well as multifold increase in email traffic in the first weeks was nothing short of overwhelming. In many cases, supervisors had to spend sizable part of their days on managing their subordinates’ anxiety. Nevertheless, as soon as the immediate transitional issues were addressed, DBH began making concerted efforts to establish greater stability for staff and leaders by maintaining a steadier routine, encouraging interpersonal connectivity, decreasing the number of meetings, mass emails, and minimizing procedural changes (e.g., coding and documentation changes for clinical encounters). This proved to be incredibly helpful and appreciated.

Lessons learned and a look forward

The operational changes described above highlighted the fact that a sizable segment of behavioral health services can be virtualized. In fact, the outcomes of recent survey sent out by the DBH to its key personnel indicated that greater utilization of VBH is desirable. Ideally, of course, the technology should be truly portable, reliable, and adaptable to mission requirements. For instance, it should be possible for the clinic voicemails to be checked remotely, all staff would have laptops, and providers should have access to and be well trained on VBH equipment and processes. To heighten readiness, annual refresher training on VBH should be implemented into the routine training curriculum for all staff. A well-devised contingency plan for rapid transition to virtual operations should also be in place. In fact, Madigan DBH now has standard operating procedures on both the Behavioral Health Triage Clinic as well as VBH operations. It helps that the collaborative deployment of both was already tested in battle. As of the time of this writing the fight continues, but we believe that this experience not only strengthened our resilience and resolve but also broadened our capabilities to better serve our beneficiaries in the future.

Corresponding author: Marat V. Zanov
marat.v.zanov.civ@mail.mil, 253-968-6055

Attestation: this material has not been published or is under consideration for publication elsewhere.
A Web-Based Alternative to the Behavioral Health Data Portal

Adam C. Freed

3rd Infantry Brigade Combat Team, 25th Infantry Division

Since its fielding, the behavioral health data portal (BHDP) has been a regular aspect of Army behavioral health care. Per the order that indicated its implementation, BHDP is a “web-based application that collects clinically relevant, standardized Behavioral Health (BH) data directly from patients (self-report) …to better inform initial clinical assessments and track treatment outcomes. Patient BH data is stored in real-time and BH providers can view the survey results immediately.” Despite being a web-based platform, BHDP requires access to a government network connection; thus, assessments on the BHDP cannot be completed from a home computer or smartphone. Patients typically complete the BHDP by arriving early for their scheduled appointment and completing the assessment measures on a computer kiosk in the clinic waiting room. These results are available to the provider in real time. For the provider, BHDP’s utility is not just from its ability to administer BH screening tools and surveys, but also to organize patient lists, produce histograms that can be shared with patients, and generate outcome data (Brown, 2013). BHDP is not solely useful for clinical care and psychotherapy; the use of screening measures is required for most administrative evaluations in the Army. In this way, BHDP has become an essential part of Army operations.

The rapid pivot to virtual behavioral health encounters in response to COVID-19 made the standard practice of BHDP infeasible. Patients could not come into the clinic to complete BHDP due to risks of exposure, and BHDP could not be accessed from outside the clinic. Without BHDP, current safety protocols, clinical assessments, and administrative BH support to units would suffer. To prevent this, a method was devised to obtain critical information that was normally obtained via BHDP. This was accomplished by creating a fillable web-based form that was accessible on any device with an internet browser. The purpose of this endeavor was to continue capturing BH-related patient self-report data, inform clinical assessments, and provide clinical outcome metrics to assist providers in delivering higher-quality care.

Design and Implementation

Using Google’s G Suite, a fillable survey form was created that featured screening tools normally found on BHDP – the Columbia Suicide Severity Rating Scale (C-SSRS), the Patient Health Questionnaire (PHQ9), the Generalized Anxiety Disorder 7 Item Scale (GAD7), and the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). Screening questionnaires for sexual assault history and traumatic brain injury also were added, since these are required for most administrative evaluations. Screening questions assessed during evaluations for positions of significant trust and authority also were added to this fillable form. Using skip logic, a logical flow was created to guide patients through the correct screening measures depending on their selected reason for appointment.

A fillable form stores completed data in a linked spreadsheet that organizes and scores the measures. As a safeguard to ensure patient privacy, the only identifying information that this spreadsheet captures is a timestamp that indicates completion. This timestamp is the only information that can used to identify a patient’s responses, designed deliberately to mitigate the potential risks of collecting patient data and information through this web-based platform. Once completed, a separate “dashboard” consolidates the completed assessment scores so they can be discussed with the patient in session, just like BHDP could be utilized. If risk items are endorsed, this dashboard indicates that additional evaluation is warranted, which allows for inquiry in real time during the session.

In terms of workflow, at the start of a virtual session, the BH provider sends a unique survey link to their patient via text message or email. The provider can request that the patient verbally indicates when they are complete, which helps associate the correct responses in the spreadsheet. At the end of this session, the dashboard can be exported directly into the patient’s electronic medical record the same way that BHDP scores are often reported.
Access to the virtual screening tool was provided to behavioral health officers (BHO) assigned to the 25th Infantry Division, as well as BHOs within two other major commands. A user’s manual was distributed to providers with instructions on how to set up personal copies of the survey form and spreadsheet within Google Drive, and follow up “tech checks” were completed to ensure BHOs could utilize the form, spreadsheet, and dashboard prior to use with patients. Informal feedback indicated that this tool provided equivalent assessment information to the core BHDP capabilities, allowing for improved patient care and maintaining outcomes assessment.

Conclusion
BHDP as a system provides several benefits that support high quality behavioral health care, but network requirements made BHDP inaccessible during COVID-19. The need to change and adapt lead to the development of a web-based alternative that used easily accessible means and methods that could be accessed by patients anywhere, using a personal device of their preference. While novel, this project was intended to be a temporary solution, and will not be replacing BHDP for a unit or clinic. However, BHDPs inaccessibility during COVID-19 and the relative ease of an alternative method to obtain patient data prompted reflection on BHDP as a system. The alternative method was streamlined for critical information, and can also be accessed from a patient’s smart phone or personal computer. This is in-line with typical telehealth practice, which involves minimal “waiting room” time for completing assessments.

GEN Omar Bradley (1967) wrote, “If we continue to develop our technology without wisdom or prudence, our servant may prove to be our executioner.” The COVID-19 pandemic illustrates how quickly a well-established system can be rendered ineffective due to the shift to seeing patients remotely. Clinics have become reliant on the BHDP screening tools for many workflow requirements and assessments. In the future, an update to BHDP that allows for remote access or incorporating its functions into MHS Genesis via a secure messaging system may maximize the ability to obtain self-report data securely, in turn reducing barriers for patients.

Author Note
The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the U.S. Government, the Department of Defense, or the Department of the Army.

Correspondence regarding this article should be addressed to Adam C. Freed, adam.c.freed2.mil@mail.mil

References available upon request.

Air Force Mental Health Technician Support During COVID-19

Senior Master Sgt. Amanda Frampton

Office of the Command Surgeon, Air Education and Training Command

During this time of uncertainty, it may feel like we’re being pulled in 500 different directions and asked to continue with our “normal” operations as much as possible and support other demands that are being levied upon us. Our Mental Health Technicians (4Cs or 4-Charlies) in Air Education and Training Command are redefining what “normal” is during the pandemic, while still delivering quality patient care in various different methods and providing Disaster Mental Health (DMH) services when requested.

To maintain appropriate social distancing and to protect the health of our staff and patients, the majority of patient care has transitioned to telehealth. The 4Cs are still conducting triages, assessments, and individual and group counseling sessions, and have rapidly adapted to utilization of a supported video-teleconference platform. This allows for patients to still receive care during COVID-19 and reduces the risk of contracting the virus. The technicians are completing the assessments over the phone or video platform, having a provider complete the safety assessment and determine future needs. Along with most other career fields, the technicians have altered their duty schedules and shifts to best support the delivery of care and minimize the number of staff in the clinic at one time.

In addition to clinical care, 4Cs and Mental Health Providers across AETC have partnered with other support agencies to include Chaplains, Military Family Life Consultants (MFLCs) and installation Violence Prevention Integrators (VPIs) to provide DMH outreach to units on managing COVID-19 stress and anxiety. At Goodfellow Air Force Base, Texas, technicians created distraction
bags filled with crossword puzzles, word searches, jigsaw puzzles and other goodies to distribute to quarantined students to help pass the time while under movement restrictions. Technicians assigned to Wilford Hall Ambulatory Surgical Center at Lackland Air Force Base, are also heavily involved with DMH visits to the Basic Trainee population. Technician teams conduct daily walkabouts with the quarantined trainees to check on their mental well-being. In addition to these daily checks, technicians continue educating trainees on how to recognize symptoms of depression and anxiety by teaching deep breathing and meditation techniques to help effectively manage stress.

Mental Health technicians are not only taking on additional roles within their flights but supporting the needs of the groups and wings they are assigned to. Many are performing in roles such as infection control monitors, securing appropriate donning/doffing of personal protective equipment. They also assist in screening stations by interviewing patients for symptoms of COVID-19, and confirming use of the proper level of protection prior to entering the facility or when additional testing is required. Our flights at Air Education and Training Command have put together newsletters and informational tips which leaders may distribute to their units on multiple avenues regarding how to curb boredom, managing stress and anxiety, remaining socially connected while maintaining social distancing, and when to seek additional help.

It’s a very difficult time right now and changes are rapidly occurring as soon as they are communicated. Nevertheless, our Mental Health technicians are embracing changes while continuing to serve our populations with high quality patient care in a safe environment.

**Author Note**

Correspondence concerning this article should be addressed to Amanda Frampton, amanda.frampton@us.af.mil

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**Training in Evidence Based Psychotherapies in the Wake of COVID-19: An Examination of Online Training**

Maegan M. Paxton Willing, Sybil Mallonee, Gim M. Reo, Jennifer M. Phillips, Danielle L. Carrier & David S. Riggs

Uniformed Services University of the Health Sciences, 4301 Jones Bridge Rd., Bethesda, MD 20814

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The Departments of Defense (DoD) and Veterans’ Affairs (VA) emphasize the use of evidence-based psychotherapies (EBPs) for the treatment of mental health disorders. Currently, many providers are experiencing a decrease in patient load providing greater opportunity to receive training in these treatment modalities. Multi-day in-person workshops have been used extensively in the VA and DoD to train providers in EBPs; however, due to restrictions related to the current COVID-19 crisis, in-person training is not feasible.

Online training has become an established alternative to in-person training because it has the ability to disseminate information widely, is relatively cost-effective (Harned et al., 2014; Weingardt, 2004), and allows training to continue during quarantine. Synchronous (e.g., ‘live,’ as opposed to pre-recorded) training offers an alternative method of traditional online training through virtual classrooms or teleconferencing learning environments.

The interactive nature of synchronous training environments (e.g., Zoom, Second Life) offers a number of potential benefits over asynchronous models, particularly in its ability to enhance learner engagement by mimicking characteristics of in-person training. For example, synchronous workshops offer the learner an opportunity to feel as though they are part of a group of learners and allow for the inclusion of role-playing exercises as typically occurs during in-person workshops. Additionally, synchronous environments may provide learning benefits by increasing key factors including visual cues, active communication, and emotional expression in the online environment. One such way is through the opportunity for learners to ask and receive answers to questions in real time as they arise during the training.

To our knowledge, only one previous study has examined synchronous online training of EBP protocols and reported initial support for the effectiveness of this type of training platform for EBPs (Mallonee et al., 2018). However, given the relatively small number of workshops examined and the preliminary nature of the synchronous workshops in the earlier report, further analysis is warranted to support the utility of this approach to training EBPs. This need has been amplified by COVID-19-precipitated restrictions on in-person gatherings and the move to online platforms for a variety of clinical and training activities. These changes have emphasized the lack of information regarding online training op-
tions that are both acceptable and effective for training military psychologists. Using program evaluation data from multiple years of EBP workshops conducted by the Center for Deployment Psychology (CDP), the present study aimed to compare in-person and online synchronous training to assess the effectiveness and satisfaction of online training for the dissemination of EBPs.

Method

Participants

Participants were behavioral health providers who attended online or in-person workshops in EBPs conducted by the CDP. Program evaluation assessments were not completed by all attendees ($N = 2,611$). At in-person workshops, 805 participants completed pre-training evaluations and 727 completed post-training evaluations; for online workshops, 382 completed pre-training evaluations and 623 completed post-training evaluations. Consistent with CDP’s established program evaluation procedures, personally identifying information and demographic information were not collected to ensure anonymity of responses.

Procedure

EBP workshops were advertised in a variety of ways, including, but not limited to, online postings on CDP’s website and distribution of information through electronic mailing lists compiled by CDP. Interested learners self-selected into either in-person or online training.

Data were collected by CDP as part of standard program evaluation activities. All enrolled learners were provided the opportunity to voluntarily complete anonymous pre-training and post-training program evaluation surveys using the online data collection platform, SurveyMonkey. All participants were informed the provided information would be used to determine the effectiveness of the workshops and assist in improving them in the future. Participation in the program evaluation assessment was not monetarily compensated; however, the participants were given the opportunity to acquire continuing education credits (discipline dependent) for participating in the EBP workshops.

Data from CDP workshops held between January 2016 and December 2017 were analyzed for the present paper. This included 26 in-person EBP workshops and 68 online EBP workshops. CDP trainers provided EBP workshops for Cognitive Behavior Therapy for Depression (CBT-D), CBT for Insomnia (CBT-I), Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE), and CBT for Suicide Prevention (CBT-SP). In-person workshops were conducted by one or two trainers and online workshops were conducted by two trainers, with all trainers conducting both in-person and online workshops. Both in-person and online training modalities included didactic presentations, video-recorded EBP case examples, small group discussions, and role-playing exercises to practice techniques.

Measures

CDP faculty developed program evaluation surveys to ensure alignment with the objectives and content of the workshops. The pre-training survey consisted of an EBP-specific knowledge measure that was repeated at the post-training assessment. The post-training assessment also included items to assess participants’ self-reported readiness to utilize EBP techniques before and after receiving the training as well as satisfaction with the workshop experience. Presenter ratings and additional workshop feedback were assessed but not analyzed in the present study.

Knowledge questionnaires

Knowledge questionnaires were developed specific to the content of each workshop and consisted of 15 multiple choice questions. Scores on this measure represent the percent of correct answers. Each knowledge questionnaire demonstrated acceptable levels of internal consistency: CBT-D (Cronbach alpha = .81), CBT-I (alpha = .74), CPT (alpha = .76), PE (alpha = .84), and CBT-SP (alpha = .84).

Perceived readiness and satisfaction

Perceived readiness for executing EBP techniques was measured using a 5-point Likert scale (1 = not at all, 2 = minimally, 3 = moderately, 4 = mostly, 5 = completely) in response to “How prepared were/are you to use [EBP] with your patients?”. Overall satisfaction was measured using a single item (“Please rate your overall level of satisfaction with the [EBP] training”) with a 5-point Likert scale (1 = not at all satisfied, 2 = slightly satisfied, 3 = somewhat satisfied, 4 = mostly satisfied, 5 = very satisfied). For both items, EBP was replaced by the name of the specific protocol.

Training Satisfaction Rating Scale

The Training Satisfaction Rating Scale (TSRS; Holgado Tello et al., 2006) measures a participant’s satisfaction with different elements of a training program. The TSRS is a 12-item scale using a 5-point response format (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). Items on the TSRS assess whether the training objectives and content were met, if the methodology and training context were appropriate, and if participants were satisfied overall with the usefulness of the training. In the present study, the TSRS was highly internally consistent (alpha = .98).

Data Analysis

Because surveys were anonymous, pre- and post-training surveys could not be matched. Therefore, surveys were treated as independent observations in all analyses. Knowledge gains and change in readiness were assessed using independent-subjects t-tests to examine pre-training equivalence and post-training significance using SPSS 24.0. Mann-Whitney U tests were used to examine participant satisfaction and the TSRS, as these data were found to violate the assumption of normality. A 20% equiva-
Pre-training knowledge scores were equivalent between the groups (online $M = 43.14$; in-person $M = 41.96$; 90% CI [-0.98, 3.35]; Table 1). Regardless of modality, knowledge scores after the training were significantly higher than pre-training ($t[2067.27] = -33.04$, $p < .001$; pre-training: $M = 42.31$, $SD = 18.22$; post-training: $M = 69.69$, $SD = 19.48$). However, on the post-training assessments participants in the online workshops ($M = 71.791$, $SD = 18.77$) had significantly higher knowledge scores than those attending in-person workshops ($M = 67.79$, $SD = 19.93$; $t[1056.46] = 3.36$, $p < .01$).

Pre-training readiness scores were not equivalent (online: $M = 2.22$, $SD = 1.13$; in-person: $M = 2.56$, $SD = 1.26$), with in-person participants having significantly higher scores ($t[1176.78] = -4.89$, $p < .001$). In-person participants ($M = 4.08$, $SD = 0.72$) continued to indicate significantly higher perceived readiness than online participants ($M = 3.93$, $SD = 0.67$; $t[1185] = -3.91$, $p < .001$), at post-training. However, the change in perceived readiness scores for online participants ($M = 1.71$, $SD = 0.94$) was significantly greater than that of in-person participants ($M = 1.53$, $SD = 1.02$; $t[1172.61] = 3.16$, $p < .01$), suggesting participants in the online program increased their sense of readiness more than those in the in-person workshops.

Initial Mann-Whitney U tests of the satisfaction data showed a non-significant difference between in-person and online workshops; therefore, equivalence testing was used to further examine the groups. Participants were equally satisfied with the training they received, with a difference in median of 0 (90% CI: 0-0). The width of the confidence interval is zero due to the discrete nature of the data and the large proportion of respondents who were completely satisfied (68.0% of online and 71.3% of in-person respondents).

The TSRS (Holgado, et al., 2006) assessed usefulness of the training, satisfaction with the teaching methods, and objectives met. There were no group differences for usefulness of training received (online $Mdn = 15.00$; in-person $Mdn = 15.00$, $U = 169,745.50$, $p = .56$) or objectives met (online $Mdn = 15.00$; in-person $Mdn = 15.00$, $U = 165,298.50$, $p = .13$). However, participants in the in-person group ($Mdn = 29.50$) were significantly more satisfied with the teaching methods than were those who attended the online workshops ($Mdn = 28.00$, $U = 154,351.50$, $p < .01$). Further analysis of the individual items comprising the subscale revealed a significant difference for only one item (“The training enabled me to share professional experiences with colleagues”) with in-person learners reporting greater satisfaction ($Mdn = 5.00$) than online learners ($Mdn = 4.00$, $U = 213,304.00$, $p < .001$).

Discussion

Participation in EBP workshops increased learner knowledge of the protocols and perceived readiness to use the protocols in both in-person and online training modalities. Notably, online learners demonstrated significantly higher post-training knowledge scores and greater increase in perceived readiness compared to participants in the in-person workshops. Though these differences were small compared to the overall effects of attending a workshop, they suggest that the unique qualities of synchronous online learning platforms may provide an increased benefit to some learners.

The present data do not offer the opportunity to determine why learning might have been enhanced in the online workshops; however, a few possibilities have been identified by our trainers. The interactive, online setting is novel to many of the participants which may enhance attention to and engagement with the material. Also, participants in the online workshops have the ability to ask questions via a monitored chat box, which gives learners the opportunity to have questions answered as they arise without interrupting the flow of the workshop for others while allowing other learners to view the answers to these questions. It also is possible that individuals feel more comfortable asking questions in an online chat box than having to raise their hand and speak in an in-person setting. Future research will need to examine aspects of the online synchronous learning environment that enhance learning.

Both online and in-person groups indicated high satisfaction with the workshops. Generally, there were no differences in satisfaction with the training; however, in-person learners were slightly more satisfied with the teaching methods than online learners. This difference was driven by a single item indicating learners would benefit from increased opportunity to share experiences with colleagues. Notably, several participants in recent online workshops have inquired about the possibility of including online “networking” opportunities as part of, or in addition to, the workshops. It is possible that these requests reflect the same interest in sharing the experience with colleagues.

Recommendations for Online Trainings

These results provide assurance that the use of online EBP training during the COVID-19 crisis can be effective. The positive outcomes observed among learners attending online workshops suggest that the synchronous online training environment might be able to replicate critical components of effective in-person training, including cognitive, social, and teaching presence (Garrison et al., 2000). These are natural components of effective in-person training, but require effort to apply them to online training. However, aspects of synchronous online platforms may provide opportunities for their inclusion. For example, the use of avatars or video may increase one’s ability to project personal traits into the community, thus promoting a greater sense of social presence and community (Tu & McIsaac, 2002).
Tu & McIsaac (2002) highlight the importance of communication, interactivity, and social context as contributors to social presence in a learning environment. Online trainers should encourage learners to utilize tools such as chat boxes and voice to ask real-time questions, receive timely responses, and exchange information with instructors and other learners. As the level of interactivity also influences the sense of community through participating in a variety of task types (Tu & McIsaac, 2002), trainers should utilize facilitated break-out groups and role-playing exercises as well as more informal interactive small group discussions, much like what would happen during in-person training. These elements offer opportunities for informal exchange of information among learners that may facilitate the sense of community.

Summary and Future Directions

The present study utilized program evaluation data from a large sample of providers to compare the outcomes associated with in-person and online training modalities and indicated they were quite similar. Although the use of an ongoing training program precluded random assignment, pre-training knowledge scores were equivalent for participants in online and in-person workshops suggesting the groups were comparable. The use of equivalence testing to examine non-significant differences strengthens our conclusion that there is no apparent learning decrement associated with the online workshops compared to the in-person workshops. Indeed, program evaluation data suggest that learning may actually be enhanced in the synchronous online workshops. These results provide support for online training and may increase trainee comfort in attending online workshops and conferences.

The present study capitalized on the availability of program evaluation data from an existing and ongoing training program. Although fortuitous, these data have some inherent limitations. As mentioned above, learners self-selected which workshop to attend, possibly influencing their satisfaction with the training. Additionally, trainees’ pre- and post-training assessments were not able to be linked requiring a between-subjects approach. Finally, trainees were asked to report their perceived readiness before and after receiving the training at the post-training assessment point. While this approach is consistent with evaluation methodology, responses may have been influenced by recall bias. Conclusions about the utility and limitations of synchronous online training of psychotherapy skills will be enhanced by randomized studies that evaluate learners’ comfort with technology and the training modality as well as modality preference to elucidate how such factors influence learning and training satisfaction.

These findings offer assurance to both participants and trainers that the move to online EBP workshops precipitated by COVID-19 is not likely to compromise their effectiveness or the learning experience. Furthermore, these results provide support for the utility of synchronous online training formats for workshops and conferences as we transition into the “new normal” following the COVID-19 crisis, a potentially important option when considering the need to train clinicians across large and dispersed care networks such as the DoD and VA.

References available upon request.

Table 1
Knowledge Score by Training Modality

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<tr>
<th>Training Modality</th>
<th>Pre-training</th>
<th>Post-training</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Overall</td>
<td>42.31</td>
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<tr>
<td>In-person</td>
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<td>17.57</td>
</tr>
<tr>
<td>Online</td>
<td>43.14</td>
<td>19.67</td>
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Note. Scores represent percent correct.

Author Note

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Correspondence: Maegan M. Paxton Willing, megan.paxton.ctr@usuhs.edu
Phone: (301) 295-3968
When I reported to Naval Medical Center Portsmouth (NMCP) for my psychology internship training year in August 2019 I never imagined nearly half of my training would be hijacked by a worldwide pandemic. The COVID-19 pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; Mayo Clinic, 2020) was declared a Public Health Emergency of International Concern in January 2020 (World Health Organization, 2020), a little over 4 months into my training year at NMCP. At the time, I had just completed my first rotation in neuropsychology and was excited to begin my second rotation in outpatient care. As the information about the virus began to spread, questions regarding the potential impact the virus could have on our operations began to circulate. It was at this time, the leadership of our program, under the guidance of CAPT Michael Franks and Dr. Mary Brinkmeyer, began to prepare us for potential change that may result from the health risk posed by the virus. After the virus was deemed a pandemic in March 2020, NMCP moved quickly to a posture of protecting staff while still fulfilling our mission, which included mobilizing the USNS Comfort to provide support to the hardest hit city in our nation, New York City. As the medical center began to initiate adjustments at every level of the hospital, the psychology internship program worked to define our place within the vortex of change.

Following national recommendations, NMCP command-initiated restrictions to staffing and in-person sessions beginning in March. This change could have been a dramatic interruption to the internship training program and the required hours for APA accreditation. However, the leadership within the Department of Mental Health (DMH), including the training directors and education program team, aggressively worked to ensure our instruction experienced as little interruption as possible. By leveraging many of the APA-approved changes for internship training programs (APA, 2020), the training team ensured my cohort continued to receive appropriate instruction, supervision, and patient contact hours. Changes included shifting to port and starboard teams, where interns and post-docs reported to the clinic on alternating days to limit in-person contact. When assigned to clinic duty, our physical presence served to provide staffing for acute patient needs and allow for direct supervisory contact if a serious concern arose during patient care. The remaining days relied on virtual access whereby we were expected to continue providing patient care, attend didactic and diversity trainings, and participate in supervision. Initially, the transition had a few bumps, primarily associated with technical challenges, but those were resolved and we rapidly shifted into a routine that allowed for continued productivity. It helped that mental health as a practice provides a unique opportunity for virtual care as much of the therapeutic work is completed by the patient, relying on the provider for direction and support “to help people learn to cope more effectively with life issues and mental health problems,” (APA, 2019).

Once the changes driven by the pandemic started to become reality, I began to worry how these shifts towards the “new normal” in operation might impact my career within the Navy. Being a newly minted Lieutenant, the impact on my chances for promotion were a legitimate concern. I worried that this potential interruption in my training year could result in delayed graduation from internship, ultimately making me harder to promote. I was also concerned that many of the changes happening within the hospital would leave junior officers like me underutilized as senior command struggled to define our new operational posture. However, my leadership encouraged me to view this ever-changing situation created by COVID-19 as an incredible opportunity for growth and development.

Through many conversations with my supervisors and leaders in DMH, the profound opportunity to adjust our position to incorporate virtual care became clear. COVID-19 has forced the military to quickly shift and embrace virtual options for patient care in order to adhere to precautions associated with COVID-19. As the pandemic has unfolded in the US, the overall impact on mental health has begun to manifest with people demonstrating increased distress due to the unique demands of social distancing and societal interference, including economic impacts. The pressure for increased mental health services at NMCP has reflected the demand in the nation as requests have accelerated and more severe symptom acuity has been observed. Despite the inherent concerns associated with operating and fulfilling my duties in the midst of a pandemic, I am grateful to have the opportunity to serve my country and grow as a naval officer under the leadership of NMCP.

In order to respond in an efficient and coherent manner, policy changes within the NMCP DMH were implemented primarily via a top down structure, with command initiated broad changes, including directives regarding personal spacing, personal protective equipment, and general work hours. DMH then took the initiative to provide specific recommendations and instruction for our area. Initially, there were challenges to ensure appropriate coverage while also adhering to legal requirements for civilian
employees and contractors. Under the leadership of the newly appointed department head, CDR J. Porter Evans, DMH management worked tirelessly to clarify expectations and provide support while teams shifted to the port and starboard sections. Email was used as the main means of communication as in-person meetings were no longer an option.

Supervision hours were a primary concern and the department ensured from the start of the transition that regular individual and group supervision were maintained via virtual communication. Throughout the COVID response, we continued to receive approximately 4 hours of scheduled supervision per week, with faculty supervisors consistently available by phone for emergent needs outside of scheduled supervision. When assigned to in-clinic operations, a supervisor was always on site and available to address potential patient concerns that may have arisen.

Within the training department, implementation of recommendations and instruction was quick and without conflict. Despite the rapid reorientation of our schedules and work expectations for the internship training program, leadership was also candid with the entire team, issuing emails with complete information regarding changes in posture as soon as the information was available. Leadership also worked to quell rumors while substantiating potential alternatives to the way we were currently doing things in order to prepare us for the changes. The shift to virtual health worked more seamlessly than expected. Patients responded well to the change and demonstrated good gains in treatment (as evidenced by decreased symptom acuity, stability at subclinical levels, and few critical reactions) despite the potential fears that virtual health would limit the effectiveness of treatment. Of note, specific treatment modalities (i.e., CBT) lent themselves to be more appropriate to be delivered over the phone as compared to protocol interventions when access to video conferencing systems were limited. While protocol treatments required adjustments to be made to ensure fidelity, most patients responded well to the necessary changes.

Of course, not everything was smooth sailing. Some services were eliminated out of necessity. The highest value service that was lost due to COVID-19 restrictions was psychotherapy groups, primarily due to the inability to adhere to distancing requirements. For some patients, groups were the foundation of their treatment plan and this loss undermined their therapeutic process. The use of virtual services for groups was limited as the service was not vetted prior to the initiation of the COVID-19 response. For some clinicians, the loss of groups resulted in increased patient contact to ensure safety and treatment progress. Within the training department, this shift was absorbed well without complaint as it ensured continued accrual of training hours. The training department also issued instruction for patient contact requirements, allowing patients with low acuity to be contacted on a biweekly or monthly basis. These changes helped the interns to maintain an appropriate case load while also preserving appropriate expectations for clinical hours.

Overall, the changes necessitated by COVID-19 have opened a trove of opportunities and adjustments that was unforeseen, but of potentially high value to moving NMCP patient care into the future. As a psychology intern, it has been a rare and exceptional experience to watch senior leadership embrace the challenge and work within the various levels of the hospital to ensure we meet the demands placed upon us by this pandemic. The potential created for leadership and innovation can yield a crop of high impact patient care that allows Navy Medicine to continue defining its place on the cutting edge of medicine. While challenging, answering the call made by the various changes outlined have created unique career opportunities to meet the needs of NMCP, the Navy, and the Nation.

References available upon request.

Author Note

The material included in the present document has not been published or is under consideration for publication elsewhere. For further information, please contact: LT Benjamin B. DeVore at benjamin.b.devore.mil@mail.mil.

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In March 2020, Public Health England (PHE, 2020) published guidelines for the UK that aimed to reduce the transmission rate of Covid19. These guidelines advised individuals to socially distance, work remotely, and refrain from non-essential travel. The Chief of the Defence Staff (CDS) General Sir Nick Carter and Permanent Secretary Sir Stephen Lovegrove advised that these exceptional measures be applied equally to Ministry of Defence (MoD) staff who were not part of the coronavirus response or other essential defence activity (Forces Net, 2020).

UK military installations aligned their working practices to the above guidance (British Army, 2020a) leading to a significant number of MoD personnel working remotely (Jones, 2020; Sabbagh, 2020). This included military mental healthcare professionals, who were instructed to see patients on a face-to-face basis only on the condition that they could not be contacted via other means and required risk assessment and acute care (Mental Health Headquarters conference, 2020). Like all aspects of military healthcare, the UK’s military clinical psychologists adapted to meet the psychological needs of military personnel and operational priorities.

**UK Defence Clinical Psychology and Covid19**

UK Defence retains over 100 psychologists. Comprising both uniformed and crown (civil) servants, these professionals work across clinical, research, and occupational (i.e. industrial/organisational) domains (McCauley & Breeze, 2019). Primarily located within the Defence Clinical Psychology Service (DCPS) and the Defence Medical Services, the MoD’s clinical psychologists are a significant cadre within the organisation. They operate across every national and international military Department of Community Mental Health (DCMH), in addition to the Defence Medical Rehabilitation Service (DMRC) and other healthcare specialty and/or military formations. The primary mission of the DCPS is to provide professional clinical care, consultation and research to support the UK Armed Forces (UKAF).

Operating within a secondary occupational military mental healthcare context, DCPS psychologists also support the provision of psychological services and/or resources in primary and tertiary healthcare settings. Working with military mental health peers (e.g. psychiatrists, psychiatric nurses, mental health social workers, mental health therapists), they fill clinical lead roles within teams, national-lead positions within clinical specialties, subject-matter expert duties across services, and consultant advisory functions within medical leadership contexts. Their duties include the provision of assessments, diagnoses, treatments, consultations, training, leadership, supervision and research. Overseas operational deployments may be required, especially for uniformed clinical psychologists, whilst others may be eligible for taskings involving consultation and training visits to operational theatres.

**Clinical Psychology Service Delivery**

Covid19 has seen telemedicine becoming the new norm for military clinical psychology service delivery. Utilising various audio-visual information-technology platforms and applications, such as the MOD-funded ‘Attend Anywhere’ (Attend Anywhere, 2020), our clinical psychologists have adapted most of their practice to remote working. Emergent and high-risk cases are seen in-person for acute consultations, whilst utilising appropriate Personal Protection Equipment (PPE). Such a pivot to practice processes has required immediate familiarisation with relevant guidelines from professional bodies, military instructions, and governmental policies. These matters address the new challenges related to ethics, confidentiality, security, and risk management. Other areas of practice reorientation have entailed assessment formats, psychotherapeutic processes, care planning, occupational health and fitness/suitability for duty determinations, multi-disciplinary team working, supervision, and effective liaison and consultation with command. Some psychotherapeutic interventions have benefited from the use of electronic resources such as virtually accessed psychological ‘homework’, including a digitised version of a trauma focussed therapy workbook (Resick et al., 2014), and self-help material informed by the Covid19 (e.g. DMRC, 2020).

**Neuropsychological and Rehabilitative Healthcare**

Our psychologists play a significant role in the provision of neuropsychological and rehabilitative healthcare across the UK military. Those working at the DMRC have drawn on the expertise and experience of an existing neuropsychological service delivery system for mild-Traumatic Brain Injury (mTBI). Aspects of the model utilise various types of telemedicine communication platforms, which complement the remote working policies arising from Covid19. When clinically appropriate, remote cognitive assessments are conducted. They involve a similar stand-
ard battery to those used for face-to-face consultations. This virtual process has added time to each consultation, due to technical and logistical factors. Also, caution is applied when interpreting results, as the observational and related data and metrics are impacted by the telemedicine communication systems. In addition, patient’s ability to engage in prolonged screen-time and concerns regarding fatigue remains a concern.

Furthermore, our psychologists actively engage in consultation and supervision with peers to advise on changes to clinical services and supporting rehabilitative staff in sustaining resilience and avoiding burnout. Indeed, DMRC psychologists are aiding their occupational therapist colleagues in sustaining a cognitive rehabilitation service. Monthly Chronic Regional Pain Syndrome clinics are run by our psychologists via a remote service delivery model. Whilst it is limited in obtaining a comprehensive assessment of a patient’s physical functioning, significant data is gained on elements of psychosocial functioning, which can be integrated effectively with associated clinical information to inform case conceptualisation and shape clinical care planning.

Remote individual psychotherapy and psycho-educational consultations for certain rehabilitative conditions have continued, but group therapy interventions have been postponed. Specifically, complex trauma therapy has been suspended in recent weeks, due to the therapeutic challenges related to the uncertainty of the evolving social-distancing restrictions. However, this may alter in the coming weeks, as service policies may evolve. Efforts are also well underway to develop additional virtual pain psychology services. Fundamentally, the pandemic has provided an opportunity to work differently; and arguably in some cases more efficiently, as a result of the various adaptations to practice. One might consider the utility of maintaining such alterations following the end of the pandemic, perhaps producing a more flexible and efficient service.

**Leadership in Defence Clinical Psychology**

The UK Surgeon General recently noted that the nation’s military psychologists, “provide a leadership-based approach to through-life clinical, occupational and research resources across UK Defence, helping to develop and deploy effective and evidence-based assets” (Bricknell, 2019). This aspect of our role has been ever-present during the Covid19 crisis. Indeed, many of our psychologists have carried significant leadership commitments during the pandemic, in terms of managing and supervising fellow psychologists, leading multidisciplinary teams (MDT), and shaping organizational and operational policy. Head of Defence Clinical Psychology has been a key stakeholder in the Covid19 planning for operational decisions pertaining to mental health provision across Defence Medical Services.

The science of psychology is integral to the concepts and practice of leadership. The leadership framework referenced by UK military psychologists during Covid19 is consistent with the model outlined in Figure 1. The self-isolating and social distancing measures of Covid19 have amplified the challenges associated with leading and working for a geographically-dispersed service, with assets throughout the UK and across the globe. Leadership during Covid19 is humbling. Day after day, colleagues juggle clinical caseloads, family commitments, social distancing, home schooling, technological challenges, illness and bereavement and all with good humour and a ‘can do’ attitude. Recruitment has not stopped, requiring interviews to be conducted online and new staff have joined the service. This poses significant challenges for onboarding and orientation processes, including the completion of training requirements. More than ever, psychologically-informed leadership has been needed to model adaptive responses to change, work effectively within changing and uncertain systems, retain the ability to diagnose situational requirements and act accordingly (Norris et al., 2019).

![Figure 1](image)

**Figure 1.** Following this paragraph

Psychologist colleagues in clinical lead roles have sustained the mission, including the provision of support to command via the delivery of regular remote MDT meetings and case conferences. Peer support and supervision continues through virtual platforms. As such, liaison with command structures remains a priority, and the communication and dissemination of information within and between teams is protected. Indeed, to support the professional cohesiveness and overall morale of the clinical psychology cadre during Covid19, our head of service has established and facilitated a weekly cadre meeting. The virtual DCPS ‘Covid Café’ is designed to provide an opportunity for peer support and ‘seed’ other beneficial cadre activities such as virtual journal clubs and continuing professional development (CPD) events. Covid19 ‘war’ stories are shared and there are the occasional outbreaks of morale, which help to make new members of the service feel welcome and consolidate existing working relationships. A recent online survey of DCPS members highlighted the value placed on these online activities, with several people commenting that they now feel more...
connected with their psychology colleagues than pre-
Covid19.

Leadership in the time of Covid19 is best summarised in
the words of the Queen from Alice’s Adventures in Won-
derland, “Why, sometimes I’ve believed as many as six
impossible things before breakfast.” Covid19 has re-
vealed that it is possible to create a sense of community
and belonging within a dispersed national and interna-
tional military psychology service with no physical con-
tact and only minimal means. It has also reminded us that
radical change can happen at pace. Psychology has value
to add when we need to ‘reframe’ a situation or experi-
ence in the face of uncertainty and change. Covid19 has
 taught us never to underestimate human resourcefulness,
or kindness, and to remember that nothing lifts the spirits
like sharing a funny dog video online with colleagues.

Defence Clinical Psychologists as Healthcare Organi-
sational Consultants

Covid19 has produced a range of professional and per-
sonal challenges for healthcare professionals. Defence
clinical psychologists recognise their value in leading on
staff wellbeing and support. As such, a suite of psycho-
logically-informed initiatives have been established to
maintain and enhance team cohesion and morale for De-
fence clinicians. Using virtual platforms, metrics were
obtained relating to staff perceptions of working during
Covid19, which addressed adaptations to practice, stress
and wellbeing, coping responses, and areas for improve-
ment to wellness and performance. In response to such
data, the UK’s military clinical psychologists have ac-
tively supported clinical peers by developing and deliver-
ing web-based CPD sessions, supervision and consulta-
tion services, and tailored psychological resources and
materials. Furthermore, there has been an increased
 awareness of the need to recognize new skills in other
team members, thus facilitating growth through change
in adversity.

Operational Psychological Health Promotion

A key responsibility for our clinical psychologists entails
contribution towards the promotion of mental health and
wellbeing; and the prevention of impairing psychological
problems arising from operational service. This is largely
associated with the provision of psychological resilience
resources and skills training. Covid19 has seen a national
campaign on such matters by the lead author. This in-
volved her collaboration with colleagues to enhance and
deliver a psychologically-informed Covid19 resilience
media program, based on the Optimising Performance
through Stress Management and Resilience Training
(OPSMART) system. This was disseminated to UK mili-
tary personnel across the globe, via a variety of media
platforms. The media products included a British Army
webpage on mental resilience, an animated infographic
video (figure 2 ) on sustaining and improving mental re-
silience during Covid19, and a pre-recorded interview,
advertising the mental health support available to all mili-

tary personnel and introducing the work of a clinical psy-
chologist in the military (British Army, 2020b).

![Mental Resilience](image)

**Figure 2.** Thumbnail of the mental resilience
during COVID-19 infographic

Training the next Generation of Military Psychologists

The DCPS places emphasis on the training of future clini-
cal psychologists with the ambition that they will be in-
spired to serve in the British military healthcare system
once qualified. This involves offering a final year special-
ist placement (i.e. internship) for clinical psychology doc-
toral trainees. Students experience the work and culture of
a military clinical psychologist, via exposure to a variety
of clinical and organizational learning units. Successful
trainees must be effective in adapting to frequent changes
throughout their studies. However, the emergence of
Covid19 has brought an unexpected and sudden resonance
to this longstanding training phenomenon.

As one of our trainees noted: “Our training had not in-
cluded a course on ‘How to cope in a global pandemic’.”
Thus, Covid19 has seen real world dangers being a signif-
icant component of the trainee’s learning experience, in-
cluding risk of the pandemic for the student, their peers,
friends, colleagues, and family members. This was cou-
pled with the pressures of adapting to new modes of virtu-
al service delivery (i.e. patient care, staff support, com-
mand liaison, group supervision, etc); whilst attending to
remote teaching methods, and completing doctoral re-
search during a national emergency. Therefore, Covid19
has afforded the student a unique experience of military
healthcare duties, in which one might function as a cli-
nician at risk of harm, whilst serving those on the frontline.

Conclusion

Military clinical psychology is integral to the provision of
mental health services across the UKAF. The pivot to in-
creased telemedicine platforms has sustained the delivery
of assessments, treatments, consultations, supervision,
teaching, research, and psychologically informed media
products. Pertinent challenges involve the ongoing offer-
ing of neuropsychological assessments, specific therapeu-
tic interventions, and group programmes. Covid19 continues to produce uncertainties regarding the future utility and efficacy of new and evolving modes of care and consultation. As scientist practitioners, we will seek to engage in research on how best to deliver such services. Despite the demands arising from the pandemic, Britain's military clinical psychology cadre will continue to provide for the health, readiness, and operational effectiveness of the UKAF.

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Correspondence of concern for this article should be addressed to Rebecca Collins, Department of Community Mental Health, Merville Barracks, Colchester Garrison, CO2 7UT. Email: Rebecca.collins125@mod.gov.uk

References available upon request.

Steaming to Assist Los Angeles with COVID-19
Nicholas Grant
Navy Medical Center San Diego

From March through May 2020 the USNS Mercy was activated in response to the COVID-19 pandemic and was deployed to the port of Los Angeles to provide relief to the local hospital systems as they prepared for a potential influx of patients experiencing symptoms of the virus. Among the over 1,000 members of the crew was the Mercy’s first-ever comprehensive mental health team (MHT) who worked diligently to establish mental health services, organize and disseminate supportive resources and provide various levels of consultation. This team consisted of a neuropsychologist, a psychiatrist, a clinical psychologist, a mental health nurse and five behavioral health technicians (BHT). In addition to being deployed from the ship’s homeport in San Diego to Los Angeles, there were multiple unique aspects of this mission for the mental health team that posed both interesting opportunities and new challenges.

Mental Health Services
In order to ensure that the crew had access to mental health care, one of the first tasks the team set out to accomplish was establishing triage and referral processes as well as organizing the clinical services that would be offered through the Mercy’s Mental Health Clinic (MHC). Since the MHT was owned by the Directorate of Medical Services, triage services were established within sick call. This allowed the BHTs to provide additional support to sick call while also serving as the first line for mental health triage and assessments. The ship psychiatrist developed an educational decision tree to both help train the Independent Duty Corpsmen and assist the BHTs in making initial assessments of each patient’s level of acuity (reacting vs. injured vs. ill) and recommendations for the appropriate level of care. Each case was then either staffed by one of the psychologists or the psychiatrist, and received a referral to the appropriate level of care depending on the needs of the patient. Services available to the crew included psychoeducational classes, brief individual therapy with one of the ship psychologists, medication evaluation and management with the ship psychiatrist, or referral to a Chaplain, if appropriate or requested.

Supportive Resources
Perhaps the biggest impact the MHT had on the mission was the supportive resources they organized and disseminated to the Mercy’s crew. Based on input from the BHTs and discussion with the providers, one of the first resources developed were the Stress Mitigation and Resiliency Training (SMART) classes. These courses focused on principles of cognitive-behavioral therapy, improving coping and problem-solving skills, strengthening resiliency and stress management techniques, and increasing effective interpersonal communication. The materials for these courses were adapted from curriculum regularly circulated by shipboard mental health providers to include more focus on managing uncertainty, experiences of anxiety and coping skills related to COVID-specific worry. The BHTs also organized a successful course on mindfulness meditation and one on sleep hygiene. These courses were co-led by the MHT nurse and the BHTs with specific focus on providing support to the crew while also providing educational and practical experience for the BHTs.

Another major resource developed by the MHT was the Keys to Cope section of the Plan of the Day. This daily entry consisted of pieces of psychoeducation or behavioral health tips to help crew members navigate through common issues experienced related to COVID, being deployed and clinical themes brought to the attention of the MHT. Topics ranged from practical advice on improving sleep hygiene, to psychoeducation on the importance of self-care when experiencing increased stress associated with uncertainty, anxiety or being away from loved ones. As aspects of the mission changed and Sailors began...
transiting safely between hotels and the ship, topics related to accessing electronic support tools, such as the Veteran Affairs’ National Center for PTSD’s COVID Coach mobile app, were also included to increase accessibility. As the mission came to an end topics focused more on accessing local services upon returning home, reintegrating with family members and work under COVID-specific restrictions that were not in place at the onset of the deployment and additional online supportive resources.

Consultation

The MHT engaged in both formal and informal consultation around topics related to mental health and morale through the mission. Requests for formal consultation came from leadership, various levels of the chains of command, as well as the individual level. This ranged from requests for advice on how to improve the morale and mental wellbeing of the crew, to individual Sailors wanting to discuss ways they could support family members and loved ones back home who were experiencing their own stressors around uncertainty as the COVID situation continued to develop and the country continued to limit their ability to engage in routine daily activities. The informal variety presented themselves more so in casual conversations in which Sailors might ask for clarification on a Keys to Cope topic or for information “for a friend” on how to approach a particular situation. Consultation in either form was strengthened by the robust collaboration between the MHT and the three chaplains deployed for this mission. The MHT was intentional in taking the time to develop these relationships, which came easy as they were all experienced Navy chaplains with diverse backgrounds and experiences in counseling and working together with mental health providers. In joining with the chaplains to assess any morale or clinical issues present on the ship and communicate with leadership, the MHT was able to expand itself to an even more impactful “Team of Helpers”.

Opportunities and Challenges

All deployments come with their own unique challenges which thus offer new opportunities to problem solve, be flexible and use psychological science to better help service members. One particular aspect of this deployment that was new, was the implementation of social distancing while providing mental health services onboard the USNS Mercy. For individual services, the use of masks and physical distancing within the MHC was bit easier to engage in than for the provision of the psychoeducational classes, which originally were scheduled for a space that did not allow for physical distancing. The MHT worked in collaboration with the chaplains and various departments across the ship to get permission to use the Ward Room for the classes, as it had already been organized to ensure proper physical distancing. This resulted in a class schedule that was changed repeatedly regarding times and location, a challenge for getting Sailors to engage, or even connect them with the resources we are referring them to. The opportunity it offered was a current and ongoing example of dealing with uncertainty, managing stress and adjusting to ongoing change as the world continued to adjust to COVID.

Another unique challenge during this time was the disappearance of members of the MHT to required restrictions of movement (ROM). Multiple members were placed on ROM due to symptoms of the common cold, although thankfully none of them tested positive for COVID. This almost immediate lack of availability changed the ability for scheduled patients to be seen. The opportunity that this presented was the MHT to work even more closely than they were before, from the Department Head to the most junior BHT. Protocols were updated to ensure that patient coverage was always available, patients whose scheduled appointments would be impacted would be contacted and that there were always multiple crises plans in place based on the evolving availability and location of the MHT and patients.

Overall, the MHT onboard the USNS Mercy did some exceptional work under an unprecedented situation and worked in collaboration not only to build a strong team but provide solid, evidence-based services to an outstanding crew who were dedicated to helping the people of Los Angeles. The success of the mental health work conducted on this mission would not have been possible without the contributions and leadership of the MHT members CDR Josh Kenton, LCDR Daniel Tarman and LCDR Christina Carter, as well as the outstanding efforts of the behavioral health technicians: HM2 Terrance Stevens, HM2 Josue Sanchez-Duran, HM3 Benjamin Shaw, HM3 Daniel Villa and HN Bryan Humphrey.

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Embedded Mental Health aboard USNS COMFORT (T-AH20) in response to COVID-19

Shawnna Chee, USN
Naval Medical Readiness and Training Center, Portsmouth Virginia

“Give me your tired, your poor, your huddled masses yearning to breathe free…” – excerpt of poem on Statue of Liberty, New York Harbor, by Emma Lazarus.

On March 29, 2020 thousands of television viewers watched worldwide as a U.S. Naval vessel, the USNS COMFORT (T-AH-20) arrived in New York Harbor accompanied by hundreds of smaller maritime vessels, surrounded by dozens of video-capturing helicopters and guarded by NYPD and U.S. Coast Guard cutters. Requested by the Governor of New York as a backup for hospitals throughout New York City at its height of the COVID-19 outbreak and anticipated mass casualty situation, this ship was sent off from the pier at Naval Station Norfolk, Virginia by the President of the United States himself. Advertised as a “1,000 bed hospital” the expectations were high for the 1,200 crew onboard, most of which were given less than 48 hours’ notice and without a defined end date in mind, facing a volatile pandemic, the worst the world has faced since the early 20th century. This article aims to explore the unique application of expeditionary mental health support the mental health team (MHT) aboard the COMFORT adapted during the request for support to New York City. This article will discuss the unique challenges faced by the MHT aboard the COMFORT, and will not include typical shipboard deployments that were also inherent to this mission. For a summary of aircraft carrier mental health care the readers are directed to a fine article Diary of an Aircraft Carrier Psychologist, by Amanda Berg, 2019.

Unique Challenges specific to this mission included the ship’s hasty departure, intense media coverage, the perceived political agenda of the overall mission, and risk of exposure to healthcare workers due to the unbelievably contagious nature of the virus. There were also daily updates and changes in care and safety protocols, highly stressful and complex patient care issues leading to end of life issues, death, and grief which resulting in physical, emotional and cognitive exhaustions that tested traditional mental health service delivery aboard the ship. Additional challenges included no access to the known stress control mechanisms due to gyms being closed, no morale and welfare activities or therapeutic groups allowed due to social distancing requirements, long hours with no days off, and the eventual geographic separation of those needing services.

The USNS COMFORT is essentially a floating hospital, built from a retired oil tanker, managed by the Maritime Sealift Command (MSC), whose “primary mission is to provide an afloat, mobile, acute surgical medical facility to the U.S. military that is flexible, capable and uniquely adaptable to support expeditionary warfare. Comfort’s secondary mission is to provide full hospital services to support U.S. disaster relief and humanitarian operations worldwide” (Fact Sheet, 2020). A sister ship, the USNS MERCY (T-AH-19), resides on the west coast of the U.S. while the COMFORT resides on the east coast. Typically used for overseas humanitarian support, during times of unique crises, the hospital ships can be called up for duty in the U.S. to support anticipated mass casualty and medical overflow; the last of which was in 2005 after both Hurricanes Katrina and Rita.

On a typical day, the COMFORT’s Military Treatment Facility (MTF) has a critical core of U.S. Navy medical personnel assigned to this platform for a specified amount of time, typically 2-3 years. Until the ship receives orders for a mission, most of the MTF’s medical personnel work at an outside clinic or military hospital, in this case, the Naval Medical Center in Portsmouth, Virginia. The critical core can be augmented by additional medical personnel from anywhere in the world and from the Reserve component, as prescribed by the mission requirements. Given the unique nature of the mission, the medical billets (types of personnel) generally required for a traditional humanitarian mission included medical disciplines that were not directly utilized nor anticipated being needed for the COVID-19 mission. For example, surgeons went underutilized while the very few ICU nurses were working overtime. To augment, nurses who specialized in other areas were realigned (e.g. PACU, ER, MedSurg, Ward) to the ICU to backfill and given “on the job training” for the critical care patients. This shift caused staff anxiety, uncertainty and fear of both malpractice and ethical concerns. In addition, the ship was not designed for critically ill, ventilated patients who required intubation for weeks at a time and, therefore, continuous tube feeding, acute dialysis and personal protective contact precautions; thereby unexpectedly increasing the workload of the very few dietitians, nephrologists, and supply personnel. Being an old ship, communications onboard are rather archaic with paper medical records and charts, use of physical “runners” to pharmacy and lab, limited space

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and very few computers also added to the already complex situation.

To put things into perspective, the COMFORT had just completed a several month humanitarian mission through South America and the Caribbean ending in Nov 2019, and was in a Phased Maintenance Availability (PMA) period for general repairs and modernization; meaning it was essentially not supposed to be available for use at the time it was recalled for this mission. With the ship largely torn apart at the time it was recalled, the MSC personnel worked tirelessly to render the ship sea worthy enough to make it the roughly 270 nautical miles North while the pre-deployment ‘sea trials’ that typically take place well in advance of a deployment were conducted enroute. Departing only 5-days after being called to duty also impacted the pre-sail stocking of critical supplies such as food, medications, medical equipment and most importantly Personal Protective Equipment (PPE). When the ship left the pier at Norfolk Naval Base, it had less than 7% of its required supplies onboard for a typical mission. Despite these initial logistical challenges, the ship being moored at a pier in a large metropolitan area meant that supplies and additional personnel could be made available, but would take weeks.

The personnel on board included highly skilled, widely experienced and motivated sailors with an unwavering dedication to mission success. Other factors that decreased the burden included MHT members who were also combat tested and diverse in their experiences within Navy medicine. Representatives of various enlisted ranks of behavioral healthcare technicians (BHTs) included one E-3, two E-5’s, one E-6, and an E-7 Chief who acted as a liaison between the other departmental senior enlisted leadership formed a robust team. The MHT leads included two Licensed Independent Provider (LIP) officers, both O-5 Commanders; an active duty Navy psychologist and Navy Reserve psychiatrist, each with more than 20-years’ experience in their respective specialties. Two of the BHT’s had recently deployed on the ship’s latest mission and were familiar with the operations of how a typical sick call functioned and the nature of the ship.

Embedded Model
Realizing the challenges early on, the MHT adopted the embedded mental health model, which means to be present in all spaces aboard the ship to the personnel. There was never a moment when a staff member could not reach someone available to help during the 24-hour day. The MHT members walked the ship constantly, wore the required PPE standing with the staff members in the ICU or on the wards, met with each division leadership regularly, ate at a different table and with different people (including the area with box lunches) in order to be available and approachable. The MHT quickly established 12-hr shifts (0600-1800), 7 days/week for the BHTs located in the Sick Bay and a 24-hr on-call schedule every other day for the LIPs. The day before departure and during transit, the MHT established face to face communications with each division by meeting at the morning muster and introducing the team, discussing the care available and established a point of contact for each division. All divisions or sections aboard the ship were assigned a dedicated BHT member who was essentially embedded in those areas, and “floated” to the work spaces every day. This was advertised as “support in your work spaces and in your faces” in order to maintain access to and gain situational awareness of group or individual needs.

In the Navy, the BHTs are highly skilled and trained to conduct full psychiatric interviews and counseling-level interventions (e.g. sleep hygiene, cognitive behavioral therapy techniques and suicide risk assessments). Every case was staffed with the LIPs at the daily evening shift-change meeting. This allowed the LIP’s to roam the ship and visit with staff in their spaces to assess morale, intervene in the moment, and report back the needs to the leadership in real-time. The LIPs also provided consultation to the command management using research which revealed the most effective leadership style was one of “Identity Leadership” described by Van Bavel (2020) as “in a pandemic, there is a particular demand for leaders who represent and advance the shared interests of group members and create a sense of shared social identity among them.” (pg 16). Largely due to the difficulty with sharing information on the ship, the command leadership was encouraged to display the recommended sense of collective self-efficacy by using the internal 1MC speaker system to send uplifting messages or status updates and occasionally visit the staff in their work spaces to be seen as available for any inquiries the staff may have.

As the ship pulled in to NYC pier 90, the MHT reached out to colleagues using email, social media and phone calls to obtain as many resources related to the mental health mission as possible. For example, the Naval Postgraduate School donated 875 “warfighter sleep kits” to augment the difficult shipboard environment to improve sleep. An online search for managing stressors related to COVID revealed an excellent “Coronavirus Anxiety Workbook” a 26-page downloadable PDF, with live links...
Leveraging Resources

Although the intent of the mission was to support New York City hospitals off-load their non-COVID infected patients allowing hospital staff to treat those with the most need; after only a few days, it became clear this was not possible. As soon as the first patient onboard tested positive for COVID, the infectious disease and preventative medicine standards were immediately changed and the ship was literally and physically divided into “red zone” and “green zones” to decrease unnecessary transmission of the virus and protect the staff who were not in direct patient care. Of course, this created a geographical burden for the MHT as the red zone designated staff were moved off the ship and into a hotel several blocks away, and told to self-isolate by staying in their single rooms, not to go outside nor congregate between 12-hour shifts.

The early efforts to establish POC’s for each division included expanding the MHT with the Chaplains office on board. Not only were there more support providers available throughout the ship, offering additional stress relief, one Chaplain was able to be relocated to the hotel with the red-zone personnel. The Chaplain offered Sunday spiritual services and allowed for the “in your spaces and faces” aspect to those while isolated off duty. Since the MHT members were able to float between the zones, there was concern for their eventual exposure to COVID and real possibility of being infected, and requiring isolation or quarantine, potentially disrupting traditional established therapeutic encounters. Luckily, due to the location of the ship, all staff had access to cell service while on the top decks. This connectivity was leveraged to the advantage of the MHT by encouraging the continued use of tele-medicine with an existing onshore provider as many of the land-based clinics were transitioning to anyway, in the event an LIP or BHT became sick. In addition, cell service was utilized routinely in counseling sessions or hallway interactions as “hip pocket training” by downloading free, evidenced based behavioral healthcare mobile apps recommended by the National Center for Tele-health and Technology.

MHT members found that applying reframing, reassurance and radical acceptance worked best for supporting the crew while they worked in the spaces. Reframing offered overworked providers or those expressing guilt about patients who had decompensated or died, that the patients may not have had the opportunity to receive the care we were providing, given the circumstances in the outlying hospitals. That caregivers and providers were given the opportunity to make the patient as comfortable and well cared for as possible in their final moments was the real mission in some cases. Reassurance came in the form of the MHT acting as information messengers, since the limited number of computers onboard often left the busiest staff without information published in all-hands emails or even in the plan of the day (POD). This offered reassurance to the staff that their requests have been pushed up the chain of command, and their concerns and grievances had not gone ignored. The MHT offered updated information about the status of patient discharges and successful recoveries to boost their focus. Radical acceptance leveraged aspects of dialectal behavioral therapy (DBT) such as distraction, emotional regulation and distress tolerance techniques applied in the moment. For example, the complexity of the critically ill patients, extreme heat in the crowded patient spaces down below deck, combined with fatigue and insufficient nutrition in the boxed lunches provided to those in the red zone (eaten in a converted physical therapy space) often left staff overwhelmed, emotional and panicked. A MHT member was often available in the area for an immediate intervention of distraction techniques by helping them change their focus from upsetting thoughts and emotions to more enjoyable or neutral activities, self-soothing, improving the moment and focusing on Pros and Cons that often allowed the staff member to return to work immediately. Behavioral strategies of activity planning (to eat on a schedule, taking breaks where possible, taking advantage of the fresh air while transporting to their off ship hotel room, and thinking of ways to get exercise without a gym or space) were included for longer term support. If not readily available, most crew members had the cell phone number to text an LIP who could arrive within minutes to assist.
Flexible Mindset

The initial expectation of MHT was one of “force preservation”, meaning support for the crewmembers to keep them capable of performing their jobs with minimal disruption to the overall mission. “Pivot” became the mission buzzword. Not only did the medical providers need to adjust, or pivot away from, their initial expectations, but the MHT did too. Given the patients who were brought on board from the local hospitals included those with serious and persistent mental illness, often homeless, indigent or without access to consistent civilian care, the LIPs needed to adjust their focus on treating the patients from NYC in addition to the staff. Again, early planning and leveraging resources paid off as the ship’s formulary had been reviewed early on and medications that could be utilized for more serious mental health symptoms were ordered and available. The MHT also shifted focus toward training the staff members how to best manage an acutely psychotic and assaultive patient; perhaps one who was COVID positive, to keep the staff and other patients safe. Having the MHT staff embedded in the patient treatment spaces allowed bedside evaluation and counselling for patients brought onboard who were depressed about their condition, had difficulty sleeping, no longer cared to eat or had trouble adjusting to their new circumstances. This also provided an opportunity for training the BHTs who may otherwise not have encountered patients with such acute needs.

As the mission came to an end, rather unexpectedly and abruptly, the MHT were further challenged as many of the augmented personnel were sent home or back to their commands at separate intervals, and without the benefit of any closure or formal debriefing. Further mental health concerns were anticipated as many of the red-zone staff, particularly reservists from other states, who had been isolated to a hotel between shifts, were then chartered by plane or bus to a 14-day Restriction of Movement (ROM) status in yet another hotel away from family, friends or other supports. The MHT reached out to NMCP Behavioral Health to voice these concerns, and were offered the staff support 24-hr call line as well as plans to make contact with the personnel during their ROM status.

From this expeditionary experience, the MHT found that several things benefit the application of the embedded model of mental health support. First, was embracing embedded mental health model and physically reaching out to each division and assigning a member of the team as a point of contact and floating in the work spaces daily. Being available in person was key. Second, was the collection and allocation of resources (sleep kits, handouts, evidenced based research, etc) and using this to act as a liaison between the management and front line workers to make their needs and overall level of morale known. Third, was the flexible application of traditional psychotherapeutic techniques to the work space and at the bed-side along with the use of behavioral health mobile apps and telehealth providers on shore for continuity of care. Overall, the application of military operational and embedded mental health care that has been utilized in a variety of settings within Navy medicine allowed for meaningful application of traditional mental health care in an otherwise non-traditional setting.

References available upon request.

Author Note

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the United States Navy, the Department of Defense, or the United States Government.

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Correspondence concerning this article should be addressed to Shawnna Chee, TBI Services, Naval Medical Readiness and Training Center, Portsmouth, 620 John Paul Jones Circle, Portsmouth, Virginia 23708. E-mail: Shawnna.m.chee.mil@mail.mil
An abundance of research suggests that the wellbeing of healthcare providers (HCP), and, more widely, healthcare staff, is essential for the quality and safety of healthcare systems. Provider burnout, frequently resulting from a chronic sense of low wellbeing, is a “state of vital exhaustion” (WHO, 2004) in response to chronic or unrelenting occupational stress. Burnout is associated with significant issues from the individual provider level to the “employer organization, patients, and the healthcare system as a whole” (Salyers et al., 2016), and is characterized by “high levels of emotional exhaustion, cynical attitudes, and a diminished sense of personal accomplishment at work,” (Salyers et al., 2016). HCPs experience burnout at a rate roughly double that of the general population (Powell, 2019).

While burnout has substantial and long-lasting implications for the HCP’s physical (e.g., insomnia, weight gain), social (e.g., divorce), and mental health (e.g., depression, substance use), the impact and consequences of burnout reaches far beyond that of the HCP. The financial cost of burnout on the U.S. healthcare system is estimated to exceed $4.6 billion a year (Han et al., 2019), a likely underestimation as it does not include costs of downstream effects such as increased medical errors and malpractice lawsuits (Hall et al., 2016). Critically for the Department of Defense, a significant portion of the costs of staff burnout directly result from staff turnover to include the cost of physician training and replacement. These are substantial concerns for Army recruiting and retention, and thus further elevate the need to prioritize HCP wellbeing even during normal operations.

The 2003 outbreak of severe acute respiratory syndrome (SARS) alerted researchers, HCPs, and the public as to the substantial psychological effects of a major infection on HCPs. Studies uncovered staggering estimates of up to 35% of hospital workers reporting experiencing a high degree of acute psychological distress, burnout, and post-trauma symptoms (Maunder et al., 2006; Nickell et al., 2004). Providers operating during the current COVID-19 pandemic are experiencing similar stressors to those that were prevalent among HCPs during the SARS outbreak, to include fear of contagion and of infecting family members, extended work hours, social isolation, unfamiliar tasks, heightened scrutiny, and sometimes daily changes to policies and procedures.

Even under normal conditions, staff burnout contributes to adverse patient outcomes, increased staff turnover, poor recruiting and retention, and degraded operational readiness, all of which are exacerbated by the compounded stress of an event like a pandemic. Thus, the wellness and resiliency of HCPs in current times shadowed by COVID-19 must undoubtedly be at the forefront of the minds of leaders among healthcare and hospital systems.

As a result, a network of individuals associated with Madigan Army Medical Center (Madigan) have consolidated efforts into a Staff Wellness and Resiliency working group. Members of this working group are multidisciplinary and from, among other departments, vascular surgery, behavior health, nutrition, chaplaincy, Healthcare Resolution, and Graduate Medical Education. Importantly, as the COVID-19 crisis continues to tax HCPs, efforts are transitioning away from immediate efforts into longer-term initiatives and interventions.

The endeavors undertaken by the working group are not new to Madigan; efforts to enhance provider wellness and resilience have been underway for years. However, a key component in the successful long-term implementation and utilization of available resources is buy-in and support by Command. Hospital-level leadership must voice support for an overall wellness strategy and normalize teaching and accessing resiliency resources. Previously, a lack of clear organizational strategy and messaging from hospital leadership has resulted in the slow adoption of emphasis on provider wellbeing leading up to the COVID-19 crisis. However, likely in part due to observable HCP distress as a result of COVID-19, the efforts of the working group are rapidly gaining traction among hospital leadership.

To date, the working group’s efforts center around three primary and reciprocal domains of HCP wellbeing: a) personal resilience on the part of the provider; b) a culture of wellness; and c) efficiency of practice (Bohman et al., 2017; see also Salyers et al., 2016). While the majority of interventions and research surrounding HCP wellbeing emphasize personal resilience, efforts are being made both at Madigan and in the healthcare field more broadly to engage in organizational interventions. Below, we discuss the three domains of employee wellbeing, and local efforts occurring at Madigan in response to the COVID-19 pandemic.

**Personal Resiliency**

Personal resiliency consists of the “set of individual skills, behaviors, and attitudes that contribute to personal physi-
cal, emotional, and social wellbeing – including the prevention of burnout” (Bohman et al., 2017). A vast array of clinical care outcomes such as job satisfaction, turnover, occupational safety, and patient outcomes (e.g., post-discharge recovery time, patient-provider communication) are associated with positive HCP wellbeing. There is a critical need for organizations to promote personal resilience-enhancing behaviors.

At its core, Madigan has embraced several long-standing programs that aim to promote personal resiliency, and these programs have increased in both awareness and urgency during the COVID-19 crisis. One such initiative which has been embraced by Madigan is that of the Move to Health: Powered by Performance Triad (M2H). M2H is a compilation of eight domains of self-care which are deemed essential for holistic health and wellness. These eight domains include sleep, physical activity, and nutrition (derived from the Army Performance Triad; https://p3.amedd.army.mil/), personal/work-life balance, physical surroundings, power of the mind/mindfulness, spirituality, and family/social relationships (see Figure 1). The M2H initiative has been well-socialized within the language and culture at Madigan, which provides a strong foundation upon which to incorporate new interventions.

An initiative that has taken priority since the initial surge of COVID-19-related hospital changes has been the creation and publication of behavior health-related tip sheets. These tip sheets entitled Madigan Wellness Minutes, are brief, visually appealing, and easily-digestible topics developed by behavioral health subject matter experts (see Figure 2 for example tip sheets). They are posted to the outward-facing public Madigan community Facebook page with over 18,000 followers; the Madigan Public Affairs Office has reported that these tip sheets are “tremendously popular” and are among the most consistently ‘liked’ and ‘shared’ postings to the site. Previous and upcoming topics of Wellness Minutes include addressing sleep disruptions, coping with stress, Acceptance and Commitment Therapy for COVID-19 (using the acronym FACE COVID), psychological first aid, and substance use. For access to download or distribution of these tip sheets, join the Facebook page at https://www.facebook.com/MadiganHealth/.

**Figure 1.** The Move to Health (M2H) holistic health wheel of self-care.

**An initiative that has taken priority since the initial surge of COVID-19-related hospital changes has been the creation and publication of behavior health-related tip sheets.**

**Figure 2.** Examples of Madigan Wellness Minutes tip sheets.

**Culture of Wellness**

The second component of HCP resilience is that of an organization’s ‘Culture of Wellness’ (Bohman et al., 2017). HCPs work within and as part of a larger organization. Even the most resilient HCPs will struggle in a negative culture and climate. Below, we will discuss the concept of culture, the outward mindset, climate, and current events, and initiatives for sustaining and improving organizational climate and culture throughout the COVID-19 pandemic and beyond.

Culture is not explicitly created, but is crafted by leadership and events over time. It is the shared history and understanding of how members solve problems. Kotter and Heskett conceptualize culture as an organization’s personality with both visible and invisible elements (1992). The military health system has its own culture, each hospital has a subculture, and each team has a further subculture. Each level is influenced and shaped by leadership. Over several years and multiple leaders, Madigan has worked...
towards developing an outward mindset culture (Arbinger Institute, 2016). The outward mindset encourages consideration of other’s needs, objectives, and challenges as relevant as one’s own. It promotes a culture of wellness to include self-care, personal and professional growth, compassion, and importantly a shared and deep sense of community.

Wellness culture does not occur quickly but through the sustainment of a supportive climate over time. Climate is how the people in an organization are collectively feeling. An unsupportive organization cannot instantly flip to a culture of wellness in a crisis, just like a pessimistic person does not suddenly find the bright side of life. Yet, disasters can generate a sense of urgency, and leaders and HCPs can utilize the urgency to create or further enhance a previously-established positive climate. Sustaining a positive climate can lead to deep cultural improvements. Creating a positive climate during the COVID-19 pandemic can lead to sustained improvements in MHS culture.

Direct and organizational leaders influence organizational climate, and behavioral health specialists can help. Madigan Leadership has done significant work towards shaping a supportive environment during the COVID-19 pandemic, and the programs described next are only parts of the larger response. However, they are examples of how behavioral health experts can contribute to the overall wellness culture. The Trauma Event Management (TEM) team created the Madigan Support Program to provide individual and group peer support to HCPs. Madigan staff can request a peer support session with a member from the Department of Behavioral Health or participate in a group session with 3-10 other Madigan HCPs. While dialogues regarding the development of a peer support program had been occurring for about six months, the COVID-19 crisis allowed the team to spur action for implementation. Furthermore, in response to episodes of low HCP wellbeing, department and team leaders were offered behavioral health support through initiatives similar to Combat Operational Stress Control tenets such as a behavioral health needs assessment and psychoeducation for their teams. The programs will become established during this crisis and, hopefully, lead to a long-standing effort across Madigan to ensure that HCPs are emotionally cared for and supported.

A culture of wellness is an essential element of excellent patient care. An outward mindset is vital to creating a supportive work environment, and it is dependent on people in the organization to create a positive climate. A favorable environment is critical for the MHS to meet its mission and be a place for HCPs to feel supported and ready to treat patients. Behavioral health providers can help leaders in creating a positive climate improving the overall culture of the organization.

Efficiency of Practice

While an organizational culture of wellness and personal resiliency remain key components of an organizational wellness strategy, the importance of changes in practice efficiency is often overlooked. Efficiency of practice is defined by Bohman et al. as “the value-added clinical work accomplished divided by time and energy spent.” Factors that have been found to contribute to efficiency of practice include “workplace systems, processes, and practices that help ... teams to provide compassionate, evidence-based care…” (2016). Recent data evaluating the impact of staff burnout suggest that the prevalence of burnout within an institution has a stronger negative impact on patient safety than low Culture of Safety scores. In addition to building resiliency and establishing a culture where the importance of wellness is recognized and supported is available, offices and work areas can evaluate processes and practices to explore why such high levels of resilience are necessary.

At the front line, the process of caring for patients during the COVID-19 pandemic is a more demanding, anxiety-provoking experience than at baseline. As a result, we must undertake efforts to minimize the stress of providing patient care, acknowledging that many tasks or work areas may be new, different, or unfamiliar due to personnel shortages and limited resources. Now more than ever, effective communication is paramount in all of our workspaces. The DHA Memorandum “DHA Team Resiliency for Enhanced Effectiveness and Patient Safety” outlines many of the techniques that have already been socialized through the TeamSTEPPS communication tool.

A key element of effective communication, particularly during times of frequent change and uncertainty, is making information broadly available to all staff with the use of SBAR (Situation, Background, Assessment, Recommendation), and regular and consistent briefs, huddles, and debriefs. While often simple to implement in work areas where people are co-located, teleworking for many Madigan staff raises the risk of staff being left “out of the loop.” The TeamSTEPPS framework reminds leaders that effective communication is key and encourages new and innovative solutions for maintaining that communication. Taking care of ourselves (using tools like the I’M SAFE checklist) and our teams (with huddles, situation monitoring, and task assistance) is also a key area of emphasis. Continually assessing changes in patients, staff, and mission, actively seeking and offering support, and vigilance with protocols, policies, and procedures are tasks which may appear at first glance to be common sense gain a great deal of importance and may require a conscious effort by individuals and teams at a time of maximal stress. These tools build a more efficient practice that is safer for staff and patients alike, and fosters a culture of wellness. Effective teams build personal resiliency in an environment of authentic mutual support.

In addition to the effective tools we can use to provide patient care on the front lines, the COVID-19 pandemic has led to drastic, sweeping changes in the way we manage people and provide patient care. We are experiencing an unprecedented use of telemedicine, for instance, and protocols and procedures around the Madigan community are being adjusted or revised to minimize unnecessary
Many of these changes have improved both the patient and provider experiences around the hospital. While many of these practices may not be sustainable post-pandemic, many may be best practices that make our offices, clinics, and clinical areas more efficient overall. As we proceed through the pandemic, it is important for leaders to critically appraise new practices, share best practices, and continue to build a culture of broad sharing and collaboration that will allow best practices to be adopted more broadly. These unprecedented times present us the opportunity to rebuild our practices and procedures after the pandemic in a way that will improve the experience of patients and staff at Madigan for years to come.

**Conclusion**

Adaptability and flexibility are core tenets of the Army and have served its members well throughout the COVID-19 pandemic and resultant changes to Army Medicine. One major area that has been brought to the forefront of Army leadership has been that of healthcare provider wellbeing and resiliency. While long-standing efforts have been underway to enhance HCP resiliency, the COVID-19 has produced an increase in both attention and effort, resulting in numerous initiatives gaining a foothold among healthcare leaders and providers. Initiatives at Madigan Army Medical Center include the development of a Staff Wellness and Resiliency working group, the publication of brief and appealing tip sheets on various topics related to wellness, the standing up of both individual and group peer support programs for Madigan providers, an increased emphasis on solid provider communication, and a transition to telemedicine. Perhaps most importantly, while these resources are available to HCPs, the simultaneous push by hospital Command to increase knowledge of the availability of resources to HCPs has been exceptional. New efforts will be made to ensure this positive attention and dedication to staff resiliency continues to gain traction throughout and beyond the COVID-19 pandemic and to create lasting changes to HCP resiliency within and across Army medicine.

**Author note**

“The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government.”

Christina L. Hein, PhD
Madigan Army Medical Center, U.S. Army
Christina.l.hein.mil@mail.mil or 703-618-4722

References available upon request.
Divison 19 Team:

Crises tend to reveal vulnerabilities, and the COVID pandemic demonstrated how vital clear communication is to mission success. Even before COVID-19, the Presidential Trio’s mandate to the Communications Committee was to enhance Division 19’s brand messaging. To meet this mandate, we are striving to ensure all our media products are high-quality, and messaging is consistent with our mission. As such, we have focused on two priority tasks:

1. Secure a redesigned, modern website, &
2. Consolidate our communication channels (e.g., the Division 19 Listservs, Facebook group page, Twitter account (@APADiv19), and website (www.militarypsych.org)

Our current website has performed a largely static informational function, and it is used for major news items in Convention season. It has also been managed by Alex Wind essentially since its inception. Though our Communications Committee has grown to seven Members and Student Affiliates in three years, it has become clear that our small group of part-time volunteers is not resourced to manage a modern news website, build content on our social media outlets, and secure additional digital assets (e.g., LinkedIn, Instagram, YouTube) – at least, not without leveraging additional technology.

At the MYM, we were granted a budget for a website redesign and for acquiring software to consolidate our social media.

The current status for both initiatives is this:

1. The website redesign is the first priority. A redesigned website would be dynamic, making www.militarypsychology.org a news-based, modern, and professional site with a message and visual aesthetic that our members can be proud of. We are currently shopping a Request For Proposals to web developers.

2. Due diligence has been done on social media consolidation platforms. We are currently negotiating prices, but an ultimate product will allow Comms Committee users to post on multiple accounts simultaneously, schedule posts, and track engagement. Expect both products to be operational during 2020. Dr. Katherine (Katt) Rahill, our Chair-Select, is spearheading both efforts.

Regarding current engagement, our Facebook group has 1400+ members, Twitter has 1700+ followers, and the Announcements listserv has 3400+ subscribers! One benefit of membership is you may post to the listserv. Please email announcements to div19list@gmail.com. Content-producing Committees (e.g., Membership, ECP, Students) are asked to leverage the Comms Committee so we can help distribute your content. Lastly, please email me if you want to get involved!

In your service,

Jeremy Jinkerson, PhD / Capt, USAF, BSC
Communications Committee Chair
jeremy.jinkerson@gmail.com
EXCOM Treasure Report
Ryan Landoll

The Financial Vision for Division 19: Leveraging Our Past to Innovate Our Future

Division 19 members, I am so honored to be serving as your Division treasurer for the next three years. I ran on a platform of financial transparency, financial responsibility, and financial creativity. Although being successful as a division will require all three, I want to open this newsletter by focusing on financial transparency. This of course, goes hand in hand with financial responsibility as a membership-focused organization and together these two set the stage to allow for financial creativity.

Before going any further, I have to thank the incredible work of outgoing Treasurer, Dr. Scott Johnston, who steered the helm for us fiscally over the past six years. Thanks to Dr. Johnston’s work, our Division moved through some very tumultuous times in APA and our country in far better financial shape than we started. He has built for us a solid foundation that allows us to serve our members and to be innovative in our programming. I am also personally grateful for his leadership and mentorship as I assumed this role this year – in the midst of our global pandemic that has changed so much from a public health, psychological, and financial perspective – all things at the intersection of this role. His steady guidance has been instrumental in a smooth transition. Thank you, Dr. Johnston!

As part of financial transparency and financial responsibility, this year at our Mid-year Meeting, we passed the first Division 19 budget. This budget allows us to see in one place and at one time, our spending for the year and allows us to prioritize and innovate those things which serve our members. It also allows us to quickly and easily share those results with you so that you can see the value of your division membership and hold us accountable to protect that awesome responsibility.

As background, prior division spending was allocated by single motions – a great idea would come from our membership and trickle up to our leadership and we would move forward. Things we had spent money on before would continue – with appropriate adjustments, but there was not a holistic look at our spending. This served our division well for many years – in fact, it was part of the reason that we ended up with surplus funds that grew our investment. But as our innovative ideas grew, over the past two years we have started the process of spending against our reserves. This is not inherently a problem – it is a sign of growth. But it became important that we made the decision to spend against our reserves with full information and hence this budget process was created.

Below you will see the 2020 budget. A few things I want to point out about this budget:

1. Most important this year was the creation of the process. We did little to change our past year’s spending patterns, focusing this year on adjusting to having an annual budget process. This was done so that this new process would have minimal disruption on programs and services you have come to expect from the division and that programs which require advance planning would not hit funding disruption.

2. For that reason, you will note that this year we are projected to spend about $50,000 against our reserves. Our reserves are around $500,000 and have weathered the Coronavirus well because of their distribution in longer-term yields. In addition, our revenue projections are conservative – the great work of our Editor for Military Psychology suggests that our journal royalties will in reality be much higher. Finally, many of our convention expenses will be deferred with the movement to a virtual convention. As a result, the projected use of our savings is likely to be considerably lower.

3. Outlining a budget – and sharing with our membership – is the first step in financial transparency and responsibility. Our next step – creativity – will involve the exploration and creation of new revenue streams, which will further allow us to meet the funding expenses of these important division efforts.

We hope by increasing our transparency, we will increasing our membership engagement. So please, share your thoughts on our budget! You can always reach me at rlan-doll@alumni.unc.edu. Honored to serve as your Division Treasurer and welcome your feedback,

Ryan Landoll
### 3 Year Budget Report

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<td>354</td>
<td>7,520 (+2100%)</td>
<td>*</td>
</tr>
<tr>
<td>Admin/Misc</td>
<td>7,705</td>
<td>3,666 (-52%)</td>
<td>*</td>
</tr>
<tr>
<td>Net Income</td>
<td>45,698</td>
<td>(1,958)</td>
<td>(42,474.56)</td>
</tr>
<tr>
<td>Total Assets</td>
<td>548,858 (30 Sept 17)</td>
<td>562,000 (30 Nov 18)</td>
<td>525,666 (31 Dec 19)</td>
</tr>
</tbody>
</table>

*APA utilized different categories, presented to show overall budget trends. Decision this year to make newsletter digital to curb growing print costs*
Division 19 Membership Committee Updates
Kristin N. Saboe

First, please let me extend gratitude to my predecessor, Dr. Michelle Kelley, on her excellent leadership of the membership committee in 2018 and 2019. I moved into the role of membership chair this year for Division 19. It is great to meet those I do not yet know, as the new division membership committee chair.

Introductions aside, let’s talk membership! As of May 2020, our total Division 19 membership was 1,274. Of our current 2020 members, 560 (44% of Division Membership) are Student Affiliates. Our Student Affiliates are a nearly equal mix of new members (N = 283) and returning members (N = 277). These students will become our future Early Career Psychologists (ECPs) and I continue to be impressed by the proactivity, community, and engagement of our student affiliates and ECP members. Further, we had 63 new professional or international affiliates join in 2020. Our membership grew nearly 5% since our membership roster as of May 2019. We hope to continue our growth trajectory in the years to come as we grow our inclusive and diverse community of military psychologists serving military, veteran, and national security contexts. Increased membership not only ensures a thriving Division 19, but it also increases the voice of Division 19 and its members in APA and our communities. Our successful growth as a division is a representation of its members – thank you for continuing to provide a fun, inviting, engaging, and impactful division for new members to join.

We hope to continue our growth as a division this year. Supporting our 2020 Division 19 President’s theme, we will be working extra hard to ensure all military psychologists – applied, research, and practice-focused – find a professional home in Division 19. We need all members to help drive this inclusivity of all psychologists with interests aligning with our division. Invite your colleagues and students to join! The first year is free and I am confident they will be hooked just as soon as they observe the breadth, depth, and impact this group provides. And, as always, please contact me at kristin.saboe@gmail.com if you have ideas as to how we can broaden our membership appeal or increase our membership.

Have you renewed your 2020 membership? Do you know someone interested in Division 19 membership?

2. Enter your APA User ID and password or register for an APA website account.
3. Follow the instructions to renew/sign up!
4. Note: even if you’re not an APA member, you can join Division 19 as a Professional Affiliate ($30; for non-students) or a Student Affiliate ($10; for graduate and undergraduate students).

Division 19 Membership Breakdown, May, 2020

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>22</td>
</tr>
<tr>
<td>Professional Associate</td>
<td>106</td>
</tr>
<tr>
<td>Due Exempt Associate</td>
<td>3</td>
</tr>
<tr>
<td>Dues Exempt Fellow</td>
<td>41</td>
</tr>
<tr>
<td>Dues Exempt Member</td>
<td>94</td>
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<tr>
<td>Fellow</td>
<td>32</td>
</tr>
<tr>
<td>International Affiliate</td>
<td>19</td>
</tr>
<tr>
<td>Student Affiliate</td>
<td>560</td>
</tr>
<tr>
<td>Member</td>
<td>397</td>
</tr>
<tr>
<td>Total Membership</td>
<td>1274</td>
</tr>
</tbody>
</table>
Summary of Accomplishments & Planned Activities

- We have retrieved three banker’s boxes of Society historical documents from HumRRO and are in discussions with the APA archivist to archive these materials.
- We are working with the chair of the Division 19 Communications Committee, Katt Rahill, to develop a Society Wikipedia web page. We are writing the Society’s history for that proposed Wikipedia entry. We expect to have the draft history by this fall.
- The first four past president bios/profiles have been delivered to the Society web manager more are on the way.
- We published two past presidents’ bios/profiles in the Spotlight on History column during the last year and a third profile for George Bennett will be published in the spring newsletter.
- To test another way to generate a past presidential bios/profiles for the website, we will conduct our first past president interview this summer.
- We need to recruit new history committee members – there are only two of us now.
Another academic year has ended, yet this time it doesn’t feel familiar. As we transition into summer, we must recognize the incredible accomplishments of our many students. For those who have attained their master’s degree, bravo! For students headed off to internship, congratulations for completing the academic requirements you have been working on for many years! For our soon to be graduates, we send you all a wealth of best wishes. I hope you all find meaningful ways to celebrate and reflect on these incredible accomplishments!

I want to encourage all graduating students to consider remaining engaged and involved with the division through our growing early career psychology network. Questions about the value of staying involved? Please email our Early Career Psychology committee chair, Neil Shortland at Neil_Shortland@uml.edu

I hope you and your families are healthy and doing well during these unprecedented times. Many of us are navigating education, research, and clinical work in a dynamic and complex learning environment. We want you to know the work you all are doing is meaningful and important. Students involved in our organization continue to provide clinical services and conduct research related to COVID-19. Thank you for the amazing work you are doing!

Dr. Eric Surface, our current division president, has themed the 2020 year Stronger Together, which has truly taken on new meaning in the world we face today. Since my involvement on this leadership committee, I have been amazed to experience the power of like-minded individuals working together in unique ways. I hope we can continue to do just that by looking ahead and remaining committed to our mission.

In February, the Student Affairs Committee convened at the Division 19 annual midyear meeting in Arlington, VA. Our student affiliates were top topic of conversation throughout this meeting. I am pleased to share with you that the executive committee of our division is dedicated to supporting students now more than ever. The following are some of the positive steps that transpired during that meeting:

1. As a student group, we have recognized that our past and current programming heavily leans toward clinical health psychology, which leaves many students in our field left out. Therefore, we have refocused our efforts to be more balanced and dedicate our focus and programming to research, applied, and I/O psychology students and careers as well as clinical health psychology.

2. The executive committee passed a motion to support the proposal of a division by-law amendment to create a position for a student voting representative. Student membership makes up approximately 1/3 of division membership, and we are excited to move toward an official vote to make this representative official. This addendum will formally be voted on during our annual executive committee meeting (traditionally held at APA). We plan for the formal position to be voted on by all Division members in our 2021 election cycle. Students interested in this position are encouraged to keep an eye on our email listserv and social media accounts over the next few months as we will rigorously advertise this opportunity.

   This will not be a formal position on the Student Affairs Committee. Instead, this member will be elected to this position by all voting division members. This representative will be an even stronger voice on our division’s executive committee and will support the advancement and advocacy of students in our division. If you are interested in this initiative and believe it is an appropriate by-law amendment, please join us at the annual business meeting (open to all division members) and vote in favor of this amendment.

3. The SAC has created a new Student Initiative Fund! The purpose of the Division 19 Student Initiative Fund is to support psychology student engagement at the individual, local, and campus chapter levels. Specifically, students and campus chapters engaged in activities, research, or grassroot efforts to further the science, practice, and advocacy of military
The Military Psychologist

psychology. This year, Division 19 will award up to 10 awards, $300 each in value, not to exceed **$3,000 in total awards** to graduate/undergraduate students who plan to demonstrate excellence in advancing the science and practice of military psychology in unique and novel ways. While we are still in the planning phases of implementing these funds, we hope to have applications up and running soon! Please again keep an eye out on our networking platforms and plan to find application materials on our website under the “funding page.”  

https://www.division19students.org/funding.html

**APA Convention** - The APA Convention, originally scheduled for 06-09 AUG 2020, is no longer going to be held in person. APA and Division 19 are committed to providing a meaningful virtual experience with speakers, collaboration opportunities, and unique ways to be engaged as a student. We do not have all the details at this time, but we are dedicated to making APA a great experience for you this year. Please stay tuned as we work to develop a great program for students.

I’d like to congratulate **Felicia Andresen** and **Westley Youngren** for being awarded the 2020 Division 19 Student Research Grant. These students received a $1500 research grant and have been invited to present their research during the APA virtual conference. Thank you both for your contributions to research in military psychology! For students planning to attend the APA virtual conference, please look out for the division 19 programming schedule to find out more about these and other exciting presentations. Check out our website, social media pages, and listserv announcements in the weeks leading up to the convention for the most up-to-date information regarding panels, social events, and convention logistics!

I would also like to take this opportunity to sincerely thank my friend and colleague Keen Seong Liew. Keen is a student in the Clinical Psychology PhD program at the Uniformed Services University of the Health Sciences (USUHS). Prior to his graduate studies in psychology, Keen was a combat medic in the U.S. Army. He commissioned into the U.S. Navy in 2017 and began his training to be a Navy Psychologist at USUHS. His research interests lie within the field of cognitive, health, and clinical psychology. He is currently working with Dr. David Krantz and researching the role of stress and stress markers in the relationship between sleep disorders, traumatic brain injury, posttraumatic stress disorder, and physical health among military service members and veterans. Along with his rigorous study schedule, Keen acts as our primary Virtual Project Officer and supports our team in the creation, development, production, and maintenance of our technology platforms. Our team is truly appreciative for the time and energy Keen brings to support student affiliates. I am personally grateful for the ways Keen steps up to support the many initiatives we have as a committee, and also additional initiatives from the larger division leadership. Keen is flexible and resilient, I am honored to call him my friend and colleague, and I am excited to see where his career as a military psychologist takes him.

Our leadership team are students as well and we understand the added stress that COVID-19 has caused on students, institutions, and psychology providers in our communities. If you have ideas as to how we can help, please do not hesitate to ask me personally, or at our committee email div19studentrep@gmail.com. We are stronger together and we look forward to seeing many of you at the 2020 Virtual APA Convention!

V/r  
Ethan Bannar, M.S.  
Chair, Student Affairs Committee, Society for Military Psychology

**Point of Contact Information**

For further information, please contact:  
Ethan Bannar  
ethan.bannar@du.edu
Announcements
Brianna Staley Shumaker, PhD

Announcement Requests
Please submit any announcement requests for volunteer opportunities, research participant requests, training opportunities, or other requests to Bri Shumaker at brianna.e.shumaker.mil@mail.mil.

General

Join Division 19 on social media!
- Facebook group: APA Division 19 – Military Psychology
- Twitter: @APADiv19, @Div19students
- LinkedIn group for ECPs: APA Division 19 - Military Psychology - Early Career Psychologists

COVID-19 Resources
Ongoing COVID-19 coverage can be found on the APA’s COVID-19 Information and Resources special section. This section will be continuously updated with all new articles throughout the COVID-19 pandemic (https://www.apa.org/topics/covid-19).

The APA has provided information on telehealth guidance for behavioral health providers and clinical psychologists during COVID-19. For detailed information on your state’s telehealth guidance, visit: https://www.apaservices.org/practice/clinic/covid-19-telehealth-state-summary

Psychological First Aid Free Online Trainings
Interested in sharpening your disaster response clinical skills? Disaster psychologists point to training in Psychological First Aid (PFA) as a means of rapidly and effectively helping people in distress during COVID-19 (https://www.apa.org/topics/covid-19/distress-mental-health). There are a number of free online trainings on PFA with two notable options listed below:

John Hopkins University

This specialized course provides perspectives on injuries and trauma that are beyond those physical in nature. Learn to provide psychological first aid to people in an emergency by employing the RAPID model: Reflective listening, Assessment of needs, Prioritization, Intervention, and Disposition. The RAPID model is readily applicable to public health settings, the workplace, the military, faith-based organizations, mass disaster venues, and even the demands of more commonplace critical events (e.g., dealing with the psychological aftermath of accidents, robberies, suicide, homicide, or community violence).

This course is intended for both experienced providers and lay individuals. It takes approximately 8 hours to complete. (https://www.coursera.org/learn/psychological-first-aid)

National Child Traumatic Stress Network

The National Child Traumatic Stress Network offers two free online courses: Psychological First Aid (PFA) and Skills for Psychological Recovery (SPR). PFA and SPR intervention strategies are intended for use with children, adolescents, parents and caretakers, families, and adults who are survivors or witnesses exposed to disasters or terrorism. PFA and SPR strategies can also be used with first responders and other disaster relief workers.

Each course takes approximately 5-6 hours to complete and requires account registration. (https://learn.nctsn.org/course/index.php?categoryid=11)

Conferences

APA 2020 Convention: Going Virtual

In response to the COVID-19 pandemic, APA 2020 will be going virtual. Additional guidance will be provided to Division Leadership and Program Chairs over the next few weeks. Stay tuned for email updates from Division 19.

Dates: August 6-9, 2020
For more information, visit: https://convention.apa.org/

Causes and Consequences of Parent-Child Separations: Pathways to Resilience

Penn State’s 28th Annual Symposium on Family Issues focuses on circumstances of parent-child separation that have become increasingly evident in the social-political-economic context of the 21st century, namely parental incarceration, migration and deportation, and military deployment. Speakers from multiple disciplines will consider the societal factors that have given rise to increasing numbers of children and youth who are experiencing separation and the implications of separation for their well-being. Special emphasis will be placed on factors like family and community resources and supports that promote youth and family well-being in the face of separation, and on the processes through which these and other protective factors give rise to positive functioning in youth and their families. Speakers will highlight the implications of their research for evidence-based programs and policies that foster youth and family resilience.

Dates: October 26-27, 2020
Registration is required. For more information, visit: http://www.pop.psu.edu/event/3719/28th-annual-symposium-family-issues

The Military Psychologist
Job Opportunities

DoD Positions for Clinical Psychologist with Top Secret Clearance (Various Locations)

The DoD is actively recruiting Clinical Psychologists with Top Secret Clearance at a variety of locations to include:

1. Clinical Psychologists with Top Secret Clearance at Ft Belvoir, Ft Meade, and Buckley AFB. Inactive clearance may be reactivated if within 2 years of expiration.
3. Clinical Psychologists in TN, LA, FL, and MS. Top Secret Clearance is not required for these positions.

Applications and inquiries can be directed to Nedra Dean at rld@rldeanassoc.com or 301-710-3647.

Assistant Professor of Clinical Psychology – Tenure Track (The University of Tulsa)

The Department of Psychology at The University of Tulsa (TU) seeks candidates to fill 2 full-time tenure-track positions in Clinical Psychology at the rank of Assistant Professor, beginning August 15, 2020. Interested candidates should apply immediately. Tenure-track faculty have a 9-month contract period (Aug 15-May 15). Successful candidates are expected to develop a funded research program, teach undergraduate and graduate level courses, and supervise the clinical work of graduate students. Application materials and inquiries should be sent electronically to jamie-rhudy@utulsa.edu. See the Announcement section for additional details about the program, position, and how to apply (https://www.militarypsych.org/announcements).

Active Grant Opportunities

Below is a list of active grant opportunities through the APA and the American Psychological Foundation. Visit https://www.apa.org/apf/funding/grants for detailed information.

- David H. and Beverly A. Barlow Grant: $8,500:
  - Deadline: Sept. 15, 2020 (Topic: anxiety)
  - Target individuals: graduate students and early career psychologists

- The Drs. Rosalie G. and Raymond A. Weiss Research and Program Innovation Grants: $1,000:
  - Deadline: Sept. 15, 2020 (Topic: addressing social problems in vulnerable populations)
  - Target individuals: early career psychologists

- Bruce and Jane Walsh Grant in Memory of John Holland: $15,000:
  - Deadline: Sept. 15, 2020 (Topic: influences of personality, culture, and environment)
  - Target individuals: early career psychologists

- Div.42/Steven O. Walfish Grants: $2,000:

- David H. and Beverly A. Barlow Grant: $8,500:
  - Deadline: Sept. 30, 2020 (Topic: standards, practices and methods)
  - Target individuals: graduate students and early career psychologists

Participation Requests

Call for Participants: Mentorship Interest Survey

Due to the diversity of membership of Division 19 and the known benefit of mentorship for personal and professional growth and development, it is important to identify the needs of mentees within the division and determine who is available to serve as mentors. This survey aims to identify the mentorship needs of Division 19 and create a mentor resource for individuals seeking mentorship and those who self-identify as able and willing to be mentors (https://www.surveygizmo.com/s3/5574464/Division-19-Mentorship-Survey).

For additional questions or more information, please contact Kathryn Eklund, Ph.D. at kathryn.e.eklund.mil@mail.mil.

Call for Female Veterans: Deployment Experience and Stress

My name is Shalonda Griffin and I am a 4th year student at the Philadelphia College of Osteopathic Medicine. We are currently in the process of seeking female veterans for a study to understand the military experiences and stress during and following deployment. If you choose to be a part of this study, you will be asked to complete questionnaires. Your participation will be completely voluntary and anonymous, meaning that the researchers will not be able to identify you. In addition, you may discontinue your participation at any time without consequence. Answering some questions may be associated with mild discomfort related to your military experience during or after deployment. If you are deemed eligible to participate and complete the survey in its entirety, you may choose to enter a secured raffle to possibly win one of six $50 gift cards. This study is approved by the Institutional Review Board of Philadelphia College of Osteopathic Medicine (IRB# H19-060X). The responsible investigator is Shalonda Griffin who is under the direction of Robert A. DiTomasso, Ph.D., ABPP, Principal Investigator.

If you understand the nature and terms of participation in this project and agree to participate, please follow the link: https://redcap.pcom.edu/surveys/?s=4WJE3FC7X8

If you would like to explore other ongoing research studies in need of participants, please see here: http://www.division19students.org/research-recruitment-announcements.html
Military Social Science Laboratory (MSSL) at Utah State University

The Military Social Science Laboratory (MSSL) at USU is accepting 1-2 doctoral students to start Fall 2020. Dr. Becky Blais is the PI of this lab and she investigates how trauma exposure among military service members/veterans relates to individual and interpersonal function. Recent studies focus on combat exposure, military sexual trauma, suicide, PTSD, sexual dysfunction, and relationship distress. The MSSL is part of the Combined Clinical/Counseling PhD program. Students with clear research experience (in any area) will be competitive. USU is located in beautiful Logan, UT. Outdoor activities abound (Utah does have the best snow on earth!). Come join us! For more information, see: [http://psychology.usu.edu/academics/grad/clinical-counseling/application-process?fbclid=IwAR1N_fYU1097Tudnaq18kUp55WPSYTzVzPwWj32sedbm4Od4sCM0j4p-tSWjg](http://psychology.usu.edu/academics/grad/clinical-counseling/application-process?fbclid=IwAR1N_fYU1097Tudnaq18kUp55WPSYTzVzPwWj32sedbm4Od4sCM0j4p-tSWjg)

Military Specific Online Courses and Webinars

Center for Deployment Psychology Online Courses

The CDP ([https://deploymentpsych.org/online-courses](https://deploymentpsych.org/online-courses)) provides interactive web-based training to educate professionals working with Service Members, Veterans, and their families for FREE (CE credit available for cost). Highly Recommended: Military Culture: Core Competencies for Healthcare Professionals

Center for Deployment Psychology Webinar Series

Recorded webinar topics available to watch for free. Topics extend back to JAN 2015 ([https://deploymentpsych.org/webinars](https://deploymentpsych.org/webinars))

Massachusetts General Hospital Psychiatry Academy

MGH ([http://mghcme.org/courses/find-courses](http://mghcme.org/courses/find-courses)) offers 30+ FREE on-demand sessions related to treating veterans and their families. Topics include Military Culture, Trauma, Treatment, and Military Family Challenges.
INSTRUCTIONS FOR CONTRIBUTORS TO THE MILITARY PSYCHOLOGIST NEWSLETTER

Please read carefully before sending a submission.

The Military Psychologist encourages submission of news, reports, and noncommercial information that (1) advances the science and practice of psychology within military organizations; (2) fosters professional development of psychologists and other professionals interested in the psychological study of the military through education, research, and training; and (3) supports efforts to disseminate and apply scientific knowledge and state of the art advances in areas relevant to military psychology. Preference is given to submission that have broad appeal to Division 19 members and are written to be understood by a diverse range of readers. The Military Psychologist is published three times per year: Spring (submission deadline January 20), Summer (submission deadline May 20), and Fall (submission deadline September 20).

Preparation and Submission of Feature Articles and Spotlight Contributions. All items should be directly submitted to at least one of the following assigned Section Editors: Feature Articles (Tim Hoyt: timothy.v.hoyt.civ@mail.mil), Trends Articles (Joseph B. Lyons: joseph.lyons.6@us.af.mil), Spotlight on Research Articles (Christine Hein: chein9@gmail.com), and Spotlight on History (Paul Gade: paul.gade39@gmail.com). For example, Feature Articles must be of interest to most Division 19 members; Spotlight on Research Submissions must be succinct in nature. If longer, please, consider submitting to the Division 19 Journal, Military Psychology, at the email address military.psychology.journal@gmail.com. If articles do not meet any of these categories, feel free to send the contribution to the Senior Editor, Shawnna Chee (shawnna.m.chee.mil@mail.mil) for potential inclusion.

Articles, including references, must be in electronic form (word compatible), must not exceed 3,000 words, and should be prepared in accordance with the seventh edition of Publication Manual of the American Psychological Association (APA-7). All graphics (including color and black-and-white photos) should be sized close to finish print size, at least 300 dpi resolution, and saved in TIF or EPS formats. Submissions should include a title, author(s) name, telephone number, and email address of corresponding author to whom communications about the manuscript should be directed. Submissions should include a statement that the material has not been published or is under consideration for publication elsewhere. It will be assumed that the listed authors have approved the manuscript.

Preparation of Announcements. Items for the Announcements section should be succinct and brief. Calls and announcements (up to 300 words) should include a brief description, contact information, and deadlines. Digital photos are welcome. All announcements should be sent to section editor, Bri Shumaker (briannashumaker@gmail.com).

Review and Selection. Every submission is reviewed and evaluated by the Section Editor, the Editor in Chief, and American Psychological Association (APA) editorial staff for compliance to the overall guidelines of APA and the newsletter. In some cases, the Editor in Chief may also ask members of the Editorial Board or Executive Committee to review the submissions. Submissions well in advance of issue deadlines are appreciated and necessary for unsolicited manuscripts. However, the Editor in Chief and the Section Editors reserve the right to determine the appropriate issue to publish an accepted submission. All items published in The Military Psychologist are copyrighted by the Society for Military Psychology.