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Editor's Column

Shawnna Chee

Welcome to the Summer Issue of *The Military Psychologist* (*TMP*) newsletter.

Division 19 is active this summer with the upcoming 126th Annual American Psychological Association (APA) Convention August 9–12th in San Francisco, CA. Our 2018 APA Convention Program Committee Chairs, Angela Legner and Lindsey Monteith, have provided the newsletter an agenda outlining the Division 19 programming including featured Division 19 Symposium sessions, an EXCOM meeting, and collaborative programing happening throughout the week. Let me also direct your attention to the details available on the Division 19 website at https://www.militarypsych.org/convention-home.html and pay particular attention to the exciting Hospitality Suite sessions, organized by Ryan Landoll, which will certainly offer networking opportunities you won't want to miss.

Next, the new Communications Committee, highlights of all the technological ways to keep up to date with The Society including the Division 19 website (www.militarypsych.org), the APA Division 19-Military Psychology Facebook page, our Twitter account (@APADiv19), and our listerv email div19list@gmail.com. There is really no reason you should miss out on upcoming opportunities and events with all these available lines of communication.

Our current president, Mark Staal, offers a more detailed view of his vision and initiatives as he approaches the halfway point of his term. Dr. Staal is clearly a visionary and broad thinking leader—you won't want to miss his Presidential Address on Friday, August 10th at this year's APA Convention.

Our Feature Article provides insight into the differences of PTSD symptoms of those with combat trauma versus military sexual trauma. The authors' findings provide readers with a greater understanding of elements of a traumatic experience that differentially affect PTSD symptom presentation and hope to inform clinicians and researchers about ways to individualize treatment for better outcomes. This dovetails nicely with the first Trends Article that explores how various therapeutic components of the Boulder Retreat organization's flagship program, Warrior PATHH, for veterans dealing with posttraumatic stress through principles of posttraumatic growth.

In keeping with the annual convention theme, there are two articles that I decided to include as Trends Articles as they highlight conferences focused on PTSD and the latest research and developments; the San Antonio Combat PTSD Conference (coming up October 23–24, 2018) and the District of Columbia Psychological Association Military Psychology Conference (recently held in April 2018). Both of these reports provide insight into some of the major players in PTSD treatment and research as well as resources for our members working within the military culture.

This Issue's Spotlight on Research shares an article about the rates of suicidal ideation in military wives. This is a pertinent reminder of how psychologists and behavioral healthcare providers need to include the family into a holistic treatment approach to our veterans' care. I'd like to thank Paul Gade for his contribution with the Spotlight on History article about Arthur Otis' contribution to military assessment and selection of recruits in the World War I era. These historical perspectives are vital to remind us of who we are as psychologists and where we've been.

And finally, our Early Career Psychologist (ECP) Committee update has information about how to get more involved in leadership opportunities within the division with the opening of a representative position from the applied/operational community and guidance for how to complete research grant applications. A new thing they are doing here is spotlighting an individual ECP, this time a Dr. Robin Gobin, to gain momentum for membership and readership among the committee. This is not to be outdone by with Announcements Section highlighting research opportunities, pre-doctoral internship and post-doctoral fellowship opportunism and job announcements. Look into getting involved today!

As always, it is such a pleasure to be involved with this great Society doing meaningful work within our military community. Please continue to send in your program ideas, your research, your announcements and any other future opportunities to excel for publication to our newsletter. Until the Fall issue, stay safe and I wish you all "blue skies"!

Shawnna Chee, PsyD, ABPP
Editor, *The Military Psychologist*

President's Column

Mark A. Staal

The summer season is upon us, and APA 2018 is looming. As I approach the half-way point in my presidential year, I would like to take the opportunity to update the membership on my five initiatives: (a) push for innovative practice and application, (b) intentionally emphasize our Society's branding across platforms, (c) manifest an appreciation for the diversity of practice domains resident within the division, (d) establish and launch a Task Force (TF) for the development of Operational Psychology Practice Guidelines, and (e) continue focus on the injustice that resulted from the Hoffman report.

My effort to address Initiatives 1 and 3 (pushing for innovation and showcasing our diversity of practice) has largely fallen into two avenues of effort: (a) being proactive in my support for any EXCOM or membership recommendations concerning innovation, creative application, or promotion of practice domain diversity, and (b) encouraging convention engagements, poster presentations, and invited sessions and symposia that capture the same spirit or intent. We have implemented changes to our electronic footprint, websites, social media platforms, and a number of important policies. We also have an outstanding portfolio of material for this year's convention that I believe will highlight innovative practice and diversity.

In terms of Initiatives 4 and 5 (launching an Operational Psychology [OP] Practice Guidelines TF and addressing Hoffman-related injustices) we have taken concrete steps on both fronts. The OP Practice Guidelines TF was set in motion in February and we are currently working on a draft -document. We were fortunate to have received presidential nominations from several key applied APA divisions along with nominations from various national-level associations who identified and commissioned senior psychologists to represent these entities on the TF. We have also initiated a relationship with the APA and its various support elements that will assist the TF in developing and finalizing the OP Practice Guidelines as they progress. Our efforts to address the unfortunate steps taken by the APA post-Hoffman have been three-fold. First, the Society's Executive Committee met with Dr. Arthur Evans (APA's CEO) at our Mid-Year Meeting and shared our concerns and detailed requests with him and his team. He was receptive, thoughtful, and appreciative. We will continue this lane of engagement going forward. Second, by invitation of the American Psychology Law Society (APLS), I was fortunate to be able to debate and discuss the ethics of national security psychology with Dr. Steven Reisner at the Society's annual meeting. The feedback from APLS members was positive and hopefully we can gradually replace the false narrative that has pervaded the larger APA community. Third, Division 48's President, Dr. Alice LoCicero, recently authored a book chapter entitled, *Military Psychology: An Oxymoron*. In response, Sally Harvey and I wrote to the book's publisher to inform them of the misinformation and inaccuracies littering the chapter. We have, furthermore, shared a review of the chapter with the President of the APA (Dr. Daniels). We find it irresponsible and unprofessional for one division president to attempt to delegitimize and call for the disbanding of another division's community of practitioners.

I have left a discussion of Initiative 2 until the end because I intend to spend a little more time exploring the brand and value-proposition of "military psychology." When I first thought about this issue as a presidential initiative, I cringed. I'm not a salesperson and I apologize upfront to any of you who have a sales or marketing background, but I've never liked being the target of a sales pitch. Despite what I say in the next few paragraphs, I hope none of you finish this column thinking you just got taken. Instead, my intent is for a frank but thoughtful discussion concerning our Society's brand and value proposition.

So, what is a brand? For those of us in the 50+ category, we all remember the Pepsi challenge that took place in 1975. You'd walk up to a grocery store and out front would be a table with Coke products and Pepsi products, and a healthy stack of Dixie cups. Someone at the table would ask if you wanted to take the challenge (could you pick Pepsi from Coke and which did you like better). It was a strategy by Pepsi to try to take back market share that had been gobbled up by Coke. It was easy to taste the difference, and quite frankly, you either liked the sweeter-tasting Pepsi or you didn't (and based on research into single-sip taste-test methodology, most consumers naturally pick the sweeter-tasting drink). It was a marketing ploy that instantly got more people drinking Pepsi and once they picked the sweeter drink, they were well on their way to becoming Pepsi-branded. As a counter to the loss in market share, Coke then did the unthinkable, they stopped making Coke and tried to re-brand themselves under "New Coke" (an attempt to improve competition with Pepsi a decade later by making a sweeter-tasting Coke). It was a disaster and they quickly brought back Coke under a

new name, "Coca-Cola Classic." Thankfully, the balance between good and evil was restored. Once Coke Classic (the original Coke) returned, consumers who had previously been branded to Coke, returned in droves.

So, what does that mean for Division 19? Our Society delivers a product and our members are consumers of that product. There are tangible benefits to membership, such as our journal, this newsletter, and a line on your vita under professional affiliations. There are of course many intangible benefits as well, such as professional identity, the ability to hold office, and a sense of community. In general, military psychology has been expanding its market share within the APA at a time when other divisions have been contracting. However, anecdotal evidence suggests that the impact of the Hoffman report has had a negative effect on our brand. Some graduate students and their faculty have raised concerns about military psychology and its position on various controversial issues. Furthermore, some active duty psychologists have dropped their APA and society memberships as well as refused to become members in the first place, due to the Association's recent changes in policy. One such example is the Association's prohibition against psychologists providing mental healthcare to detainees under U.S. military custody. As required by U.S. and International Law, this prohibition amounts to a violation of common article III of the Geneva Conventions. Because it is the military psychologist's duty by law to provide healthcare to those under detention, our colleagues must choose between obeying the law and international treaty or following APA policy. As a result, many have chosen to avoid this ethical dilemma by simply never becoming members.

In simple terms, Division 19's brand is its promise to its members, and its value proposition is its promise of delivered value. Our brand is more than a logo or a catch phrase, it communicates who we are, what we are all about, and what we aren't. It serves to differentiate our community and products from others, and it is the face of our organization that we present to the outside as well as the character that we display and share with our members. According to marketing literature, building brand identity is critical for organizations in competitive markets. Personally, I believe that the Society for Military Psychology has a strong value proposition. It provides a sense of professional identity and a voice or platform for its members. It acts as a professional resource and it advocates for its membership to the broader Association and practice community.

Going forward, I ask for your support and collaboration in living out our collective values. In a real sense, you, our members, are our brand, and how you conduct yourselves—your professionalism and character—are our value proposition to the various communities we serve. Thank you for all you do. See you all in San Francisco!

Honored to Serve,
Mark
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Differences in Posttraumatic Stress Disorder Symptom Severity for Military Veterans with Combat vs. Military Sexual Trauma

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In a nationally representative sample, veterans were shown to be more likely than civilians to have a lifetime diagnosis of posttraumatic stress disorder (PTSD), with 7.3% of veterans meeting criteria for a lifetime PTSD diagnosis (Lehavot, Katon, Chen, Fortney, & Simpson, 2018). There is considerable heterogeneity in PTSD symptom presentation among individuals diagnosed with PTSD as a result of differing traumatic experiences (DiMauro, Carter, Folk, & Kashdan, 2014). Among military veterans, the type of trauma experienced is one potential factor that may contribute to this heterogeneity, with military sexual trauma (MST) and combat trauma being two of the most commonly endorsed traumatic experiences during military service (Miller et al., 2013).

MST is defined as "psychological trauma, which in the judgement of a Veterans Health Administration mental health professional, resulted from a physical assault of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training" (U.S. Code, Title 38 § 1720D). When limiting the definition of MST to sexual assault, a recent meta-analysis found that approximately 2% of men and 24% of women report MST during their service (Wilson, 2016).

Combat exposure is more common than MST among deployed military veterans, with one study reporting that 85–90% of Operation Iraqi Freedom/Operation Enduring Freedom veterans experienced combat exposure during their military service (Tanielian, 2009). Relatively few female veterans report combat exposure; however, this number is anticipated to increase with female veterans' recent ability to serve in combat roles (Kamarck, 2015). Because of restriction on female veterans serving in combat roles, gender is difficult to disentangle from trauma type in combat-related PTSD; however, no relationship between gender and PTSD symptom severity has been found among military veterans in two large meta-analyses (Brewin, Andrews, & Valentine, 2000; Tolin & Foa, 2006).

As differences in baseline clinical presentation can affect treatment response (Galovski et al., 2016), identifying factors, such as type of trauma experienced, which may explain heterogeneity in PTSD symptom presentation has the potential to inform care. Sexual assault-related MST has been shown to be more predictive of PTSD diagnosis than other types of trauma, including combat trauma (Kang, Dalager, Mahan, & Ishii, 2005). Recently, researchers have investigated differences in symptom presentation among veterans who have experienced trauma but do not have a confirmed PTSD diagnosis. In each case, sexual trauma was associated with greater PTSD symptom severity based on a self-report screening measure of PTSD (Graham et al., 2016; Jakob, Lamp, Rauch, Smith, & Buchholz, 2017; Smith, Summers, Dillon, & Cougle, 2016). In the only study to specifically compare survivors of MST to survivors of combat trauma, survivors of MST were found to report more severe PTSD symptoms on a self-report screening measure of PTSD (Sexton, Raggio, McSweeney, Authier, & Rauch, 2017).

Although research has examined the effect of exposure to combat and sexual trauma on PTSD symptom severity, no studies have compared PTSD symptom severity in veterans with a confirmed diagnosis of combat- versus MST-related PTSD. Considering survivors of MST have a greater likelihood of being diagnosed with PTSD compared to survivors of combat trauma (Kang et al., 2005), it is difficult to disentangle whether PTSD symptom severity differences in studies of trauma exposure are a result of higher diagnosis rates or of greater PTSD symptom severity due to a specific trauma type. Limiting analyses to veterans diagnosed with PTSD will help clarify group differences in PTSD symptom severity.

The current study aims to build upon existing research by investigating how PTSD symptoms differ based on trauma type within a sample of veterans formally diagnosed with PTSD. PTSD symptom severity was compared between veterans diagnosed with either combat- or MST-related PTSD based on their self-reported most severe lifetime trauma (i.e., index trauma).

Method

Participants

Baseline data from two randomized clinical trials (RCTs) were used for the current study. The first RCT was an examination of the effectiveness of cognitive processing therapy in treating male (n = 15) and female (n = 113) veterans with MST-related PTSD (Surís, Link-Malcolm, Chard, Ahn, & North, 2013). The second study was a pharmacotherapy RCT examining the efficacy of a novel intervention (dexamethasone + exposure task) in treating male combat veterans (n = 91) with PTSD (Surís, Holliday, Adinoff, Holder, & North, 2017). Participants for both studies were recruited via similar procedures and received monetary compensation for their participation. Both RCTs were approved by the local Institutional Review Board, and all participants voluntarily gave written consent.

For statistical analyses, participants were grouped by their index trauma, either combat (n = 91) or MST (n = 128). To create independent groups, veterans who endorsed both combat and sexual trauma (n = 48) were excluded from analyses. This resulted in a final sample of 171 veterans (MST: n = 92; Combat: n = 79). Sociodemographic characteristics (i.e., age, education, race/ethnicity, and gender) for each group can be found in Table 1.

Measures

The same assessment measures were used in both RCTs, allowing cross-study comparison. In addition, a demographic questionnaire was administered to obtain sociodemographic information (i.e., age, education, gender, and race/ethnicity).

The Clinician Administered PTSD Scale (CAPS), a 30-item semi-structured interview, was used to diagnose PTSD and assess the frequency and intensity of *Diagnostic and Statistical Manual for Mental Disorders,* 4th ed., text rev. (*DSM-IV-TR*) PTSD symptoms (American Psychiatric Association [APA], 2000; Blake et al., 1995). A total score for the CAPS is generated based on summing frequency and intensity scores for the *DSM-IV-TR* PTSD symptoms. In addition, symptom cluster scores are obtained by summing the respective symptoms for the three *DSM-IV-TR* PTSD criteria (CAPS criterion B [CAPS-B]: re-experiencing, CAPS criterion C [CAPS-C]: avoidant/numbing, and CAPS criterion D [CAPS-D]: arousal). The CAPS has strong reliability and concurrent validity to other measures of PTSD (Blake et al., 1995).

The PTSD Checklist (PCL) is a 17-item, self-report measure that assesses the perceived intensity of each of the 17 *DSM-IV-TR* PTSD symptoms severity (APA, 2000; Weathers et al., 1993). A total score for the PCL is generated by summing each of the 17 items. The PCL has strong test-retest reliability and concurrent validity to measures of PTSD symptom severity (Wilkins, Lang, & Norman, 2011).

The Life Events Checklist (LEC) was administered to determine the presence of multiple traumatic experiences. The LEC exhibits psychometric validity as an assessment of lifetime trauma exposure (Gray, Litz, Hsu, & Lombardo, 2004).

Procedure

For further information regarding inclusion and exclusion criteria and study procedures, see Surís et al. (2017) and Surís et al. (2013). Measures of interest (i.e., CAPS, PCL, LEC, and sociodemographic questionnaire) were administered at at a single baseline session in both RCTs. Although data from two distinct RCTs were used for the present study, both studies had similar inclusion (e.g., military-related PTSD) and exclusion (e.g., active substance dependence, psychosis, unstable bipolar disorder, or suicidal/homicidal features) criteria. In addition, both samples were treatment-seeking veterans and the present analyses included only baseline data, excluding possible treatment effects.

Analytic Plan

Independent samples t-tests were used to identify significant differences in trauma groups for continuous sociodemographic variables (i.e., age and education). A chi-square analysis was used to identify a potential relationship between trauma group and race/ethnicity. Gender was included as a competing factor in analyses due to the known discrepancy between groups. Although the inclusion of gender did not identify significant trauma group by gender interactions, it provided further information regarding the approximate contribution of gender on symptom severity. As a result, five 2 (trauma type: MST vs. combat) × 2(gender: male vs. female) analyses of variance were conducted with CAPS total score, CAPS-B score, CAPS-C score, CAPS-D score, and PCL total score included as outcome variables. A Bonferroni correction was used to correct for five statistical tests (i.e., 0.05/5), producing a threshold of significance at $\alpha = 0.01$.

Results

Sociodemographic

No significant differences between trauma groups were found for ethnicity or education ($p > .05$; see Table 1). Age significantly differed between the groups, $t(130.27) = 3.07$, $p = .003$, with veterans in the MST group being significantly older; therefore, age was entered as a covariate

in the analysis of outcome measures. In addition, as expected, gender was disproportionate between the groups, with the combat trauma group including only male veterans and the MST group including both male and female veterans.

PTSD Symptom Severity

Means and standard deviations for outcome variables by trauma group are included in Table 2. A significant main effect of trauma type was found for the PCL, $F(1,166) = 10.67$, $p = .001$, $\eta^2_{partial} = .06$, and CAPS, $F(1,167) = 16.29$, $p < .001$, $\eta^2_{partial} = .09$, total scores, with the MST group experiencing greater self- and clinician-reported PTSD symptoms. The MST group also had significantly higher CAPS-B (re-experiencing) scores, $F(1,167) = 11.81$, $p = .001$, $\eta^2_{partial} = .07$, and CAPS-C (avoidant/numbing) scores, $F(1,167) = 16.00$, $p < .001$, $\eta^2_{partial} = .09$. In contrast to other findings, a significant main effect was not found for trauma type on CAPS-D scores (hyperarousal), $F(1,167) = 2.16$, $p = .144$. There was not a main effect of gender for any of the analyses ($p > .05$). In addition, after correcting for multiple statistical tests, age was not a significant covariate for any analysis ($p > .01$).

Discussion

Within individuals diagnosed with PTSD, there is considerable heterogeneity in symptom severity and presentation (DiMauro et al., 2014). Results support that trauma type is one variable that results PTSD symptom heterogeneity, with veterans who endorse a history of MST-related PTSD experiencing greater clinician-rated and self-reported PTSD symptom severity. This finding was consistent for both re-experiencing and avoidant/numbing symptom groups.

Hyperarousal symptom severity did not differ between trauma groups, despite overall PTSD symptom severity being lower in veterans with combat-related PTSD. The distribution of PTSD symptoms between symptom groups may differ based on trauma type, with survivors of combat-related PTSD experiencing a greater proportion of hyperarousal symptoms in comparison to re-experiencing and avoidant/numbing symptoms. Differences in symptom distribution based on trauma type may have treatment implications. For example, focusing on hyperarousal symptoms may be more important for veterans with combat-related PTSD than for veterans with MST-related PTSD.

TABLE 1

Sociodemographic Variables by Trauma Type

Variable	Military sexual trauma (n = 92)				Combat trauma (n = 79)				χ^2	t
	M	*SD*	*n*	*%*	*M*	*SD*	*n*	*%*		
Education	14.18	2.02			13.90	1.95				.94
Age	45.58	9.55			39.66	14.68				3.07**
Gender									135.29***	
Male			10	10.87			79	100.00		
Female			82	89.13			0	0.00		
Race/ethnicity[a]									8.76	
White, non-Hispanic			37	40.22			46	58.97		
Black, non-Hispanic			39	42.39			20	25.64		
White, Hispanic			4	4.35			4	5.13		
Black, Hispanic			1	1.09			1	1.28		
American Indian/ Alaska Native			1	1.09			1	1.28		
Native Hawaiian/ Pacific Islander			1	1.09			0	0.00		
Other			9	9.78			6	7.69		

Note. [a]One veteran in the combat trauma group "declined to state" race/ethnicity.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 2

PTSD Symptom Severity by Trauma Type

Variable	Military sexual trauma (n = 92)		Combat trauma (n = 79)		F
	M	SD	M	SD	
CAPS-B	22.37	6.11	18.84	5.73	11.81**
CAPS-C	33.97	8.00	27.43	8.80	16.00***
CAPS-D	26.00	5.47	23.84	6.14	2.16
CAPS-T	83.13	14.76	70.38	15.69	16.29***
PCL[a]	64.82	12.03	56.30	11.77	10.67**

Note. CAPS = Clinician Administered PTSD Scale; CAPS-B = criterion B: re-experiencing; CAPS-C = criterion C: avoidance/numbing; CAPS-D = criterion D: arousal; CAPS-T = Total Score; PCL = PTSD Checklist; PTSD = posttraumatic stress disorder.

[a] PCL data were missing from 1 participant in the combat trauma group.

*p < .05. **p < .01. ***p < .001.

Although veterans with combat-related PTSD report substantial PTSD symptoms, there are multiple theories that potentially explain why veterans with MST-related PTSD may report significantly greater PTSD symptoms. Survivors of sexual trauma, more so than nonsexual trauma (e.g., combat trauma), may experience changes in interpersonal beliefs regarding the benevolence of others (Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009), which could influence the severity of PTSD. Specific to military and veteran populations, researchers suggest that MST may result in increased PTSD symptom severity due to required continued interaction with the perpetrator(s), loss of social support, and perceived consequences of reporting the trauma (Surís & Lind, 2008). A greater understanding of elements of a traumatic experience that differentially affect PTSD symptom presentation may inform clinicians and researchers about ways to individualize treatment.

One limitation of the present study is the unbalanced sampling of gender between trauma types. Although gender has not been found to affect PTSD symptom severity among military veterans in previous investigations (Brewin et al., 2000; Sexton et al., 2017; Tolin & Foa, 2006), a gender-balanced study design would be required to definitively determine the role of gender in influencing PTSD symptom severity. In addition, although inclusion criteria for both studies required an index trauma of either MST or combat trauma, the exact number of *DSM-IV-TR* criterion A traumatic experiences endorsed by the sample was not collected. Because trauma load is positively associated with PTSD symptom severity (Jakob et al., 2017), it is important for future researchers to assess and statistically account for multiple traumas. Our convenience sample included baseline data of treatment seeking veterans. Although there is not a reason to suspect that combining common data elements would affect results, differences in patient self-selection between studies cannot be ruled out.

This study's findings contribute to the literature by identifying how diagnosed PTSD from MST may result in increased PTSD symptom severity compared to PTSD resulting from combat. Additional research examining the role of gender in veterans with combat-related PTSD remains necessary. Researchers should continue to focus on understanding factors (e.g., trauma type) that contribute to the variability in PTSD symptom presentation and severity as differences in symptom presentation and severity may affect treatment selection and focus of intervention.

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Boulder Crest Retreat: Integrating Non-Traditional and Traditional Interventions for Military Veterans

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Although estimates vary, experts generally agree that up to a third of Iraq and Afghanistan veterans battle some form of psychological ailment as a result of their service (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al, 2004). More specifically, estimates of the prevalence of posttraumatic stress disorder (PTSD) in these same groups range between 15% to 25% (Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Institute of Medicine, 2014; Tanielian & Jaycox, 2008). Arguably the most troubling and perplexing psychiatric issue associated with the recent conflicts in Iraq and Afghanistan is the significant increase in suicide ideation, attempts, and completions over the past decade (Rudd et al., 2015).

Research funding and dissemination of evidence-based treatments for psychiatric disorders in veterans has been a major priority for the military and veterans administration health care systems. The most noticeable focus has been on the treatment of PTSD. In this article we discuss how elements of the traditional evidence-based approaches can be integrated with innovative, nontraditional ways to provide better outcomes for veterans suffering from psychological trauma. This kind of integration is being developed at Boulder Crest Retreat in Virginia and Arizona.

Success and Failure with Evidence-Based Treatments

According to the recently released Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guidelines for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2017), there are several psychotherapies deemed to have sufficient evidence to support their use in the treatment of PTSD with veterans. Those with the highest level of recommendation are "trauma-focused" psychotherapies, which are interventions that require the veteran to actively confront the trauma through talking, imagining or writing about the traumatic event. Although trauma-focused therapies like prolonged exposure, cognitive processing therapy, and eye movement desensitization and reprocessing outperform waitlist and treatment-as-usual controls and result in clinically significant reductions in symptoms, the majority of veterans do not achieve remission. In fact, up to two-thirds of "successfully" treated individuals retain the PTSD diagnosis (Schnurr et al., 2007; Steenkamp, Litz, Hoge, & Marmar, 2015). In addition to the magnitude of effects, these therapies face the problem of early termination or "dropout" of treatment, which can be as much as 40 percent or higher with particular therapies (Kehle-Forbes, Meis, Spoont, & Polusny, 2016; Schnurr et al., 2007). And lastly, trauma-focused therapies appear to be only marginally more effective than nontrauma-focused psychotherapies (e.g. interpersonal psychotherapy, acceptance and commitment therapy), questioning the use of these interventions as "first-line" treatments considering their high dropout rates.

If a veteran is not interested in a trauma-focused psychotherapy, or if the therapy is not available, the VA/DoD guidelines (2017) recommend the use of four specific medications to include three selective serotonin reuptake inhibitors (paroxetine [Paxil], sertraline [Zoloft], fluoxetine [Prozac]), and one serotonin norepinephrine reuptake inhibitor (venlafaxine [Effexor]). Even though many more medications are used with veterans battling PTSD and related disorders, the guidelines do not support their use due to lack of research supporting their efficacy or because the risks of these medications outweigh the benefits.

Considering the limitations of psychotherapeutic and pharmacological treatments, it is reasonable to consider other forms of interventions that do not neatly fit within the traditional evidence-based model of care and that are not as readily studied by researchers or have findings published in top-tier peer-reviewed journals. These may be single interventions such as mindfulness, exercise, or relaxation training or programs that combine multiple interventions in a structured and deliberate format. A good example of the latter is Boulder Crest Retreat.

Boulder Crest and the Four “P's”: Philosophy, People, Place, & Program

Boulder Crest Retreat for Military and Veteran Wellness (BCR) is a community-based, nonprofit, multisite, private organization based in Bluemont, Virginia with an additional center in Arizona. The flagship program of BCR, Warrior PATHH (Progressive and Alternative Training for

Healing Heroes), uses a variety of complementary and alternative interventions for posttraumatic stress and is based on the concept of posttraumatic growth (Tedeschi & Moore, 2016). Warrior PATHH begins with a 7-day onsite residency with an 18-month follow-up program facilitated primarily through web-based sessions with BCR staff members. Preliminary results are encouraging, and it is useful to consider how positive outcomes of the Warrior PATHH program are achieved. There appear to be four essential components that together produce favorable outcomes, based upon data being gathered in an ongoing program evaluation.

Philosophy

The program has a coherence to it because there is a fundamental philosophy that guides the activities in the program and how they are implemented by program staff. The philosophy is based on the posttraumatic growth (PTG) concept. The PTG concept is that traumatic events can often be catalysts for positive change, since the events that create psychological distress by contributing to confusion about self-identity, the world, and the future also open up opportunities for questioning, exploration, and reconsideration of long-held assumptions about these matters. The result of this process is a rebuilt set of core beliefs that better serve the trauma survivor in accounting for what happened and how to proceed into the future.

The PTG concept provides several ways of understanding trauma and its aftermath that are salutary.

1. There is a sense of possibility for growth in the aftermath of trauma, not simply ongoing struggle with symptoms of PTSD or related disorders.
2. There is a process that can be understood and implemented to facilitate PTG. Veterans who have experienced trauma have a path they can travel to be more than PTSD symptoms or people who have overcome symptoms.
3. Veterans who are perceived as having this potential for growth are more likely to be treated with respect and valued.
4. Veterans who understand that PTG is the philosophy underpinning the Warrior PATHH program see themselves as suffering not because of character defects or something else that is wrong with them, but because of what happened to them. This understanding helps to relieve shame and self-stigma from those who are suffering.
5. The PTG model suggests specific domains of growth that can be noted as indicators of progress that give meaning to the experiences of trauma and their aftermath, so that trauma can be tolerated or for some, even valued, since it is no longer meaningless or in vain.
6. The PTG model posits that to facilitate PTG, trauma survivors will benefit from expert companionship. Note that the assumption is that PTG can be facilitated, but that the process itself is rather common and naturally occurring without professional intervention. The concept of expert companionship emphasizes that trauma survivors first need companionship, and the companion must be first willing to learn from the trauma survivor about their life and experiences, and not start with taking a position of knowing how that person should live their life. The concept of expert companionship emphasizes that relationship is more important than technical expertise. Therefore, paraprofessionals and partners in the trauma survivorship can be very effective in facilitating PTG.

People

The people who guide the participants through the program embody the concept of expert companionship. With the majority of staff being veterans, there is a quickly developing sense of trust. All staff are involved in respectful interactions with the veterans in the program, including those who are not directly responsible for implementing it. Therefore, the important elements of the people at BCR are the following.

1. They are familiar with the military experience from their own service or from close connections with veterans.
2. They are very good listeners and learners and approach the veterans in the program with respect and encouragement. They enjoy their work and the energy and fun that shows up in their work relaxes participants.
3. They understand the PTG concept and expert companionship, and therefore do not focus on symptoms.
4. The language used is consistent with a respectful approach with the veterans. They are called “students” rather than “patients” or “clients,” and the staff are “guides” rather than “therapists” or “technicians.” The program itself is referred to as “training” rather than “therapy” as training can be thought of an extension of military life and experience.

Place

Most veterans receive therapy in clinics and hospitals. These environments imply that a disease or disorder is being treated. Often they are institutional and somewhat unpleasant. In contrast, BCR is in a rural setting devoted to the Warrior PATHH program, with buildings and facilities built out of wood and stone in rustic designs. The grounds and buildings are impeccably kept, again demonstrating respect for the participants. The food that is served is healthy and delicious and not at all institutional. The environment is quiet and this provides an opportunity

to quiet the mind, as meditative techniques are integrated into the program. A good deal of time is spent outside in the quiet and beautiful environment. There are some data to indicate that activity in natural environments is a healing experience for veterans (Westlund, 2015).

Program

The Warrior PATHH program is structured around the PTG intervention model that includes five elements:

1. Psychoeducation about physiological and psychological trauma response and PTG;
2. Emotion regulation training, including meditative techniques;
3. Constructive self-disclosure about trauma and life in the aftermath of trauma;
4. Narrative development that integrates perspectives on life before military service, the experiences of military service, and the aftermath of deployment and service as the veteran returns home; and
5. Missions that could be developed to transmit the learning about the value of life, living courageously, and other understandings to those in society who have not been exposed to these perspectives.

The program incorporates elements that are found in some traditional trauma interventions, but in ways that weave these into experiences that do not appear to be "therapy." For example, emotion regulation strategies appear throughout the program in such activities as archery, kayaking, or meditation. Disclosure is encouraged throughout but not demanded, and in the bonfire discussions held at the end of each day, there is safety in the calm environment and the simple acceptance and lack of analysis given to disclosures. This way of interacting with program participants helps overcome the reluctance and resistance many might feel, and as a result, the dropout rate over 18 months is extremely small.

The program is designed to develop a small team that will continue to rely on each other for support over at least 18 months of continuing study and support through video conferencing. Therefore, care is shown in this commitment to support and encouragement, and each team member feels a shared obligation to maintain the mutual support that developed during the first week of the program at BCR.

Integration of PATHH Elements

The integration of the Warrior PATHH program philosophy with the setting, the program elements and the people who act as guides creates an experience for participants that appears to be unique in the field of trauma intervention. Without any one of these elements, the outcomes are likely to be compromised. However, we believe that the successful components of Warrior PATHH could be integrated into traditional mental health programs.

The setting is likely the element that is most difficult to reproduce, but there may be ways to incorporate some aspects of a calming, natural environment in many settings that do not have the facilities available at BCR. For example, traditional hospital and clinic "campuses" often have dedicated outdoor spaces for patients and guests to relax. These spaces could be incorporated in to care programs for veterans. At a minimum it provides a break from the often impersonal and sterile offices in which veterans typically receive care.

Integration of the PTG philosophy into PTSD care for veterans would be less of a challenge. The framework of PTG is based on concepts familiar to clinicians as its roots are based in cognitive, behavioral, interpersonal, and existential concepts. We do not believe a PTG model of care should replace evidence-based therapies, but rather integrated into their delivery.

The people component of the program is arguably the easiest to integrate into traditional mental health settings. BCR staff are trained in basic techniques such as active listening and reflection. They are taught how to convey genuineness and compassion and are regularly reminded of the importance of being non-judgmental. These are all basic skills clinicians should already possess. However, as psychologists who have been involved with training and supervision of therapists for many years, we have grown to believe that these basic yet powerful techniques and approaches to patient care are often overlooked, forgotten, or ignored. One can generate many hypotheses as to why this has occurred, but we believe there is a direct negative correlation between these skills and the proliferation of manualized therapies.

Many of the program interventions used in Warrior PATHH are based on sound psychological principles. For example, psychoeducation about trauma and its effects is often the initial phase of psychotherapy. The ability to engage in emotional regulation, whether it be through meditation, mindfulness, or a variety of relaxation techniques are key to dealing with the intense psychological and physiological reactions associated with past traumatic events. And self-disclosure and adaptive narrative development are cornerstones of all trauma-focused therapies and many non-trauma focused therapies.

Lastly, supporting trauma survivors in the creation of a new "mission" in their posttrauma lives mirrors the important aspect of psychotherapy in which patients are supported in their desire and tendency to grow and mature as humans. Helping the veteran find meaning and purpose in his or her life is arguably the greatest collaborative goal that can be set and worked toward in therapy. This is perhaps a key guiding principle in this program. Veterans are expected to see their continuing value to their families, communities and country in the service they can provide because they have a growth perspective on the adversity

they have experienced. At BCR, veterans are not merely healed from symptoms but are encouraged to use their considerable strengths on continued meaningful missions of service.

Conclusion

We hope that the example of the BCR program will encourage those who work with veterans and other trauma survivors to look beyond the narrow focus on evidence-based treatments to consider the broader possibilities of healing that lead to lives that are truly meaningful in spite of the tragic parts of the life story. With this perspective, our veterans are likely to be treated with more respect and encouragement and the outcomes for them will please them and their families and inspire the rest of us.

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The San Antonio Combat PTSD Conference—Guiding the Future of PTSD Research

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Lifetime prevalence of posttraumatic stress disorder (PTSD) in the general American population lingers around 6.8%, but certain subgroups (i.e., military service members and veterans) are at a significantly higher risk of developing PTSD (Fulton et al., 2015; Gradus, 2017). PTSD in post-9/11 veteran populations has been reported near 23% and as high as 29% in Vietnam-era veterans (Fulton et al., 2015; Gradus, 2017). PTSD is a costly disorder with far reaching effects both to society and to those suffering (Lindgren, Kaysen, Werntz, Gasser, & Teachman, 2013).

National Response to a Growing Public Health Crisis

Recognizing the mounting public health crisis spurred by the post-9/11 wars, the U.S. Department of Defense (DoD) funded the **S**outh **T**exas **R**esearch **O**rganizational **N**etwork **G**uiding **S**tudies on **T**rauma **a**nd **R**esilience, or STRONG STAR, in 2008. STRONG STAR is a multidisciplinary and multi-institutional research consortium led by The University of Texas Health Science Center at San Antonio (UT Health San Antonio) and based in South-Central Texas. Its aim is to develop and evaluate the most effective early interventions possible for the detection, prevention, diagnosis, and treatment of combat-related PTSD and related conditions in active-duty military personnel and recently discharged veterans.

In their effort to best carry out this charge, and as part of the STRONG STAR grant award, consortium investigators and collaborators have assembled in San Antonio, Texas, on an annual basis for the past 10 years for a STRONG STAR annual meeting. Traditionally, the focus of the meeting has been to establish future directions both for research and clinical treatment and to address issues faced while conducting PTSD research with active-duty military and recently discharged veterans.

Building on the successes of the original STRONG STAR Consortium, UT Health San Antonio and the U.S. Department of Veterans Affairs' (VA) National Center for PTSD were selected for joint funding by the DoD and VA to lead the Consortium to Alleviate PTSD (CAP). The CAP shares the vision of the original STRONG STAR, with some additional and specific areas of research interest. One focus of CAP is to test adaptations to existing evidence-based treatments to improve treatment response in service members and veterans with PTSD. Another focus of CAP is to evaluate the use of biomarkers for the diagnosis of PTSD and the prediction and measurement of treatment response.

Over the years, as STRONG STAR grew and the CAP was formed, the STRONG STAR/CAP annual meetings became an unprecedented gathering of many of the nation's top military, civilian, and VA clinicians and researchers interested in developing and evaluating the most effective treatments possible for combat-PTSD and related conditions. Meeting discussions progressed from specific study activities to the sharing of information on scientific advances and the identification of research gaps related to the care and treatment of psychologically wounded warriors.

Working Meeting Transformed into Premier Scientific Conference for Combat PTSD

In 2016, the annual STRONG STAR/CAP meeting was opened to the public for the first time as the San Antonio

Combat PTSD Conference. In doing so, STRONG STAR and CAP leadership aimed to make the conference a premier annual event that brings together world-class military, civilian, and VA researchers, health care professionals, and health care policy makers for an important purpose: notably, the exchange of scientific data, information, and ideas related to emerging outcomes and ongoing scientific and translational research on the assessment and treatment of combat-related PTSD and comorbid conditions in active duty service members and veterans who deployed in support of combat operations since September 11, 2001. The conference takes place each year during the third week of October and is presented by the STRONG STAR Consortium, the Consortium to Alleviate PTSD, and the Department of Psychiatry at UT Health San Antonio.

The inaugural San Antonio Combat PTSD Conference (www.combatPTSDconference.com) held in 2016 was attended by 368 national, regional, and local researchers, clinicians, and government officials. In line with the original annual meeting format, presentations from the 2016 conference specifically centered on ongoing and recently completed STRONG STAR and CAP studies. However, the call for poster submissions was open to the public and resulted in more than 20 poster presentations from researchers across the nation. Attendees, including psychologists, licensed professional counselors (LPC), licensed clinical social workers (LCSW), and licensed marriage and family therapists (LMFT), were able to earn up to 12 continuing education (CE) credits sponsored by the Bexar County Psychological Association.

The 2nd Annual San Antonio Combat PTSD Conference was held October 18-19, 2017, and attracted nearly 300 attendees from across the nation. The 2017 conference was expanded to include keynote speakers, plenary sessions, breakout symposia and a clinician-focused panel discussion. The call for submissions was opened to the public and resulted in a total of 36 presentations and 25 poster presentations across two days from STRONG STAR and CAP studies as well as studies from the broader scientific community. CEs were sponsored by the American Psychological Association (APA) Division 19. Psychologists, LPCs, LCSWs, LMFTs were eligible to receive 12 CE credits for attending and evaluating 2 days of presentations. Keynote presentations included discourse from the Chair of the Department of Psychiatry at Yale University, Dr. John Krystal, on the utilization of ketamine and its role in PTSD treatment as well as from the Director of Military and Veterans Health Policy at APA, Dr. Heather O'Beirne Kelly, on the political climate in Washington DC, surrounding politics, policy, and PTSD.

Findings Reported at the 2nd Annual San Antonio Combat PTSD Conference

For the full 2nd Annual San Antonio Combat PTSD Conference program including presentation abstracts visit: www.combatptsdconference.com/2107-program-presentations/

Looking Ahead: The 3rd Annual San Antonio Combat PTSD Conference

The 3rd Annual San Antonio Combat PTSD Conference will be held October 23-24, 2018 in San Antonio, Texas. As in 2017, the call for submissions is open to the public (www.combatptsdconference.com/submissions/), and the agenda will be comprised of keynote speakers, plenary sessions, breakout symposia, and panel discussions. In addition to the clinician-focused panel discussion, the 2018 agenda will include a military senior leader panel discussion focused on current issues surrounding PTSD in the military. *2018 topics of interest for submissions* include: (1) emerging outcomes and ongoing scientific research on the assessment and treatment of combat-related PTSD and comorbid conditions (sleep, chronic pain, suicide, substance use disorders); (2) use of biomarkers to understand mechanisms of PTSD and comorbid conditions; (3) dissemination of evidence-based treatments for PTSD to health care providers and policy makers; (4) implementation of evidence-based treatments for PTSD in DoD and VA settings; (5) ethical issues for mental health professionals; and (6) cultural competence and diversity. Once again, an application for CE sponsorship though APA Division 19 will be submitted.

The San Antonio Combat PTSD Conference continues to grow each year in both depth and breadth; quickly becoming the seminal event for the dissemination of state-of-the-art combat-related PTSD treatment research. Conference proceedings have the synergy required to make major scientific advances in the behavioral and biomedical sciences and to have a significant public health impact in preventing chronic PTSD in a new generation of combat veterans. The conference not only offers the chance to gain insights into cutting-edge advances in evidence-based treatment research and trends but it also affords several opportunities to network and shape potential collaborations with the leading experts in the field, truly guiding the future of PTSD research.

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District of Columbia Psychological Association (DCPA) Military Psychology Conference

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Professional conferences are an opportunity for attendees to share knowledge, learn from subject matter experts, develop relationships, and inspire younger generations to pursue an education or career in a field. Now more than ever, military cultural competence is paramount for both military and civilian psychologists. These events foster a sense of community and engagement that should be recognized as a fundamental aspect of progress. The DCPA Military Psychology Conference on April 27, 2018 was no exception.

Held at The Chicago School of Professional Psychology in Washington, DC, this DCPA event provided undergraduate and graduate students, academics, practitioners, spouses, the civilian and general military community, policy makers, and leaders a chance to learn about behavioral health issues, assessment, treatment, resilience-building, and performance enhancement for military members. Over 60 people attended, and the conference was sold out a month in advance. The meeting provided 6 hours of continued education units with sessions presented by nationally recognized military subject matter experts in suicide, neuropsychology, resilience, medical and operational settings, complicated PTSD, veterans transitioning to work, and women in the military.

Dr. Gerald (Jerry) Krueger – Past President of The Society for Military Psychology (APA Division 19) and Applied Experimental and Engineering Psychology (APA Division 21) – began the conference by reviewing military clinical psychology history from World War I to the present date, reciting the unique assignments and increased contributions of military psychology over the years. He explained the role of military psychologists throughout various wars and conflicts and pointed out that Division 19 has been in existence since 1947, when APA underwent a re-organization.

Dr. David Jobes, a professor at the Catholic University of America, indicated that at no other time in the history of psychology has there been such broad based work in suicide prevention, and none so well-funded as research sponsored by the Department of Defense and the Veterans Health Administration. Dr. Jobes went on to provide an overview of the problem of suicide in the military. He gave examples of the empirically validated clinical assessments of suicide risk as well as examples of clinical treatments for suicidality in service members, approaches that have shown efficacy in randomized controlled trials. Further, Dr. Jobes clarified that treating mental health conditions does not necessarily treat suicidality. He mentioned, however, that from a neuroscience perspective, specifically targeting suicide ideation through Cognitive Behavioral Therapy and/or Dialectical Behavior Therapy may be effective in reducing suicide ideation by re-engaging the prefrontal cortex, which gets suppressed by limbic system activity.

Next, CAPT Carrie Kennedy, the Navy Clinical Psychology Specialty Leader and Division Chief of DoD's Psychological Health Center of Excellence, presented on neuropsychology in the military. She noted that only about 16% of TBIs among the military population are due to combat or blast exposure; the remaining 84% occur in the context of sports injuries, accidents, etc. She emphasized the importance of flexibility in a deployed setting and optimizing the use of corpsmen and medics as force multipliers in concussion assessment. According to CAPT Kennedy, high-risk commands now view psychologists as critical assets, making it vitally important for neuropsychologists to have cultural competence in various military specialties.

CAPT Kennedy described her experience with the multitude of opportunities for psychologists in the Navy; listing

*The opinions, conclusions, and recommendations expressed or implied within this article are those of the contributors and do not necessarily reflect the views of the U.S. Department of Defense.

her combat-zone experience in Afghanistan assessing combat service members with acute concussions and her aerospace psychology training, which included water survival and flight training.

This was followed by a Military Resilience panel chaired by Dr. COL(R) Paul Bartone, a past President of the Society for Military Psychology. He spoke on the construct of hardiness in the military and presented a systematic review of evidence and identification of best practices in peer support for the Tragedy Assistance Program for Survivors. He also outlined how military units can increase hardiness among their ranks, suggesting that leaders can help individuals feel a sense of commitment and control, and view uncertainty as a challenge rather than an obstacle. Further, he reminded the audience that subordinates tend to look to the manner in which leaders respond to failure, defeat, or obstacles and follow suit. MAJ Karl Umbrasas, a current postdoctoral fellow at the Army's Forensic Psychology Fellowship at the Walter Reed National Military Medical Center then spoke about resilience in military organizations, and how forensic issues can cause a breakdown of organizational resilience, and a contextual understanding of why and how delinquent behavior might occur. He reminded the audience that as military psychologists, we often also function as forensic psychologists so it is important to have a basic understanding of relevant laws, standards, and guidelines in order to practice competently.

MAJ Umbrasas was followed by COL John Via, former Psychology Consultant to the Army Surgeon General, who spoke on developing brain fitness and enhancing performance in high potential leaders or operational organizations by increasing well-being in areas such as exercise, healthy diet, social activity, and meditation.

Dr. Dave Riggs, Chair of the Department of Medical and Clinical Psychology as well as Executive Director of the Center for Deployment Psychology at the Uniformed Services University presented a useful method of conceptualizing complex PTSD cases and how to decide where to start treatment. He emphasized that many of what clinicians might view as problems are effective coping techniques that serve a purpose for individuals struggling with multiple chronic stressors. His message to clinicians was, "Clinical work and research are not that different -- hypothesis testing is [asking] 'If I push this button, what happens?'"

The next presentation described career options by the senior active duty military clinical psychologists for the Army, Navy, and Air Force who attended the conference (for those curious, the Marine Corps does not have their own psychologists, but is served by Navy psychologists, providing a wide range of opportunities). Several experts, including CAPT Carrie Kennedy, Lt Col David Cordry, COL John Via, Dr. Nathan Ainspan (Chair) , and Dr. Tony Jiminez, served on a panel to provide guidance on the intricacies of thriving within the military and then successfully transitioning into civilian life.

Dr. Nathan Ainspan, of the Transition to Veterans Program Office, who described specific characteristics that employers look for that are inherent in service members as they transition to veteran status. Along with varying technical skills, he emphasized that because of the military culture, many service members entering the workforce have highly marketable nontechnical skills such as decision making, dependability, attention to detail, and strong ethics. His program office also offers resources and classes for veterans in the transition process, and encourages service members to start planning for their transition early and as if it were "a deployment to somewhere like Afghanistan, where the culture and customs are completely different." As such, providers have a duty to assist service members in finding the resources most valuable to transition into the civilian work force. Dr. Tony Jimenez offered information on how psychologists leaving the service could become licensed in the District of Columbia.

The last panel of the day touched on different areas concerning women in the military. CDR (P) Arlene Saitzyk, lead at the Marine Corps Embassy Security Group and Assistant Specialty Leader for Navy Psychology, shared a brief history of women in the military. She also advised that women need sponsorship as well as mentorship from higher ranking professionals in their field, both men and women. 1LT Hannah Martinez, a doctoral student at the Uniformed Services University, discussed female-specific suicide risk factors for female service-members. Dr. Jessica Gallus reviewed the impact of sexual harassment and what is being done in the Air Force and other services to better educate and prevent its occurrence. Dr. Allison Abbe of the Institute for Defense Analysis (IDA) shared her current work on resilience for females specifically in the military and how commands can better create a climate for inclusion. Finally, LTC (P) Ingrid Lim and Maj Catherine Ware shared their experiences as females in the military, both as psychologists and in different fields (Maj Ware was a pilot and LTC (P) Lim was an engineer prior to becoming psychologists). These women were a testament to the fact that female leaders are continuing to rise in the military and that many female leaders take diverse roles and paths to success. They explained that competence of varied layers of diversity, including rank and branch of service (not only gender) can shape a woman's career. Perseverance, awareness, and resilience were themes for all the women who presented. Finally, they emphasized that benefits of diversity do not come from avoiding bias, but by becoming aware of its existence.

The Trust, an organization that provides insurance for psychologists, sponsored lunch and a later reception. During this time, attendees were able to meet with the presenters and discuss in further detail the topics presented at the

conference. The DCPA conference was a wonderful melding of individuals with diverse expertise from different military branches. The general consensus from all in attendance was that the day was well-organized with insightful speakers on highly relevant topics. This conference may serve as a model for regional military psychology conference/symposium or a stand-alone mid-year conference/symposium.

A number of book recommendations were made during the conference the complete list is below:

Bowles, S., & Bartone, P.T. (Eds.). (2017). *Handbook of Military Psychology: Clinical and Organizational Practice*. New York ,NY: Springer International Publishing

Gawande, A. (2011). *The Checklist Manifesto: How to Get Things Right.* Hampshire, England: Picador.

Johnson, W. (2018). Athena Rising: How and Why Men Should Mentor Women. New York, NY: Routledge.

Junger, S. (2016). *Tribe: On Homecoming and Belonging*. New York, NY: Twelve.

Kennedy, C. H., & Zillmer, E. A. (Eds.). (2012). *Military Psychology: Clinical and Operational Applications*, Second Edition. New York, NY: The Guilford Press

Michel, K., & Jobes, D. A. (Eds.). (2011). *Building a Therapeutic Alliance with the Suicidal Patient*. Washington D.C.: American Psychological Association.

Tzemach Lemmon, G. (2016). *Ashley's War: The Untold Story of a Team of Women Soldiers in the Special Ops Battlefield*. New York, NY: Harper Collins.

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Spotlight on Research

Colleen Varga

Column Introduction

Welcome to the Spotlight on Research Column! This column showcases research activities and projects underway in many of the research laboratories within the Department of Defense (DoD), partnering organizations, and the academic and practitioner community in military psychology. Research featured in the column includes a wide variety of studies and programs, ranging from preliminary findings on single studies to more substantive summaries of programmatic efforts on targeted research topics. Research described in the column is inclusive of all disciplines relevant to military psychology—spanning the entire spectrum of psychology including clinical and experimental, as well as basic and applied. If you would like your work to be showcased in this column, please contact Colleen Varga at colleen.varga.1@us.af.mil.

This edition of the newsletter spotlights a small study examining the risk of suicide among military wives. Although a great deal of attention has been focused on suicide risk among active duty and veteran military members, this researcher highlights the number of shared risk factors that may put military wives at significantly higher risk for suicidal ideation or attempt than civilians not married to military members. The present article addresses an unexamined research question to better understand the rates of stress as well as history of suicidal ideation or attempt among women married to active duty military members.

Rates of Suicidal Ideation in Military Wives

Robi L. Nelson

Research Overview

Active duty and veteran military suicide is a complex and ongoing concern. As early as 2005, suicide rates in service members exceeded civilian rates. In 2005, known service member suicide rates had increased to 13.7 per 100,000 (Griffith, 2012). According to the Centers for Disease Control, national rates of completed suicide in 2005 were 10.9 per 100,000 (Hsiang-Ching, Hoyert, Xu, & Murphy, 2008). To put those rates in perspective, in 2012, after the rates continued to increase annually, there were 522 completed service member suicides (Smokenski et al., 2013), a 34% higher rate of completed suicide that the civilian population in 2012. As a result, the Department of Veterans Affairs and other organizations have funded research related to this problem, identifying a plethora of risk factors for service members. However, little research is available on the equally disturbing issue of suicide in military family members.

In 2012, Griffith concluded that risk factors for military populations were strikingly similar to known risk factors for civilians. In 2013, the DoD also reported comparable risk factors across military and civilian populations but cited additional risk factors such as stress related to military life, loss or grief, stress related to parenting, and decision-making that were specific to the military population (Crudo, 2013). The literature to date identifies suicide risk factors for service members including male, age 17–19, White, past or current mental health or substance abuse diagnosis, relationship problems, job problems/financial stress, suicidal ideation, feelings of loneliness, childhood abuse (Griffith, 2012), hopelessness, chronic pain (Barnes, Walter, & Chard, 2012), and lack of community resources and support (Langhinrichsen-Rohling, Snarr, Smith-Slep, Heyman, & Foran, 2011).

Post-traumatic stress disorder (PTSD) and major depression disorder (MDD) are notably associated with service member suicide (Griffith, 2012; Langhinrichsen-Rohling et al., 2011; Rozanov & Carli, 2012). In addition, there may be a connection between combat exposure, traumatic brain injury (TBI), and suicide in veterans. A 2012 study provided evidence that the effect of these factors was likely mediated by PTSD (Barnes et al., 2012). In other words, it is not combat exposure or brain injury that increases suicide risk, but rather the symptoms of PTSD that develop as a result. This conclusion is reinforced by Rozanov and Carlie's 2012 meta-analysis emphasizing the role of the symptoms of PTSD in suicide risk.

It is likely that service members and their families share risk factors for suicide. Specific risk factors for military wives have not been identified to date, but Gilreath et al. (2016) found that military-connected children had significantly higher rates of suicidal ideation, suicidal planning, and suicide attempts than nonmilitary-connected children. In the general population, support exists for the idea of

spousal shared risk factors specific to suicide. One study found that individuals whose spouse had died by suicide were significantly more likely to commit suicide themselves (Agerbo, 2003). Adding to the literature, Dirkzwager, Bramsen, Ader, and van der Ploeg (2005) explored secondary traumatization of spouses and parents of Dutch soldiers. They found that the spouses of soldiers with PTSD had significantly more symptoms of PTSD than the spouses of soldiers without PTSD.

Stress level, a known risk factor in suicide, has been demonstrated to be shared among spouses as well. Rook, Dooley, and Catalano (1991) showed that husband's occupational stress uniquely contributed to wives' stress levels, even after accounting for vulnerabilities to other stressors such as parenting, lack of community support, and marriage tension. Results supported the idea of spousal stress transmission and may support increased stress as a potentially shared spousal risk factor for suicide.

Other risk factors known to contribute to service member suicide, such as depression and PTSD, have also been demonstrated to be elevated in military spouses. Verdeli et al. (2011) reported significantly elevated levels of depression and anxiety in military wives as compared to their civilian counterparts. Stahl (2012) similarly found a significantly higher rate of PTSD than national average estimates. Mansfield et al. (2010) found significantly higher levels of depression and anxiety in spouses of soldiers who had deployed as compared to spouses of soldiers who had not deployed. This suggests that although deployment may not be a specific or direct risk factor for increased risk of suicide in service members, it may be one for their wives. In addition, other risk factors that are known to significantly correlate with suicide risk such as age, stress related to parenting and military life, financial stress, lack of community support, and relationship problems are also feasibly shared by military spouses.

With regard to military wives specifically, it is feasible that they share the majority of service member-specific suicide risk factors, with the implication that their risk for suicide is similarly greater than that of civilians. Perhaps the most compelling model for this is that of emotional contagion proposed by Hatfield, Cacioppo, and Rapson (1993). According to this theory, emotional contagion is the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person and consequently converge emotionally; referred to as catching someone else's emotions. In a military family with both spouses exposed to risk factors, as well as emotional risk factors such as MDD and PTSD present in service members, the wives may experience the shared emotional risk factors of their service member. Emotional contagion may be especially applicable to military wives, as Doherty, Orimoto, Singelis, Hatfield, and Hebb (1995) found that women engage in more emotional contagion than men.

Problem to Solve

In January 2013, the DoD produced a report on tracking military family suicide rates but there is no evidence at this time that it has been implemented (Garrick, 2013). At the time of the report, tracking death by suicide among military members and/or their family members was highly variable across branches of service. In 2013, the Military Family Lifestyle Survey identified that about 10% of military wives have considered suicide (Blue Star Families, 2014). This is nearly double the prevalence of suicidal ideation in the general population, which the Centers for Disease Control and Prevention (CDC) estimate to be 5.7% (Crosby, Han, Ortega, Parks, & Gfroerer, 2011). The survey was not subject to any professional peer-reviewed scrutiny, making it necessary to empirically confirm the findings. This study sought to investigate suicidal ideation and risk factors in military wives.

Solution and Approach

To mitigate potential confounding variables, participants were limited to military wives. A total of 24 participants volunteered for the study and were included for data analysis. Twenty-one participants were Air Force wives, one participant was a Marine Corps wife, and one participant was an Army wife. Participant ages ranged from 20 to 61 (M = 39.04, SD = 11.90). Twenty participants identified as Caucasian, two as Latina, one as African American, and one as Asian. Age at first marriage ranged from 19 to 34 (M = 23.46, SD = 3.96). Participants' years of education ranged from 12 to 20 (M = 13.70, SD = 2.18). The number of deployments the participants' family had been through ranged from 0 to 10 (M = 2.30, SD = 2.56).

Participants were met individually by the principal investigator with consultation oversight by a licensed psychologist. Participants completed a demographics questionnaire, the revised Suicidal Behaviors Questionnaire (SBQ-R), Beck Depression Inventory–II (BDI-II), and Beck Hopelessness Scale (BHS). Participants scoring higher than a 7 on the SBQ-R were individually assessed for suicide risk under the supervision of a licensed psychologist. Upon completion of testing, participants were provided a written debriefing of the study, invited to ask questions, and asked to consider referring other military wives to the study. Each participant was given a handout and briefed on local resources for mental health support, regardless of their test results or whether they reported experiencing suicidal ideation.

A demographics questionnaire was created that assessed age, age at first marriage, ethnicity, history of physical and psychological concerns, and stress from known service member-specific risk factors including: relationship problems, job-related problems, financial problems, lack of community resources/support, and parenting. The service member-specific risk-factors were assessed on a 5-point Likert scale with 5 representing the highest stress.

A total stressor score was calculated. The possible range for the total stressor score was from 6 to 30.

BDI-II. The BDI-II is a 21-item Likert-style inventory assessing severity of depression symptoms in a two week period. A total score of zero to 13 is considered minimal, 14–19 is mild, 20–28 is moderate, and 29–63 is severe.

BHS. The BHS is a 20-item true or false inventory assessing the specific depression symptom of hopelessness in a one-week period. Total scores of 0 to 3 are considered to fall in the minimal range, whereas 4 to 8 represents mild, 9 to 14 moderate, and 14–20 severe hopelessness. Scores over 9 have been shown to predict eventual suicide (Beck & Steer, 1993).

SBQ-R. The SBQ-R was included to assess suicidal ideation. This particular measure was selected to parallel the work done by Rudd, Goulding, and Bryan (2011) that explored risk factors for completed suicide in military members. The SBQ-R is a four-item scale that addresses lifetime suicidal ideation, ideation frequency of the past year, past suicide attempts, and self-reported likelihood of a suicide attempt in the future. Scores range from 3 to 18, with higher scores indicating increased risk. A cut-off score of 7 and above indicates potential suicide risk (Osman et al., 2001).

Findings

Results show total stressor scores ranged from 6 to 23 (M = 14.00, SD = 4.99); BDI-II scores ranged from 0 to 28 (M = 10.42, SD = 8.77). The mean score was reflective of minimal depressive symptoms in the sample. BHS scores ranged from 0 to 8 (M = 1.92, SD = 2.02), with the mean score indicative of minimal hopelessness in the sample. SBQ-R scores ranged from 3 to 11 (M = 4.67, SD = 2.24) and four participants (16.67%) had a score above the cut off of 7. In addition, 50% of the participants endorsed responses other than never for the SBQ-R item "Have you ever thought about or attempted to kill yourself?"

A two-tailed Spearman's rho correlation matrix was populated to explore the relationship between age, age at first marriage, total stressor score, BHS score, BDI-II score, and SBQ-R score (see the appendix). The results indicated a statistically significant moderate correlation between total stress and SBQ-R score, $r_s = .41$, $p < .05$. The results also demonstrated a statistically significant strong positive correlation between scores on the BDI-II and BHS, $r_s = .60$, $p < .01$. No other correlations were significant.

Implications

Prevalence rates of suicidal ideation in military wives in this study were higher than the 10% suggested by the 2013 Military Family Lifestyle Survey (Blue Star Families, 2014). This was explored using the SBQ-R in two ways. The first, more stringent criteria for classifying suicidal ideation used a cut off score of seven or higher, identified by the measure authors to be indicative of suicide risk. The second was to identify the proportion of participants that endorsed responses other than never for the SBQ-R item "Have you ever thought about or attempted to kill yourself?" Results in this study indicated that 16.67% of military wives had scores of 7 or higher, and that 50% of military wives have thought about or attempted suicide. These rates suggest that suicidal ideation rates in military wives are significantly higher than the national average. It is possible that selection bias may have contributed to the high level of reported suicidal ideation in military wives in the present study. That is, the nature of the study elicited volunteers with increased rates of suicidal ideation.

Stress was significantly correlated with suicide risk, suggesting that individuals under more stress have more severe suicidal ideation. In general, stress has been demonstrated to predict suicide in the literature and the results of this study are consistent with stress as a risk factor. The BDI-II and BHS were statistically significantly correlated, as expected given the high convergent validity between the measures (Beck, Steer, & Brown, 1996).

There were a number of important limitations to this study. Most prominent was the small sample size that resulted in the use of only nonparametric statistics. Increased sample size would enable the use of more powerful statistics that may have better illuminated the underlying nature of the relationship between the variables. Another important limitation is the generalizability of the findings from this study. The vast majority of the participants were Air Force wives with a noted lack of ethnic and age variability, making it difficult to speak to suicide risk for military wives of differing services, ethnic background, or age. Lastly, this study explored suicidal ideation in married wives and the results cannot be generalized to male spouses or non-married partners of military members.

Given the potentially dramatic nature of the results related to suicide risk in military wives, future research is of the upmost importance to more firmly establish the prevalence rate of suicidal ideation in military spouses. Future research should use much larger sample sizes to identify risk factors and subsequently develop programming to address and mitigate these factors, with the future goal of decreasing the risk of suicide among military spouses.

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Appendix: Matrix Correlations Between Variables

Variable	Age	Age at first marriage	Total stress	SBQ-R	BHS	BDI-II
Age	1.00 —					
Age at first marriage	.14 .53	1.00 —				
Total stress	-.28 .19	.20 .36	1.00 —			
SBQ-R	.02 .91	.10 .65	.41* .05	1.00 —		
BHS	-.17 .44	.33 .11	.39 .06	.25 .25	1.00 —	
BDI-II	.03 .89	.17 .43	.36 .08	.22 .31	.60** .00	1.00 —

Note. Values provided in the format of r_s directly above p value. *$p < .05$, two-tailed. **$p < .01$, two-tailed.

Spotlight on History

Profile: Arthur S. Otis (1886–1964)

Paul A. Gade

Lt. Arthur S. Otis (in 1919).

Arthur Otis is an important but relatively unknown figure in the history of the U.S. Army's mental testing program developed during WWI. Robert M. Yerkes is usually considered the founder of military psychology and the Army's psychology program during WWI, and rightly so; however, Arthur Otis was the primary architect of the group-administered tests that underlay the testing program. Otis developed the methods and multiple-choice format for the mass "intelligence" testing program that was important for developing the Army's selection and classification system that that tested nearly two million men in a very short time. The history of this huge event usually credits Yerkes with founding the Army's mass testing program that revolutionized the way men could be selected for military service and assigned to military jobs.

Yerkes as the American Psychological Association (APA) president also served as the chairman of the newly formed Psychology Committee of the National Research Council (NRC), which was a subdivision of the National Academy of Sciences (NAS). The work of this committee was to help the United States use psychological science to prepare the country and especially its military services for a war that seemed inevitable. To accomplish this, the APA established 12 committees, subsumed under the NRC Committee on Psychology to address various topics thought to be important for the war effort. One of these committees, The Committee on the Psychological Examination of Recruits, focused heavily on how to use the emerging science of intelligence testing to screen men for military induction. Yerkes also chaired this committee and it was this committee that was responsible for developing the Army Alpha and Beta tests and the Army's mental testing program.

Although it is true that Yerkes was the driving and organizing force behind the use of "intelligence testing" to screen Army draftees, it was Otis whose methods and formats made it possible to test all Army draftees and recruits. Yet his name rarely appears in the historical record of the development of the Army's mass testing program. The developers of the Army's testing program are usually listed as Yerkes, Bingham, Goddard, Terman, Haines, Wells, and Whipple—all the members of The Committee on the Psychological Examination of Recruits. Otis is not mentioned at all. It seems likely that at least Otis's initial omission was due to the fact that as a doctoral student of Terman, Otis and his yet to be completed dissertation were not known to Yerkes and the other committee members other than Terman. Furthermore, as a graduate student and not a well-known psychologist, he certainly would not have been appointed to such an important committee. It wasn't until Terman introduced Otis's group testing ideas and methods to Yerkes and the committee at a pivotal meeting at the Vineland Training School in May 1917 that his work became known to them. However, in retrospect, Yerkes did acknowledge Otis's importance to developing the testing program in his 1921 National Research Council report as follows:

> The contribution made by Arthur S. Otis in devising a system of group tests, deserves special mention. … Otis generously placed all of his methods, together with correlational data they had yielded, in the hands of Terman, who brought them before the Committee. The scale which resulted from the committee's work bears a close resemblance to the Otis scale. Four of the 10 tests in the original Army scale for group testing were taken from the Otis scale practically without change, and certain others were shaped in part by suggestions from the Otis scale. (Yerkes, 1921 p. 299)

Until Lewis Terman suggested using the Otis paper-and-pencil group testing method, Yerkes apparently had planned to have recruits and draftees prescreened by their officers and sergeants with only those identified as exceptional or unsatisfactory subsequently tested with the Stanford-Binet test or a shorter, as yet undeveloped 10-minute individually administered test. Such individual screening could only have been accomplished by recruiting an enormous number of psychologists to administer the individual intelligence tests or by training a large number of non-psychologist administrators to give the tests. It was Yerkes' good fortune as well as that of the U.S. Army and psychology in general that Terman introduced the testing methods developed by Arthur Otis to the committee. Clearly the Otis tests formed the basis and the model for the tests that were used to screen draftees for Army service and job placement.

The development, or perhaps more appropriately, the evolution of the idea for the group test that became the Army Alpha is an interesting one. According to Otis, the idea for developing a group test arose from a conversation he had with Terman about the need for a group test for school children that would allow schools to screen students more quickly and effectively and in larger numbers than would the Stanford-Binet test. Otis described the discussion with Terman as follows:

> So I told Dr. Terman that I thought that we were very much in need of a group test by which a whole roomful of pupils could be tested at one time. I said, "Why don't I make that a subject for my doctor's dissertation?" and he said, "Well, if you can do that, why it certainly would be wonderful, so go to it—more power to you! So I said, 'Well, that's what I'll do.'" (Siegel, 1992, p. 233)

And that is exactly what he did.

Arthur Sinton Otis was born on July 28, 1886 in Denver, Colorado and grew up in California living mostly in Pasadena during his high school years. He was a multitalented individual and music was a lifelong passion for him. He learned to play the piano and the violin as a young boy and learned to play the trombone as a Stanford undergraduate where he also sang in the glee club and as a member of the school orchestra wrote operettas and the Stanford football fight song. He was also a member of the Stanford Chess Club and its Intercollegiate Chess Team and a member of the Philosophy Club as well.

Otis entered Stanford University as a freshman in 1906 majoring in civil engineering. Having developed a keen interest in psychology during his first two years, he changed his major during his junior year and graduated with a B.A. in psychology in 1910 at the age of 23. The psychology department was small offering only eight courses in psychology and had only two faculty members, Frank Angell and Lillien Martin. Angell had taken his doctorate in Wundt's laboratory in Leipzig University in Germany. He was an introspectionist and follower of E. B. Tichner. Martin was one of the early female psychologists having been on the Stanford faculty since 1899. She was said to be mainly a psychophysist in her professional orientation (Siegel, 1992).

Although the psychology department and the education department had little in common and the education department faculty often criticized the psychology department for what they believed was a lack of cooperation and support, when Otis returned to Stanford in the fall of 1910 he enrolled in the education department's master's program. He likely enrolled in the education department because it was far larger with four full-time faculty members and four additional lecturers and assistants and offered 32 courses compared to the eight offered by the psychology department. At the same time as Otis enrolled in the education department's master's degree program, Lewis Terman accepted a full-time faculty position as assistant professor of educational psychology at Stanford at the invitation of the education department's chairman, professor Ellwood Chubberly. Terman, a 1906 Clark University Ph.D., had been a professor at the Los Angeles Normal School, later to become UCLA, prior to his move to Stanford. In his first year in the education department, Otis enrolled in Terman's measurement of intelligence course, a course that forever changed the direction of Otis's professional life. Otis earned an M.A. in education in 1915 and began work on his Ph.D. under Terman in 1916. His pursuit of a doctorate was interrupted by WWI and he did not finish that degree until 1920.

It was during the Great War that Otis, as a lieutenant in the U.S. Army and a member of Major Yerkes' test development and implementation team that he refined and implemented his ideas for group administered paper-and-pencil intelligence testing. Although he had originally developed the group testing approach for use in schools, he and Terman both saw the potential for applying it to the scientific and systematic induction of men into the military services and assigning them to the various military jobs. Terman convinced Yerkes to adopt Otis's approach and to make Otis part of the team developing the testing program. Otis and others on the team found it fairly easy to translate the test items written to classify students to those needed to

screen new recruits for the Army. This then became the Army examination a. Scores on the examination a were to be used to determine a soldier's ability to serve in the Army, his Army job classification, and his leadership potential. Inductees who were either illiterate or non-English speakers took the examination b, a test constructed by the committee that was intended to be a close nonverbal equivalent of examination a. However, postwar analyses showed that examination b was not the equivalent of examination a. The head start on group testing provided by Otis enabled the committee to create, field test, and revise the examination a with amazing quickness fielding the first test in July 1917. The revised examination a was designated as the Army Alpha and was the operational test that was administered to more than 1,250,000 men between April 1 and December 1, 1918 (Yerkes, 1921).

Unfortunately, for a variety of reasons the Army's testing program appears to have had little impact on the selection and classification of inductees in WWI. But it did have a large impact on psychological testing and the burgeoning mental testing programs in schools and businesses following the war. It also had a subsequent impact on the military services as psychology refined and improved its methods and the military services realized the value of cognitive ability testing for selecting inductees and making their job assignments. Otis carried his work forward into the educational testing market, developing the Otis Group Intelligence Scale and other selection and classification tests. Perhaps the best known of these is the Otis-Lennon Mental Ability Test. Many of us remember taking an Otis test during and before high school.

As mentioned earlier, Otis was a multitalented man and probably a genius by most standards. For example, during his last 10 years of life he devoted himself to the study of Einstein's theory of relativity publishing two books on the topic. The second book, *Light Velocity and Relativity* (Otis, 1963) was an attempt to refute Einstein's theory and replace it with his own more classical theory.

References

Otis, A. S. (1963). *Light velocity and relativity* (3rd ed.). Yonkers-on Hudson, NY: C. E. Burckel.

Siegel, E. J. (1992). *Arthur Sinton Otis and the American mental testing movement*. (Unpublished doctoral dissertation). University of Miami, Miami, Florida.

Yerkes, R. M. (Ed.) (1921). *Memoirs of the National Academy of Sciences: Vol. 15. Psychological examining in the United States Army.* Washington, DC: Government Printing Office.

Point of Contact Information

For further information, please contact:
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George Washington University
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Early Career Psychologists Committee Report

Ryan R. Landoll

As the chair of the Division 19 Early Career Psychology Committee and want to extend my welcome as a Division 19 early career psychologist (ECP) member. A lot of exciting changes have occurred with the ECP committee, particularly following the Society's Mid-Year Meeting. To start, we have completely redesigned the ECP portion of our Society's website. Check it out at www.militarypsych.org/ecp-home.html. Here are the highlights:

We have expanded our ECP committee to include liaisons to represent the diversity within Division 19 membership. These include our Guard/Reserve liaison (Michael Brennan), VA liaison (Candice Presseau), and our Student/ECP Transition liaison (Gretchen Kirk), who will specifically help us navigate the needs of students in their transition year to full members. Our staggered chair team represents other important constituencies, including the Navy (Adrienne Manasco, Past Chair), Air Force (Ryan Landoll, Chair), and academia (Neil Shortland, Chair Elect). We are still looking for a representative from the applied/operational community, the U.S. Army, and the international community (www.militarypsych.org/ecp-committee.html).

I want to briefly highlight 3 key features of membership:

1. For the first time this year, the Division is offering Professional Development grants of up to $2,500 which can be used for any professional development purpose both research and applied/clinical. The deadline for application is **June 1st**! More detail is available at: Caution-https://www.militarypsych.org/ecp-professional-development-grants.html.
2. Speaking of weblinks, we have completely revamped our ECP section on the Division 19 website—I encourage you to check it out at Caution -www.militarypsych.org/ecp-Caution-home.html. It includes sections on how to get more involved with Division 19 to maximize your membership.
3. Some of you indicated when you submitted your email to membership that you wished to receive "no junk." This email list contains only ECPs and we use it very sparingly (approximately 2–3 times a year). We do encourage you all to join our Division 19 listservs (information available on our website), but if you wish to opt out of these emails, please respond directly and we will remove you from subsequent emails. There will likely be another email in about 1–2 months containing ECP-centric programming at APA convention, and then another near the end of the year with a call for committee membership.

Another new feature of our new website, is the ECP spotlight, highlighting the exciting things our members are doing. Check out our first ECP spotlight, Dr. Robyn Gobin.

Dr. Robyn L. Gobin, Ph.D., is a licensed clinical psychologist (IL) and assistant professor in the Department of Kinesiology and Community Health at the University of Illinois at Urbana Champaign. She graduated from the University of Oregon with a Ph.D. in clinical psychology and completed pre-doctoral and post-doctoral fellowships specializing in interpersonal trauma and women's health at the VA Boston National Center for PTSD Women's Health Sciences Division, the Providence VA PTSD Clinic, and the VA San Diego Military Sexual Trauma and Interpersonal Trauma Program. Currently, Dr. Gobin directs the Transforming Trauma and Mental Health Research Laboratory. Her program of research focuses on alleviating the mental health effects of interpersonal trauma by developing and testing novel interventions for trauma-exposed populations. She is also interested in the use of technology to deliver mental health interventions and the impact of African American culture on trauma recovery. Populations of interest include military veterans, women, and ethnically diverse individuals. Through her research, Dr. Gobin seeks to improve PTSD treatment outcomes, reduce mental health stigma, and increase treatment engagement among individuals with PTSD. Dr. Gobin has authored several articles in peer-reviewed journals, and her research has been funded by the International Society for the Study of Trauma and Dissociation and the American Psychological Association Minority Fellowship Program. She maintains a small trauma-focused private practice in Champaign, IL.

1. Why did you join Division 19?

I had the privilege of completing internship and two postdoctoral fellowships in the VA healthcare system. During this time, I learned a lot about military culture and the unique challenges faced by women veterans. While conducting research and providing mental health

services in the VA, I developed a special affinity for serving the veteran population. Joining Division 19 seemed like the next logical step given its commitment to supporting research and practice that addresses military problems.

2. What do you find are the most important benefits to you?

I appreciate the opportunity to connect with colleagues who are passionate about promoting mental health and wellness among military Veterans. I also enjoy reading the latest military-related science and practice developments in the Military Psychology Journal.

Thank you for your membership and support of military psychology. If you have any questions or I can be of any further assistance, please let me know. I encourage you to apply for the Professional Development grants and hope to see you at APA!

Kind regards,
Ryan R. Landoll, Ph.D., ABPP, Maj, USAF
ryan.landoll@usuhs.edu

Communications Committee Report

Brian Lees

Hello Division 19'ers!

The Division 19 Communications Committee oversees our Listservs, Facebook group, Twitter account, and website.

The committee has grown and includes Ft Belvoir research psychologist Alexander Wind, PhD, who manages our website with the help of Student Affiliates Brooke Long and Daniel Perez; Airforce Captain Jeremy Jinkerson and Student Affiliate Kevin Hardiman, who assist me with the Listservs; and Navy Captain Carrie Kennedy who manages our Facebook group.

Our most interactive social media presence is on our "APA Division 19-Military Psychology" Facebook closed group. We have over 1,000 members and people are posting and commenting daily. We also have our Twitter account (@APADiv19) with over 1,000 followers. We are already using #MilitaryatAPA2018 hashtag as we near the APA Convention. Please take a look and use it for your Tweets as well!

We invite you to peruse our website https://www.militarypsych.org/. It's chock full of new information on the 2018 APA convention, awards, and for early career psychologists (ECPs). Take a look at what the ECP Committee Chair, Air Force Major Ryan Landoll, made for the ECP section and what Student Affiliate Brooke Long did for the Leadership section. It looks great!

Our primary "Announcement" listserv has grown to over 3,000 subscribers! One of the benefits of being a Division 19 member is that you are entitled to have us post something for you: be it a job, a training, or a conference. Please email div19list@gmail.com for instructions on the best way to compose your post. Our "Discussion" listserv has grown to 235 subscribers. There was a recent push to include psychologists in other divisions and any professional interested in military psychology (such as lawyers, anthropologists, historians, etc). Please join the discussion and encourage your colleagues to join as well by visiting or sharing this link http://lists.apa.org/cgi-bin/wa.exe?A0=DIV19DISC. This offers us the opportunity to communicate with each other as well as with professionals who may be interested in our field.

We look forward to connecting with you!

Point of Contact Information

For further information, please contact:
Brian Lees, PsyD, ABPP, LCDR
US Public Health Service
Chair, Division 19 Communications Committee
Div19list@gmail.com

APA Program Committee Report

Angela E. Legner, PsyD and Lindsey L. Monteith, PhD

On behalf of your Division 19 Convention Programming Committee, we are very excited that you will be joining us at the annual meeting in San Francisco, CA, from August 9–12, 2018. For general information about the annual conference, please visit the conference website http://convention.apa.org/. We also invite you to check out our website, https://www.militarypsych.org/convention-home.html, for up-to-date Division 19 relevant programming including our hospitality suite schedule and social activities. Also do not forget to follow APA and Division 19 conference activities on social media using #APA2018 and #MilitaryatAPA2018.

Presidential Address

We welcome everyone to attend Dr. Mark Staal's Presidential Address on Friday, August 10, 2018, from 3:00 p.m. to 3:50 p.m. in the Hilton San Francisco Union Square Hotel Continental Ballrooms 7 and 8.

Welcome Reception and Social

Division 19's Welcome Reception is scheduled for Thursday, August 9, 2018, from 4:00 p.m. to 5:50 p.m. in the San Francisco Marriott Marquis Hotel Yerba Buena Salons 3 and 4. The Annual Social is scheduled for Friday, August 10, 2018, from 4:00 p.m. to 5:50 p.m. in the Hilton San Francisco Union Square Hotel Continental Ballrooms 7 and 8.

Suite Sessions

We have several exciting programs that are being planned for our hospitality suite, which is being organized by Dr. Ryan Landoll, our current suite coordinator and incoming program chair for the 2019 convention. The suite programming will take place in the Marriott Marquis Hotel. A final schedule, with the suite room number, will be posted to the listserv and the Division 19 website https://www.militarypsych.org/ prior to the conference.

Continuing Education

The American Psychological Association is offering more than 65 continuing education (CE) credits. We are excited to announce that 14 of our outstanding sponsored presentations were accepted as CE programming this year. This is double the CE sessions offered in 2017! Please see below for the complete list of our CE Sessions:

- Implementing the Future of Psychological Health—Evidence-Based Practices for Busy Clinicians
- Patriotism in Public Service—Serving Our Country and Service Members
- The Role of Resilience in the Selection of Elite Military Forces
- Measuring the Impact of Programs to Improve Psychological Outcomes in Veterans
- Sleeping on the Battlefield—How the Military is Enhancing Sleep to Reduce Combat Stress
- Ethical Issues Relevant to Collaborative Suicide Prevention Between Psychologists and Chaplains
- Risk and Resilience in the Psychological and Interpersonal Functioning of Service Members
- Postvention in the United States Military—Supporting Survivors of Suicide Loss
- Developing Specialty Practice Guidelines—The Case for Operational Psychology
- Addressing Complex Care Needs for Service Members and Veterans
- Integrating Family-Centered Care With Service Members and Veterans
- Opioid Misuse and Management in the Military Health System—Trends, Clinical Outcomes, and Strategies
- Promoting Spirituality and Meaning-Making in Moral Injurious Events to Reduce Psychological Distress
- Building the Knowledge Base of Military Sexual Trauma—New Findings, Future Avenues and Barriers

Sessions offering continuing education (CE) credits have been reviewed and approved by the American Psychological Association Office of Continuing Education in Psychology (CEP) and the Continuing Education Committee (CEC) to offer CE credits for psychologists. The CEP Office and the CEC maintain responsibility for the delivery of the programs. For additional information on sessions offering CE credits and how to register for credits, please visit http://www.apa.org/convention/ce/index.aspx.

We look forward to seeing you in August! As always, thank you for your continued support of our division.

Point of Contact Information

Angela E. Legner, PsyD
2018 Convention Chair
angelalegner@gmail.com

Title	Date	Time	Location
Executive Committee Meeting	Thu 8/9	8:00 a.m.–9:50 a.m.	San Francisco Marriott Marquis Hotel Pacific Room B
Command Climate Single-Item Measures—An Innovative Approach for Reducing Survey Burden	Thu 8/9	9:00 a.m.–9:50 a.m.	Moscone Center Room 2008
Addressing Complex Care Needs for Service Members and Veterans*	Thu 8/9	10:00 a.m.–10:50 a.m.	Moscone Center Room 151
The Many Faces of Operational Psychology	Thu 8/9	11:00 a.m.–11:50 a.m.	Moscone Center Room 3001
Measuring the Impact of Programs to Improve Psychological Outcomes in Veterans*	Thu 8/9	12:00 p.m.–12:50 p.m.	Moscone Center Room 214
Postvention in the United States Military—Supporting Survivors of Suicide Loss*	Thu 8/9	1:00 p.m.–1:50 p.m.	Moscone Center Room 208
The Role of Resilience in the Selection of Elite Military Forces*	Thu 8/9	2:00 p.m.–2:50 p.m.	Moscone Center Room 104
Skill-Building Session: Ethical Issues Relevant to Collaborative Suicide Prevention Between Psychologists and Chaplains*	Thu 8/9	3:00 p.m.–3:50 p.m.	Moscone Center Room 216
Welcome Social	Thu 8/9	4:00 p.m.–5:50 p.m.	San Francisco Marriott Marquis Hotel Yerba Buena Salons 3 and 4
Risk and Resilience in the Psychological and Interpersonal Functioning of Service Members*	Fri 8/10	8:00 a.m.–8:50 a.m.	Moscone Center Room 308
Patriotism in Public Service—Serving Our Country and Service Members*	Fri 8/10	9:00 a.m.–9:50 a.m.	Moscone Center Room 312
Poster Session 1	Fri 8/10	12:00 p.m.–12:50 p.m.	Moscone Center Halls ABC
Business Meeting	Fri 8/10	2:00 p.m.–2:50 p.m.	Hilton San Francisco Union Square Hotel Continental Ballrooms 7 and 8
Presidential Address—Dr. Mark Staal	Fri 8/10	3:00 p.m.–3:50 p.m.	Hilton San Francisco Union Square Hotel Continental Ballrooms 7 and 8
Annual Social	Fri 8/10	4:00 p.m.–5:50 p.m.	Hilton San Francisco Union Square Hotel Continental Ballrooms 7 and 8
Integrating Family-Centered Care With Service Members and Veterans*	Sat 8/11	8:00 a.m.–8:50 a.m.	Moscone Center Room 307
Implementing the Future of Psychological Health—Evidence-Based Practices for Busy Clinicians*	Sat 8/11	9:00 a.m.–9:50 a.m.	Moscone Center Room 154
Sleeping on the Battlefield—How the Military Is Enhancing Sleep to Reduce Combat Stress*	Sat 8/11	10:00 a.m.–10:50 a.m.	Moscone Center Room 152
Developing Specialty Practice Guidelines—The Case for Operational Psychology*	Sat 8/11	11:00 a.m.–11:50 a.m.	Moscone Center Room 105

Poster Session II	Sat 8/11	12:00 p.m.–12:50 p.m.	Moscone Center Halls ABC
Building the Knowledge Base of Military Sexual Trauma—New Findings, Future Avenues, and Barriers*	Sat 8/11	4:00 p.m.–4:50 p.m.	Moscone Center Room 104
Opioid Misuse and Management in the Military Health System—Trends, Clinical Outcomes, and Strategies*	Sat 8/11	5:00 p.m.–5:50 p.m.	Moscone Center Room 312
Veterans' Spiritual Struggle and Moral Injury—Mental Health, Chaplaincy, and Mitigating Factors	Sun 8/12	9:00 a.m.–9:50 a.m.	Moscone Center Room 2018
Working Toward Resolution of Perpetration-Based Traumas—A Cognitive Behavioral Approach	Sun 8/12	10:00 a.m.–10:50 a.m.	Moscone Center Room 2022
Promoting Spirituality and Meaning-Making in Moral Injurious Events to Reduce Psychological Distress*	Sun 8/12	11:00 a.m.–11:50 a.m.	Moscone Center Room 307

*Offers Continuing Education (CEs).

Announcements

Christina Hein, MA

Announcement Requests

Please submit any announcement requests for volunteer opportunities, research participant requests, training opportunities, or other requests to Christina Hein at chein9@gmail.com.

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

Publication Opportunities

First Author Student Research Opportunity on Data Collection and Moral Injury

Interested in first author publication and presentation opportunities? I'm looking for a motivated student or students to work with me on an unfunded research project on data collection and moral injury modeling. This is my dissertation follow-up research, where I'm studying whether moral injury's core symptoms can predict its secondary symptoms. (Please see my 2016 Traumatology article entitled "Defining and Assessing Moral Injury: A Syndrome Perspective" for more information on the syndrome model.) Interested parties, please inquire at Jeremy.jinkerson@gmail.com/Jeremy.jinkerson.2@us.af.mil

Research Participation Requests

Perspectives on Moral Injury

This dissertation project is designed to compare military members' and veterans' perspectives on the concept of 'moral injury' with those held by mental health professionals. Moral injury is a new research area focused on psychological consequences that may occur after a betrayal of "what's right" during high-stakes situations, such as military deployment. The survey is open to any English-speakers aged 18 or older with military culture familiarity (e.g., personal experience, professional career training). Individuals who have both a military service background and professional mental health experience are also encouraged to participate as well.

If you choose to participate, you will be asked to respond to survey items about your current perspectives on moral injury. No previous education in understanding moral injury is needed. If you are a service member or a veteran, you will also be asked to respond to items about deployment experiences as well. The survey will take approximately 30–40 minutes to complete. Your responses to the survey items will be anonymous and kept confidential. https://wmichcas.qualtrics.com/jfe/form/SV_71dOm8ZqHmP9E8J

Psychologists' Willingness to Engage in Select Discussions with Clients

The brief survey is part of a dissertation being conducted by Sean McCormick, a doctoral student at Carlow University. The purpose is to learn more about psychologists' willingness to engage in select discussions with clients. If you are a practicing doctoral-level psychologist who provides therapy/counseling to patients/clients, then please consider completing the following online survey, which should take 5–10 minutes to complete. Responses will be completely anonymous. Each participant will have the option to be entered into a drawing to receive one of four $50 gift cards to Amazon.com.

If you have any questions, concerns or comments about the study, please contact Sean McCormick at smccormick@live.carlow.edu or Dr. Frances Kelley at fakelley@carlow.edu.

Link to the Study: https://www.surveymonkey.com/r/sean_mccormick_dissertation

Mindfulness for Coping with Deployment for Military Children

This survey is part of a dissertation being completed through the California School of Professional Psychology –Alliant International University San Francisco. The study aims to assess the usefulness of a children's book using mindfulness to aid military children coping with deployment.

To participate in this study, you must be a mental health professional between 25 and 80 years old of any sex; must be either a psychologist or MFT, LPC, or MSW; must have worked with young children in a counseling or therapeutic capacity for a minimum of 2 years; and possess knowledge about mindfulness and possibly military culture. All participants who complete the study will be given a $25 amazon gift card as a way to thank you for providing your support and time to the study. If you meet this criteria, please click: https://alliant.qualtrics.com/jfe/form/SV_cBWFQZ2eTSIPlFX

OR: you must be a female between the ages of 18 and 68 years old, you must have at least one child between the ages of 3 and 5 and have a male significant other who is an active duty member of a branch of the U.S. Military who is considered "active duty." If you meet this criteria and are interested in participating, please click: https://alliant.qualtrics.com/jfe/form/SV_9LDLzK0Q2HZDpit

If you have any questions about the study, you may contact me, Kayla Prout, at kprout@alliant.edu or my supervisor, Fred Heide at fheide@alliant.edu.

Additional Research Opportunities

If you would like to explore other ongoing research studies in need of participants, please see: http://www.division19students.org/research-recruitment-announcements.html

Job Opportunities

1st Special Warfare Training Group (Airborne) Psychologists, Ft. Bragg, NC

Two GS13 Civilian Operational Psychologist positions (one currently open for several more days, and another forthcoming), appropriate for both experienced and entry-level operational psychologists.

The U.S. Army John F. Kennedy Special Warfare Center and School (SWTG; the Special Operations Center of Excellence) serves as the entry point and training pipeline for Army Special Operations Forces (Special Forces, Civil Affairs, Psychological Operations). At SWTG, we have a team of psychologists who support assessment and selection, as well as consult to several areas of training. This includes program development, performance enhancement/coaching, high-risk training oversight, education, and a plethora of duties supporting advanced operational psychology related to Special Activities (some of which could be overseas if interested).

Completion or willingness to complete SERE C training is required. If you, or any colleagues have any interest or even any questions, I am happy to entertain them so please feel free to contact me and/or forward to other potential candidates as well!

Shanna Reyes, Psy.D, MAJ, MS, Command Psychologist

1SWTG(A), USAJFKSWCS, Cell: 202-279-1567

NIPR: shanna.reyes@socom.mil

SIPR: shanna.reyes@usasoc.socom.smil.mil

Predoctoral Internship Opportunities

National Defense University Research Internship Fall 2018 and Spring 2019

We are currently accepting applications for an internship opportunity with at the Institute for National Strategic Studies at the National Defense University at Fort McNair in Washington, DC for the Fall 2018 and Spring 2019 semesters. Interviews will be conducted in June and July.

Internship applications of highly motivated undergraduate (considering graduate school with 3.5+ GPA) and interested graduate psychology students are currently being accepted for the Institute for National Strategic Studies at the National Defense University. If accepted, students will be members of the Leadership Fitness Lab and work with COL (Ret.) Stephen Bowles on various topics including:

- emotional intelligence, personality, well-being, and performance in military recruiters;
- military (injured & non-injured service member) couples resilience, PTSD, and relationship quality;
- leadership, emotional intelligence, and well-being; and
- yoga, resilience, sleep, and dreams;
- non-research areas of internship: psychological healthy workplace development, community professional education, conference/symposium assistant & mindfulness course TA.

Responsibilities include:

- literature reviews, power point presentations, preparation of classroom materials, poster presentations, manuscript editing and writing;
- preparing publication submissions;
- coordination of articles with co-authors and organization of community events;
- organizing of literature review, manuscripts and other relevant research material;
- data base entry/management/data analysis;

Hours preferred:

- 12–16 hours per week during school year for local students in school (with an option for course credit);
- 36+ hours per week during summer and academic year (with an option for semester credit).

This can be flexible depending on class and work schedules. We are looking for someone with an interest in research, particularly in military-related psychology, but not necessarily exclusive to that topic. If interested, please review the Application Process below and submit the needed documents to Dr. Stephen Bowles at stephen.bowles.ndu@gmail.com

Application Process: Submit CV, Unofficial Transcript, Submit Writing Sample (5-10 pages) & Interview

To view an active list of predoctoral internship opportunities, please see: http://www.division19students.org/research-recruitment-announcements.html

Post-Doc Opportunities

Womack Army Medical Center (Ft. Bragg, NC)

Womack Army Medical Center offers world-class Internship training in state-of-the-art facilities at the U.S. military's largest base. Train with us at Fort Bragg—home of the legendary 82nd Airborne, the XVIII Airborne Corps, and the U.S. Army Special Operations Command. We are also seeking faculty members to join our team, with the aim of training highly qualified, diverse psychologists prepared to excel amid the dynamic challenges of service in the U.S. Army. Train or teach within a practitioner-scholar model, emphasizing empirically validated clinical practice. Special emphasis is placed on developing Interns' ability to provide efficient and multiculturally competent clinical services to a large and diverse population of Active Duty Military Service Members.

Faculty applicant requirements: Qualified applicants must possess a doctoral degree in Clinical or Counseling Psychology, state licensure, and an interest in teaching and supervision. Open positions may be viewed at: https://www.usajobs.gov/ CPIP Phone: 910-570-3447

CPIP Email: usarmy.bragg.medcom-wamc.mbx.cpipprogramdirector@mail.mil

Self-Paced Courses and Webinars

Center for Deployment Psychology Online Courses

The CDP (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 January 2015 (https://deploymentpsych.org/webinars).

Massachusetts General Hospital Psychiatry Academy

Massachusetts General Hospital Psychiatry Academy (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.

SOCIETY FOR MILITARY PSYCHOLOGY

Division 19 of the American Psychological Association

Society for Military Psychology: Website

Check out Division 19 Society for Military Psychology website: www.apadivisions.org/division-19

This website will keep you up to date with the Society's goals and progress as well as information on how to join and get involved. The website provides information regarding:

- Information from the leadership
- News and events
- Training, continuing education, and career opportunities
- Awards
- Access to publications—*Military Psychologist* Journal and the online version of *TMP* newsletter
- Membership updates

The Society is dedicated to the advancement of science, improvement of practice and development of leaders, goals that are anchored in an unwavering commitment to ethics and a call to serve. Our community represents the diversity that defines the profession of psychology with our members engaged across the spectrum of the field in the Department of Defense and the Department of Veterans Affairs. Division 19 has continued to demonstrate growth, largely due to our commitment to, and support of, our students and early career professionals.

The Society for Military Psychology encourages research and the application of psychological research to military problems. Members are military psychologists who serve diverse functions in settings including research activities, management, providing mental health services, teaching, consulting, work with Congressional committees, and advising senior military commands. The division presents four annual awards at the APA convention, including the Yerkes Award for contributions to military psychology by a nonpsychologist, plus two student awards, one of which is a travel award. Members receive the quarterly journal *Military Psychology* and the newsletter *The Military Psychologist,* published twice a year.

For specifics, please go to the DIV19 webpage:

http://www.apadivisions.org/division-19

DIVISION MEMBERSHIP APPLICATION FOR JANUARY–DECEMBER 2018

Use this form to join the divisions and sections listed below—division assessment rates can be found on the following pages of this form. Memberships are for January–December. Applications received in August and later will be applied to the next membership year. Do not send cash; do not fax or email credit card information!

Note: Or join online through the division's website www.apadivisions.org/division-19/membership/

PLEASE TYPE OR PRINT CLEARLY – ESPECIALLY YOUR EMAIL.

Name:_____

Mailing address:_____

City, state, postal code, country:_____

Work phone:_____ Home phone: _____

Fax:_____ E-mail address:_____

APA membership number/category (if applicable):_____

Membership Category

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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 one of the following Section Editors: **Feature Articles** (Katie Copeskey: copeskey@gmail.com), **Trends** (Joseph B. Lyons: joseph.lyons.6@us.af.mil), **Spotlight on Research** (Colleen Varga: colleen.varga.1@us.af.mil), 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 the article 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 Editor in Chief (Shawnna Chee: shawnna.m.chee.mil@mail.mil) for potential inclusion.

Articles must be in electronic form (word compatible), **must not exceed 3,000 words**, and should be prepared in accordance with the most current edition of the *Publication Manual of the American Psychological Association* (e.g. reference/citations). 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 Christina Hein (chein9@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.

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