



THE MILITARY PSYCHOLOGIST

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Division 19 of the American Psychological Association

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January–December 2015

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Editor's Column, Spring, 2015

Joseph B. Lyons



Do you enjoy military psychology topics? Do you yearn for an opportunity to support our brave men and women serving this great country? Are you looking for an opportunity to publish an idea, a research paper, a position paper, or to share your opinion about military psychology topics?

If you answered “yes” to any of these questions, then by all means read on.

Greetings! Welcome to the 2015 Spring edition of *The Military Psychologist*. We have an exciting set of papers and reports for your reading pleasure in this issue, so let’s take a look at what you can find inside.

We will get things started with a message from the President of our Division 19, Dr. Thomas Williams. Dr. Williams discusses the importance of communicating our science and other contributions to the public. He offers a call to action to recognize the research and applied contributions of Division 19 members from the past as means to work toward future challenges.

Next, we will move to our feature articles. *Ciro Visone* will kick things off with a paper discussing some of the challenges facing our veterans as they reintegrate after periods of deployment. Next, *Krista Kovatch* discusses the potential benefits of group therapy for children in military

families. *Dr. Antonio Puente* and *Michael Francis* follow with a paper highlighting *Dr. Puente’s* extensive career in military psychology geared toward clinical neuropsychology. We close with a paper from *Dr. Patrick DeLeon* focused on the importance of interprofessional collaboration.

Following the feature articles, we have the inaugural edition of the “Trends” section of the newsletter. In this issue, Trends will focus on techniques for clinical practice. *Holloway Marston* and *Alicia Kopicki* provide a paper discussing the role of service dogs as a mechanism for treatment of PTSD. Next, *Michael Sapero* discusses the importance of shared vulnerability within a treatment context for veterans.

Our “Spotlight on Research” column features an article by *Sally Kabbara*, *Dr. James Earnest*, *Dr. Timothy Allison*, and *Dr. Eric Morrison* on the topic of military sexual trauma among homeless women veterans. In the “Spotlight on History” column, *Dr. Paul Gade* provides a call to action to support his efforts in building the profiles of military psychologists. Finally, we have a number of informative and interesting reports and announcements from our dedicated Division 19 committees. A huge thank you to everyone who contributed to this newsletter!

Happy reading!

Division 19 President's Message

Thomas J. Williams, Ph.D.

Military Psychology: Proud, Engaged, and Looking Forward

We, as the Society for Military Psychology, can feel justifiably proud of our membership's multifaceted contributions, which advance scientific knowledge in the application of psychology in a variety of settings around the world. The diversity of our membership and the nature of our professional responsibilities allow us a rare opportunity to both model our profession's values and demonstrate how our actions are nested within an ethical foundation to "improve the conditions of individuals, organizations, and society" (American Psychological Association, 2010; APA). This represents a noble and important foundation for the values of the American Psychological Association (APA), which we maintain and adhere to within our division. Indeed, we must strive to help make evident, reassert, and acknowledge that our actions as psychologists do indeed reflect those values. As members of our profession, we strive in all we do to demonstrate how our actions reflect those values, which is perhaps unknown to some.

And strive we must—first, to ensure that the public better understands the important contributions of psychologists focused on military issues, which have helped establish the *very foundation of psychology* as a profession. We must also strive to ensure we help champion and represent how the science and application of psychology have been pivotal to our military and national security interests in a time of great threat. As the world turns its attention to global threats, many nations are also reflecting on the 100 years since the beginning of World War I. Therefore, it is perhaps fitting that all psychologists consider reflecting on the readiness with which some of the earliest founding members of our profession and the APA recognized their responsibilities to society and to the needs of our military. This sense of responsibility to serve society was captured well in a call to duty to all psychologists that came from an earlier president of the APA, Robert Yerkes, with the following: "Our knowledge and our methods are of importance to the military service of our country, and it is our

duty to cooperate to the fullest extent and immediately toward the increased efficiency of our Army and Navy" (Yerkes, 1917). Members of the Society for Military Psychology fully understand this call to duty and the commitment it reveals to help provide service to our society, the military, and the organizations that help protect it . . . in today's increasingly perilous world!

It is that call to duty that imparts a sense of deep honor for me to serve as the president of our division. It is this same call to duty that shapes one of my major initiatives: To help translate the tremendously valuable and multifaceted contributions of our Division 19 membership to the public. This is a very positive story that will help highlight the tremendous talent of our dedicated and diverse membership and the extraordinary value of their achievements in settings that range from independent practice to academic, clinical, international, military, organizational, operational, and research.

My second initiative is to facilitate increased recognition for how our Society for Military Psychology members provide exemplary models for our profession through their excellence in practice, science, education, and the way by which their daily contributions promote the public interest and safety. We do all of this in a way that convincingly reflects the values outlined in our ethics code—with a pursuit of excellence and with the knowledge of the diversity in the various settings around the world in which our members provide their expertise. We do all of this while affirming our commitment to ethical actions that serve to promote the general welfare, safety, and protection of our society.

We are indeed a division that is moving forward due to the great leadership initiatives put in place in previous years by dedicated members of our division leadership team. We recently (February 18, 2015) completed our Division 19 mid-year meeting and I would like to highlight a few examples of what we are moving forward to achieve: We reviewed our truly excellent Division 19 program for the

APA Annual Convention in Toronto in August, 2015; discussed and approved the initiation of a review of our division bylaws and strategic plan to bring them up-to-date; we identified ways to increase our international membership; reviewed our initiatives in support of women in psychology and for early career psychologists; approved funding for division webinar programs that will assist students and all members of the division with the potential for continuing education and other training opportunities. We also approved student research and travel awards and received great service from our Treasurer, Scott Johnston, on how to ensure we sustain our financial strength in the near and long-term. Again, this is just to highlight a few items.

I want to publicly thank each of you because it is only through your membership and collective efforts that our division remains strong and vital within the profession of psychology. A significant part of Division 19's strength and vital momentum is, as was noted above, in the linkage to our profession's past, its relevance to society today, and the appeal of our future. By paying homage to our past and recognizing the relevance and appeal of our future, we contribute to the tremendous success of our truly outstanding student membership committee. They bring to our division a very inspiring energy created by their dedication to the mission of our division, which is expressed through the strength of our student members in over 35 student chapters in universities across the nation. We are fortunate to have such talented and capable student leaders who help us represent the great benefits afforded by membership in our division. By their actions, they help ensure a strong future for our division.

We are most effective and will remain the strongest if we have your trust and confidence that our division is representing and responsive to your professional needs and interests. One important way we are able to do that is by ensuring that we have the largest possible number of members voting in the upcoming Division 19 election. Your vote helps to ensure that the "collective will" of our membership is heard. In this election round, we will elect

a president-elect, APA Council representative, and member at large. Your vote will make a difference! Please consider taking the small amount of time to engage in one of the most cherished rights we can exercise: Voting for the individual who will best represent you and our Division as one of its leaders.

I want to close by noting how the APA recently identified the need to help educate the public on how psychology achieves a "boundless application in everyday life." I offer to you that members of Division 19 do that every day by applying their psychological knowledge to help our nation and our military personnel (active, reserve-component, retired, veterans, and their family members), organizations, communities, and members function more effectively and with greater safety. Our fellow members of the Society for Military Psychology represent a great and dedicated team of professionals who are "proud, engaged and looking forward!" I am so very proud to engage the issues and opportunities that help to advance our division's interests as we move forward.

Thank you for what each of you do every day to help advance those interests, our division, and our profession. I hope to see you in Toronto!

All the best,

Tom

Thomas J. Williams, PhD

President

APA Division 19

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Reintegration Difficulties Continue to Challenge Veterans at Home

Ciro Visone

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The following is a personal rant aimed at reawakening a serious topic.

Victimology is the study of the physical, emotional, and financial harm suffered by an individual as a result of an illegal activity (Campbell, 2010). But how does this definition pertain to individuals sworn to protect the very freedoms that allow this concept to exist? Veterans are victims of the “fog of war.” The uncertainty of combat is exacerbated by violence witnessed through the eyes; the anxiety felt by the nervous system; the constant stressors of fight or flight; the never-ending sleep disturbances.

As a U.S. Marine Corps veteran, I am one of the fortunate members of our armed forces who doesn't suffer from mental or physical trauma. As a doctoral psychology student however, I become enmeshed in the anguish that some of my patients (clients) are forced to re-experience each time they step into therapy with me. As a human being, I'm empathetically torn by the reality that is; a torment which may never be eased. Perhaps more agonizing than witnessing my fellow brothers and sisters readjust to civilian life are the obstacles placed before them daily. One might call me biased, because I, too once wrote a check to these great colors, payable up to, and with my life. Nevertheless, I hope to give an understanding of the obstacles to “re-assimilation” from the perspective of a Marine-turned-psychologist.

Background

Trauma is an event in which the ordinary systems of care that give individuals control, connection, and meaning have become inundated (Herman, 1997). A person in this state risks losing complete autonomy and independence. Returning to civilian life is anything but captive, but service members face more than overcoming mental health issues; they face a system which can inadvertently make this transition difficult.

Society has historically supported its military at the beginning of mass tribulation, such as was the case immediately following 9/11. However, as quickly as public

opinion rallies behind military action, so does it crumble when it feels “action has taken too long to accomplish.” Part of this is the result of new generations coming of age, who may not have the recollection of the initial shock of why military action was required, coupled with opinions by individuals given the inadvertent power to influence society as a whole, namely entertainers and other celebrities.

Although reintegration and treatment efforts by the U.S. Departments of Defense (DoD) and Veteran Affairs (VA) continue to improve, there is still much work to be accomplished. Notwithstanding, how these obstacles add to the cumulative stressors with which veterans are subsequently faced after experiencing combat may be misunderstood. The result is difficulty in veteran re-assimilation and ineffective treatment of posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and substance-abuse disorders, among other health conditions.

Problem

During a 2004 Congressional briefing, veterans admitted that society's response to their return home pressured them into feeling responsible for experiencing character flaws, leading to shame, guilt, loss of innocence, and increased fear (Cook, 2004). Veterans further expressed feeling a “loss in the goodness of humanity” based on how they were regarded and treated by the general public. In anticipation of approval and acceptance, many are met with defiance and defamation of their character, as well as criticism of “their part in the war.” The mistreatment of Vietnam veterans sadly continues to be a perfect example of the above statement. When antiwar public sentiment is directed at individuals returning from combat, PTSD treatment not only becomes difficult, but symptoms are exacerbated.

A study by the *New England Journal of Medicine* suggested that over 90% of Iraqi and Afghan war veterans have either witnessed the mutilating of a human body, were themselves the target of heavy fire, or aided in collecting fatally wounded troops (Hoge et al., 2004). The

veteran returns home a victim, a product of the oath taken to protect one's home, "against all enemies, foreign and domestic." Rather than overcoming the mental and physical wounds acquired in combat, the service members must now face an encore of ridicule, however small or great, resulting in "revictimization," followed by internalization. The depression, anxiety, and sleep disturbances suffered in war are reignited. The panic is resumed. There is once more "fight or flight," only this time against the self.

Current Approaches

Currently, evidenced-based treatments of PTSD and TBI include copious amounts of cognitive-behavioral therapy (CBT). Military personnel view this as "talk therapy," and its effectiveness varies for different service members. In addition, many veterans are prescribed medication and attend support groups. For those who return home to families, family therapy can also be implemented, because PTSD can affect the entire familial system. In the direst of cases, eye movement desensitization and reprocessing (EMDR) has been shown to be effective by allowing the physiological processing of traumatic events in the brain (Stickgold, 2002). As this occurs, the victim essentially becomes desensitized to the memory. When the nervous system enters fight or flight, the process of dissociation causes the brain to rapidly store information without accurately processing it. For veterans, this means constantly reliving the emotions as they actually occurred.

The latest treatment for combat-related PTSD involves a form of exposure therapy, forcing the veteran to relive *actual* moments experienced in combat. Once again, the goal is to allow for desensitization to take place through reprocessing of the trauma. For this to occur, the emotional response must be reactivated (Foa & Kozak, 1986). Virtual reality exposure therapy (VRE) allows the veteran to describe a particular incident to a therapist, which then becomes virtually recreated for the veteran to relive as often as required for habituation to take place. The veteran can then reprocess the event according to his or her own terms (in the safety of the therapeutic environment), and move forward with the event.

Despite advancements in evidence-based treatment modalities, challenges aggravate the lingering difficulties in returning home. Public dismay toward our postcombat military creates a process of "revictimization," as do insufficient treatment efforts by administrations expected to

aid veterans such as the DoD and the VA. The Institute of Medicine (IoM) was tasked by Congress to survey the readjustment of veterans to civilian life. Forty-four percent indicated they were distraught with the challenges faced upon returning home (IoM, 2013). Difficulties included not receiving adequate treatment, with a portion indicating they had yet to receive any type of medical care whatsoever. In addition, many indicated being overlooked for employment, as veteran unemployment rates have surged to 30%; double the rate for same-aged individuals. Furthermore, the IoM reported that many of the evidence-based treatments available for cognitive rehabilitation are not being implemented by the DoD or the VA. This might result in the institutionalization of questionable policies and the use of methods that have little scientific validity, causing even further damage to returning veterans.

The DoD assesses cognitive functioning after TBI, using the Automatic Neuropsychological Assessment Metrics (ANAM) and the Military Acute Concussion Evaluation (MACE; IoM, 2013). In a sample of 502 veterans reporting TBI symptoms postdeployment, 70% reported no significant change in neuropsychological testing when compared with baseline (Roebuck-Spencer et al., 2012). Similarly, the MACE has been found to detect cognitive impairments in only 20% of those clinically diagnosed as concussed (Coldren, Kelly, Parish, Dretsch, & Russell, 2010). Moreover, DoD policy alarmingly forbids clinicians from restricting patient access to personal firearms, even when suicidal. This raises questions of concern regarding veteran safety during periods of depression.

Meanwhile, the VA strongly implements acceptance and commitment therapy (ACT) as its primary treatment of depression. However, when compared with the long-term effectiveness of more conventional modalities such as CBT, ACT recipients report greater depression and anxiety scores (Forman et al., 2012). Specifically, twice as many CBT patients are rated in the normal range of functioning at follow up. Last, patient follow-ups are sparingly conducted and clinicians are rarely evaluated on performance.

Proposed Solution/Call to Action

To adequately provide services and treatment to those returning from combat, we must not only become competent in understanding veterans as people, but also refrain

from projecting feelings about war toward those who were asked to fight it. *Treating veterans as the problem is the problem*. Negative public opinion and poorly organized government approaches are subpar responses to “why veterans struggle.” Not only is this unacceptable, but unethical. I have proposed several menial solutions to this crisis, and although elementary in nature, I believe them to be quite powerful if properly implemented.

Positive veteran transition must first begin with proper education at all levels, regardless of the experience a particular individual or sector may have in dealing with military personnel. My veteran clients *choose* me. When arriving to the clinic at which I currently intern, veterans are skeptical of entering into a therapeutic relationship until they hear about another veteran available to offer them services. This isn’t because I am better or more skilled in whatever treatment modality I implement, this is because I understand them and who they are. I am aware of their struggles, not merely as their own, but also as a product of an environment that can seem as though it has shifted from positive predeployment support, to lackluster postdeployment acceptance.

In addition to education, our government administration must implement a “checks and balances” system in which each holds the other responsible. This may be done through routine reviews of each other’s programs and through the sharing of information regarding what is effective and what isn’t. Standardized assessments between agencies should also be implemented so that neuropsychological scores are readily comparable. Treatment should be a collaborative, integrative approach between all involved parties. If the DoD and VA are tasked with ensuring the healthy re-assimilation of combat-forged men and women, both should essentially agree on one uniform method to accomplish the mission, by working jointly, rather than independently.

Last, individuals with the power to influence society ought to utilize that power benevolently. Regardless of political affiliation, it should not matter how liberal or conservative an individual is, or what animal (donkey or elephant) he or she votes for on Election Day. Negative personal sentiment can make life difficult for veteran transition. Even though freedom of speech is at the core of this country’s foundation, we should be more conscious of how powerful words can be.

Take Away Message

When veterans “ship out” they leave behind a nation mourning and promising to “be here for them” upon return, a nation drenched in nationalistic patriotism. The opposite should not be true upon their return, yet more often than not, this has been the reality. My hope is that we begin implementing change now, at this very instant. I fervently pray that we begin ameliorating how we accept veterans back into society by understanding them, not merely “clapping our hands” at sporting event half-time shows. I ask you, my fellow Division 19 members, esteemed colleagues, and psychologists, to do your part in extending this message about awareness and education to all you know. Our military has fought for us. Now let’s fight for them. And finally, do me a favor . . . always stand for that national anthem, remove your hats, and stop talking.

I leave you with words from some of history’s most prolific and influential men.

“We sleep safely at night because rough men stand ready to visit violence on those who would harm us” (Orwell, n.d.).

“I offer neither pay, nor quarters, nor food; I offer only hunger, thirst, forced marches, battles and death. Let him who loves his country with his heart, and not merely his lips, follow me” (Garibaldi, n.d.).

“Live for something rather than die for nothing” (Patton, n.d.).

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The Benefits of Group Therapy With Children in Military Families

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Since 2001, over 2 million children have had at least one parent deployed and thousands have faced the loss of a parent. Children in military families face unique challenges and opportunities for growth that children in civilian families do not. According to the Department of Defense (2012), active duty families with a child between the ages of 6 and 11 years were 30.8% of all children within active duty families, and more than 2 million American children have had a parent deploy to Iraq or Afghanistan. Families who serve in the military often face additional psychological stressors, such as multiple deployments, frequent relocating, and possible parental injury or death.

With young families starting to develop new family roles and responsibilities, these children are often faced with challenges that may make it difficult for some of their peers to understand and may feel isolated. Children ages 3 to 5 with a parent deployed tend to exhibit more behavioral symptoms than children in the same age group without a deployed parent, and may struggle with peer acceptance (Coulthard, 2011). School-age children may cope by internalizing their stress, such as withdrawing from others, or externalizing their stress, such as making irritable comments. Throughout all phases of the deployment cycle, children have been identified to exhibit behavioral changes that affect school performance, irritability, and symptoms of depression that civilian youths do not. Youths in military families between the ages of 11 and 17 have higher prevalence of emotional and behavioral difficulties than youths in civilian families, with increases of distress during a parent's deployment (Chandra et al., 2011). With the increase of young children in military families who are facing longer deployments with shorter time between deployments, support is needed and group therapy is a particularly helpful intervention that has been underused.

Children and adolescents in military families have demonstrated the need for mental health support. Between 2003 and 2008, the mental health visits for youths of active duty parents have doubled from 1 million to 2

million outpatients, and one third of children with a deployed parent were identified to be "high risk" for psychosocial issues (Davis, 2011). Youths in military families who are 14 and under have increased in total inpatient psychiatric care from 35,000 in 2003 to 55,000 in 2008 (Sogomonyan & Cooper, 2010). Although more families are seeking mental health care, stigma continues to be a barrier associated with mental health care, and some fear it may jeopardize the service member's career. The most common risk factors identified for youth and the impact of deployment include age, mental health of the nondeployed parent, and reintegration. Protective factors include family support, parental well-being, religious organizations, and families who feel supported by their communities. One way to increase community support for youths in military families is group therapy. Military families typically engage in individual or family therapy, with minimal use of a group therapy modality, despite group psychotherapy being included in TRICARE benefits. It is possible that military families may not be aware of this option, or there are too few group options available.

Group therapy is designed to allow a member to be both a receiver and giver of care. Children in military families often epitomize resilience, and the ability to be in both roles may feel more comfortable. A group therapy format designed for children in military families can also normalize developmental issues and conflicts that are unique to these families. Children of military families may feel an opportunity to build insight and share coping strategies that their civilian peers may not be aware of. As peer groups are becoming increasingly more important during this age, school-age children may connect easier with those in their age group—an option not readily available in a traditional individual therapy format. Group therapy can also increase empowerment through family and peer connection, enhance emotional stability, and build competence.

Military culture already encompasses a strong support system, and group therapy can reflect that system. Overall, the application of group therapy for youths in military families

has only begun to be examined in the literature. Rush and Akos (2007) designed a 10-session deployment group for middle- and high-school-aged students. With both psychoeducational and process groups, the purpose of the group was to increase knowledge of deployment, build competences (such as coping and developmental tasks), and build a peer network. A different study examined a creative arts approach for middle-school-age children in military families. Using an eight-session expressive arts process group, Kim, Kirchhoff, and Whitsett (2011) used arts as a medium to facilitate discussion on the unique challenges military families face. Both studies included a family component, in which additional family members were invited to either learn the child's experience of deployment or observe the works of art they created as an expression of being in a military family. Overall, both studies found the inclusion of family to be beneficial to increasing communication and improving family relations.

Overall, group therapy appears to be an effective modality; however, more research is needed. Most group therapy within military culture has examined benefits for the service member. Although research examining military family support is relatively new, this is an underresearched area that may decrease the negative impact of deployment. Programs may benefit from using an outcome measure to identify how long the benefits last and identify specific strengths of the group. Group therapy programs that address the intersection of multiple cultures and their impact on the family may also reach a wider range of children.

For military families who exemplify service before self, the need to support family resilience is evident. Overall, mental health professionals need to have general military cultural competency and would benefit from training with empirically supported practices when working with youth in military families. Research is needed in the development of empirically supported group therapy techniques and targeted intervention strategies at different phases of deployment with youths at different stages of development. Subgroups of military families, such as the intersection of multiple cultural identities and active duty compared with reserve duty, are areas that need further development to enhance effective therapeutic interventions.

Children and adolescents in military families are known to be a resilient group, but resilience does not mean impermeability. Development of effective group therapy may help mitigate the risk factors associated from deployment can help

build upon the strength of this population. Stigma may continue to be a factor that limits some from obtaining help, and further public education to address stigma within the military and mental health may be beneficial. Advocacy for comprehensive mental health care coverage for children and adolescents in military families and awareness of the strength to face psychological distress may also help.

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Clinical Neuropsychology and the Marine Corps: A Biographical Account of a Military Psychologist

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What is a neuropsychologist to do when he teaches, practices, and does research 40 miles away from the largest United States Marine Corps base east of the Mississippi? Simple—interface the two, many, many times over. This is a short story of a long history that involves one person's attempt to teach, practice, and research military psychology.

Teaching: For the last 30 years, Puente has taught over 7,500 students, including graduate students and post-doctoral fellows. Though numerous students have come from Camp Lejeune in Jacksonville, North Carolina, the most significant interface has been with graduate students. About 10% of graduate students have been veterans of the military. The most recent one, for example, is the coauthor of this article, Michael Francis, a Marine Corps infantry veteran who completed three combat deployments during his 4 years of active duty.

Although we are located relatively close to Camp Lejeune, there has been minimal collaboration between our university and the Marine Corps base. One reason may be attributed to the lack of research and teaching being conducted at the university associated with the military. Another may be that the Marine Corps is an exclusive organization. Since Francis, a Marine, has joined the Neuropsychology Lab, more opportunities to collaborate with the Marine Corps have arisen. Michael's connections with Marine enlisted and officers, whom he served with, have helped to bridge the gap that sometimes exists between the military and academia. Most notably, Michael's thesis will include active duty Marines from Camp Lejeune, as well as veterans from the Wilmington/Jacksonville area. In addition, one of our former students is now a civilian contracted clinical neuropsychologist and another is the lead psychometrist at Camp Lejeune.

During Puente's time teaching and mentoring veteran students, he has noticed a few important characteristics. First, veterans will accomplish all assigned tasks, sometimes

improvising, adapting, and ultimately overcoming obstacles. This most likely does not come as a surprise to active duty or military members. However, it is a quality that stands out in a university/lab setting. Second, the work ethic veterans possess is outstanding. It is as if they approach each task as a life or death matter, and are deeply appreciative to have the opportunity to work on projects related to their past experiences. Lastly, the attention to detail that veterans exhibit is surprising. It is the attention to detail that enabled veterans to accomplish various missions and operations while deployed and to keep one another and themselves alive. Nevertheless, when such characteristics are novel in students and research assistants, they are noticeable and appreciated.

Clinical: Puente has evaluated and treated Marines and sailors from Camp Lejeune and was the first psychologist to accept TRICARE in Wilmington. Over the last three decades, we have personally completed hundreds of neuropsychological evaluations on Marines returning from the Vietnam War, Gulf War, Operation Enduring Freedom, and Operation Iraqi Freedom. Approximately a decade ago, he noted that the injuries sustained by these soldiers were different than the ones seen with Puente's work with concussions and the Carolina Hurricanes National Hockey League team. The residuals noted in concussion and traumatic brain injury were clinically different than those from blast injuries. Significant emotional residuals were present and could have evolved from posttraumatic stress disorder (PTSD), and the neuropsychological symptoms were more subtle. For example, a common problem was reduced processing speed. The protocols that have historically been used in clinical neuropsychology did not appear to be sensitive to the symptoms presented by these Marines. As referrals increased, two of Puente's students relocated to Jacksonville, the home of Camp Lejeune, to start providing neuropsychological services to these individuals.

Research: Based on our work with these veterans and active duty military, a "blast battery" was developed in

consultation with the neuropsychology staff at Walter Reed Medical Center. Puente and two former students, Karen Johnson and Alan Steed, began administering neuropsychological evaluations of Marines and sailors from Camp Lejeune who had been referred for testing after suffering a traumatic brain injury (TBI), many of which were a result of combat related improvised explosive devices (IEDs).

Conducting research with a military sample of combat veterans has attracted the attention of military veterans and military reserve students to Puente's lab. The lab has compiled a data set of approximately 1,300 Marines and sailors, which included roughly 150 variables per person. Demographic data included age, gender, ethnicity, education, and handedness, as well as ASVAB scores. Additional variables applicable to military service, location deployed, number of times an individual has been exposed to an IED or other forms of brain injury, and whether or not the member experienced a loss of consciousness. For example, we have determined that there are approximately 53 different ways to receive a brain injury, according to many military sources. Neuropsychological tests scores were collected included but not limited to the ASVAB, California Verbal Learning Test (CVLT), Finger Tapping, Grip Strength, Wechsler Adult Intelligence Scale (WAIS) III and IV, and Wechsler Memory Scale (WMS) III and IV. These are fairly standard tests used in neuropsychological evaluations, but there were anecdotal and qualitative indications that they may be sensitive enough to capture the subtle deficits noted. While the WAIS and WMS have very useful subtests in regard to TBI, such as measures of processing speed, the tests are relatively lengthy. Finger Tapping and Grip Strength measures focus on motor functions and assist in some cases identifying whether brain trauma is lateralized. In addition, the Minnesota Multiphasic Personality Inventory (MMPI; MMPI-II), the Trauma Symptom Inventory (TSI), as well as the Test of Memory Malinger (TOMM) were added. Tests such as the MMPI and TSI are primarily used in the diagnosis of PTSD.

Recent research has focused on the TSI, MMPI, and the TOMM and the validity of these measures in the assessment of PTSD, and was presented during the Neuropsychological Assessment of Blast Injuries symposium at the 2014 APA convention in Washington, D.C. Other ongoing research has focused on repeated testing within individuals. This research primarily sought to find whether any statistical differences were found in test scores between

initial and repeat testing. This was presented and discussed further during the Neuropsychological Assessment of Blast Injuries symposium. The complete findings of the four studies presented can be found at <http://www.militarytbi.org>.

In addition to PTSD, the Neuropsychology Lab group has conducted research on processing speed. The following are examples of questions that we are addressing: (a) Do the number of times an individual sustains a blast injury affect processing speed?; and (b) Is loss of consciousness predictive of scores on measures of processing speed? This research will be presented at the 2014 National Academy of Neuropsychology convention. We are eager to share our findings with members of Division 19 (contact us at Puente@uncw.edu).

By the end of the fall of 2014, we will have cleaned up the data set. At that point we will embark on comprehensive statistical analyses as well as begin a program of data sharing. We are also establishing more permanent and formal collaboration with Thomas DeGraba, M.D., Deputy Director, Chief of Medical Operations at the National Intrepid Center for Excellence (including the addition of his daughter, an undergraduate at UNCW, to our research team). The eventual goal is to interface our neuropsychology lab group with the Intrepid Program as well as with Camp Lejeune, and work collaborative to more effectively understand the role of brain injury and PTSD in active duty military and military veterans.

It is not typical for universities, private practices, and military settings to interface, but this is one case where teaching, practice, and research has synergy and robustness. This is also an illustration of how clinical, pedagogical, and scientific activities can interface for the benefit not only of the professionals and students involved but also of the military personnel we seek to understand and serve. As information as well as our data set becomes available, we will let the readers of *The Military Psychologist* know as well as through our website <http://www.militarytbi.org>.

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Interprofessional Collaboration: The Future

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For our nation's health-care professionals, these are very "interesting" times. Change is always unsettling, especially when it is difficult to predict with any sense of certainty what the future will bring. Under the visionary leadership of American Psychological Association (APA) President Nadine Kaslow, the Council of Representatives endorsed moving toward competency-based education, an approach which has been adopted by nearly every other health-care profession. At the end of last year, the Accreditation Council for Pharmacy Education, Commission on Collegiate Nursing Education, Commission on Dental Accreditation, Commission on Osteopathic College Accreditation, Council on Education for Public Health, and the Liaison Committee for Medical Education formed the Health Professions Accreditors Collaborative (HPAC). They are committed to discussing important developments in interprofessional education and exploring opportunities to engage in collaborative practice around the common goal of better preparing students to engage in interprofessional collaborative practice. They anticipate inviting other disciplines to join their effort later this year in response to inquiries.

If one reviews the training models of the other health professions, there is considerable interest (especially within nursing and public health) in exposing their next generation of practitioners to the nuances and importance of appreciating health policy—and how, for example, over the past decade, various health-policy experts have increasingly urged the nation to emphasize developing *systems* of care, rather than continuing to rely upon individual practitioner expertise. Unfortunately, we have observed that such training is relatively rare within psychology's training programs. Integrated and patient-centered, data-driven holistic primary care provided by interprofessional teams is one of the cornerstones of President Obama's Patient Protection and Affordable Care Act (ACA). And, it has clearly been a high personal priority for U.S. Army Surgeon General Patty Horoho during her tenure.

Those colleagues trained in providing mental health and/or behavioral health care face significant challenges in effectively addressing our nation's pressing needs. On a recent Health Resources and Services Administration (HRSA) national advisory committee conference call it was noted: "Mental health disorders rank in the top five chronic illnesses in the U.S. An estimated 25% of U.S. adults currently suffer from mental illness and nearly half of all U.S. adults will develop at least one mental illness in their lifetime. In 2007, over 80% of individuals seen in the emergency room (ER) had mental disorders diagnosed as mood, anxiety and alcohol related disorders."

At the Uniformed Services University of the Health Sciences (USUHS), nursing and psychology practitioners are pursuing ways to systematically share expertise. A number of courses are jointly taught and/or coattended; for example, Stress and Trauma in the Military Context, Introduction to Physiology, and Health Policy. Mental health students enrolled in both training programs (doctor of nursing practice/clinical and medical psychologist) regularly use the university's simulation lab where live actors "play out" various symptomatology for the trainees as they are monitored on closed-circuit TV. Discussions are currently underway to facilitate cross-professional critiques of these experiences. An underlying question: Why should there be different training models?

A Very Far-Reaching Vision

In January of this year, the Military Compensation and Retirement Modernization Commission, a blue ribbon panel established by Congress in 2013, submitted its 302-page *Report of the Military Compensation and Retirement Modernization Commission: Final report*. Even a cursory review provides a sense of the unprecedented magnitude of their recommendations. "Our volunteer Service members are the strength of our military, and it is our continuous duty and obligation to ensure that the Services are properly resourced . . . in considering the military health benefit, we focused on sustaining medical readiness by recommending a new readiness command, supporting el-

ements, and framework for maintaining clinical skills” (Maldon et al., 2015).

The commission report also calls for unifying joint capabilities by creating a joint-readiness command to ensure health and combat-casualty care for military service members and to help establish new standards for those essential medical capabilities:

The critical nature of joint readiness, including the essential medical readiness . . . make it clear that four-star leadership is needed to sustain dedicated focus on the joint readiness of the force. Ensuring that the hard-fought progress achieved during the past decade in the delivery of combat casualty care on the battlefield, the global capability for evacuating casualties and providing critical care while in transit, and the research that has led to advances in wound care and hemorrhage control, requires strong oversight at the highest level. The Commission thoroughly evaluated the merits of a four-star joint medical command Medicine is only one component of joint military readiness. The essential nature of military medicine by itself warrants four-star oversight, and the Commission concludes the best course of action is to create a four-star Joint Readiness Command to manage the readiness, as well as the interoperability, efficiency, and “jointness” of the entire military force, including medical readiness . . . (Maldon et al., 2015, p. 69).

The Commission also identified that the value of TRICARE is hampered by inefficiencies that result in part from restrictive contracting procedures, a framework that “prevents adaptation” and one that struggles to identify and control overutilization of services (Maldon et al., 2015, p. 94). In essence, TRICARE has not evolved in response to the changes in health:

Health care is a constantly changing industry. The features of health care, including technology and the models for paying for and delivering care, rapidly evolve. Rather than attempting to replicate a private-

sector health-care system within DoD, and consequently following behind, the Commission believes beneficiaries would be better served by having direct access to the innovations found in private-sector health care. Furthermore, under commercial insurance, carriers have the tools, including the advancements in payment and delivery models . . . and the monetary and nonmonetary incentives . . . to increase value by operating more efficiently (Maldon et al., 2015, p. 69).

The Commission report provides an important overview and assessment of policy options to help ensure that our nation and military health-care system provide both choice and access to health care that is valued and efficient. In a resource-constrained environment, the focus on joint initiatives, increased value, and efficiency helps demonstrate relevance.

‘Cause I’m leavin’ on a jet plane. Don’t know when I’ll be back again. Aloha, Pat DeLeon, former APA President—Division 19.

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The Impact of Service Dogs on Post-Traumatic Stress Disorder in the Veteran Population

Holloway Marston and Alicia Kopicki

More than 2 million veterans have deployed to combat zones during this most recent conflict, of whom 13%–20% are believed to have developed posttraumatic stress disorder (PTSD; RAND Corporation, 2008; Sayer et al., 2010). Data suggest that only 50% of these returning veterans access care, and merely 40% of these treatment seekers experience significant improvement in their symptoms of PTSD. This suggests that only a fraction of those with symptoms is improving because only 20% of all returning veterans with PTSD are seeing a reduction in the frequency, intensity, and duration of their symptoms of PTSD (Hoge, 2011). This unfortunate reality is believed to be due to factors such as stigma, lack of trust in mental health providers, and the belief that available treatments are ineffective (Hoge, 2011; Sayer et al., 2010).

Veterans have provided anecdotal reports stating that service dogs have helped them recover from PTSD when they could not find relief from other interventions (Ruiz, 2012; Winkle, Crowe, & Hendrix, 2012). Alternative treatments such as this could help the 40% of veterans who do not experience improvements after participating in treatments such as prolonged exposure (PE) and cognitive processing therapy (CPT), which are considered the gold standards for treating PTSD (Monson & Friedman, 2006). However, lack of awareness and empirical evidence in support of this intervention appear to have prevented this form of treatment from being widely used and accepted by mental health service providers who treat veterans affected by PTSD (Foreman & Crosson, 2012).

In response to the large number of veterans returning home from combat affected by PTSD, nonprofit organizations have begun training service dogs as an alternative intervention for this population, because of the high volume of requests from returning veterans for this form of treatment (Foreman & Crosson, 2012). There is a gap between the demand and availability of service dogs largely due to the lack of research on which funding and grant requests are based (Sachs-Ericsson, Hensen, & Fitzgerald, 2002). Many of these organizations have been accredited by Assistance Dogs International, which is the

certifying body tasked with setting standards of excellence within this specialty (Sachs-Ericsson et al., 2002). An accredited service dog is protected under the Americans With Disabilities Act, indicating that the dog cannot be refused entrance anywhere, including restaurants and airports (Shubert, 2012). Certified organizations train highly skilled service dogs for the purposes of helping returning veterans recover from PTSD.

Service dogs are trained to complete many complex tasks that are intended to provide support to veterans when they experience difficulty with their symptoms of PTSD (Foreman & Crosson, 2012). Esnayra and Love (2005) described their findings when studying service dog behaviors and found the dogs can be trained to confirm the safety of a room by patrolling its perimeter for the purposes of providing the veteran with a greater sense of safety prior to entering (Esnayra & Love, 2005). A service dog can also turn on the lights to interrupt a veteran's nightmare, remind the veteran to take medication by alerting him or her at the proper times, and can even prevent a veteran from being startled by nudging him or her gently when someone is unexpectedly approaching or by blocking a person who is coming too close to the veteran (Esnayra & Love, 2005). These behaviors are intended to assist veterans with PTSD because the service dogs provide support and increased means of coping with the associated symptoms such as hypervigilance, fear, nightmares, the fight-or-flight response, and impaired memory (Esnayra & Love, 2005).

Based on anecdotal reports, once veterans begin to manage their PTSD symptoms after being paired with a service dog, their quality of life has improved (Foreman & Crosson, 2012). Veterans have reengaged in many life tasks that their symptoms previously prevented them from participating in, such as work, school, and socializing with family and friends (Freedom Service Dogs, personal communication, December 5, 2012). In addition, veterans reported that they depended less on medications to cope with symptoms that have side effects, such as drowsiness, which further impeded their ability to engage in life tasks.

Hoge (2011) reported that ~60%–80% of all returning veterans affected by PTSD will not recover through treatments such as CPT or PE. Monson and Friedman (2006) stated that alternative interventions are necessary for the purposes of treating PTSD, because in their estimates, the current available evidence-based treatments did not resolve symptoms in 50% of the veterans who received them. Moreover, many veterans reported that they would prefer not to engage in treatments such as CPT or PE (Hoge, 2011). Although it is clear that CPT and PE are an important part of recovery for some veterans, experts have indicated that alternative treatments, such as the service dog interventions, are needed to assist veterans who have not found success with current evidence-based therapies (Hoge, 2011).

Despite these positive anecdotal reports from veterans, using service dogs as a treatment for PTSD is not yet widely accepted by providers who treat veterans. The U.S. Department of Veterans Affairs (VA) has expressed concern about the efficacy of this treatment because of the belief that it has the potential to cause veterans to not attribute improvements to their own ability but rather to the support of their dog. For example, it has been suggested that service dogs could negatively affect exposure interventions, because when the veteran engages in behaviors that were previously feared, he or she may attribute this change to the presence of the dog rather than his or her own ability to overcome the fear (McIntosh, 2009). For these reasons, as well as the lack of sufficient evidence of its effectiveness, the VA does not support the use of service dogs for treating PTSD symptoms (McIntosh, 2009). Other researchers also acknowledge the lack of empirical evidence for this treatment (Love & Esnayra, 2009; McIntosh, 2009).

Theoretical Framework

The literature suggests that service dogs are effective because they address the biological, psychological, and social aspects of PTSD symptoms. On a biological level, Yount, Olmert, and Lee (2012) suggested that when individuals interacted with dogs, their stress levels were reduced, as evidenced by a decrease in cardiac reactivity and cortisol. These responses were associated with reductions in hyperarousal, social isolation, and pain and sleep disturbances, which are important indicators that PTSD symptoms are becoming less severe (Yount et al., 2012).

Evolutionary theory suggests that humans intrinsically find other living things comforting, which can lead to the calming of aroused physiological states (Henry & Crowley, 2011). Research suggests that when humans interact with animals, the physiological stress reaction is reduced, as evidenced by lower heart rates and cortisol levels (Sachs-Ericsson et al., 2002; Yount et al., 2012). Data suggest that increases in oxytocin and dopamine, as well as a reduction in cortisol, result in this calming response for individuals who interact with dogs (Horowitz, 2008). Oxytocin is a stress-reducing hormone, and interactions with dogs have been found to increase this neurochemical (Yount et al., 2012). Calming interactions with dogs, including petting and quietly talking to them, have been shown to result in a physiological stress reduction response (Yount et al., 2012). These interactions may even serve as grounding exercises, which are coping skills taught to veterans for the purpose of helping them manage their symptoms of PTSD (Esnayra, 2007).

Oxytocin has also been found to play an important role in the physiology of PTSD (Yount et al., 2012). Research suggests that oxytocin reduces symptoms related to PTSD such as anxiety, fear responses, hyperarousal, interpersonal difficulties, social isolation, physical pain, and sleep disturbances (Yount et al., 2012). Additional empirical findings suggested that oxytocin reduces interpersonal conflicts, negative communication, aversive conditioning of social stimuli, and the stress response (Yount et al., 2012). The neurochemical has also been found to increase accurate identification of emotional states in others, the processing of positive social information, and the use of social support (Yount et al., 2012). Pointedly, oxytocin has been found to positively affect symptoms of PTSD in combat veterans, and this neurochemical was found to decrease the physiological response that occurred when exposed to memories of combat trauma (Yount et al., 2012).

Oxytocin acts on the hypothalamic-pituitary-adrenal (HPA) axis, which is believed to be the pathway in the brain that is affected by PTSD (Hoge, 2011; Yount et al., 2012). Oxytocin has also been shown to decrease cytokines, adrenocorticotrophic hormone, and cortisol, which are the substances in the brain that activate the HPA axis, resulting in the increased physiological responsiveness associated with PTSD (Horowitz, 2008; Yount et al.,

2012). In addition, oxytocin acts on the amygdala and other important structures of the central nervous system that are believed to be involved in the physiological processes of PTSD, causing a connection in the prefrontal cortex (Yount et al., 2012). This is an important occurrence related to PTSD because this connection with the prefrontal cortex increases appraisal and evaluation of stimuli, which could reduce the experience of freeze reactions or sensing false danger triggers in a veteran's environment (Yount et al., 2012). Therefore, the positive effects of oxytocin appear to result in many improved responses that could translate into an enhanced quality of life for veterans who are paired with service dogs. Experiences such as reduced hypervigilance and improved connections with sources social supports as a result of oxytocin are examples of outcomes that would help veterans recover from their trauma with the assistance of their service dogs.

Psychologically, Yount et al. (2012) reported that individuals who endorsed having a bond with their dogs felt that the dogs served as a buffer against stressors. Attachment theory suggests that a service dog provides the veteran with a secure base effect (Valsecchi, Prato-Previde, Accorsi, & Fallani, 2010). Escolas et al. (2012) found that veterans with PTSD are significantly more likely to report experiences consistent with an insecure attachment style. This study reported that PTSD is correlated with attachment style because of the way in which serious symptoms can negatively affect interactions with a veteran's support system (Escolas et al., 2012). In addition, the attachment style from which individuals interact reflects the way in which they see themselves and others (Escolas et al., 2012). Furthermore, combat PTSD can be interpreted by veterans as an interpersonal violation, commonly resulting in withdrawal, impairment, and disruptions in attachments (Escolas et al., 2012). Therefore, if a service dog is capable of helping to repair a veteran's ability to form attachments, his or her overall quality of life would also likely improve as a result.

Veterans with secure attachments are much less likely to be affected by symptoms of PTSD (Escolas et al., 2012). Empirical studies have indicated that service dogs form a strong attachment with their paired individual (Valsecchi et al., 2010). (Escolas et al., 2012) indicated that "any relationship in which proximity to the other affects security is an attachment relationship" (p. 58). Attachment

theory suggests that dogs stimulate a nurturing response from individuals who interact with them (Horowitz, 2008). A strong attachment with a service dog could be particularly important in the recovery process and overall improved quality of life for many combat veterans, because of the potential to overcome the inability to feel connected to others as a result of their PTSD (American Psychiatric Association, 2013).

Finally, on a social level, Sachs-Ericsson et al. (2002) found that individuals with service dogs felt less isolated socially and felt more comfortable when initiating social interactions with others. Social provisions theory proposes that the service dog provides the veteran with feelings of self-worth, as well as nurturance, and a consistent source of support (Henry & Crowley, 2011). One study found that disabled individuals experienced reduced feelings of loneliness after being paired with their service dogs (Winkle et al., 2012). In addition, disabled individuals also stated that they felt an increased sense of security once being paired with their service dog because of the acquired emotional support gained from the dog (Winkle et al., 2012).

Social mediation theories state that the service dog stimulates conversation and impromptu interactions with the community, as well as enhances the veteran's social desirability (Henry & Crowley, 2011). Also, Winkle et al. (2012) stated that service dogs have a positive effect on socialization and community involvement for paired individuals. In addition, Horowitz (2008) reported that the bond between a human and a dog tends to promote social cohesion. Data suggest that community members smiled at and spoke to individuals paired with service dogs more frequently than disabled individuals without service dogs (Eddy, Hart, & Boltz, 1988). These findings are particularly important for veterans who may experience social isolation because of a disabling mental health diagnosis, because service dogs appear to promote positive interactions with others (Eddy et al., 1988). This idea is supported by one study's findings that 75% of disabled individuals surveyed reported making new friends after being paired with their service dogs (Sachs-Ericsson et al., 2002; Winkle et al., 2012). This is significant because increasing social support for veterans affected by PTSD as a result of their combat experiences has been shown to positively influence recovery from PTSD and improve their quality of life (Bailey, Eng, Frisch, & Snyder, 2007; Escolas et al., 2012).

Treatment Effects

Esnayra and Love (2005) reported positive results from their study, which looked at the effects of psychiatric service dogs on the symptoms of individuals diagnosed with a mental illness. Their findings indicated that more than 86% of individuals in their study with agoraphobia and anxiety reported a reduction in their symptoms (Esnayra & Love, 2005). In addition, greater than 80% of their respondents diagnosed with PTSD, panic, and depression reported a decrease in the mental health symptoms they experienced. Specifically, more than 84% reported a decrease in symptoms as a result of the service dog intervention (Esnayra & Love, 2005). The investigators also indicated that 40% of their participants stated that they were able to reduce the amount of medication needed to treat their symptoms after being paired with a service dog (Esnayra & Love, 2005). These findings are encouraging because they specifically relate to symptoms of anxiety, depression, and PTSD, which are diagnoses that veterans must frequently cope with as a result of their service (Jakupcak et al., 2009).

Knisely, Barker, and Barker (2012) reported within the *U.S. Army Medical Department Journal* that individuals who engaged in animal-assisted therapies experienced a reduction in their anxiety and depression symptoms. Similarly, research findings suggested that individuals who lived alone or were institutionalized experienced a reduction in symptoms of depression and anxiety after interacting with a therapy dog (Shubert, 2012). Yount et al. (2012) also reported data suggesting that symptoms of depression showed improvement following animal interactions. Furthermore, Sachs-Ericsson et al. (2002) reported that 70% of participants indicated a reduction in the level of anxiety and depression they experienced after being paired with their service dog. Most pertinently, Winkle et al. (2012) stated that service dogs have also been shown to improve the quality of life of paired individuals, as well as their symptoms of depression. These findings are promising and suggest that similar effects might be found with members of the veteran population once paired with a service dog specially trained for treating symptoms of PTSD.

Recommendations

A well-designed research study considering the issues presented in this article is relevant for returning Iraq and Afghanistan war veterans because it could provide empir-

ical support that service dogs are effective for treating their PTSD symptoms. Such a study is currently being conducted at the Adler School of Professional Psychology to investigate many of the variables discussed. The positive anecdotal reports from veterans about the benefits of service dogs for PTSD symptoms suggest that this treatment modality should be investigated and subsequently made available to more veterans. Many returning veterans are requesting treatment in the form of a specially trained service dog, as evidenced by the long waiting lists with the nonprofit organizations. Because data suggest that this population may not typically reach out for support when needed, conducting a well-designed study to determine the efficacy of the treatment is a necessary contribution to the field.

Many have advocated that efficacy studies of alternative treatments for PTSD are needed so that veterans can be informed about other treatments that have been shown to alleviate symptoms (Hoge, 2011). Considering that this is a relatively new method of therapy, a well-designed study could provide reliable evidence of its effectiveness, which would support veterans' testimonies that service dogs do improve their quality of life (Ruiz, 2012). Under controlled conditions, the objective of the study is also to rule out alternative explanations for how service dogs heal veterans.

These findings would also be relevant to mental health professionals who wish to refer veterans with PTSD symptoms for alternative treatments. Mental health professionals could base their treatment recommendations on studies that demonstrate the effectiveness of service dogs in alleviating symptoms of PTSD in veteran populations. Policy changes and support for the use of this intervention will only occur if awareness is brought to the mental health field through research. As stated, empirical evidence supporting the use of service dogs for PTSD is needed to effect this change.

Research also has the distinct opportunity to improve funding opportunities through grants for the nonprofit organizations that train and provide service dogs to veterans. Researchers who provide data to these organizations could offer them an opportunity to showcase their efficacy to prospective grant providers. A carefully designed study such as the one advocated for within this article is currently being conducted by a research team at the Adler School of Professional Psychology along with community partners who train and provide

accredited service dogs free of charge to returning veterans. The study is currently in the data-gathering and participant recruitment phase. Plans to publish the findings by the end of this year are currently in place.

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Through the Darkness Within: A New Relational Approach for Treating Combat Veterans

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I was working as a clinician on an inpatient neurocognitive rehabilitation unit for returning combat veterans with acute posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) at a Veterans Affairs (VA) hospital last spring. This was an intensive inpatient program for male and female combat veterans, and I was one of the clinicians for the male veterans whose needs could not be met in other programs. They came to us after suicide attempts and prolonged periods of homelessness and drug use. I was sick for two days and remember receiving a text from a colleague written on behalf of the men in the unit that read, “You are a wussy for being sick. Suck it up and get back to work!” Through their teasing and backhanded way of expressing concern, I knew then that I had a firm and authentic relationship with those men. I would now be able to engage them in their treatments.

Evidence-based treatments (EBTs) like eye movement desensitization and reprocessing (EMDR), prolonged exposure, integrative restoration (iRest), stress inoculation training (SIT), and cognitive processing therapy (CPT) are instrumental for addressing the myriad concerns that impact male combat veterans with PTSD. The transformational power of neurofeedback and mindfulness practices to help regulate emotionality and improve judgment, insight, and problem solving is well studied and documented. These processes and EBTs should be used for combat veterans precisely because of their struggle with emotional dysregulation and executive functioning impairment. However, if we, as therapists, cannot relate to combat veterans, or if they fail to bond with us, then treatment adherence and engagement can be potentially negated or impeded. Because EBTs are all time-bound, the therapeutic relationship must be made rapidly and authentically to maximize treatment efficacy of any of the PTSD treatment protocols. This paper proposes a style of relating to male combat veterans that can serve as the foundation for the therapeutic alliance that is crucial for success with exposure-based and affect-regulating protocols. I call this a process of shared

vulnerability; a practice where I, as therapist, engage these men by offering vulnerability in exchange for their trust. In essence, I become a “battle buddy” on the psychological battlefield, where each one fights to regain a sense of himself, lost in a war overseas, without minimizing or demeaning the actual combat experiences.

The purpose of this article is to inform readers about a new approach for forming therapeutic relationships with male combat veterans, as there are particular codes, languages, and approaches that I have found work well with that particular population. Healing and transformation occur when there is space to freely process one’s darkest thoughts and actions without fearing being judged. For our combat veterans, this includes having space to process the terrifying and harmful impulses and behaviors that led them to kill or watch their buddies die. For therapists to create this genuine healing space, we too must undergo a process of self-reflection that brings our own darkness not only into awareness, but into the room through a process of shared vulnerability.

The field assumes that therapists strive to create relationships that are built on warmth, trust, empathy, active listening, and a generally nonjudgmental attitude. While working with male combat veterans with acute distress and suicidality, I found that this client-centered approach was not sufficient for them to feel safe and trusting enough to be vulnerable in treatment. When I allowed myself to be vulnerable with them, I found they allowed themselves to engage on a deeper and more vulnerable level with me. Currently, there is such a push by insurance companies and institutions for brief and symptom-reducing treatment and there is far less importance placed on the therapeutic relationship or the therapist’s experience of the veteran in treatment. The truth remains, however, that how we behave and what we think during a session absolutely impacts treatment, especially with male combat veterans who are on guard against judgment and falseness, and who

thirst for authenticity. Furthermore, our internal reactions to a client, which are evidenced in body language, tone of voice, and conversational content, can significantly disrupt the application of any evidence-based practice. Contemporary interventions for treating combat veterans do not focus on therapists' internal reactions or their ability to form authentic relationships, and, in fact, the data now suggest that imaginal exposure to past trauma is the most important factor for treating PTSD, not the relationship. However, we are still charged with the daunting task of relating to our veterans while balancing our own internal reactions with the mission of providing a treatment service.

The combat veterans with whom I have worked closely have all benefited from some form of EBT. However, they have also commented that our relationship was the most meaningful aspect of their treatment. They described their bonding to me as central in being able to whole-heartedly plunge into very difficult discussions and follow prescribed protocols. What they reported was most helpful was that I talked about my own struggles with sexuality, family, and substance use and recovery. Although I have not been in combat, my real-life examples of suffering place me on a similar psychological battlefield, where we acknowledge the fear, guilt, and shame and how these emotions drive our behaviors.

In my sessions, I share my vulnerability as a means of relating and to act as a model. I cannot relate to every trauma or experience my patients have, but I have experienced the many underlying states of emotionality that accompany difficult experiences. For example, when a patient might talk about the shame of being overweight and the struggle to regain control over impulses, I might share that, although I haven't experienced that issue, I certainly know what it feels like to hate parts of myself. I know the effort it takes to feel love for parts of myself for which I feel ashamed. A small offering of my experience can help patients be willing to explore their shame in more depth. The veterans whom I have treated using shared vulnerability have reported being able to love themselves again, not wanting to die, and wanting to reconnect with their families. Through being able to love themselves again, despite the shame and horror they carry, they become more resilient and can engage fully in the EBTs we offer.

Shared Vulnerability: What is it and How is it Applied in Therapy?

Therapists struggle with shame, guilt, impulses, compulsions, and desires, as all humans do. To deny this is to create a rupture between our perceived "good" selves and the veterans' perceived "bad" selves. In other words, when we present ourselves as untouched, well-adjusted, and fluidly adaptable entities without acknowledging or even hinting at our struggles, traumas, regrets or difficulties (in due time), we will encounter what one veteran labeled as the "you don't know jack about me" attitude in session. We are essentially not as "human" in the veteran's eyes, and therefore, potentially useless if not dangerous. This particular veteran was speaking about a clinician with whom he could not relate because the therapist "couldn't understand why I might need a shot of tequila to come into treatment." After years of walking across California, homelessness, suicidality, and avoiding treatment, this veteran needed that one shot of alcohol to calm him down enough to make the trip to the mental health clinic for support, where, unfortunately, the on-call clinician refused to see him until he "stopped drinking." There seemed no reflection on that clinician's part as to how much courage it took, and how much vulnerability it represented, for the veteran to ask for help.

Clinically speaking, enabling this polarity disrupts our ability to remain vulnerable with the veterans who yearn for deep and authentic human connection, and that is unmarred by pretense, therapeutic distance, or judgment. However, we are generally taught that this part of ourselves has no place in treating others, and so we rarely invite our own fallibility into our work. We all have elements in our past that speak to human struggle, and these could be used as tools in the veterans' favor, not as topics to be kept private. What this does is polarize aspects of ourselves and those of the veteran, for whom daily life is already about avoiding these very issues. Shared vulnerability can be the catalyst for forming authentic relationships and also for creating a healing space necessary for the veterans to find transformation within the paradox of being good people who have done or witnessed harm.

Many of our combat veterans face moral injury from the realities of warfare. As told by many of my veterans who are aware of this fact, every action of their current civilian lives is measured against these past actions. How can the

future have any happiness and meaning after the unintended killing of a child, even when that action was in accordance with the mission or orders by superior officers? They come home with this weighing heavily in their hearts and souls. As a result they drink, and use drugs, and hate themselves, and fight, and walk for thousands of miles, and do not know how to relate to their spouses and children. I have not seen combat or killed a child and so do not know those specific pains, but I have hurt myself out of shame and grief, and I know the longing to feel whole and clean again. I can relate to my veterans as a result of coming from a Holocaust-surviving family, as I have a felt sense of what PTSD feels and looks like. I know the struggle of containing my anxiety and fear, and I have seen my family struggle to control theirs. Many of my veterans have reported that these disclosures helped them to feel safe and comfortable with me. Sharing vulnerability in session not only normalizes their experiences, but also places us into an approximation of the realm of darkness where our veterans live. We drop into their darkness by admitting to our own and offer support from that place of alliance.

A Note on Disclosures

More traditional psychotherapy perspectives as well as many cognitive-behavioral (CBT) approaches either firmly discourage disclosure or ignore it completely in their treatment approaches. Offering relevant pieces of our history functions in several ways: First, the veteran has a concrete sense that we experience and have potentially overcome suffering in some form, thus humanizing us (examples here could include past substance use and recovery, issues of sexuality, or having witnessed death). Second, the disclosure, when appropriate and relevant, not exhibitionistic or competitive, acts to strengthen the bond between therapist and veteran so that trust is more easily built. Last, the disclosure acts as a primer for and an example of vulnerability. Though therapy is not about the therapist, treating combat veterans *is* about the relationship, as they have been conditioned to count on their brothers in arms for moral, emotional, and psychological strength through challenging situations. One caution when using disclosures: They would be a matter of professional judgment specific to individual clients as an intervention targeting specific behaviors. The therapist needs to be comfortable enough with his or her “dark places” to disclose these things, because they will spread like wildfire—

especially in an inpatient unit. Therapists need be judicious about what, when, and to whom they disclose. Not all veterans will appreciate disclosures and some could be offended by the inference of comparison. The truth is we are not so much disclosing personal stories as the feeling states or tones we experienced during those events. We are communicating that we understand those feelings of terror, loss, despair, hopelessness, anxiety, and so forth, that the veteran is expressing in session. The disclosure is not about telling similar stories, but in sharing the feelings that arise in the retelling and reliving. In this way, the veteran can use our sharing as a model for processing his own feelings, without thinking we are trying to undermine his experience by comparing it to ours.

In this style of relational therapy, it should be made explicitly clear that in no way do we ask our veterans to help us process what we share. It is our responsibility to have processed any unresolved issues we carry prior to sharing as it can quickly, and unknowingly, turn into a joint session where the therapist and veteran alike are working on the therapist’s issues. They are not responsible for fixing or caregiving. When this happens, we should be clear that our sharing and vulnerability is an offering we make in honor of their efforts in therapy and as a way to relate to their pain. As with any client that tends toward being a caregiver, I express my gratitude and gently bring the focus back to them. As a side note, depending on a clinician’s framework, talking about the needs evidenced in the veteran’s caregiving behavior can be useful.

Veteran Experiences of Shared Vulnerability

On my way out of the VA and before I left for Alaska, the veterans in the inpatient TBI unit I was working on gave me a book in which they all signed some notes. What struck me most was the heartfelt camaraderie and mutual respect that was apparent in each of the notes. One 31-year-old Air Force veteran who had been deployed wrote,

Mike, I’m seriously glad to have met you. You’re the best therapist I’ve ever had bro, and I’ve had a few! You’re an awesome Friend too and I can’t say that about ANY other doctor I have ever been treated by. Thanks for always being there for me, for the good and bad times. I’ll miss you Brother.

The irony was that when he was first admitted he had come from another hospital where his medication-seeking behavior (including drastic self-harm) was so strong that they discharged him and sent him to our program. The first

thing he asked me after I introduced myself was “Can you prescribe meds?” After I offered some education about the scope of my practice, he slumped into his wheelchair and quickly fell asleep. The second time I met him, I talked about an incident that took place while I was in college and offered this intervention, “I know what it’s like to want that stuff so bad I’ve hurt myself. You can continue to do that, or you have the choice to do something different and move on with your life.” He looked at me straight in the eyes at that point, sat upright in his chair, and gave me his name. After many weeks of simply building trust and rapport by sharing vulnerability in session, his drug-seeking behavior was reduced and, in fact, he began to talk openly about cravings and relapses while in the hospital. He engaged in therapy throughout his stay in our program, and we are still in touch.

Another vet wrote, “I hope your next group is as challenging and smart and gifted and perfect and beautiful as myself. Love you Bud!” His humor and admission of love was not lost on me. From a ranger who was blown up by an improvised explosive device (IED) and sustained severe traumatic brain injury, facial reconstruction, and subsequent Tramadol abuse, his ability to attach and attune to a therapist became the mechanism by which his treatment was administered. Without this necessary attachment he refused to work with clinicians “who don’t care about me as a person.” He needed clinicians “to be real with me and not just see me as this loser burnout,” which I was. As a result, I became a part of his inner circle, which extended only out to his parents and a few other combat veterans. This allowed us to process very painful details of his combat trauma, where he lost many of his unit. After we established a firm relationship, I could then engage him in the iRest protocol, which he had not been open to before.

Shared vulnerability as a process underlies the interventions we use in session. Veterans connect to the clinician, not the treatment protocol. The veteran feels heard, seen, understood, and cared for in the relationship. This relational practice asks clinicians to be fully themselves as models for how veterans can relearn and return to being fully alive.

Considerations and Cautions

There is a host of considerations when applying a relational framework to treating male combat veterans. Writing on each is outside of the scope of this introductory

paper. However, as the field adapts to the growing relational needs of our returning combat veterans, these considerations must be fleshed out more thoroughly and incorporated into training programs. For the sake of space and time, I will only address one particular caution that was presented to me by several senior VA clinicians who also employ a relational perspective in their treatment.

Ethical considerations are the same within this relational style as in any other form of treatment. Therapists should carefully and closely follow the ethical guidelines and principles set by the APA’s code of conduct. There is always the possibility that enmeshment arises between therapist and veteran. Without clear role boundaries, the therapeutic relationship has the potential for turning into a friendship, as mutual and shared vulnerability do create an intense intimacy. There is no ethical guideline that specifically deals with this phenomenon, but I have spoken with many therapists at various VA hospitals who have also observed that friendships can arise when both clinician and veteran are mutually vulnerable.

All the clinicians I have spoken with who use a similar relational style report that they are honored and happy to have a lasting therapeutic relationship with their veterans even after treatment has ended, but that they are aware of the messy nature of this style during treatment. The concern is how these blurred lines and the potential enmeshment might disrupt the administration of PTSD protocols like prolonged exposure or cognitive processing therapy, as treatment outcomes and intervention efficacy are still a priority. I have heard of veterans asking for personal favors, like selling their artwork to a clinician or to other inpatient veterans and then becoming upset when a boundary is set. Another veteran wanted to sell power tools to his therapist who he knew was working on his house. These examples can occur between a therapist and any clinical population; however, employing shared vulnerability can increase the likelihood of enmeshment because boundaries become more obscure. In addition, it is important that the clinician engage in continued self-reflection and consultation when working within this relational frame to ensure ethical violations have not occurred.

Conclusion

EBTs could be extremely beneficial for helping combat veterans process their traumas and experiences in war. Data are clear that imaginal exposure treatment, neurofeedback, iRest,

SIT, and other affective and attentional regulation practices help reduce PTSD symptoms long after the protocols are completed. No VA is without their experts in these protocols. It is also clear that combat veterans deserve and yearn for safety, trust, and authenticity that must be built into the therapeutic relationship. Regardless of the protocol chosen, clinicians must have buy-in from their veterans, and I have found repeatedly that shared vulnerability is one method for establishing such a relationship.

I have shared personal information in this paper as I do in session because context matters. Knowing more about me alters and impacts how you read what I am writing, as it does for the veterans I serve in session. When my veterans make fun of me for doing yoga and practicing meditation, they cherish the fact they can make fun of me at all. It is endearing and wonderful to relate deeply to male combat

veterans, even though I have never been in combat. It is an honor to share an hour in rawness and authenticity with men who struggle so deeply to regain a hold of their souls, as Edward Tick would write. I make myself known to them as I ask them to make their selves known to me. This is the essence of shared vulnerability. We owe it to our combat veterans, who willingly would give their lives for their brothers in arms, and for us, to be real with them when they seek help from us.

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Spotlight on Research

Krista Ratwani

Welcome to the Spotlight on Research Column! This column showcases research activities and projects underway in many of the research laboratories within the U.S. Department of Defense, 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 Krista Ratwani at kratwani@aptima.com or 202-552-6127.

This edition of the newsletter features research examining the impact of military sexual trauma (MST) on the ability of homeless women veterans to reintegrate into society. This work details important findings that show the significant and long-lasting impact that MST can have on an individual. The research ends with a discussion of changes that can be made to help ensure that our veterans receive the necessary care they deserve upon returning home.

Homeless Women Veterans With Military Sexual Trauma: Reintegrating into the Civilian Sector

Sally Kabbara, James Earnest, Timothy Allison, and Eric Morrison

The Chicago School of Professional Psychology

Research Overview

Homeless women veterans struggle with traumas experienced during military service as they attempt to reintegrate into the civilian sector. According to the Society for Women's Health Research (2008), female service members faced the risk of military sexual trauma (MST), the term that the U.S. Department of Veterans Affairs (VA) uses to refer to experiences of sexual assault or severe, repeated sexual harassment experienced during military service. The purpose of this study was to determine if MST was the barrier for women veterans attempting to reintegrate into the civilian sector while residing at the nation's largest nonprofit homeless initiative in Long Beach, California. The ADVANCE Women's Program (AWP), located on site at the United States Veterans Initiative (U.S. VETS; <http://www.usvetsinc.org/information-center/portfolio/advance-womens-program/>), is a gender-specific initiative assisting homeless women veterans with reintegration into the civilian sector. An archi-

val study was accomplished at U.S. VETS to investigate the assumption that women veterans who do not attain housing or income have been victims of MST. A Pearson chi-square analysis showed that women veterans ($n = 50$) who did not attain AWP goals were significantly more likely to have MST than women veterans who attained one ($n = 21$) or both ($n = 29$) AWP goals, $\chi^2(2, 100) = 19.14, p = .000$.

Problem to Solve

A relationship between the effects of MST on the overall health of women veterans has been established by research, and MST remains an important concern because of its high prevalence and numerous negative physical and mental health impacts (Burns, Grindlay, Holt, Manski, & Grossman, 2014). Cases of MST have continued to grow, with one in five women reporting having experienced MST (NCHV; National Coalition for Homeless Veterans, 2014). The sensitive nature of MST requires a welcoming,

safe space for women to receive treatment (SWAN; Service Women's Action Network, 2014). Federal agencies have worked directly with service providers, both within and beyond the homeless veteran community, to engage in a series of prevention programs that has prevented many women veterans from sliding into homelessness (NCHV, 2014). An audit released in 2012 by the VA Office of the Inspector General found that 1 in 3 programs did not specify the gender of homeless veteran populations they intended to serve, nor did they have segregated, secure, trauma-informed competency facilities for women (NCHV, 2014). SWAN's policy work on MST includes a national campaign to educate policymakers, the media, health professionals, and nonprofit organizations about the causes and consequences of MST (SWAN, 2014). As part of the Homeless Veterans Outreach Initiative, the VA has taken steps to assist homeless women veterans with comprehensive, individualized care including health care, housing assistance, job training, and education that enables women veterans to become self-sufficient (U.S. Department of Veterans Affairs, 2012a).

U.S. VETS: United States Veterans Initiative

Although U.S. VETS has been in existence since the early 1990s, the services provided have been exclusive to male veterans that were living on the streets in Los Angeles, California (U.S. VETS, 2013). As the number of homeless women veterans has increased, the need to house women separately has been foreseen.

ADVANCE Women's Program

In 2001, the conception of the AWP provided homeless women veterans, and women veterans that were single mothers, with a safe and sober living environment (U.S. VETS, 2013). Women with Children, a program for single mothers at AWP, offers services specific to the needs of women veterans who are mothers, such as job assistance, child-specialized case management, and access to schools, playgrounds, and weekend activities for their children (U.S. VETS, 2014). Often, women veterans use the employment resources on site and secure employment through Veterans in Progress (VIP; U.S. VETS, 2013). The goals of the VIP program were to help homeless veterans gain residential stability, increase their skill levels and income, and achieve a greater level of self-determination through employment (U.S. VETS, 2014).

Although AWP affords women veterans counseling services (U.S. VETS, 2013), not all women veterans are interested in taking advantage of those services. Instead, some women veterans are resistant to using any of the services toward recovery, are often confrontational with staff and fellow veterans, and are inconsistent with substance-abuse treatment, medical appointments, and sustaining their individual treatment plans. Historically, if women veterans are advised to seek counseling, most often they voluntarily exit the program.

It is unclear whether homeless women veterans that have left the AWP received treatment elsewhere. Nor has it been clear if women veterans recover from homelessness and reintegrate into the civilian sector, because they cease communication with AWP when they exit the program. Observations and discussions among AWP staff members have led to the idea of investigating the assumption that MST has been the motive behind homeless women veterans failing to complete the program.

Solution and Approach

There were no live participants in this study. This investigation was based on an archival review of case files of former women veteran residents at the AWP.

Variables

Predictor variables are from one population, which sampled homeless women veterans. The study included two categories: homeless women veterans with MST and homeless women veterans without MST. We were also interested in measuring whether each veteran met the goals of the AWP, i.e., increased income and permanent housing. Homeless women veterans either increased their income or they did not; they either secured permanent homes or they did not.

Design

A correlational design was used to suggest a simple relationship between continuous dichotomous variables and independent observations for MST. A Pearson chi-square statistic for association was used to determine the strength of the variables.

Procedure

A sample of 100 archival case files was removed and reviewed from archival boxes stamped with AWP and distinguished by year. Case files were reviewed with per-

mission from the U.S. VETS Initiative internal review board and stored in a secure location on site. For security purposes and the privacy of prior residents, case files were not removed from the archival storage container. A thorough investigative review of each case file was accomplished for the indication, or memorandum of MST.

The archival investigation was an in-depth search for specific annotations indicating MST, discovered through case-manager notes and documentation and revealed through hand-written or typed weekly or biweekly narratives. MST was documented in admissions screenings, intakes, and checklists, by which the resident checked for sexual trauma and MST, but declined treatment, as evidenced by checking that they were not interested in receiving treatment. MST was recorded on supplemental notes such as postscripts, sticky notes, and slips of notepad paper, found at times in various parts of the case file. The supplemental notes were inserted as reminders for case managers to offer or suggest MST treatment immediately or at a later time, as evidenced by written side notes acknowledging that the veteran did not want to pursue any type of treatment or discuss the issue further. MST was substantiated through incident reports filed by the AWP program coordinator and on-site veteran service assistants (VSAs); incident reports were initiated after a confrontation occurred or the veteran was distressed and disclosed pertinent information, such as MST, suicidal ideation, or violent thoughts. For each case file in which MST was verified, a tally mark was made on a clipboard with a hand-written log. The log had separate columns titled with each variable; a tally mark was made for MST or no MST, without reference to the identification of the veteran.

After observing first for MST, another less in-depth review of the case file was completed to determine if AWP goals were attained. This information was easily located in Part I of each case file. After verifying the numbers of goals, if any, were attained, a tally mark was made on the same log used for MST recordings. Separate columns for increased income, obtained housing, or no goals attained were listed next to the indication of MST and no MST columns. After each individual case file was reviewed, the case file was closed and filed back in to the appropriate archival file box from where it was pulled. Although the privacy of each individual case file was kept confidential, relevant information for the purpose of this study was noted and recorded.

Findings

Descriptive statistics reveal a sample size of 100 AWP case files containing information pertaining to homeless women veterans. Most (70%) of these cases showed documented evidence for MST (see Table 1). Descriptive statistics also show that half (50%) of this sample size of homeless women veterans failed to meet any of the goals set by AWP, regardless of whether they had MST. By comparison, the number of homeless women veterans who attained one or both of the AWP goals was 21% and 29%, respectively (see Table 1).

As predicted, homeless women veterans who attained none of the AWP goals were significantly more likely to have documented MST in their case files than those who attained one or both AWP goals, $\chi^2(2, 100) = 19.14, p = .000$ (see Table 2). The number of women veterans who attained both goals was slightly higher than the women veterans who attained one goal, but the observed number of women who attained one or two goals was less than the expected count.

Implications

At the conception of this study, the assumption that MST was the underlying barrier toward reintegration did not appear substantial, especially because women veterans entered AWP willingly, undergoing question-sensitive screenings and intake interviews to get off the streets and into a safe environment. In addition, most of them appeared motivated to work toward their homeless recovery

Table 1
Descriptive Statistics of Variables of Interest

Measure	<i>f</i>	%	<i>M</i>	<i>SD</i>
Military sexual trauma self-reported ¹			.70	.46
Yes	70	70		
No	30	30		
Goal objectives met ²	.79	.87		
None	50	50		
One	21	21		
Both	29	29		

¹ Military sexual trauma (MST) self-reported represents every case file found with annotations of MST. ² Goal objectives met represents whether or not the women veterans attained the goals set forth by Advanced Women's Program.

Table 2

Pearson Chi Square Between Women Veterans With Documented Military Sexual Trauma (MST) and Level of Goal Attainment in the Advanced Women's Program (AWP)

Measure	Goal attainment						χ^2	df
	None		One		Both			
Count	O ^a	E ^a	O	E	O	E		
Self-reported MST ^b	45	35	10	15	15	20	19.14	2*

^a O = observed count; E = expected count. Women veterans who attained none of the AWP goals were significantly more likely to have documented MST than those who attained one or both AWP goals, $\chi^2(2, 100) = 19.14$, $p = .000$. ^b Documented MST represents every case file found with annotations of MST.

* $p < .05$.

by achieving self-improvement benchmarks throughout their stay. Moreover, there existed a strong sense of esprit de corps at the U.S. VETS, which promoted an atmosphere of familiarity and safety relative to the military culture. However, as shown in Table 2, MST has been a significant factor in one's ability to meet AWP goals and reintegrate into society.

Homelessness among women veterans is expected to rise as increasing numbers of women in the military reintegrate into their communities as veterans (NCHV, 2014). The consequences of MST are often long-term and survivors require immediate, adequate treatment for recovery; otherwise, the stress and depression that follow experiences of MST affect the survivor's economic stability (SWAN, 2014). Himmelfarb, Yaeger, and Mintz (2006) shed light on understanding risk factors for and taking steps to prevent MST. In a study aimed at identifying specific risk factors for women veterans' homelessness, Hamilton, Poza, and Washington (2011) revealed five predominant risk factors that precipitate experiences initiating pathways toward homelessness which included (a) childhood adversity, (b) trauma and/or substance abuse during military service, (c) postmilitary abuse, adversity, and/or relationship termination, (d) postmilitary mental health, substance abuse, and/or medical problems, and (e) unemployment. These pathways form a "web of vulnerability," each juncture of which should be a target for VA and community-based organizations to engage in prevention or intervention efforts on behalf of women veterans. Ed-

ucating providers, especially civilian providers, will not only better serve women veterans with their intricate physical and mental health needs, but it will alleviate the barriers between provider and patient (U.S. Department of Veterans Affairs, 2013b).

MST victims do not need to report the incident(s) when it happened or have other documentation that the incident occurred (U.S. Department of Veterans Affairs, 2013a). All health care for treatment of mental and physical health conditions related to MST, including medications, is provided free of charge (U.S. Department of Veterans Affairs, 2010). VA has made significant progress in serving women veterans, but not all of the comprehensive needs of women veterans have been met (U.S. Department of Veterans Affairs, 2012b).

While the VA continues to research better ways to serve women veterans, collaborative efforts by the armed services and nonprofit organizations continue to assist and strengthen women veterans. Postdeployment resilience training is designed to enhance soldier mental skill development, adaptation to the stressors of combat, and management of the transition from combat to home through a strength-based approach (Castro, Adler, McGurk, & Bliese, 2012). Enhancing the process of resilience for female veterans requires an assessment of the strengths and protective factors that foster healthy reintegration (Carlson, Stromwall, & Lietz, 2013). Foran, Adler, McGurk, and Bliese (2012) demonstrated that it is not only important what is taught in resilience training but how it is taught; although there are many differences in these programs, including timing of implementation, length of the training, type of trainer, number and type of participants, and presentation modality, there are commonalities across the programs in that they provide psychoeducation about coping with stressors and mental health.

Assumptions and Limitations

Two significant limitations of this study included not analyzing data from each branch of service in which women veterans served and not acknowledging their ranks; comparisons between all branches of service would have pointed toward the branch with the most MST victims. This type of data may have indicated the need for preventive measures within a particular branch of service. In addition, this information may have initiated an investigation into why one particular branch

would have more sexual assault incidences than any other armed-forces branch. If sexual coercion is a prevalent problem relative to advancement and promotion within the military, perpetrator status may indicate a pattern among distinct levels of management.

Another limitation in this study worth mentioning is that the perpetrators may not necessarily have been servicemen; sexual assault(s) may have occurred while off-duty or in the line of duty by foreign nationals or civil service employees. Information regarding the number of assault occurrences and the status (foreign or civilian) of the perpetrators might be used to suggest the need for stiffer precautionary hiring methods within the U.S. Department of Defense, such as implementing instruments measuring violence risk. More important is that this type of information could serve as a forewarning for female service members working among civilian employees or foreign nationals, not to frighten them, but as implemented safety precautions.

Socioeconomic status (SES) and wartime era demographics were disregarded in the present study. Race and age are two demographics which would have emphasized the diversity among women veterans at AWP, but were overlooked. Applewhite (1997) found that veterans of color experienced double jeopardy, i.e., they contended with issues of prejudice and racial discrimination as well.

Conclusion

It is significant to note that there are additional sources of MST that include foreign nationals and civilian contractors. The military must be aware of these additional sources of trauma and address the force-protection issue for women in the armed services.

There is a profound need to put together a collaborative team at U.S. VETS to modify existing policies at AWP. In contrast to existing conditions at AWP, a positive environment would include providing a quiet place for women veterans to feel safe to build trust and confidence in themselves to begin their journey toward recovery. It would further assist women veterans who are in treatment to decompress without noisy distractions or chores. The staff would be trained to be mindful of each woman veteran's triggers and personality. A team mindset among staff would be fostered, which should consist of one or two full-time women mental health professionals. It would allow women veterans to recover from homelessness while learning to cope with their MST. More-

over, current models of investigated treatment may be implemented, given the unique needs of each individual woman veteran. For example, a combination of current treatment models, peer counseling, and resilience training may be modified to be applied at the AWP. Whereas peer counseling is an imperative component to establish a channel of communication, treatment models and resilience training are innovative and still under observation and investigation; nonetheless, a combination of all three incites motivation and creativity for implementing necessary changes as needed.

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Spotlight on History

Paul A. Gade

A couple of years ago, I instituted profiles of military psychologists as an ongoing project for the Spotlight on History column. These profiles are meant to familiarize our members, prospective members, and others with the military psychology achievements of important psychologists, many of whom are well known for their achievements outside of military psychology. To date, we have profiles on Meredith Crawford and Ray Crystal. David Segal and I are working on a profile for Sam Stouffer. I would like to target the next few profiles on those psychologists whose names are attached to our current six achievement awards—namely, Arthur Melton, Charles Gersoni, John Flanagan, Jay Uhlaner, Robert Nichols, and Robert M. Yerkes. Lorraine Uhlaner and I are working on a profile for her dad, Jay Uhlaner, which we hope to publish in the Fall 2015 newsletter. Lorraine tells me that Jay is now almost 98 and doing reasonably well for his age. I need help in developing profiles for the following:

- Arthur Melton
- Charles Gersoni
- John Flanagan
- Robert Nichols
- Robert M. Yerkes

Although I can contribute information to the profiles for all of these psychologists, I need others to

- take the lead and fully develop one or more of these profiles, or
- provide me with any information you have on any of the six people to include pictures.

- Please contact me if you are able and willing to take on one or more of these profiles or if you have any information about any of the six psychologists.

Recently, Sophia Rabe-Hesketh, the president of the Psychometric Society, contacted me for information about some of our past presidents. She is putting together bios on their past presidents and asked me for help in locating pictures of some who had been presidents of our Society. She is looking in particular for pictures of the following:

- John C. Flanagan
- Philip DuBois
- Jack Dunlap
- Robert Thorndike
- Lloyd Humphreys

I was able to locate a good picture of Hubert Brogden, one of their past presidents but not a president of our Society. You can find a list of the Psychometric Society at <https://www.psychometricsociety.org/content/past-present-and-incoming-presidents>. If any of you can help Sophia with her quest for information about these past presidents, please let her and me know. Her e-mail address is sophiarh@berkeley.edu.

This got me to thinking that bios and pictures of our society's past presidents would be a good project for me to undertake for our society's 70th anniversary. But again, I will need the help of our society members to do this. If any of you, especially our past presidents, have information and/or pictures for any of our past presidents, please send them to me. To help with this, I have appended a list of our past and current president. Take a look at the list.

Past Presidents of the Society for Military Psychology – APA Division 19

Service Years	President
1946–1948 ^a	John G. Jenkins
1948–1950 ^a	Arthur W. Melton
1950–1952 ^a	Frank A. Geldard
1952–1953	Paul M. Fitts
1953–1954	Jack W. Dunlap
1954–1955	Philip H. DuBois
1955–1956	Robert L. Thorndike
1956–1957	Charles W. Bray
1957–1958	Lloyd G. Humphreys
1958–1959	George K. Bennett
1959–1960	Franklin V. Taylor
1960–1961	Robert M. Gagne'
1961–1962	John C. Flanagan
1962–1963	Walter Grether
1963–1964	John T. Dailey
1964–1965	Meredith Crawford
1965–1966	Richard Trumbull
1966–1967	Philip Sperling
1967–1968	William McClelland
1968–1969	Launor Carter
1969–1970	J. E. Uhlaner
1970–1971	Saul B. Sells
1971–1972	Gordon A. Eckstrand
1972–1973	Julien M. Christensen
1973–1974	Howard A. McFann
1974–1975	Earl A. Alluisi
1975–1976	Arthur J. Drucker
1976–1977	Earl I. Jones
1977–1978	Paul D. Nelson
1978–1979	Elaine N. Taylor
1979–1980	Robert R. Mackie
1980–1981	E. Ralph Dusek
1981–1982	James K. Arima
1982–1983	Robert Nichols
1983–1984	A. David Mangelsdorff
1984–1985	Martin F. Wiskoff
1985–1986	Randall M. Chambers
1986–1987	Joyce L. Shields
1987–1988	Francis J. Fishburne
1988–1989	Timothy B. Jeffrey

Service Years	President
1989–1990	W. Steven Sellman
1990–1991	Jared B. Jobe
1991–1992	Richard W. Bloom
1992–1993	Brian K. Waters
1993–1994	Paul A. Gade
1994–1995	Stephen L. Goldberg
1995–1996	Gerald P. Krueger
1996–1997	Russell J. Hibler
1997–1998	Deirdre J. Knapp
1998–1999	James E. Griffith
1999–2000	William Strickland
2000–2001	Janice Laurence
2001–2002	Jane Arabian
2002–2003	Henry L. Taylor
2003–2004	Paul Bartone
2004–2005	W. Brad Johnson
2005–2006	Dana H. Born
2006–2007	Michael G. Rumsey
2007–2008	Michael D. Matthews
2008–2009	Will Wilson
2009–2010 ^b	Larry James
2011	Armando X. Estrada
2012	Tonia Heffner
2013	Rebecca Porter
2014	Kathryn T. Lindsey
2015	Thomas Williams

^a Each of the first three Division chairmen served a 2-year term. Changes to the bylaws in 1952 replaced the title “chairman” with “president” and divided presidential service into three 1-year terms of: President-Elect, President, and Past-President. ^b The service period for Society officers was changed from the annual APA convention to annual APA convention to 1 January to 31 December of each year.

APA Program Chair Report

Nate Ainspan, Ph.D., and Becky Blais, Ph.D.

As the program cochairs for the 2015 annual meeting, we are pleased to report that the meeting is shaping up to be exciting, informative, and a full program composed of presentations, meetings, activities, and social events from morning to evening.

First, we want to thank everyone who submitted proposals. Without your input and effort we would not have any program, let alone one that is as strong and educational as the program we have this year. We especially thank the members who generously volunteered their time to serve as our proposal reviewers. Their names are at the end of this article. We are fortunate to have so many members who are willing to donate their time to ensure our program maintains the high level of quality that we come to expect.

We received 86 paper/poster abstracts and 21 symposia submissions for the program. This does not take into account the proposals submitted earlier to the collaborative programming. While receiving such a high number of proposals is a strong testament to the investment and talent of our members, it left us with the difficult task of selecting proposals that would not be presented at the conference. Papers/posters were reviewed by at least two blind reviewers and symposia were reviewed by at least three blind reviewers. To increase the number of Division 19 programs, we coordinated with other divisions who had not filled their hours and were able to forward two symposia to Division 14 (Society of Industrial and Organizational Psychology), who accepted them into their program. At a time when APA is reducing the number of hours available to the division, such collaboration between divisions allows us to present more military psychology programs. A number of the collaborative sessions with a military focus were accepted into the collaborative programming, so even more sessions will be of interest to our members.

Last year we received feedback from members that having a suite large enough for us to host suite presentation sessions and social interactions was beneficial. Given this

positive feedback, we will organize a similar suite session this year. We have several suite sessions scheduled and hope that our members take advantage if this opportunity.

Division 19 is known for its great receptions, parties, and social activities, and we have not forgotten to plan for these. We have requested from the EXCOM and received approval for funding for these parties and social activities. We look forward to hosting and having fun with you.

Remember that this year the convention is being held in Canada, and U.S. citizens will need a U.S. Passport Book for travel by land, sea, or air. and a Passport Card for travel by land and sea. International presenters who are currently in the United States and not U.S. residents may also require a visa. Please ensure your necessary documentation is up-to-date.

For information about travel arrangements, hotels, and other information about the meeting, visit the APA website at <http://apa.org/convention/index.aspx>.

We look forward to seeing you in Toronto from August 6th through 9th.

2015 Program Reviewers

Amy Adler
Andrew Blatt
Lisa Boyce
Thomas Britt
Janice Brown
Corissa Callahan
Kathleen Campbell
Catherine Caska
Richard Coder
Missi Cox
Katherine Dondaville
Angela Febbraro

Jessica Gallus
Alice Garven
Jeff Goodie
Michael Harvey
Sally Harvey
Michele Hill
Tim Hoyt
Heidi Keller-Glaze
Amelia Kotte
Ann Landes
Becky Lane
Crystal Marchese
George Mastroianni
Chad Morrow
Vladimir Nacev

Kristine Rae Olmsted
Murrey Olmsted
Mark Paris
Thomas Patterson
Donna Pickering
Arlene Saitzyk
Michael Schwerin
Heather Sones
Kerry Sudom
Eric Surface
Megan Thompson
Thomas Williams

Nate Ainspan and Becky Blais
Division 19 Program Cochairs

Continuing Education Committee Report

By Freddy A. Paniagua, Ph.D.

Continuing Education Committee (in alphabetical order): Nathan D. Ainspan, Jay Morrison, Freddy A. Paniagua, and Yaron Rabinowitz

The committee welcomed our new member, Yaron Rabinowitz, Ph.D., ABPP. Dr. Rabinowitz is an operational psychologist at the Marine Special Operations School, Camp Lejeune, North Carolina.

The main objectives of the CE Committee of Division 19 include the following:

1. The development of high-quality pre-convention CE opportunities at the APA Convention in Association with the APA Continuing Education Committee.
2. Facilitate the development of CE opportunities for psychologists who are having problems fulfilling CE requirements for the renewal of their licenses because of sequestration and severe restrictions on military psychologists traveling to conferences. In order to facilitate the implementation of this objective, the Division 19 CE Committee has a mechanism for military psychologists who have expertise in various topics to be able to offer CE programs at their commands in conjunction with Division 19. This objective has been approved by the APA Office of CE Sponsor Approval, and the intention is to provide this service free of charge for military psychologists. The forms and the process to submit CE programs associated with this objective are available at <http://www.apadivisions.org/division-19/students-careers/continuing-education/index.aspx>.

Although the second objective targets military psychologists as potential presenters of CE workshops in their commands (or when traveling to other posts), nonmilitary psychologists interested in presenting CE workshops targeting military psychologists are also welcome to submit proposals to the Division 19 CE committee. Presenters also receive CE credits for the number of hours they

present. Interested presenters are encouraged to contact the chair of the committee, Freddy A. Paniagua, at faguapan@aol.com for additional details and/or help with the development of a CE workshop that follows the criteria established by the APA Office of CE Approval.

The Division 19 CE Committee is pleased to inform this committee met the annual reporting requirements and received approval from the APA Office of CE Approval to continue offering CE credits during the September 2014 to August 2015 period.

With support from Dr. Jay Morrison, committee member, the committee developed and implemented a special project with emphasis on a Facebook post advertising the CE committee opportunities through established professional listservs and social media. For further details regarding this initiative, please contact Jay Morrison at jay.a.morrison3.mil@mail.mil

The Division 19 Continued Education Committee reviewed a proposal sent to the committee on February 5, 2015, by Angela E. Legner, M.A., Chair, Division 19 Student Affairs Committee (SAC). This proposal emphasizes the development and implementation of virtual/online CE workshops on military psychology of “interest for Division 19 students . . . as well as other Division 19 members.” SAC suggested to the Division 19 Committee to support this virtual/online CE proposal with the purchasing of an Adobe Connect platform for \$425 per year. The Division 19 CE Committee agreed to support this initiative. Ms. Legner, however, was informed in an e-mail dated February 10, 2015, that the goal of this committee “is not to provide the infrastructure or the logistic in the implementation of the particular CE, but to review and approve CE proposals that are not scheduled during APA

convention.” The Division 19 CE Committee also informed Ms. Legner that if the EXCOM approves the SAC’s proposal and the purchasing of that virtual/online, Division 19 CE Committee “will be happy to review proposal from the SAC for consideration for CE credits approved by the APA-CE Sponsor Approval Office.” Ms. Legner was also informed that the Division 19 CE Committee is the only entity in Division 19 approved by APA

to provide CE credits via programs scheduled outside APA regular conventions and during the APA annual pre-convention program. If the EXCOM approves that proposal, the role of the Division 19 CE Committee would be to review proposals submitted by SAC and certify the number of CE credits offered by such proposals, including CE credits for presenters delivering the program via virtual/online training.



SOCIETY FOR MILITARY PSYCHOLOGY

Division 19 of the American Psychological Association

Division 19 Annual Awards



The Society for Military Psychology is soliciting nominations for several awards this year, including the following: 1. The **Arthur W. Melton Early Achievement Award**—recognizes early career achievements in military psychology made within 5–10 years of entry into the field. 2. The **Charles S. Gersoni Military Psychology Award**—recognizes excellence in military psychology in the areas of research, service, product development, and/or administration made by an individual and/or group. 3. The **John C. Flanagan Lifetime Achievement Award**—recognizes career long achievements in military psychology. 4. The **Robert S. Nichols Award**—recognizes excellence in service by uniformed clinical psychologists to military personnel and their families. 5. The **Julius E. Uhlaner Award**—recognizes outstanding contributions in research on military selection and recruitment. 6. The **Robert M. Yerkes Award**—recognizes outstanding contributions to military psychology by a nonpsychologist. Achievements to be recognized by these awards must reflect advancement of the profession of military psychology, improved effectiveness of military psychology systems, or service on behalf of the welfare of military personnel and their families. Nominations are due 30 May, 2015 (midnight EST) and should include the following: 1. A nomination letter describing the qualifications of the nominee in no more than 2–3 pages, 2. A current resume/vitae of the nominee. Please submit nominations to Dr. Kathryn T. Lindsey (kt.lindsey@verizon.net) in PDF format and list the name of the nominee and the award on the subject line of your email (e.g., John Doe, Julius E. Uhlaner Award). Winners will be notified prior to 30 June 2015, and awards will be presented during the Society for Military Psychology Business Meeting at the 2015 APA convention in Toronto, Canada.

Division Membership Update

David M. Barry

Thank you to the nearly 750 individuals who joined Division 19 or renewed their membership since August 2014. You are part of a vibrant community of students and professionals who are dedicated to the science and practice of psychology in military contexts. Please help grow this community by telling your colleagues about the benefits of Division 19 membership. Here are some frequently asked questions from prospective and current members:

1. *Why should I join or renew membership with Division 19?* Whether you are a first year graduate student or experienced professional, you will be eligible for travel awards, research grants, writing contests, and other opportunities that Division 19 offers its members. You'll receive access to our journal *Military Psychology* and triannual newsletter, *The Military Psychologist*. You will have immediate access our listservs, websites, and social media outlets, which consolidate job opportunities, research findings, clinical tools, and other important announcements related to military psychology. You will also be able to build and maintain relationships with civilian and uniformed professionals throughout the world. Our programming and networking opportunities at the annual APA Convention are well-attended, informative, and fun. Lastly, there are many opportunities to influence our field through leadership roles within Division 19.

2. *Do I have to be a dues-paying member of APA to join Division 19?* No. You can join Division 19 as a Professional Affiliate or Student Affiliate without belonging to APA. Go to <http://memforms.apa.org/apa/cli/divapp/> and sign up for an APA User ID (that way, you can use the APA website to sign up for Division 19). In order to be considered a Full Member or Associate of Division 19, though, you will need to also be a Member or Associate of APA.

3. *I'm a Student Affiliate and I graduate this year. What happens next?* After you finish celebrating your hard-earned accomplishments, e-mail me (dmbarry63@gmail.com) or Keith Cooke (kcooke@apa.org) to let us know you graduated! We will automatically upgrade your membership status to Full Member, Associate, or Professional Affiliate **for free**. You will immediately be eligible for awards and grants and gain access to our growing Early Career Psychologist (ECP) community. Your upgraded membership will continue until the end of the calendar year.

4. *What are the Division 19 membership types and their dues?*

a. *Full Members* and *Fellows* have doctoral-level degrees and are full members of APA. Dues are \$27 a year.

b. *Associates* are full members of APA with master's-level degrees. Dues are also \$27 a year.

c. *Professional Affiliates* belong to Division 19 without being associated with APA. Dues are \$30 a year.

d. *Student Affiliates* are undergraduate or graduate psychology students who may or may not be members of APA/APAGS. Dues are \$10 a year.

e. *International Affiliates* live outside the United States and Canada. Dues are \$30 a year.

It is easy to sign up or renew your membership online at <http://www.apa.org/membership/renew.aspx> or <http://memforms.apa.org/apa/cli/divapp/>. If you have any additional questions or ideas for enhancing membership opportunities, please contact me at dmbarry63@gmail.com or Keith Cooke at kcooke@apa.org. Thank you for being part of our team!

Early Career Psychologists Committee Report

Katy Dondanville, Psy.D.

Early Career Psychologists Committee (in alphabetical order): **Katy Dondanville (Chair), Arwen DeCostanza, Jessica Gallus, Rhett Graves, Miliani Jimenez, Brian Lees, Jay Morrison, and Krista Ratwani**

The early career psychologists committee discusses and identifies activities, projects, and programs that promote the engagement and participation of early career professionals.

The ECP Committee has a number of exciting initiatives underway:

1. Annual Convention

The Committee is working with the Programming Committee to develop a number of sessions “for ECPs” and “by ECPs” in the Division 19 Hospitality Suite. Possible program sessions include:

- So I Just Graduated, Now What? EPPP, Fellowships, Getting a Job, ABPP
- Achieving Successful Careers in Military Psychology
- Mentoring Opportunities—Career and Research
- Preparing Division 19 Students for Internship

Toronto here we come! We encourage you to take advantage and apply for travel funding through the Division 19 Travel Awards Program!

2. Connecting Division 19 ECPs Throughout the Year

- Come check us out at the APA Division 19 Military Psychology Early Career Psychologists Linked-In page. We have over 100 members.
- Announcement-Only Division 19 listserv: don't miss any special announcement! Subscribe or send announcements to DIV19ECP@lists.apa.org.

- Come check out Division 19 on Facebook: APA Division 19 – Military Psychology Group.
- “Coming Soon”: Keep a look out for Division 19 on Twitter

3. Collaboration Between Division 19 ECPs and Students

This fall the ECP Committee piloted an Internship Mentorship Match Program between six graduate students and six ECPs. Overwhelming feedback from students and ECPs indicated the program was very successful! We hope to expand the Mentorship Match and develop additional programming to increase the competitiveness of Division 19 students.

4. Highlighting a Division 19 ECP Member

David D. Luxton, PhD, MS, was recruited in July 2014 to the Naval Health Research Center as a Research Health Scientist. He is the Principal Investigator of the Millennium Cohort Study (<http://www.millenniumcohort.org/>). The Millennium Cohort Study is the largest prospective health study in U.S. military history and Dr. Luxton is the first psychologist to serve as Principal Investigator!

If you are interested in contributing to programming for the Convention or in highlighting recent achievements, please contact Katy Dondanville.

Katy Dondanville

University of Texas Health Science Center at San Antonio
STRONG STAR Consortium

E-mail: dondanville@uthscsa.edu

Students Affairs Committee Report

Angela Legner (Chair), Jennifer Barry, and Kevin O'Leary

This year will be one of vitality and expansion. It is my hope as the new Student Affairs Chair to continue the groundbreaking work that David Barry and Jennifer Barry started in 2014. Our success this past year would not have been possible were it not for the tireless efforts of Dave and Jenn. They are the true trail blazers of our committee! Please join me in congratulating them. *Bravo Zulu on a job well done!*

The Student Affairs Committee is off to a great start with several exciting initiatives currently underway to better assist us in supporting our student members. These initiatives are in keeping with our objectives to *promote student awareness, competence, scholarship, and community engagement* in the military psychology community.

Student Affairs Committee Changes

Along with my transition come some important changes to the SAC leadership team. First, Jennifer Barry is now serving as the Past Chair and will be responsible for overseeing the Student Awards Program and serving as a senior leader for the SAC. Second, I would like to officially welcome Kevin O'Leary as our new Chair-Select. Kevin, who served as Campus Representative from Antioch University (New England) in 2014, joins our team and will be handling all communications functions for the SAC, including managing the student website, LinkedIn page, Twitter, listserv, and Gmail account. We are very excited to have Kevin aboard and know he will lead by example! Finally, in an effort to meet the growing needs of our membership, we added a position to the SAC and appointed Jeremy Jinkerson to serve as our new Virtual Projects Officer. The SAC will truly benefit from Jeremy's professional background and experience as a seasoned Campus Rep from Fielding Graduate University. As VPO, Jeremy will be assisting us in developing web-based student training presentations. Please join me in welcoming Jeremy aboard!

Student Chapter Network Changes

The SAC enjoyed tremendous growth this past year with the launch of our Campus Representative and Student Chapter Network. I am happy to report that our commu-

nity continues to grow thanks to our very enthusiastic Campus Representatives! We currently have Campus Representatives at 35 separate graduate institutions across the country! Please join me in welcoming the newest additions to our CR community! In addition, I want to recognize the CRs currently serving as senior leaders, along with those individuals who have completed their terms. The SAC truly appreciates your dedicated efforts on behalf of the Division!

Given the rapid growth of our CR and student chapter network across the country, one of our goals for this year was to develop a sustainable student leadership structure. I am pleased to report that the SAC has taken the next step in our strategic plan to organize our Student Chapter Network into regions headed by Regional Representatives. In addition, we have selected two very motivated individuals, Lynnea Vis from Adler University, to lead the Central Region Student Chapters, and our Campus Rep from Colorado State University, Nate Tenhundfeld, to lead the West Region. Since the SAC Chairs are collectively located on the East Coast, the Eastern region will fall under the SAC's auspices and report to the Chair-Select, Kevin O'Leary. The Regional Representatives will serve as central points of contact for the Campus Reps and coordinate regional training, volunteer outreach, mentorship, and social activities throughout the year. Lynnea and Nate, thank you for stepping up to serve as regional leaders!

SAC Vision for 2015

Another important goal for this year will be to continue to increase student involvement at the 2015 APA Convention. Every year, the SAC strives to promote student attendance and involvement at the convention, but we also understand that some students may find traveling difficult and costly. To offset travel costs to the 2015 convention in Toronto, Canada, we are offering 12 awards, at \$750 each, to undergraduate and graduate students presenting at the convention. The application deadline for the travel awards is April 1, 2015. In addition to our travel awards, graduate students may apply for our annual research grants. Last

year, we awarded two research grants in the amount of \$1,500 to *Andrew Smith* and *Kathryn Feltman*. Congratulations to both of you! To keep up with student research needs, this year we will be offering six research grants at \$500 each, with the option of receiving an optional \$750 for travel expenses. Please visit our website, <http://www.division19students.org>, for application details.

For those students planning to attend the convention this year, we have some exciting news to share with you! We are collaborating with the Division 19 Early Career Psychologist Committee to provide our student members with new student-oriented programming! We plan to offer professional networking events with the ECPs and other Division 19 members, and an internship preparation presentation that will be included in our suite programming. In addition, we plan to offer interdivisional programming with student leaders from other divisions on various military psychology topics of interest. Of course, we are also planning several social activities this year, including a field trip to the beautiful CN Tower, among other popular tourist destinations in Toronto. Stay tuned for more information on 2015 convention programming and social activities via our listserv and website updates!

Virtual Presentations

In addition to promoting upcoming training opportunities offered by various military psychology organizations, the next step in our strategic plan for this year

will be to launch a virtual presentation series for our students. The primary focus of these presentations will be to increase the number of qualified candidates for commissioned or civil service in the United States Armed Forces, the Department of Veterans Affairs, and other governmental organizations. With the help of our VPO, Jeremy Jinkerson, and the ECP Committee, we will be developing a series of online presentations and panel discussions on various military psychology-related topics including internship preparation, among other topics of interest. By tapping into our existing network of subject matter experts in the military psychology community we will be able to provide students with professional training that is unprecedented and advances the practice of military psychology. *Stay tuned for more information on this via our listserv!*

In closing, we heard from students and have been working around the clock to implement several exciting initiatives including changes to our leadership team, increased APA convention programming and virtual presentations. As we have been called upon by our student members to increase membership benefits in the division, we also ask students do their part and provide the SAC with feedback. Let us know how we may improve your experience. We hope to see you at the convention and virtually!

Best wishes for a successful year!

Angela Legner, *Chair*

Announcements

Jonathan Frank

Welcome to the Announcements section and your chance to spread the word about relevant information you would like shared with the community. Please take advantage of this resource by e-mailing myself at jonathan.frank@us.af.mil with a short write-up of your announcement details.

General

Call for Papers

The American Psychological Association's (APA's) gray literature database, PsychEXTRA, seeks submissions. PsychEXTRA provides scientific and reliable information for psychology professionals, researchers, teachers, and students. The following documents are highly desired by customers with various professions:

- Scientific and technical reports
- Conference presentations, papers, abstracts, posters, and programs
- Magazines, newsletters, and student journals
- Guidelines, protocols, manuals, and standards
- Updated brochures and fact sheets for counselors and patients

Participant Requests

The Natural History Study (DVBIC) seeks eligible participants for a congressionally mandated study investigating the recovery of TBI over a period of time within the military. The goal is not only to learn more about TBI but also to gain enough information that policy makers can create higher quality health care for service members. The study is currently in its third year. If you or someone you know served in the military after October 2001 and are interested in joining the Natural History of TBI Research Study, call (855) 993-8242 or email natural.history2@dvbic.org.

The Caregiver Quality of Life Study (DVBIC) seeks eligible participants for a congressionally mandated study investigating the effect of caring for a service member or veteran on the caregiver's quality of life. Caregivers must

be providing care to a service member or veteran who sustained a TBI after 2001 while serving in the military. Participants may be asked to participate in a small group discussion, telephone interview, and web-based self-report measures. Caregivers can participate for up to 15 years and may be compensated for their participation. If you or someone you know may be interested, please call (855) 821-1469 or email caregiver.study@dvbic.org.

Sarah Krill Williston (University of Massachusetts-Boston) seeks participants for her dissertation research study. The purpose of this study is to examine common beliefs, knowledge, and attitudes about mental health problems, treatments, and treatment seeking among veterans who have served since 2001. Any veteran who has served since 2001 and can speak English is eligible. For more information, contact sarah.krill@gmail.com.

Jillian Hunsanger is conducting a study examining the impact of health behaviors, emotion regulation strategies, and life experiences on posttraumatic stress symptoms in individuals who have experienced combat. She is seeking active-duty service members or veterans who have deployed at least once for a 15- to 30-min anonymous survey. The study is being conducted by the Department of Psychology at Oakland University, Rochester, Michigan. For more information, please contact jahunsanger@oakland.edu.

Conference and Meetings

18th International Symposium on Aviation Psychology

The 18th International Symposium on Aviation Psychology (ISAP) will be held in Dayton, Ohio, May 4-7, 2015. The ISAP is offered for the purposes of presenting the latest research on human performance problems and opportunities within aviation systems, envisioning design solutions that best utilize human capabilities for creating safe and efficient aviation systems, and bringing together scientists, research sponsors, and operators in an effort to bridge the gap between research and application. Although the symposium is aerospace oriented, ISAP welcomes anyone with basic or applied interests in any domain to the

extent that generalizations from or to the aviation domain are relevant. Please visit <http://isap.wright.edu> for more information.

2015 Department of Defense Survival, Evasion, Resistance, and Escape Psychology Refresher Training Workshops

Walter Reed National Military Medical Center Department of Psychology, in conjunction with the Joint Personnel Recovery Agency (JPRA)—Human Factors, presents the 2015 Survival, Evasion, Resistance, and Escape (SERE) Psychology Refresher Training Workshops. The workshops will occur June 23–25, 2015, at JPRA’s PRETC Training Facility in Fredericksburg, Virginia. Workshops will present and discuss current activities and recent developments in supporting isolated personnel from initial training through reintegration. This includes policy and practice changes that are occurring throughout the U.S. government and how those changes are affecting SERE psychological support to isolated personnel. Key concepts in working with casualty affairs officers for family support from initial isolation through reintegration. The role of SERE psychology in supporting SERE training will be discussed. The ethics of SERE psychology practice will be a major topic of each workshop. The primary audience is Department of Defense (DoD) SERE psychologists with proper clearance and an interest in or need to know about the state of the art in SERE psychology and military operational psychology concepts and techniques. Other select psychologists and mental health professionals from DoD, interagency, or allied nations who provide support to isolated personnel are invited to attend. Register by sending an email to Dr. Gary Percival and Mr. Patrick Kern at gary.percival@us.af.mil and patrick.kern.3@us.af.mil.

Inter-University Seminar on Armed Forces and Society

The Biennial International Conference of the Inter-University Seminar (IUS) on Armed Forces and Society will be held in downtown Chicago, Illinois, at the Palmer House Hilton from October 30 to November 1, 2015. IUS conferences provide an opportunity for focused exchange and vigorous criticism, covering topical and theoretical issues as well as cutting-edge research, and draw together scholars and military professionals from around the globe. Conference panels will begin Friday morning, October 30, 2015, with panels both morning and afternoon and the IUS

Welcome Reception and Dinner that evening. The conference concludes Sunday, November 1, 2015, at noon. For more information, go to www.iusafs.org/notices/CFP.asp.

International Society for Traumatic Stress Studies Annual Meeting

The International Society for Traumatic Stress Studies (ISTSS) would like to inform the members of Division 19 about the ISTSS 31st Annual Meeting, November 5–7, 2015, in New Orleans, Louisiana. There will be an exclusive track dedicated to military trauma-focused content. We hope you will consider attending. For more information, go to www.istss.org/home1.htm.

Employment Opportunities

APA Executive Director—Science Directorate

The APA is seeking a senior-level psychologist for the position of Executive Director for its Science Directorate. The APA Science Directorate is one of the four key content-area components of the APA Central Office (along with the Education, Practice, and Public Interest directorates), and its Executive Director is a member of the APA Executive Management Group, reporting to the APA chief executive officer. If interested, please apply online at www.apa.org/careers/apa-jobs/index.aspx. All inquiries in reference to this position should be sent to L. Michael Honaker, PhD (mhonaker@apa.org). Applications will be accepted until the position is filled.

STRONG STAR Multidisciplinary PTSD Research Consortium

STRONG STAR postdoctoral fellows work for the Department of Psychiatry at the University of Texas Health Science Center at San Antonio, and they work on some of the largest research studies and clinical trials in the nation designed to evaluate the use of evidence-based therapies for posttraumatic stress disorder (PTSD) and related conditions. Fellows receive expert training and ongoing weekly supervision in evidence-based treatments for PTSD, as well as high-quality training and supervision in the assessment of PTSD and trauma-related problems. In addition to their clinical roles, our postdoctoral fellows have published articles in high-quality, peer-reviewed journals; cowritten book chapters; and presented research at national conferences. Other achievements by STRONG STAR fellows include being awarded student loan repayment through the National Institutes of Health. Fellows

receive a competitive salary (\$45,000 per year) and exceptional health care and retirement benefits. Fellows are required to have completed an APA Accredited Internship. For more information about STRONG STAR, please see www.strongstar.org. To begin the application process, please send your curriculum vitae and statement of interest, including desired location, to Katy Dondanville, PsyD, ABPP (dondanville@uthscsa.edu). Applications will be reviewed on a rolling basis.

Security Clearance Job Opportunities

Clear Resolution Consulting, LLC seeks a psychologist to conduct psychological assessments of government civilians, military personnel, and contractors to assist in employee selection, decisions regarding travel assignments for employees, consultation to management and human resources personnel, and security clearance determinations. The resource also provides consultation in support of various agency missions. The incumbent will screen individuals for high-risk or public safety occupations, conduct evaluations of a forensic nature (either criminal or civil), and provide consultation on psychological related matters. This is a full-time contractor position that offers full employee and family medical, dental, and vision plans; life and AD&D insurance; generous holidays and personal leave; 401(K) with company matching; short-term/long-term disability insurance; and tuition assistance. If hired, employee must be able to obtain TS/SCI security clearance and sit for a full-scope polygraph. To apply, send e-mail/resume to Patrick.OBrien@CRCtoday.com or call (202) 683-8515.

The Defense Health Agency, National Capital Region is seeking a forensic psychologist to serve as the senior Subject Matter Expert on Forensic Psychology for the Army Clinical Psychology and Forensic Psychiatry Consultants, Army Office of the Surgeon General, Senior Legal Counsel to the Office of Secretary of Defense, and the Army Vice Chief of Staff. The incumbent will direct an array of forensic psychology services that include a program of assessment, consultation, and training as well as provide consultation, liaison, and expert opinion to DoD legal and medical agencies regarding psychological issues with a complex forensic component. Opinions include review of the work product of other forensic professionals, habeas reviews, military commission cases involving terrorism and illegal combatants, opinions given

to Chief Legal Counsel for the Secretary of Defense, review of cases and procedures related to forensic psychology for the Office of the Army Surgeon General, and opinions rendered in complex and high-profile criminal cases, including military death penalty cases. Assists with development of forensic behavioral health policy for the Army Office of the Surgeon General through consultation with the Army Forensic Psychiatry Consultant. Responsible for conducting a comprehensive program of training events that support Army psychology and forensic psychology across the DoD. Works in conjunction with the Program Directors of Army fellowship, residency, and internship programs to provide specialty training in forensic psychology, including a forensic psychology rotation for the medical treatment facility clinical psychology residents; provides forensic fellowship training opportunities for psychologists in the Navy and Air Force; and works in consultation with appropriate personnel to develop selection procedures for the forensic psychology fellows. Functions as the supervisory director of the forensic psychologists within the Department of Psychology, including supervising of lower grade employees and trainees, as well as performing administrative actions required to manage the Forensic Psychology Fellowship Program. For more information, go to www.usajobs.gov/GetJob/ViewDetails/392954900.

See <http://jobs.leidos.com/job/Washington-Psychologist-Job-DC-20001/52857000/> for an additional opportunity as follows: TS/SCI psychologist job in the Washington, DC area. Description: Candidate must have extensive knowledge and consulting experience related to identifying and neutralizing national security concerns in a high-risk operating environment. Must have direct experience in providing CI and polygraph issue resolution and psychological consultation services, performed in a highly sensitive national security operating environment. The candidate must be a behavioral subject matter expert who will support a variety of collaborative efforts with other agencies to promote state-of-the-art information exchanges that develop new insights regarding emerging vulnerabilities and threats that affect the mission, operations, management practices, and resource allocations. The candidate also must be a recognized expert in the intelligence community (IC) who can engage in outreach efforts with other IC elements and promote participation in interactive projects that benefit the CI mission and improve relationships with

other Department of Energy (DOE)/National Nuclear Security Administration (NNSA) management centers. These activities are ongoing, may be iterative and of unpredictable duration, and are difficult to quantify. The candidate must have specialized knowledge of both the utility and the limitations of the polygraph as used in a CI screening context, as well as specialized knowledge in supporting the development of unique product/program tools for deployment in psychological and assessment venues. The candidate must have the ability to develop, author, and support specialized counterintelligence-oriented risk assessment material. The candidate should have the ability to conduct presentations and courses that demonstrate strong, recognizable expertise in behavioral dynamics and interpersonal relationships and that enable recipients to recognize, understand, and mitigate national security-related vulnerabilities and threats associated with foreign intelligence operatives and trust-betraying insiders.

Specific duties include, but are not limited to, the following:

- Providing individualized consultations to management in regard to medical, psychological, and/or behavioral conditions that may affect placement or retention of DOE/NNSA personnel in high-risk assignments.
- Providing specific medical and/or psychological consultations to investigative elements regarding subject behavioral motivations and intentions, as well as formulating related interaction strategies in support of highly sensitive investigations that have significant national security implications.
- Engaging in behavioral consulting with other DOE/NNSA elements to ensure that CI-related objectives and values are directly considered or factored into decisions affecting major operational activities, including such matters as adjudicating clearances, promoting sound personnel security practices, insider threats, cyber security violations and incidents, and recognizing emerging threats.
- Performing evaluations and associated postevaluation support. This support shall include consulting with medical practitioners, as necessary, and developing written recommendations to facilitate decisions by the Director, Office of Intelligence and Counterintelligence, and/or the Secretary of Energy.
- Conducting medical and/or psychological interviews and/or assessments of candidates who are under consideration for DOE/NNSA high-risk access at headquarters and, when applicable, at field sites. The goal of these interviews and assessments shall be to determine the nature of any medical and/or psychological condition(s) that candidates may have that may adversely impact national security and affect decisions regarding high-risk placements.



SOCIETY FOR MILITARY PSYCHOLOGY

Division 19 of the American Psychological Association

Mental Health Beliefs and Barriers to Care Among Recently Returning Service Members and Veterans



What do veterans and service members think about common mental health issues? The purpose of this study is to examine common beliefs, knowledge, and attitudes about mental health problems, treatments, and treatment seeking among veterans who have served since 2001.

Any veteran who has served since 2001 and can speak English is eligible. We want to hear from as many veterans as possible, including men and women veterans, and veterans who identify as racial or ethnic minorities. Participation involves completing a confidential online survey, which takes less than 45 minutes to complete. **Veterans may be entered into a raffle to win a \$50 gift card to Amazon.com for completion of the study.** Participants may experience emotional distress while answering some of the questions, though this distress is expected to be minimal and transitory.

Here is the link to the survey: <https://www.psychdata.com/s.asp?SID=163447>

Protecting Confidentiality: All study data is kept on a 128-bit SSL encrypted online server that is username and password protected, and only the research team may access it. Participants who complete the study and are not interested in participating in the raffle can complete the online questionnaires anonymously. If participants are interested in being entered in the raffle and/or being contacted for future studies, they will be asked to provide their contact information. This information will be stored in a separate file within the PsychData online system and will be connected to their data by the Participant ID number in this separate file. Only study personnel will have access to the file contact information, and this file will be erased once the study is completed. Therefore, for participants who elect to complete the raffle and/or be contacted for future studies, their data will be confidential, not anonymous.

The principal investigator of this study is Sarah Krill Williston, MA (sarah.krill@gmail.com), and the faculty advisor is Dr. Lizabeth Roemer (lizabeth.roemer@umb.edu), from University of Massachusetts Boston's Department of Psychology (617-287-6350).

This study was approved by the UMASS Boston Institutional Review Board on 11/20/2014. The UMASS Boston IRB can be contacted as 617-287-5374.



SOCIETY FOR MILITARY PSYCHOLOGY

Division 19 of the American Psychological Association

Announcements



Call for Papers

Embedding the Concept of Suspicion in Research on Business and Applied Psychology

The *Journal of Business and Psychology* announces a Special Issue and Call for Papers on the construct of suspicion. Both theoretical and empirical submissions are welcome. The complete call is available at <http://newhouse-faculty.syr.edu/lhirshfield/wp-content/uploads/sites/2/2014/04/suspicion-call-for-papers.pdf>.

This link includes (a) an associated invited article in the *Journal of Business and Psychology* by Philip Bobko, Alex Barelka, Leanne Hirshfield, and Joseph Lyons (“Invited Article: The Construct of Suspicion and How It Can Benefit Theories and Models in Organizational Science,” which can also be obtained directly at http://newhouse-faculty.syr.edu/lhirshfield/wp-content/uploads/sites/2/2014/04/BBHandL_JBP-.pdf), which provides an initial measure of state suspicion; and (b) a review of social science literatures on the concept of suspicion (Bobko, Barelka, & Hirshfield, 2014, *Human Factors*).

In that review, suspicion was defined as “a person’s simultaneous state of cognitive activity, uncertainty, and perceived malintent about underlying information that is being [electronically] generated, collated, sent, analyzed, or implemented by an external agent.” The notion of “external agent” was purposively left general; that is, one might be suspicious about another individual, a competitor, a group or team of individuals, an organizational entity, or a system in general (computer or otherwise).

In the full Call for Papers, we suggest that the underrepresented concept of suspicion can have important links to many subdisciplines in business and applied psychology. For example:

- What is the role of suspicion in leadership? What is the role of suspicion in decision making? If organizational systems incorporate automatized decision aides, will user suspicion of the aides influence decision making models?
- How might the concept of suspicion change (if at all) at the group/team level? Also, within groups, is suspicion contagious? What is the role of culture in theories of suspicion?

The final due date for any submission is June 30, 2015: First complete draft of regular length manuscript (in APA style) is due. Submissions before that date are welcome. To submit, corresponding authors should first register in the *Journal of Business and Psychology* system (at <https://www.editorialmanager.com/jobu/>).

Again, please see the complete Call for Papers for more details (including links for associated papers).

Division 19 Membership Application Form

Name: _____

Mailing address: _____

City, state, postal code, country: _____

Work phone: _____ Home phone: _____

Fax: _____ E-mail address: _____

APA membership number/category (if applicable): _____

Member Associate Fellow Life Status

Student Affiliate International Affiliate No Membership in APA

Division 19 Membership Desired:

Member/Associate/Fellow (\$27) International Affiliate (\$30) Professional Affiliate (\$30)

Student Affiliate (\$10) Life Status Publication Fee (\$19)

Cardholder name (the name appearing on credit card): _____

Cardholder's billing address: _____

Credit card number: _____ Expiration date: _____

Card type (only MasterCard, Visa, or American Express): _____

Daytime phone number and email address (if available): _____

Amount to be charged in US Dollars: _____ Cardholder signature: _____

MAIL APPLICATION TO:

APA Division 19 Services, ATT Keith Cooke, 750 First Street, NE, Washington, DC 20002-4242

For questions call Keith Cooke at 202-216-7602 or email kcooke@apa.org

Please DO NOT fax or email credit card information!

Online application is available at <http://www.apa.org/about/division/div19.aspx>

INSTRUCTIONS FOR CONTRIBUTORS TO *THE MILITARY PSYCHOLOGIST* NEWSLETTER

Please read carefully before sending a submission.

The Military Psychologist encourages submissions 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 submissions 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 **February 1**), Summer (submission deadline **June 1**), and Fall (submission deadline **October 1**).

Preparation and Submission of Feature Articles and Spotlight Contributions. All items should be directly submitted to one of the following Section Editors: **Feature Articles/Trends** (Joseph B. Lyons: joseph.lyons.6@us.af.mil), **Spotlight on Research** (Krista Ratwani: ratwani@aptima.com), and **Spotlight on History** (Paul Gade: paul.gade39@gmail.com). For example, Feature Articles must be of interest to most Division 19 members; Spotlight on Research submissions must be succinct in nature. If longer, please, consider submitting the article to the Division 19 journal, *Military Psychology* (military.psychology.journal@gmail.com). If articles do not fit into any of these categories, feel free to send the contribution to the Editor in Chief (Joseph B. Lyons: joseph.lyons.6@us.af.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., references/citations). All graphics (including color or black-and-white photos) should be sized close to finish print size, at least 300 dpi resolution, and saved in TIF or EPS formats. Submission should include a title, author(s) name, telephone number, and e-mail address of the 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 Jonathan Frank (jonathan.frank@us.af.mil).

Review and Selection. Every submission is reviewed and evaluated by the Section Editor, the Editor in Chief, and 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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