THE MILITARY PSYCHOLOGIST

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Division 19 of the American Psychological Association

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In this issue:

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Officers & Committees

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

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Editor's Column

Bri Staley Shumaker

Responding to Change with Adaptability and Insight

Welcome to the first issue of *The Military Psychologist* in 2025! As the new editor-in-chief, I am delighted to present this issue to you.

The Greek philosopher, Heraclitus, long ago posited that change is inherent in everything. Some changes are so small they are almost imperceptible, passing in a moment. Other changes feel much larger, offering hope—or despair, depending on one's perspective. As we kick off a new year, we find ourselves once again on the precipice of great change as our nation enters a period of transition that will inevitably shape policies, priorities, and the collective mindset of the country.

In times of uncertainty and change, it is important to remind ourselves of what we can and cannot control. We cannot control others, but we can control our own actions and responses.

Heraclitus reminds us that, while we must remain adaptable to change, we must also learn from history, our mistakes, and our successes. We must look to the past to gain insight for the future.

Change in all of its forms, while inevitable, is often uncomfortable. In fact, our current understanding of neural networks teaches us that our brains enjoy routine, the familiar. Change disrupts our brain's ability to act on autopilot. It is both a disruptor of comfort and driver of growth, both internally and externally. As military and civilian mental health professionals who serve the DoD, we understand that change is not only a challenge but an opportunity to adapt, lead, and support one another. When we adapt to change, we are able to navigate the complexities of the moment and develop resiliency. As psychologists, we are better able to find the solution and assist our clients.

As I reviewed the article submissions for this issue of *The Military Psychologist*, I could not help but see this theme of adaptability amidst change. Several authors introduce innovative treatments for mental health disorders, while others identify current weaknesses and ways we can improve within our current systems. We adapt in order to achieve the common goal of helping and healing the patients, systems, and organizations that we serve. While we maintain high standards and utilize the evidence-based treatments that we know, it is also important for us as scientists to question, challenge the status quo, and be open to new insights, nevertheless viewing novel ideas with a critical scientific eye.

It is with great pride that we introduce the new President of Division 19, Arlene Saitzyk, PhD. She is a distinguished leader with a remarkable career in both military service and psychology. A graduate of Cornell University with a doctorate from Michigan State University, she brings extensive clinical and leadership expertise honed through a 23-year Navy career, retiring as a Captain in 2023. Her roles have included Director of Mental Health for Navy Medicine, Director of Behavioral Science for the Marine Corps Embassy Security Group, and Aerospace Clinical Psychologist at the Naval Aerospace Medical Institute. She has provided critical guidance on behavioral health and counterintelligence for over 2,000 Marines worldwide, evaluated aviation personnel for flight status, and trained future leaders in aerospace and expeditionary medicine. A decorated member of Division 19, she has received both the Julius E. Uhlaner Award for excellence in military psychology research and the Robert S. Nichols Award for her contributions to military personnel and families. In 2023, she was honored as a Fellow of Division 19 by the American Psychological Association, underscoring her lifelong commitment to advancing military psychology. In her inaugural column, Dr. Saitzyk reflects on the start of her term with heartfelt gratitude for the Society's recent accomplishments and the invaluable contributions of past Division 19 presidents and members. As the Society for Military Psychology embarks on another year, we extend our thanks to Dr. Saitzyk for her inspiring vision, which centers on ***Connection, Communication, and Cause.*** We look forward to her visionary leadership in the coming year.

In this issue, the articles span a compelling range of topics, starting with innovative interventions for posttraumatic stress disorder, including Stellate Ganglion Block and MDMA/psychedelics. These articles are written by two renowned experts in their field—James Lynch, MD, a physician who is double board certified in family and sports medicine and is a retired U.S. Army colonel, and Mark Bates, PhD, a retired Air Force lieutenant colonel, military psychologist, and Air Force pilot. We continue with an in-depth look at the EMDR Group Traumatic Episode Protocol (G-TEP): A promising adaptation of trauma-focused therapy that integrates group and individual treatments to reduce posttraumatic stress disorder symptoms and alcohol cravings. From there, we delve into the persistent stigma surrounding mental health care in the military, emphasizing the need for systemic cultur-

al change to support help-seeking behaviors. The unique experiences of female servicemembers and veterans are explored, offering tailored approaches to enhancing care for this growing population. We then explore the parallels between military culture and psychological models in order to build trust and improve outcomes for veterans. One of our newsletter committee members, Taylor Zurlinden, PhD, shares a personal account of providing psychological care amidst trauma, illustrating the complexity of treating others while navigating one's own personal reactions and experiences. Finally, we include a review of a book focused on supporting loved ones with mental illness, and Austin Hamilton, PhD explores the Office of Strategic Services' (OSS) groundbreaking World War II assessment program in our spotlight on history section. We also have updates from the Military Psychology Foundation, our Representatives to the APA Council, and the Membership Committee. As always, we thank Pat DeLeon (past president of APA and former member of Senator Inouye's staff), for his reflections on current events in the world through the lens of our military psychology profession.

I will leave you with a friendly reminder to stay connected! Please read updates contained in this issue to stay informed about current events in Division 19. There are always opportunities to get involved!

We, as always, are in search of suitable articles for *The Military Psychologist*. Please feel free to email us with any article ideas and/or questions. If you already have an article for us, please send it along! We can be contacted at Div19newslettercommittee@gmail.com.

Here's to a year of adaptability and insight in the midst of change!

Very Respectfully,

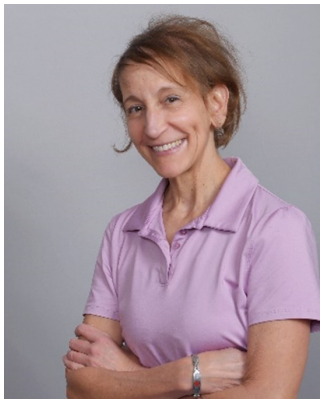
Brianna Staley Shumaker, PhD, ABPP

Editor-in-Chief

The Military Psychologist

President's Column

Arlene Saitzyk



Happy New Year friends and colleagues,

It seems to me at the start of each new year, folks are a bit more thoughtful, understanding, and giving with their time, patience, and outlook. My hope is to carry this grace throughout the year. I have gained so much both personally and professionally through Division 19, and am grateful for the privilege to give back by serving as your new president and supporting our Division 19 leaders and members.

For those who don't know me well, I first became a member of Division 19 in the early 2000's, shortly after joining the military. Prior to joining nearly 25 years ago, I worked with violent teens in residential treatment, but one fine day I heard the phrase "Accelerate Your Life," decided to join the Navy, and my life direction was changed forever (just kidding, sort of). I am a retired Navy Captain with experience in both clinical and operational psychology, and leading mental health policy and programs for the Navy and Marine Corps. I'm also fellowship trained as a pediatric psychologist, and served overseas caring for service members' children. Within Division 19, it has been my honor to serve as Member-at-Large, chair the inaugural Advocacy Summit, and support the Society Leadership Program as a mentor.

Before I get into my intentions for this new year, I want to express sincere appreciation for the privilege of supporting our Past President, Bill Brim. If you know Bill, you know he is a humble one, but was amazing at accomplishing his priorities - Clear Communication/Individual Engagement/Global Impact. Thank you, Bill - our website, social media, and listserv comms are so much better, our members are more involved in all aspects of our organization, and we certainly have been having global impact! Thanks to you and another huge thank you to our past-Past President, Bruce Crow, for leading from the front in supporting mental health efforts for Ukraine, and fostering exchange of vital information at the past two conventions. A quick look at the contents of the first Military Psychology journal issue for 2025 is also notable, as five out of eight articles showcase significant research from our international colleagues!

I also want to share my gratitude for the other officers who completed their terms in 2024: Marcus VanSickle (Member-at-Large) and Delaney Granko (Student Member-at-Large), as well as welcome aboard our newly elected officers for 2025: Carrie Kennedy (President Elect), Adeline Ong (Member-at-Large), and Elizabeth Finer (Student Member-at-Large). And, I am looking forward to working with the elected officers who will be continuing to lead our Executive Committee: Bill Brim (Past President), Mark Staal and Tim Hoyt (Council of Representatives), Angela Legner (Secretary), Ryan Landoll (Treasurer), and Jenn Barry and Ashley Markovic (Members-at-Large). Finally, I want to take a moment to shout out THANK YOU to all our Committee Chairs and look forward to collaborating throughout the year!

My intentions for the new year center on three concepts: connection, communication, and cause.

#1 Connection: Debra Kawahara's APA presidential theme "strength in unity" applies nicely to Division 19 too. Although we are quite a diverse group, we come together to *positively* advance science and practice on *all* issues related to the military and national defense through education, research, and training. I will work to expand our member programs to include a variety of mutually supportive venues, and will look to do more of this in-person – it's healthy for us! I also want to support opportunities for mentorship and collaboration across disciplines, APA divisions, and oceans too, which can result in our greater impact across APA.

#2 Communication: I will build on Bill's great work, along with our Communications chair, Anna Gai Donaldson, to continue to improve our website and streamline communications. Additionally, good communication means promoting science and being proactive in preventing the spread of misinformation. I'd like to invite you to peruse the following websites: first, how psychological science may counter misinformation effectively: https://www.apa.org/pubs/reports/health-misinformation, and second, a more general source that highlights using science to inform and advocate: https://www.apa.org/science. Along these lines, I want to say thank you in advance to our new Chief Science Officer, Kris Holland – welcome aboard!

#3 Cause: I look forward to working with our newly-official Advocacy Committee on a variety of issues, including supporting our professional identity, promotion and retention of military psychologists, evidence-based treatment, and applied psychology practice.

I am a huge reader, so to wrap up I want to offer some insights from a book I recently read, called "The Well-Lived Life" by Gladys McGarey, a physician who lived to be 103 years old (she died at the end of last year). In this book (published when she was 102), she offered her

secrets to health and happiness at every age, and I'd like to share three of them, as they relate to Division 19, and to starting the year off right:

1. You are here for a reason – so, do what you love. Dr. McGarey calls this your "juice." For me, I treasure authentic connections, so I will be looking for opportunities to bring our members together for growth, inspiration, impact, and hopefully some good laughs too.

2. Everything is your teacher. Even the bad (I mean the challenging) things. We just need to change up our attitude and response. As Dr. McGarey says, "Each of us has the wisdom to get through the impossible moments – we must believe that." Sounds a little bit like cognitive behavioral therapy, and I will keep this top of mind with any challenges ahead as we advocate for military psychology.

3. You are never truly alone. And, when you have a community of support, you can do anything. Our organization embodies this. In fact, I've heard Division 19 described many times as a source of comfort and "home." I don't take that lightly – whatever I/we can do to support members, committees, causes, please let me/us know!

Here's to a great year!

Very Respectfully,

Arlene Saitzyk PhD

2025 President, Society for Military Psychology

New Frontiers in Military Mental Health Science and Practice: Catalyzing Therapy with Psychedelics

Mark J. Bates

Introduction

The intersection of military mental health and emerging therapeutic approaches requires careful consideration, particularly when examining promising yet experimental treatments like psychedelic-assisted therapy (PAT). This analysis provides a high-level overview of PAT's potential role in military mental health care, while acknowledging the need for thorough scientific validation and alignment with both military organizational values and tactical requirements. Consistent with the DoD's three pillars of Force Health Protection: (1) promoting wellness and sustaining health to deliver a healthy and fit force; (2) preventing acute and chronic casualties during training, deployments and war; (3) providing high-quality health care in peacetime and on the battlefield, the potential use of PAT must be in accordance with these pillars as new frontiers in treating trauma-related disorders and sustaining a healthy and fit force. Contemporary research suggests that PAT, which combines psychedelics like psilocybin and MDMA with traditional psychotherapy, shows promise in symptom reduction, therapeutic engagement, and treatment adherence. As military medicine has historically balanced innovation with prudent caution in "going to the sound of guns" (proactively addressing needs), the examination of PAT's applications for addressing complex psychological challenges within military and veteran populations warrants thoughtful investigation. While maintaining operational readiness remains paramount, research indicates that psychedelic therapies may enhance warrior effectiveness through improved mental wellness and cognitive flexibility. However, as Brim et al. (2024) emphasize, careful consideration is essential, particularly given that psychedelic substances like MDMA remain prohibited for active-duty personnel outside approved research settings. Also, while psychedelic-assisted therapy offers unique potential for addressing complex psychological challenges, it is not a simple solution to mental health struggles. Rather, it often involves confronting difficult emotions and experiences, with the goal of fostering deeper emotional resilience, mental clarity, and psychological flexibility over time.

The Need for New Treatment Options in the Military Community

The prevalence of mental health challenges within military populations underscores the importance of exploring innovative treatment approaches while maintaining the highest standards of care. Recent data illustrates both the scope of these challenges and the opportunities for enhanced therapeutic interventions.

Statistics from 2022 indicate that approximately 17.6% of active-duty personnel sought psychological health treatment, though this likely understates the actual need, as it only reflects those actively pursuing care (Curry, 2024). While Trauma-Focused Cognitive Behavioral Therapy (CBT-TF) serves as the primary psychological intervention for PTSD in both active and veteran populations, current treatment approaches face significant challenges. A review of randomized clinical trials (RCTs) found that noncompletion rates for trauma-focused therapies, such as prolonged exposure therapy (PE) and cognitive processing therapy (CPT), ranged from 25% to 48% among active-duty military personnel and veterans (Steenkamp et al., 2020). In routine clinical practice at the Veterans Administration (VA), the rates of noncompletion were even more concerning, with over 60% of veterans who started PE or CPT failing to complete treatment over a fifteen-year period (Maguen et al., 2019). Response and remission rates within one to six months were 35% for PTSD, 45% for depression, and 41% for anxiety among Army military personnel receiving behavioral health services (Hepner, 2021). Earlier research also highlighted that many service members who could benefit from mental health treatment, particularly for PTSD, often didn't access available services (Hoge, 2014). Additionally, concerns persist regarding career impacts, security clearance maintenance, and fitness for duty, especially when treatment involves chronic psychotropic medications.

These findings suggest the value of investigating additional therapeutic approaches that might better serve military personnel while maintaining the highest standards of care and operational readiness. In other words, we need more tools in the toolbox, that can complement and even sharpen our existing and necessary tools and can therapeutically and practically address cognitive distortions.

Federal and State Initiatives Supporting Psychedelic-Assisted Therapy

The landscape of psychedelic-assisted therapy (PAT) within military healthcare is evolving through strategic federal and state initiatives that prioritize rigorous scientific validation while maintaining military organizational values. These initiatives demonstrate a methodical approach to investigating psychedelics' therapeutic applications, supported by empirical evidence from randomized controlled trials (RCTs) and complementary research methodologies.

The Veterans Administration (VA) has adopted a systematic approach to evaluating PAT through carefully designed pilot studies and strategic research partnerships.

A significant milestone occurred in September 2023 with the VA's State of the Art (SOTA) Conference on psychedelic treatments, which convened 72 subject matter experts to develop an evidence-based framework for implementing MDMA and psilocybin therapies within the VA system. This strategic groundwork led to concrete actions: in January 2024, the VA's Office of Research and Development issued a Request for Applications (RFA) focusing on MDMA and psilocybin research for PTSD and depression treatment. The formation of an Integrated Project Team (IPT) in April 2024 further strengthened the VA's systematic approach to research implementation (Wolfgang, 2025).

The Department of Defense (DoD) demonstrated its commitment to exploring innovative treatment options through the 2024 National Defense Authorization Act (NDAA), which identified psychedelic research as a critical gap area. The subsequent allocation of $10 million for DoD-wide psychedelic medical trials reflects a measured approach to advancing evidence-based therapeutic options for service members and veterans.

At the state level, Oregon's Measure 109 established a precedent for regulated therapeutic applications of psilocybin, implementing comprehensive oversight mechanisms. Colorado's Proposition 122 (also known as Natural Medicine Act of 2022) expanded this framework, creating structured protocols for licensed healing centers offering supervised psilocybin sessions, scheduled to commence in 2025, while maintaining appropriate municipal oversight. Texas has emerged as a leader in supporting MDMA and psilocybin research for PTSD treatment, particularly focusing on veteran care through coordinated private and state initiatives. Maryland's proposed legislation for clinical trials investigating psychedelic-assisted therapy for veterans with trauma-related disorders exemplifies the growing scientific interest across multiple regions of the country.

These coordinated federal and state initiatives reflect a careful, evidence-based approach to evaluating psychedelic therapy's potential role in military and veteran mental health care.

Psychedelic-Assisted Therapy FDA Drug Development Process

The integration of psychedelics like psilocybin and MDMA as therapeutic catalysts represents a significant development in mental health treatment paradigms, particularly for PTSD and related conditions. The FDA's methodical evaluation of these treatments provides a rigorous structured approach to validating novel therapeutic modalities.

Recent Phase 3 clinical trials evaluating MDMA-assisted therapy for PTSD have demonstrated promising outcomes, with 67% of participants showing substantial improvement to the point of no longer meeting PTSD diagnostic criteria, compared to 32% in the placebo group (Mitchell, 2023). The FDA's request for additional data exemplifies their methodical evaluation approach, particularly given this treatment modality's innovative nature. This careful assessment is essential as MDMA-assisted therapy represents a novel treatment paradigm that uniquely integrates pharmacological intervention with specialized psychotherapy protocols.

It is also important to note that the FDA's review process identified several areas requiring attention in the New Drug Application (NDA) for MDMA. Primary concerns centered on aspects of study protocols, particularly regarding informed consent procedures and the management of psychological risks associated with intense psychedelic experiences and inadequate blinding. Additional considerations included therapist-participant relationship dynamics, long-term psychological impact assessment, outcome consistency across diverse populations, and protocols for managing adverse reactions during sessions. These factors influenced the FDA's decision, emphasizing the importance of refined study designs and enhanced safety protocols in future investigations.

The FDA's designation of Breakthrough Therapy status for both psilocybin-assisted therapy in treatment-resistant depression and LSD-assisted therapy for generalized anxiety disorder (GAD) reflects their recognition of these treatments' potential to significantly advance current therapeutic options. Initial clinical investigations have shown encouraging results, with both psilocybin and LSD interventions demonstrating meaningful effectiveness in symptom reduction for depression and anxiety, respectively.

The FDA maintains stringent safety and efficacy standards through their established three-phase clinical trial system, with many potential treatments not meeting these comprehensive requirements. While this thorough evaluation process requires considerable time and resources, it serves as a crucial foundation for establishing psychedelic-assisted therapies' scientific validity.

Despite developmental challenges as a new treatment paradigm and field of contemporary research, the growing body of research evidence and increased advocacy continue to build a substantive foundation for integrating psychedelic-assisted therapy into established mental health treatment protocols for military personnel and veterans. The ongoing regulatory review process serves as an essential quality control mechanism to ensure these therapies meet both safety and efficacy standards for broader clinical implementation.

Psychedelic Drug Definitions, Categories, and Examples

The term "psychedelic" derives from Greek etymology signifying "mind-manifesting," highlighting these compounds' capacity to facilitate introspective exploration and access innate healing mechanisms. In the military mental health context, both the terminology and specific substances like LSD carry historically-influenced perceptions that warrant careful consideration. To effectively evaluate their therapeutic potential for service members and veterans, it's essential to develop an evidence-based

understanding of the distinct compounds classified as psychedelics.

Examples of Psychedelic Drug Categories:

- **Serotonergic Classic Hallucinogens (Psychedelics)**: This classification encompasses psilocybin (derived from specific mushroom species) and LSD (lysergic acid diethylamide), which primarily interact with the 5-HT_2A serotonin receptor. These compounds can induce significant alterations in perception, cognition, and emotional processing. While their therapeutic potential is noteworthy, historical misconceptions necessitate careful consideration when evaluating their integration into military mental health protocols.
- **Entactogens and Empathogens**: MDMA (3,4-methylenedioxymethamphetamine) represents a distinct category. Unlike traditional psychedelics, MDMA promotes emotional accessibility and interpersonal connection, showing particular promise for treating combat-related PTSD and moral injury.

Examples of Additional Psychedelics from Natural and Synthetic Sources:

- **5-MeO-DMT**: Sourced from *Bufo alvarius* toad secretions and specific botanical species, characterized by brief but profound altered states.
- **Ibogaine**: An alkaloid extracted from the *Tabernanthe iboga shrub*, showing potential applications in substance use disorder treatment.
- **Ayahuasca**: A traditional Amazonian preparation combining DMT with MAO inhibitors from two different plant sources, utilized for therapeutic and spiritual purposes.
- **Peyote and San Pedro**: Cacti containing mescaline, historically used in ceremonial contexts for extended psychospiritual experiences.
- **Synthetic Analogues**: Compounds like 2C-B, offering varied therapeutic applications and duration profiles.

Understanding the distinct characteristics of different psychedelic compounds is crucial for psychedelic-assisted therapy. Each substance presents unique pharmacological profiles, therapeutic applications, and safety considerations that require careful evaluation within the context of military medicine's commitment to evidence-based practice and operational readiness. Considering psychedelics to be a homogeneous category falls short and underscores the significant diversity in tolerability, impact, side effects, and safety; differences which begin (and end) at the 5HT-2A receptor.

A fundamental consideration in evaluating psychedelics for military mental health applications is the distinction between pharmaceutical-grade compounds and unregulated substances. Street variants of MDMA, colloquially known as "Molly," present significant risks due to variable purity and potency, contributing to understandable institutional caution. In contrast, pharmaceutical-grade psychedelics are manufactured under rigorous quality control protocols, ensuring consistent potency and safety parameters essential for therapeutic applications.

This pharmaceutical distinction underscores the importance of standardized compounds in clinical research and therapy protocols. By maintaining stringent quality controls, these substances can be administered with optimal safety margins and therapeutic efficacy, facilitating their potential integration into evidence-based mental health interventions.

Mechanisms of Change

Understanding the mechanisms of psychedelic-assisted therapy (PAT) reveals promising pathways for enhancing therapeutic outcomes, particularly for service members facing complex mental health challenges like PTSD and co-occurring conditions. Also, by addressing the interplay of biological, psychological, and social factors, PAT aligns with a biopsychosocial model, integrating wellness-focused approaches to foster both individual recovery and overall resilience.

While there are multiple biological and psychological processes that theoretically contribute to PAT's effectiveness, neuroimaging research has identified crucial interactions with serotonin 2A receptors, which modulate the default mode network (DMN). The DMN governs baseline thought patterns and self-perception (i.e., our sense of who we are, and the typical ways view ourselves, interpret the world around us, react, and pursue goals), and its modulation enables enhanced neural connectivity across brain regions in what has been termed the Relaxed Brain Under Psychedelics (REBUS model; Carhart-Harris, 2019). Though this modulation and the experience of its effects can be significant, it creates opportunities for adaptive perspective shifts, enabling individuals to reconstruct their self-perception and interpersonal dynamics. Thus, PAT extends beyond symptom management, fostering comprehensive psychological development by addressing entrenched habitual, and pervasively persistent cognitive patterns. This neurological mechanism has been validated through extensive research, including functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) studies, demonstrating psychedelics' capacity to facilitate transformative therapeutic experiences (Carhart-Harris et al., 2012; Vollenweider & Kometer, 2010).

The synergy in PAT parallels military combined arms doctrine, where psychedelics and psychotherapy collaborate for maximum therapeutic impact. The psychedelic component functions as a catalyst, facilitating emotional processing and reducing psychological barriers, while psychotherapy provides structured guidance for integrating insights into sustainable healing practices. This integrated approach shows particular promise for conditions

like PTSD, where traditional interventions may show limited effectiveness. Similar to military operations, where coordinated arms achieve superior outcomes compared to single-domain approaches, the combination of psychedelics and psychotherapy offers a comprehensive treatment framework. Understanding this careful orchestration and emerging evidence base can inform military psychologists' evaluation of PAT's potential for service member care.

Psychedelic-Assisted Therapy Treatment Phases

PAT implementation follows a structured, phase-based protocol ensuring safety and effectiveness. These phases align with military operational planning principles, providing a systematic framework for implementation and evaluation.

Pre-Treatment Phases that Ensuring Readiness

- **Screening Phase:** Drawing parallels with pre-mission personnel assessment, this phase implements comprehensive evaluations to determine therapeutic suitability. The screening process employs evidence-based protocols to assess both physiological and psychological readiness, examining cardiac risk factors that could be impacted by autonomic arousal during dosing sessions, and evaluating psychological stability with particular attention to conditions like manic presentations that might contraindicate treatment. This methodical approach reflects military medicine's commitment to risk mitigation and operational readiness. Also, the interdisciplinary collaboration between medical and mental health professionals during screening ensures a holistic assessment of physical and psychological readiness.
- **Drug Tapering Phase:** This phase mirrors operational stand-down periods, requiring careful management of existing medications, particularly serotonergic compounds that could interact with psychedelic agents. The systematic reduction of contraindicated medications follows established medical protocols, ensuring optimal conditions for therapeutic engagement while maintaining patient safety and physiological stability.

Treatment Phases that Provide Sequential Structure

- **Preparation Phase:** Analogous to pre-mission briefings and rehearsals, this foundational phase establishes essential groundwork for therapeutic success. Clinicians provide comprehensive education about psychedelic effects and potential psychological responses, while developing individualized coping strategies. This preparation embodies the military principle of thorough training, ensuring participants possess the psychological tools and understanding necessary for meaningful engagement with the therapeutic process.
- **Dosing Phase:** This critical phase parallels mission execution, representing the culmination of careful preparation and planning. Under controlled conditions, participants engage with the psychedelic experience while maintaining therapeutic support and safety protocols. The emphasis remains on maintaining an adaptive mindset while navigating potentially challenging psychological territory, similar to the flexibility required in complex military operations.
- **Integration Phase:** Reflecting the military's after-action review process, this phase facilitates the processing and application of therapeutic insights. Participants work with clinicians to contextualize their experiences and develop strategies for implementing psychological insights into daily life. This structured reflection period proves essential for consolidating therapeutic gains and fostering sustained psychological resilience. It is essential for participants to approach their experiences with the understanding that PAT is not a one-time solution but part of a broader journey toward emotional well-being. By working closely with therapists, participants can process the insights gained from their sessions, transforming challenging experiences into actionable strategies for leading a more fulfilling life. The integration phase also highlights the importance of an interdisciplinary team, combining clinical expertise in trauma processing, wellness strategies, and relational dynamics to create a sustainable path to recovery.

Common to other therapies, the foundation of all PAT intervention, is the development, nurturing, and maintenance of the therapeutic bond/relationship. This phase-based approach demonstrates how PAT can be implemented and communicated within existing military medical frameworks, emphasizing safety, preparation, and systematic evaluation throughout the therapeutic process. The careful structuring of these phases reflects the military medical community's commitment to evidence-based practices while acknowledging the unique needs of service members and veterans.

Psychedelic-Assisted Therapy Relevance for Military Members and Veterans

The treatment's condensed format (typically requiring only one to three dosing sessions involving taking a psychedelic drug) addresses a common concern of many military members about medication dependence. This presents a compelling alternative to conventional long-term pharmacological interventions, which often require daily medication administration and may create a sense of diminished personal agency in the healing process.

Group-Based Therapy and Peer Support in the Military Context

The adaptation of psychedelic-assisted therapy to group treatment models presents a distinctive advantage for military personnel and veterans. The VA's innovative approach of conducting group sessions with veterans who served together in "fire teams" leverages established unit cohesion and trust, fostering an optimal therapeutic environment. Research on group-based approaches indicates that shared healing experiences can produce robust outcomes, enabling veterans to rebuild both internal stability and external connections while strengthening their sense of community and shared purpose. Furthermore, group-based interventions may provide an ideal framework for addressing moral injury, particularly when social wounds stem from perceived betrayal or compromised trust in leadership relationships.

Transdiagnostic Benefits

Current research demonstrates that psychedelic-assisted therapy shows promise in addressing multiple psychological conditions affecting military members and veterans, conditions that frequently co-occur (studies indicate over 80% co-occurrence with PTSD; Walter, 2018):

- **PTSD:** Clinical trials investigating MDMA-assisted therapy have demonstrated compelling evidence for reducing PTSD symptomatology and enhancing overall psychological functioning among service members (Mitchell, 2023b; Mitchell, 2024).
- **Major Depressive Disorder, including Treatment Resistant Depression:** Controlled studies of psilocybin-assisted therapy have documented sustained improvement in depressive symptoms among individuals who previously showed minimal response to conventional therapeutic approaches (Davis, 2021).
- **Alcohol Use Disorders:** Systematic investigations of both MDMA and psilocybin interventions reveal promising outcomes in reducing alcohol consumption patterns among individuals diagnosed with alcohol use disorder (Bogenschutz, 2015b).
- **Anxiety Disorders:** Current evidence suggests that therapeutic protocols incorporating psychedelic compounds, particularly psilocybin, show marked effectiveness in addressing various anxiety presentations, including generalized anxiety disorder and end-of-life related anxiety, yielding substantial improvements in emotional regulation capacities and psychological resilience (Griffiths, 2016; Ross, 2016).
- **Suicide Risk:** Recent preliminary research through an open-label pilot investigation of psilocybin-assisted therapy with patients experiencing depression and persistent suicidal ideation demonstrated meaningful reductions in both suicidal thoughts and depressive symptoms, with therapeutic gains maintained through a 12-week follow-up assessment period (van der Vaart et al., 2024).

Also of particular relevance to military mental health providers, **Moral Injury**, while not formally recognized in the DSM, represents a significant psychological concern among service members that may be particularly responsive to PAT interventions. Moral injury manifests when individuals experience violations of core moral or ethical principles, either through personal actions or witnessing others' conduct, encompassing both active transgressions and failures to act. While often co-occurring with PTSD's fear-based responses, moral injury distinctly involves profound moral-spiritual wounds leading to self-condemnation and withdrawal. Traditional therapeutic approaches emphasizing fear extinction and cognitive restructuring may inadequately address the fundamental betrayal of moral values inherent in these experiences (Lehrner, 2021). PAT, particularly utilizing MDMA, facilitates enhanced emotional processing and interpersonal trust, enabling service members to address moral transgressions within a supportive clinical environment. This therapeutic framework helps military personnel overcome shame-based barriers and judgment fears, promoting self-forgiveness and moral reconciliation.

Fitness for Duty, Readiness, and Retention Considerations

The integration of psychedelic-assisted therapy into military treatment protocols necessitates careful evaluation of likely impact around important operational concerns related to fitness for duty, readiness and retention and including commitment to the warfighter mission, potential harms, potential substance abuse, and potential for duty limiting profiles and side effects.

- **Fitness for Duty, Readiness, and Retention:** By addressing underlying mental health challenges through PAT, service members may experience enhanced performance under stress, improved tactical decision-making, and superior functioning in high-pressure combat environments.

  PAT extends beyond mere symptom alleviation, offering transformative experiences of meaning and connection—elements vital for military personnel's successful reintegration into their units, families, and civilian communities. Research also demonstrates PAT's capacity to enhance cognitive flexibility and facilitate flow states. These outcomes, combined with symptom reduction, align naturally with core military values emphasizing personal agency, unit cohesion, and psychological resilience. Therefore, these improvements could significantly enhance retention rates and overall warfighter effectiveness by promoting sustained psychological preparedness.
- **Commitment to the warfighter mission:** An important consideration for military psychologists involves understanding PAT's potential impact on a healthy force's primary mission: the ability to

"locate, close with, and destroy the enemy." Specific concerns may arise regarding psychedelics' influence on service members' combat attitudes, including perspectives on killing or mortality risk. Current evidence does not indicate that PAT compromises tactical engagement capabilities or undermines the warrior ethos. Rather, research suggests potential enhancements in emotional regulation and reduction of combat-related stress impacts. These therapies often facilitate deeper understanding of actions and moral frameworks, potentially leading to more considered, ethical decision-making while maintaining combat effectiveness. By addressing underlying trauma and moral injury, PAT may enhance service members' ability to process and integrate their experiences, potentially resulting in a more resilient and mentally prepared fighting force.

- **Ensuring safety and minimizing harms:** Another concern is ensuring safety and minimizing potential harms. Clinical evidence from controlled settings indicates that psychedelic substances like MDMA and psilocybin, when administered therapeutically, demonstrate a favorable safety profile without significant adverse physical or psychological outcomes. Research shows that while psychedelic experiences can be intense, qualified professionals effectively manage challenging episodes within therapeutic environments, often facilitating meaningful emotional breakthroughs (Mithoefer et al., 2011; Mitchell, 2023a). This evidence suggests that with appropriate medical oversight, psychedelic interventions may enhance operational effectiveness while maintaining duty readiness.
- **Minimizing substance abuse risk:** There is also the question if the controlled therapeutic use of psychedelics could encourage substance abuse. Interestingly, emerging research reveals an unexpected benefit: participants in psychedelic-assisted therapy frequently report decreased dependence on both illicit substances and prescription medications. Multiple studies demonstrate that individuals receiving PAT, particularly with psilocybin, show reduced alcohol consumption and improved management of various substance use disorders (Bogenschutz et al., 2015b; Johnson et al., 2014). These findings hold particular significance for military personnel facing substance use challenges, suggesting PAT's potential to enhance force retention and psychological preparedness.
- **Minimizing adverse impacts of side effects and profiles:** Psychedelic therapy involving one to three doses offers a targeted and brief intervention with lasting benefits, which contrasts with the daily prescription of psychotropic medications that can result in duty-limiting side effects such as sedation, cognitive impairment, and fatigue. This approach not only reduces the likelihood of these disruptive outcomes but also provides a more focused and manageable therapeutic experience that allows service members to maintain optimal performance and readiness while addressing underlying mental health challenges.

Overall, the rigorous preparation and integration phases of PAT can ensure that military members are equipped to process and grow from potentially challenging experiences. These therapeutic encounters help service members build a stronger foundation for emotional regulation and psychological readiness, ultimately contributing to their effectiveness in military roles.

Anecdotal Evidence from the Field

Beyond controlled clinical studies, substantial field evidence demonstrates veterans' engagement with and response to psychedelic healing approaches. A notable contingent of U.S. Special Operations Forces veterans reports therapeutic benefits from compounds like ibogaine and 5-MeO-DMT in addressing trauma-related psychological and cognitive challenges. These substances have shown promising potential for alleviating symptoms associated with PTSD, depression, and anxiety, as documented in firsthand accounts from individuals who have explored these alternative therapeutic modalities (Davis et al., 2020). Additionally, veterans consistently report favorable outcomes from utilizing psychedelics for psychological healing and spiritual growth across various non-clinical contexts (Davis et al., 2024).

While these experiential accounts suggest increasing receptivity to psychedelic interventions, it remains essential to carefully consider associated risks, particularly in unstructured settings. Current harm reduction frameworks emphasize the importance of comprehensive education for potential participants, including detailed safety protocols. This encompasses understanding possible adverse reactions, medication interactions, and the critical nature of appropriate setting and professional oversight, especially for individuals with existing mental health conditions. Implementation of these harm reduction approaches helps optimize therapeutic potential while mitigating risks.

Provider Requirements and Benefits

Delivering effective psychedelic-assisted therapy requires specialized expertise and thorough understanding of non-ordinary states of consciousness. Clinicians must develop competency in supporting individuals through profound emotional experiences, facilitating therapeutic processing while maintaining safety and containment. This inner-directed therapeutic approach necessitates practitioners to skillfully guide clients in accessing and integrating internal experiences throughout their healing process. Additionally, providers need refined awareness of trauma dynamics, particularly when supporting military personnel and veterans who may present with complex, attachment, and/or developmental trauma histories.

Psychedelic-assisted therapy offers unique professional rewards, providing opportunities to witness transformative healing as clients navigate meaningful insights and resolve enduring emotional challenges. The profound

therapeutic alliance formed through these shared experiences significantly enhances treatment outcomes, contributing to lasting positive changes.

Barriers and Implementation Considerations

The developing field of psychedelic-assisted therapy faces a number of implementation challenges and considerations.

- **Therapist training and trained therapists:** A primary consideration involves securing adequate resources, particularly specialized training for clinicians in managing expanded consciousness states and trauma-related manifestations and a cadre of therapists who are trained to competently provide this specialized type of therapy. Therapist training must also include strategies for helping participants set realistic expectations, emphasizing that PAT may involve emotionally intense experiences that require additional therapeutic support for meaningful integration and sustained personal growth. Training programs must also emphasize interdisciplinary collaboration, equipping teams to navigate the complex interplay of pharmacological interventions and psychotherapeutic processes.
- **Logistical barriers.** The operational requirements of delivering these treatments—including the necessity for dual therapist presence in certain protocols and extended treatment sessions lasting six to eight hours—create significant resource constraints. In addition, appropriate space and controlled settings would need to be identified to support psychedelic therapy dosing sessions, during which the participant is able to lie on a comfortable bed-like surface for a period of six to seven hours.
- **Cultural Resistance and Stigma:** Military institutions understandably express caution regarding psychedelic interventions, often due to historical associations with recreational substance use. Indeed, in 1971, then President Nixon directed the DoD to commence drug urinalysis to identify service members needing rehabilitation for Vietnam associated addiction. Leading up to unit wide urinalysis testing, the stigma of street drugs, drug abuse, and an ethos of "*turning on, tuning in, and dropping out*" posited by counterculture and LSD-promoter, Timothy Leary, precipitated the passage of the Controlled Substance Act of 1970. Addressing these concerns requires robust empirical evidence demonstrating safety and treatment efficacy. Clear distinction must be maintained between clinical applications and recreational use. Extensive data from clinical trials, FDA-sanctioned research, and comprehensive meta-analyses consistently validate the safety and effectiveness of psychedelic-assisted therapy when conducted in controlled therapeutic environments.
- **Integration of social support networks:** The integration of social support networks, particularly family members and peers, remains fundamental in providing comprehensive care for military personnel and veterans throughout their therapeutic journey. Research by Monson (2020) has demonstrated successful outcomes in utilizing MDMA-assisted therapy with veterans and their spouses in dyadic therapeutic settings.

Limited Access to Treatment

Active-duty military personnel currently encounter significant constraints regarding treatment accessibility, with participation restricted to formal clinical research environments. Wolfgang and Hoge (2023) delineate specific legal parameters governing VA and DoD psychedelic-assisted therapy trials. While active-duty service members face present restrictions, research participation remains viable with proper authorizations. The DoD and VA operate within established regulatory frameworks that enable therapeutic trials, supported by federal guidelines and FDA's Expanded Access provisions for MDMA -AT. Military healthcare providers must recognize these interventions' investigational status and their limitation to controlled research settings.

Military patients pursuing psychedelic-assisted therapy face several critical considerations. The resource-intensive nature of these treatments, particularly MDMA-AT requiring up to 80 therapist-hours per patient, demands strategic patient selection and resource allocation. Military providers must carefully evaluate factors including clinical severity, potential treatment outcomes, and implications for duty status or medical separation. As these interventions become available, developing ethical frameworks for treatment prioritization becomes essential. Providers must also maintain awareness of potential non-prescribed psychedelic use when treatment access is limited, while carefully balancing patient care needs with military operational requirements.

Broad Frontier with Many Research Opportunities

Psychedelic-assisted therapy represents an evolving frontier in mental health treatment, encompassing numerous opportunities, research considerations, and unexplored territories. Unintended consequences require management of harm reduction techniques, which may result from even the appropriate and clinical use of psychedelics. While this article provides a comprehensive overview of current research findings and clinical practices, it addresses several crucial aspects deserving deeper examination. These include the complex mechanisms of action, the diverse array of psychedelic compounds under investigation, variations in treatment protocols, opportunities for participation and contribution in clinical trials, and the multifaceted ethical considerations.

Psychedelic-assisted therapy offers a transformative approach to mental health care by using a synergistic combination of a psychedelic drug and good therapy to foster a person's ability to fully engage with and process their

emotions and to understand and correct cognitive distortions. However, it is vital to recognize that these therapies are not a quick fix and are a collaborative process that requires preparation, commitment, and skilled therapeutic support.

Significant work remains in addressing critical questions about optimal PAT implementation, including appropriate psychedelic selection, dosage and administration routes, disorder-specific applications, timing considerations within service members' careers, therapeutic approach selection, provider qualification requirements (e.g., chaplain, nurse, psychologist), and as frequently emphasized, necessary therapist training and experience levels. Within the military context, several implementation questions warrant further investigation, presenting valuable research opportunities. These include examining optimal timing for intervention such as immediately following trauma exposure (e.g., post-combat scenarios), upon return from deployment, or prior to separation from active duty.

For those interested in this field, continued exploration of peer-reviewed clinical trials, study findings, and emerging research remains essential. For those interested in current research initiatives, information on all clinical trials including psychedelic-assisted therapy trials for veterans with PTSD are readily accessible through the ClinicalTrials.gov website. One example is an open-label proof-of-concept psilocybin therapy for veterans with PTSD being conducted by Ohio State University (e.g., Davis, 2023). Another example is a two-week MDMA-assisted Massed Prolonged Exposure protocol for PTSD, currently under investigation at Emory University (U.S. National Library of Medicine, n.d.).

Conclusion

Military service members and veterans face heightened mental health challenges, including PTSD, depression, and anxiety, due to the demanding and high-stress nature of their roles. These conditions not only affect personal well-being but also pose substantial obstacles to mission readiness and operational effectiveness. While traditional therapies such as Trauma-Focused Cognitive Behavioral Therapy (CBT-TF) have shown effectiveness, high dropout rates and limited engagement highlight the need for alternative approaches that can offer additional support with this population.

Psychedelic-assisted therapy (PAT), a field currently under rigorous investigation, presents a potentially promising additional therapeutic approach and option for enhancing military mental health care. By integrating substances like MDMA or psilocybin with psychotherapy in controlled settings, PAT facilitates deep emotional processing and healing. Preliminary studies and anecdotal evidence suggest that these therapies may lead to significant improvements in mental health, especially in alleviating symptoms of PTSD and addressing moral injury—a key concern for military personnel.

The potential benefits of PAT extend beyond symptom relief. Research indicates that psychedelic therapy could enhance fitness for duty, improve cognitive flexibility, and promote overall life satisfaction—factors that contribute to both individual well-being and mission readiness. As military personnel face unique stressors and trauma, integrating PAT into mental health care could lead to more effective and sustainable treatment outcomes.

Moving forward, it is crucial to conduct further research to substantiate the effectiveness and safety of psychedelic-assisted therapy for military service members and veterans. Collaboration between military institutions, mental health professionals, researchers, and policymakers is essential to ensure that these therapies are introduced in a manner that is both safe and aligned with military values. By addressing current barriers to implementation and continuing to investigate PAT's potential, we can build a more comprehensive, holistic approach to mental health care that supports service members in their duties and overall well-being, in support of fullest Force Health Protection possible.

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Mark J. Bates, PhD, a retired U.S. Air Force lieutenant colonel, served as an airlift pilot for nine years and a clinical psychologist for 11 years. His psychology roles included training at the Uniformed Services University of Health Sciences, an internship at Malcolm Grow Medical Center (MGMC) at Andrews AFB, commanding the mental health flight at Hanscom AFB, and directing the clinical psychology residency at MGMC. Post-retirement, he led the Psychological Health Promotion (Resilience and Prevention) mission at the DoD Psychological Health Center of Excellence for over nine years, which was a good fit with his passion for an integrative, wellness and performance focus. Transitioning into psychedelic therapies, Dr. Bates completed the Psychedelic Therapies and Research certificate at the California Institute of Integral Studies (CIIS). He is now as a psychedelic-assisted therapist and researcher at Sunstone Therapies, working on clinical trials involving MDMA, methylone, psilocybin, and 5-MeO for conditions such as depression, treatment-resistant depression, and PTSD as part of an exceptional team committed to continually evolving the quality of care and research for those affected by complex mental

health challenges and disorders. In addition, he has a strong interest in education and training and serves as a consultant mentor for psychedelic therapists.

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Stellate Ganglion Block for Anxiety and Post-traumatic Stress Disorder

James Lynch

Stellate Ganglion Block for Post-traumatic Stress Disorder (PTSD): Calm the body—Calm the mind

The stellate ganglion block (SGB) is a procedure in which an injection of a long-acting local anesthetic, using ultrasound guidance, is made in the side of the neck around the main nerve that controls the "fight or flight" response (the sympathetic nervous system). This nerve, (the cervical sympathetic chain) which is a two-way conduit, connects the parts of the brain that control the fight or flight response (referred to as the central autonomic network) to the rest of the body. By blocking or "turning off" the traffic in the cervical sympathetic chain, it is believed that the parts of the brain that control the fight or flight response are allowed to completely reset, resulting in long-term relief of the associated anxiety symptoms. Multiple peer-reviewed medical studies show that SGB results in significant long-term improvement in chronic anxiety symptoms associated with post-traumatic stress disorder. The SGB takes less than 15 minutes to perform, and benefits are seen in as little as 30 minutes.

The Military Roots of Stellate Ganglion Block's Successes: Born out of US Special Operations

As with many other areas in medicine, military physicians and scientists have paved the way from theory to practice in this area as well. The world's leading SGB experts are former U.S. Army physicians and combat veterans. How, and why, did this come about? Over two decades of continuous combat operations, primarily in Afghanistan and Iraq, our servicemembers and families endured multiple combat deployments with rapid turnaround between deployments in many cases lacking adequate recovery time and resources. For roughly 20% of veterans this resulted in a gradual onset of post-traumatic stress symptoms which presented with a variety of symptoms such as being emotionally cut-off from families and friends, poor sleep, anger, and irritability.

Many combat veterans simply would not ask for help for fear of being pulled off the line. Standard therapies such as daily medications (with associated side effects) or talk therapy with a "stranger" were not desirable options for many. Innovative clinicians sought other options. Stellate ganglion block had anecdotal evidence of providing relief of PTSD symptoms, so it was investigated as a potential novel treatment option for active-duty soldiers and sailors in several units on the East coast. Following early successes, stellate ganglion block was added to augment traditional psychotherapy among some of our nation's most elite warriors—dramatically assisting struggling teammates to remain highly functioning Rangers, Green Berets, and SEALs after a safe and simple shot in the neck. This was between 2010 and 2012. Word spread.

Although it has over 14 years of support in the medical literature, using SGB for PTSD is a relatively new indication for a procedure which has been performed since the 1920s (Lebovits et al., 1990; Lipov et al., 2022; Lynch et al., 2021, 2023; Mulvaney et al., 2014, 2015a, 2015b, 2020, 2021; Rae Olmsted et al., 2020). Due primarily to successful use in the U.S. military, SGB has grown in popularity both inside and outside of military medicine. Recent research has demonstrated stellate ganglion block also to provide clinically significant improvement in anxiety symptoms as well as symptoms of traumatic brain injury (TBI; Mulvaney et al., 2024). The research around SGB in brain health is an evolving area, which has been led primarily by current and former military physicians and therapists.

Treatment for PTSD

Post-traumatic Stress Disorder is a familiar topic to many clinicians who care for veterans, but this innovative PTSD treatment called Stellate Ganglion Block may be new to some. PTSD prevalence for servicemembers who returned from deployments in Iraq and Afghanistan has been estimated to be between 11% to 22%. PTSD is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a serious accident, a terrorist act, combat, or rape or who have been threatened with death, sexual violence or serious injury. For many veterans, PTSD may result from sexual trauma, combat, or a combination of these or other traumatic events such as domestic violence. Symptoms may become apparent years after a traumatic event and may manifest as: irritability, angry outbursts, problems concentrating or sleeping, avoiding activities and situations that may trigger distressing memories and difficulty experiencing positive emotions. Many servicemembers/veterans may not present with classic reexperiencing symptoms such as nightmares or flashbacks.

A comprehensive summary of PTSD treatment may be found elsewhere and is outside the scope of this article. Despite exhaustive research and clinical practice guidelines, there is agreement among many who treat PTSD that many existing therapies are inadequate for a substantial number of their clients or patients. A recent metanalysis recommended that PTSD psychotherapies should be limited to cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), cognitive therapy (CT), and narrative exposure therapy (NET;

Yunitri et al., 2023). High treatment dropout rates have brought into question the effectiveness of trauma-focused PTSD treatments among military populations. Drop out rates average roughly 25% across treatment types (Edwards-Stewart et al., 2021). Medications like SSRIs (e.g., sertraline, paroxetine) have been shown to reduce PTSD symptoms and are most effective when combined with therapy. However, medications alone may have limited long-term benefits and demonstrate dropout rates ranging from 30-50%. This is often due to side effects, perceived ineffectiveness, reluctance to take daily pills, or difficulty in adjusting to long-term medication use (Watts et al., 2013).

Too Good to be True? Evidence Supporting SGB for PTSD

After performing detailed counseling for the procedure, the stellate ganglion block procedure takes less than 15 minutes to perform and is not painful. SGB is not a fad; it has been well studied and validated. Since 1990, there have been over 25 original studies published in the peer-reviewed medical literature documenting SGB's safety and effectiveness in treating PTSD symptoms. Research has shown consistently that SGB can reduce PTSD symptoms by 50% and is particularly helpful in improving symptoms of irritability, surges of anger, difficulty concentrating, and trouble falling or staying asleep. In November 2019, a large multicenter, randomized clinical trial was published in JAMA Psychiatry demonstrating twice the effect of SGB over a placebo procedure. This study was conducted at three military hospitals—Womack Army Medical Center at Fort Bragg/Liberty, NC; Tripler Army Medical Center in Hawaii; and Landstuhl Regional Medical Center in Germany.

What do Therapists Say?

In a study conducted by Lynch et al in 2021, SGB was rated at least as useful as the most valuable interventions listed in the American Psychological Association Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. 100% of respondents characterizing SGB as 'Very Beneficial' or 'Somewhat Beneficial', and 0 respondents characterizing SGB as 'Not Helpful' or 'Harmful'. Of surveyed behavioral health clinicians with personal experience incorporating SGB into their trauma-focused psychotherapy, 95% of respondents would recommend SGB to a colleague as a useful tool for the treatment of trauma-related disorders. Given the findings from this study, it was recommended that behavioral health providers should consider using SGB in conjunction with standard trauma-focused care (Lynch et al., 2021).

Conclusion: SGB works

Advances in neurobiological models of PTSD have allowed us to deploy more effective treatments for addressing PTSD (Lynch, 2020). New insights about the role of the cervical sympathetic chain now allow us to directly address some of the most debilitating symptoms experienced in post-traumatic stress. By administering an ultrasound-guided injection of local anesthetic, a successful stellate ganglion block procedure precisely targets elevated sympathetic tone and resets the body's sympathetic response system. SGB is an invaluable adjunct to trauma-focused therapy with a success rate of approximately 80%. The effects of a successful block are immediate and can last from six months to many years when paired with effective psychological interventions. Stellate ganglion blocks helps calm the body and calm the mind, thereby allowing those suffering from the effects of trauma to more effectively participate in their therapy.

About the Author: James H. Lynch, MD

A veteran of 31 years of service, Dr. Jim Lynch is board certified in Family Medicine and Sports Medicine and has extensive experience treating those suffering from the effects of trauma. A retired colonel and veteran of combat deployments to Panama, the First Gulf War, Iraq, Afghanistan, Syria, and several locations in Africa, Dr. Lynch has been a pioneer in the world of PTSD treatment using stellate ganglion block. He has published multiple articles in the medical literature on SGB, presented his research in international forums in Germany, the Netherlands, Australia, and Portugal, and has served as a staunch advocate for improving PTSD treatment options. Dr. Lynch provides expert SGB treatment at his clinic in Gambrills, Maryland.

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Full text articles of supporting literature are available at: https://drjameslynch.com/evidence/

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The Effectiveness of an EMDR Group Traumatic Episode Protocol in an Intensive Outpatient Dual Diagnosis Program

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According to the joint DoD-VA (2023) Clinical Practice Guidelines, Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure (PE) are the top recommended individual and manualized trauma-focused psychotherapies for the treatment of posttraumatic stress disorder (PTSD). EMDR is an eight-phase trauma treatment protocol focusing on a traumatic memory while simultaneously experiencing bilateral stimulation. Bilateral stimulation is associated with a reduction in the vividness of a traumatic memory, an ability to link fragments of a memory together, and put the memory away in an autobiographical format. This can consequently reduce a client's PTSD symptoms significantly and help people recover from trauma (Maxfield, 2019).

Group Traumatic Episode Protocol (G-TEP) was developed by psychologist Elan Shapiro after a need was identified to work with groups impacted by negative life-changing traumatic events. There is growing evidence that G-TEP is effective in reducing PTSD symptoms and other mental health disorders. There have been several studies using G-TEP with refugees, civilians, and health care workers. In addition, there have been two randomized control trials of G-TEP, one with EMDR treatment of COVID -related stress (Farrell et al, 2023) and another with internally displaced adults in Northern Iraq (Bizouerne et all, 2023). G-TEP has not been utilized as a treatment modality for any U.S. active-duty military population, nor has it been combined with individual EMDR treatment. At Madigan Army Medical Center at Joint Base Lewis-McChord, the first two authors integrated both a specific group EMDR protocol (G-TEP) and individual EMDR into an Intensive Outpatient Treatment Program (IOP) for six weeks with a dually diagnosed (PTSD and Alcohol Use Disorder) population of active-duty service members.

Method

The participants were referred by their primary behavioral health providers for treatment for ongoing PTSD symptoms and alcohol cravings. Participants were screened by the G-TEP-IOP providers for suitability to the group. All participants were required to have a minimum of 30 days of sobriety, no active suicidal ideation, and the ability to attend six consecutive weeks of treatment. All five service members (4 men; 1 woman) participated in the pre-, mid-, and post- evaluations. All participants (n = 5) processed multiple traumatic events during the duration of treatment. All service members met the diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, text revision (American Psychiatric Association, 2022) for PTSD and Alcohol Use Disorder. Participants engaged in GTEP three times per week and individual EMDR therapy twice per week during the IOP. Active-duty service members included in this report were stationed at Joint Base Lewis McChord, Washington at the time of treatment.

In addition to the co-facilitators of this G-TEP-IOP, other staff included an addictions social worker, a psychologist, two yoga instructors, a recreation therapist, and a MSW practicum student. Group therapy was Monday through Friday from 0930-1230 and each service member had individual EMDR in the afternoons twice a week. The current pilot project was approved by the Department of Clinical Investigations at Madigan Army Medical Center as an Evidence-Based Project.

Group Sessions and Topics

G-TEP. G-TEP was held three times per week for 1.5 hours per session. These group sessions were focused on reprocessing a memory of an adverse life event or major trauma. During the first week of the IOP, GTEP groups were spent outlining IOP, information about EMDR compared to other evidence-based trauma treatments, and resource building using Group Resource Enhance Protocol.

Trauma and the Brain. These groups were held once per week for the first three weeks for 1 hour per session. These sessions were psychoeducation based and included information on PTSD, how traumatic memories are stored in the brain when unprocessed and when processed, ways to recognize triggers, and insight into the window of tolerance and participants' PTSD symptoms.

Addiction. These groups were held once per week for 1.5 hours per session for six weeks. These sessions were a blend of psychoeducation and processing groups to include topics such as substance use and the impact on your brain and body, triggers and cravings, the stages of change, values, and relapse prevention.

Interpersonal Skills. These groups were held once per week for 1.5 hours per session for six weeks. These sessions were psychoeducation based, and included insight into the benefits of vulnerability, communication styles and skills, attachment styles, and emotions.

Leisure and Recovery. These groups were 2.5 hours per session, for four sessions, during the six-week program. These groups were led by the recreation therapist,

and the program used was *12 Steps to Sober Leisure* by Abagail Bernard. The protocol uses a distinct emphasis on a person's leisure in recovery and incorporates elements of the Twelve Steps of Alcoholics Anonymous (Bernard, 2018).

Mindfulness. These groups were once per week for 1 hour per session for six weeks. These sessions were psychoeducation based and included information on mindfulness practices, and coping and grounding skills. All individuals participated in mindfulness exercises and were encouraged to use them outside of the group.

Expressive Therapy Group. This group met twice during the program for 2 hours per session. The activities included the "The Newspaper," and "The Mask." The newspaper activity had group participants write or draw three news articles about themselves. They highlighted their personal accomplishments in life and shared with the group. During the mask activity, participants wrote down their inner fears and then decorated a mask on how they presented to themselves to the world and shared with the group (Maltz et al., 2020).

Yoga. These sessions were once per week for 1 hour per session for five weeks. These sessions were led by certified yoga instructors to assist clients through different movements to facilitate awareness of the body and release built up emotions, stress, and tension.

Participants

Data was collected using the (PCL-5), Generalized Anxiety Disorder (GAD-7), (PHQ-9), (ISI), and the (PACS) at pre-, mid-, and post- treatment through a single study, quasi-experimental design.

Measures

Patients completed the following self-report measures during the course of clinical treatment:

PTSD Checklist (PCL-5). The PCL-5 is a 20-item self-report questionnaire, corresponding to DSM-5 symptom criteria for PTSD. It has shown to be valid and reliable in quantifying PTSD symptom severity (Blevins et al, 2015).

Generalized Anxiety Disorder (GAD-7). The GAD-7 is a 7-item self-report anxiety questionnaire that has been proven to be reliable and valid in primary care with the general population (Löwe et al., 2008). The GAD-7 was developed in 2006 to assess different aspects of anxiety related symptoms.

Patient Health Questionnaire (PHQ-9). The PHQ-9 is a 9-item self-report depressive symptom scale that was originally introduced in 2001 to screen adult patients in the general population. The PHQ-9 is a reliable and valid measure of depression severity (Kroenke et al., 2001).

Insomnia Severity Index (ISI). The ISI is a 7-item measure that assesses the subjective quality of sleep, the severity of symptoms, and the satisfaction with their sleep patterns. It is used as a brief screening tool for insomnia and was proven to be a reliable and valid instrument to detect insomnia in the general population (Morin et al. 2011).

Penn Alcohol Craving Scale (PACS). The PACS is a 5-item self-report scale to measure alcohol cravings and risk for relapse. The survey focuses on frequency, intensity and duration of thoughts about drinking. The PACS is a valid and reliable measure to assess for alcohol cravings (Flannery et al., 1999).

Results

Outcome measures at baseline and at follow-ups are presented in Table 1, Table 2, and Figure 1. There were significant and substantial reductions of both PTSD symptoms and alcohol cravings at the post-treatment evaluations compared to the baseline. The PCL 5 decreased from M = 48 (SD = 9.1) to M = 33 (SD = 13.2), t (4) = 4.8, p= .009. The PACS decreased from M = 13.6 (SD = 6.3) to M = 4 (SD = 4.2), t (4) = 4.9, p = .008. After six weeks of GTEP and individual treatment, PCL-5 and PACS scores reduced significantly in all five participants, with minimal to no changes among the GAD-7, PHQ-9 and ISI. Reductions of PTSD symptoms and alcohol cravings were associated with an overall improvement of a sense of wellbeing, ability to communicate more effectively with their partner, decreased alcohol cravings, decreased intrusive symptoms, and no longer feeling alone.

Table 1

Participant reported decreases in PTSD symptoms during GTEP

Case	Age	PCL-5 Baseline	PCL-5 Midpoint	PCL-5 Post	PCL-5 1-month Follow-up
1	39	49	40	38	28
2	26	62	48	48	17
3	22	39	18	12	0
4	43	49	53	35	38
5	31	41	47	32	39
Mean (SD)		48 (9.1)	41.2 (13.8)	33 (13.2)	24.4 (16.2)

Table 2

Participant reported decreases in alcohol cravings during GTEP

Case	Age	PACS Baseline	PACS Midpoint	PACS Post	PACS 1-month Follow-up
1	39	18	14	10	10
2	26	4	0	0	0
3	22	20	6	4	5
4	43	11	5	0	7
5	31	15	24	6	-
Mean (SD)		13.6 (6.3)	9.8 (9.4)	4.0 (4.2)	5.5 (4.2)

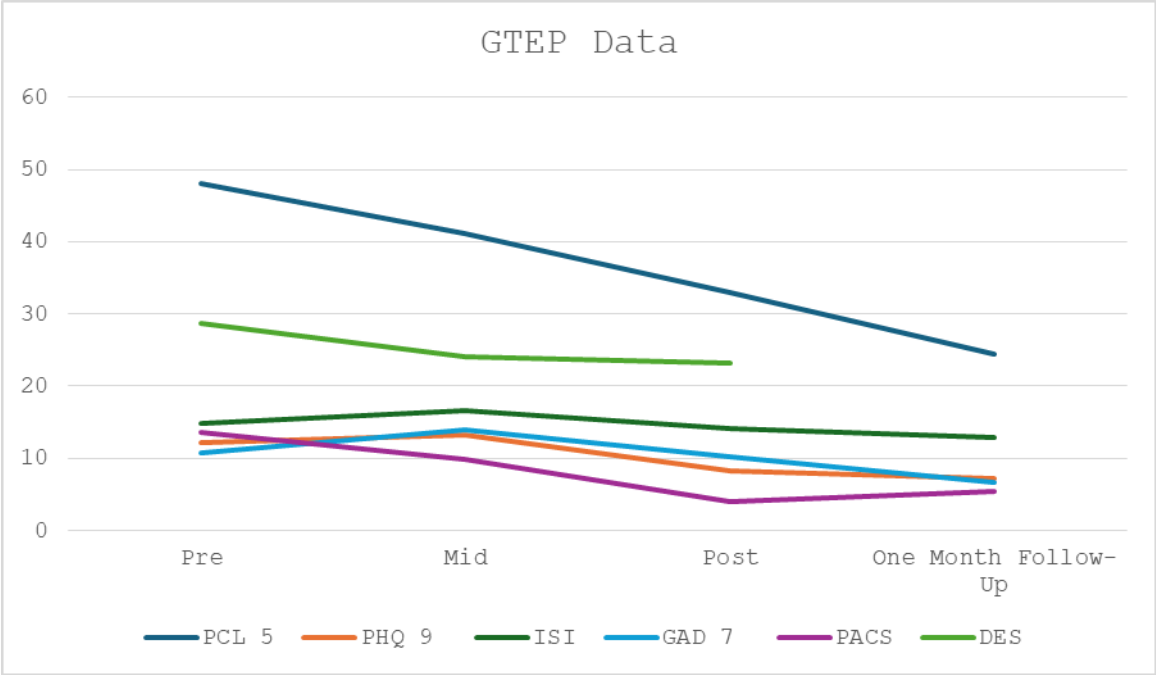

Figure 1. *Outcome measures over the course of the G-TEP treatment protocol*

Case Results of Two of the Participants

Case 1 - A 39-year-old combat engineer sought help for his intrusive memories and nightmares from his two deployments to Iraq and operational deployments to various locations. He was referred by his primary behavioral health therapist. After 19 years in the Army, he was struggling with the severity of his posttraumatic stress symptoms and suffering from the moral injury of war. One year prior to this program, he was suicidal with intent and was admitted to inpatient psychiatry. He had previously shown little progress in treatment. During G-TEP and individual EMDR, he reprocessed adverse life events from his teenage years, his father's death, and several memories of from deployment including explosions, the deaths of two battle buddies, witnessing others severely injured in vehicle accidents, and other traumatic aspect of war. As an example of one day of IOP in the six weeks of the program, he was able to reprocess a death from his first Iraq deployment during G-TEP, and in individual EMDR, he reprocessed a different deployment trauma. Over the duration of this 6-week IOP, his PTSD symptoms reduced on the PCL-5 from 49 to 38. At the one-month follow-up, the PTSD symptoms on the PCL-5 further reduced to 28.

Case 3 – A 22-year-old first generation Mexican male mechanic, sought help for nightmares of his best friend's suicide, the murder of a close friend, and the death of another friend from a drive by shooting - all occurring prior to his enlistment in the military. The memories of these deaths were causing him nightmares and other intrusive PTSD symptoms. This was interrupting his ability to work in his unit and causing dysfunction in his day-to-day life. He had only been enlisted in the Army for two years prior to this behavioral health IOP. During G-TEP and individual EMDR, he was able to reprocess memories of an adverse life event from childhood, a racial trauma, the suicide of his best friend, and the deaths of two other friends. Over the duration of this IOP, his PTSD symptoms reduced on the PCL-5 from 39 to 12 during the six weeks of

treatment. At the one-month follow-up, the PTSD symptoms on the PCL-5 further reduced to 0. At the end of treatment, he was able to return to his unit full time and discontinued behavioral health services since he felt he no longer needed services.

Discussion

This is the first report of both G-TEP and individual EMDR treatment utilized in an IOP setting for trauma and substance use with an active-duty military population. Based on the data and self-report by the participants, it enabled each participant to completely process multiple memories of traumatic events over the course of a few weeks. The ability to process multiple traumatic memories in both group and individual sessions resulted in a reduction of both PTSD related symptoms and alcohol cravings.

This evidence-based practice pilot project was limited by the small number of participants, difficulty obtaining participants, limited ability to probe answers when an increase in scores were reported, and potential risks of survey bias due to secondary gain. Despite these limitations, the positive results suggest that G-TEP can be used successfully to treat PTSD symptoms and alcohol cravings in an intensive outpatient program in military personnel. For future studies, we recommend a larger sample size, utilization of the moral injury scale, and a comparison study to examine the efficacy of EMDR therapy across protocols. Future trials should also assess how being in a group setting may influence the outcome of treatment and the benefits of using qualitative techniques to better understand the overall personal impact of G-TEP.

It is recommended that this group be replicated utilizing G-TEP and individual EMDR therapy in other intensive outpatient programs in combination with coping skills groups. Additionally, implementation may also be considered in an outpatient behavioral health clinic utilizing GTEP and individual EMDR once a week for service members who have sufficient coping skills. Finally, it is possible that if G-TEP and individual EMDR are utilized with service members with PTSD and no substance use disorder, it may be even more successful.

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the U.S. Government, the Department of Defense, the Department of the Army, or the Defense Health Agency. Correspondence concerning this article should be directed to Danielle Parker (danielle.n.parker16.mil@health.mil) or Camille Zeiter (camille.m.zeiter.civ@health.mil)

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The Stigma of Seeking Mental Healthcare Among Servicemembers: A Scoping Review and Gap Analysis with Implications for Future Research

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Summary

This project is a scoping review of the research on the stigma of accessing mental healthcare among United States (U.S.) active duty servicemembers (ADSMs) that identifies knowledge gaps and proposes future research. Under the mentorship of clinical and research psychologists, this scoping review was conducted from a nurse scientist lens, demonstrating the value of a multidisciplinary, systems approach to studying stigma and other barriers to mental healthcare.

Background

Barriers to mental healthcare, like stigma, are pervasive in the military and may prevent servicemembers from pursuing the services they need. Despite recent initiatives, such as anti-stigma campaigns (Military Health System, 2025), telehealth expansion (Madsen et al., 2023), and the integration of behavioral health providers into primary clinics (Military Health System, 2023) and military units (Galloway & Martinez, 2024; Martinez et al., 2023), utilization rates among servicemembers are relatively low (Hom et al., 2017; Meadows et al., 2021; Nugent et al., 2020). Research indicates that 23–40% of soldiers who screened positive for a mental health disorder sought care, with many reporting stigma as a significant factor (Hoge et al., 2004; Kehle et al., 2010; Warner et al., 2011). However, challenges persist even when servicemembers do access mental health treatment. Millennials receiving care within the Military Health System are less likely than older generations to rate their mental health as "good" and report higher dissatisfaction with mental healthcare (Baker et al., 2020). Only half of the respondents reported experiencing no issues while accessing services, indicating that barriers, like stigma, may hinder healthcare engagement for the other half (Baker et al., 2020).

Stigma—structural, public, and self-stigma—contributes to servicemembers' level of engagement with formal mental healthcare. Structural stigma refers to policies and practices that create or reinforce barriers (Campbell et al., 2023; Hemeida et al., 2022). Public stigma is the negative perceptions or discrimination from others, while self-stigma involves internalized beliefs of weakness associated with mental health care (Acosta et al., 2018; Goffman, 1963; Skopp et al., 2012; Zinzow et al., 2013). The military emphasizes resilience, stoicism, and strength, which may exacerbate stigma, creating an environment where getting counseling or utilizing other formal resources is perceived as contradictory to military values (Acosta et al., 2018; Foster et al., 2021; Schiffer & Saucier, 2023; Zinzow et al., 2013).

While shared experiences exist across the military, servicemembers in each component encounter stigma differently due to variations in organizational structures and institutional norms. These differences influence perceptions of mental healthcare. Recognizing the need to consider these nuances, this scoping review focused exclusively on ADSMs. Future reviews could examine stigma among guard and reserve members to understand the challenges inherent to other components. The primary aim of this review was to examine the stigma surrounding mental healthcare as experienced by U.S. ADSMs, identify gaps in the literature, and compile recommendations for future research.

Method

The scoping review focused on stigma, recognizing it as a singular construct separate from other barrier subtypes (Adler et al., 2015; Britt et al., 2008; Hernandez et al., 2014; Nugent et al., 2020; Skopp et al., 2012; Vidales et al., 2021). Thus, the search strategy was developed with a medical librarian to ensure comprehensive identification of relevant stigma literature (see Table 1). The initial search was conducted on October 13, 2023, and the final search was on January 2, 2025. A total of 920 studies were identified (see Figure 1), and Covidence, a review management tool, was used for the screening and full-text review (Covidence, 2024). After duplicates were removed and studies were systematically screened, 80 articles met the inclusion criteria, and the data were manually extracted.

Eligibility Criteria

The scoping review included articles conducted within the U.S. that focused on ADSMs and examined the stigma surrounding mental healthcare. Exclusion criteria included studies outside the United States, those involving piloted interventions, and research targeting non-active-duty populations.

Table 1

Keywords and Subject Headings

Database	Keywords and Subject Headings	Initial Results
PsycINFO	(DE "Mental Health Stigma" OR mental-health-stigma* OR ((MM "Mental Health" OR MM "Mental Disorders" OR MM "Anxiety Disorders" OR MM "Stress and Trauma-Related Disorders" OR depression OR anxiety OR ptsd OR post-traumatic-stress-disorder* OR posttraumatic-stress-disorder OR mental-health) AND (MM "Stigma" OR stigma*))) AND (DE "Military Personnel" OR DE "Air Force Personnel" OR DE "Army Personnel" OR DE "Coast Guard Personnel" OR DE "Commissioned Officers" OR DE "Enlisted Military Personnel" OR DE "Marine Personnel" OR DE "National Guard Personnel" OR DE "Navy Personnel" OR TI (military OR active-duty OR airmen OR army OR air-force OR navy OR marines OR marine-corp* OR coast-guard OR sailor* OR soldier* OR space-force OR personnel-reliability-program OR security-clearance OR service-member* OR service-member*)) Limiters - Published Date: 20000101-; English Language; Peer Reviewed	389
PubMed	(mental-health-stigma*[tiab] OR ((“Mental-Health”[majr] OR “Mental Disorders”[majr] OR depression[tiab] OR anxiety[tiab] OR ptsd[tiab] OR post-traumatic-stress-disorder*[tiab] OR post-traumatic-stress-disorder[tiab] OR mental-health[tiab]) AND (“Social Stigma”[mh] OR stigma*[tiab]))) AND (“Military Personnel”[majr] OR military[ti] OR active-duty[ti] OR airmen[ti] OR army[ti] OR air-force[ti] OR navy[ti] OR marines[ti] OR marine-corp*[ti] OR coast-guard[ti] OR sailor*[ti] OR soldier*[ti] OR space-force[ti] OR personnel-reliability-program[ti] OR security-clearance[ti] OR service-member*[ti] OR service-member*[ti]) AND english[lang] AND (2000:3000/12/12[pdat])	317
CINAHL	(mental-health-stigma* OR ((MM “Mental Health” OR MM “Mental Disorders+” OR depression OR anxiety OR ptsd OR post-traumatic-stress-disorder* OR posttraumatic-stress-disorder OR mental-health) AND (MM “Stigma” OR stigma*))) AND (MM “Military Personnel+” OR TI (military OR active-duty OR airmen OR army OR air-force OR navy OR marines OR marine-corp* OR coast-guard OR sailor* OR soldier* OR space-force OR personnel-reliability-program OR security-clearance OR service-member* OR service-member*)) Limiters - Published Date: 20000101-; English Language; Peer Reviewed	214

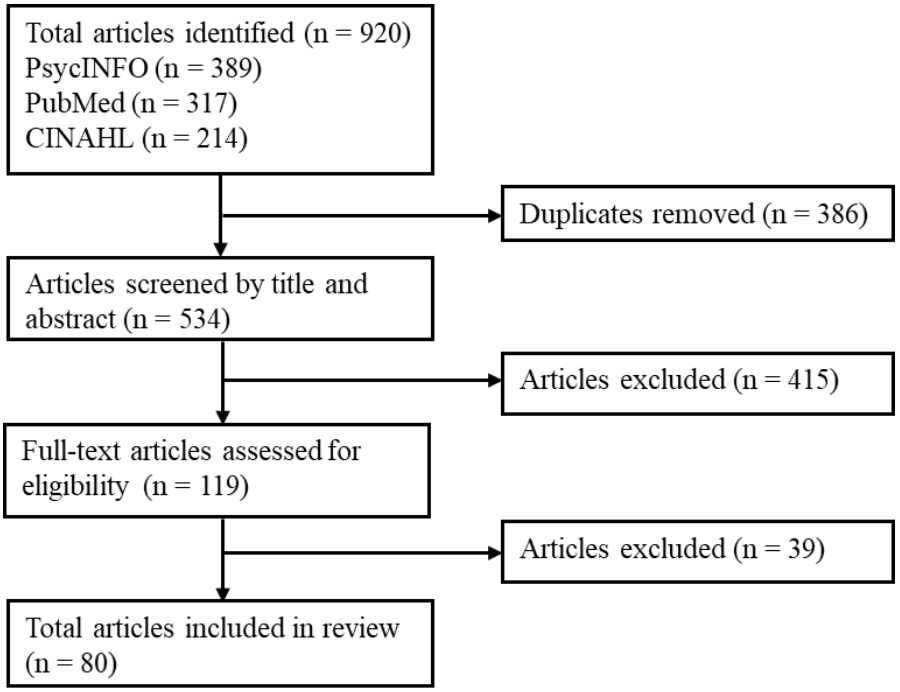

Figure 1. *Search, Screening, and Selection Strategy Flow Diagram*

Findings Summary of Literature Gaps and Recommendations for Future Research

The results of this review indicate that stigma remains a significant barrier to mental healthcare among U.S. ADSMs, with evidence suggesting that structural, public, and self-stigma deter engagement with mental health services (Ben-Zeev et al., 2012; Blais et al., 2014; Britt et al., 2015; Brown & Bruce, 2016; Skopp et al., 2021; Yamawaki et al., 2016; Zumwalde et al., 2023). The literature has primarily focused on ADSMs returning from combat deployments in regions like the Middle East; the evolving landscape of military conflict introduces new challenges. As the U.S. Department of Defense shifts its strategic priorities to address global conflicts involving near-peer adversaries, space warfare, and cyberspace operations, the cognitive and psychological pressures on servicemembers may intensify. Expanded information operations may intensify the mental and emotional strain on ADSMs, especially those in military intelligence (Cohen et al., 2020; LeMay Center for Doctrine, 2022).

The confidence afforded to ADSMs is high, triggering strain among them, who may repress emotions to avoid impacting their job performance (Van Dillen et al., 2022). Previous research has demonstrated that employees working in high-stress jobs are at an elevated risk of developing mental health problems (Britt et al., 2016). Also, ADSMs are more likely than the general population to experience severe psychological distress, which could be further exacerbated by additional stressors from impending conflicts (Center for Behavioral Health Statistics and Quality, 2018; Meadows et al., 2021).

This scoping review revealed that the stigma surrounding mental healthcare in military contexts has unique implications due to the emphasis on operational readiness. While stigma is a pervasive barrier in many settings, the military presents distinct challenges where structural stigma can intersect with self-stigma and public stigma in unique ways. The need for strategic interventions to address these stigma-related barriers is critical, particularly for those in high-stress roles such as intelligence, where the repercussions of mental health challenges may be perceived as career-threatening. These findings underscore the urgency for tailored approaches to reduce stigma, foster a supportive environment, and improve access to mental healthcare as the military navigates an evolving operational environment.

In addition, current research has yet to fully explore how military service-related factors influence the prevalence, mechanisms, and subgroup patterns of stigma, leaving a critical gap in the literature. Future studies should seek to quantify the prevalence of stigma and other barriers to mental healthcare about military service-related factors such as security clearances, occupational roles, and other structural factors. By addressing these gaps, researchers can provide the military with actionable insights to design targeted interventions, ultimately enhancing servicemembers' mental health and readiness.

Discussion and Conclusion

This scoping review highlights the continued role of stigma as a barrier to mental healthcare among U.S. ADSMs. Synthesizing existing literature highlights critical gaps in understanding the prevalence and mechanisms of stigma across the military, emphasizing the need for interventions tailored to unique structural dynamics and organizational differences. Structural stigma creates systemic barriers that can discourage ADSMs from seeking care. For example, policies can perpetuate stigma that contributes to a perception that accessing mental health services is professionally risky. In response to such challenges, initiatives like the Brandon Act have sought to improve access to care by addressing systemic barriers. However, its impact on reducing stigma and improving care availability remains underexamined.

Moreover, while stigma is a significant barrier, it becomes insurmountable when compounded by systemic issues like limited appointment availability and long wait times. Addressing stigma in the military will require a dual approach: implementing changes to reduce structural barriers while also developing interventions to mitigate stigma. The findings of this review emphasize the importance of reducing stigma through targeted strategies considering the military's operational and cultural contexts. As the U.S. Department of Defense adapts to evolving global conflicts, addressing mental health stigma and ensuring accessible, timely care are paramount to maintaining mission readiness among servicemembers.

Future research could prioritize quantifying stigma and other barriers to care while exploring how military service-related factors influence these dynamics. By filling these gaps, researchers can provide actionable insights to foster a supportive culture and reduce stigma, ultimately supporting mental healthcare for ADSMs. This review is a foundation for future studies that aim to advance the understanding of mental healthcare barriers in the military.

Author Note

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Psychotherapeutic Considerations in Facilitating Treatment Efficacy in Female Veterans and Active Duty Service Members

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The number of women serving in the U.S. military is rapidly growing and their available occupational roles are ever expanding. Following the end of the draft in 1973, it is reported that women comprised only 8% of the officer corps and 2% of enlisted forces. In 2018, the officer corps was comprised of 19% women and the enlisted component was comprised of 16% women. In 2013, Secretary of Defense Leon Panetta ordered all branches of the military to open combat roles to women no later than 2016. As roles have evolved, women are exposed to a greater variety of experiences in the military, including traumatic events. Coupled with the increasing number of women serving, the psychotherapy community should anticipate greater mental health care needs and utilization by women service members and veterans over time.

In the active duty and veteran sectors, women's needs are varied across the life span and include unique roles in both personal and professional spheres. This paper was written to address some of these unique needs and experiences and includes information related to 1) demographic characteristics and health care needs, 2) accessing mental health care, 3) treatment considerations, 4) the utility of single-gender therapy options, 5) building resilience, 6) offering holistic care, 7) intersectionality, and 8) training providers.

Demographics of Women Service Members/ Veterans and Their Health Care Needs

Female service members/veterans differ from their male counterparts in meaningful ways. Some studies of mental health help-seeking and assessment of mental health needs have observed that, when compared to men, women are more likely to be single, younger, report lower combat exposure, have completed more education, and have a history of greater use of mental health services, but are higher risk for PTSD, suicide, and depression (e.g., Adams et al., 2021). Studies circumscribed to Department of Veterans Affairs (VA) healthcare users suggest that women are likely to be older than their male counterparts (Maguen et al., 2010). Such findings suggest that the healthcare setting in which women are seen may be related to key demographic characteristics that should be considered when providing care.

Even within sex, female service members/veterans are diverse in their identities. As of 2015, 42% of female veterans using VA identified as a racial/ethnic minority, with the most common minority identity being Black (30%; Frayne et al., 2018). Sixteen percent of women service members identified as a gender or sexual minority (Meadows et al., 2018), and 43% are 18-44 years old, 46% are 45-64 years old, and 12% are 65 years old and older (VA, 2018). Older women veterans are more likely to access VA care relative to women veterans who served in military operations in Iraq and Afghanistan (Bielawski et al., 2014; Washington, 2011). As we strive to improve the care we offer female service members/veterans, it is vital that we understand our patients' intersecting identities. It is further imperative that we take responsibility for learning about minority stress (Meyer, 1995) and come to understand and engage with the process of cultural humility (Tervalon & Murray-Garcia, 1998).

Females are at increased risk for mental health concerns relative to their male military and civilian counterparts. Recent surveillance data show that women are twice as likely to die by suicide relative to their civilian counterparts. They are also nearly twice as likely as their male military counterparts to be diagnosed with a mental health concern, such as posttraumatic stress disorder (PTSD; e.g., Adams et al., 2021; Lehavot et al., 2018), adjustment disorder related to their military experience, and depression (Maguen et al., 2010). There are many factors that could account for these gender differences. For example, women are more likely to report exposure to military sexual trauma (Blais et al., 2022; Kimerling et al., 2007; Morral et al., 2015) and are more likely to seek treatment (Gaffey et al., 2021), resulting in a higher likelihood of being diagnosed with a mental health disorder.

Indeed, these demographic factors could impact the manner in which women initiate and progress in mental health care. For example, it is possible that identifying as single may be a component of more limited social support or social connectedness, and indeed, female veterans are

known to have smaller social networks than men veterans or civilians of either gender (Campbell et al., 2021). Alternatively, being single could mean the absence of relationships that create distress or tension secondary to the low satisfaction or quality, and distress and tension are associated with higher suicide risk (Blais & Geiser, 2019; Blais, 2020a, b). Similarly, being single may suggest a lack of dependents (e.g., children, aging parents), but could also mean greater responsibilities associated with single parenting. Notably, women who are actively serving whilst being single parents may have very few childcare options or supports available to them, particularly as they navigate permanent changes of duty station. In a recent focus group of pregnant service members who already had at least one child while in the military, several women reported that as they attended to the regular care needs of their children (e.g., staying home to provide care when the child was too ill to go to school), they often felt as though they had to choose their career or their child, a feeling that was reinforced by their immediate command who would council them out of the military when they could not easily fulfill both roles (Blais, personal communication, September 22, 2022).

Moreover, women may experience discrimination that exacerbates psychological and social stressors both during and after military service. Research shows that nearly one-third of women experience gender bias during their service and have difficulty connecting with their female counterparts (Thomas et al., 2018). For example, female service members frequently report that they are held to different fitness and readiness standards by their peers and immediate command, and failure to meet those requirements can lead to being ostracized. Females who are postpartum are expected to meet fitness standards six months after delivery, regardless of complications during pregnancy or delivery (US Army Public Health Center, 2019). Excelling in those standards can also lead to feeling ostracized as members of their unit perceive them to be threats (Blais, personal communication, September 22, 2022). Women further report verbal interpersonal violence perpetrated by fellow female service members. Such violence is hypothesized to be the result of masculine socialization over time or women leaders holding women subordinates to different standards than male subordinates (Blais, personal communication, September 22, 2022). For those actively serving, both these explicit biases as well as more subtle microaggressions should be discussed to understand their impact. And for those that have separated, such factors should be explored as possible barriers to connecting with others after military service.

Accessing Mental Health Care

Notable barriers to accessing mental health care have been identified and include logistics, access, and stigma (Lehavot et al., 2013; Vogt et al., 2006). Optimistically, more recent data suggests that wait times may be decreasing as many women reported timely appointments and overall high satisfaction with care received (Brunner et al., 2019). That said, the COVID-19 pandemic introduced access challenges for both men and women, which may have impacted these gains. However, there was a rapid increase in the use of tele-mental health (Connolly et al., 2021), which might have mitigated these challenges. For those not able to access care quickly, delays may create opportunities for decreased motivation for change and increased utilization of unhealthy coping, such as binge drinking, social isolation, and maintaining unhealthy relationships. These factors can result in greater psychological distress and dysfunction over time, potentially resulting in more complex needs once care is initiated.

Treatment Considerations

Military culture largely discourages expression of emotions and encourages aggression, independence, and decisiveness, traits that are typically associated with masculinity (Ashley et al., 2017). In contrast, traits associated with femininity (e.g., kindness, emotionally expressiveness), are often deemed undesirable or unhelpful. Derogatory language is often used to sexualize and harass women service members and veterans. Hearing this language has been associated with women leaving the military earlier than anticipated (Dichter & True, 2015). Further, women have reported that if they socially engage with male service members, they may be called "easy," whereas if they decline sexual advances, they are seen as "playing hard to get" or "a challenge" (Blais, personal communication, September 22, 2022). Internalized misogyny can develop when females spend time in an environment that devalues women and, therefore, they may choose to avoid VA care due to feeling unworthy of receiving care (Mattocks et al., 2012) or not wishing to revisit this culture. Despite intervention, females reported stable perceptions of gender and sexual harassment when utilizing VA services, with the most frequent perpetrator identified as male veterans (Fenwick et al., 2021). Moreover, the authors of this paper have heard female veterans express that it is difficult for them to see themselves as a "veteran" and worthy of services because of their gender. A sense of inclusion, cohesion and social support are borne out in the literature as important contributors to emotional well-being (Costa & Kahn, 2010), but females may miss out on these experiences, due, in part, to the hypermasculine expectations of behavior and de-valuing of women in the military.

While a number of efficacious treatments are available to treat women service members and veterans, it is important to note that the clinical trials for the primary treatments offered to address individual psychological concerns, such as PTSD or depression (Eftekhari, 2013; Kaysen et al., 2014) or interpersonal issues, such as low relationship satisfaction in the context of a PTSD diagnosis (see review, Kugler et al., 2019), have largely been tested with a male service member/veteran as the identified military patient. Importantly, studies show that women reported greater reductions in PTSD in prolonged exposure and cognitive processing therapy (Khan et al., 2020), highlighting the importance of additional studies in women. Notwithstanding, the preponderance of testing in male samples makes it unclear whether these interventions are

optimally designed for women who may be navigating unique roles, index traumas, and symptoms. While cognitive processing therapy was initially developed to treat women survivors of sexual assault, the majority of studies in military samples include men (e.g., Kaysen 2014). Clinicians should consider that alterations in treatment could be needed to address unique cultural concerns, exposures, or expressions of distress. For example, Blais (2020a) observed that women's reports of low romantic relationship satisfaction were associated with higher self-reported anhedonia (e.g., loss of interest, social detachment) and dysphoric arousal (e.g., anger, irritability, sleep disruption), but men's reports of low romantic relationship was associated with higher anhedonia only (see also, Renshaw et al., 2014). Such results suggest that when addressing low relationship satisfaction in women, therapies may be most effective if they addressed *both* anhedonia and dysphoric arousal clusters whereas these treatments in men may achieve the same or similar gains by addressing anhedonia only. Moreover, among survivors of military sexual assault, a mechanism of women's relationship dissatisfaction was difficulties with the sexual response cycle (e.g., low arousal, lubrication) and their subjective happiness with sexual activity, but in men, it was engagement in compulsive sexual behavior that was associated with lower relationship satisfaction (Blais, 2021b). Relatedly, women were more likely to report more exposures to sexual violence across the life cycle relative to men, including before they joined the military and after (Blais et al., 2022), and reported different posttraumatic responses to these exposures, particularly as the number of exposures increased (Tannahill et al., 2021). These studies suggest unique, gender-informed points of intervention.

When offering treatment to address posttraumatic stress and dysfunction, it will be critical to understand the sources of trauma that create the greatest distress. A recent review suggested that up to 40% of women report exposure to military sexual harassment and assault (Wilson, 2018). However, there is evidence of barriers to reporting (Andresen & Blais, 2018; Blais et al., 2018), suggesting the review's estimate is likely low. Emerging evidence suggests that exposure to sexual violence during military service creates unique and perhaps heightened challenges for women. For example, when exposure to sexual violence was compared to other military trauma exposures among women, such as combat, military sexual violence exposure was associated with higher sexual dysfunction and lower sexual satisfaction (Blais et al., 2020; Pulverman et al, 2021) as well as increased risk for suicide (Blais and Monteith, 2019). Indeed, while some studies show that VA-enrolled men have a higher risk for PTSD more generally, exposure to sexual violence during military service confers a greater risk for PTSD in women than men, such that overall rates of PTSD look similar to that of men when women report such exposures (Tannahill et al., 2020).

Unfortunately, some providers do not feel equipped to adequately assess and address concerns related to military sexual violence using patient-centered approaches. Providers report that they feel uncomfortable asking about exposure to sexual violence and therefore avoid asking in-depth questions (Bergman et al, 2019). Indeed, a qualitative analysis exploring barriers to disclosing exposure to military sexual violence during screening revealed that some women opted not to disclose because they felt the topic was not important to their provider or that their provider did not care (Blais et al., 2018). Collectively, these findings suggest that additional training would be helpful in reducing discomfort when asking questions about sexual assault histories. Clinicians should do all they can to take a proactive approach that creates a safe space for discussing such experiences.

Supporting Women's Engagement in VA and Community Settings: The Importance of Single-Gender Offerings

As female's roles have changed in the military, their integration has been met with concerns from their male peers. Specifically, findings from the *Gender Integration Study* (TRADOC Analysis Center, 2015) observed that integration of women in the military has increased concerns that physical fitness standards would be lowered to accommodate women, and lowering these standards would result in greater risk of death in combat. Other concerns included the ability of women to become pregnant during service, thus making them temporarily unavailable to serve and perhaps distracted by non-military matters. Such concerns or stereotypes may discourage women from taking on multiple roles concurrently (e.g., serving, motherhood) or feel as though they are a liability to their unit if they do. Not surprisingly, many women service members and veterans continue to lack a sense of belonging and support (e.g., Thomas et al., 2017a; Burkhart et al., 2015) and avoid using VA provided health and social services once discharged, with only 37.2% of women Veterans enrolling in VA in 2019 (Congressional Research Service, 2021).

Anecdotally, some female service members and veterans describe using a "buddy system" with other women when using the restroom, laundry facilities, or to access their car in a parking lot (Blais, personal communication, September 22, 2022), in order to increase their sense of safety against assault. Some females feel betrayed when they are promised an experience of comradery and instead are mistreated by those meant to keep them safe (Andresen et al., 2019; Dichter & True, 2015; Holliday & Monteith, 2019). This experience is called institutional betrayal (Smith & Freyd, 2014). Clinicians treating women service members and veterans should have some understanding that their patients may have experienced disillusionment in the military as a consequence of their gender. Furthermore, concerns that institutional betrayal may continue as females transition out of the military is a reasonable concern that may impact care. This knowledge may help inform case conceptualization and aid in building a therapeutic relationship.

In order to increase usage of VA services, researchers have explored factors that draw women to the VA and help maintain engagement. Factors include the VA's focus on Whole Health (Krejci et al., 2014), peer social sup-

port, proactive clinicians (Evans et al., 2019), and specialized mental health services for women (women-only groups, receiving care in women-only settings, seeing a female provider; Kimerling et al., 2015) as well as addressing unhelpful behaviors of men (Moreau et al., 2020). Of those who do engage in mental health care at the VA, only half report that the institution met their mental health care needs completely or very well, and women are more than twice as likely to report their needs were met if they were able to engage in gender-related services as often as desired (Kimerling et al., 2015). To improve engagement and satisfaction with VA services, recommendations from the literature include targeted programming for women veterans and service members, single gender offerings, improvement of services at points of separation and transition, available childcare, peer outreach, and telehealth services (Thomas et al., 2017a; Thomas, 2017b; Brooks et al., 2014; Durham et al., 2017). Finally, given that the majority of female veterans are not seeking care at VA, and much of what is known about health care use comes from VA studies, non-VA clinics may need to be sensitive to unique needs that were not captured in VA studies.

Research on both female civilians and veterans suggests that single-gender treatment groups can uniquely benefit women. Females may be more likely to initially engage and to stay in treatment when single-gender groups are offered (e.g., Weller, 2005; Oliva et al., 2012). Furthermore, research suggests that single-gender groups can facilitate better mental health outcomes, including reduced alcohol use and better social adjustment for women compared to mixed gender groups (see Grella, 2008 for a review focused on substance abuse treatment). Perhaps lending to improved treatment outcomes, women in single-gender groups report a sense of connection, safety, and group cohesion (e.g., Greenfield et al., 2013), and are more likely to stay in treatment (Brady & Ashley, 2005). A sense of safety is critical among female service members and veterans, as the majority of women who experience military sexual violence are assaulted by fellow service men (e.g., Blais et al., 2018; Morral et al., 2015). Thus, co-ed groups may trigger traumatic memories in a counter-therapeutic manner. Groups could address any treatment topic or function as a process group, providing a space for women veterans to discuss their experiences as women in the military, as women veterans, and how other intersecting identities can impact health and wellbeing. VAs can also set up women's only waiting areas, which may promote a sense of safety, particularly in clinics that see predominantly male clientele.

Building Resilience in a Group that is Likely to be Revictimized

Building resilience among women service members/veterans is critical to ensuring positive well-being and value before, during, and after military service. In addition to stressors experienced related to wartime that can decrease resilience, women are also at greater risk for sexual revictimization, which contributes to even greater dysfunction relative to other stressors (e.g., Blais & Monteith, 2019). Indeed, rates of sexual revictimization are high among women veterans (Tirone et al., 2020a; Tirone et al., 2020b), and notably higher than the rates of revictimization in men (Blais et al., 2022).Strengthening a sense of community and shared identity among women service members and veterans is a viable and promising pathway to resilience employed by women veterans (e.g., Leslie & Koblinsky, 2017) and can be furthered by creation of gender-specific groups devoted to discussing the intersection of military experience and gender, as described below. Increasing participation in these communities would be a wise treatment goal and focus. Mental health providers in the community can also assist with social prescribing of resources such as WoVeN, or Women Veterans Network, a program for women veterans to build connections with one another (Brownley & Dunn, 2021).

Additional strategies for building resilience include meaning-making of military service (Leslie & Koblisnky, 2017), and increasing self-efficacy and internal locus of control, or the sense that one has agency over outcomes (Agaibi & Wilson, 2005). Cognitive behavioral strategies are helpful in enhancing a sense of self-efficacy (Gallagher et al., 2013), suggesting that this treatment approach might be especially fruitful for increasing resilience in this population. Recommended strategies for enhancing resilience following trauma exposure for people more generally include therapeutic trauma disclosure to close others and engaging in altruistic or prosocial behavior (Agaibi & Wilson, 2005). Indeed, these strategies seem particularly relevant for women service members and veterans. Although disclosure of trauma to military personnel or supervisors has been linked to dissatisfaction and disillusionment with the military, disclosure to close others is not (Dardis, Reinhardt, Foynes, Medoff, & Street, 2018). Clinicians could thus work with women service members and veterans to identify appropriate personal sources in their lives to whom they can have therapeutic disclosure and enhance their resilience.

Lastly, engagement in prosocial and altruistic activities is strongly linked to a sense of military identity (Castanheira, Chambel, Lopes, & Oliviera-Cruz, 2016), which may be both a reason for joining the military to begin with and a pathway to resilience further in a service member's career or following separation. Although military members may experience disruptions in this aspect of their identities following separation or military-related traumas (McCormack & Ell, 2017), re-engagement in civic activity, connection to community, and volunteer work can foster a sense of resilience and recovery among women veterans and military personnel (Angel et al., 2019), and for those that maintain a strong sense of military identity following separation, engagement in prosocial and altruistic activities may be a way to honor and preserve this identity in a values-driven approach. Given the aforementioned deficits in women veterans' social support networks (Campbell et al., 2021), such re-engagement in prosocial or altruistic activity may have the added benefit of enhancing social support and social connection.

In summary, many strategies exist for enhancing resilience in a vulnerable population such as women service

members/veterans, and these are both easily integrated into standard mental health practice (e.g., fostering self-efficacy, meaning-making) and require creativity on the part of practitioners (e.g., connecting to community organizations, enhancing structural and functional social support).

Offering More Holistic Care

Research shows that exposure to sexual violence in the military is associated with higher eating disordered behavior, depression, PTSD, and risk for suicide, as well as poor relationship satisfaction, all of which are associated with poorer sexual function and satisfaction (Blais, 2020c; Blais et al., 2017; Kimerling et al., 2007). Unfortunately, sexual health is largely ignored in most assessments and interventions (Dickenson & Blais, 2021). Moreover, similar to the concerns of asking about sexual victimization reported by providers, many providers feel uncomfortable asking about sexual well-being (Zhang et al., 2020). These findings highlight the need for graduate and professional schools to more adequately train students on how ask sensitive questions about sex, sexuality, and sexual assault. Anecdotally, clinicians report that clients have expressed gratitude about being asked about their sexual well-being, with some clients reporting discomfort initiating the topic, signaling the need for clinicians to be proactive on these topics (Sadovsky, 2003). Asking about sexual well-being or ensuring your clinic assesses for sexual satisfaction and function is a key way to provide more holistic care. Indeed, the VHA has had a requirement to conduct annual sexual health reviews with veterans since 2017 (VA, 2017).

Intersectionality, Minority Stress, and Clinicians' Cultural Humility

Intersectionality is defined as how various identities (e.g., race, gender, class) and experiences interact and overlap to influence social relations among individuals and groups (Collins & Bilge, 2020). Women veterans do not uniformly have the same experience while accessing mental health resources. For example, women who identify as a sexual minority (e.g., lesbian) and/or gender minority (e.g., transgender) are more likely to endorse harassment from male veterans and feel unwelcome at VA compared to women who do not identify as a gender and/or sexual minority (Shipherd et al., 2018). Negative impacts of these experiences extend to care engagement as these women report missing or delaying care due to fears about interacting with other veterans (Shipherd et al., 2018). This is an example of intersectionality whereby (put simply) the experience of being both a woman and identifying as a gender and/or sexual minority confers unique risk for harassment, shaped by the historical discrimination and exclusion of women and individuals who identify as lesbian, gay, bisexual, and transgender. That said, intersecting minority identities do not always equate to more difficulties. Although women veterans of a minority race/ethnicity or sexual orientation may experience higher severity of mental health symptoms compared to White and heterosexual women, women who are both racial/ethnic and sexual minorities may develop resilience from their experiences, resulting in less severe mental health symptoms (Lehavot et al., 2019).

As we work with women service members and veterans, it is important to be continually curious as to how each woman's intersecting identities affect how she is treated by others, how she is differentially impacted by systems, and how her identities shape the way she experiences the world around her, including her interactions with those of us serving as providers of care. We must not assume that being a woman is the most important or salient identity for women service members and veterans, and we must acknowledge that this may change throughout the course of treatment. In fact, helping women identify and even celebrate this aspect of their identity may be a critical part of intervention given their time and service in a masculine culture. It is vital that we validate the adverse impact of chronic "othering"/feeling out of place and microaggressions (Sue et al., 2007) and we can explore with our patients the synergistic connections between their multiple identities.

Training Providers

As we train new clinical providers, women's experiences in the military and as veterans must be uniquely highlighted if we are to build a culturally sensitive workforce. Seminars orienting trainees to military culture should include information on the history of women in the military and ways in which men and women's experiences might differ. It is imperative that we strive for cultural humility, a concept that incorporates a lifelong commitment to self-evaluation and self-critique, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities (Tervalon & Murray-Garcia, 1998). It is critical that providers see the process of understanding the experience of women service members and veterans as a life-long learning process where expertise is not a goal.

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Embracing Parallels in Clinical Work

Marco A. Bongioanni

The military is a team sport, not an individual sport, and the lowest echelon of this team is the two-person team. In this team, each member strives to look out for others, whether in combat or in garrison. The term, 'I've got your back', becomes not simply a figure of speech, but a manifestation of military culture. While the specific nomenclature can sometimes differ by service branch; battle buddy, shipmate, wingman, guardian, or simply brother/sister, these are byproducts of the fixed, collective, and 'we' based military collectivistic culture. Military culture dictates that the group's goals be placed ahead of personal goals. To this end, success is measured by group achievement. This is in stark contrast to the fluid individualistic 'I' based stereotypical Western civilian culture that is predominant in the United States. Civilian culture often emphasizes individual achievement and self-reliance. Even further, from a career standpoint the profession of arms is not simply a job or occupation. The military teaches you first to manage people, then ideas. For service members, managing big ideas, policies or campaign strategies is reserved for senior military leaders. Prior to embarking on such endeavors, junior military leaders' success is predicated upon effectively managing the wellbeing and development of their subordinates. This is a stark contrast to the civilian world where you could be highly successful in your career field and never actually manage people. Because of these stark differences, many have suggested that there is a large gap or divide between military and civilian cultures. The following model further illustrates these differences. Using *parallels* by connecting two like items are a potential way for clinicians to help bridge this gap between military and civilian culture (Bongioanni, 2023a).

(Bongioanni, 2023b)

Understanding Parallels within the Framework of a Multicultural Counseling Orientation

Because we are speaking about cultural differences, it is important to first see military and civilian culture within the framework of a multicultural counseling orientation. The Owen and colleagues' (2011) model notes that a multicultural orientation has three domains:

- Cultural Humility: Ability to maintain a personal stance that is nonjudgmental and other oriented.
- Cultural Opportunity: Moments in session when a counselor can address and focus on a client's cultural identity.
- Cultural Comfort: Ability, through humility, to engage a client's various cultural identities.

Missed **cultural opportunities** are ultimately **missed opportunities** to improve your client's outcome (Owen, Tao, Leach & Rodolfa, 2011). Parallels can therefore provide potential opportunity windows to fill the framework of multicultural counseling competence when working with service members and veterans.

Understanding Parallels Relationship to Implicit Military Culture

The military has both explicit and implicit cultural components. Explicit elements can include hierarchies, ranks, uniforms, missions, occupations, organizational structures, jargon, terms, and demographics to name several. Implicit elements include intangibles such as the values and guiding ideas that encompass the warrior ethos. Connection to this warrior culture is heavily implicit and lasts long after a service member departs the service and extends into their veteran identity. This is an important factor in understanding why parallels can be a cultural opportunity. "The elements of military culture that may be the most powerful and enduring just because they are implicit and intangible and cannot be shed along with the uniform (List, Lebowitz, Gray, & Nash, 2016)." Arguably, many clinicians focus on surface level explicit aspects when trying to create cultural opportunities and miss the deeper implicit aspects.

Why Use Parallels?

As noted, a parallel can be seen as anything in life that is similar in comparison. Some may say that a good parallel has interwoven components of a metaphor, analogy, or allegory. The technology field calls these 'spin-off's', or

something that is originally designed to support a specific purpose in a specific setting that was later discovered to have a generalized benefit outside the domain for which it was originally indented. Even biology has the term 'exaptation' to describe a trait that is co-opted for a purpose other than that for which it had originally evolved. Others may see parallels simply as 're-framing', a skill often used in psychology to help clients see their situation in a new light or perspective. The methodology of using parallels to achieve more positive therapeutic outcomes for service members and Veterans is currently mainly anecdotal and has not been tested in research or empirically proven. However, we can look to significant research that shows establishing a better therapeutic alliance leads to improved outcomes as likely guides for this model (Johnson et al., 2018).

Potential Parallel Application in Clinical Work

There are many different types of parallels that can be conceptualized by taking an implicit military cultural concept and connecting it to a psychological model. The best parallels have clear therapeutic goals, can be easily summarized, and are applicable with a variety of populations of service members and veterans no matter what era they served or if they served in combat or peacetime. Below are some potential examples of parallels and their applications to clinical work:

Opportunities for Further Parallels upon Separation

Upon separation, the service member who has now become a veteran, is severed from the collective military culture and the bond of the two-person team. While this bond can never be re-created, it can be re-connected by encouraging a veteran to engage in further implicit parallels that help re-establish a sense of connection and community and that somebody or something 'has their back'. Some possible further parallels upon separation might be:

- Joining a Veterans Service Organization (VSO)
- Engaging in a sport/athletic pursuit
- Joining a student veterans group
- Volunteering to help in your local community
- Staying engaged with family/friends
- Thriving in your vocational/professional career
- Involving yourself in veteran community advocacy
- Focusing on your favorite hobby/pleasurable activity
- Staying active in a church/religious/spiritual community (Bongioanni, 2017)

Examples of Potential Parallel Application in Clinical Work

Military Concept	Implicit Cultural Parallel	Psychological Model
Marksmanship	Breathing is a fundamental in marksmanship all service members understand. It can be paralleled to teach other breathing skills.	Mindfulness Breathing Techniques
Military Planning	The military has many different linear processes that guide planning to achieve goals and mission success. Life goal setting models have a very similar linear step by step format and can be easily paralleled.	Life Goal Setting Models
Military Values	Parallel existing knowledge of military values to increase motivation, self worth, and connect to other value-based skills.	Dialectical Behavior Therapy (DBT) Values Work
After Action Reviews (AARs)	The military conducts these after any mission to capture lessons learned. This process can be paralleled to worksheets used in Cognitive Behavioral therapies.	ABC Worksheet from Cognitive Behavioral Therapy
Negotiating Obstacle Courses	These build physical and mental confidence by making you confront your fears head on. Parallel to obstacles in civilian life that may not immediately have to be confronted if they do not pose a significant threat.	Techniques for Negotiating Life Obstacles
Resilience Training	Multiple components of positive psychology are instructed in the military. Parallel clients existing knowledge and explore further.	Social Resilience Model or Post Traumatic Growth Model
Personal Protective Equipment (PPE)	PPE protects your body from harm. Parallel to various skills that can protect your mind.	DBT exercises interpersonal effectiveness, emotion regulation, and distress tolerance
Physical Fitness	Physical fitness is a part of readiness and daily life in the military. Parallel client's knowledge to quality of live improvement.	Whole of Health/Wellness/Therapeutic Lifestyle Change techniques

Best Practices when Using Parallels

Before using a parallel, a clinician should determine if leveraging parallels is appropriate for the client they are working with. A culturally competent intake form and process can help determine this. Some key factors to determine might be:

- Does the service member or veteran highlight their military experience as one based in positive or negative thoughts/beliefs/emotions?
- 'Time Effect': Are they recently separated, or did they separate 50 years ago?
- Based off the service member or Veterans traumas or experiences, does the parallel need to be further modified so that it does not become a trigger?
- Will using the parallel ultimately *create a cultural opportunity* to build *trust* and *connection*?

The military is an insular world. Collective warrior cultures typically stay exclusive to their community and are often mistrustful of outsiders. Because of the military/civilian gap or divide, many service members and veterans often feel lost in an individualistic world. "Isolation kills and emotional pain can only be processed in the community." (Bobrow, 2015 p. 39). Parallels provide an avenue for connection and can further enable a service member or Veteran to find purpose, even in an individualistic world.

Parallels Built Connection & Trust

As we have seen, a parallel can be a way to reframe what the service member or veteran already knows in order to educate them about a psychological model. The best ones leverage implicit experiences as cultural opportunities and show the clinicians military cultural competence, ultimately improving the clients clinical outcome, They can help build ***connection*** **and** ***trust***. Clinicians should encourage service members and veterans to embrace parallels as a way to reconnect with the collective 'we' based culture that is lost, particularly when one separates from the service. It is likely not possible to fully recreate in civilian life the same battle buddy, shipmate, wingman, guardian, or simply brother/sister that the military brings. However, what is fully achievable is finding parallels that can create a similar sense of trusting connection, where somebody or something is telling you consistently: 'I've got your back'.

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Deployment Diary: Treating the Trauma You're In

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I will be the first to admit, I have not had the longest career as a military psychologist, or as a psychologist period. However, during that time, I've packed in a lot of workshops, trainings, and lectures on military specific CBTs, trauma, and self-compassion. I have been warned about compassion fatigue and have been reminded to have a solid self-care plan to deal with secondary trauma.

However, I recently found myself in a situation where I quickly realized that I had zero real-world training, and hardly any preparation. The situation? Treating a trauma that you, yourself, are in.

It is one thing to hold the weight of someone's worries, fears, and pain. It is another to be sitting in the bunker with those same folks, in the eerie silence of a desert night, wrestling with your own worries, fears, and pain. But I'm getting ahead of myself, let me set the scene for how I ended up there.

I deployed in Fall of 2023, and if you follow the news in *any* fashion, you know the geo-political scene changed dramatically in a very short period of time. The deployment I was initially tasked with was significantly different from the deployment I ended up experiencing. Fast forward, and at the end of January 2024, I found myself in a situation that I could not have dreamed of just one year prior.

Tragedy struck, and I have a vivid memory of pacing my room that morning, and thinking to myself, "oh, this is what my patients are talking about when they discuss feeling helpless in the midst of chaos." I tried every coping skill I have ever recommended to patients, finding they were only marginally helpful. It was the first of many such experiences over the next several weeks where I gained a lot of insight and empathy into many of my patients' stories.

Eventually I arrived on scene. I expected to help others as a psychologist but quickly realized that what people needed from me in that moment was to be me, Taylor, a human. A person to give a hug, a person to just sit in silence with, and a person to let you crack a dark joke with zero judgment. Those moments bought me some time to figure out what I actually needed to be doing as a psychologist. Eventually, as the hours passed, the adrenaline wore off, and people wanted - no *needed* - to talk.

Thankfully, I had gotten to know these people over the previous months, so getting them to trust me enough to open up was not challenging. It was an odd experience to sit with them as they shared their fears, worries, doubts, and questions, while simultaneously listening to see if we needed to bunker dive once more *(side note: getting ushered out of the office and into a bunker by a patient as we discussed how hard it was for him to allow himself to stop for a second and feel his emotions was a very unique experience to say the least)*. Normally, the folks sitting across from me are long removed from their trauma, by time or distance, or both. But in this moment the fears were relevant, and strong, and I found myself connecting on a deeper level. Come to think of it, the A/C units in the rooms *did* sound like rotor blades in the quiet of the night. And you're right, second attacks are always possible. And there are people to be angry at, really angry at. And yeah, it's hard not to let your mind wander before bed and spin itself up. And, and, and…

I found myself worn out quickly, likely due to the frequent nighttime consultations requested by the base leaders, trying to navigate a challenging situation; as well as the countless requests to talk from people who just weren't sure they could ever feel safe enough to sleep again. Normally sleep is one of my favorite things to treat, but this was not so easy, especially when I was also running on fumes.

Any psychologist who has been instructed on how to avoid compassion fatigue will tell you that routine and basic self-care are vital to prevent burnout. Yet, these were two things in very short supply. I quickly found myself out of my depth, and feeling woefully unprepared. How on earth did anyone think that I could help? I've not been doing this for too long. I'm a plain ole' Air Force psychologist. I didn't get any special training for austere locations and heavy enemy activity. Heck, I had only been licensed for just over a year, and this was not on the EPPP.

Imposter syndrome is one thing I've experienced quite a bit since donning the uniform. But this was different. This was an overall feeling of "I am *definitely* not supposed to be here. A mistake has been made!" This feeling was so intense because not only did I not have easy solutions for others, but I was also wrestling with my own feelings. As medical providers, we are driven to help and heal, and watching my fellow medics come to terms with Rule Number 2 of MASH was difficult. Knowing I had no magic skill to take away their pain in the days and weeks to come was brutal. I was feeling profoundly powerless and was worried that others would quickly catch on to the possibility that I was *not* the person they wanted to help.

I was asking myself, how do I treat this trauma, this very trauma, that I am also experiencing?

Just then, in a period of intermittent Wi-Fi, I received a text from an incredible mentor (whom I'll call Dr. K) that ended with this:

"P.S. You've got this. No one is ever prepared. You're in good hands and you're not alone."

I remember smiling at the text, realizing that she must have seen the news, known where I was located, and pieced together my current situation. I shot back a quick "thank you!" prior to again losing wi-fi.

The whole interaction lasted a few moments and could have easily gone unnoticed in the chaos. However, in that moment, I felt profoundly seen and understood. How did she know I felt unprepared? Why did she think, "I got this?" Because I, for sure, did not feel any "I got this" energy.

The text made me stop and think: "Wait, if no one is ever prepared, that means no one has any expectations for me." Up until this point, I had been telling myself that the senior leaders around me had a better idea of what I should be doing than I did. But maybe she was right, maybe everyone else felt just as off-kilter; and if that was the case, the only thing anyone was doing was the best that they could at that moment.

I can do that. I was not at the top of my game for a multitude of reasons. And the evidence on what *not* to do immediately following a trauma was a bit clearer than what *to* do, but I could piece something together. And so, I tried:

There were a lot more moments of silence in sessions than normal, which were sometimes awkward.

There were a lot less reassurances, because they just felt trite.

There were fewer breathing techniques, because no one wanted to take a deep breath.

However, there was also a lot more authenticity, more "I know exactly what you mean." A lot more validation and normalization, that while appropriate, felt more poignant for me.

Treating the trauma I was in, was about showing up as an authentic person, who happened to have some skills in therapy, but who was also just a fellow human on this journey. I am sure if someone was there observing me, they'd have a lot of feedback on what I could have done better. Even I have some thoughts on some "woulda, coulda, shoulda's"; but, at the end of the day we made it.

I took a few days off once the dust settled, because compassion fatigue is real, and I was running on E. It was not that I did not care, it was just that after a week of holding so many heavy things, I just could not find space for everything. Heavy things, I could handle; everything else, not so much.

I eventually was able to get back into my routine, talk some things out with a Chaplain and some friends, and process my own experience. I realized that while I do not personally practice all of the skills that I preach, journaling my experience was profoundly healing. This journal entry is definitely not fit for public consumption, but allowing myself to be raw and honest was powerful. I felt the power of processing a trauma from beginning to end on the other side of the couch so to speak.

Before I get into a few brief takeaways, I want to address something. You may notice that this article focuses much more on my experience than on tips and tricks for navigating this experience. That is intentional. I think the most important thing you can do as a provider is recognize your own reactions in those situations you could have never expected. I hope my honesty allows others to be more honest with themselves, because there really is no "10 things you need to do" or "5 step plan to treat…" for these situations.

Overall, as a provider, treating a trauma that you're in, I'd say this: Remember first and foremost that you are human, and that is powerful. Second, remember that there really is not a clear guidebook for every situation, everyone is just doing their best. And finally, don't forget to practice some of those incredible coping skills that you've been spending everyday talking about. You are just as important as your patients and deserve just as much healing as they do. Take space for it, *make* space for it.

And finally, I'll end with this: I do not know what situation you may find yourself in, deployed, in garrison, in a VA, or at a university. But, just in case you do not have a Dr. K in your life, please know this:

P.S. You've got this. No one is ever prepared. You're in good hands and you're not alone.

The views expressed are those of the author(s) and do not reflect the official views or policy of the Department of Defense or its Components.

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Spotlight on History: The Assessment of Men

Austin Hamilton

Right person, right place, right time. These are words that many military psychologists use to describe the essential core function of assessment and selection (A&S). This spotlight on history highlights the landmark endeavor of the Office of Strategic Services (OSS) to create and implement a robust and accurate A&S program that was unprecedented during its time. Remarkably, many of the early lessons psychologists learned remain applicable today. For those of you currently serving in A&S settings, you likely already know about this remarkable feat. For other military psychologists across our diverse community, I hope this edition's article leads to further exploration.

Military psychologists have been called upon to construct and apply the best available methods of predicting which candidates would be most successful across each military occupation. During World War I (WWI), these efforts took on historic proportions, leading Robert Yerkes and a number of other prominent early psychologists to apply their craft to the war effort. Following *The Great War*, the US hastily disbanded their military psychologists thinking that war on such a massive scale was unlikely to occur again. Then in 1939, Nazi Germany invaded Poland launching Europe into a second world war. Not long after, the U.S. commissioned a robust number of psychologists eager to answer their nation's call, and once again A&S was a central focus for many military psychologists.

As was the case during WWI, early World War II (WWII) assessment measures focused on aptitude and relied heavily upon intelligence as a predictor for occupational placement. In a general sense, this was effective in identifying core attributes that placed young servicemembers in specialty fields and training programs where their skills were further developed and ultimately applied to the overarching war effort. Simultaneously (i.e., 1941), the US was developing approaches to assessing, selecting, and training individuals who would serve as spies and special agents in the newly founded Office of Strategic Services (Waller, 2011).

The mandate of the OSS, as the forerunner of the Central Intelligence Agency, was to bridge the perceived gap between the U.S. and its WWII adversaries in terms of intelligence gathering and other clandestine special operations (Lenzenweger, 2015). As one can imagine, such a mandate required individuals to serve behind enemy lines or in foreign lands far removed from traditional military support and command oversight. Environmental conditions dictated that successful OSS agents must possess a unique set of traits and skills that enabled them to cope with tremendous stress while operating largely independently. Therefore, a new system of assessment and selection needed to be developed and implemented in the context of a war that had already started. Indeed, the stakes could not be greater.

To truly understand the context in which the OSS assessment and selection program emerged, it is important to recognize that it was fundamentally results-driven. In other words, the program was not strictly based on a rigid theory of personality but was designed to efficiently identify, select, and deploy agents into the field (Handler, 2001). The task of developing the program was made even more difficult by the fact that the OSS assessment staff initially had no clear understanding of what they were expected to predict (i.e., what made a successful officer) (Lenzenweger, 2015). The assessment staff did, however, know what approaches were *not* successful. OSS staff found traditional selection tests used prior to the OSS program to be poor predictors of how agents fared in the field (Handler, 2001). In sum, previously used measures were adequate at identifying highly intelligent agents who then struggled to apply initiative and common sense in highly demanding settings (OSS Assessment Staff, 1948). Henry Murray, together with OSS psychologists Robert Tryon and James Hamilton, highlighted the importance of innovative assessment and selection methods that utilized a screening board of experts (Nichols, 1946) to evaluate candidates across multiple domains.

In the beginning stages of design, the assessment staff worked hard to reduce over 20 variables down to seven major evaluating constructs. The seven major variables included motivation for assignment, energy and initiative, effective intelligence, emotional stability, social relations, leadership, and security (OSS Assessment Staff, 1948). The staff also identified three specific qualification variables—physical ability, observation and reporting skills, and propaganda expertise—that were incorporated for certain specialized roles. Assessors were instructed to rate each candidate on a normally distributed six-point scale. This was later reduced to four categories (i.e., inferior unsatisfactory, low average satisfactory, high average very satisfactory, and superior outstanding). Each of the 10 variables were assessed across multiple methods (e.g., interview, questionnaire, individual task, group task, projection test etc.) to maximize the validity of measurement. In all, approximately 90 datapoints were collected on each candidate (Handler, 2001).

Candidates in groups of 18, would often be brought to a Virginia estate approximately 40 minutes outside of Washington D.C. where they would undergo three and a half days of testing and observation (Handler, 2001). Candidates participated in an initial interview and were then

informed that they would reside at the assessment school throughout the process. Additionally, they were forbidden to reveal their real identity during the assessment period. They were required to create a false identity, fabricate a back story (i.e., place of birth, former employment, and historical life events), and defend it vigorously unless assessors provided a code word (Condition X) at which point the candidate would be permitted to interact truthfully. Observations could be made at any time regardless of whether candidates were involved in formal assessments or when candidates were off guard during dinner or other "casual" settings (OSS Assessment Staff, 1948). Deception was used extensively over the 3.5-day assessment period. The assessment also included a simulated interrogation. Candidates were persuaded to believe that they would be fired from the OSS if they failed this test. They were then given 10 minutes to fabricate a cover story explaining why they were caught reading a secret file. The aggressive interrogation took place in a basement under harsh lighting which produced significant emotional turmoil. After the interrogation [regardless of how the interrogations went], the candidates were informed that they had failed the test. During the debriefing, once the candidate's guard had been lowered, OSS staff would again attempt to get the candidate to reveal their true identity (Handler, 2001).

Another example of creative (and undoubtedly frustrating) use of deception comes from the construction test. During this event, candidates were given 10 minutes to direct two other individuals in the construction of a life-sized replica of a model using 5- and 7-foot poles. The event itself was designed to measure leadership, social relations, energy and initiative, and emotional stability (i.e., frustration tolerance). Unbeknown to the candidates, the other two individuals on the team were not fellow candidates but rather "stooges" placed there to frustrate the candidates. One "stooge" was instructed to be passive and sluggish while the other forcefully offered impractical suggestions and was aggressive and critical:

> "The two assistants were not permitted, by their secret instructions, to disobey orders, and they were supposed to carry out whatever directions were given to them explicitly. Within the bounds of this ruling, though, it was their function to present the candidate with as many obstructions and annoyances as possible in ten minutes. As it turned out, they succeeded in frustrating the candidates so thoroughly that the construction was never in the history of S [Virginia testing site], completed in the allotted time." (OSS Assessment Staff, 1948, p103.)

Within the text, the assessors provided specific dialogue illustrating the many tactics used to frustrate, distract, and sometimes demolish the very construction they were asked to assemble. Poor leaders were said to have refused to continue the assessment while good leaders sought to patiently instruct their "helpers" to salvage what remained (OSS Assessment Staff, 1948).

Remarkably, after more than 70 years, many of the constructs measured by OSS staff remain just as relevant and consistent with terms used today. As described by Picano, et al. (2022) modern key competencies for high-risk operational personnel assessment and selection include stress tolerance, cooperation, adaptability, physical ability, judgement, motivation, and initiative. Similarly, constructs introduced by the OSS staff, such as motivation, energy, and initiative, are still used today under terms like initiative and motivation, while also incorporating the OSS concept of motivation for assignment.

Emotional stability emerges in modern assessment as stress tolerance (i.e., the ability to tolerate frustration and effectively manage emergencies). The OSS construct of leadership is best captured by modern constructs of cooperation and judgement. Physical ability (i.e., physical fitness, stamina endurance, and the ability to endure harsh living conditions) is just as valued today as it was in 1948 and bears the same name. In fact, physical fitness is one of the strongest predictors of successful completion of modern A&S programs across multiple high-risk occupations (Picano, et al., 2022). While the construct of intelligence has evolved since WWI, cognitive ability continues to be a central component to any A&S program. Early OSS staff found pure reliance on intelligence to be insufficient (OSS Assessment Staff, 1948). Rather, they believed practical or effective intelligence to be an important variable to consider. Today, cognitive ability is known to be one of the strongest predictors of both job performance and successful training across a wide range of occupations (Schmitt, 2014; Schmidt & Hunter, 1998 ETC)

Many of the tactics, particularly deceptive tactics, used by OSS staff, would struggle to meet Institutional Review Boards (IRB) today. But given the context and potential ramifications of sending ill-equipped American agents into hostile settings prompted creative if not unorthodox solutions. Many of the lessons learned continue to influence modern approaches to A&S and have furthered the overarching science related to personality assessment and personality theory. (Handler, 2001). They represent yet another key contribution to the world of psychology provided by military psychologists. Indeed, many of the constructs explored in the 1940s remain relevant some 70 years later.

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Book Review: Loving Someone with a Mental Illness or History of Trauma

Taylor Zurlinden

Loving someone with a mental illness or history of trauma: Skills, hope, and strength for your journey by Michelle D. Sherman, PhD, ABPP and De Anne M. Sherman is an approachable and practical guide for those dealing with the challenge of loving someone with a mental health condition. From the first pages of the introduction, the authors paint a very clear picture of their purpose: "In the pages that follow, we balance straightforward, research-based information and recommendations with an empathic voice to attempt to connect with both minds and hearts" (x). I would say whole-heartedly that they accomplished this aim in this book.

Prior to the first chapter, the authors provide a guide that lists an experience someone may be having related to their loved one's mental illness, and the corresponding chapter that can assist them. For example, if you are feeling a lot of worry, sadness, anger, exhaustion, or guilt turn to Chapter 1; if you are unsure what to say to empower and comfort your loved one turn to Chapter 6. These guides demonstrate that the book is meant to be relatable and practical, helping connect folks with the resources and skills they may need at that exact time. To be clear though, while I think that these guides are great, I also believe that reading the full book is well worth the time.

Part I: Reflecting on Your Experience

The book starts with a self-assessment and reflection on the reader's journey, coping skills, and strengths. The ACT-based approach is empathetic and insistent: This is a significant challenge that will demand a lot from you, *and* you need to take care of yourself through the difficulties. The opening chapters are both compassionate and empowering, focusing on living a fulfilling life moving forward, emphasizing coping skills, support networks, and understanding the hardships associated with mental illness. What I appreciate most, is that these are not trite "take a warm bath" coping skills that can often feel out of touch with reality, but effective principles such as "make time for yourself" and "confide in [others]." They are not prescriptive "do this one thing and get better" type skills but provide the reader a framework to customize their own skills.

I think that perhaps the most compelling aspect about this first section is that it feels purposeful and intentional. When writing about dealing with a loved one's mental illness, it can sometimes feel like authors write the obligatory "take care of yourself" sections, only to rush into the "real" focus of the book. However, this book makes clear that the true focus is on the reader. The book is designed for the caretaker or loved one's own benefit, and the authors make this evident even in how they structure the book, beginning with reflection and growth *before* moving into practical advice and guidance; highlighting that the caregiver's wellbeing is vital to the whole process.

Part II: Supporting Your Loved One

These chapters focus on goals and navigating the health care system. The goals chapter emphasizes empowering your loved ones towards their goals, not dragging them to your desired destination for them. It also emphasizes helping your loved one set up their own supportive environment and community, something that can go a long way towards protecting your own wellbeing and relationship (see Part I). The chapter on health care provides summary information about different treatment options, laws governing privacy and information, and questions to consider asking providers. There is no crash course for loved ones on how to most effectively use the health care system to assist their loved ones, but I propose that this chapter should be a recommended first stop for many about to embark on the caregiving/supporting journey.

Part III: Strengthening Your Relationship With Your Loved One

While these chapters are specifically tailored towards strengthening relationships in which one member may have a mental health challenge, they could also be useful guides for any relationship. Limit-setting, cool down periods, and trigger management are just a few of the skills presented in this section. Specific chapters focus on intimate relationships and parenting with a partner who has mental health challenges, allowing readers to choose the chapters most relevant for their situation. Perhaps most striking is that the authors do not try to create a comprehensive guide for these topics within this book, choosing instead to build on what already exists. They spend significant time explaining various resources and organizations that can provide more tailored assistance, highlighting niche groups that may be undiscovered otherwise.

Part IV: Managing Common Challenges

Finally, the book concludes with the weightiest topics, such as addiction, trauma, and crisis situations. These chapters are patient-focused, educational, and empathetic– a balance many mental health professionals can recognize is challenging. While these chapters are not meant to be an exhaustive guide, they are packed full of incredible resources, and activities, helping restore some sense of control in some of the most uncontrollable situations.

Overall, this book is an incredible wealth of information and resources for anyone loving someone with mental illness. I appreciate that the authors do not make assumptions about one's level of education/understanding/health literacy, instead explaining everything in terms that are clear (yet not so simple that it is demeaning). Perhaps most importantly, the book does not attempt to be the sole guide but instead provides connections to organizations and other literature throughout. While the book itself is not therapy, the authors champion seeking care throughout and provide insight on how to make treatment most effective. This mother-daughter writing duo truly combine their strengths and backgrounds to generate an incredible resource that I cannot wait to share with my patients moving forward.

Disclaimer: The opinions herein are the views of the author and not the official views of the Departments of the Air Force or Defense.

Council of Representatives

Mark Staal & Tim Hoyt

Hopefully you have all seen the APA Apportionment Ballot reminders on the Facebook page and the Listserv each year in November and December reminding you to "Vote 10 for 19." For those of you unfamiliar with this process, all APA members get 10 "votes" or ballots each year on the apportionment ballot that determines the relative representation on the APA Council of Representatives. These 10 ballots can be allotted by each member to the Division(s) or State(s) they want represented on the Council.

The results of the Apportionment Ballot for the 2026 seats were released in January. A total of 320 members cast 1,294 votes for Division 19. This was an increase from the 245 members who voted for Division 19 the previous year. As a result, we have 1.5% of the total votes cast and will maintain two seats on the Council of Representatives for 2026.

Divisions 39 and 53, and the California state delegation gained a seat on Council. Divisions 14, 32, and 36 lost a seat on Council. For next year, Division 19 could increase our number of seats if we got about 50 more members to vote. Note that our voter turnout is about 21% (320 out of around 1,500 Division members), so we have plenty of room to increase our voter engagement!

There are a total of 162 seats on the Council of Representatives. For 2026, the Divisions with more than one seat are as follows:

Number of Seats (2026)	Divisions
5	39
4	12, 17, 40, 42
3	2, 14, 16, 38, 44, 45, 53
2	3, 5, 7, 8, 9, 13, 15, 18, 19, 20, 22, 29, 35, 41, 50, 54, 56

The remaining Divisions have one seat each on Council for 101 total. The rest of the seats on Council are allotted to the State, Provincial, and Territorial Psychological Associations: Each of the 50 states (two for California), the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands each receive one seat; Alberta, British Columbia, Manitoba, Nova Scotia, Ontario, and Quebec also receive one seat.

As is always important to consider in an election year, voter turnout within APA is pretty low. Only about 8% of eligible members and 3% of eligible students actually vote when apportionment is being decided or the APA President is elected. Those who show up (or those who reply to the voting email) will be the ones with a voice in APA!

Division 19 Membership Committee Update

Erin Moeser-Whittle

Greetings, Division 19 Members and Affiliates!

I hope everyone had a wonderful holiday season, and that your year is off to a great start! Our total membership stands at 1,030 – a decrease of about 30% from this time last year. Our student affiliates continue to make up the largest proportion of membership at 42%, followed by Members at 28%. Although our numbers have declined in recent months, we are optimistic that our membership will grow and exceed our 2024 total of just under 1,500.

Here's where you can help! If you have colleagues who may be interested in joining Division 19, please direct them to our membership page (https://www.militarypsych.org/prospective-members/) or have them contact me at new_members@militarypsych.org. Current members can reach me at membership@militarypsych.org. Benefits of joining Division 19 include receiving our journal, *Military Psychology*, our newsletter, *The Military Psychologist*, and being a part of our listserv.

The Membership Committee is excited to serve its role in attracting and retaining members through collaborations with other Division committees and Division leadership. We will be working with the Presidential Trio to promote and increase member engagement throughout the year; with the International Committee to make joining the Division easier for International Affiliates; and with the Communications Committee to improve the website to maximize utility and member engagement. We also plan to reach out to the Student Affairs Committee, Early Career Psychologists Committee, Diversity in the Military Committee, and the meeting committees (APA Convention, Military Psychology Summit, and Division 19 Research Symposium Series) to assist with various events and initiatives.

A call for the 2026 Membership Chair Select will be going out soon - be on the lookout if you would like to be more involved in the Division and help to grow our outstanding membership base!

Thank you all for your amazing work and dedication to serving our military service members, veterans, and their families, and I look forward to seeing what 2025 will bring!

MILITARY PSYCHOLOGY FOUNDATION

Foundation Report

The **Military Psychology Foundation (MPF)** raises funds, manages the endowment, and supports initiatives and programs of Division 19 – The Society for Military Psychology.

Following a $400,000 initial investment, the Foundation has already raised an additional $39,550 in donations and $91, 637 in investment returns, for a total of $531,187 (as of 10 JAN 2025). All funds are invested in moderate yield, safe long-term investments through a larger community fund – The San Deigo Foundation – that helps the MPF to manage its investments and donations portal. Beginning in 2025, the yields from the endowment will help to pay for Division 19 activities such as awards, travel funds, and conference expenses. In this way, the Foundation will free the Society from many of its current expenses as the endowment and yields continue to grow! The Foundation welcomes your (tax-deductible) donation to support military psychology programs and awards.

For more information and to donate, please visit: https://www.militarypsych.org/foundation/

All donations large and small are welcome and tax-deductible!

We also accept Corporate or Organizational donations. These will be recognized in multiple ways, such as in our journals, newsletters, and in conference materials and events. Corporate/Organizational Donor tiers are:

Up to $499	**Organizational Donor**
$500-$4,999	**Bronze Organizational Donor**
$5,000-$9,999	**Silver Organizational Donor**
$10,000-$39,999	**Gold Organizational Donor**
$40,000+	**Platinum Organizational Donor**

Special thanks to our Founding Donors!

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- Lynnea Vis

*Platinum Founding Donor ($2,500 and up)

Military Foundation board of trustees (from left):
Eric Surface, Ryan Landall, Kristin Saboe, Paul Bartone and Chair, Scott Johnston

SCAN to DONATE

Reflections on the Profession

Pat DeLeon

Past APA President (2000)

Interesting Times Ahead: We are currently in the very early days of the 119th Congress. The last time the Republican Party (GOP) controlled the White House and both Houses of Congress was January 20, 2017 to January 3, 2019, when Donald Trump served as President, having being inaugurated on January 20, 2017. Clearly, it is too early to predict with any sense of certainty how the next two years might evolve. Of high priority should be resolving the complex issues surrounding the *Appropriations* decisions for the coming fiscal year. Those serving within the military should appreciate that on December 23, 2024, President Biden signed the Servicemember Quality of Life Improvement and National Defense *Authorization* Act for FY 2025. This was the 64th consecutive year in which the Defense authorization legislation was signed into public law.

Although, unlike last year, there were few provisions in the DOD authorization legislation directly addressing behavioral/mental health issues, AMSUS recently reported that: "The mental health of active-duty US military personnel is a growing concern, with diagnoses of mental health disorders rising by nearly 40% from 2019 to 2023, according to a Department of Defense report. The report highlights anxiety, depression and PSTD as the most common issues, with PTSD rates notably higher among female Servicemembers. Efforts are underway to promote help-seeking behaviors and reduce stigma. 'Mental health is health, period. We must do more, at every level, to end the stigma against getting help. We all need counsel, community and connection. Reaching out is a sign of strength and resilience,' said US Secretary of Defense Lloyd Austin."

Systemic Vision: We thought it would be timely, and perhaps informative, to reflect upon our nation's overall health care environment, and particularly upon the underlying issues which must/should be addressed in the coming Congress. In 2021, the National Academy of Medicine (NAM) released its report *Priorities on the Health Horizon: Informing PCORI's Strategic Plan*. The Patient-Centered Outcomes Research Institute (PCORI) was established in 2010, after considerable political debate as to whether the federal government should expand its efforts to measure, and perhaps ultimately proffer, quality of care standards for health care.

PCORI's mandate was to "identify national priorities for research, taking into account factors of disease…, gaps in evidence, practice variations and health disparities…, [and] the potential for new evidence." Over the next decade its authority was expanded, resulting in broad strategic planning efforts. For this report, NAM and PCORI facilitated an expansive dialogue with key stakeholders to engender trust through a focus on shared commitments to progress on improving health for all Americans in the decade ahead. As unfortunately is still the case today, "Despite the fact that the United States spends twice as much per capita on medical services as any other developed nation – and 50% more than the second highest spending nation – its health performance ranks below the top 24 among the community of all nations."

Two meetings were convened to engage in "Blue Sky" thinking about emerging trends, priorities, and opportunities in health and health care. The first focused upon Emerging Technologies; Social and Environmental Factors; Optimizing Value; and Infrastructure. The second focused on two topics which evolved from the earlier meeting: (1) The Development of a Patient-Centered Learning Health System and (2) How PCORI could use its unique mission, capabilities, and core activities to improve patient experience, outcomes, and value in health and health care. From these discussions four cross-cutting themes were identified: (1) Health Equity -- every person has an equivalent prospect to reach their full potential for health and well-being. (2) Value Disconnect – discrepancy between prevailing health system incentives and forces, and the importance of the results to patients and society. (3) Learning Health System – alignment of evidence, informatics, incentives, and culture for effectiveness, efficiency, equity, and continuous learning. And, (4) Emerging Technologies – developing tools with varying individual and aggregate potential to affect human health and well-being.

There was uniform agreement that "Health is influenced by numerous biological, behavioral, social, cultural, environmental, geographic, economic, health system, and public policy factors, most of which are interdependent at some level." And, that "The forces that influence health also contribute to the experience of health care, from prevention to late-life care experiences." It was further noted that the cumulative impacts of health inequities have translated into a decreasing life expectancy in the U.S. from 2016 to 2019. Person-centeredness is critical; people do not experience social needs in one silo and health outcomes in another. The traditional culture of patient-clinician care organization interaction is contrary to the notion of the patient and family as "customer/owner" of the processes involved. Broad collaboration is essential for attaining just health and systemic transformation.

The current financial incentives and system fragmentation *promote volume over value*, resulting in unneeded services, inefficient care delivery, high prices, administrative waste, and missed prevention opportunities. A "learning health system" is one in which the alignment of

evidence, informatics, incentives, and culture naturally accelerates advances in health system effectiveness, efficiency, equity, and continuous learning. There is a compelling need to be more nimble and coordinated to learn from every health-related patient and family experience, embedding evidence into health care at every opportunity. And, an observation that permeated both meetings was that the full potential of precision medicine, informed by predictive analytics, can only be realized if equity is its cornerstone. Still to be determined -- Will we as a nation and/or our elected officials learn from this "Blue Sky" vision? How will our nation's health care system and health professions training programs ultimately be transformed?

Continuing RxP Maturation: Beth Rom-Rymer: "It was a great pleasure to present the keynote address at the 20th anniversary celebration of the Louisiana Academy of Medical Psychologists early this year. We honored Glen Ally, who continues to dedicate himself to our vaunted field and we honored the late- Jim Quillin and John Bolter for their significant achievements, contributions, and mentorship in the field of medical psychology. Jim and John left us too soon!

"Understanding human behavior was my dream when I was five. And, it has been my life's work. Psychology is at a crossroads. There are infinite currents pulling at our finite strands of concentration. Will pulling one strand undo all that we have accomplished in the last 130 years? What are the salient challenges and opportunities for Psychology in the next ten to twenty years? As we continue to explore new frontiers, will we be able to hear the signal over the noise? Will there be a place at the table for all? How do we take advantage of the cacophony of opportunities while heralding the strides that prescribing psychologists have made? Who are we as psychologists? What is our essential identity? As I was lobbying for our Prescriptive Authority legislation in Illinois, that was a question that I was often asked.

"In October of 2022, I spent a week in South Africa, with my South African psychologist colleagues. We had prepared a panel on RxP for their 26th Annual South African Psychology Congress in Johannesburg, highlighting their work in building a robust RxP Movement. A global perspective must be cultivated as the foundation for the future of psychology, and for those we serve and teach. Pursuant to this vision, I have been collaborating with colleagues in Brazil, Canada, China, Jamaica, UK, Netherlands, Norway, Poland, Jordan, South Africa, Japan, Singapore, and Taiwan to expand the scope of psychological practice and to serve the most vulnerable among us.

"Research by Phil Hughes has found that in Louisiana and New Mexico prescribing psychologists are at least as effective as psychiatrists; we are seeing very similar types of patients; we are providing increased access to high-level comprehensive prescriptive care; and we are providing much-needed mental health care to children and adolescents. As Phil presented to our Louisiana audience, he received many rounds of rousing applause. We will soon have exponentially increasing numbers of medical and prescribing psychologists around the country. Louisiana medical psychologists have been prescribing since 2005. They are the epitome of pioneers and innovators! I know they will continue to be visionaries in incorporating cutting-edge knowledge, new technologies and therapeutic innovations into their work as we all grow our professional expertise and careers."

Personal Reflections: Mike Feuerstein, USU Professor Emeritus: "In 2004, following my diagnosis of a malignant cerebellar glioma (Stage 3), I had no idea what my future would hold. I was told that I did not have much time to live, and I was dumbfounded. Following the whirlwind of my diagnosis and treatment, I asked my neuro-oncologist, 'Now what?' and was told to 'Just live life.' I was further advised that there was nothing more I really could do. At the time, however, I had a need and felt compelled to do more. I was familiar with chronic care, self-management, and brain plasticity and felt that this knowledge might help guide me and potentially other cancer survivors as well. Previously an active researcher, educator, and clinical/consulting psychologist focused on stress, work, pain, disability, and chronic illness, I now faced an uncertain future, wondering how long I would live and what I would do with that time I now had as a 'cancer survivor.'

"My luck began to turn. At about the same time that I became a 'cancer survivor,' the Institute of Medicine [now NAM] had convened a meeting and published findings on cancer survivorship which proved to be my new North Star. Over the years, this report has been the source of efforts by many involved in cancer survivorship research, practice, and health policy. Following this report, several doctorly prepared nurses from the City of Hope Medical Center, along with a group of leaders in the emerging area of cancer survivorship, launched a training program for nurses, physicians, and administrators, covering recent advances in cancer survivorship with a focus on best practices for quality cancer survivorship care. I was fortunate to provide a 'cancer survivor's perspective' as a lunchtime speaker.

"The IOM meeting, the City of Hope training program, and similar initiatives laid the groundwork for new cancer survivorship efforts in research and health care. Several governmental agencies, universities, private foundations, and public funders in the U.S. and worldwide began to focus on those who survive cancer treatments. After much introspection, I began to believe I too might survive, which presented an opportunity to integrate my newfound knowledge in public health with my clinical work, specifically in the context of cancer survivorship. There were numerous scientific journals devoted to cancer treatment and survival outcomes, yet none focused on the post-treatment phase and the long-term optimization of survivors' functional capacities. Personally, this post-treatment period was even more challenging than the side effects experienced during treatment, and I learned that I was not alone in this experience.

"In 2007, I founded the *Journal of Cancer Survivorship: Research and Practice (JCS)*, aiming to communicate the complexities of managing cancer survivorship over time for clinicians, researchers, and cancer survivors to help reduce the unmet burdens and optimize function. The key pillars of *JCS* include: (1) Interdisciplinary Approach; (2) Global Perspective; and (3) Long-Term Survivorship Care. Despite our progress, significant challenges still exist. Local and global demand from cancer and resultant cancer survivorship continue to pose a major public health challenge worldwide. I am very thankful to all those who gave their time and effort to *JCS* over its two decades of existence." "Come in, she said. I'll give ya shelter from the storm" (Bob Dylan, *Shelter from the Storm*).

Announcements

Grace Seamon-Lahiff

Announcement Requests

Please submit any announcement requests for volunteer opportunities, research participant requests, training opportunities, or other requests to the Announcements Section Editor, Grace Seamon-Lahiff at seamon@cua.edu.

General

Division 19 Election Results

Division 19 is honored to announce election results for our new leadership. Congratulations to:

- Carrie Kennedy, PhD – President-Elect
- Adeline Ong, PsyD – Member-at-Large
- Lizzy Finer, MA – Student Member-at-Large
- Mark Staal, PhD – Council Representative

Join the Communications Committee

The Divisions' Communications committee is looking for people to join their team! If you are interested please reach out to Anna Donaldson at: comms_committee@militarypsych.org.

Check out the Committee's APA Community Page

After logging into APA's website, select the "Groups" tab and search for Division 19!This page is an additional avenue of communication and a great way to draw new members to the Division. Please check it out, and post away!

Division 19 Mentorship Program

Division 19 has launched a mentorship program for all members, not just for students or early career psychologists. Matches are made based on personality fit, professional development opportunities, and experiential preferences. However, more mentors are needed as the program continues to grow in popularity!

To become a mentor please visit:

https://docs.google.com/forms/d/e/1FAIpQLSfHKYjBGoO3OhWBgjtGkkbEWmyz6zyKcfw8SHVcnFpUpdZMTQ/viewform

To become a mentee please visit:

https://docs.google.com/forms/d/e/1FAIpQLSdPrpoqiN3fZT9qIBzXnAyQX-nAkmao4ZVEb82HJ3i5G80_hg/viewform

Join Division 19 on social media!

- Facebook group: APA Division 19 – Military Psychology
- Twitter: @APADiv19
- LinkedIn group for ECPs: APA Division 19 - Military Psychology - Early Career Psychologists

Upcoming Conferences

AMSUS Annual Meeting

The Society of Federal Health Professionals will meet for their annual conference March 3-6 at the Gaylord National Resort and Convention Center in National Harbor Maryland. For more information about registrations, continuing education information, and seminar information, please visit: https://www.amsus.org/events/annual-meeting-2/.

Division 19 2024 Military Psychology Summit

This year's Division 19 Military Psychology Summit will be hosted in partnership with the Center for Deployment Psychology, Catholic University of America, KBR, and the DC Psychological association. The conference will be held in a hybrid format March 5th through 7th. To get more information on the summit and to hear more about the FREE CEUs, please visit: https://www.militarypsych.org/summit/.

Military Mental Health Coalition Conference

The annual Military Mental Health Coalition conference will take place on April 24th-25th on Camp Ripley in Little Falls Minnesota. The theme for this year's conference is "Transitions". For more information please visit: https://www.militarymentalhealthcoalition.com/annual-conference.

14th Annual Traumatic Brain Injury Conference

The annual Traumatic Brain Injury conference will be held in Boston May 5th and 6th. This conference is open to researchers and providers working in industry, academia, or the military and government space. For more information on registration and the conference agenda please visit: https://www.tbiconference.com/.

Preparing for APA 2025

Now that APA 2024 has wrapped, it's time to begin planning for 2025! The 2025 conference will be held in Denver Colorado August 7 – 9. Submissions for posters and presentations will open in late October or early November. Please monitor the Division listserv and social media accounts for real-time updates.

Preparing for the Center for Deployment Psychology Evidence Based Practice Conference.

Preparations for this year's CDP Evidence Based Practice conference are underway. If you would updates for this conference submit your contact information to join the conference email list. https://deploymentpsych.org/content/2024-ebp-conference-opt

Early Career and Graduate Student Resources

The DHA Young Investigator Competition

Every year during the Military Health Research Symposium, Defense Health Agency (DHA) hosts the young investigators competition. This competition recognizes future innovations in military health research submitted by residents, fellows, doctoral candidates, post-docs, and early career providers within five years of obtaining their degree. Information on this year's winning submissions is located here. For those interested in applying for next year's competition please visit: https://mhsrs.health.mil/SitePages/Young-Investigators.aspx.

Division 19 Early Career Psychologists Listserv

If you are an early career clinical or research psychologist consider joining the Division 19 Early Career Listserv. To join please go to: www.militarypsych.org/ECP-home/.

Students Seeking a Doctoral Degree in Psychology Can Now Apply for HPSP

For the first time Psychologists can apply for the VA's Health Professional Scholarship Program (HPSP). This program provides financial assistance in exchange for working in the VA system for two to three years after graduation. All those interested in applying can find more information by visiting this link: https://www.va-ams-info.intelliworxit.com.

Division 19 Online National Chapter

The Division 19 student affairs committee is excited to host its first national online campus chapter! The goal of this virtual chapter is to connect all students who are interested in military psychology. The committee hopes an online chapter will provide student affiliates from smaller campuses and communities the opportunity to connect with like-minded peers regardless even if their institution does not have an officially sponsored chapter. During meetings you can look forward to psychology-related group discussions, journal reviews, webinars, and collegial deliberation. Additionally, there are opportunities for students to take on leadership roles. More information on the Division 19 student affairs committee and upcoming online chapter meetings can be found here: https://www.militarypsych.org/student-affairs/.

Student Initiative Fund

The Student Initiative fund exists to support psychology students' engagement at the individual, local, and campus chapter levels. Students and campus chapters can apply for funding for activities, research or grassroots efforts to further the science, practice, and advocacy of military psychology. **Applications for this fund will be reviewed on a rolling basis. There is not a deadline for submissions.** For more information and application materials please visit: https://www.division19students.org/funding.html.

Connect with Division 19 Students on Social Media

- Email div19studentrep@gmail.com
- Facebook @Division19Students
- Instagram @Division19Students

Self-Paced Courses, Webinars, and Conference Archives

Center for Deployment Psychology DoD Child and Families On-demand Trainings

As part of the DoD Child Collaboration Study, CDP and the Kennedy Krieger Institute are offering evidence-based, on-demand trainings for providers working with military connected children and military families. To learn more about the available courses please visit: https://deploymentpsych.org/DoDKidsStudy?utm_medium=email&utm_source=govdelivery.

Center for Deployment Psychology Evidence Based Practice Conference Archive

Recordings of the 2021, 2022, and 2023 conferences can be found here: https://deploymentpsych.org/2021-EBP-Conference-Archive.

Center for Deployment Psychology Online Courses

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

SAMHSA Military Mental Health Webinar Series

For the last four years SAMHSA has been hosting military and veteran mental health webinars. A list of archived webinars can be found at: https://www.samhsa.gov/smvf-ta-center/resources/webinars.

VA's PTSD Consultation Program

Beginning in September 2021, the National Center for PTSD has launched a lecture series for providers committed to serving the military community. The list of upcoming webinars and lectures can be found here: https://www.ptsd.va.gov/professional/consult/lecture_series.asp.

Division 19 Webinar Series

Offering a range of topics from acquiring a VA internship to navigating the health systems for each branch of service, Division 19 has prepared a series of how-to webinars to assist early career psychologists navigate the field of military psychology. Those webinars can be found here: https://www.division19students.org/webinar-series.html.

District of Columbia Psychology Association Home-Study

The DC Psychological Association has a menu of home-study webinars available for APA approved CEU credits. While there is a discount for members the webinars are available for all professionals. https://dcpa-education-center.thinkific.com/collections

Additional Military Special Interest Groups and Organizations to Explore

The ISTSS Military Special Interest group

https://istss.org/membership/for-members/special-interest-groups-(1)

The ISTSS Moral Injury Special Interest Group

https://istss.org/membership/for-members/special-interest-groups-(1)

The Association for Contextual Behavioral Science Military Special Interest Group

https://contextualscience.org/act_for_military_sig

Australasian Society for Traumatic Stress Studies

https://www.astss.org.au/

APA Division 18, the Division for Veterans Affairs Psychologists

https://www.apadivisions.org/division-18/sections/veterans

INSTRUCTIONS FOR CONTRIBUTORS TO *THE MILITARY PSYCHOLOGIST* NEWSLETTER

Please read carefully before sending a submission.

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

Preparation and Submission of Feature Articles and Spotlight Contributions. All items prepared for submission should be directly submitted to *The Military Psychologist* email: **Div19newslettercommittee@gmail.com**. Questions about which section your submission best fits, please reach out to the section editors directly for guidance: **Feature Articles** (Taylor Zurlinden: taylor.zurlinden@gmail.com), **Trends Articles** (Krista Highland, krista.highland@usuhs.edu), **Spotlight on Research Articles** (Christine Hein: chein9@gmail.com), and **Spotlight on History** (Austin Hamilton: hami3505@bears.unco.edu). For example, Feature Articles highlight the interests of most Division 19 members; Spotlight on Research Submissions are original, quantitative studies more succinct in nature than other scholarly articles. For full-length research articles, please consider submitting to the Division 19 Journal *Military Psychology* through the online submission portal: https://www.editorialmanager.com/mil/

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

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 the **Announcements Section** editor, Grace Seamon (seamon@cua.edu).

Review and Selection. Every submission is reviewed and evaluated by the Section Editor, the Editor in Chief, and 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 submissions. Submissions well in advance of issue deadlines are appreciated. The Editor in Chief and the Section Editors reserve the right to determine the appropriate issue in which to publish an accepted submission. All items published in *The Military Psychologist* are copyrighted by the Society for Military Psychology unless in the public domain.

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