State of Psychology in the US Armed Forces

1

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Military psychology is a specialized branch of psychology that applies psychological knowledge and practice in order to promote the overall readiness of individual service members (SMs) and the military as a whole (Page, 1996). Military psychologists engage in a variety of services, such as providing direct clinical care, advising military commands, consulting, teaching, and conducting research activities. Military psychologists are comprised of military personnel (active duty, reservists, and retirees) as well as Department of Defense (DoD) personnel and contracted civilians. The application of psychology to military domains requires military psychologists to fully grasp military policies, procedures, and operations (Melton, 1957). Moreover, active duty and reserve psychologists share the uniform of those they serve and often deploy themselves to support the needs of deployed units.

Unforeseen, the nascent field of American psychology came to have a substantial impact on the operations of the United States (US) military, starting with the First and Second World Wars and continuing into the postwar period. Through various accomplishments during this time, American psychology achieved greater public recognition and acceptance as an invaluable resource to its nation (Seligman & Fowler, 2011). All in all, the rapid advancement of American psychology throughout the twentieth century was predominantly the result of its work with the US Armed Forces.

America's military engagement in World War I (WWI; 1917–1919) born the first large-scale application of psychological principles to military operations. When the US entered WWI, the field of contemporary psychology had only recently been established. The first psychology laboratory was stood up in 1879 in Germany by William Wundt, shortly followed by the first American psychology laboratory by G. Stanley Hall, a student of Wundt's, in 1883. Hall then founded the American Psychological Association (APA) less than 10 years later. Before WWI, psychology was primarily a research-academic discipline with limited use in practical settings (Seligman & Fowler, 2011). One of the first applied psychological projects, initiated by The

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Committee on Methods for the Psychological Examination of Recruits and headed by Robert Yerkes, conducted over 4000 psychological screenings with Army and Navy recruits (Driskell & Olmstead, 1989). Two years into the war effort, approximately 1,726,966 recruits had been administered intelligence tests. The verbal Alpha and nonverbal Beta tests were administered for the purposes of placing individuals into certain jobs and specialties and were the first mental ability tests to be administered in a group setting (Driskell & Olmstead, 1989; Page, 1996). The Woodworth Personality Data Sheet (an earlier version of modern personality inventories) was also administered for rapid personnel selection and classification (Page, 1996). Psychology efforts during WWI "bolstered the perception of psychology as a valuable science that could produce results of practical and immediate significance" (Driskell & Olmstead, 1989, p. 44). Following WWI, membership in the APA vastly increased from 300 to 3000 members and over 30 universities established doctoral psychology programs (Seligman & Fowler, 2011).

Psychology was also heavily utilized by the US military during World War II (WWII; 1941–1945). After war was again declared in Europe, the Personnel Testing Section was established to develop plans for mass personnel selection (Driskell & Olmstead, 1989). In addition to testing, WWII expanded the use of psychological principles to various domains, such as clinical services, research, and consulting (Summers, 2008).

The field of clinical psychology emerged during WWII, with the demand of so many military personnel needing psychological care due to their wartime experiences. Prior to WWII, psychotherapy treatment was solely provided by psychiatrists. Due to a shortage of psychiatrists to meet the larger need as the war continued, psychologists began to play a role in treating mental illness (Seligman & Fowler, 2011). In addition to treating the psychological scars of war, military psychologists were needed to help SMs in adjusting from civilian to military life, dealing with the stressors of operational work, delinquency, and successfully transitioning back from overseas (Crawford, 1970).

Throughout WWII, significant advances were made in the study of human factors, training and job performance evaluation, and understanding the effects of environmental factors and stressors on human performance (Driskell & Olmstead, 1989). Psychology also led efforts to maintain and improve domestic morale for the war (Summers, 2008). More than 60,000 interviews were conducted with soldiers to learn about concerns they had as they engaged in war. Known as *The American Soldier* series, this was the first social psychological investigation conducted by American psychologists (Summers, 2008).

As WWII came to an end, psychology kept its footing within the clinical, applied, and research arenas to serve the military's ever growing needs. By the end of the war, the number of psychologists in therapeutic roles propelled the establishment of one of the first clinical psychology training programs for advanced specialty mental health care at Brooke General Hospital at Fort Sam Houston (Summers, 2008). As 550,000 SMs were discharged from the military due to neuropsychiatric problems, which equaled about 49% of all medical discharges (Summers, 2008), the Veterans Administration (VA) launched a major program to fund the training of clinical psychologists to accommodate the mental health needs of returning SMs (Seligman & Fowler, 2011). Befittingly, the VA is noted to have been "the birthplace of professional psychology training (Summers, 2008, p. 626)." As the VA began having problems meeting the mental health needs of war veterans, Congress passed the Mental Health Act of 1946, which established the National Institute of Mental Health (NIMH). This legislation provided funds for training professionals in mental health service and research and also gave money to states to provide mental health treatment (Summers, 2008).

In 1946, the Society for Military Psychology (Division 19) was established within the APA to provide a forum for those interested in promoting the application of psychology within the military (Driskell & Olmstead, 1989). Also, from the success of utilizing psychological principles during the First and Second World Wars, the Secretary of the Navy announced the need for continued

psychological research. Congress established the Office of Naval Research (ONR) in 1946, the first federal organization to support scientific research (Driskell & Olmstead, 1989). In the 1950s, the Army Research Institute for the Behavioral and Social Sciences (ARI) expanded its capacities and created laboratories that employed psychologists to study human factors both within and outside the military context (Summers, 2008). Further demonstrating psychology's integral role in the war efforts, the first two volumes of the *American Psychologist* contained mostly psychology research conducted in WWII and summary reports about the use of psychology for military applications filled *Psychological Bulletin* (Crawford, 1970).

The utilization of psychology continued. During the late 1940s and early 1950s, human engineering was the most studied area within the military and engineering psychology soon became a separate line of study (Crawford, 1970). Subsequently, research on information flow and decision making moved to the forefront of military research (Crawford, 1970). Other research areas of interest that surfaced during the wars and continued to grow include training, effective leadership, unit cohesion, and team and group performance (Driskell & Olmstead, 1989). Also, studies of cross-cultural interactions emerged, establishing a new field of political psychology that focuses on improving the ability of the United States to interact with foreign counterparts (Crawford, 1970).

Advancing its efforts within selection and assessment, the Armed Forces Qualification Test (AFQT) was introduced in 1950 for screening and supplemental evaluation of military personnel. In 1974, the single test battery, the Armed Services Vocational Aptitude Battery (ASVAB), which is still used today, was established to screen and assign individuals to specific jobs within the services.

Today, a primary role of military psychologists is providing clinical treatment to military personnel and their families. Wars spanning from WWII to the Korean and Vietnam Wars to the recent wars in Iraq and Afghanistan have resulted in progressive conceptualizations and treatments for deployment- and trauma-related problems (e.g., posttraumatic stress disorder; PTSD). The psychological needs of military families, who are also impacted by stressors of military life, have been acknowledged and have become an important area in military psychology. More recently, the past decade has seen the growth of positive psychology (Matthews, 2008). Positive psychology is the study of positive emotions, positive traits, and positive institutions (Seligman, Steen, Park, & Peterson, 2005). It is not meant to replace traditional psychological treatments that alleviate illness and dysfunction but can be another tool for military psychologists. Providing a framework of principles and techniques that can be used by the healthy majority, positive psychology can be used to enhance resilience and teach individuals to adjust more effectively to new circumstance and stressors (Matthews, 2008). The military is a prime environment for the use of positive psychological applications and resilience building since the majority of its workforce is composed of young, healthy individuals (Matthews, 2008; Seligman & Fowler, 2011).

Through its work with the military, American psychology rose to become a major scientific discipline and profession as well as the largest doctoral-level scientific society in the world (Seligman & Fowler, 2011). Since World War I, military psychology has served as a viable model for using science in practical ways to solve problems and answer questions (Crawford, 1970). As such, other fields such as industry, education, and engineering, have welcomed psychology and have used psychological principles to advance their fields (Driskell & Olmstead, 1989). It is without a doubt that both American psychology and the US military have benefited from its collaborations and continue to help each other thrive in areas of general understanding and innovative applications.

Military Psychology

Military psychologists perform a multitude of roles within the Armed Forces, such as providing psychological services to the ten million

beneficiaries of the Military Health System (MHS), working with operational forces, consulting with military commands/leaders, and providing expertise in assessment as well as program development, implementation, and sustainment. To advance these efforts, the Surgeon General of each service appoints a senior psychologist who serves as the subject matter expert on psychological health issues and is responsible for the overall health of the community. In the Army and Air Force, these senior psychologists are the Consultants to the Surgeon General. In the Navy, the senior psychologist is referred to as the Specialty Leader to the Surgeon General. These psychologists have wide-ranging responsibilities to include advocating for their communities, recommending personnel moves, advising on policy, filling open positions, drafting congressional testimony, answering various inquiries, and mentoring psychologists.

The following sections of this chapter were written by the Army Consultant, the Navy Specialty Leader, and the Air Force Consultant. Each senior psychologist describes how psychologists enhance the performance of SMs and commands and provide examples of the various ways that psychologists are utilized within the military branches. The Army Consultant provides details of how military healthcare systems function to serve all of its consumers efficiently, and describes the role of clinical psychologists within embedded behavioral health, an initiative that brings psychologists directly into military units. The Navy Specialty Leader highlights the assorted paths of how its clinical psychologists access into the military and reports on efforts to continuously assess the needs of its psychology community. The Air Force Consultant describes the career progression of its clinical psychologists and provides a closer look at one of the most critical military programs, suicide prevention. What is described within each section is not necessarily unique to that one service. The Army, Navy, and Air Force have many similarities, learn from each other, and continue to work toward tri-service collaborations to best take advantage of the valuable contributions that psychologists offer the military enterprise.

Army Clinical Psychology

Army behavioral health has experienced incredible growth and transformation over the last decade. The total number of outpatient behavioral health visits increased from approximately 900,000 encounters in Fiscal Year 2007 (FY2007) to over two million in FY2013. Behavioral health resources also dramatically increased as the number of civilian psychology positions doubled from around 500 to 1000 over the same time period. Since 2012, the behavioral health officer authorizations in all Army Brigade Combat Teams doubled from one to two, dramatically increasing both the Active Component and Reserve Component psychology authorizations. Starting in 2013 and continuing through 2017, the majority of Functional Support Brigades and Army Special Operations Command units also grew to two behavioral health officer authorizations each. The total number of behavioral health officer authorizations almost tripled from 65 in 2010 to 179 in 2015. The number of psychology authorizations has increased to its highest total of 248 psychologists for FY2017. Also, to meet the growing needs of operations, internships and residency programs have increased. The internships in the Army are now up to five locations, as well as various residency programs. Similarly, the Navy and Air Force have also recently augmented their training programs to meet the operational needs of their branches.

The Behavioral Health Service Line

On Army posts (also referred to as garrison), behavioral health needs for soldiers and their families are now supported through the Army's Behavioral Health Service Line (BHSL), which provides standardized, integrated, and centralized tracking of its behavioral health programs and behavioral health patients (Lopez, 2013). The BHSL implements Army-wide standards to provide soldiers and families a uniform care experience at any Army post. The BHSL operates as a single behavioral health system that supports the readiness of the force by promoting

health, early identification of behavioral health issues, delivery of evidence-based care, leveraging the broad Army community, and monitoring efficiency and quality metrics. The BHSL is made up of 11 standard clinical programs, which include Embedded Behavioral Health, Primary Care Behavioral Health, and Child and Family Behavioral Health Services, to include School Behavioral Health. Along with providing direct care, these programs proactively address the stigma related to seeking behavioral healthcare by focusing on reaching soldiers and families where they are located, thereby decreasing barriers to care and improving access to care. In addition to the BHSL programs, there are several Army-wide healthcare programs that rely on psychologists to be successful, such as Interdisciplinary Pain Management, Traumatic Brain Injury, and the Patient Centered Medical Home.

Behavioral Health Data Portal A key BHSL program is the Behavioral Health Data Portal (BHDP). BHDP is an Army-wide, web-based application that includes standardized behavioral health intake questions and assessments as patients enter into behavioral health clinics. Clinicians can then use the patient-entered data to inform their clinical care and to track outcome measures. BHDP allows for real-time display of outcome measures for clinical care and aggregates data at a clinic level for meaningful program evaluation.

Key elements of BHDP include (1) rapid check-in capability using a military ID card, (2) sorting and filtering patient lists by provider and clinic, (3) provider ability to track patient care, (4) clinical outcomes graphed, (5) report of deployment history, (6) integrated deployment health assessment data, (7) Warrior Transition Unit status, (8) standardized documentation templates integrated with patient reported data, (9) provider determined risk levels over time, and (10) patient satisfaction data. Along with clinical outcome measures of PTSD (PCL-5), depression (PHQ-9), and anxiety (GAD-7), BHDP was updated in 2014 with evidence-based screening for suicidal ideation using the Columbia Suicide Severity Rating Scale (C-SSRS). This allows for better detection of suicidal ideation among patients accessing behavioral health care and should lead to earlier intervention to help prevent suicidal behavior.

BHDP was piloted in April 2012 and was adopted as an Army-wide program in December 2012 via Operational Order 12–47. By June 2014, BHDP had been used in over 50,000 behavioral health encounters a month with a total of over 550,000 surveys collected Army-wide. In 2015, the National Guard received funding to roll-out a version of BHDP to all 52 states and territories. BHDP is being tested in settings outside of Army behavioral health clinics as well. It is being piloted for use as a behavioral health screening tool for patients in primary care settings working with primary care psychologists. Capability is also being built within BHDP for use in Child and Family behavioral health clinics.

The former Assistant Secretary of Defense for Health Affairs mandated in September 2013 that BHDP be adopted throughout Air Force behavioral health and Navy mental health clinics. Tri-service goals for BHDP are to improve patient care by implementing a centralized and standardized system that collects various types of care-related information. This not only reduces redundancy, streamlines care, and prevents patients from becoming lost during transitions, but also allows the opportunity for clinical outcomes to be tracked in order to better assess the effectiveness of clinical care in the military.

The Embedded Behavioral Health (EBH) Program The EBH program, an Army-wide BHSL program that was established by a Headquarters Department of the Army Order in July 2012, demonstrates the valuable role that military psychologists serve as consultants to unit leaders on a variety of issues. The EBH program was designed as a public health model where clinic providers establish longitudinal relationships with a unit's chain of command. EBH is an early intervention and treatment platform that promotes soldier and unit readiness. EBH consists of multidisciplinary behavioral

health clinics within the supported unit's area and ensures close communication between unit leaders and behavioral health providers. These providers are aware of the unit's mission readiness and soldiers' safety status, and regularly report trends to leadership.

Consultation with military leaders has always been a key role for military behavioral health/mental health providers in all of the services (Bey & Smith, 1971). Military psychologists consult with leaders about individual SMs, systemic issues, and unit functioning. They frequently need to make determinations of fitness for duty in order to ensure the readiness of the unit. They evaluate and treat medically-not-ready SMs and consult with their respective leaders on how the unit can assist in the rehabilitation of the individual or provide an environment to prevent further deterioration of SMs while they are being separated from the military. Finally, they coordinate follow-up care after a SM is discharged from an inpatient psychiatric hospital stay. Unit-level consultation can include predeployment or resiliency classes, stigma that may prevent engagement in behavioral health care, unusually harsh or lenient unit climates, rates of acute admissions or safety-related events, lack of follow-through on recommendations, and delayed processing of behavioral health related administrative separations.

Throughout the military enterprise, engaging leaders is especially vital because the behavioral health of a unit and its members is impacted to a large degree by leader behavior (Britt, Davison, Bliese, & Castro, 2004). SMs who had a more positive view of their leaders and described higher unit cohesion reported lower stigma and perceived barriers to behavioral health care (Wright et al., 2009). This is critical as stigma and barriers to care in the military have been well documented (Olmstead et al., 2011). Military psychologists can address cohesion and overall unit functioning with leaders, which proactively addresses the stigma related to seeking behavioral health care, and thus impacts the behavioral health status of a unit.

To optimally perform their roles, military psychologists must understand military norms as they pertain to culture, behaviors, and expectations. Cultural competence is as necessary in the military subculture as it is in any unique culture. Unit psychologists must speak the "language" of their service and avoid psychological jargon. They shape the expectations of leaders in what services psychologists provide and what the limitations are of the profession. The restrictions of communication with unit leaders are clarified in several DoD Instructions [DODI 6490.08 (2011); DODI 6490.04, (2013)]. Military psychologists can only share protected health information in specific situations that include harm to self or others, harm to the mission, inpatient care, acute medical conditions interfering with duty, substance abuse treatment, and command-directed mental health evaluations. To inform SMs of these boundaries, they are included in the standardized limits of confidentiality forms used in military behavioral health clinics.

Operational Psychology

Similarly throughout all the services, psychology has expanded into other areas of the military outside of health care facilities and direct clinical care. Operational psychology is an area of increasing emphasis. "Operational psychology involves the application of the science of behavior to national security, law enforcement, and military operations (Williams, Picano, Roland, & Bartone, 2012, p. 37)". It is the use of psychological principles and skills to enhance the effectiveness of military and intelligence operations. The roles of operational psychologists are varied. They may perform clinical duties on post or deployed, but their primary mission is to assist with military operations and/or national security. The initial role of operational psychologists was to conduct assessments as part of the selection of personnel for training of particular missions. The scope of their services has now expanded far beyond that. Roles for psychologists with special operations units include consulting with intelligence teams, contributing to indirect assessments, counterintelligence operations, and security clearance evaluations.

The importance of operational psychology is exemplified by that fact that some officer positions typically have a finite number of authorizations while operational psychology positions continue to grow. The efforts of operational psychologists have increased the acceptance of behavioral health within various operational communities such as special operations, aviation, and recruiting as evidenced by the rapid growth of operational psychology positions as well as the expansion of their roles.

Navy Clinical Psychology

The mission of Navy clinical psychology is to improve the psychological health of Sailors and Marines by promoting evidence-based comprehensive care, supporting warriors across the deployment cycle, and building a ready and resilient fighting force. As of August 2016, Navy clinical psychology had over 200 positions (or billets) for active duty psychologists across the world. Almost all of these 200 billets are filled, resulting in the Navy clinical psychology community being just about 100% staffed. There has been tremendous growth within the Navy clinical psychology community, almost doubling over the past 10 years. As both the number of billets and the percentage of manning increase, a key aspiration of the Navy clinical psychology community is that each Sailor and Marine continues to receive the highest quality of care.

The majority of Navy clinical psychology billets are located at Military Treatment Facilities (MTFs), with a quarter of those located overseas. About 20% of the billets are located within operational commands and about 5% on aircraft carriers. Finally, about 15% are training billets. As the Specialty Leader makes billet recommendations, priority goes to overseas and operational billets. Active duty psychologists rotate duty stations about every 2 or 3 years. Similarly across the services, to make billet rotation decisions, the Specialty Leader/Consultant utilizes the "detailing triangle." That is, needs of the military, professional considerations, and personal concerns are considered when choosing the best next duty station.

In an effort to reach and maintain 100% staffing, the accession paths for each military branch are constantly being adjusted to try to anticipate future needs. There are currently five accession paths to become a clinical psychologist in the Navy. The first is to attend the Uniformed Services University of the Health Sciences (USUHS) Clinical Psychology Ph.D. program. Two new students are accepted each year. After 4 years of tuition-free training, the officer is required to complete 7 years of obligated service. With the Health Professions Scholarship Program (HPSP), individuals attend a civilian doctoral program and then attend the Navy APA internship program at Naval Medical Center Portsmouth (NMCP). The Navy currently selects five HPSP recipients each year. The third accession path is to enter through one of the 12 APA predoctoral internship slots at Naval Medical Center San Diego (NMCSD) and Walter Reed National Military Medical Center. The fourth accession path is to enter through one of the two APA postdoctoral internship slots at NMCP. Both the pre- and postdoctoral internships incur 3 years of obligated service. The final accession path is through direct accession. A direct accession psychologist is required to already be licensed in any state and incurs 3 years of obligated service. The number of direct accessions varies from year to year, but has averaged about three per year.

In order to improve accession and retention rates of Navy clinical psychologists there are various opportunities for special pay. There is incentive pay for being licensed, retention bonuses for signing up for additional years of service, and board certification pay, which can all add up to about $30,000 of additional pay per year. The Navy accesses about 25 psychologists at various levels of training and loses about 15 psychologists per year. This net growth of 10 psychologists per year will hopefully maintain the community at 100% staffing.

Navy Operational Psychology

Similarly across all three services, psychologists have been rapidly expanding into operational roles. Prior to the year 2000, an active duty psy-

chologist could easily spend his/her entire career practicing in MTFs. In the late 1990s, psychologists started expanding their operational involvement as they began serving on aircraft carriers. As combat operations expanded in the Middle East, the positions available for clinical psychologists grew significantly and have almost doubled over the past 10 years. For Navy psychologists, the vast majority of the growth has occurred in operational settings, such as Marine infantry and special operation units, Presidential support duty, and Survival-Evasion-Resistance-Escape training units.

Operational commanders increasingly realized that psychologists directly assist in accomplishing their missions and in keeping SMs prepared in the fight. Navy psychologists started being assigned to Marine infantry units and Navy Special Warfare units as embedded mental health providers as well as the submarine community and units in the Marine Logistics Group. The largest changes for these embedded psychologists were that they now found themselves assigned to line units, reporting to line commanders, and involved in more prevention work vice treatment. To facilitate integration into the line units and to decrease stigma, these embedded psychologists often found themselves on convoys, at combat outposts, and out on patrols. There is some debate as to whether psychologists should be in these embedded roles. Advocates cite increased return to duty rates, improved access to care, decreased mental health stigma, and accolades from line leadership. Those opposed cite danger, unnecessary risk to scarce psychological resources, and compassion fatigue.

Assessing the Needs of Navy Psychologists

Given the various work- and military-related stressors that psychologists in the military have the potential to face, it is important to routinely monitor their wellbeing and readiness. In collaboration with the Navy Specialty Leader, the Naval Center for Combat & Operational Stress Control (NCCOSC) conducted a needs assessment of Navy clinical psychologists in 2014. There were 86 psychologists who completed the questionnaire and they reported low to average levels of distress and high life satisfaction. Psychologists reported average scores on a general stress measure, yet a little over 20% endorsed high levels of stress. Although psychologists endorsed a high level of life satisfaction overall, 20% reported below average life satisfaction.

The needs assessment also found that job satisfaction was high for psychologists whereas professional burnout was mixed. For all dimensions of job satisfaction that were assessed, the psychologists scored higher than comparison norms. When assessing professional burnout, emotional exhaustion (i.e., feelings of being emotionally overextended by one's work) was higher than a comparison sample whereas levels of depersonalization (i.e., having an unfeeling and impersonal response toward patients or those you care for) were similar. Scores on personal accomplishment (i.e., feelings of competence and successful achievement) were higher than the comparison group. Additionally, psychologists endorsed more challenges in balancing work and family compared to nonmilitary norms.

Finally, the needs assessment found that psychologists generally reported positive deployment experiences. Approximately, 36% of psychologists had been deployed one time and 60% were deployed two or more times. Overall, exposure to combat and aftermath of combat as well as PTSD scores were low. And, following deployment, 14.3% of psychologists felt they required mental health services. For those who had deployed, 81% described their deployment experiences as positive overall.

Being ready to deploy to anywhere around the world with little notice is a hallmark of being a Navy psychologist. As the needs assessment indicated, over the past 15 years, psychologists have deployed frequently to Iraq, Afghanistan, Djibouti, Bahrain, and aboard ships. One psychologist summed it up well: "These memories are of tremendous happiness, pride, struggle, and horror, but through them all I doubt I will ever feel a greater sense of purpose, camaraderie, and honor." (The Navy Psychologist, 2015). This is the essence of serving as a clinical psychologist in the military.

Air Force Clinical Psychology

Air Force clinical psychology is a vibrant community and is better manned than ever. The Air Force pursues a range of options to close the manning gaps of active duty Air Force psychologists. One such effort has been to continue the increased compensation and training efforts to recruit and retain psychologists. Since 2009, the Air Force has been offering special pay plans for psychologists including incentive bonuses for licensed psychologists of $5000 per year and retention bonuses of up to $20,000 per year for a 4-year commitment. To attract new psychologists, the Air Force has continued with its three APA-approved clinical psychology internships with 20–24 interns accessed and trained per year. The Air Force has also introduced accession bonuses of up to $15,000 per year for fully qualified applicants, resulting in the accession of many fully qualified applicants to the Air Force psychologist community. The Psychology Consultant works closely with the Air Force Personnel Center to maintain and further develop specialty-specific sustainment models. These efforts appear to be paying dividends as the Air Force is now at 92% manned for active duty psychologists, up from 89% last year, and 70% 3 years ago. There are currently 262 positions for psychologists in the Air Force with 241 well qualified active duty psychologists on hand to fill those positions.

Retention of these skilled individuals is critically important. Currently, junior psychologists tend to separate from the Air Force prior to completing a 20-year career at a greater rate than the Air Force average. This is likely due to other opportunities and/or family demands available for these young psychologists that pull them away from a career in the Air Force. The more senior psychologists tend to stay in for a full 20-year career at greater rates than the Air Force average. This makes sense because these are individuals who have committed to an Air Force career and as a result find it satisfying, rewarding, and tend to remain. Fortunately, since 2011, accessions into the Air Force have outpaced retirements and separations out of the Air Force.

There are some specific milestones critical for successful promotions for Air Force psychologists that directly impacts retention. Psychologists come into the Air Force as Captains (all services bring in new officers that are completing their graduate degree at an O-3 grade that is Captain in the Air Force and Army and Lieutenant in the Navy). At this stage, they are actively engaged in obtaining all their basic professional qualifications. They are completing their APA-approved internship, doctoral degree, and postdoctoral supervision requirements. They are expected to obtain their psychology licensure within 18 months of graduation from the internship and to learn to apply clinical skills in a military environment. In addition, they are expected to be involved with junior leadership and other professional development activities. They are encouraged to participate in flight and squadron activities and even Installation-wide events in order to learn officer skills. Their typical first duty assignment (after internship) is to work in a Mental Health Element, Alcohol Drug Abuse Prevention and Treatment program, or Family Advocacy with a focus on ultimately leading an element as the Element Chief.

After several years on active duty, these young psychologists become more senior Captains and Majors. At this point, they have obtained the basic professional qualifications as a psychologist. Although they are fully licensed and capable of independent practice, they continue to obtain training in various empirically-based therapies, such as exposure-based therapies (e.g., Prolonged Exposure). They are also much more involved with larger scale wing and hospital or clinic projects. They are encouraged to seek opportunities to expand management and supervisory skills. They are also encouraged to complete Squadron Officer School, which is the rank-appropriate professional military education for Captains, and Air Command & Staff College, which is the rank-appropriate professional military education for Majors. At this stage, they are generally on their second or third duty assignment opportunities in small leadership roles as Element Chief and or even as a Flight Commander at a smaller clinic. They can consider overseas assignments,

and this is a good time to apply for fellowship specialty training in psychology. At this juncture, they obtain advanced professional qualifications by seeking advanced board certification in a specialty area. They are also becoming more polished Air Force officers with enhanced leadership and professional development activities. They work at Major Commands (MAJCOM), AF-level working groups, lead base Integrated Delivery System, and possibly attend the Intermediate Executive Skills Course. Job opportunities expand and they can become faculty at a psychology training site and attend a postdoctorate fellowship in Clinical Health Psychology, Neuropsychology, Forensic Psychology, Combat Operational/Aviation Psychology, or Pediatric Psychology. They are also eligible for MAJCOM Mental Health Consultant or a Mental Health Flight Commander leadership position.

The next step for a psychologist is to become a Lieutenant Colonel. As senior psychologists, there are more leadership and professional development opportunities available to them. They attend the Intermediate Executive Skills, if they have not already, and seek out and become a squadron commander course (if selected). They then attend rank-appropriate professional military education, Air War College (or equivalent). Job opportunities for Lieutenant Colonels include Internship director, Air Staff action officer, Squadron commander, or other Specialty positions such as Air Force Inspection Agency Inspector, Special Operations, or Air Force Safety Center.

The next step is Colonel, and once this rank is obtained, members seek out and complete advanced leadership and professional development activities such as Interagency Institute for Federal Health Care Executives, and MHS CAPSTONE. Professional military education includes the Senior Developmental Schools (i.e., Air War College, The Eisenhower School). Potential duty assignment opportunities as Colonel include Group commander, large squadron commander, AFMOA Mental Health Division Chief, and SG Consultant for Air Force Psychology. Other specialized leadership positions are also available including SAMMC Department Chair, AFSOC, and other DoD staff positions. After this stage, psychologists are eligible to become General Officers and, if selected, are then moved into very senior AF Medical Service leadership positions.

Embedded Air Force Psychologists

Similar to the Army and Navy, embedding psychologists into Air Force operational units has become a critical alliance between medical and the line. The primary purpose of using psychologists embedded into line units is to enhance warfighters' operational effectiveness, to ensure the highest state of psychological readiness at all times, to prevent negative mission impact, and to reduce mental health stigma. The embedded psychologist provides units with many types of psychological health activities, including prevention and education on mental health related issues. This education is largely accomplished in briefings specifically tailored for the individual or unit's mission (i.e., suicide prevention, stress management/relaxation training, anger management, sleep hygiene, "warrior mindset," alcohol and drug abuse prevention, etc.).

The embedded psychologist allows unit members to be identified and referred for mental health treatment early enough to prevent degraded performance both professionally and personally. This embedded model is also an effort to decrease negative stigma about seeking mental health treatment by encouraging early help seeking. It capitalizes upon the proximity effect of having a familiar face in the unit, so that unit members are more likely to find the psychologist approachable. The embedded psychologist provides a link to the local leadership, a critical element in communicating with the leadership on unit morale, individual mental health, and mission effectiveness. Through consultation and referral, the embedded psychologist liaises with other helping professionals (i.e., chaplain, medical personnel, military family life consultants, etc.) to foster a healthy community within the unit. No medical treatment is provided in the unit setting. All treatment must occur within the Mental Health

Clinical area in the hospital or clinic. Once the embedded psychologist identifies someone in need of care, they arrange to have the individual seen within the clinical areas.

In March of 2012, the Air Force Surgeon General directed Air Force Mental Health to establish a full-time embedded mental health provider at seven bases to care for high operational units. This effort has since expanded to nine bases. Preliminary data indicate a reduction in both distress and PTSD incident rates in this population. One operator who had contact with the embedded mental health team stated that, "without their proximity, the level of services engaged by members of our group would drop off dramatically, as they simply would not seek help from across the base. Proximity is essential." It appears that the embedded role of the Air Force clinical psychologist will continue to be a mainstay in the Air Force, along with the rest of the military branches.

Fundamental Issues Addressed by Military Psychology Across the Services

Suicide Prevention

Suicide prevention is a vital initiative across all three services. The Air Force Suicide Prevention Program (AFSPP) is a community-based, evidence-based approach that has demonstrated a reduced suicide rate in the 15 years since the program was initiated. The 11 key elements of the AFSPP foster a much stronger Wingman culture. These elements can be grouped into three broad categories:

- Leadership and community: commander's involvement, unit-based preventive services, wingman culture, suicide tracking and analysis, post suicide response ("postvention"), Integrated Delivery System, Community Action Information Board, and the Community Assessment Survey.
- Education: suicide prevention training for all Airmen, addressing suicide prevention through professional military education, guidelines for commanders on the use of mental health services.
- Protections for those under investigation: investigative interview policy and Limited Privilege Suicide Prevention program.

The installation suicide prevention program manager is a mental health provider and a subject matter expert on suicide prevention and as such leads the program. Air Force suicide prevention is a community program and so involves the shared responsibility of all the base helping agencies, leadership, and the individual members themselves.

Leaders at all levels are a key component of the AFSPP. Leaders are taught and encouraged to stress the importance of individual well-being and the important role this plays in suicide prevention. This includes removing barriers to help seeking and creating a climate that does not tolerate any actions that belittle, humiliate, or ostracize those who are in need of help. The idea is to communicate strength-based messages focusing on resilience, overcoming life's challenges, and early help seeking. A good way to do this is to highlight examples where an Airman sought help early and as a result had a successful outcome. Also, the AFSPP emphasizes personal responsibility so that each Air Force member knows to be a good Wingman to others as well as themselves (e.g. Ask Care Escort [ACE]), and Airmen are taught to seek personal support when needed.

Training is a key component of the AFSPP and psychologists are heavily involved with this aspect. In 2015, the Air Force shifted the training vehicle from a computer-based suicide prevention annual training program to in-person training within small groups. The training is designed to be facilitated in small groups by supervisors or leaders from the Airmen's own unit and has been lauded as a welcome change. Additional training includes the Frontline Supervisor Refresher Training, which is an annual refresher course reinforcing the in-person the Frontline Supervisor Training for at-risk career fields. There is also Memorial Guidance training which supports leaders in postsuicide efforts by offering recom-

mendations regarding memorial services and other efforts to comfort the grieving, support survivors, and encourage those in need to seek help, all the while avoiding glamorization of the death to prevent copycat suicides.

An additional Air Force resource is the Family Guide for Suicide Prevention. This is a user-friendly pamphlet providing straightforward information on suicide protective factors, risk factors, and warning signs to better educate our family members. The Post-Suicide Response Supplement for Installation Suicide Prevention Program Managers, another key resource, provides information and recommendations for installation suicide prevention programs to effectively support leaders in their responses to suicides and suicide attempts. Offering support early is associated with increased help-seeking behavior and should always be highly encouraged by unit leaders.

The Army and Navy also have their own suicide prevention programs. The Navy's suicide prevention program is part of the larger twenty-first Century Sailor & Marine initiative, which provides Sailors and Marines and their families with the support network, programs, resources, training and skills needed to overcome stress and adversity and thrive. The Every Sailor, Every Day campaign educates individuals on strategies to manage stress, recognize risk, seek help and intervene early, while promoting proactive and open communication. In the Fall of 2015, a new message as part of the campaign was launched which encourages simple acts that may contribute to saving someone's life. The "1 Small ACT" campaign, formed from the Navy's Ask Care Treat (ACT) model, aligns with the collaborative communications efforts between the DoD Suicide Prevention Office and Veterans Affairs (VA) campaign of the Power of 1 concept, which promotes the idea that one simple act has the power to make a difference (Navy Expeditionary Combat Command Public Affairs [NECC], 2016).

The Army's Health Promotion Risk Reduction policies and programs includes various suicide prevention efforts, particularly at battalion and brigade precommand courses. Interventions such as the Ask, Care, Escort-Suicide Intervention program and Applied Suicide Intervention Skills Training program aim to identify personnel who may be at risk for suicide, as well as promote suicide prevention and provide outreach services. The Army has also created various working groups at the installation level, which includes the Suicide Senior Review Group, the Survivor Outreach Services, and the Specialized Suicide Augmentation Response Team/Staff Assistance Team Visits. Additionally, the Army Study To Assess Risk and Resilience in Service members (Army STARRS) is the largest study of suicide and mental health among military personnel to date. A primary aim is to identify risk and protective factors for suicide among SMs and provide a scientific basis for effective and practical interventions to reduce suicidal behavior and also target associated mental health problems (Morales, n.d.).

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) continues to be a significant issue that military psychologists must identify, address, and monitor throughout all branches of the military. PTSD can occur after someone experiences, or witnesses, a traumatic event. Examples of such events can be combat, a terrorist attack, sexual or physical assault, a serious accident, a natural disaster, or childhood sexual or physical abuse. PTSD can be a significant condition especially when symptoms continue more than 1 month after exposure to a trauma and significant distress or impairment in social, occupational or other important areas of functioning. The symptoms of PTSD fall into four main categories: intrusions (e.g., nightmares); avoidance; negative alterations in cognitions and mood (e.g., guilt); and alterations in arousal and activity (e.g., hyperarousal). The vast majority of people who experience or are exposed to traumatic events will have an immediate reaction and may experience some initial challenges, but they will recover quickly and have no long-term effects. While some people may experience stress symptoms after experiencing trauma, diagnosis of PTSD by a qualified medical provider is

different. If symptoms continue for more than 1 month after a trauma and/or worsen, cause significant distress, and/or interfere with daily functioning at home and work then an evaluation by a medical provider is needed to determine if a diagnosis of PTSD is appropriate.

The incidence rate of PTSD for active duty personnel is 0.6%. This number is based on SMs being diagnosed in a medical setting and may be artificially low due to stigma and other barriers that prevent some members from seeking help (see also Riggs & Malonnee, Chap. 3, this volume). Higher rates of PTSD have been cited, but those accounts are often referring to positive answers to anonymous screening questions on the health assessment questionnaires (Hoge et al., 2004).

Efforts to Reduce Mental Health Stigma

In addition to identifying and treating mental health disorders (e.g., PTSD), military psychologists lead the effort to reduce mental health stigma in all the services and work with commanders and leaders to promote early help seeking.

Concerns that seeking mental health care will impact one's career or security clearance is an issue that is shared across all three services. For example, according to the 2013 Community Assessment Survey, 33% of Airmen report a belief that seeking counseling is not likely to have a negative impact on their career and 26% believe that seeking counseling is likely to have a negative career impact.

To learn more about patterns of communication between mental health providers and unit leaders, a study of 1205 Airmen at eight installations by Rowan and Campise (2006) found that in 90% of cases where Airmen self-referred to mental health, no contact was made with the member's unit. In the 10% of cases involving contact with the unit, 70% of the contacts were made to inform the command there were no concerns or to provide recommendations to support the airman. In 25% of cases when the chain of command referred, no unit contact occurred. Out of the 75% of cases that contacts occurred after the command referral, 93% were to inform the command that there were no concerns or to provide recommendations to support the Airman.

Information is typically only shared with the senior leadership in the unit (e.g., the Commander and/or First Sergeant in an Air Force unit) and typically involves issues surrounding the SM's safety, fitness for duty, and what the command can do to help improve the likelihood that a SM will benefit the most from treatment. If the SM is not World Wide Qualified (i.e., fit for duty), the individual is placed on temporary medical profile in order to complete treatment. Senior leadership is often a tremendous asset by collaborating with individuals in care to address work/family issues and modifying schedules to facilitate treatment. As is the case for all three services, promoting appropriate communication between behavioral/mental health providers and command leaders improves overall care and recovery and can be an impetus for reducing mental health stigma throughout the military.

Conclusion and Thoughts for the Future

Military psychology has served as a model to the broader discipline for how to bridge science and practice. Collaborations between the field of psychology and the US military resulted in significant advances in clinical and research arenas, such as assessment and selection, psychological treatment, training and job performance evaluation, as well as understanding the effects of environmental factors and stressors on human performance. Military psychology also showcases an exemplary training program and professional development philosophy that will foster generations to come. The military is strongly committed to the training and professional development of its new accessions. Each branch offers excellent training opportunities through APA approved internships and fellowships in a variety of settings (e.g., operational, intelligence, aerospace) and subspecialties (e.g.,

pediatric, forensic, neuropsychology). Moreover, military psychologists enter into leadership positions relatively early into their careers, equipping them with the experiences and abilities to lead and serve valuable roles in a multitude of ways such as clinical leadership in department settings, medical leadership within operational units, and supervisory and administrative leadership in strategic staff positions.

Military psychologists play a pivotal role within the overall military organization and have become behavioral science assets essential to all military communities, and there is no doubt their roles and responsibilities will continue to increase in scope and demand. Similarly, military psychology continues to grow within the psychological community as a whole. Division 19 (Society for Military Psychology), one of the original 19 chapters of APA, has a strong commitment to advancing science and practice, promoting scholarship and leadership, and building a community and collaborative efforts that includes national and international initiatives. Although membership in the overall APA organization has been getting smaller, Division 19 continues to experience an increase in its membership.

After a remarkable history, recent trends suggest that military psychology is approaching another important inflection point. This time, the major change will be consolidation between the services. The Goldwater-Nichols Department of Defense Reorganization Act of 1986 drove the interoperability of military services, but each branch has retained its unique customs, cultures, and practices. Meanwhile, military medicine is blazing toward true integration. Several military medical facilities, including flagship medical centers such as Walter Reed National Medical Center in Washington DC, are now administered by the Defense Health Agency (DHA) rather than individual services. When operating overseas as part of Joint Task Forces, psychologists provide services not just to those wearing their own service uniform but any soldier, Sailor, Airmen or Marine assigned to the mission.

A true joint future might be close at hand. In 2015, The Military Compensation and Retirement Modernization Commission, working at Congress's behest, recommended more tightly integrated medical capabilities across the MHS. As this chapter goes to press, both houses of Congress have passed draft legislation that would increase the authority of DHA and reduce authorities for individual service medical departments. It is not hard to imagine a near future in which even more training, deployments, and other assignments for psychologists are conducted jointly.

Regardless of which agency ultimately becomes responsible for training and organizing military psychologists, several things are nearly certain. The continued destigmatization of mental health and behavioral health services will rightly increase the demand for clinical psychology within the military. Humanitarian and peace missions will continuously require the services of deployable uniformed psychologists to address the mental health and behavioral health concerns among impacted populations and those SMs deployed to assist these populations. Meanwhile, so long as the US finds itself engaged in low level conflicts where special operations and intelligence capabilities are at the forefront, we can expect robust demand for operational psychology as well.

To meet these needs, military psychologists must not only deliver excellence every day, but also communicate how the behavioral sciences support SMs and military units/commands as well as the military and nation as a whole. Attracting talent to the ranks will require messages that highlight military psychology's excellence, diversity and contributions. As this chapter has demonstrated, military psychology has a great story to tell, a proud history, and a bright future.

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