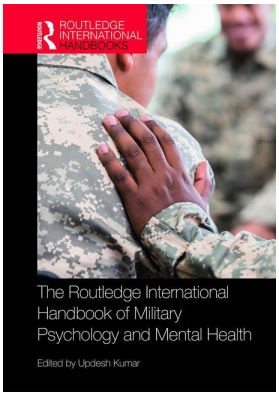

The Routledge International Handbook of Military Psychology and Mental Health

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Clinical health psychology applications in military settings

Publication details
https://test.routledgehandbooks.com/doi/10.4324/9780429281266-24
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Published online on: 19 Dec 2019

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CLINICAL HEALTH PSYCHOLOGY APPLICATIONS IN MILITARY SETTINGS

Ryaja Johnson and Larry C. James

The health of the U.S. Armed Forces is paramount for the defense of the United States. More than 2.8 million service members have been deployed in support of wars in Afghanistan and Iraq since 2001 (Meadows et al., 2018). Riggs and Mallonee (2017) estimated that 15%–35% of service members returning from the wars experienced substantial psychological distress and reintegration problems. The most common injuries sustained by service members from almost 20 years of continuous war are, posttraumatic stress disorder (PTSD; 4%–25%), mild traumatic brain injury (mTBI; 8%–20%), and depression (5%–15%; RAND, 2016; Riggs & Mallonee, 2017). It is noteworthy to mention that service members report a variety of other problems that are psychological or impact psychological functioning; these include anxiety, sleep disturbances, diabetes, chronic pain, asthma, relationship difficulties, substance use problems, and suicidal ideations (Hunter et al., 2018; Ogbeide, Landoll, Nielsen, & Kanzler, 2018; Riggs & Mallonee, 2017).

The widely-accepted definition of "health" was authored by the World Health Organization in the Preamble to the Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948). The U.S. Department of Defense (DoD) has taken considerable steps to improve the population health and mission readiness of the 1.37 million active duty service members and an additional 170,000 Guard and Reserves members seen within the Military Health System (MHS; Military Health System, 2019). One major step taken by the DoD in most military primary care treatment facilities was the integration of behavioral health personnel, mainly clinical health psychologists, as full-time team members in what is referred to as "Patient-Centered Medical Homes" (PCMH; Hunter, Goodie, Dobmeyer, & Dorrance, 2014).

To maintain the health of service members, MHS adopted Quadruple Aim as their ultimate goal. Quadruple Aim consists of the following four objectives:

- Readiness: Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- Population Health: Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

- Experience of Care: Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.
- Per Capita Cost: Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity (MHS, 2013).

The role of a clinical health psychologist naturally complements the DoD and MHS aims to maintain a healthy fighting force. The primary objective of a clinical health psychologist is to apply scientific knowledge of the interconnectedness of behavioral, emotional, cognitive, social, and biological components in health and disease to promote and maintain health. Clinical health psychologists accomplish their objective from a psychological perspective of prevention, treatment, and rehabilitation of illnesses and the improvement of the health care system (Council of Clinical Health Psychology Training Program, 2019).

Clinical health psychologists understand common medical problems and treatments and take a biopsychosocial approach to screening, assessment, and intervention (Hunter et al., 2014). Targeting behavioral factors that contribute to a patient's physical health is the distinct focus in clinical settings (Clinical Health Psychology Specialty Council, 2017; Council of Clinical Health Psychology Training Program, 2019). Clinical health psychologist can employ numerous evidence-based interventions designed to target the diverse array of problem presentations common in primary care. Interventions primarily consist of cognitive–behavioral approaches (Haibach et al., 2017). A clinical health psychologist is typically referred to as Behavioral Health Consultant (BHC) when integrated into a primary care setting because there is an emphasis on consultation, with the BHC providing feedback to the primary care physician on a unified treatment plan for a patient (Corso et al, 2012; Dobmeyer, 2013; Landoll, Nielsen, & Waggoner, 2017; Ogbeide et al., 2018).

Unique clinical applications for military veterans suffering from mental health and/or medical disorders

Service members experience a variety of mental and medical concerns during their military careers. Common complaints are PTSD, mTBI, depression, anxiety, insomnia and nightmares, diabetes, chronic pain, asthma, relationship difficulties, substance use problems, and suicidal ideations (Dobmeyer, 2013; Hunter et al., 2018; Ogbeide et al., 2018; Parker et al., 2017; RAND, 2016; Riggs & Mallonee, 2017). Additionally, service members compared to civilians are more likely to smoke cigarettes and misuse alcohol (DoD, 2013). Weight management has also become a great concern in recent years (Haibach et al., 2017; Meadows et al., 2018; Parker et al. 2017). In 2015, the prevalence of obesity amongst service members ranged from 6.4% in the Marine Corps to 18.0% in the Army (Meadows et al., 2018).

When service members returning from deployment suffer from mental health disorders or preventable chronic diseases, their readiness for duty is greatly impeded. Additionally, service members' ability to effectively reintegrate with families and their civilian communities is negatively impacted after deployment (Riggs & Mallonee, 2017). Given the large number of service members who have been deployed and the subsequent high psychological burden associated with combat, it is of no surprise that the DoD has devoted considerable attention and resources to behavioral health support (Russell et al., 2014).

The DoD has recognized that the health and ultimate readiness of the Armed Forces depend upon psychosocial well-being. Since the late 1990s, the DoD has been implementing mental health-related programs to increase readiness (Hunter et al., 2014). One of the major

evidence-based transformations within DoD was the integration of biomedical and psychosocial care into the primary care setting (Haibach et al., 2017; Mauksch, Peek, & Fogarty, 2017). The integration of clinical health psychologists within primary care clinics in military medical facilities is known as "Primary Care Mental Health" (PCMH); which is largely modeled after the civilian consultative model of integration known as "Primary Care Behavioral Health" (PCBH; Dobmeyer, 2013; Landoll et al., 2017).

PCBH is a population-based health care service delivery model within primary care in which the medical staff and BHC work as a team to manage behavioral health problems and biopsychosocially influenced health conditions (Hunter et al., 2014; Ogbeide et al., 2018; Reiter, Dobmeyer, & Hunter, 2018). PCBH was designed to resemble the primary care model in structure and function with an emphasis on evidence-based assessment, intervention, and consultation for common mental health concerns, health risk behaviors, and chronic medical conditions (Corso et al., 2012; Haibach et al., 2017; Hunter et al., 2014). The BHC is a team-based generalist, providing fast-paced, same-day accessible services, consulting with providers and educating patients, inquiring about patient's clinical progress, and arranging follow-up care or referral to mental health specialists (Dobmeyer, 2013; Mauksch et al., 2017; Ogbeide et al., 2018; Reiter et al., 2018).

PCBH assessment and intervention are typically 15- to 30-minute appointments and are not considered psychotherapy due to patients visiting the BHC only once or twice (Corso et al., 2012; Haibach et al., 2017; Hunter et al., 2014). Interventions are largely empirically supported cognitive–behavioral treatments, e.g., behavioral activation, cognitive restructuring, goal-setting, problem-solving, relaxation training, self-monitoring, and stimulus control (Corso et al., 2012; Haibach et al., 2017; Hunter et al., 2014). Interventions are designed to improve patients' everyday functioning (Reiter et al., 2018).

Using PCBH as a guide, in 2010 the DoD and MHS developed PCMH with the intent of integrating clinical health psychologists within primary care clinics to serve as BHCs to the medical team (Hunter et al., 2014). The goal was to improve the detection, diagnosis, and treatment of psychosocial health issues in service members seeking medical care from their primary care physician (Hunter et al., 2014; Ray-Sannerud et al., 2012). Within the PCMH model, the primary care physician retains full responsibility for service members' care decisions (Ray-Sannerud et al., 2012).

The BHC receives a "warm handoff" of the patient from the primary care physician. A warm handoff is a transfer of care between two medical team members that occurs in front of the patient (Agency for Healthcare Research & Quality, 2017). A central expectation of the BHC by the medical team is a swift response to the primary care physician (Mauksch et al., 2017). The BHC's time with the patient is limited (typically one or two sessions, 15 to 30 minutes per session) and solution focused (Ogbeide et al., 2018; Ray-Sannerud et al., 2012). Within this brief window of time, the BHC is required to make rapid and accurate assessment and treatment decisions in support of the primary care physician's treatment plan (Corso et al., 2012). Given the time constraints in the primary care setting, the clinical health psychologist tends to be highly directive, ask closed-ended questions, ask the patient to generate specific examples of problems, educate patients about diagnoses, teach behavioral skills, and encourage skill practice between appointments (Corso et al., 2012). The BHC provides recommendations and feedback to the primary care physician to engage in collaborative decision-making regarding the overall care of the patient (Ray-Sannerud et al., 2012). If necessary, the BHC refers the patient to traditional psychotherapy (specialty mental health care) when the patient's symptoms or functioning has not improved after several BHC visits (Ogbeide et al., 2018). It is estimated that between 16% and 54% of patients with mild to moderate symptoms who are treated by BHCs are referred to specialty mental health providers (Mauksch et al., 2017).

The PCMH model of care is known by different names in the Air Force, Army, and Navy. Within each department, the implementation of PCMH varies as well.

Air Force

The Air Force implemented the Behavioral Health Optimization Program (BHOP) circa 2000 (Dobmeyer, 2013; Hunter et al., 2014). The intent of BHOP was to improve clinical preventive services while meeting the needs of service members who reported low interest in receiving behavioral health care in spite of experiencing significant behavioral health concerns (Funderburk, Dobmeyer, Hunter, Walsh, & Maisto, 2013). The Air Force integrated clinical health psychologist into primary care settings in an attempt to achieve the following BHOP goals: (a) offer acceptable services to patients and their primary care providers, (b) include improved shared decision-making with patients, (c) increase access to behavioral health services, (d) have collaborative team-based health care management, (e) broaden the range of behavioral health services within primary care, and (f) be prevention-focused with early identification and treatment of behavioral health conditions (Hunter et al., 2014).

The BHC's fast pace mirrors the rapid pace of the primary care clinic. Typically, BHCs have open slots in their schedules for same-day appointments, which allows for a larger number of airmen to receive behavioral health services (Funderburk et al., 2013; Hunter et al., 2014). BHOP is managed centrally and has demonstrated the ability to be deployed across a variety of treatment environments within the Air Force (Landoll et al., 2017).

Ray-Sannerud et al. (2012) conducted a longitudinal study on patients who received behavioral health care at an Air Force Base integrated family medicine clinic. The results of their study suggest that approximately two years after the final appointment with a BHC, patients maintained global mental health functioning improvements, gained over the course of the BHC's intervention. The findings in the Ray-Sannerud study align with the growing body of research that supports the claim of symptom reduction and functional improvement across the course of integrated primary care treatment in general.

Army

The Army launched the Re-Engineering Systems of Primary Care Treatment of Depression and PTSD in the Military (RESPECT-Mil) in 2004 (Hunter et al., 2014). RESPECT-Mil uses a care management model to enhance the identification, assessment, and treatment of the two most common behavioral health concerns that present in military primary care settings: PTSD and depression. RESPECT-Mil integrates clinical health psychologists into the primary care setting, providing soldiers with education, screening tools, and treatment. The Army is seeking to implement RESPECT-Mil into additional primary care settings in an effort to reduce the stigma associated with seeking mental health care (Army Medical Services Corps, n.d.). The narrow focus of RESPECT-Mil is in contrast to the PCBH model which was designed to target all behavioral health problems that present in a primary care setting (Hunter et al., 2014).

RAND conducted an independent implementation evaluation of RESPECT-Mil in 2015. The findings suggest that RESPECT-Mil is identifying a considerable number of service members who report depression and PTSD symptoms (Wong et al., 2015). Of the 13% of soldiers who screened positive, 65% resulted in a probable diagnosis of a mental health disorder (Wong et al., 2015). For the soldiers in the "depression prominent" category who received treatment, 42% experienced at least a 50% reduction in depression symptoms from baseline to

the last follow-up assessment. Similarly, 33% of the soldiers in the "PTSD prominent" category who received treatment experienced at least a 50% decrease in symptoms (Wong et al., 2015).

Navy

The Navy initially launched Behavioral Health Integration Program (BHIP) in 2003 to encourage collaborative primary care physicians and BHC care and management of psychosocial problems in the primary care settings (Hunter et al., 2014). In 2010, the U.S. Navy Bureau of Medicine and Surgery mandated that the Navy focus on readily accessible, comprehensive, and patient-centered care (Navy and Marine Corps Public Health Center Public Affairs, 2016). Out of that mandate, Medical Home Port (MHP) was developed—the Navy's version of the PCMH model (Navy and Marine Corps Public Health Center Public Affairs, 2016; Patient-Centered Primary Care Collaborative, 2019).

MHP aims to ensure that the medical care received by sailors and marines is all-inclusive and integrated with other care provided within the health care system (Patient-Centered Primary Care Collaborative, 2019). Presently, BHIP is the program being used by the Navy to seamlessly integrate mental health care into MHP. BHIP-MHP is increasing same-day access to mental health care and health-behavior services by integrating clinical health psychologists (referred to as Internal Behavioral Health Consultants; IBHCs) in the primary care setting (Navy and Marine Corps Public Health Center Public Affairs, 2016). Additionally, IBHCs improve triage to specialty mental health for patients who require specialty services (Hunter et al., 2014).

Delivery of innovative clinical health psychology applications in a military setting

There is a growing body of research that confirms that integrated behavioral health models of service delivery can be effective and cost efficient, can improve primary care physician and patient satisfaction with care and patients' access to behavioral health services, and can lead to better patient health outcomes due to improved treatment adherence (Corso et al., 2012; Funderburk et al., 2013; Landoll et al., 2017; Ogbeide et al., 2018). Additionally, integrated behavioral health models reach populations that otherwise may not receive behavioral health services (Ogbeide et al., 2018). Patients receive more comprehensive care and validation of the importance of their behavioral health care needs (Shearer, 2012). Furthermore, patients are significantly more likely to engage in specialty mental health care after contact with a BHC (Ogbeide et al., 2018).

Integrating clinical health psychologists into primary care is now becoming a core element of standardized care across all branches of service (Parker et al., 2017). In a military medical setting, clinical health psychologists are tasked with not only providing clinical care for the common concerns that present in primary care settings but also providing care across a broad range of behavioral health concerns related to deployment (Riggs & Mallonee, 2017). Treatment engagement, insomnia and nightmares, stress management, physical and social environments, and spiritual practice have important physical and mental implications to service members' readiness (Haibach et al., 2017; Parker et al. 2017).

The United States DoD has taken significant steps to integrate clinical health psychology applications: how it evaluates, mitigates, and treats psychological injuries associated with deployment (Hunter et al., 2014; Riggs & Mallonee, 2017). Steps taken include deployment of mental health providers into theater with service members; consistent screening of service members for psychological complaints; education of leaders and troops regarding the signs,

symptoms, and treatment of common psychological health problems; and efforts to reduce stigma associated with seeking psychological health care (Riggs & Mallonee, 2017).

James, Folen, Porter, and Kellar (1999) as well as others (James & Folen, 1999) pioneered innovative clinical health psychology applications in military settings. These authors embedded military health psychologists directly into primary care and specialty clinics more than two decades ago and pioneered the application of Neuro EEG biofeedback, pharmacological intervention for smoking cessation prescribed by health psychologists. Also, in 1999, James and Folen (1999) designed a clinical psychopharmacology training program for military clinical health psychologists. The program led to military clinical health psychologists being credentialed to prescribe psychotropic medications, order and interpret medical labs, and independently perform health assessments on medical patients at their military hospital.

Delivery of behavioral health care in the military is partially grounded on the assumption that service members are most comfortable receiving care from familiar service providers. It is important that the same behavioral health provider be stabilized within an assigned unit to provide service members with continuity of care, foster trusting relationships, and simplify behavioral health care access and utilization (Russell et al., 2014). Thus, an innovative approach is to increase the number of clinical health psychologists embedded within units. A clinical health psychologist within a unit will be best positioned to detect health risk behaviors, diagnose mental health problems, and provide behavioral health interventions for chronic medical conditions.

Each branch of service is currently at various stages of embedding military psychologists within operational units. These positions offer psychologists the opportunity to interact directly with the troops and leaders on a consistent basis (Riggs & Mallonee, 2017). Due to the nature of primary care settings, clinical health psychologists tend to see patients after they have developed medical concerns. If clinical health psychologists were embedded in military units with regular contact with leaders and troops, they could individually engage with a service member to rapidly identify and address issues before they become pathological (Riggs & Mallonee, 2017).

Given the high ops tempo of the military, there is a significant need for preventative care and brief interventions for service members with functional complaints that can potentially adversely impact individual readiness as well as unit readiness. Preventive interventions may take the form of educational briefings during commander's calls. Briefings can be specifically tailored for the unit's concerns or generalized for an overview of healthy behavioral strategies (Johnston, Robinson, Earles, Via, & Delaney, 2017). Unit leaders and troops may be encouraged to view the clinical health psychologist as working with the unit to achieve their goals, rather than working to disrupt their goals. The clinical health psychologist should strive to improve unit performance by improving physical health rather than treating mental disorders (Riggs & Mallonee, 2017).

Consultation with commanders has been a key role for military behavioral health providers in all service branches for many years (Johnston et al., 2017). Military units have well-recognized leadership hierarchies and are typically close-knit teams. The attitudes and viewpoints of unit members often reflect those of the unit leaders (Riggs & Mallonee, 2017). Educating unit commanders and leaders about what clinical health psychologists can do to further the mission of the unit can be valuable (Riggs & Mallonee, 2017). By working with commanders, clinical health psychologists may make psychological interventions be seen as part of an overall effort to improve the readiness and physical performance of the unit (Johnston et al., 2017; Riggs & Mallonee, 2017). Having a clinical health psychologist on site may enhance a commander's understanding of the connection between body and mind, thereby enabling unit leadership to detect when their troops are experiencing behavioral health issues. Commanders can have troops meet with the clinical health psychologist early enough to prevent medical conditions from degrading performance both professionally and personally (Johnston et al, 2017; Riggs & Mallonee, 2017). Finally, the embedded

model may decrease negative stigma about receiving mental health treatment by encouraging early help seeking (Johnston et al, 2017).

The primary rationale for the DoD's inclusion of behavioral health providers within military units is to increase service members' access to care and promote early prevention and intervention (Russell et al., 2014). An embedded clinical health psychologist can provide on-the-spot consultation to commanders and risk assessment and crisis intervention to service members, as well as referrals to medical providers and/or specialty mental health providers. With a clinical health psychologist in the unit, a biopsychosocial assessment can be made to view troops with medical concerns in an occupational context (Mauksch et al., 2017). Potential behavioral health patients receive their first touch more quickly, and service members have better access with less stigma. Rather than waiting for outside referrals or overcoming resistance to go to a specialty clinic, the barriers are lowered for service members when clinical health psychologists are embedded in their units (Mauksch et al., 2017). Clinical health psychologists embedded into units enhance service member's operational effectiveness, increase psychological readiness to prevent negative mission impact, and reduce mental health stigma (Johnston et al., 2017).

For those clinical health psychologists who remain integrated into primary care clinics, it is still important to visit units periodically to interact with leaders and troops. While in a deployed environment, as part of or alongside operational units, clinical health psychologists are better able to interact informally with the troops. Through these interactions, they are able to evaluate any changes in behavior that might become pathological somewhere down the line (Riggs & Mallonee, 2017). While in a stateside environment, periodic visits to units will allow clinical health psychologists to identify behaviors that might warrant attention or treatment, detect early any psychological adjustment issues allowing for quick and brief interventions, and offer informal counseling to encourage positive health changes without documenting the service member's medical record (Riggs & Mallonee, 2017). Regular interaction with service members improves the chances that they will receive specialty mental health care when it is needed (Ogbeide et al., 2018; Riggs & Mallonee, 2017).

Clinical health psychologists in the military are best represented by the manner in which the specialty continues to leverage the biopsychosocial model to anticipate and meet the needs of the DoD, the MHS, and service members (Parker et al., 2017). The embedding of clinical health psychologists into operational units is a natural outgrowth of the biopsychosocial model of treatment. Unit embedding provides the type of continuity and access envisioned in the concept of the MHS's Quadruple Aim.

Overview of military clinical health psychology graduate training programs

It is important to note that military psychologists and clinical health psychologists working in a military setting are not the same. As a specialized branch of psychology, military psychology applies psychological knowledge and practice to promote the overall readiness of individual service members and the military as a whole (Johnston et al., 2017). The application of psychological research to address military problems requires military psychologists to fully grasp military policies, procedures, and operations (Johnston et al., 2017).

Most military psychologists incorporate into their clinical work the practice and concepts of clinical health psychologists within general behavioral health clinics and/or primary care settings, but they are not considered clinical health psychologists (Parker et al., 2017). Individuals graduating from military-specialized clinical health psychology postdoctoral fellowship programs or those who obtain board certification in clinical health psychology are considered clinical

health psychologists in the military (Parker et al., 2017). Military settings account for one-third of all American Psychological Association (APA)-accredited postdoctoral fellowships in clinical health psychology (Parker et al., 2017). The Air Force, Army, and Navy each offer APA-accredited training in clinical health psychology.

Air Force

The Air Force offers an intensive predoctoral internship rotation and a two-year postdoctoral fellowship in clinical health psychology. Interns and fellows are exposed to a broad range of clinical health psychology-related clinical problems. These include but are not limited to the following: cardiac and pulmonary rehabilitation, diabetes education program, insomnia management, pain management, primary care behavioral health consultant service, sleep clinic, tobacco cessation, and weight management (59th Medical Wing, 2018; Parker et al. 2017). Interns learn evidence-based biopsychosocial assessment and treatment strategies (e.g., biofeedback and relaxation) to target a broad spectrum of clinical concerns (Parker et al. 2017).

The curriculum of the Air Force's Clinical Health Psychology Fellowship is designed to teach the application of psychological principles and behavioral strategies for management and prevention of chronic disease using a scientist-practitioner model of training (59th Medical Wing, 2018). Fellows are trained to be outstanding clinicians, researchers, teachers, supervisors, and consultants in the field of clinical health psychology and become uniquely equipped to address the complex presenting problems faced by airmen (59th Medical Wing, 2018).

Army

The Army offers intensive predoctoral internship rotation and a two-year postdoctoral fellowship in clinical health psychology. Depending on the location of the training, the experience interns receive may vary. Interns serve in integrated primary care settings and are exposed to biopsychosocial assessment and treatment experiences as well as learning skills such as mindfulness-based stress reduction (Parker et al. 2017).

The curriculum of the Army's Clinical Health Psychology Postdoctoral Fellowship is designed to provide integrated training using a practitioner-scholar model to develop skills related to the unique application of clinical health psychology in the Army. Fellows are trained to develop and carry out treatment protocols, create and direct clinical programs, consult and collaborate with other providers in patient care, and educate other health care professionals about clinical health psychology contributions to patient care (San Antonio Military Medical Center/Brooke Army Medical Center, 2018). Fellows receive a breadth of experiences in pain clinic, amputee center, GI clinic, health lifestyle programs, oncology, cardiothoracic, and bariatric surgery (Parker et al. 2017; San Antonio Military Medical Center/Brooke Army Medical Center, 2018).

Navy

The Navy offers a predoctoral internship rotation in clinical health psychology. The main objectives in the internship program are to ensure interns leave with experience and knowledge in the management of patients with medical complaints and have effective tools to offer sailors and marines in an operational setting (Parker et al. 2017). Skills taught are similar to those highlighted in the other military services' programs with a focus on biopsychosocial assessment to view patients in occupational, social, and personal contexts (Parker et al. 2017). The Navy does not offer a postdoctoral fellowship in clinical health psychology.

Recommendations for civilian university training programs to enhance their curricula

Interest in military-related health psychology has undoubtedly risen due to ongoing war for almost 20 years. With the increasing prevalence of PTSD, mTBI, and behavioral health issues among service members, there is a full-scale push to increase the number of mental health providers and resources to behavioral health support within the DoD (Barry & Barry, 2017; Russell et al., 2014). This increasing need for mental health providers has made civilian university training programs an integral part in the training and development of future clinical health psychologists working in military settings.

The APA's taxonomy for education and training in professional psychology health service specialties provides an aspirational educational and training sequence for professional psychology health services specialties training programs (APA, 2012). Clinical health psychology specialty education and training begins at the doctoral level, continues during internship with experiential training, and usually concludes with intense postdoctoral training but can also include post-licensure training (Council of Specialties in Professional Psychology, 2019). The taxonomy highlights four stages of education and training (doctoral, internship, postdoctoral, and post-licensure training). Within each of the four stages of education and training, there are four levels of education and training opportunities (exposure, experience, emphasis, and major study). Each level of education and training opportunity represents an increased intensity in the education and training activities, *exposure* being the lowest intensity and *major study* being the highest intensity (APA, 2012).

At the doctoral level, civilian universities have opportunities to enhance their training programs to include an emphasis in military-related health psychology training at each level of education and training opportunity. Figure 24.1 is an example of how civilian universities can provide students with opportunities in coursework and clinical experience to learn about clinical health psychology in military settings.

The DoD requires their mental health providers to have training in evidence-based practices (EBP; Barry & Barry, 2017). The majority of the psychologists who are primarily being hired by the DoD to fill BHC positions have a cognitive-behavioral or behavioral-theoretical orientation (Funderburk et al., 2013). Ninety-six percent of Air Force BHP in the Funderburk et al. (2013) study reported using cognitive–behavioral approaches as at least one form of intervention. It is imperative that civilian training programs offer variety of EBP in their curriculum and externship/practicum sites to greatly increase students' ability to secure relevant internships and otherwise prepare for a career as a clinical health psychologist in a military setting (Barry & Barry, 2017).

For a psychologist to be culturally competent is as necessary in a military setting as in any other culture. To optimally perform as a clinical health psychologist in military settings, one must understand military norms as they pertain to culture, behaviors, and expectations, as well as other aspects that directly or indirectly impact mental health care efforts (Johnston et al., 2017; Riggs & Mallonee, 2017). Clinical health psychologists must be able to understand and speak the language of their particular branch of service and avoid psychological jargon when interacting with service members (Johnston et al., 2017). Taking military psychology classes will enable students to gain specialized knowledge and approaches to working with the diverse psychological needs of service members. Students will also become familiar with military culture, military and mental health policy, and the psychological and physiological effects of military duty.

Some graduate programs offer courses and externship/practicum opportunities for clinical and research training with military populations at DoD facilities, enabling students to gain

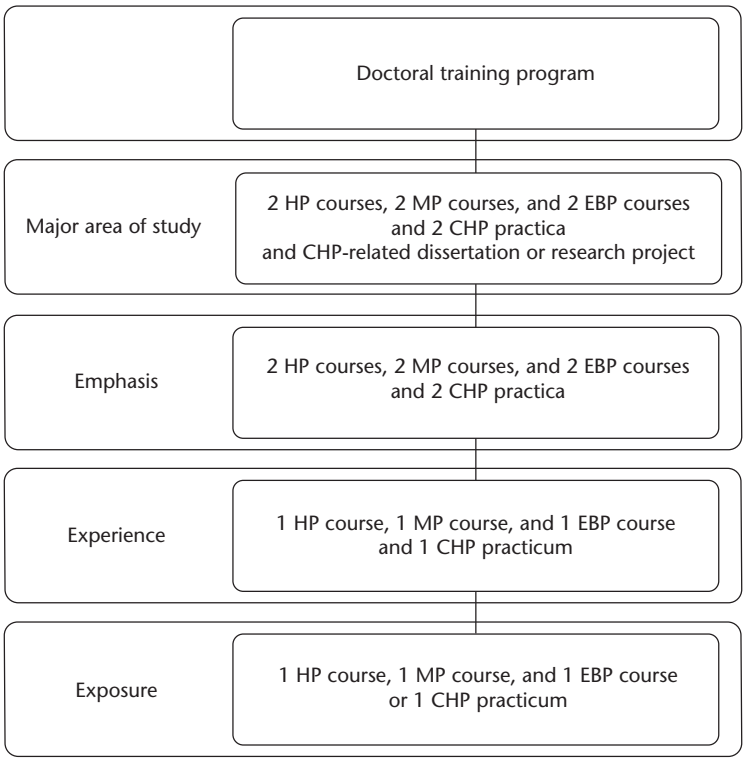

Figure 24.1 Note: Clinical Health Psychology (CHP), Health Psychology (HP), Military Psychology (MP), Evidence-Based Practices (EBP).

Source: Adapted from Taxonomy for Clinical Health Psychology (Council of Specialties in Professional Psychology, 2019).

clinical experience directly with service members (Barry & Barry, 2017). Having clinical health psychology rotations within DoD externship/practicum experience will allow students the opportunity to promptly apply what they learn in the classroom as well as expose students to the rigors of BHC work prior to internship or postdoctoral experience.

Challenges and innovations for the future

Challenges

Military culture and values and the attitudes held by service members may inhibit treatment-seeking even if clinical health psychologists are embedded within units. The core values of each branch of service embody mental, moral, and physical strength. These values can contribute to maladaptive denial of pain and distress and therefore a reluctance to acknowledge the need for help (Riggs & Mallonee, 2017). In a study exploring barriers to seeking mental health treatment, researchers found that 65% of the service members did not seek treatment due to beliefs that they should be able to handle their problems on their own or because they did not want to believe they had a problem (Kim, Britt, Klocko, Riviere, & Adler, 2011).

Stigma surrounding behavioral health problems and biopsychosocially influenced health conditions is complex, as there are perceived external and internal negative consequences of acknowledging psychological problems. Service members in all branches of service express

concerns that seeking mental health care will negatively impact their careers or security clearances (Johnston et al., 2017; Riggs & Mallonee, 2017). The chief stigma-related concern expressed by service members is worrying that their commanders or members of their unit will negatively respond to the presence of psychological health problems and/or seeking mental health care (Riggs & Mallonee, 2017).

A way internalized stigma manifests is reluctance to acknowledge to others, including care providers, behavioral health concerns (Riggs & Mallonee, 2017). This stigma is a significant cause of symptom under-reporting and has been well-documented in research exploring service members' behavioral health treatment-seeking decisions (Britt, Wright, Sipos, & McGurk, 2018; Riggs & Mallonee, 2017). Additionally, service members' negative attitudes toward mental health treatment are associated with lower interest in care; this is in spite of recognition of significant problems (Britt et al., 2018).

Another major challenge the DoD faces is the cost and logistics associated with training and employing hundreds of additional clinical health psychologists to embed into units. Currently, the Air Force trains and employs one or two clinical health psychologists each year (59th Medical Wing, 2018). The Army has one clinical health psychologist training position open per year (San Antonio Military Medical Center/Brooke Army Medical Center, 2018). According to Parker et al., there were less than 2% of active duty Naval psychologists trained as clinical health psychologists (2017). Currently, military settings account for one-third of all APA-accredited postdoctoral fellowships in clinical health psychology (Parker et al., 2017). Military and civilian institutions will have to increase the annual training of clinical health psychologists to meet the demand.

Innovation

Attempts to reduce the stigma associated with receiving behavioral health services have focused efforts on normalizing psychological reactions to deployment and educating service members about symptoms of PTSD and other behavioral health problems (Riggs & Mallonee, 2017). Embedding clinical health psychologists into units increases accessibility to behavioral health care and early detection of behavioral health concerns, as well as reducing the stigma associated with being referred to mental health specialty clinics (Johnston et al., 2017; Mauksch et al., 2017; Riggs & Mallonee, 2017; Russell et al., 2014). To alleviate service members' fear that seeking mental health treatment will adversely impact their careers, clinical health psychologists can offer informal counseling to encourage positive behavioral change without documenting the counseling on the service member's medical records (Riggs & Mallonee, 2017).

In most clinical settings, due to time constraints and concerns about patient reactions, primary care physicians may find it difficult to speak with patients about behavioral health services (Landoll et al., 2017). Non-physicians spend more time with patients and may be in a better position to be a conduit to behavioral health services (Landoll et al., 2017). Clinical health psychologists can train medical personnel and military unit leaders on how to communicate the benefits of seeking BHC services. Training may increase positive perceptions of the usefulness of BHC for service members as well as medical personnel and unit leadership.

Within the PCMH model, the Air Force has recently instituted approaches to improve team members' understanding of the consultative model. The Air Force has developed clinical pathways for anxiety, depression, obesity, and sleep difficulties. These pathways enable the BHP to develop an initial treatment plan in collaboration with the rest of the patient's primary care team (Landoll et al., 2017). Team members become more accustomed to consulting with the BHP when there is a clearer understanding of how behavioral health contributes to the overall health of each service member.

The training conducted at the unit level can provide a realistic description of behavioral health problems and treatments as well as focus on increased access to a BHC and the effectiveness of the short-term, solution-focused interventions. Emphasis on unit readiness and improvement of physical performance may mitigate service members' reluctance to seek care, alleviate negative attitudes towards behavioral health care, and reduce stigma concerns within the unit (Britt et al., 2018).

Conclusion

The health of the U.S. Armed Forces is paramount for the defense of the United States. The DoD has taken considerable steps to improve the population health and mission readiness of its active duty, Guard, and Reserves members. The role of a clinical health psychologist naturally complements the DoD and MHS objectives to maintain a healthy fighting force. A clinical health psychologist within a unit will be best positioned to detect health risk behaviors, diagnose mental health problems, and provide behavioral health interventions for chronic medical conditions. By working with commanders, clinical health psychologists may make psychological interventions be seen as part of an overall effort to improve the readiness and physical performance of the unit (Johnston et al., 2017; Riggs & Mallonee, 2017). Clinical health psychologists embedded into units enhance service members' operational effectiveness, increase psychological readiness to prevent negative mission impact, and reduce mental health stigma (Johnston et al., 2017).

Military culture and values and the attitudes held by service members may inhibit treatment-seeking even if clinical health psychologists are embedded within units. Stigma surrounding behavioral health problems and biopsychosocially influenced health conditions are complex, as there are perceived external and internal negative consequences of acknowledging psychological problems. To alleviate service members' fear that seeking mental health treatment will adversely impact their careers, clinical health psychologists can offer informal counseling to encourage positive behavioral change without documenting the counseling on the service member's medical records (Riggs & Mallonee, 2017). Embedding clinical health psychologists into military units increases accessibility to behavioral health care and early detection of behavioral health concerns, as well as reducing the stigma associated with being referred to mental health specialty clinics (Johnston et al., 2017; Mauksch et al., 2017; Riggs & Mallonee, 2017; Russell et al., 2014).

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