

Professional Statement

Professional Work, Education, and Long Term Plans

Upon completion of my Army internship in XXXX at XXX Medical Center, I was assigned to the WWth Medical Detachment as the unit's clinical psychologist and continue to hold this position. Presently, I am serving my second tour in Iraq as the Officer in Charge (OIC) of a combat stress control preventive team. My primary duties include providing psychological assessment and intervention services (acute, chronic, and crisis) to combat and combat support troops, coordinating and supervising the mental health coverage of over 2500 Soldiers, conducting psychological preventive services (e.g., suicide prevention and redeployment briefings), and consulting with unit commanders regarding mental health, organizational, and leadership issues. The majority of cases I see are problems related to relationships at home, acute and chronic stress, and symptoms related to traumatic events. Overall, my primary objectives while deployed are to ensure that Soldiers in my area of responsibility are provided the best level of mental health care possible and to maintain the integrity of the military unit.

When not deployed, I divide my week between the outpatient clinic at XXXX Medical Center and the XX^h Medical Detachment, XXX, XX. With regard to the former, my primary responsibilities include conducting diagnostic intakes on Soldiers returning from Iraq and providing brief psychotherapy targeted at Soldiers dealing with nightmares and posttraumatic stress issues. With regard to the latter, my primary responsibility is making sure that the behavioral science technicians of the unit are adequately trained to provide basic clinical and preventive services while deployed.

In addition to my clinical and educational activities, I have made it a priority to stay involved in the profession at different levels. I am a member of the XXX State Psychological

Association and the American Psychological Association (Divisions 18, 19, 55, 56).

Currently, I am the Membership Chair for Division XX and a member of the Clinical Practice Committee for Division YY. Furthermore, I am on the editorial boards for *Traumatology* and *Psychiatric Rehabilitation Journal*, as well as an active manuscript reviewer for several other scientific journals. I am in the process of developing a text for Routledge Publishers with the working title, "WWW." The volume is being co-edited by Dr. YYY XXX. It is designed to be a manual on the psychological treatment of returning veterans.

Over the past two years, most of my continuing education (CE) has been related to the assessment and treatment of trauma and trauma related disorders. Specifically, my last CE workshop was on the application of prolonged exposure with service members in Iraq. Before deploying, I attended a workshop on psychological first aid and the application of cognitive-behavioral therapy (CBT) in deployment settings. Since the Fall of 200X, I have also been working on my M.S. in clinical psychopharmacology through Fairleigh Dickinson University, Teaneck, NJ.

After completion of my active duty commitment to the Army, I plan to continue my work with service members in the Veteran's Administration (VA) system. Ideally, after serving as a staff psychologist, I would move into a chief psychology slot and one day become a VA consultant at the national level in order to promote and develop programs system wide. Furthermore, I hope to teach on a part-time basis at the university level, continue my research and writing, and gain experience in grant writing.

My primary reason for seeking board certification in clinical psychology is so that I continue to meet the highest standards of care and competence in the profession. At a minimum, I have a responsibility to my patients to ensure that I set rigorous training and

educational goals for myself and subsequently meet those goals. Not only does this protect them, but I also believe it strengthens the profession as a whole.

Science Base and Application

Regardless of whether or not a psychologist is actively engaged in the production of research, I think it is imperative for all psychologists to be effective consumers of research. As a profession, this is how we gauge our effectiveness and determine if a particular approach or technique is best suited for the individual patient.

As a military psychologist, I am often times faced with difficult clinical situations, particularly in the combat environment. Traditional techniques such as nondirective counseling or long-term psychotherapy may not be practical. In many cases, due to the service members mission requirements, I may only have access to them for three or four appointments. Therefore, utilizing short-term interventions that have been shown to be effective for the particular problem that I am dealing with is usually the best choice.

Two examples of the issue mentioned above that have manifested in my practice are the treatment of nightmares and posttraumatic stress symptoms. During my tour in 200X, I found myself dealing with a number of service members suffering from nightmares. To my surprise, many of these individuals presented with minimal additional posttraumatic symptoms. Coupled with the need to provide treatment in an abbreviated manner, I decided to review the research on the treatment of nightmares from a short-term approach. As a result, I became aware of Dr. Barry Krakow and his research on Imagery Rehearsal Therapy (IRT). Dr. Krakow and his colleagues have repeatedly shown that IRT is an effective treatment for nightmares, which can be conducted in a fairly brief fashion (Krakow & Zadra, 2006; Krakow et al., 2001). Although the research on the use of IRT in a combat environment and with acute nightmares was virtually nonexistent, with Dr. Krakow's

consultation I was able to tailor this approach to meet my needs at the time. Consequently, I was able to help a number of service members deal with their nightmares and publish the first report on the use of IRT in a combat environment (Moore & Krakow, 2007). With regard to posttraumatic stress symptoms, I have relied heavily on the use of Prolonged Exposure and with the assistance of current research, have adapted it to the combat environment (Cigrang, Peterson, & Schobitz, 2005).

Theoretical and Empirical Basis

Toward the end of my M.A. program in counseling, I found myself frustrated with the realization that I knew a little bit about a lot of theoretical orientations. Consequently, I decided to attend the Adler School of Professional Psychology (ASPP) in Chicago and focus my attention on the theory and practice of Individual Psychology (IP). However, it was also at ASPP that I was introduced to the highly influential books, *Cognitive Therapy: Basics and Beyond* (Beck, 1995) and *Clinical Applications of Cognitive Therapy* (Freeman, 2004).

I do not consider myself an “Adlerian.” When asked what my theoretical orientation is, I typically claim cognitive-behavioral because this is what guides most of my clinical practice. This may seem contradictory, but IP and CBT share many of the same principles. For instance, both place great emphasis on “collaborative empiricism” or “therapeutic equality,” believe that how we perceive and think about events and situations are largely responsible for how we feel and behave, and appreciate the fact that knowledge is not enough and that action is a key ingredient of change. In short, my understanding of human nature and personality is shaped by Adlerian principles (e.g., inferiority feelings, striving for superiority, social interest) but my views on the maintenance and amelioration of problems is cognitive-behavioral (the latter of which provides the foundation of my practice as a military psychologist).

My ability to use CBT as a military psychologist is my strongest asset. While deployed, many of the cases I deal with are related to interpersonal conflicts with peers and supervisors and ruminations about infidelity and deceit by loved ones back home. Utilizing CBT allows me to effectively deal with most of these issues through challenging negative thought patterns, testing the evidence for such beliefs, and analyzing and challenging cognitive errors. In addition to the interpersonal problems that patients often present with, I am also confronted with numerous posttraumatic issues. I am able to apply CBT principles and methods, specifically combining cognitive and exposure techniques, in treating Acute Stress Disorder, early Posttraumatic Stress Disorder (PTSD), and hopefully preventing chronic PTSD (Foa, Hearst-Ikeda, & Perry, 1995; Foa et al., 1999).

From an assessment standpoint, my approach is to clearly identify the referral question or presenting problem. After I have done this, I complete a semi-structured interview and focus on the presence, duration, and severity of symptoms. Although I feel that a motivational style interview or an assessment that incorporates interventions throughout can be extremely beneficial, I am often times forced to focus my efforts on DSM-IV criteria in order to provide documentation and support for the presence of a psychiatric disorder. Many of the intakes I am asked to complete are for screening purposes and the referral question, “Does this Soldier have a psychiatric diagnosis” is very common.

With regard to issues of individual and cultural diversity, I strive to maintain an ongoing awareness that I cannot use CBT – or any form of therapy for that matter – in a cookbook fashion. To minimize or exclude the values, traditions and beliefs of an individual due to my own shortsightedness and/or cultural ignorance does a tremendous disservice to my patient. Specifically, I run the risk of not forming an adequate therapeutic relationship (if I form one at all) and potentially hinder therapeutic gains due to issues of trust, frustration,

and uncertainty on the patient's part. Therefore, adapting treatment, particularly standard protocols, to the patient ensures that I provide the best level of care possible and maintain a sound therapeutic and mutually respectful relationship.

Complex Interpersonal Interaction

The Army is fertile ground for the development of complex and challenging interpersonal interactions. Being a junior Medical Service Corps officer, I have encountered several interpersonal conflicts with more senior officers. One in particular dealt with issues of confidentiality and privacy. After a Private First Class (PFC) presented to my clinic for difficulties he was having with his wife, I received a call from his Battalion Commander (Lieutenant Colonel) asking personal questions regarding the mental status of this PFC. As I have done many times, I informed the senior officer that unless a Soldier presented to my office as part of a Command Directed Referral (similar to a civilian court ordered evaluation) or provided consent to release information to his or her superiors (this particular Soldier had not), I was unable to release information except under certain circumstances consistent with limits of confidentiality. Unfortunately, this Commander did not accept this feedback and indicated that he was giving me a "direct order" to provide the information he was seeking. When I attempted to explain my situation to him again and offer possible solutions to this situation (i.e., talking with the Soldier regarding the possibility of signing a release or the Commander submitting a Command Directed Referral), he shouted several expletives, informed me that he was going to call my Commander, and hung-up the phone. Although I knew I was right from a professional standpoint, I was extremely anxious about "disobeying" a direct order.

About an hour later, a representative from this Commander presented to my office and encouraged me to cooperate with the Commander's request, and if I didn't, I could be

viewed as difficult and not a “team player”. Furthermore, it was implied that this Commander could have some impact on my career. At this point, I decided to request a mediator from legal. As a result, my original position was affirmed by the legal representative and the Commander was informed that if he continued to press this matter he risked having a formal complaint registered against him by the patient. There were no further problems after this meeting.

Issues of Diversity

Part of my responsibilities as a deployed Army clinical psychologist has been to provide evaluations and recommendations regarding the mental health status of Iraqi soldiers, police, interpreters and insurgents. Not being fluent in the native language or very familiar with the customs, values, and traditions of this diverse group of people, has made this aspect of my job difficult.

One specific example of how individual and cultural diversity issues have impacted my work is when I was asked to perform a mental health evaluation of an Iraqi soldier that had lost both of his legs after his truck had been hit with an Improvised Explosive Device. With the assistance of an interpreter, I began to explain to this soldier who I was and my reason for coming to see him. Immediately, I noticed a confused look on his face. When I asked the interpreter to help me understand his confusion, I was told that it had never occurred to this soldier that the loss of his legs would have anything to do with the possible development of psychological problems. The soldier passionately described to me via the interpreter how it was God’s will that he lost his legs and how fortunate he was that God had spared his life. I was surprised, to say the least. After leaving his bedside and having an in-depth discussion with the interpreter, I realized that I approached this evaluation with significant cultural and religious biases, which were based on my assumptions derived from

my prior experiences with Americans. The interpreter helped me realize that this man's attitude would not be considered unusual, particularly for a Kurdish Muslim.

As a result of this experience, and with the help of interpreters native to Iraq, I have developed a greater appreciation for the many differences among the people of Iraq. Whether Arab or Kurdish, Sunni or Shite, Christian or Muslim, there are many unique and distinct differences within this culture. Due to developing a greater understanding of these differences, I feel that I have been more effective in these types of encounters, such as conducting suicide risk assessments with suspected insurgents, assessing for psychotic processes in Iraqi police officers, and providing clinical services to Iraqi interpreters.

A Challenging Ethical Dilemma

Practicing psychology in a deployed environment is not unlike practicing psychology in a rural one. Often times, the military psychologist will find themselves isolated from peers that could provide supervision or that could be used as a source of referrals. As a result, the psychologist stationed in remote areas will likely be faced with ethical issues related to boundaries of competence.

One specific example of this issue for me was when I was asked by my higher medical command to implement a traumatic brain injury assessment program. Basically, I was asked to complete comprehensive neuropsychological test batteries on service members that had experienced blast injuries from Improvised Explosive Devices. It was the intent of my higher command to document the presence and severity of any neuropsychological injuries so that determination of disability status and coordination of care would be made easier upon the service member's return home. Although I did have some training in neuropsychological assessment, I did not have an internship or postdoctoral fellowship specific to neuropsychology, nor did I have the availability of clinical supervision.

In thinking through this issue, I felt that I had four options to choose from. First, I could accept the task and provide the service requested by my higher command based on my prior training in neuropsychological assessment (1400 practicum hours, formal pre-doctoral coursework). Second, I could coordinate with a psychologist at a different base that was more qualified to provide this service. Third, I could refuse the tasking and base this refusal on my lack of training and expertise. Fourth, I could provide an alternate, but related service.

Ethical standard 2.01 states that psychologists provide services only “within the boundaries of their competence.” Considering my training and my interpretation of this standard, I did not feel that option one was appropriate. Furthermore, I did not deem this to be an emergency and standard 2.02 did not apply. With regard to option two, there was not an appropriately trained psychologist that I could refer to for this service. In fact, after my investigation, it appeared that I had the most training in this specialty within my area of operation. I did not feel that refusing the tasking was in the best interest of the population I served, so option three did not seem like a viable choice. Based on the ethical standard 2.01 (d), “psychologists are asked to provide services to individuals for whom appropriate mental health service are not available...if they make reasonable effort to obtain the competence required by using relevant research, training, consultation, or study”, I decided to provide a closely related service for which I had considerable training (administering a brief and repeatable neurocognitive test) while obtaining consultation from a former professor who was board certified in clinical neuropsychology and gaining more knowledge in this area through utilizing relevant research and study.

* I verify that no ethical or legal action has taken place against me since admission to candidacy.

References

- Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: The Guilford Press.
- Cigrang, J.A., Peterson, A.L. & Schobitz, R.P. (2005). Three American troops in Iraq: Evaluation of a brief exposure therapy treatment for the secondary prevention of combat-related PTSD. *Pragmatic Case Studies in Psychotherapy*, 1(2) (1), 1-25.
- Foa, E. B., Dancu, C. V. & Hembree, E. A. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, 67, 194-200.
- Foa, E. B., Hearst-Ikeda, D. & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology*, 63, 948-955.
- Freeman, A., Pretzer, J., Fleming, B., & Simon, K. M. (2004). *Clinical Applications of Cognitive Therapy*. (2nd ed.), New York: Plenum Press.
- Krakov, B. & Zadra, A. (2006). Clinical management of chronic nightmares: Imagery rehearsal therapy. *Behavioral Sleep Medicine*, 4, 45-70.
- Krakov, B., Johnston, L. & Melendrez, D. (2001). An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. *American Journal of Psychiatry*, 158, 2043-2047.
- Moore, B. A. & Krakow, B. (2007). Imagery rehearsal therapy for acute posttraumatic nightmares among combat soldiers in Iraq. *American Journal of Psychiatry*, 164, 683-684.

Assessment Sample

Contextual Statement

XX is a 23 year-old, active duty Army Sergeant who is currently deployed to Iraq. This is his first 12 month tour since he joined the Army approximately 2.5 years ago and he currently works as an aviation medic. This is his first appointment.

XX presented to the combat stress clinic after acknowledging mental health “at risk” questions on the Post-Deployment Health Assessment (PDHA). The PDHA is a physical and psychological screening measure given to all Soldiers serving in operational environments prior to returning home. XX was referred by his unit physician after he answered affirmatively to several questions related to exposure to combat and witnessing potentially traumatic events.

During his tour, XX reported responding to a mass casualty incident in which numerous Iraqi civilians were injured or killed (many of which were children). As a flight medic, he has also been confronted with numerous life and death situations, including triaging critically injured patients, performing lifesaving measures on Soldiers while in route to the hospital, and coming under and returning fire in hostile areas.

XX reported a history of a relatively unstable childhood. He reported being in foster care for several years and periods of behavioral “acting out”. He also reported that his mother has a significant psychiatric history that has required periods of involuntary hospitalizations.

Rationale

My rationale for completing a semi-structured and diagnostically focused intake was based primarily on the fact that I was being asked to assess if there was a psychiatric disorder present, if immediate intervention was necessary, and provide assessment and treatment recommendations for the Soldier once he returned home. As is standard, my recommendations are given to the Soldier evaluated and his/her provider in charge of healthcare for the unit. This is why I explicitly asked permission to talk with XX's unit physician after the evaluation.

Considering that my time with XX was limited (one session), I didn't feel that formal psychological testing was practical. However, as I do with all patients that come through my clinic, he was given the PTSD Checklist-Military Version (his score was 36, which is considerably lower than PTSD groups). Moreover, I felt that it was appropriate to maintain a relatively "clinical" disposition as ongoing assessment and intervention were not possible. Because of these reasons, my goal was to collect as much clinical data as possible within the time provided so that I could provide a "working diagnosis" and a baseline assessment for the Soldier, his physician, and the eventual mental health provider he will see after he returns home.

Theory of Practice

XX acknowledged "low-grade" psychological symptoms for much of his life (apathy, feelings of isolation, mood disturbances). Except for some decline in his mood, it appears that these symptoms have remained relatively stable throughout his deployment. However, he has developed new symptoms (nightmares, intrusive thoughts, guilt feelings) as a result of his experiences in Iraq.

Before I provide my theoretical explanation for XX's current situation, I want to put forth that my analysis is tentative and certainly not necessarily the "truth". A case conceptualization such as the one that follows typically develops over a period of time and may entail several assessment/therapy sessions.

First, I believe that due to his unstable upbringing and the unpredictable nature of his early important relationships, he never fully developed a strong sense of what Adler called "social interest". Social interest includes affective (feeling connected and able to empathize with others), cognitive ("knowing" that the welfare of the individual is related to the welfare of the whole group), and behavioral (person moves toward socially useful and constructive goals such as cooperation with others) components. In cases where this doesn't happen, the individual may withdraw and develop distorted and negative views of self, others, and the world. Furthermore, Adlerian Psychology refers to safeguarding techniques, which are cognitive and behavioral strategies for protecting self-esteem. In XX's case, it appears that as a means to protect himself from threatening people and the emotional consequences associated with those people, he emotionally and mentally withdrew from those around him. Obviously, this can impact the quality and level of an individual's mood.

Regarding his current situation, distinguishing between what is normal and abnormal in a combat environment can be difficult. Typically, if there is a dramatic decrease in functioning then immediate intervention is appropriate. However, experiencing some guilt, having doubts regarding competency, and dealing with a certain level of intrusive thoughts is expected. Although I think XX would benefit from exploring some of his views about the world, his safety, and his future, I also believe that

he still maintains an adequate level of functionality and adaptability. Furthermore, from my experience working with redeployed Soldiers, I have found that symptoms such as sleep disturbance, decreased mood, decreased appetite, and intrusive thoughts remit after being removed from the combat environment.

Diagnosis

XX reported numerous symptoms to varying degrees including sleep disturbances, decreased appetite, periods of guilt and self-doubt, and periods of decreased mood. He also reported recurrent and intrusive thoughts, distressing dreams, hypervigilance, and avoidance behavior subsequent to exposure to multiple traumatic events. Based on the knowledge that some of these symptoms are adaptive and normal in the combat environment, often remit after returning home, and may have alternative explanations (e.g., decreased appetite due to eating the same food for a year, sleep disturbances due to multiple roommates in small living quarters and varied work schedules), my diagnostic formulation is as follows: Axis I – Adjustment Disorder With Mixed Anxiety and Depressed Mood, Chronic; Axis II – None; Axis III – None; Axis IV – Ongoing Occupational Stress; Axis V – 65 (Current). My differential diagnoses for Axis I are PTSD and Dysthymia.

Recommendations

First, I recommended that XX seek a higher level of care, including evaluation and treatment if needed, once he redeploys back home. As noted previously, XX reported a variety of anxiety and mood related symptoms. I also stressed the importance of being aware of any increase in alcohol use as this may be a method of coping for XX. Unfortunately, this is not an uncommon occurrence for redeploying Soldiers. I believe

that a more accurate assessment can be made once he returns home and is allowed time to reintegrate back into his life. Along with this recommendation and the fact that he will need to complete the Post-Deployment Health Reassessment (PDHRA) after three months of being home, I feel that he has a good chance of getting the care that he needs and deserves.

Ethical Issues

The ethical issues related to boundaries and dual relationships in the deployed environment are common personal and professional struggles for military psychologists. In the case of XX, I had several encounters with him prior to the intake. Being a medic, he has provided routine medical services to me on several occasions. Since we live in the same area, we have shared shower trailers, church services, and the dining facility. I am also friends with the physician that is responsible for his supervision, which has brought us together in pseudo-social situations on numerous occasions. On two separate occasions, I have been asked by XX for “advice” on what to do about family problems he was having back home.

If I would have been asked to evaluate XX back in the states at a military medical clinic, I would have most likely referred him to another provider due to our personal and professional history. However, as I mentioned in my professional statement, practicing psychology in a combat environment is not unlike practicing psychology in a rural one. After discussing this issue with the referral source and XX, and recognizing that I was the only provider in the area, I decided to complete the evaluation.

Reflection

I was surprised at how subdued I came across during the interview. To some it may seem as if I were detached or overly “clinical”. I probably was to an extent, which was likely related to the goal of the session and my previous relationship with the Soldier. I don’t feel that this interview is a great example of my interpersonal and rapport building skills (rapport had already been established in other interactions), but I do think it reflects my ability to stay focused and collect useful information. Overall, I think the session went well and I was able to address the original referral question.

*I attest that written informed consent was obtained. It should also be noted that prior to beginning the therapy session, Soldiers review and sign a comprehensive limits of confidentiality form while filling out paperwork in the waiting room. I then review these limits and ask if there are any questions prior to entering my office. Prior to taping the session, I reviewed the specific limits of confidentiality with XX and only reiterated the four most common issues on the tape.

Intervention Sample

Contextual Statement

SS is a 25 year-old, active duty Army Sergeant who is currently deployed to Northwestern Iraq in support of Operation Iraqi Freedom. This is his second 12 month tour over the past three years and he currently works as a Cavalry Scout. This is his fourth appointment (third imaginal exposure appointment).

SS presented to the combat stress outpatient clinic due to increased distress associated with repeated traumatic events, intrusive thoughts, sleep disturbances, and nightmares. Specifically, SS reported that he was having difficulty avoiding thoughts of a traumatic event that occurred approximately two years prior in which he was part of an intense firefight with insurgents while on patrol in a hostile neighborhood in Iraq. During this firefight, one of his friends was injured and SS took shrapnel injuries to the hand. His intrusive thoughts of the event and nightmares associated with the event (and of similar content) were the primary reasons given for seeking treatment.

SS reported that after returning home from his first tour in Iraq, he was diagnosed with Posttraumatic Stress Disorder by a psychologist at the medical center where he was stationed. He reported that he met with a psychologist for a few sessions, but decided to stop going to treatment. The reason cited for stopping treatment was that he was seen by three different providers during his brief attempt at treatment, which he reports was due to staffing issues within the medical center. Based on the reported symptoms at intake and prior psychiatric history, SS was diagnosed as follows: Axis I - Posttraumatic Stress Disorder, Chronic; Axis II – No diagnosis; Axis III – None; Axis IV – Ongoing Occupational Stress; Axis V – 51 (Current).

Rationale and Goals

SS agreed to 5-7 sessions of treatment for his PTSD utilizing a protocol developed specifically for service members serving in combat zones. The primary treatment components were prolonged imaginal and in-vivo exposure, education about common reactions to trauma, breathing and relaxation training, and cognitive therapy focusing on identifying and changing maladaptive cognitions.

The rationale behind the method of treatment was that exposure to distressing memories, feelings, and environmental cues would facilitate habituation, and in turn, would decrease the symptoms SS was experiencing. This is the specific rationale for the exposure portion of the treatment, which is widely supported in the literature. Also, educating him on the common reactions to trauma and teaching him relaxation techniques would provide him a greater sense of control and mastery over his current situation. Although minimal, it would also provide him some tools of defense in case he was faced with subsequent traumatic events. This portion of the treatment is consistent with the military view of normalizing events and providing practical and accessible methods of self-aid. The cognitive therapy would help address any maladaptive beliefs about his safety, abilities, environment, and future.

The goals of the intervention were to decrease his posttraumatic stress symptoms as measured by the PTSD Checklist-Military and verbal report, ensure that he maintained an acceptable level of functioning in which he continued his mission as a scout (as determined by SS, his Commander, and myself), and provide him with as much control over his disorder as possible so that he can return home and reintegrate back into his life successfully.

Theory of Practice and Relevant Research

The current Clinical and Practice Guidelines of the DoD/VA recommend cognitive-behavior therapy and exposure therapy as the “best choices” when treating PTSD from a non-psychopharmacological approach. Although treatments such as Stress Inoculation and relaxation training, Cognitive Processing Therapy, and Eye Movement Desensitization and Reprocessing have considerable scientific support for their use, Prolonged Exposure is the cognitive-behavioral approach that has the most empirical backing, particularly with military populations in combat environments.

With regard to the submitted intervention practice sample, SS was starting to show a decrease in his ability to function effectively and was dealing with a significant amount of psychological and psychophysiological distress. He was showing an increase in avoiding others within his unit due to feeling anxious about the possibility of past stressful events being discussed. Consequently, he was withdrawing from those around him and spending much of his time alone in his room ruminating about the past. Although this practice example doesn't capture the full effect that his distorted cognitions were having on him, he spent a considerable amount of time during the day suffering from guilt due to thoughts such as, “I am weak for being afraid”, “I am an evil person for taking the lives of other people”, and “I will never get better and will be screwed up my whole life”. Furthermore, his guilt feelings were often activated when he tried to reconcile his religious beliefs and military duties.

Consistent with my belief that PTSD responds best to both a behavioral and cognitive approach, I attempted to confront his avoidance through exposure based techniques and calm his anxiety through a competing activity such as diaphragmatic

breathing. Also consistent with my beliefs and practice, I tried to make SS more aware of how his thoughts were impacting his anxiety and confidence. This has been a challenge as we have had a difficult time mastering the identification of automatic thoughts via thoughts records. However, based on my experience, he doesn't possess the level of cognitive distortions that often manifest in individuals following trauma. I felt that focusing more on the exposure as opposed to the cognitive aspects of the treatment early on would have a greater short-term payoff and that focusing more on cognitions at the later stages of treatment would help with maintaining gains already achieved.

Diversity and Ethical Issues

In my work with SS, religious values and traditions were an issue that I had to be aware of during our sessions. Specifically, SS is a devout Christian and attempts to live his life by a strict set of religious values. I also have a strong religious background. However, being influenced by the military culture, I have seen an increase in my use of profanity over the past few months since I came back to Iraq. Often times my use of profanity helps establish rapport with my patients. It did not in this situation. Fortunately, I realized this very early on in our relationship and was able to adjust accordingly.

An ethical issue that often occurs in my work with Soldiers in a deployed environment is related to the question, "How do I send an already psychologically hurt Soldier back to the same stressful environment?" This is never an easy question to answer and will undoubtedly give me pause for the remainder of my military service.

As a military psychologist, I am always faced with the challenge of serving both the Army and the individual. My instincts were to recommend to his Commander that he

be sent back to the states for treatment. However, it is not that simple. Firstly, SS did not want to be sent home. He wanted to serve the remainder of his tour and anything short of 12 months would be seen as a failure by him. Secondly, returning a Soldier to the rear is not always the best move. Lessons learned from past wars have shown us that removing a functioning Soldier from the battlefield for psychiatric reasons may stigmatize the individual and inadvertently lead them into the “sick” or “broken” role. And thirdly, SS would get more individual attention in Iraq as opposed to being sent back to an overcrowded military mental health system. After talking with SS and consulting with other military psychologists, it was decided that providing treatment in this environment was the best choice.

Reflection

After watching the video of myself, I realized that my style in treatment has become more directive. This makes sense as taking a passive approach with Soldiers tends to delay results and passivity is not consistent with the Army culture. However, this is an issue I will need to address after leaving the military as this may not be the best approach with non-military patients. I believe that I was relaxed and informal during the session and hopefully this allowed SS to be more at ease. Differences in rank have a tendency to cause communication problems and trust issues in therapy. Even though I was somewhat directive, I do feel that SS and I collaborated on issues such as treatment progression, homework assignments, and changes that could be made to improve our work together.

*I attest that written consent was obtained.