

SECTION I

Ethical Issues in Specific Settings and
Challenging Populations

1 Ethical Considerations for Working with Military Service Personnel

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Military psychologists and psychiatrists have admirably served the nation in support of military forces, military families, and as consultants to the Department of Defense (DoD) since the First World War. More recently, social workers and counselors are employed by the DoD to provide for the needs of service members and their families at military installations around the globe. Psychologists, psychiatrists, and social workers may become commissioned officers in the medical services corps within each branch of the military (Air Force, Army, and Navy), serving simultaneously as military officers and licensed mental health practitioners. Psychologists constitute the largest group of military mental health providers; at present, approximately 500 uniformed (active-duty) clinical psychologists are employed in contexts as varied as service academies, medical centers, outpatient clinics, aircraft carriers, and forward deployed combat stress hospitals (Budd & Kennedy, 2006). An additional 500 civilian psychologists are employed in military clinics, primary care services, and medical centers.

The most prevalent activities of military mental health professionals (MHPs) include candidate screening, counseling and psychotherapy, psychoeducation, and psychological evaluations to discern fitness for duty, fitness for deployment, security clearance, and capacity to stand trial (courts martial). The context of practice for military MHPs is quite unique (Johnson, 2016; Kennedy & McNeil, 2006). Because they are often deployed to combat theaters or isolated military bases as the sole mental health provider, MHPs must be very competent generalists immediately following credentialing and commissioning. Moreover, they must be particularly skilled in treatment triage, crisis intervention, neuropsychological screening, traumatic stress disorders, and rapid screening for psychopathology (Johnson, 2016).

Owing to their unique status as both commissioned officers and mental health service providers, and the not infrequent tension between their licensed practitioner obligations and their obligations to support the military mission, military MHPs sometimes encounter challenging ethical quandaries and conundrums. In this chapter, I discuss those aspects of mental health practice in the military that are likely to create ethical tensions for MHPs. I then focus attention on three specific ethical issues that are most likely to create dilemmas and, at times, significant conflict and

personal distress for MHPs. These include multiple relationships, competence and self-care, and conflict between ethical standards and federal laws or regulations. I provide illustrative cases to bring each of the three ethical issues to life for the reader. For consistency, I will rely primarily on the *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association (APA, 2010) when referring to specific ethical standards; however, the ethics codes of the allied mental health professions (e.g., ACA, 2014; NASW, 2008) are quite consistent on the ethical issues I discuss. This chapter concludes with a brief set of recommendations for responsible and ethical practice in military settings.

Mixed-Agency Tensions and Embedded Assignments

Various aspects of mental health practice in military settings conspire to create ethical tensions for MHPs. Most fundamentally, ethical issues can be linked to an active-duty provider's dual identity as medical professional and commissioned military officer and his or her embedded status as not only a service provider for a military unit, but also a member of that same unit. Most of the ethical conundrums unique to military contexts can be traced to these two factors (Johnson, 2016).

Mixed-Agency Tensions

Mixed-agency, the simultaneous commitment to two or more entities, is ubiquitous for uniformed MHPs. From the moment psychologists, psychiatrists, and social workers take the oath of office and begin wearing the uniform, they must carefully balance sometimes competing obligations to their clients and the DoD (Kennedy & Johnson, 2009). For the most part, mixed-agency ethical dilemmas occur when the MHP's loyalties or ethical obligations to an individual client create tension or conflict with obligations to the military unit more broadly, the commanding officer, or DoD regulations (Howe, 2003; Johnson & Koocher, 2011).

The role stress created by mixed-agency dilemmas is often exacerbated for MHPs during deployments – particularly in time of war. In this context, providers must make frequent decisions regarding whether to return service members to combat. For instance, in a combat setting, it may be the clinical opinion of an Army psychiatrist that a traumatized soldier's health and well-being would be best served by a period of limited duty away from the front lines. But this professional inclination may be in conflict with the operational reality that the soldier's unique expertise and experience are essential to achieving a critical upcoming mission objective. As a provider, the psychiatrist may wish to arrange a medical evacuation for the soldier; as an officer, the psychiatrist has an acute appreciation of the overarching mission and the necessity of tempering individual interests with those of the unit and even the nation (Johnson, Grasso, & Maslowski, 2010).

Mixed-agency dilemmas for military MHPs are intensified by four facets of the job. First, uniformed MHPs always have *dual identities*; that is, simultaneous identities as military officer and licensed service provider (Jeffery, Rankin, & Jeffery, 1992; Zur & Gonzalez, 2002). There are often moments when one's clinical

training – often emphasizing a stringent focus on the needs and best interests of the client – does not mesh well with one’s military training and commissioned sensibilities; the needs of the military loom large for an officer. At times, military providers have described feeling like “double agents” who are now and then forced to choose between client-centered therapeutic interests and organization-centered administrative interests (Camp, 1993). One’s dual identity may create truly unique tensions for a military MHP who must deploy with clients (e.g., eat, sleep, and travel) while observing boundaries, upholding good order and discipline, and attempting to be “therapeutic” during brief extra-therapy encounters.

Second, there are few mental health contexts in which the provider is obligated to place a superordinate mission first and foremost. Any military officer worth his or her salt will acknowledge that achieving the military mission must at times trump individual interests (Driskell & Olmstead, 1989). Upon commissioning, the military MHP assumes a federally mandated obligation to defend the Constitution and protect the nation first and foremost. Despite genuine concern for the psychological well-being of individual service members – particularly one’s own clients – the deployed MHP is committed to promoting the fighting power and combat readiness of both individuals and the military unit generally (Page, 1996).

Third, there are occasional tensions between professional ethical standards and federal laws or DoD regulations, such as the Uniform Code of Military Justice (UCMJ). Although the military MHP is bound to adhere to both ethical and military codes, there are sometimes tensions or conflicts between the two around issues such as confidentiality, multiple relationships, informed consent, and provision of services through a third party (the government; Johnson, 2008; 2016). Jeffery and colleagues (1992) have detailed cases in which military psychologists have been sanctioned by an ethics board for complying with DoD regulations (e.g., client records released to an investigator without consent long after the psychologist had rotated to a different assignment and no longer had any authority to protect records at a previous facility) or, alternatively, have been sanctioned by the government for refusing to comply with a regulation or even a direct order (e.g., to turn over a client’s record) when doing so was interpreted by the provider as a clear violation of his or her ethical obligations.

Finally, because military MHPs do not enjoy the luxury and clarity of definitively serving either an individual *or* an organization, it can be vexing to discern who exactly the primary “client” is in any specific situation (APA, 2010; Johnson, 2008). Often, when an evaluation of a service member is requested, there are multiple stakeholders involved, most often the individual client, his or her immediate supervising officer, the commanding officer, and perhaps even an investigative, credentialing, or special operations entity within the DoD.

Embedded Assignments

Military MHPs are increasingly assigned to active combatant military units such as Air Force air wings, Army or Marine Corps brigades, or Navy ships, most often aircraft carriers or helicopter landing ships. Rather than provide services exclusively in traditional clinics and hospitals, professionals embedded with active units become

part of the fabric of the unit and the community. Some colleagues and I have defined embedded psychology this way:

Psychological practice in an environment characterized by the intentional deployment of a psychologist as part of a unit or force when the psychologist is simultaneously a member of the unit and legally obligated or otherwise bound to place the unit’s mission foremost. (Johnson, Ralph, & Johnson, 2005, p. 73)

On the upside, embedded MHPs are often seen as more credible and approachable by members of a unit who might benefit from services. On the downside, an MHP’s embedded status can easily amplify ethical tensions for providers. Considerable maturity and thoughtful deliberation are required to serve clients’ best interests when a practitioner is also a member of a small military community. Embedded assignments amplify tensions in several ways.

First, when an MHP literally lives with his or her clients – eating, exercising, and sleeping in shared berthing units – and encounters clients in all manner of unexpected ways in the course of day-to-day activities, maintaining boundaries and clearly demarcated role contours can be frankly impossible. Embedded MHPs technically have multiple roles with all of their clients. Further, they must often provide services to friends, colleagues, and even superior officers for whom they work (Johnson, 2008). As solo practitioners, they often are unable to refer “clients” to other providers or otherwise avoid multiple relationships that may be uncomfortable for both themselves and their clients (Zur & Gonzalez, 2002).

Second, embedded MHPs often cannot effectively anticipate and prepare colleagues or clients for sudden shifts in professional roles (Johnson et al., 2005). For instance, military clinicians may be asked to conduct a formal evaluation (e.g., fitness for duty, security clearance) with a current or former client, sometimes creating distress for a client and a rupture in a previously helpful clinical relationship. Alternatively, the MHP may find him or herself assuming supervisory duties with clients, or conducting an evaluation with the child or spouse of a close colleague. Embedded practice can easily create distress in a provider when an unexpected role shift appears contrary to the best interests of a client.

I now turn to three of the top ethical challenges facing MHPs who work in the military. These challenges are not presented in any order of significance. The illustrative cases used to introduce each topic are composites; each represents an amalgamation of several cases with critical identifying details masked. Each case is followed by an analysis of the practitioner’s essential ethical quandary as well as his or her approach to resolving the issue while keeping the best interests of the client and the exigencies of the military mission in balance.

Multiple Relationships

The Case of CPT Smith

Air Force Captain (CPT) Smith, fresh from a psychiatry residency and newly commissioned, reported to a small Air Force hospital at an air base in rural Japan. Captain

Smith and his wife soon befriended another active-duty couple, John and Marie, both physicians, at the hospital. Located in the same small officer housing area, the two couples became fast friends and shared meals together frequently. Six months into their deepening friendship, Marie appeared at CPT Smith's office one morning before work. She was in tears. With the door closed, she confided that John was having an affair. Although he'd denied it when confronted, Marie had discovered text messages on his phone and receipts in his wallet that clearly indicated he was involved with a younger woman on the base named Rhonda. She confessed that John had done this once before when the two were in medical school. CPT Smith provided empathy and a listening ear. He also felt broadsided. John and Marie were the only close friends he and his wife had made, and he had frequent interaction with both of them around the hospital. In tears, Marie asked that he keep her concerns confidential. Over the next several weeks, Marie began losing weight. In brief, tear-laden conversations with Marie, he learned that she was becoming more depressed, restricting food intake, and even making small lacerations on her body to "punish herself" for being an unsatisfactory spouse. Feeling more distressed himself, CPT Smith wondered how he could possibly begin seeing Marie as a patient in light of their friendship. Still, he recognized that he was the only mental health provider on the base. He expressed serious concern about Marie's mental state and offered to see her in regular therapy sessions. She expressed profound relief and acknowledged that she needed assistance; she admitted that the quality of her work as an Internal Medicine physician at the hospital was slipping. However, she refused to go through formal channels, citing the small hospital community and the potential effects of a psychiatric diagnosis on her fitness for deployment and subsequent career in Air Force medicine. Of course, providing undocumented care would prevent CPT Smith from opening an official client record and documenting Marie's diagnostic intake and subsequent therapy notes. CPT Smith felt trapped. He wanted to be helpful to a friend and fellow healthcare provider. He empathized with her realistic concerns about her career and the disintegrating state of her marriage. He also worried that Marie manifested some personality psychopathology and that her current distress and impairment might be diminishing the quality of her patient care. As an aside, CPT Smith was deeply troubled by the possibility that John was having an affair with the same "Rhonda" that CPT Smith was seeing in therapy; a young medical technician at the hospital who had disclosed to CPT Smith that she had recently become involved with a married man. Meanwhile, CPT Smith felt unable to share any of this information with his own wife, who couldn't understand why John and Marie had become distant and stopped socializing with them. CPT Smith felt caught in a quandary. Should he bring Marie's mental status to the attention of the hospital commander, perhaps forcing her to receive mental health care? Of course, that approach would likely sabotage any therapeutic relationship the two might have. Should he simply do what he could for her informally as a way to help protect her patients by improving her functioning? Providing therapy under the radar carried risks to both his professional standing and the military mission. As he pondered the most appropriate way forward, CPT Smith's anxiety spiked again when it occurred to him that he and his wife had just celebrated the news of their first pregnancy and that John was the only obstetrician available to them.

Discussion

Multiple relationships occur when an MHP is in a professional relationship with a person and then adds a different – potentially conflicting – role with that person, or someone closely associated with that person (e.g., friend, family member, loved one). Multiple relationships are particularly concerning when they place vulnerable clients at risk of exploitation (APA, 2010). Although there are certain bright-line multiple relationships that we would all agree carry the risk of real harm to a client (e.g., sexual or business relationships), other multiple roles are less obviously likely to cause harm. Kitchener (2000) cautioned that the probability of causing harm to a client in the context of multiple roles increases whenever: (a) clients have role expectations of the MHP that go unfulfilled; (b) the behavior or obligations associated with one role conflict with those of another; (c) the MHP's professional obligations conflict with his or her personal interests; or (d) the MHP holds increasing levels of power and prestige vis-à-vis the client.

The case of CPT Smith illustrates in stark terms just how ubiquitous multiple relationships are in military settings (Johnson & Johnson, 2017; Johnson et al., 2005; Staal & King, 2000). Although ethics codes caution MHPs to avoid entering into professional roles with close friends or family members, or to avoid shifting roles with clients without appropriate informed consent, CPT Smith discovered just how quickly the contours between friend, client, and colleague can become blurred. Particularly in embedded contexts or isolated duty stations, MHPs often find themselves assuming clinical roles with colleagues or administrative, supervisory, or evaluative roles with clients without adequate opportunity to anticipate the new roles or provide much in the way of informed consent. When embedded with a deployed unit, the challenge of preserving typical provider–client boundaries is challenging enough, let alone preventing multiple relationships. Consider this description of a typical stroll down the main passageway for a Navy aircraft carrier psychologist:

One client stops to tell me how the last phone conversation with his wife went. Ten steps later someone who is not a client stops to ask about whether his son has ADHD. Five more steps and I'm having a conversation with a person I've never met about his wife's history of depression and how he "can't even talk to her anymore." Finally, just before arriving at my destination, a sailor whom I've seen for a few appointments stops me to lament about why he can't ever seem to have intimate relationships with women who are not prostitutes. (Johnson et al., 2005, p. 74)

As have other military MHPs before him, CPT Smith has discovered that, as the only mental health provider in a small, isolated unit, he automatically holds a "potential" multiple role with every member of the community should they require mental health care. Unlike other providers in larger communities, he cannot easily refer active-duty members to other colleagues or civilian providers. In the case at hand, all active-duty personnel may be required to receive medical care through formal military channels. There may also be language or cultural barriers were he to try and refer Marie to a provider in the civilian community.

Notice that in this case, the provider must struggle with several competing interests and obligations. Some of those to whom he owes some consideration include Marie (although she has not formally become a client just yet), the medical patients to whom Marie provides services, and the hospital's commanding officer who has a vested interest in the quality of care provided by practitioners as well as the maintenance of good order and discipline among his or her staff (fraternization between John and Rhonda, if this is true, would constitute a serious violation of military law). Moreover, CPT Smith himself has a personal stake in the outcome of this situation. His primary social network and the quality of care his spouse might receive all hang in the balance. This case highlights the fact that military MHPs may often feel pinched both emotionally and ethically by unavoidable multiple relationships with colleagues and clients. Countertransference might easily lead CPT Smith to harbor resentment and anger at Marie and John for costing him a key source of social support while also placing him in an untenable position professionally.

If there is a silver lining in this case, it is the fact that a pre-existing friendship between members of the military can enhance trust and willingness to engage in needed mental health care; it may also stimulate real empathy and genuine care in crafting a treatment plan or disposition recommendation that is most likely to be in the client's best interests. I conclude discussion of this case with several brief recommendations for managing multiple relationships in military settings (Johnson, 2008, 2014; Johnson & Johnson, 2017).

- *Accept that every member of the military unit is a potential client.* Remain aware that any member of the community, including close friends and superior officers, may require your professional services. Adopting such an informed and cautious perspective is likely to help a uniformed practitioner to make wise and informed decisions about levels of self-disclosure as well as engagement in romantic or social relationships within a military community.
- *Increase your own comfort with routine boundary crossings and benign multiple relationships.* While remaining vigilant for boundary violations or harmful multiple roles, it is important to accept that not all extra-therapy contact, nor all dual relationships with a person at work, are likely to cause harm (Gutheil & Gabbard, 1993). If you can model calm acceptance of multiple roles while showing you are concerned about protecting your clients' best interests, chances are that your clients will be less anxious about routine role blurring as well. There is something culturally sensitive about appreciating the potential benefits of multiple relationships in the military.
- *Provide informed consent regarding boundary crossings and multiple roles as early in a professional relationship as possible.* It is always wise in military contexts – particularly in embedded units – to discuss upfront the likelihood of extra-treatment interactions and how the client would like to handle them. Similarly, it might be wise to address with friends and colleagues how you handle situations in which you are called upon to provide professional services for them.
- *Carefully document uncomfortable multiple-role relationships.* Particularly when a multiple relationship with a client is unanticipated and difficult – or potentially

harmful – for the client, be careful to document your efforts to discuss and manage the relationship with your client’s best interests at the fore.

- *Maintain a strong external consultation relationship.* It is always helpful for a military MHP in an isolated job or deployed unit to maintain a consulting relationship with another MHP who can help him or her troubleshoot prickly boundary issues and develop strategies for minimizing and managing multiple relationships when they occur.

Preserving Competence and Practicing Self-Care

The Case of LT Ridley

Navy Lieutenant (LT) Ridley’s story was not unusual. With a recent doctorate in clinical psychology and a commission in the Navy’s Medical Services Corps, she had endured a whirlwind officer indoctrination school in Rhode Island, followed by an intense internship year at Walter Reed National Military Medical Center, where she completed rotations with severely wounded warriors rehabilitating from serious injuries suffered in Iraq and Afghanistan. Once assigned to her first duty station, a large medical center in Florida, she managed only nine months before being tabbed for deployment to Iraq. For six months, she provided services to severely traumatized soldiers and marines; she listened to their difficult stories hour after hour, day after day. She was also exposed to disturbing images with some regularity (e.g., severely wounded service members, corpses of enemy combatants when transiting between bases in an armored vehicle). Upon her return to the USA, she had only four months to try to reacclimatize to a noncombat context when she was again tabbed for deployment – this time to Afghanistan – with a forward deployed military surgical hospital. After eight additional months deployed in severe and unpredictable surroundings punctuated by distant explosions and constant sleep deprivation, she found herself sitting across from a Marine Corps Sargent one afternoon. As he described a horrific IED explosion and the carnage he witnessed in the aftermath, LT Ridley felt herself detaching; in her mind’s eye, she was bombarded with disturbing images from both deployments, including some of her own clients who had been killed – a few just before their scheduled rotation home. Staring at the patient before her, it occurred to her that she had not heard a word he had said in nearly ten minutes. With two weeks to go before her own rotation back to the USA, she was vaguely aware that she was entirely depleted. Some invisible boundary had been crossed and all her reserves of empathy and compassion were used up. When LT Ridley returned to Florida and attempted to reintegrate into her normal routine, including a full load of clients – primarily young enlisted sailors who had never served in combat – she discovered an emotional barrier between herself and her clients. Showing them genuine compassion and empathy was often a struggle; sometimes, it was impossible. Detachment offered her a sense of self-protection. Most concerning was that she sometimes experienced sudden feelings of intense anger with patients who showed emotional weakness. She was especially

irritable with “whiney kids” who had never served in combat and therefore had not – in her honest moments – earned the right to complain about anything. She found it quite distressing that she could no longer muster the empathy needed to feel helpful for these young service members. She also worried about her difficulty sleeping, intrusive images from her deployments, and a slow but steady increase in her use of alcohol. She wondered what to do. She worried that limiting or suspending her clinical work – as recommended by her ethics code if a psychologist was too distressed to provide competent care – would cause serious career repercussions. Seeking care in the hospital would feel uncomfortable for her and cause an awkward dual role for one of her colleagues as well. And besides, none of them had expressed any concern about her work, nor even bothered to check in with her about her readjustment from deployment. Perhaps she was making a mountain out of a molehill. Maybe she should just give it some more time and hope things improved. Sitting in her office at lunch, she mentally calculated the clients standing between her and her first drink of the evening.

Discussion

Thousands of military healthcare providers, including psychiatrists, psychologists, and social workers, have deployed to combat zones in support of the global war on terror during the last decade and a half. Often embedded in military units or stationed at forward casualty/triage clinics and hospitals, these MHPs endure unpredictable living and work environments, extended absences from family, exposure to direct threat, and frequent exposure to traumatic client material (Johnson, Bertschinger, Snell, & Wilson, 2014; McLean et al., 2011). It is rather inevitable that some of these MHPs, like LT Ridley in this case, will become “wounded healers” (Daneault, 2008), professionals who have become so distressed that – at least temporarily – they have become impaired. A few of them have articulated their experiences quite poignantly (e.g., Kraft, 2007).

In the case of LT Ridley, two prominent psychological/emotional syndromes seem to leave her at risk for diminished competence to practice. The first is *secondary traumatic stress*. When an MHP is vicariously or secondarily traumatized by repeated and extended exposure to clients’ traumatic disclosures, it is not uncommon for them to report troubling experiences such as intrusive images, generalized fear, sleep disturbances, and persistent affective arousal (Tabor, 2011). The second syndrome – deeply entwined with the first – is *compassion fatigue* (Figley, 2002): a state of emotional exhaustion and diminished emotional resources as a result of empathizing with clients who are in serious pain (Shapiro, Brown, & Biegel, 2007). The greater the empathy in professionals like LT Ridley, the more they are at risk of experiencing helplessness, inefficacy, and emotional detachment following extended periods of working empathically with traumatized clients. Most concerning is that compassion fatigue may portend a state of *empathy failure*, which occurs when a previously competent professional begins to process client experiences and feelings on a purely cognitive level, perhaps no longer being capable of emotional processing and effective mirroring (Johnson et al., 2014). In the case of LT Ridley,