Counselors and the Military: When Protocol and Ethics Conflict

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The U.S. Department of Veterans Affairs (VA) and TRICARE have approved professional counselors to work within the military system. Counselors need to be aware of potential ethical conflicts between counselor ethical guidelines and military protocol. This article examines confidentiality, multiple relationships and cultural competency, as well as ethical models to navigate potential dilemmas with veterans. The first model describes three approaches for navigating the ethical quandaries: military manual approach, stealth approach, and best interest approach. The second model describes 10-stages to follow when navigating ethical dilemmas. A case study is used for analysis.

Keywords: **military, ethics, veterans, counselors, competency, confidentiality**

The American Community Survey (ACS; U.S. Census Bureau, 2011) estimated that 21.5 million veterans live in the United States. A reported 1.6 million veterans served in the Gulf War operations that began post-9/11 in 2001 (U.S. Census Bureau, 2011). Gulf War post-9/11 veterans served mainly in Iraq and Afghanistan, in operations including but not limited to Operations Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND) (M. E. Otey, personal communication, October 23, 2012). Holder (2007) estimated that veterans represent 10% of the total U.S. population ages 17 years and older. Pre-9/11 data suggested that 11% of military service members utilized mental health services in the year 2000 (Garvey Wilson, Messer, & Hoge, 2009). In 2003, post-9/11 comparative data reported that 19% of veterans deployed to Iraq accessed mental health services within one year of return (Hoge, Auchterlonie, & Milliken, 2006). Recognizing the increased need for mental health assessment, the U.S. Department of Defense (DOD) mandated the Post-Deployment Health Assessment (PDHA) for all returning service members (Hoge et al., 2006). The PDHA is a brief three-page self-report screening of symptoms to include post-traumatic stress, depression, suicidal ideation and aggression (U.S. DOD, n.d.). The assessment also indicates service member self-report interest in accessing mental health services.

Military service members access mental health services for a variety of reasons. In a qualitative study of veterans who accessed services at a Veterans Affairs (VA) mental health clinic, 48% of participants reported seeking treatment because of relational problems, and 44% sought treatment because of anger and/or irritable mood (Snell & Tusaie, 2008). Veterans may also present with mental health symptoms related to post-traumatic stress disorder (PTSD), depression, and suicidal ideation (Hoge et al., 2006). Depression is considered a common risk factor of suicide among the general population, and veterans are additionally at risk due to combat exposure (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). The DOD (2012) confirmed that 165 active-duty Army service members committed suicide in 2011. Furthermore, researchers asserted that suicide caused service member deaths more often than combat (O'Gorman, 2012). Hoge et al. (2004) reported that veterans were most likely to access mental health services 3–4 months post-deployment. Unfortunately, researchers suggested that service members were hesitant to access mental health treatment, citing the stigma of labels (Kim, Britt, Klocko,

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Riviere, & Adler, 2011). Studies indicated that mental health service needs are underestimated among the military population and are therefore a potential burden to an understaffed helping profession (Garvey Wilson et al., 2009; Hoge et al., 2006). In May of 2013, the DOD and VA created 1,400 new positions for mental health providers to serve military personnel (DOD, 2013). Moreover, as of March 2013, the DOD-sponsored veterans crisis line reported more than 800,000 calls (DOD, 2013). It is evident that the veteran population remains at risk for problems related to optimal mental health functioning and therefore requires assistance from trained helping professionals.

Historically, the DOD employed social workers and psychologists almost exclusively to provide mental health services in the military setting. Recently, the DOD and VA expanded services and created more positions for mental health clinicians (U.S. VA, 2012). Because licensed professional counselors (LPCs) are now employable by VA service providers (e.g., VA hospitals) and approved TRICARE providers (Barstow & Terrazas, 2012), it is imperative to develop an understanding of the military system, especially of the potential conflict that may exist between military protocol and counselor ethical guidelines. The military health system requires mental health professionals to be appropriately credentialed (e.g., licensed), and credentialing results in the mandatory adherence to a set of professional ethical standards (Johnson, Grasso, & Maslowski, 2010). However, there may be times when professional ethical standards do not align with military regulations. Thus, an analysis of the counselor ethical codes relevant to the military population is presented. At times, discrepancies between military protocol and counselor ethical codes may emerge; therefore, recommendations for navigating such ethical dilemmas are provided. A case study and analysis from the perspective of two ethical decision-making models are presented.

Ethical Considerations for Counselors

The mission of the American Counseling Association (ACA) Code of Ethics (2005) is to establish a set of standards for professional counselors, which ensure that the counseling profession continues to enhance the profession and quality of care with regard to diversity. As professional counselors become employed by various VA mental health agencies or apply for TRICARE provider status, it is important to identify specific ethical codes relevant to the military population. Therefore, three categories of ethical considerations pertinent to working with military service members are presented: confidentiality, multiple relationships, and cultural competence.

Confidentiality

The ACA Code of Ethics (2005) suggests that informed consent (A.2.a., p. 4) be a written and verbal discussion of rights and responsibilities in the counseling relationship. This document includes the client right for confidentiality (B.1.c., p. 7) with explanation of limitations (B.1.d., p. 7). The limitations, or exceptions, to confidentiality include harm to self, harm to others and illegal substance use. In the military setting, counselors may need to consider other exceptions to confidentiality including domestic violence (Reger, Etherage, Reger, & Gahm, 2008), harassment, criminal activity and areas associated with fitness for duty (Kennedy & Johnson, 2009). Also, military administrators may require mandated reporting when service members are referred for substance abuse treatment (Reger et al., 2008). When these conditions arise in counseling, the military may require reporting beyond the standard ethical protocol to which counselors are accustomed.

Counselors working in the VA mental health system or within TRICARE may need to be flexible with informed consent documents, depending on the purpose of services sought. Historically, veterans represented those who returned from deployment and stayed home. Currently, military members may serve multiple tours of combat duty; therefore, the definition of *veterans* now includes active-duty personnel. This modern definition of *veteran* speaks to issues of fitness for duty, where the goal is to return service members ready for combat.

Informed consent documents may need to outline disclosures to commanding officers. For example, if a service member is in need of a Command-Directed Evaluation (CDE), then the commander is authorized to see the results of the assessment (Reger et al., 2008). Fitness for duty is also relevant when service members are mandated to the Soldier Readiness Program (SRP) to determine their readiness for deployment. In these situations, counselors need to clearly explain the exception to confidentiality before conducting the assessment. Depending on the type of agency and its connection to the DOD, active-duty veterans' health records may be considered government property, not the property of the service provider (McCauley, Hacker Hughes, & Liebling-Kalifani, 2008). It is imperative that counselors are educated on the protocols of the setting or assessments, because "providing feedback to a commander in the wrong situation can be an ethical violation that is reviewable by a state licensing authority" (Reger et al., 2008, p. 30). Thus, in order to protect the client and the counselor, limitations to confidentiality within the military setting must be accurately observed at all times. Knowledge of appropriate communication between the counselor and military system also speaks to the issue of multiple relationships.

Multiple Relationships

Kennedy and Johnson (2009) suggested creating collaborative relationships with interdisciplinary teams in a military setting in order to create a network of consultants (e.g., lawyers, psychologists, psychiatrists), which is consistent with ACA ethical code D.1.b to develop interdisciplinary relationships (2005, p. 11). However, when interdisciplinary teams are formed, there are ACA (2005) ethical guidelines that must be considered. These guidelines state that interdisciplinary teams must focus on collaboratively helping the client by utilizing the knowledge of each professional on the team (D.1.c., p. 11). Counselors also must make the other members of the team aware of the constraints of confidentiality that may arise (D.1.d., p. 11). In addition, counselors should adhere to employer policies (D.1.g., p. 11), openly communicating with VA superiors to navigate potential discrepancies between employers' expectations and counselors' roles in best helping the client.

In the military environment, case transfers are common because of the high incidence of client relocation, which increases the need for the interdisciplinary teams to develop time-sensitive treatment plans (Reger et al., 2008). Therefore, treatment plans not only need to follow the guidelines of A.1.c., in which counseling plans "offer reasonable promise of success and are consistent with abilities and circumstances of clients" (ACA, 2005, p. 4), but they also need to reflect brief interventions or treatment modalities that can be easily transferred to a new professional. Mental health professionals may work together to best utilize their specialized services in order to meet the needs of military service members in a minimal time allowance.

For those working with military service members, consideration of multiple relationships in terms of client caseload also is important. Service members who work together within the same unit may seek mental health services at the same agency. Members of a military unit may be considered a support network which, according to ethical code A.1.d., may be used as a resource for the client and/or counselor (ACA, 2005, p. 4). However, learning about a military unit as a network from multiple member perspectives may also create a dilemma. Service members within a unit may be tempted to probe the counselor for information about other service members, or tempt the counselor to become involved in the unit dynamic. McCauley et al. (2008) recommended that mental health professionals avoid mediating conflicts between service members in order to remain neutral in the agency setting.

However, there are times when the unit cohesion may be used to support the therapeutic relationship. Basic military training for service members emphasizes the value of teamwork and the collective mind as essential to success (Strom et al., 2012). It is important for counselors to approach military service member clients from this perspective, not from a traditional Western individualistic lens. Mental health professionals also are warned not to be discouraged if rapport is more challenging to build than expected. Hall (2011) suggested that the impor-

tance of secrecy in the military setting might make it more difficult for service members to readily share in the therapeutic relationship. Researchers noted that military service members easily built rapport with each other in a group therapy session, often leaving out the civilian group leader (Strom et al., 2012). It might behoove counselors to build upon the framework of collectivism in order to earn the trust of members of the military population. Navigating the dynamic of a unit or the population of service members accessing care at the agency may be a challenge; however, counselors are able to alleviate this challenge with increased knowledge of the military culture in general.

Cultural Competence

The military population represents a group of people with a unique "language, a code of manners, norms of behavior, belief systems, dress, and rituals" and therefore can be considered a cultural group (Reger et al., 2008, p. 22). Reger et al. (2008) suggested that many clinical psychologists learned about military culture as active service members themselves. While there may be many veterans currently working as professional counselors, civilian counselors also serve the mental health needs of the military population; and as civilians, they require further training. The ACA Code of Ethics (2005) suggests that counselors communicate with their clients in ways that are culturally appropriate to ensure understanding (A.2.c., p. 4). This can be achieved by prolonged exposure to military culture or by seeking supervision from a professional involved with the military mental health system (Reger et al., 2008). Strom et al. (2012) outlined examples of military-specific cultural components for professionals to learn: importance of rank, unique terminology and value of teamwork. It behooves counselors intending to work with the military population to learn terminology in order to understand service members. For example, R&R refers to vacation leave and MOS or rate refers to a job category (Strom et al., 2012).

Personal values may cause dilemmas for a mental health professional working within the VA system. This can be especially true during times of war. Stone (2008) suggested that treating veterans of past wars may be easier than working with military service members during current combat because politics may be intensified. A counselor who does not support the current wartime mission may be conflicted when clients are mandated to return to active-duty assignments (Stone, 2008). The ACA Code of Ethics (2005) addresses the impact of counselors' personal values (A.4.b., pp. 4–5) on the therapeutic relationship. It is recommended that counselors be aware of their own values and beliefs and respect the diversity of their clients. Counselors need to find a way to value the contributions of their client when personal or political opinion conflicts with the DOD's plans or efforts overseas. If one wants to be successful with this population, Johnson (2008) suggested the foundational importance of accepting the military mission. If this is in direct conflict with the counselor's values, it may be recommended for the counselor to consider the client's value of the mission.

The ACA ethical code stresses the importance of mental health professionals practicing within the boundaries of their competence and continuing to broaden their knowledge to work with diverse clients (ACA, 2005, C.2.a., p. 9). Counselors should only develop new specialty areas after appropriate training and supervised experience (ACA, 2005, C.2.b., p. 9). Working within the VA mental health system, mental health professionals may be asked to provide a service in which they are not competent (Kennedy & Johnson, 2009). Such a request may occur more frequently here than in other settings, due to the high demand of mental health services and low availability of trained professionals (Garvey Wilson et al., 2009; Hoge et al., 2006). Counselors must determine if their experience and training can be generalized to working with military service members (Kennedy & Johnson, 2009), and may be their own best advocate for receiving appropriate training.

Awareness of when and how military service members access mental health services also might be important to consider. Reger et al. (2008) reported that military personnel were more likely to access services before and after a deployment. Researchers specified a higher prevalence rate of access 3–4 months after a deployment

(Hoge et al., 2004). The relationship of time between deployment and help-seeking behaviors suggests that counselors should be prepared for issues related to trauma. For women, combat-related trauma is compounded with increased rates of reported military sexual trauma (Kelly et al., 2008). Counselors would benefit from additional trainings in trauma intervention strategies. The VA and related military organizations offer many resources online to educate professionals working with military members with identified trauma symptoms (U.S. VA., n.d.).

Advocating for appropriate training in areas of incompetence is the responsibility of the professional, who should pursue such training in order to best meet the needs of the military population. It is best practice for mental health professionals to be engaged in ongoing trainings to ensure utilization of the latest protocols and treatment modalities (McCauley et al., 2008). Trainings may need to extend beyond general military culture, because each branch of service (e.g., Army, Marines, Navy) could be considered a cultural subgroup with unique language and standards. For example, service members in the Army are soldiers, whereas members of the Navy are sailors (Strom et al., 2012).

This article has outlined many ACA (2005) ethical guidelines pertinent to working with the military population. However, as presented, there are times when counselor ethical codes conflict with military regulations. Counselors interested in working in the military setting or with military personnel may consider decision-making models to address ethical dilemmas.

Recommendations for Counselors

The military mental health system has almost exclusively employed psychologists and social workers. Counselors interested in employment within VA agencies or as TRICARE providers may utilize the resources created by these practitioners to better serve the military population. Two ethical decision-making models are presented, and a case study is provided to demonstrate how to implement the models.

Ethical Models

The ACA Code of Ethics (2005) advises counselors to adhere to the code of ethics whenever possible, working towards a resolution of the conflict (H.1.b., p. 19). If a favorable resolution cannot be formed, counselors have the choice to act in accordance with the law or regulation. Psychology researchers have suggested ethical models for professionals to use during times of dilemma within the military setting. The first model presented considers three overarching approaches to address ethical dilemmas; and the second model presented is a more specific stage model with which to approach dilemmas. These models may serve to assist counselors as the counseling profession gains more experience in the VA system and eventually develops counselor-specific decision-making models.

Approach model. Johnson and Wilson (1993) identified three approaches for psychologists to consider when navigating the ethical quandaries of the military mental health system. The first, the *military manual approach*, occurs when professionals adhere strictly to military regulations without consideration for the specific client's needs. The second, the *stealth approach*, occurs when there is strict adherence to the mental health professionals' code of ethics, regardless of the legalities surrounding the circumstances. While the client's best interests may be at the forefront in this approach, the counselor must also take into account the possibility of being the subject of legal action for not adhering to the standards set by the military. For example, the counselor may use ambiguous wording within the client file or leave some information out altogether, so that if the files were requested, the client's information would be protected (Johnson & Wilson, 1993). The third, the *best interest approach*, occurs when the counselor maintains focus on the client's best interest while also adhering to

the standards of the military. This may require professionals to adhere to the minimum professional standards in order to accommodate the client's best interest. Although most professionals have deemed this approach the best option, it also leads to the most ambiguity. Under certain circumstances, the counselor also must take into account what is in the best interest for society as a whole, while also navigating a responsibility to the client and the military mental health system. Researchers in psychology responded to the ambiguity of this model by developing a more specific stage model to assist professionals with ethical dilemmas.

Stage model. Barnett and Johnson (2008) proposed a 10-stage model to follow when navigating an ethical dilemma. They advise that professionals must do the following:

1. Clearly define the situation.
2. Determine what parties could be affected.
3. Reference the pertinent ethical codes.
4. Reference the pertinent laws and regulations.
5. Reflect on personal thoughts and competencies on the issue.
6. Select knowledgeable colleagues with whom to consult.
7. Develop alternate courses of action.
8. Evaluate the impact on all parties involved.
9. Consult with professional organizations, ethics committees and colleagues.
10. Decide on a course of action.

Barnett and Johnson (2008) also noted that once a decision is made, the process does not end. It is best practice to monitor the implications and, if necessary, modify the plan. Documentation throughout this entire process is necessary for the protection of the counselor, the client and other involved stakeholders. Counselors working in the military mental health system may find this 10-stage model helpful when navigating ethical dilemmas.

To better understand the implementation of the two presented ethical decision-making models, a case study was developed. The case is then conceptualized from both the approach model and stage model, and the ethical dilemmas associated with the case are discussed.

Case Study

Megan is a licensed professional counselor employed at a clinic that serves military service members. She provides individual outpatient counseling to veterans and family members, as well as facilitates veteran support groups. Megan's client, Robert, is a Petty Officer First Class in the Navy. Robert is married with two children. In recent sessions, Megan became concerned with Robert's increased alcohol use. Recently, Robert described a weekend of heavy drinking at the local bar. Although Robert drove after leaving the bar both nights, Megan suspected that he was not sober enough to drive. In a follow-up session, Robert reported that his binge-drinking weekend caused friction at home with his wife, and that he missed his children's soccer games. During his most recent session, Robert was visibly distressed as he disclosed to Megan that he received orders for a deployment in 3 months. Robert is anxious about informing his wife and children of the pending 6-month deployment, as he knows it will only increase conflict at home. Robert reported that his family could use the increase in pay associated with family separation and tax-free wages during deployment. However, he also knows that deployments cause tension with his wife, which has already increased due to Robert's recent drinking binges. While leaving the session, he mentioned with a laugh that he would rather go to the bar than go home.

Analysis from approach model. Megan may consider using Johnson and Wilson's (1993) ethical approach model as she conceptualizes the potential ethical dilemma presented in Robert's case. From a military manual approach, Megan may need to report Robert's recent alcohol abuse behavior to his superior, as it may impact

his fitness for duty on his next deployment. And although Robert has not been caught drinking and driving or charged with a crime, his behavior also puts him at risk of military conduct violations. However, when Robert originally came to the clinic, he did so of his own accord, not under orders, which could mean that notifying a commanding officer is an ethical violation. In consideration of the stealth approach, Megan may review the ACA (2005) ethical guidelines and conclude that there are no violations at risk if she chooses not to report Robert's drinking habits. However, Megan contemplates whether addressing Robert's drinking binges is in his best interest overall. She understands that the money associated with deployment is important to Robert's family at this time; however, his drinking may put him at increased risk during deployment. Finally, Megan applies the best-interest approach to Robert's situation. Megan may refer Robert to the center's substance use support group. This referral will be reflected in Robert's records, but if he begins receiving treatment for his alcohol abuse now (3 months before deployment), there may be time for Robert to demonstrate significant progress before his fitness for duty assessment.

Analysis from stage model. Megan may consider her ethical dilemma from Barnett and Johnson's (2008) 10-stage model. In stage 1, she clearly defines the situation as Robert's alcohol abuse and pending deployment. In stage 2, Megan considers who may be affected in this situation. She understands that Robert's family would benefit from the extra money associated with the deployment, and therefore the family may be impacted if Robert is not deployed. Megan also notes that the family is already negatively impacted by his recent drinking binge (e.g., conflict with his wife, missed soccer games). If Robert's problematic drinking continues, he is at risk for evaluation and promotion issues. In stage 3, Megan reflects upon the ACA (2005) ethical codes in order to better understand her dilemma from a counselor's view. Robert has a right to confidentiality (B.1.c., p. 7) with limitations including illegal substance use (B.1.d., p. 7). However, Robert's current substance is alcohol, which is a legal substance. Megan considers the importance of his support network (A.1.d., p. 4) including his family and unit, but she does not have the ethical right to disclose her concerns about his substance abuse. In stage 4, Megan considers the pertinent laws and regulations of the dilemma. As per the clinic regulations, she is aware that if she makes a substance use program referral, it will be reflected in Robert's record, which is the property of the military. Megan also is aware that Robert has not committed a documented crime of driving under the influence.

In stage 5 of the 10-stage ethical decision-making model, Megan must reflect on her personal thoughts and competencies. She is very concerned about Robert's increased use of alcohol and is worried for his safety if deployed. Megan feels less confident in her ability to accurately assess for substance use problems. She facilitates the PTSD support group for the clinic, which is her specialty area. Megan recognizes that she is fond of Robert as a client and is disappointed that he could be jeopardizing his family and career with his alcohol abuse. She considers whether she is overreacting to his binge-drinking incident because of her higher expectations of him. In stage 6, Megan consults with her colleague who leads the substance use support groups at the clinic. She describes Robert's recent abuse of alcohol and inquires as to whether he is a good candidate for the substance use group, needs more intense treatment, or needs no treatment at all. The colleague suggests that the group would be a very appropriate fit for someone with Robert's symptoms.

In stage 7, Megan develops her course of action to refer Robert to the substance use group. Then, in stage 8, she evaluates the plan for potential impact on parties involved. Megan conceptualizes that Robert may be at risk for losing his deployment orders if he is accessing substance use treatment. Megan believes she has reduced this potential impact by referring to the substance support group, rather than an inpatient treatment facility, which may be more appropriate for a dependence issue. Megan recognizes that attending a 90-minute group each week will take Robert away from his family, but she also realizes that the 90-minute commitment is less than his current time spent away from the family when binge drinking. Megan reflects upon how her therapeutic relationship with Robert may be strained at the time of referral, and is prepared for a potential negative response from her client. She trusts in their therapeutic relationship and moves forward. In stage 9, Megan presents her

planned course of action to her supervisor at the clinic. The supervisor approves the referral for the support group, but also suggests that Megan consider a referral to couples counseling for Robert and his wife, which may assist with resolving conflicts before the deployment.

In the final stage, Megan proposes the treatment plan of action to Robert in their next session. Megan explains that she feels ethically obligated to refer Robert to the substance use support group, and that as of now, Robert may make this choice for himself. Megan and Robert discuss the potential that substance use treatment may no longer be a choice in the future if his current drinking behavior continues. There is more discussion of fitness for duty and how participation in the support group will positively reflect upon the assessment in the future. Megan also presents Robert with the recommendation of couples counseling to help mediate relationship conflicts before deployment. She reports that if Robert and his wife decide to receive couples counseling, she can provide a referral for them at that time.

With the ethical decision-making models presented, the counselor is able to successfully navigate the military mental health system, while still maintaining the professional standards of the counseling profession. In each model, the situation is resolved with considerable attention to the client's best interest, while maintaining the expectations of the military clinic. Psychologists developed the two ethical models presented, and counselors may choose to utilize these approaches until more counselor-specific ethical processes are created. As counselors become more permanent fixtures in the VA mental health system and as TRICARE providers, opportunities to develop an ethical decision-making model will likely arise.

Conclusion

The recent inclusion of counselors as mental health professionals within the VA system and as TRICARE providers allows for new employment opportunities with the military population. However, these new opportunities are not without potential dilemmas. Counselors interested in working with service members need to be educated on the potential conflict between counselor professional ethical guidelines and military protocols. Future research in the counseling field may develop a counselor-specific ethical decision-making model. In the meantime, counselors may utilize or adapt the ethical decision-making models created by other mental health professionals, who have a longer history working with the military population.

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