Ethical Considerations Regarding Competence in Military Psychologists Managing Dual Roles as an Officer and Mental Health Care Provider

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Overview

• Introduction
• Military Mental Health Providers
• Ethical Considerations
  – Dual roles
  – Competency and Potential Threats
  – Safeguards
• “Ellie” - Discussion
Military Mental Health Care Provider

• Tours of duty may include psychologically traumatic situations
• Potential for repeated exposure to DSM-5 Criterion A for posttraumatic stress disorder (PTSD)

Traumatic exposure can occur through direct contact in theater or via interactions with other service members (casual or clinical)

(APA, 2013; W.B. Johnson et al., 2011)
Ethical Considerations

• **Dual loyalties** – to client/patient and to military/government organization

• **Conflicts of Interest**

**Threats to Competence**
- including impairment of one’s ability to self-assess competence to practice
Multiple Roles: Case Study: “Chappy”

Therapist

Colonel, U.S. Air Force

Combatant

Health Care Personnel Delivery System?
Dual Roles

• **Military officer** – duties and responsibilities as determined by government supervisory agent (e.g., Department of Defense, U.S. Army, Commanding Officers)

• **Mental Health Care Provider** – uphold the principles and standards requisite with the position (e.g., APA, NASW)

Mixed Agency Dilemma
Mixed Agency Dilemma

- Include, but not limited to:
  - conflict between DoD regulations and APA Ethics
  - ambiguity regarding who the “client” is when making decisions such as fitness for duty
  - conflict between superior officers’ intentions and client’s well-being

(Kennedy & Johnson, 2009)
Ethical Principles of Psychology and Code of Conduct
(Ethics Code, American Psychological Association, 2010)

• Individual psychologist accountable for maintaining competence to practice

• General Principle A: “be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work (APA, 2010, p. 3)”
Ethical Principles of Psychology and Code of Conduct
(Ethics Code, American Psychological Association, 2010)

• Standard 2.06, “Personal Problems and Conflicts”
  
  (a) Psychologists refrain from initiating any activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

  (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties (APA, 2010, p. 5)
Threats to Competency

• As a result of combat exposure:
  – developing triage hierarchies
  – rendering aid to foreign combatants

  – directly observing, experiencing, or hearing about horrific and disturbing events (e.g., mutilations, death, destruction, despair)

(Gibbons et al., 2012; Johnson et al., 2014; Johnson & Kennedy, 2010; Larner & Blow, 2011; McLean, 2013)
Combat Involves Exposure to Multiple Types of Traumatic Events, Often Repeatedly
Re-experiencing symptoms as a result of fear conditioning and stimulus generalization
**Threats to Competency**

**Compassion fatigue** – reduced ability to show empathy as a result of an excessive number of clinical encounters with traumatized individuals (physically and/or psychologically suffering)

**Empathy failure** – processing of client encounters on a cognitive level devoid of emotional content

**“drain out”** – non-traumatic work can exhaust emotional, physical, and cognitive/mental resources

**Burnout** – emotional exhaustion, apathy, aversion or hostile attitudes toward clients

(Johnson et al., 2014; Linnerooth et al., 2011; Maslach & Leiter, 2008; Slatten et al., 2011)
Threats to Competency

• Secondary Traumatic Stress
  – also termed *indirect traumatization*
  – can occur through *vicarious experience* of traumatic events, descriptions, and imagery from interactions with fellow service members (clinical and non-clinical)
  – can alter a clinician’s cognitions, expectations, interpersonal relationships, sense of self
  – Danger of jeopardizing compliance with Ethics Standard 2.06
    • Herman (1992) suggested that repeated vicarious exposure could make the clinician “suspect among their colleagues (Herman, 1992, p. 9).”

(Pearlman & Saakvitne, 1995; Voss Horrell et al., 2011)
Case Study: Dr. B

• Board Certified Clinical Psychologist
  – Working with DoD for 12 years
• Residency at Ft. Gordon, GA (prescribing Ph.D.)
• Has been completing aeromedical evaluations for 10 years

• 10 years active duty in the U.S. Army (deployed to Iraq)
• Assignments include Ft. Bragg (home of the 82nd Airborne) and Ft. Carson
Case Study: Dr. B

“SSG J made everyday at our clinic interesting. He loved his jazz music, and was proud to serve double duty as a pharmacy tech and on the PSD (Personnel Support Detachment). Right before he died, I would often joke with him about his new hairdo – he was starting to grow it out and rebel a little after being in country for so long. The day before he died – we were joking about if he was “crazy” to want to try out for Special Forces – I told him “just crazy enough.” He would have done well. To SSG J’s family – know that he made a difference every day taking care of other soldiers. I will miss his smile and sense of humor.”

- Dr. B

SSG J died in Baghdad, Iraq when an improvised explosive device (IED) detonated near his humvee causing it to rollover

fallenheroesmemorial.com
CaseStudy: Dr. P

- Chief of Behavioral Health Services
- Captain in the U.S. Army

“[I] was tasked with deciding who went to war, who returned home, who would deploy at a later date to the combat zone, who could redeploy, and who couldn’t.”

Psirakis, 2009
Emotional Competence

- one’s emotional, psychological, and interpersonal functioning
  - assumed to be intact in competent mental health provider
  - self-knowledge, self-awareness, self-monitoring

Pope & Vasquez, 2011; Doverspike, 2015, personal communication
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<thead>
<tr>
<th></th>
<th>Short-term</th>
<th>Long-term</th>
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<tr>
<td>Mild</td>
<td>Acute distress</td>
<td>Chronic anxiety</td>
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<td>Brief fatigue</td>
<td>Mild dysthymia</td>
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<td>Chronic fatigue</td>
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<td>Severe</td>
<td>Uncontested divorce</td>
<td>Chronic addiction</td>
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<td>Death of a loved one</td>
<td>Severe dementia</td>
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<td>Traumatic event (ASD?)</td>
<td>Chronic/severe PTSD</td>
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Severity and Duration of Emotional Impairment
Self-assessment of Competence

- often biased, inconsistent, and repeatedly an overestimation of one’s present capabilities *in the absence of repeated trauma exposure*

- self-ratings can be worsened during deployment, following repeated exposure to traumatic material, and/or in the presence of clinically significant signs and symptoms

(Johnson et al., 2014; Johnson et al., 2012; Johnson & Koocher, 2011)
PTSD: National Center for PTSD

Working with Trauma Survivors: What Workers Need to Know

http://www.ptsd.va.gov/professional/provider-type/responders/
Safeguards

• From service member, combat Veteran, first responder, trauma physician, and palliative care literature:

  - increased clinical experience
  - strong sense of self-efficacy
  - manageable caseload
  - strong social support system
  - personal psychotherapy

(Daneault, 2008; Johnson et al., 2014; Trippany et al., 2004)
Safeguards: In Practice

• Pursuit of self-care
  – exercise
  – good nutrition
  – effective sleep hygiene
  – recreation
  – interacting with colleagues

(Trippany et al., 2004; Linnerooth et al., 2011; Johnson et al., 2012)
Diversity/Multi-cultural Considerations

• Religious beliefs/faith system
  – concurrent spirituality support

• Ethnocultural background
  – trauma history
  – sex, SES, education
  – processing of guilt (e.g., Korean ferry disaster)
A Virtual Therapist

USC Viterbi’s Louis-Philippe Morency and his team have created a virtual human named "Ellie" to converse with PTSD sufferers to help them heal.

“Ellie”
- virtual human as part of SimSensei program
- effort to avoid stigma associated with therapy
- clinician aid for decision making
- can detect object, physiological signs of distress
  - tone of voice, gaze, head movement
- Veterans who interacted with Ellie
  - “good to be able to just talk”
  - “made me feel like I wasn’t being judged”

Ethical thoughts on Ellie as a supplementary clinical tool?
References

- Johnson, W. B., Bertschinger, M., Snell, A. K., & Wilson, A. (2014). Secondary trauma and ethical obligations for military psychologists: preserving compassion and competence in the crucible of combat. *Psychological Services, 11*(1), 68-74. doi: 10.1037/a0033913