COMPROMISED CONFIDENTIALITY: DE-STIGMATIZING THE SILENT STRUGGLE OF OUR SERVICEMEN

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Abstract

Mental health disorders permeate the military. When compared to their civilian counterparts, armed forces personnel experience a disproportionately high amount of mental illnesses but receive a disproportionately low amount of treatment. This study explores the inverse correlation between mental health disorders and treatment in the military and hypothesizes that the dangerously low amount of confidentiality afforded to the psychotherapist-patient relationship by current military laws contributes to a stigma that discourages armed forces personnel from seeking treatment for their mental health disorders. By consulting a variety of scholarly resources in the fields of political science, psychiatry, and law, this study explicates and analyzes the history, causes, and impacts of mental health disorders in the military and the stigma that accompanies it. Ultimately, this study confirms the initial hypothesis and offers several suggestions the military and policymakers could use to help wounded warriors back on their feet.

Introduction

As he sat in his psychotherapist's office, Sgt. Russell reflected on the 14 years of service he had dedicated to the U.S. military. He could not stop replaying the images and re-experiencing the terror of five combat deployments in Iraq. He cried out for help in the only way he knew how—by talking to his psychiatrist, Michael Jones. Visit after visit, Russell told Jones how he—a seasoned veteran of war—could no longer sleep, eat, or think normally. The symptoms he described to Jones were more than enough to warrant a disability discharge, but Jones had no intention of giving Russell a "golden ticket" out of the army. Russell could not have been more frank: he told Jones in his penultimate visit that if he did not receive serious help, he would kill himself. Jones dismissed him by saying, "You're fixed" (Murphy, 2013, para. 13). After this, Russell stormed out of the office to Jones yelling, "Soldier, you've made your decision" (Murphy, 2013, para. 13).

On May 11, 2009, Russell returned to Jones' office and sat in silence. After 10 minutes, Jones dismissed him under his zero tolerance policy and called the military police to escort him back to his unit. Russell and his escort rode back to his unit's compound without exchanging any words. When they stepped out of the vehicle, the sound of Russell's fist crushing the jaw of his escort broke the silence. Stunned, the army escort could not resist Russell from prying the M-16 from his fingers, and he gave Russell the keys to the army vehicle at gunpoint. Just after Russell stormed off in the stolen vehicle, the escort alerted the Camp Liberty military police. By the time the "armed and dangerous" warning reached Jones' office in the combat stress clinic, Russell had arrived and kicked in the front door. Round after round escaped the muzzle of the M-16 as he murdered his way to Jones' office. Maj. Matthew Housel, the lead psychiatrist, lost his life to a bullet fired through the window of his office. Pvt. Springle felt the searing pain of a shot in his torso—pain that a round to the back of his head quickly quieted. Sgt. Christian E. Bueno-Galdos ran for his life down the corridor of the combat stress clinic—a place designed to prevent crises like these. As he ran, Russell landed a round in his flank. Sgt. Bueno-Galdos looked on with terror until Russell finished him off with a round to the eye. After taking a total of five lives, Russell raced to Jones' office. Fortunately, Jones escaped any injury at the hands of his crazed patient by jumping from the window (Murphy, 2013, para. 8).

For Russell and many like him, the pressures of war are inescapable and uncontainable. The 2009 shooting at Camp Liberty is not an anomaly. Russell's tragic story underscores the inherent tension between military necessity and confidentiality that complicates the military's treatment of mental health issues (Neuhauser, 2011). The brave men and women who dedicate their lives to protecting the liberty and security of others historically face more mental health issues than their civilian counterparts (American Public Health Association, 2015). Accordingly, the military

faces the unique challenge of managing the psychological well-being of its warriors. Sadly, the military's stoic mindset affords little confidentiality to the psychotherapist-patient relationship and creates a pervasive stigma surrounding mental health care. When viewed in light of other tensions unique to the theater of war, this places an unnecessarily dangerous number of barriers in a serviceman's path to psychological treatment. This study explicates, analyzes, and discusses the history of the military's mental health stigma, the barriers that it creates, and possible solutions that would allow soldiers to get the care they need. Ultimately, this study seeks to determine whether the current amount of confidentiality surrounding the psychotherapist-patient privilege in the military context discourages servicemen from obtaining mental health treatment. This study hypothesizes that current military laws afford a dangerously low amount of confidentiality to the psychotherapist-patient relationship, contributing to a stigma that discourages armed forces personnel from seeking treatment for their mental health disorders.

Literature Review

The military faces a difficult quagmire when dealing with mental health treatment. On the one hand, a certain amount of confidentiality must surround the psychotherapist-patient relationship so the soldier can open up about deep-seated issues plaguing his psychological composition. On the other hand, the military has a "need-to-know" ability to access the gamut of a soldier's mental health records to ensure they are in fit condition to deploy at a moment's notice. This delicate nexus of privacy and national security presents a difficult question for policy-makers and military members alike. To weigh the costs and benefits associated with the military's current mental health policies, this study consults the expertise of several journals, articles, and scholarly studies in the fields of political science, psychology, and medicine.

Some amount of explication on the severity of the mental health condition in the military is required to understand the balance between maintaining patient privacy and preserving the military's ability to know whether its soldiers are fit for duty. To explain the mental health problem in the military, this study relies on Dr. Charles Hoge's seminal study on the matter. In 2004, Dr. Hoge and several colleagues conducted the first major research effort aimed at "guiding policy with regard to how best to promote access to and the delivery of mental health care to members of the armed services" (p. 14). To do this, Dr. Hoge (2004) conducted a longitudinal study on the "prevalence of mental health problems among members of the U.S. armed services who were recruited from comparable combat units before or after their deployment to Iraq or Afghanistan" (p. 14). The study included 2,530 soldiers from three U.S. Army combat infantry units and one Marine Corps combat infantry unit

selected at random by Dr. Hoge and his corresponding military contacts (Hoge et al., 2004). According to the study, 79% of the soldiers and Marines from the selected units completed the pre-deployment survey briefing, with 58% also completing the survey after deployment (Hoge et al., 2004). Dr. Hoge attributed the decrease in respondents to the "rigorous work and training schedules" of the soldiers and Marines (Hoge et al., 2004, p. 15). After comparing the pre-deployment and post-deployment surveys, Dr. Hoge's study yielded several conclusions. First, combat conditions directly increase a serviceman's odds of mental health disorders (MHD) like post-traumatic stress disorder (PTSD) (Hoge et al., 2004). Second, the individuals who screened positive for a MHD were twice as likely to show signs of treatment-dissuading stigma as individuals who screened negative for a MHD. Third, Dr. Hoge's study was the first to identify specific kinds of stigma that discouraged psychological treatment. Therefore, Dr. Hoge's results provide internally valid evidence suggesting a stigma enshrouding mental health issues in the military.

Confirming the validity of Dr. Hoge's work, the American Public Health Association (APHA) conducted a 2015 report on barriers to mental health treatment in the military. They found that "rates of trauma and mental illness are disproportionately high in the military" (American Public Health Association, 2015, para. 1). While it may be no surprise that soldiers have a higher risk of developing a MHD than their civilian counterparts, the study also found that they receive a disproportionately low amount of treatment for their psychological issues. The APHA attributed the invariable relationship between MHDs and treatment to the military culture. They noted that "[n]early one in four veterans who have screened positive for mental illness state that they did not seek care because their leaders discouraged the use of mental health services" (American Public Health Association, 2015, para. 22). This problem is compounded by the military's psychotherapist-patient privilege policies.

To assess the impact of the military's current psychotherapist-patient policies, this study consults the work of Maj. Jennifer A. Neuhauser. As a Judge Advocate for the U.S. Army, Maj. Neuhauser offered her legal perspective on the causes behind the stigma surrounding mental health in the military. She argued that the Department of Defense's (DoD) current provisions for psychotherapist-patient privilege are "vague and overbroad, thereby permitting the perception (and in some cases, the reality) that Commanders may access mental health records at will," creating a barrier for some in their quest for treatment (Neuhauser, 2011, p. 2).

To further explicate the seriousness of the privacy problem in the military and to understand the history of the problem, this study relies on the RAND Corporation's exhaustive findings in *Mental Health Stigma in the Military* (Acosta et al., 2014). Dr. Acosta and his colleagues began their study by surveying different ways to define and operationalize the meaning of stigma in the context of military

psychology. This study adopts the same methodology, as stigma may be one of the most important independent variables that can affect this study's central dependent barrier: dissuasion from treatment. According to Dr. Acosta, even the DoD notes the plausibility of a "theoretical link suggesting that stigma may affect treatment-seeking and, ultimately, mental health recovery" (Acosta et al., 2014, p. 12). Using their operational definition of stigma and operating on the premise that stigma can affect mental health recovery, the RAND group consulted the Mental Health Advisory Team's (MHAT) publicly available data on the causes of stigma in the military. RAND's specific finding that stigma can stem from a soldier's perception that a superior will access his mental health records and use them to damage his career highlights a possible link between privacy, or the lack thereof, and stigma (Acosta et al., 2014). In fact, the RAND study identified "key tensions between the privacy of service members seeking mental health treatment and the need for commanders to assess unit fitness" (Acosta et al., 2014, p. xviii). Dr. Acosta then explored the origin and impact of those tensions and offered useful advice that could help the military eradicate any possible stigma resulting from the lack of confidentiality in the psychotherapist-patient relationship.

Despite the military's current shortcomings, the DoD has developed an intensive strategy to combat the existence and impact of stigma in relation to mental healthcare treatment. Dr. Erin Miggantz (2015) at the Naval Center for Combat and Operational Stress Control explained:

> Military anti-stigma efforts include but are not limited to the following: (a) the Department of Defense's (DoD) $2.7 million campaign focused on decreasing stigma in all military branches by inviting service members to share their stories of seeking help; (b) implementation of the combat and operational stress control continuum, allowing service members to be classified as "ready," "reacting," "injured" or "ill" rather than the dichotomous labels of "ready" or "ill"; (c) the "Real Warriors Campaign" anti-stigma initiative that invites successfully treated service members to share their experiences about the effective mental health treatments available; (d) the Operational Stress Control and Readiness (OSCAR) program developed by the Marine Corps that embeds mental health professionals in infantry regiments, logistics groups and air wings to aid in early identification and treatment of combat stress; and (e) the integration of psychology into primary care settings throughout all branches of service. (p. 1)

Despite these efforts, Dr. Miggantz (2015) concluded that "mental illness and receipt of mental health treatment is still stigmatized within the military" (p. 5). The barriers created by stigma stemming from a lack of confidentiality warrant further research to elucidate possible solutions.

Data and Methods

This study is primarily qualitative, relying on studies completed by respected experts in the fields of government, psychiatry, and medicine. The pervasive problem of stigma in the military is complex and comes from many sources. This study does not attempt to address all possible sources, instead narrowing the discussion to the relationship a military patient has with his psychotherapist and the amount of confidentiality that exists therein. In exploring the tension between psychotherapist-patient confidentiality and military necessity, this study discusses the reasons for the stigma, its impact as a barrier to mental health treatment, and possible policy solutions to help wounded warriors receive the care they need.

To ensure the internal validity of this qualitative study, several terms need to be defined and operationalized. First and foremost, this study needs an operational definition for "stigma." In the years of research on the issue, psychologists, political analysts, and military representatives have often used different definitions of "stigma." For example, the DoD Task Force on Mental Health and the DoD Task Force on the Prevention of Suicide Among Members of the Armed Forces defined the stigma of mental illness as the "negative attitudes and beliefs about or associated with people labeled as mentally ill" (Acosta et al., 2014, p. 1). However, the RAND group took a different approach to describe the meaning of "stigma." According to Dr. Acosta (2014) of the RAND group, "common conceptualizations of institutional and public stigma do not actually define 'stigma' but define instead the specific contexts in which stigma can arise" (p. 9). This means that stigma is not a "characteristic or object that one has or gives; it is a process by which someone perceives or internalizes interactions with specific people in specific contexts" (Acosta et al., 2014, p. 9). Therefore, the RAND group opted to define "stigma" as "a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or people with mental health disorders. This happens through an interaction between a service member and the key contexts in which the service member resides" (Acosta et al., 2014, p. xiv). This study adopts RAND's definition of stigma.

Additionally, an operational definition of "mental health disorder" should provide clarity to the impact of stigma as a barrier to care. For this study, the term "mental health disorder" refers to any type of mental illness induced by activity in the military. Those mental illnesses can include post-traumatic stress disorder,

substance abuse disorders, depression, and anxiety (American Public Health Association, 2015).

Research

History of the Military's Mental Health Stigma

When Pfc. Jeffery Meier arrived at a combat stress clinic in Colorado, he was asked to sign a waiver before his first session. Normally, people like Pfc. Meier glance at the terms and conditions, flip to the back page, and sign off without thinking. But for some reason, after hearing rumors that his Commanders could pull his records at a moment's notice and without his consent, Pfc. Meier decided to read the waiver. To his surprise, it explained that under certain circumstances, "[including] if he admitted violating military laws, his conversations with his therapists might not be kept confidential" (Dao & Frosch, 2009, para. 2). Pfc. Meier refused to sign.

Representing the Association for Psychological Science, Dr. Patrick Corrigan said that "the prejudice and discrimination of mental illness is as disabling as the illness itself. It undermines people attaining their personal goals and dissuades them from pursuing effective treatments" (Corrigan & Druss, 2014, para. 3). Dr. Dingfelder (2009) of the American Psychological Association chronicled the stigmatizing fears surrounding treatment for MHDs in the military when he observed that one out of every five soldiers returning from Iraq and Afghanistan reported MHD symptoms, yet only half of them sought treatment. To be sure, quantifying the exact origins, amount, and impact of stigma in the military is an impossible task. However, by using soldiers from the Iraq and Afghanistan wars as case studies, the source and scope of the military's stigma problem become evident.

Dr. Hoge's study on MHDs in the context of the Iraq and Afghanistan war efforts provided the first probing glance at the scope of the military's stigma towards mental health. The study found that time in combat zones created a direct increase in the likelihood of mental illness (Hoge et al., 2004). He noted that "the percentage of study subjects whose responses met the screening criteria for major depression, PTSD, or alcohol misuse was significantly higher among soldiers after deployment than before deployment, particularly with regard to PTSD" (Hoge et al., 2004, p. 13). This means that, absent intervening variables, the stress of war has a strong correlation to increased MHDs. Dr. Hoge's most interesting finding was that soldiers did not seek treatment for their MHDs, despite the alarming presence of MHDs among them. He found that "concern about stigma was disproportionately greatest among those most in need of help from mental health services. Soldiers and Marines whose responses were scored as positive for a mental disorder were twice as likely as those whose responses were scored as negative to show concern about being stigmatized and about other barriers to mental health care" (Hoge et al., 2004,

p. 20). Dr. Hoge recorded the various types of stigma by asking respondents why they avoided treatment and chronicling their responses in groups of key phrases. Such phrases included, but were not limited to: "[i]t would be too embarrassing," "[i]t would harm my career," "[m]y unit leadership might treat me differently," and "[m]y leaders would blame me for the problem" (Hoge et al., 2004, p. 21). Nearly half of respondents who screened positive for MHDs cited one or more of the above reasons for shunning treatment (Hoge et al., 2004). Dr. Hoge concluded that a pervasive stigma exists in the military that prevents the mentally-ill from seeking help.

To determine whether his 2004 findings applied to soldiers several months after their return from Iraq, Dr. Hoge and his colleagues conducted another study that relied on Post-Deployment Health Re-Assessment (PDHRA) tests, in addition to the Post-Deployment Health Assessment (PDHA) used in the initial study (Milliken, Auchterlonie, & Hoge, 2007). They found that the risk of mental illness increases after the initial post-deployment period while the amount of referrals for treatments—and patient commitment to those referrals—decreases. The bottom line is that military servicemen are at a higher risk of mental illness than comparable civilian populations; however, they are significantly less likely to seek treatment for their disorders.

Building more recently on the work of Dr. Hoge, the American Public Health Association confirmed Dr. Hoge's 2004 and 2007 assessments that "rates of trauma and mental illness are disproportionately high among American veterans" (American Public Health Association, 2015, para. 1). The APHA noted that nearly 50% of combat veterans from Iraq suffer PTSD and close to 40% suffer from problematic alcohol use. According to 2010 estimates, 22 veterans committed suicide every day as a result of their wartime mental illnesses. Worse, Blias and Renshaw (2013) identified studies that found that "56% to 87% of service members experiencing psychological distress after deployment report that they did not receive psychological help" (p. 77). To be sure, soldiers' experiences in combat dramatically increase their chances of developing a severe mental illness. Instead of focusing on methods of preventing the mental illness or suggesting the impossible task of reducing the stressing conditions of war, this study will now turn its focus toward one salient similarity in the Hoge and APHA studies' findings: soldiers avoid psychological treatment due to stigma despite the increased severity and scope of their mental illnesses.

It would be naïve to point to one factor (e.g., a lack of confidentiality) as the sole culprit behind the military's mental health stigma without first analyzing the types of stigma that prevent treatment. In 2014, the RAND Corporation compiled an exhaustive report chronicling the barriers to care for soldiers experiencing MHDs. Relying on seven longitudinal studies conducted by the Mental Health Advisory

Team (MHAT), Dr. Acosta and his colleagues at RAND were able to track the causes that compel a soldier to avoid treatment for his MHD.

The methodology behind the MHAT studies helps interpret and explain the resulting data. The most recent study, MHAT 7, "was conducted in 2010 in support of Operation Enduring Freedom (OEF) and was led by the Office of the Surgeon General of the Army with support from the Offices of the Surgeons General of the Navy and Air Force and the Office of the Medical Officer of the Marine Corps" (Acosta et al., 2014, p. 18). There was no lack of support from the military in the endeavor to seek out remedies to MHDs caused by combat warfare. The researchers retrieved their data from anonymous surveys completed by randomly selected platoons that together created an observable cluster sample (Acosta et al., 2014). The primary objective of the MHAT 7 research was to "assess behavioral health in land combat forces in Army and Marine Corps units" (Acosta et al., 2014, p. 18). A specific part of that objective was to determine the "factors that affected [a soldier's] decision to receive mental health services" (Acosta et al., 2014, p. 18). The Acosta study divided the respondents into two main groups: those with MHDs and those without MHDs. Soldiers who screened positive for MHDs were then asked to answer an additional set of questions to determine whether they received treatment. Further, the MHD-positive respondents who did not seek treatment were asked another series of questions to ascertain the barriers they may have faced. While the precise responses from the Army and Marine Corps differed in some respects, a few themes remained consistent between the two study populations. For instance, a substantive percentage ranging between 19.8% and 48.9% of the affected population (those with MHDs) were deterred for reasons like "my leaders would blame me for the problem," "my unit might have less confidence in me," and "my unit leadership might treat me differently" (Acosta et al., 2014). These survey questions and the results they yielded were similar to Dr. Hoge's findings in 2004 and 2007.

Further detailing the barriers to treatment for MHDs in the military, the DoD conducted its own survey of active duty military personnel in 2011. The study relied on data collected from "39,877 active-duty members of the services who were not deployed at the time of the survey" (Acosta et al., 2014, p. 21). Unsurprisingly, the findings from this massive survey were consistent with the conclusions reached by Dr. Hoge and his colleagues, as well as the MHAT and its cohort of military sponsors.

After looking at a brief history of MHDs in the military, several observations become evident. First, soldiers serving in combat situations have a higher risk of developing a MHD. There are consequently more MHDs per capita in the military when compared to the civilian population. Second, while soldiers suffer a disproportionatly higher amount of MHDs when compared to their civilian counterparts, they receive a disproportionately lower amount of treatment. Third, soldiers receive less treatment for their MHDs due to certain barriers like the anti-

mental-health stigma that pervades the military. With these observations in mind, it seems problematic that stigmatic barriers prevent soldiers from receiving care. While the above explication outlines some of those barriers, it does not explain their origins. To determine possible sources of stigma and ways to protect against it, this study must analyze the cornerstone of mental health treatment: the psychotherapist-patient relationship.

History of the Military Psychotherapist-Patient Privilege

Confidentiality is the bedrock of the unique relationship between a soldier and his psychologist. Citing Manfred Guttmacher and Henry Wihofen's *Psychiatry and the Law,* Maj. Neuhauser (2011) explained the amount of necessary vulnerability in the psychologist-patient relationship:

> The psychiatric patient confides more utterly than anyone else in the world: he exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. (p. 1030)

To get any treatment for MHDs, a soldier must share the details of his troubles with his therapist. Understandably, a soldier will not do that unless he feels safe in the confines of his therapist's office. A military psychologist himself, Charles Engel stated that "[c]onfidentiality is the foundation of effective mental health care.… Our patients' problems are deeply personal and private. Wherever we as mental health clinicians practice, our offices become the pain-strewn battlefields in prolonged wars of attrition fought against enormous personal hardships" (Engel, 2014, para. 1). He even goes so far as to call psychologists' offices "the therapeutic bunkers within which our wounded patient-warriors hunker down against an unseen enemy" (Engel, 2014, para. 2). Together, Engel and Neuhauser highlight the important role a psychotherapist plays in treating soldiers' MHDs. In many ways, therapists lead the charge in the war on mental illness—their words are their weapons, their offices are the battlefields, and the stigma their patients face is the perpetual enemy they must defeat.

Despite the important role psychotherapists play in treating soldiers' MHDs, their role becomes minimized if soldiers do not trust their ability to keep PHI confidential. To protect the sanctity of the psychotherapist-patient relationship, President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) into law in 1996. HIPAA ensures that citizens can have a confidential relationship with their psychotherapist and prevents unauthorized disclosures

of PHI, barring circumstances where the patient poses a threat to self or others (Neuhauser, 2011). That year, the Supreme Court created legal precedent that recognized the importance of confidentiality for conversations that take place in a therapist's office (*Jaffee v. Redmond,* 1996). This precedent led to the creation of Rule 501 in the Federal Rules of Evidence: psychotherapist-patient privilege (Flippin, 2003). However, because military cases are tried under the Uniform Code of Military Justice (UCMJ), the Federal Rules of Evidence do not apply. President Clinton wanted to afford soldiers the same privilege afforded to civilians. Accordingly, in 1999, he issued Executive Order 13,140 to create rule 513 in the Military Rules of Evidence (MRE)—a rule that established privilege for communications between psychotherapists and patients (Flippin, 2003).

Despite the intention to extend this privilege to the military population, MRE 513 affords far less protection than FRE 501. Eight exceptions to MRE 513 nearly eclipse the rule itself. In fact, some of the exceptions are so overbroad and vague that they threaten the privacy between psychotherapist and patient. For example, the sixth exception notes that a psychotherapist must disclose a patient's PHI without his consent so long as a military commander deems it necessary to "'ensure the safety and security' of military personnel or property, military dependents, mission accomplishment or classified information" (Flippin, 2003, p. 8). Moreover, the problem of insufficient privilege afforded to soldiers goes beyond the confines of a UCMJ courtroom.

In an attempt to apply the privacy protection provisions of HIPAA to the various branches of the military, the DoD created DoD 6025.18-R—a directive that governs the disclosure of PHI for Armed Service Personnel (Department of Defense, 2003). Pursuant to DoD 6490.08 (titled "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members"), the DoD "aims to dispel stigma through the protection of the privacy of those seeking mental health care by requiring that care not be reported to a service member's commander unless a specific duty-to-report event occurs" (Acosta et al., 2014, p. 86). However, the disclosure guidelines in DoD 6025.18-R "eventually eviscerate" the protection that DoD 6490.08 affords by requiring psychotherapists to disclose a soldier's PHI without consent for "activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission" (Department of Defense, 2003, p. 69). According to Michelle Lindo McCluer, executive director of the National Institute of Military Justice, the provisions under the military command exception are so broad that "you could drive a truck through them" (Neuhauser, 2011, p. 1012). Despite the textual provisions of privacy described in HIPAA and DoD 6025.18-R, 29% of survey respondents in a study cited by Maj. Neuhauser believed that any information shared with the mental health professional would not be kept confidential.

Using the DoD directive as a guideline, individual branches of the military created and implemented their own statutes to govern the amount of confidentiality given to patients seeking psychotherapy. Two specific branches, the Army and the Air Force, serve as helpful case studies to show the different ways DoD 6025.18-R can be interpreted. After the DoD issued 6025.18-R, the Army did nothing to limit the broad PHI disclosure allowances in AR 40-66. Under AR 40-66, a psychotherapist is obligated to disclose PHI without patient consent if there is an "official need for access" or if the military has reason to believe that the PHI relates to "any other activity necessary to the proper execution of the Armed Forces" (Department of Defense, 2003, p. 70). Notice that AR 40-66 does not define the requirements for an "official need for access" or "activity necessary to the proper execution of the Armed Forces." This allows the Commander to be his own judge in determining what requests for PHI are necessary or unnecessary. AR 40-66 also clearly allows release of PHI without patient consent for "judicial or administrative proceedings," which includes administrative or non-judicial forms of punishment (Neuhauser, 2011). Essentially, a Commander gets to decide when, where, and how to access confidential PHI and can use it to punish the patient in an administrative or non-judicial capacity.

By contrast, the Air Force's PHI disclosure regulation, AF 44-109, offers an interpretation of DoD 6025.18-R more favorable to the patient. Unlike the Army, the Air Force revised AF 44-109 after the DoD issued 6025.18-R (Flippin, 2003). The Air Force regulation prohibits all forms of disclosure prohibited under both MRE 513 and DoD 6025.18-R (Flippin, 2003). This establishes a standard practice for patients seeking treatment for MHDs. While the provisions in MRE 513 and DoD 6025.18-R still have many exceptions that can overwhelm the overarching non-disclosure rules, applying those rules and their exceptions in a uniform manner across the various branches of the military would be a step in the right direction.

The lack of confidentiality in the context of mental healthcare may be a factor preventing soldiers from seeking care. The Second District Court of Appeals for California noted that "disclos[ing] that an individual is seeing a therapist may well serve to discourage any treatment and thereby interfere with the patient's freedom to seek and derive the benefits of psychotherapy" (*Scull v. Superior Court,* 1988, at 790). Apart from the stigma created by commanders' ability to access their soldiers' records without consent, the military's disclosure of the mere fact that a soldier sees a psychotherapist is enough to create a stigmatized barrier to future care. For example, until Army officials released a Rapid Action Revision (RAR) of Army Rule 600-63, the Army required its "at-risk" soldiers (those experiencing a severe MHD) to wear bright yellow reflector jackets. One soldier described it by saying, "You've got the reason you're on suicide watch to begin with on top of the fact that you stick out like a sore thumb. It's like you're walking around in a zoo, and you're

the animal" (Neuhauser, 2011, p. 1020). While the Army has since done away with this provision, it lends credence to the fact that soldiers avoid treatment to escape breaches in confidentiality, embarrassment, signs of weakness, or their commander's disappointment. Unfortunately, the protection currently afforded to military patients in their therapists' offices does not make them feel safe enough to talk. So instead of talking, they keep everything bottled up, causing the military to face a crisis of its own creation, much like they did at Camp Liberty.

Balancing Privacy and National Security

When assessing stigmatic barriers to mental healthcare, two interests must be weighed against one another: the soldier's right to privacy and the military's need to assess a soldier's readiness for deployment. The RAND Corporation identified this difficult task in its study, reporting "a key policy tension between the need for commanders to assess the fitness of service members under their command and the need for privacy among service members with MHDs" (Acosta et al., 2014, p. 83). Understandably, the immediate objection to any policy that would enshroud military therapy in an increased amount of confidentiality would be concerns regarding national security. Even Maj. Neuhauser (2011) noted the difficulties of weighing policy proposals that would affect the nexus of a soldier's relationship to his therapist, explaining that "tensions are inherent at the intersection of mental health treatment, military necessity, and confidentiality" (p. 1006). On the one hand, service members ought to have the constitutional right to privacy—especially when dealing with issues that plague their mental health. The U.S. Senate Subcommittee on Constitutional Rights recognized this obligation owed to servicemen, stating that "[n]o persons should be more entitled to protection of their constitutional rights than the servicemen engaged in protecting the sovereignty of the United States" ("Summary Report," 1963, p. iii). However, a soldier's right to privacy cannot be absolute. According to Maj. Neuhauser, "Army officials recognize privacy in mental health treatment cannot be guaranteed because of the risk a troubled soldier will jeopardize a mission" (Neuhauser, 2011, p. 1007). The DoD observed in its *Health Promotion, Risk Reduction, and Suicide Prevention* pamphlet that the military has a legitimate "need to know" basis for determining the mental and physical capabilities of the men and women it depends on to carry out missions (Neuhauser, 2011). Without question, the military's claim—in the ambiguous name of national security—that it should be able to require therapists to disclose PHI without a soldier's consent does have merit. However, the silent soldiers suffering from MHDs have a legitimate need for increased privacy, especially since the indisputably stigmatized status-quo often deters them from treatment.

De-stigmatizing Policy Language and Improving Accountability

Despite the tricky balance between private treatment and national security, there are some areas that clearly have room for improvement. First, experts have concurred that the military could decrease the stigma associated with receiving mental healthcare by removing any unsettling language from their policies (Acosta et al., 2014). Second, the military could revise its current policies that allow commanders to access PHI with little oversight or accountability. Third, the military could consider implementing a presumption of privilege similar to that which exists between a soldier and a chaplain or a soldier and a lawyer. Creating policy provisions that address these three key areas may be a good starting place to reduce barriers to care for soldiers seeking treatment.

Turning to the first possible solution, the military needs to revise any language in its current policies that could possibly deter a soldier from treatment. For example, DoD directive 5105.21-V1 directs any person with a security clearance to report any "information that could reflect on their trustworthiness or on that of [others]" (Acosta et al., 2014, p. 97). Included in the possible characteristics of untrustworthiness are "apparent mental or emotional problems" (Acosta et al., 2014, p. 97). Such language conveys the unhelpful idea that a mental or emotional condition makes someone untrustworthy or undependable. In its survey of all military policies pertaining to the issue of mental health, the RAND Corporation discovered that 12% of the policies contained stigmatizing language that could be easily removed (Acosta et al., 2014) . If the simple revision of the text of military directives could foster a more welcoming atmosphere for treatment, then the military should seriously consider it.

Second, the military command exception to the disclosure of PHI has very little oversight or accountability. Pursuant to DoD 6025.18-R, the appropriate command authority can "use and [require the] disclosure of protected health information of individuals who are Armed Forces personnel" (Department of Defense, 2003, p. 69). Currently, the command authority does not have to seek any sort of warrant from the UCMJ—they are their own final authority to determine what is and is not "necessary" or "need to know." The present policies simply require the command authority to publish their action in the Federal Register (Department of Defense, 2003). No further measure of accountability exists. Since one of the most oft-cited barriers to care is "disappointing my unit commander" or "my unit commander will blame me," it is crucial for soldiers to know that their commanders are prohibited from simply going on a "fishing expedition" through their PHI (Hoge et al., 2004). Furthermore, it would help counteract the current implication that soldiers have to be tough enough to conquer their internal demons alone. To do this, the military may consider requiring commanders to prove the necessity of their records request before a UCMJ court.

Finally, when comparing the presumption of privilege a soldier has with their chaplain or their lawyer, the military may consider increasing the presumption of privilege that exists between a soldier and his psychotherapist. Currently, any dialogue between a soldier and his chaplain or lawyer is strictly confidential. The only provisions for disclosure arise under circumstances where the soldier poses a risk to himself or others or when disclosure is required at the order of a UCMJ judge (Flippin, 2003; Neuhauser, 2011). Soldiers should be afforded the same measure of privacy they receive when discussing matters with a pastor as a counselor, or a lawyer as counsel, when they receive treatment for life-altering MHDs.

Suggestions for Further Research

When conducting research on the effects of limited confidentiality vis-à-vis patients seeking treatment in the military, the academic community has a vast amount of resources at its disposal. The data seems expansive, the analysis seems valid, and the conclusions seem to concur: limited confidentiality in the context of psychiatric care stigmatizes military patients to the point that they avoid treatment. The military makes their justification for limited confidentiality clear; they must know the readiness of their soldiers at all times, even if that requires disclosure of PHI without consent or proof of necessity. In sum, the military plays the ambiguous and overused trump card of national security to gain unfettered access to PHI. The effects of that justification and its implementation have been studied intensely and, as this study shows, the academic consensus of its negative impacts is relatively clear.

While much research has been done on the impact of limited confidentiality, little research or projection has been done regarding the impact increased privacy would have on national security. To date, no negative impacts have been recorded or projected as a result of the military giving the psychotherapist-patient relationship the same kind of privilege it extends to chaplains or lawyers. To be sure, the military has claimed that doing so would gravely endanger national security, but that risk has never been defined, operationalized, or measured in any way. At the very least, this study suggests that further research should be conducted on the correlation between increased psychotherapist-patient privilege and actual impacts on national security.

Conclusion

Mental illness, without a doubt, pervades the military. The story of Sgt. Russell, the rogue shooter responsible for the crisis at Camp Liberty, paints an all-too-clear picture of this axiom. Unquestionably, the stigma soldiers face discourages them from seeking the mental healthcare they desperately need. Pfc. Jeffery Meier's refusal to sign the confidentiality waiver required for treatment epitomizes the impact of the stigmatic barriers that the military has inadvertently erected in the name of national

security. Sadly, the bravest men and women who dedicate their careers to protecting the interests of others do not feel safe enough to speak up for their own interests.

At the outset of this study, the following hypothesis was proposed: current military laws afford a dangerously low amount of confidentiality to the psychotherapist-patient relationship, thus discouraging armed forces personnel from seeking treatment for their mental health disorders. To confirm or deny the initial hypothesis, this study analyzed the various military laws that govern the amount of confidentiality afforded to the psychotherapist-patient relationship and consulted studies in the fields of law, political science, and psychiatry to determine the impact those laws have on patients seeking treatment. By analyzing the history of MHDs caused by time in the military and linking those MHDs to tangible barriers identified in surveys and longitudinal studies, evidence of a pervasive anti-MHD stigma appears. Analysis of the psychotherapist-patient relationship elucidates possible reasons for the existence and scope of that stigma: soldiers avoid seeking treatment from providers they cannot trust. The military's current policies, culture, and command structure undermine the nature of a therapist's job to offer a safe and secure location to work through a soldier's MHDs. Therefore, this study confirms the initial hypothesis. Current military laws afford military patients a dangerously low amount of confidentiality, dissuading them from receiving care. Hopefully, by de-stigmatizing the language in the current policies, increasing the amount of accountability in the PHI disclosure mechanism, and affording a greater measure of privacy to patients, the military will be able to wage a new front in its war on stigma so its soldiers can thrive to fight another day.

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