★ CHAPTER 17 ★

Ethical Dilemmas in Clinical, Operational, Expeditionary, and Combat Environments

Carrie H. Kennedy

Military psychology ethics has received significant visibility in recent years, with unprecedented use of psychologists during the war. Psychologists used psychometric expertise in assessing blast concussion in the combat zone, increased consultation roles, and continued to expand other evolving skill sets (e.g., prescription privileges, telehealth, embedded psychology, assessment and treatment of military stress reactions). In an organization in which consultation activities and clinical decisions can have dire consequences, military psychologists routinely address a number of difficult ethical issues. While every area of psychological practice contends with potentially conflicting loyalties, guidance, and regulations, military psychology faces a high degree of ethical dilemmas, with the added dynamics and potentially conflicting interactions of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2017; hereafter referred to as the Ethics Code), APA policy, military instructions, and military laws (i.e., Uniformed Code of Military Justice; see also Johnson, Grasso, & Maslowski, 2010; Coyne, 2019). Given the complexity of some of these interactions, the sometimes ambiguous wording of ethics codes in general, and the impossibility of ethics codes to cover every potential situation, simply following the Ethics Code is insufficient for ethical decision making (Kitchener & Kitchener, 2012).

This chapter focuses on the four environments in which military psychologists practice—traditional military treatment facilities, operational commands, noncombat expeditionary environments, and the combat

zone—and highlights the most prominent ethical dilemmas experienced in each locale. Finally, recommendations for prevention and mitigation of conflicts are presented.

TRADITIONAL MILITARY TREATMENT FACILITIES

Traditional military treatment facilities (MTFs) include both military and veterans' hospitals and clinics and encompass all aspects of mental health care, including primary-care behavioral health services, mental health outpatient assessment and treatment, addictions services, and inpatient treatment. Military providers in MTFs enjoy routine access to resources most clinical psychologists take for granted: electronic medical records, soundproofed offices, support staff, office equipment, and generally predictable schedules and patient caseloads, to name a few. Ethical conflicts tend to be those normally associated with traditional mental health care with the added dynamics of military practice.

The practice of clinical psychology in MTFs dates back to World War II, when many psychologists transitioned from primarily research and psychometric assessment to the provision of mental health care. This occurred largely because of the overwhelming mental health needs of World War II veterans and insufficient numbers of psychiatrists (see Chapter 1, this volume; see also Kennedy, Boake, & Moore, 2010). Consequently, a robust analysis of ethical dilemmas in the military comes from practice in traditional military treatment environments given the eight decades that military psychologists have been able to identify and examine these challenges. These primary ethical dilemmas include multiple/dual relationships and roles (Johnson, 2008; McCauley, Hughes, & Liebling-Kalifani, 2008; Barnett, 2013), competence (Johnson, 2008; Dobmeyer, 2013), informed consent, cultural/multicultural competence (Kennedy, Jones, & Arita, 2007; Reger, Etherage, Reger, & Gahm, 2008; Kennedy, 2020), confidentiality (Johnson, 2008; McCauley et al., 2008; Hoyt, 2013), and mixed/dual agency (e.g., Stone, 2008; Kennedy & Johnson, 2009; Johnson, 2013).

Multiple/Dual Relationships and Roles

In the day-to-day role of any active-duty military psychologist, dual roles and relationships are unavoidable. The psychologist is a military officer with inherent regulations and expectations given his or her rank, in addition to the fact that the psychologist is a member of the command and community with collateral duties, community involvement, friendships, and so on. In a large stateside MTF, these relationships are fairly easy to mitigate given significant options for referral (e.g., other military providers within the MTF and civilian referrals outside of the MTF). However, akin to rural

environments, multiple relationships are particularly common in solo and remote billets, and these can be harder to manage. It is not uncommon for a psychologist to have to enter into a clinical relationship with a subordinate, a senior officer, a roommate, or even a friend (Staal & King, 2000; Johnson, 2011). Standard 3.05, Multiple Relationships, states:

> (a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.
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> A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
>
> Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.
>
> (b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

Not all multiple relationships are contraindicated. It is important for the military psychologist to be able to objectively determine whether a dual-role/multiple relationship could be potentially harmful prior to entering into the relationship (Sommers-Flanagan, 2012). Treating a member of the command who does not work in your department, for example, and then serving on the military ball committee with that same person are not likely to qualify as potentially harmful. It is important, however, that thorough informed consent be done with every military patient, since these dual relationships arise frequently and unexpectedly and are not always so benign. Let's examine a case in which there is a clear, problematic, yet unavoidable dual relationship.

Case 17.1. The Psychologist with a Dual Relationship Problem

The psychologist was a junior officer in an overseas location. One afternoon, she received a phone call from the Commanding Officer (CO) of the hospital (also the psychologist's CO), who noted that he was command-directing another high-ranking officer in the chain of command (also one of the psychologist's superiors) for emergent mental health evaluation. The other officer's wife reported to the CO that her husband had an uncontrollable gambling habit, had lost their life savings, was now $200,000 in debt, and was voicing suicidal statements.

The psychologist knew that she should not see this officer as a patient. He was in her chain of command, which put him in a position that was not conducive to effective mental health care. The psychologist was also in a vulnerable position as he wielded power over her fitness reports and career. Although there were two other available psychologists as well as a psychiatrist, they were also in the same chain of command and thus the dual relationship was an issue for all of them. Given the specific overseas location and the lack of civilian referral options, they were unable to refer to a local provider. Given concerns about suicidality, they were unable to request a provider be flown in to do the assessment or request a telehealth appointment as neither of these options was available urgently.

Consequently, the psychologist had to do the evaluation. She mitigated this as much as possible through informed consent and openly addressing the dual relationship problem at the beginning of the assessment. Ultimately, she facilitated referral to a program in the United States, where the officer received residential treatment for his severe gambling problem.

This type of multiple relationship should obviously be avoided whenever possible and when not possible be mitigated by informed consent and other strategies. While the psychologist believed there was no option but to do the assessment, the officer's treatment needs were more ethically and effectively addressed by specialists who were not a part of his command. Unfortunately, these kinds of dual roles and relationships are not uncommon, and most seasoned military psychologists have a story similar to this one.

Competence

Competence is a particularly complicated issue in the military because there are a wide variety of jobs that psychologists may be assigned (e.g., embedded in primary care, inpatient treatment, infantry unit, aviation command, operational billet, aircraft carrier, submarine command, etc.). Although professional competence is clearly a matter for junior psychologists, this concern is not solely the domain of the new military psychologist. It is common for active-duty psychologists to hold disparately different jobs throughout their career, requiring new training for each position. As an example, one midcareer officer in the Navy has been assigned to an HIV clinic, an alcohol and drug rehab, an aviation command, a detainee mental health clinic, a combat zone hospital, in a counterintelligence position, and then back to leading a clinic in an MTF. This wide variety of experiences is not unusual for a military psychologist; however, "the range of professional competence within psychology is sufficiently broad that expertise in one area does not necessarily readily translate into another" (Nagy, 2012,

p. 170). Consequently, military psychology competence is a constantly moving target. Standard 2.01, Boundaries of Competence, states:

> (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
>
> (c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.
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> (d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

In addition to the routine reassignment of active-duty clinical psychologists, new demands have provided increasing challenges to competency. Within traditional MTFs, two of these ways are the dramatically increased utilization of telehealth in light of COVID-19 (Pierce, Perrin, Tyler, McKee, & Watson, 2021) and the rapidly evolving science supporting different treatments for a variety of mental health disorders, but especially posttraumatic stress disorder (PTSD). Note that these are simply two examples of evolving strategies in traditional military mental health care. Psychologists working with military members and in the clinical psychology field in general face advances and changes to treatment provision on a regular basis.

With the increased need for military mental health care, the decreased stigma associated with seeing mental health care providers (Kennedy, 2020), and the need for physical distancing related to COVID-19, in addition to coincident advances in technology, telehealth has become a more viable option for both active-duty and veteran service members. Studies of the efficacy and implementation of telehealth as a mainstream option for treatment are growing (see, e.g., Gros, Yoder, Tuerk, Lozano, & Acierno, 2011; Tuerk, Yoder, Ruggiero, Gros, & Arcieno, 2010; Glassman et al., 2019; Glynn, Chen, Dawson, Gelman, & Zeliadt, 2021). Although telehealth may prove to be a great option for some service members, providing better access to treatment, ethical dilemmas ultimately arise. Specific concerns related to the various modalities of telehealth are risks to privacy and confidentiality, technological competence required by the provider, assessment of client appropriateness for telehealth, empirical base of various assessment and treatment techniques delivered via telehealth, and

availability and accessibility of emergency resources when needed (Ragusea, 2012; Chenneville & Schwartz-Mette, 2020).

A second area of rapid change is the rate of publications on mental health treatments, expanding the evidence base to a degree that an individual provider cannot keep up with the science in order to provide state-of-the-art care. This has been no more true than in the case of PTSD. An APA PsycNet search revealed 2,397 journal articles and 21 testing instruments published in 2019 alone. The Department of Veterans Affairs (VA) and Department of Defense (DoD) counter this glut of information through the use of clinical practice guidelines (CPGs), systematic reviews that are revised approximately every 5 years and clearly define scientifically backed effective treatments (VA & DoD, 2017). It is up to individual providers to maintain their knowledge and competence regarding any disorder they are treating or treatment they are using, and the CPGs enable providers to do so.

While maintaining competency in a wide array of jobs with a diverse population (see the later "Cultural/Multicultural Competency" section) is a challenging task, the military provides the opportunity for a wide range of competency development. This is achieved through formal internships, fellowships and other training programs, mentorship programs, continuing education, supervision, and the encouragement of individual professional development, such as board certification by providing monetary bonuses to diplomates.

With regard to postdoctoral fellowship, between the three services, formal training is provided in clinical psychopharmacology (i.e., prescribing psychology; see Laskow & Grill, 2003, for an overview of the DoD Psychopharmacology Demonstration Project), neuropsychology, child psychology, forensic psychology, operational psychology, and health psychology. Fellowship training is approached differently between the three services, with some fellows training in military sites (e.g., Army neuropsychology postdoctoral fellows) and others in civilian sites (e.g., Navy child psychology postdoctoral fellows).

Informed Consent

Informed consent is an integral part of all mental health evaluation and care, and it is essential for service members and other individuals whom the military psychologist will evaluate or treat. In addition to more traditional information included in informed consent, the military provider must also discuss military-specific privacy and confidentiality issues (see the later discussion of confidentiality) related to military service or status of the individual in question (e.g., command-directed evaluation, special-duty evaluation) as well as all of the potential outcomes inherent in contact with military mental health providers (e.g., fitness-for-duty issues, potential loss-of-flight status). Standard 3.10, Informed Consent, states:

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent.

Informed consent should be thoroughly discussed in any first session with a military patient prior to any disclosures by that individual. Only in the case of a command-directed evaluation may a service member undergo involuntary military mental health evaluation (see Chapter 2, this volume, for a discussion of command-directed and emergent evaluations), so it is important that the service member understand the potential career repercussions of any disclosure and have the option of not revealing information. Informed consent, particularly as it relates to confidentiality, the provision of information to the service member's command, and fitness for duty should be revisited in each session.

Cultural/Multicultural Competency

Although professional competence is paramount for military psychologists, cultural and multicultural competence must be equally considered. In the military, cultural competence generally refers to the ability to evaluate, treat, and make informed decisions for both service member patients and the organization in the context of rank, Military Occupational Specialty (MOS)/rate, officer/enlisted, branch of service, mission, military instructions, and military laws. Multicultural competence, on the other hand, refers to the ability to evaluate, treat, and make informed decisions regarding a diverse array of individuals with differing backgrounds. Age, gender, race/ethnicity, religion, disability, socioeconomic status, sexual orientation and so on all play key roles in the psychological assessment and treatment

of military members. One needs not only to establish competency to work within the military with different groups but also to address any issues of individual bias and prejudice toward these same groups (Nagy, 2012).

To further explore the notion of cultural competence in military psychology, it is necessary to examine the various ways in which both civilians and active-duty psychologists come to be in the military or working in a military setting. Civilian military psychologists may have years of military experience (i.e., veterans) but in many cases may have none. In recent years, given increased demands for military mental health care, an unprecedented number of civilian psychologists have been hired by MTFs. Individuals without some type of prior military experience (e.g., prior active duty, the Reserves or National Guard) are especially at risk of decision-making mistakes because of a general lack of familiarity and understanding of the military culture (Johnson & Kennedy, 2010). Some of these errors can impact rapport, for instance, failing to use the individual's correct rank or calling a Marine a soldier, and some can be dire, such as not understanding an individual's MOS/rate and returning him or her to duty when this is contraindicated. (For an in-depth look at military cultural competence in the context of clinical evaluation and treatment, see Kennedy, 2020.)

Additionally, some multicultural issues interact significantly with military cultural competence. For example, in 2018, women made up 16.2% of enlisted ranks and 18% of officer ranks across the military (DoD, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, 2018). It is only recently that women have been able to fill many jobs in the military, previously denied to them due to gender. In 2015, the combat exclusion on women's military service was lifted, and the Services are slowly integrating women into these roles. However, women face unique challenges in serving, not due to these new roles, but in the male-dominated military in general. Understanding the history of women in the military (Kennedy & Malone, 2009), their day-to-day reality, and the unique medical and mental health needs of women in general is critical to the effective provision of mental health care. Other minority populations have similar challenges and a history of exclusion from military service (e.g., lesbian, gay, and bisexual individuals; Johnson, Rosenstein, Buhrke, & Haldeman, 2015). Consequently, providers must be familiar with the history, day-to-day challenges, current military instructions, and any ongoing issues related to cultural minorities and military service (e.g., transgender policy; Dunlap et al., 2021).

With regard to multicultural competency, in 2018, 31% of the active-duty force identified themselves as a racial minority (32.7% of enlisted personnel and 23.5% of officers), with 17.1% Black or African American, 4.5% Asian, 4.2% Other, 3% multiracial, 1.1% American Indian or Alaska Native, and 1.1% Native Hawaiian or other Pacific Islander. Additionally, 16.1% endorsed Hispanic or Latino ethnicity (DoD, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy,

2018). Furthermore, approximately 40,000 immigrants are currently serving in the U.S. military, and the military enlists about 5,000 noncitizens every year (National Immigration Forum, 2017).

Standard 2.01, Boundaries of Competence, states:

> (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

Multicultural competence is of principle importance for the military psychologist. Not only does one work with the various ethnic, racial, and religious groups from within the United States, one works with U.S. service members from foreign countries (a person does not need to be a U.S. citizen to enlist in the U.S. military), with foreign nationals, and with wartime detainees (Toye & Smith, 2011; Kennedy, Malone, & Franks, 2009; Kennedy & Johnson, 2009; Kennedy, 2011).

Confidentiality

Confidentiality is a continuous challenge for the military psychologist. Given the dual-role challenge (see the prior discussion) and the mixed-agency challenge (see the following section), knowing when something needs to be reported and to whom while maintaining the best interests of service members can be complicated. Standard 4.01, Maintaining Confidentiality, states:

> Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

Service members understand that when they see military medical providers, some of their information is not private. Their attendance at annual physical health assessments, whether or not they are up-to-date on immunizations, and the state of their dental readiness, for example, are all tracked by the command to ensure a state of continuous mission readiness and deployability. However, mental health evaluation and treatment are differentiated from this kind of routine medical maintenance. A lot of service members fall into categories in which there are strict requirements and procedures for disclosure (e.g., service members with access to classified information, service

members in special operations or other high-risk special duties, service members displaying symptoms that they are not fit for duty, etc.). On the other hand, service members who have been sexually assaulted and are seeking mental health care are protected from military disclosures (see Chapter 8, this volume). Cultural competence is key to knowing when, to whom, and what must be disclosed (Hoyt, 2013). It is notable that there is a military command exception within the Health Insurance Portability and Accountability Act (HIPAA), located in Title 45 Part 164.512 of the Code of Federal Regulations. Essentially, a health care provider, be that person civilian or military, may "use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission." Thus, as an example, if a service member is deemed not fit for duty, this may be disclosed without the consent of the service member.

However, in an attempt to decrease mental health stigma and increase help-seeking, in August 2011, the military implemented an unprecedented instruction regarding confidentiality and mental health care. Department of Instruction (DoDI) 6490.08 states, "[T]he DoD shall foster a culture of support in the provision of mental health care and voluntarily sought substance abuse education to military personnel in order to dispel the stigma" (2011, p. 2). The instruction further states that "healthcare providers shall follow a presumption that they are not to notify a Service member's commander when the Service member obtains mental health care or substance abuse education services" (p. 2). This is negated when one of the following notification standards is met: harm to self, harm to others, harm to mission, special personnel, inpatient care, acute medical conditions interfering with duty, substance abuse treatment program, and command-directed evaluation. In these cases, however, the mental health provider is directed to "provide the minimum amount of information to the commander concerned as required to satisfy the purpose of the disclosure" (p. 2). This means that most service members who are considered fit for full duty may seek help from a military mental health provider in full confidence for a wide variety of problems (e.g., postdeployment adjustment, relationship problems, non-duty-limiting mental health concerns).

It should always be remembered, however, that often the command may be better able to help solve problems and reduce mental health symptoms than the mental health provider, even in instances where no disclosure needs to be made to the command. When you consider that the command has full control over such major life variables as living arrangements, leave, and deployments, and also has the power to intervene when individuals are having pay problems or severe personal or family problems, at times it is better for the command to know that a service member is having difficulty. This allows the command to better support the service member. Consequently, in the military, psychologists should be careful about defaulting

to a view that strict confidentiality is always best and be prepared to have conversations with military patients regarding bringing their command onboard. As an example, Schendel and Kennedy (2020) present the descriptive case of a sailor in treatment for insomnia. After comprehensive evaluation, it was determined that the cause of the sleeping problem was the sailor had a roommate on an opposite shift. Getting permission to speak to the command or encouraging the sailor to request a change in room or roommate was the cure for the sailor's chronic sleep problems. This might seem simplistic, but remember that the military culture is one where you are responsible for your own problems and good service members learn to "embrace the suck." Consequently, not all personnel default to informing their chain of command when they are having difficulties.

Finally, similar to rural communities, it is important for military psychologists to address with their military patients what their expectation is when seeing them in public. It is common knowledge among military psychologists that once they have been at the same duty station for just a few months, they inevitably run into patients at the commissary, exchange, gas station, and so on. Some military patients do not want to acknowledge their care provider so as to preserve confidentiality, while others want to say hello. It is recommended that this be addressed in the first session, especially in remote and overseas bases.

Mixed Agency

Mixed agency is present in every professional interaction that a military psychologist has with an active-duty patient. This is also true at times in VA settings, given that many Reserves personnel deploy or are activated multiple times (Stone, 2008). With every clinical decision made, the psychologist has a simultaneous responsibility to the service member patient, the military/organization, and society at large. The most common clinical psychological mixed-agency dilemma occurs in the context of returning a service member to duty. For example, when making a decision regarding the aeromedical qualifications of a military aviator, one must consider the aviator-patient (e.g., best interests of the patient), the military (e.g., can the aviator currently meet mission requirements?), and society (e.g., is the aviator safe in the air; is there a threat to others?). There are a variety of ethical standards pertaining to mixed agency, the three most pertinent of which are as follows:

- 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, which states:

> If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict,

> make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

- 1.03, Conflicts Between Ethics and Organizational Demands, which states:

> If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

- 3.11, Psychological Services Delivered to or through Organizations, which states:

> (a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.
>
> (b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

Johnson and Wilson (1993) and Johnson (1995) reviewed three strategies military psychologists have used in the past to attempt to manage the mixed-agency dilemma: the military manual approach, the stealth approach, and the best-interest approach. To review, the military manual approach attempts to manage ethical conflicts by using literal applications of military rules. This approach is considered potentially harmful, tending to prevent the identification of ethical conflicts. The stealth approach is the other extreme, covering up issues that may impact the military and other military members by attempting to work solely in the context of the individual. While psychologists using this approach may believe they are working ethically in the best interests of the individual, this approach also has the potential to cause significant problems for the service member (e.g., occupational difficulty, life-threatening mistakes on the job). The best-interest approach, on the other hand, takes both the individual's and

the military's needs into consideration and applies both the Ethics Code and military regulations. This approach involves the most creative problem solving and knowledge of pertinent ethical standards, military regulations, and laws but tends to demonstrate the best outcomes (see Kennedy & Johnson, 2009). This approach is advocated throughout this chapter as the only ethical approach of the three noted to manage the mixed-agency conflict.

While fitness for duty is the most frequently encountered mixed-agency dilemma for the clinical military psychologist, a second mixed-agency dilemma unique to the current war is that of mental health care for detainees. This war marked the first time that detained enemy combatants have been provided with mental health care during their incarceration. In this case, the mixed-agency triad consists of the detainee patient, the military/other government organizations involved, and society. However, the mental health care of detainees took an unusual turn. Some have criticized that this care is provided by military mental health providers, as opposed to providers from an independent agency (Aggarwal, 2009). In 2008, members of APA voted to make it a violation of APA policy for military psychologists to work in wartime detention facilities except to treat service members (APA, 2008). Consequently, any military psychologist providing mental health care to detainees in a wartime detention facility is in violation of APA policy. However, APA policy does not affect the APA Ethics Code and is not enforceable, so psychologists may be in violation of policy while not committing an ethical violation (see Kennedy, 2012). To make this matter more difficult for military psychologists is that no other medical specialty, to include psychiatry, implemented any similar policy. This confusing situation, and consequent decision, are then left to individual psychologists as to whether or not to deploy to a wartime detention facility and, if they do, to whom they will provide services.

OPERATIONAL ENVIRONMENTS

Operational psychology is "the application of the science and profession of psychology to the operational activities of law enforcement, national intelligence organizations, and national defense activities" (Kennedy & Williams, 2011b, p. 4). Operational psychological activities do not typically involve clinical responsibilities and include such activities as assessment and selection of personnel for high-risk jobs (e.g., special operations forces, embassy security guards, aviation personnel; Picano, Williams, Roland, & Long, 2011; see also Chapter 13, this volume), security clearance evaluations (Young, Harvey, & Staal, 2011; see also Chapter 14, this volume), support for repatriated U.S. prisoners of war (see Chapter 15, this volume), counterintelligence and counterterrorism activities (Kennedy, Borum, & Fein, 2011), consultation to interrogation (Dunivin, Banks,

Staal, & Stephenson, 2011; Department of Defense, 2019), and crisis negotiation (Gelles & Palarea, 2011; Greene & Banks, 2009; Kennedy & Williams, 2011a; Kennedy & Zillmer, 2006; Shumate & Borum, 2006; see also Chapter 16, this volume).

Operational psychological activities are not as well established and studied as military psychology's clinical activities, although some of these functions (e.g., assessment and selection) predate clinical military psychology (see Chapter 1, this volume). Some of these less traditional applications of psychology have come under significant scrutiny, particularly as they pertain to the role of consultation to interrogation. This singular issue has resulted in strong emotions and great debate (see Abeles, 2010; Galvin, 2008). Some psychologists believe that members of their profession should not perform this role, that psychologists who participated were involved in the engineering of torture, and that the APA was complicit in these activities (e.g., see Soldz, 2008). Others believe that military psychologists are in a good position to influence policy, research, and practice (e.g., see Fein, Lehner, & Vossekuil, 2006) by focusing on issues such as memory distortion, effective questioning strategies, and the detection of deception (Loftus, 2011), thereby making a positive impact on current war efforts, increasing ethical and effective intelligence gathering (Brandon, Arthur, Ray, Meissner, Kleinman, Russano, & Wells, 2019), and preventing atrocities such as those that occurred at Abu Ghraib (Greene & Banks, 2009; Staal & Stephenson, 2006; Staal, 2019).

This singular disagreement within the field of psychology/APA brought the ethics of operational psychology as a whole under significant examination. Kennedy and Williams (2011b) identify four primary ethical dilemmas in these environments, namely mixed agency, competence, multiple relationships, and informed consent. Note that there is considerable overlap of ethical dilemmas within each of the four practice environments. The reader is directed to the Traditional Military Treatment Facilities section for applicable ethical standards when indicated.

Mixed Agency

Mixed agency (also called dual agency, divided loyalty, and dual loyalty; see prior discussion for the pertinent ethical standards) occurs when a psychologist has a responsibility to two or more simultaneous entities. Within clinical venues, this dilemma usually involves a service member, the military, and society at large. In operational psychological environments, this typically comes in the form of a responsibility to an individual, a government or military agency, and to society at large (Kennedy, 2012). Using crisis negotiations as an example (see also Chapter 16, this volume), the psychologist has a simultaneous responsibility to the law enforcement/military/government agency (i.e., the primary client), society at large (e.g.,

hostages, bystanders), and the individual in question (i.e., barricaded individual or hostage taker). It is notable that the psychologist in crisis negotiations will not have face-to-face interactions with the hostage taker and the hostage taker will not know that there is a psychologist consulting, yet the purpose of the consultant psychologist is to optimize the chances of a peaceful surrender and minimize/prevent loss of life. Gelles and Palarea (2011) recommend that in order to ethically manage the mixed-agency and other dilemmas inherent in crisis negotiation consultation, the psychologist must identify the client, remain in the role of expert consultant (see also Mullins & McMains, 2011), remain autonomous in consultation and free from external influence, identify boundaries and delineate the boundaries between operational consultant and healthcare provider, appreciate the uniqueness of each crisis situation, and establish and maintain professional competence. Craw and Catanese (2020) emphasize the fluidity of these incidents and the need for a flexible model of ethical decision making in order to be able to address these volatile situations as they evolve and change.

Competence

Operational psychology has grown into a subdiscipline of psychology; however, it is still in the early stages as it pertains to the development of a formal training curriculum and professional standards for competency. Standard 2.01, Boundaries of Competence, states (for other pertinent standards related to competency, see the prior MTF discussion above):

> (e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

Like the prior advances made by military psychologists during various conflicts, the evolution of the practice of operational psychology is growing on a grand scale. Fostered and predated by the work of psychologists in law enforcement, operational psychology has become a force for national security. As with the development of clinical internships following WWII as a result of the relative newness of the field of clinical psychology (see Chapter 1, this volume), the expansion of operational roles for psychologists requires the same considerations for formal education and training. The military has implemented postdoctoral fellowship training in the Navy and the Army has developed a number of formal courses (e.g., Operational Psychology, Assessment and Selection), which are used by operational psychology trainees in all Services; conferences specific to operational

psychologists are held annually (e.g., National Security Psychology Symposium; survival, evasion, resistance, and escape [SERE] psychology conference); and formalized mentorship opportunities and professional networks have been established. Military psychologists may also seek board certification in Police and Public Safety—as operational psychology functions mirror those in traditional law enforcement. This provides for the highest formal standard of professional competency awarded to psychologists in any subspecialty.

Multiple Relationships

Multiple relationships occur in operational psychology environs as they do in traditional MTFs, although the circumstances differ significantly. An important difference between operational psychologists and those military psychologists treating service members within MTFs is that operational psychologists typically do not perform clinical duties primarily. However, in any small, embedded, and/or deployed command, the military psychologist is at risk of having to manage the emergent mental health situation of a coworker or of being approached by a coworker for services. In an operational position, this may be a guard, police officer, or Special Forces personnel. This is the most frequently occurring multiple relationship dilemma in the operational psychology environment. It should be mitigated whenever possible through referrals; however, when this is not possible because of an emergency or lack of referral options, thorough informed consent (see prior Traditional Military Treatment Facilities section and Informed Consent section next) is the primary way in which to mitigate the conflict until a more appropriate referral option can be obtained.

Informed Consent

Much of the work of operational psychologists differs dramatically from the work of traditional military clinical psychologists with regard to the individual in question. When working with a service member-patient, informed consent is a standard process that includes the individual (see prior discussion for pertinent standards). In some cases, informed consent is standard for operational psychologists as well, such as in cases of security clearance evaluations or assessment and selection procedures. In these instances, the individual is readily identifiable and involved in the process of obtaining/reviewing appropriateness for a security clearance or undergoing evaluation to obtain/maintain a special duty. However, in many cases, the psychologist will have no direct contact with the individual in question when performing operational psychological responsibilities (e.g., hostage negotiation consultation, interrogation consultation, counterterrorism

consultation), and informed consent will be unable to be obtained for a variety of reasons. In all cases however, the psychologist maintains a duty to identifiable individuals even in cases where informed consent cannot reasonably be obtained and the individual does not know of the presence of the consulting psychologist (Koocher, 2009).

NON-COMBAT-ZONE EXPEDITIONARY ENVIRONMENTS

Expeditionary environments are those in which the psychologist is embedded within a military unit and provides the gamut of mental healthcare (i.e., prevention, early intervention, outpatient care, and at times inpatient treatment) to the members of that unit as well as consultation to its leadership. Examples include Operational Stress Control & Readiness (OSCAR) providers who provide clinical assessment, care, and consultation for U.S. Marine ground units (Hoyt, 2006; Vaughn, Farmer, Breslau, & Burnette, 2015), and Navy shipboard psychologists who are responsible for the crew of an aircraft carrier and the accompanying battle group (Wood, Koffman, & Arita, 2003; Berg, 2019). Expeditionary environments and embedded practice may or may not include duty within a combat zone. This section focuses on those noncombat roles and locations.

Embedded, or integrated, providers become well known to the leadership of a specific unit and to the service members within that unit. Routine interactions and a "one of us" conceptualization serve to establish a comfort level with the provider, who is seen as an approachable and credible resource. This credibility and acceptance, in turn, serve to reduce stigma and increase receptiveness on the part of both individual service members and leadership to interventions and recommendations (Hoyt, 2006). In addition, the embedded psychologist provides continuity of care. This can be a significant problem for service members receiving care at a traditional MTF who require a course of psychotherapy. Not only do service member-patients deploy frequently but so do their MTF providers. Consequently, a traditional mental healthcare model can result in significant inconsistency and disruption of care (Ralph & Sammons, 2006). Embedded mental health is able to provide continuity of care since the providers are always with the unit wherever it might be. This embedded or expeditionary care is believed to be a powerful means to prevent problems, provide informed early interventions, facilitate better care when serious problems develop, and preserve the military's resources. For example, the billeting of a psychologist on each aircraft carrier has reduced the number of medical evacuations from Navy ships (Wood et al., 2003). However, with these significant advantages come increased ethical challenges. Johnson, Ralph, and Johnson (2005) describe dual agency and multiple roles as the most significant ethical challenges in these embedded environments.

Dual Agency and Multiple Roles

Dual or mixed agency and multiple roles are significant conflicts in all areas of military practice (see prior discussion on MTF and operational environments for the pertinent ethical standards and additional information). Although dual/mixed agency has already been described in depth and is highly similar to the dual agency found in traditional MTFs, multiple roles in expeditionary environments are the most magnified of any area of military psychology practice. This is because the psychologist is always a member of the same command hierarchy, is dedicated to provide care to the members of his or her same unit, is managing the same stressors as the unit, and often does so in austere locations where there may be no referral options or relief of any kind.

As potentially the sole mental health care provider, especially when deployed, the psychologist will find him- or herself in a position of multiple roles on a regular basis. Most of the time these roles are benign or manageable; however, at times they can be significantly problematic. Johnson et al. (2010), for example, describe a case of a carrier psychologist who has to perform a security clearance evaluation for a known patient, which resulted in the patient not receiving a clearance and consequently a better job. This secondary role placed the therapeutic alliance with that patient in serious jeopardy and compromised the service member's sole source of mental health care.

Johnson et al. (2005) provide considerable analysis of multiple relationships in expeditionary environments. These authors note several ways in which psychology practice is unique for the expeditionary psychologist.

1. The psychologist has multiple roles with every service member-patient, given that the psychologist is always an officer.
2. The psychologist has no choice as to whether or not to engage in a clinical relationship with someone. Because there are no other choices available, the psychologist cannot choose to begin a therapeutic relationship, transfer care, or even terminate treatment at times.
3. The psychologist may find him- or herself in a position of having to shift psychology roles with the same individual in order to make fitness-for-duty decisions, perform a forensic evaluation, or conduct a security clearance evaluation.
4. The psychologist represents a decision maker with authority in some matters. "Embedded military psychologists frequently influence the client's life thoroughly, and salient go/no-go decisions by the psychologist commonly impact whether a client will achieve promotions or even remain on active duty" (p. 75).
5. The psychologist will have ongoing personal contact with patients. Within an embedded unit, encountering patients, for example, in

their work space, in the gym, or at command functions is a normal matter of course.
6. The psychologist will inevitably end up providing services to friends, coworkers, and even superiors.

Although it is believed that expeditionary/embedded psychology significantly reduces adverse outcomes and the need for medical evacuation, and increases service member's willingness and probability of seeking care, these are significant challenges that must be carefully and thoughtfully managed by the provider.

COMBAT ZONE

Duty in a combat zone brings all of the ethical hazards of expeditionary psychological practice (for embedded providers) as well as traditional practice in an MTF (for providers assigned to combat stress units or combat hospitals), but in a physically more dangerous and emotionally charged environment where resources may be extremely limited. Challenges develop beyond dual agency and multiple roles, as military psychologists are at increased risk of being asked to do something they are not trained to do as well as policy and nonmedical decision makers effecting clinical care. The dilemmas of dual agency, multiple roles, potential unlawful orders, professional competency, multicultural competency, and personal problems are heightened issues in the combat zone.

Dual Agency and Multiple Roles

Dual agency and multiple roles take on a new dimension in the combat zone, because without the dual roles psychologists can have a very difficult time treating service members and managing ethical dilemmas. In other words, psychologists must not only be skilled clinicians but also competent military officers. An understanding of the military hierarchy, the weapons, vehicles and other equipment used in the current conflict, military strategy, and military objectives in pertinent areas is not normally equated with skills needed by psychologists. However, understanding exactly what one's patients are being expected to do, where they may be returning to, and what operations are ongoing as well as the ability to interface effectively with the command are keys to clinical decision making and effective implementation of mental health interventions in a war zone. A competent military officer will make informed decisions regarding return to duty and will be able to effectively negotiate plans with the command, which are in the best interest of both the service member and the unit. Simply being an excellent clinician in the combat zone is insufficient to provide care for service members (see prior discussions of MTF and cultural competence).

Unlawful Orders

Occasionally, a psychologist in a combat zone may be ordered to do something either unlawful or inherently unethical. When this occurs, it is typically in the context of a superior officer (usually not an officer in the medical field) not understanding what he or she has asked the psychologist to do and thus are "a result of the senior officer not having adequate information about psychology practice, regulations or the Ethics Code, as opposed to nefarious purposes or disregard for the law by the senior officer" (Kennedy, 2012, p. 134). Brief education on psychology/medical ethics and brainstorming to effectively troubleshoot the problem usually resolve any problems related to unlawful orders. In rare cases, however, this may become an issue. Kennedy (2009) presents a case of a junior psychologist, without prescriptive authority, being ordered by a senior medical officer to prescribe medication in the combat zone in the absence of a psychiatrist. The danger is that the junior psychologist will obey the order, even though it is not lawful. Recommendations for mitigation of unlawful orders if education and alternate problem solving are ineffective are to consult with senior members of the military psychology community and the local military lawyer.

Competence

Just because someone is an excellent clinician in garrison does not mean that he or she is going to enjoy the same efficacy in the combat zone. Treating combat trauma in a war zone requires competencies very infrequently used in a traditional mental health clinic. Everything changes in the combat zone to include diagnoses (e.g., combat stress reaction; combat exhaustion), risk mitigation, and treatment options. Each war also brings unique competency challenges for military psychologists. A modern example of an ethical dilemma is the situation involving blast concussion. Psychologists were assigned the task of using neurocognitive assessment measures in theater, yet few had received formal training in neuropsychology, neurocognitive testing, or concussive/neurological injuries. Further complicating the issue was that at the height of the war there was little published on acute blast concussion and little empirically validated basis for the use of neuropsychological testing instruments in theater (Bush & Cuesta, 2010). Standard 9.07, Assessment by Unqualified Persons, states:

> Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision.

(For additional ethical standards relevant to competence, see prior Traditional Military Treatment Facilities section.) Issues regarding the Automated

Neuropsychological Assessment Metrics (ANAM) and the requirement for neuropsychological evaluation in theater for those with multiple concussions (DoD, 2010) provided significant pressure to generalists to practice neuropsychology without appropriate training. Take the following example.

Case 17.2. The Artillery Marine with a Blast Concussion

The Marine SGT was an 0811 (Field Artillery Canoneer, pronounced Oh-8-eleven). He was on a convoy when his MRAP (Mine Resistant Ambush Protected vehicle, pronounced Em-rap) hit an IED (Improvised Explosive Device). He experienced a blast concussion without loss of consciousness, but with significant confusion, approximately 10 minutes of posttraumatic amnesia, balance problems, tinnitus, severe headache, dizziness and nausea. Symptoms resolved over the course of 37 days; his ANAM scores were consistent with his pre-deployment baseline scores; and he passed exertional testing (physical exercise designed to trigger return of concussion symptoms when the concussion is not fully resolved). The issue now is, can he return to duty?

Only in the context of intersecting abilities in both cultural and professional competence can you determine the answer. The Marine's job is that he leads the crew of a Howitzer, a large weapon that fires 100-pound projectiles up to 25 miles. If he were returned to duty, there is a high likelihood that the repeated sub-concussive impacts from the weapon would cause him further problems. This is a good example of the need for both cultural (must understand the service member's job) and professional competence (must understand the dynamics of concussion as opposed to just being able to administer the cognitive testing) when making a return to duty decision of a service member.

Multicultural Competency

Another issue that arises in the combat zone is that of providing mental health services to the local population (see Tobin, 2005) or to friendly forces from other nations. Some issues arise in that different cultures define mental health and stress differently; something in one culture may be normal, where in another culture that same thing may conceived as abnormal; the vocabulary to describe mental health concepts may be very different. Additionally, even when an assessment may be able to be competently conducted, there may be no avenues to follow up or obtain treatment, particularly in war torn countries. Take the following example.

Case 17.3. The Local Soldier Who Could Get No Treatment

The patient was a member of the Afghan National Army (ANA) who was brought to a U.S. combat hospital after jumping from a guard tower after

receiving some bad news. He was physically unharmed but had voiced suicidal intent prior to jumping. The U.S. military psychologist was the only mental health provider available. To make matters more complicated, the combat hospital is only for acute admissions; there were no ANA mental health resources in that region, as well as no civilian mental health resources. The psychologist was faced with a situation in which he possessed minimal cultural competency to evaluate the individual and lacked any referral option at all.

The psychologist worked with the individual and the ANA leadership to support him as best as possible and had the medical asset attached to his unit agree to follow up. These kinds of situations are not uncommon in war zones and they can result in distress to the psychologist.

Personal Problems

In addition to the ethical challenges and logistical hurdles of managing patients outside of a traditional clinic or hospital, military psychologists are at risk of developing personal problems secondary to their own deployment stress and potentially traumatic incidents (Johnson et al., 2011). While there are no empirical studies addressing the psychological health of military mental health providers, the reality is that no one is impervious to the stressors of the combat zone, and the frequency and at times unpredictability of deployments takes a toll on military mental health providers (Johnson, 2008). Routine combat zone stressors for medical personnel can include fairly continuous exposure to the seriously wounded, dying, and dead; environmental stressors (e.g., sleep deprivation, extreme temperatures, wearing of heavy and restrictive personal protective equipment); taking indirect fire (i.e., rockets and mortars) or being fired at directly; and "nearly constant vicarious exposure to trauma through the stories of traumatized clients" (Johnson & Kennedy, 2010, p. 299). This is in addition to any of the "normal" challenges encountered in trying to manage any unexpected problems on the homefront from a war zone. Maintaining one's own mental health is a significant challenge. Standard 2.06, Personal Problems and Conflicts, states:

> (a) Psychologists refrain from initiating an 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, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

While there are multiple conceptualizations of the stressors associated with secondary trauma, compassion fatigue, and burnout (for a review, see Linnerooth, Mrdjenovich, & Moore, 2011; Maltzman, 2011), there has been no empirical study of the experience of military mental health providers in the combat zone as it relates to potentially traumatic experiences, no follow-up beyond the routine postdeployment health assessments, and no exit assessments as to whether or not this is a factor in some military psychologists' decisions to leave the military. There also is little in the way of guidance in recognizing a detriment in professional competence and then acting upon it. Johnson et al. (2011) recommend the development of a "comprehensive program for both supporting and monitoring the health and competence of deployed military psychologists, both in theater and following their return" (p. 97).

PREVENTING, MITIGATING, AND MINIMIZING RISK

While there are a multitude of ethical dilemmas that may arise in any work setting, there are also many strategies available to individual military psychologists, both active duty and civilian, that can assist significantly.

- *Know the Ethics Code, relevant state, federal and military laws, and relevant military instructions.* The practice of psychology is governed by law, and complying with the Ethics Code is often a requirement of state licensure. Understanding the requirements of the law as it relates to the field and general practice of psychology is a minimum prerequisite for psychologists (Behnke & Jones, 2012). Beyond the basic understanding of the regulation of psychology and in order to practice military psychology in an informed manner, one must be able to also apply relevant military laws and instructions (Johnson et al., 2010) and understand how these organizational regulations interact with the Ethics Code and APA policy (Kennedy, 2012).

- *Build a network of mentors, peers, and other pertinent professionals.* Military psychologists are expected to perform a wide variety of jobs, and requests for them to engage in unique duties or consultative roles occur daily. In order to manage these requests, it is essential that military psychologists have an existing network of professionals to consult (Johnson et al., 2005; Schank, Helbok, Haldeman, & Gallardo, 2010). At a minimum, it is recommended that each military psychologist have one to two senior mentors, have several peer consulting relationships, be in contact with an individual who had their job in the past, and have a good working relationship with a military lawyer (i.e., judge advocate general).

• *Take advantage of every training opportunity.* The military provides a vast amount of training, and the military psychologist should take advantage of any opportunities, even if they do not seem particularly relevant to current duties. Formal trainings such as rifle/pistol qualification, SERE training, Assessment and Selection Course, Field Medical Service Officer school, and aeromedical officer training increase cultural competency and provide essential skills for future use.

• *Adopt a personal ethical decision-making model.* There are a number of ethical decision-making models (e.g., Barnett & Johnson, 2008), some of which are military specific (e.g., Staal & King, 2000). Psychologists are urged to evaluate and adopt a decision-making model in order to systematically and objectively evaluate ethical dilemmas as they arise (Johnson et al., 2010; McCutcheon, 2011).

• *Always work toward a best interest solution.* Considering the needs of both the individual and the military can be challenging, but there is usually a course of action that will benefit both parties (Johnson & Wilson, 1993; Johnson, 1995; Johnson et al., 2010). Cultural competence is key to being able to do this well.

• *Obtain appropriate informed consent.* In situations where informed consent can be obtained, military psychologists should discuss the realities of military instructions and laws on confidentiality, where and how records are kept, what the psychologist can reasonably do for the service member-patient, other treatment options, and how the various types of treatment/intervention may impact a current military career and/or future military career goals (Johnson, 1995; Johnson et al., 2005; Schank et al., 2010).

• *Become culturally savvy.* When just beginning to work in the military environment or with military personnel, one must make a concerted effort to understand military rank structure, military jargon and acronyms, military law, and the cultural differences between the Services. Military psychologists should coordinate visits to the various commands that they serve, learn their mission, and understand the environments in which their patients/clients operate.

• *Become multiculturally savvy.* The military psychologist should seek out both multicultural-specific continuing education and a diverse array of social events; travel to different areas and experience other cultures; explore and be open to one's own beliefs and personal biases (see Kennedy et al., 2007). Prior to duty station transfer or deployment, military psychologists should study the culture into which they are going and seek cultural opportunities once they arrive.

• *Within embedded and remote billets, the military psychologist should assume that everyone is a future patient.* Experienced military psychologists have reported how they can end up in a professional relationship with just about anyone in the command. Psychologists can prepare for this by remaining as neutral as possible on controversial issues, avoiding significant self-disclosure, and building a strong support system that is not a part of the command (see Johnson et al., 2005).

• *In remote and solo environments, have a backup plan should you have to provide an evaluation to someone that creates a potentially harmful situation for that person.* If this occurs, it will most likely be someone in your direct chain of command. These plans often include an agreement to send the military member elsewhere for evaluation (possibly to another Service's base or to another country altogether) or, if the situation warrants it, to request an additional psychologist to travel to the command to perform the evaluation.

• *Within embedded and operational billets, educate the military chain of command.* With some of the newer roles for psychologists, not all commands and commanders understand both the breadth of services as well as the limitations of services that embedded/expeditionary and operational psychologists can provide. An upfront educational session for the chain of command and other pertinent members of the command can gain the psychologist significant support to keep the psychologist working within appropriate boundaries and avoiding ethical dilemmas.

• *Be prepared to say no, but have an alternate suggestion.* In the rare case where you may be asked to do something unlawful or something that you are not competent to do, be prepared to refuse the request and propose alternative options. Leaders rarely ask for something without a legitimate reason. A culturally competent psychologist can almost always propose an alternate course which meets the needs of the leader without compromising the psychologist or a service member patient. Preparation includes understanding the Ethics Code, your professional responsibilities, and being able to articulate the specific problem with the request. However, in that rare instance where an alternate course of action cannot be agreed upon, know who in your chain of command or the military psychology community you can consult and depend on for top cover.

• *Be active in your profession.* Join pertinent organizations in order to network and remain current on practice issues and advances.

• *Rely on clinical practice guidelines and the accompanying clinical support tools in order to maintain clinical professional competency.* The

VA and DoD provide clinical practice guidelines (CPGs) for PTSD, Major Depressive Disorder, Substance Use Disorders, suicide risk, and Insomnia. Additionally, VA and DoD collaborate to make clinical support tools which accompany each CPG to distill the vast amount of scientific literature into useable information for clinicians. The website to download these free materials is the Department of Veterans Affairs site (*www.healthquality.va.gov/guidelines/MH*).

- *Take care of yourself.* Our own mental health definitely impacts our abilities to provide care for others and make good decisions on the job. Military psychologists need to understand how a variety of life and job circumstances affect them (e.g., stressors, mood, medical issues, medication side effects, exposure to combat trauma, and secondary traumatization) and take action to make routine healthy lifestyle choices (Nagy, 2012; Johnson, Bertschinger, Snell & Wilson, 2014) and create a network of support through other military psychologists and mentors (Johnson et al., 2011).

CONCLUSIONS

The job of military mental health providers continues to be a dynamic one, with service in every aspect of the military mission. With each new challenge comes accompanying ethical dilemmas and the need to develop new competencies. Applying the expertise provided within this volume, getting formal education and training in aspects of the military mental health mission and the military, staying tied into professional organizations for networking and skill development and maintenance, and maintaining a vast mentorship and support network are key to managing the ethical challenges that arise.

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