Professional Psychology: Research and Practice
2000, Vol. 31, No. 6, 698–705

DOI: 10.1037//0735-7028.31.6.698

Managing a Multiple Relationship Environment: The Ethics of Military Psychology

Mark A. Staal
U.S. Air Force Academy

Raymond E. King
Kirtland Air Force Base

Military psychologists often find themselves in situations having the potential to compromise their professional ethics. Although conflicts in confidentiality are frequently the issue, multiple relationship development is also a significant concern. Case examples involving multiple relationship issues are presented, and the American Psychological Association's (APA's; 1992) guidelines concerning multiple relationship expectancies are considered. Decision-making frameworks are reviewed, and an adaptation of M. C. Gottlieb's (1993) model for multiple relationship resolution is proposed. The authors suggest recommendations for training and supervision, and they encourage continued collaboration between the APA and Department of Defense so that these dilemmas may be more adequately addressed.

The military environment presents several unique situations infrequently encountered in most traditional health care settings. One significant concern for the military psychologist is the inherent risk of multiple relationship development. According to Johnson (1995), military settings may be the most likely environments for these conflicts to occur. Such a state of affairs is particularly striking because of the military's increasing emphasis on avoiding fraternization. Adherence to what the military refers to as "good order and discipline" was recently expanded. In July of 1998, the Secretary of Defense announced that all of the Armed Services would be expected to follow consistent (and more restrictive) multiple relationship standards.

Complicating this picture further for psychologists working within a military setting is the recognition that in many instances, the client is considered to be the government. Decision making for the military psychologist is often difficult given the potential conflict that arises when considering the needs of multiple clients simultaneously (the individual and the organization). Decision-making models that will lead to the successful navigation of these concerns are needed.

Among the three branches of the military, there are approximately 400 active-duty psychologists engaged in clinical practice. The Air Force represents the largest contingent, with an estimated 200 practitioners; the Army and Navy fall somewhat behind this volume, with an estimated 100 psychologists in each service (Major J. Smith, personal communication, December 1, 1999). The majority of these individuals enter the military through one of several internship training programs in culmination of their doctoral training, most often in clinical psychology.

Although most of these individuals receive adequate education and training in general ethics during their graduate studies, it is likely that most psychologists or interns entering the military environment have not received military-specific ethics education until the point of internship training. The training received during internship often concerns only the issue of confidentiality, neglecting other areas of ethical consideration germane to military psychology.

Each branch of the military differs in its definition of fraternization (one form of multiple relationship). Air Force Instruction 36-2909 (Professional and Unprofessional Relationships, 1996) defines it as "a personal relationship between an officer and an enlisted member which violates the customary bounds of acceptable behavior" (p. 2). The emphasis on a difference in rank (officer versus enlisted status) is a reflection of the inherent power imbalance in the relationship. The Army previously interpreted fraternization as problematic if it occurred between an officer and an enlisted member who were engaged in a supervisory relationship (known as an individual's chain of command). New guidance mandates that all multiple relationships between officers and enlisted personnel can be subject to charges of fraternization if deemed inappropriate (regardless of whether they occur in a direct supervisory relationship or not). The military is concerned that such relationships may detract from the authority of a supervisor (superior officer), create the appearance of favoritism or the misuse of one's office or position, or lead to the abandonment of the

MARK A. STAAL, a Captain in the U.S. Air Force (USAF), received his PhD from Pacific Graduate School of Psychology in 1997. He is an assistant professor at the USAF Academy and is on staff in their cadet counseling service. His research interests include military psychology, ethics, and personnel selection.

RAYMOND E. KING, a Major in the USAF, received his PsyD from the Illinois School of Professional Psychology in 1987. He is the chief of operational research psychology at the headquarters of the Air Force Safety Center, Kirtland Air Force Base, Albuquerque, NM. His research interests include the study of tests used for pilot and astronaut selection and methods gauging the extent of human error in flying and health care settings.

THE VIEWS EXPRESSED in this article are those of the authors and do not necessarily reflect the official policy of the Department of Defense or other departments of the U.S. government.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Mark A. Staal, HQ USAF, 2354 Fairchild Drive, DFBL, Department of Behavioral Sciences and Leadership, U.S. Air Force Academy, Colorado 80840-6228. Electronic mail may be sent to mark.staal@usafa.af.mil.

organization's goals for personal gain or interest (Turner, 1998). Similar military expectations extend to relationships between military members and the civilians with whom they work, although such relationships are not defined as fraternization.

Concerns regarding multiple relationships have been well described by several key figures in psychology (e.g., Keith-Spiegel & Koocher, 1985; Pope, 1985). Their work has emphasized that the power differential psychologists hold over their clients is often defined in the context of emotional trust or vulnerability. They have suggested that the expected role of the psychologist is that of a client advocate, and when this advocacy shifts to meet personal needs or gain, a violation of trust has likely taken place. There are multiple concerns about such violations. They represent a breach of the provider–client relationship that may compromise the objectivity and effectiveness of the helping professional. Perhaps worst of all, violations of this nature often result in emotional damage to the client. An additional concern is the impact of the violation on the reputation of the profession, which could influence others' willingness to seek treatment.

The variety of multiple relationships faced by psychologists ranges from incidental contact to inappropriate or exploitative relationships. In a military setting, as with many small-community or rural environments, common forms of multiple relationships encountered include contact in social or personal contexts, working environments, and supervisory roles. To illustrate this point, let us consider the role of the military psychologist. On many military installations, there may be only one or two psychologists or mental health providers. Because all military psychologists are officers, most are in positions of authority and supervision over lower ranking enlisted members. Hence, psychologists in the military possess a power differential over 80%–85% of all other military members (enlisted personnel and junior officers). This power differential exists without the advent of an established clinical relationship and is based solely on the hierarchy of military rank. On average, mental health care utilization results in the care of between 5% and 10% of the base population annually. On a base consisting of 5,000 individuals, over the 3-year period that most military psychologists are assigned to any given base, a psychologist may provide various levels of individual care to between 500 and 1,000 military members (Captain T. G. Hughes, personal communication, August 26, 1999). In a community containing close quarters, housing, fitness facilities, grocery stores, recreational areas, and restaurants, it is easy to see how contact (incidental or otherwise) would frequently occur between provider and client.

One common situation faced by military psychologists concerns the care of other members within the treatment facility or hospital in which the psychologist works. Medical providers and administrative staff (or their family members) are not immune to stress or other mental health conditions. Thus, the reality is that one's dentist, family physician, nurse, or administrative support personnel might also be under one's care. An individual working within the mental health clinic directly, or as a direct supervisor, is typically referred to an outside provider. However, even this arrangement is not always well supported and may not be possible in austere military conditions, such as deployments or assignment to remote locations. Given the limited availability of military mental health providers and the breadth of mental health services offered, military psychologists often find themselves in the position of multiple professional roles.

American Psychological Association Guidelines

In an attempt to meet the need for further guidance on this and other ethical issues, the American Psychological Association (APA, 1992) revised its Ethical Principles of Psychologists and Code of Conduct. In general, APA's standards and principles provide psychologists with a fairly comprehensive behavioral guide that addresses a variety of diverse ethical situations. This guidance includes direction concerning multiple relationships, an issue that the 1992 revision specifically expanded. Standard 1.17 of the code of conduct, entitled *Multiple Relationships,* addresses these considerations directly. To be specific, the code acknowledges that multiple relationships may be unavoidable in certain situations or communities and suggests that not all multiple relationships are necessarily harmful. In taking this position, the APA has expressed an understanding of the realities faced by many practitioners in settings such as the military, rural practice, isolated or self-contained communities (i.e., lesbian/gay/bisexual), or religious groups that require multiple-relationship practice standards that can accommodate their diverse needs. The need for such flexibility is a position that has been echoed by the field at large (Barnett & Yutrzenka, 1995; Haas & Malouf, 1989; Keith-Spiegel & Koocher, 1985). Some authors have suggested that the notion of non-contact between provider and client (the underlying dynamic in multiple relationships) has evolved strictly out of a psychoanalytic tradition that may no longer dominate the current professional climate. This observation has led some to reexamine the issue as psychological interventions take the form of more education-based approaches in mental health treatment (Rinella & Gerstein, 1994).

In addressing the topic of multiple relationships, the APA has issued three expectative guidelines. First, it has stated that it is the psychologist's responsibility to be sensitive to multiple relationship issues and to refrain from entering into such relationships if it is likely that they will compromise the objectivity of the psychologist or have a deleterious impact on the client. Second, it has proposed that whenever possible, the psychologist is to refrain from establishing a clinical relationship with an individual when there is a preexisting relationship present. Finally, if and when such conflicts do arise, the psychologist should attempt to resolve the issue in the client's best interest (APA, 1992). As Schank and Skovholt (1997) stated, this revised guidance is a necessary framework but falls short of reflecting an all encompassing tool for multiple relationship decision making.

Multiple relationship issues are common in discussions of ethical behavior in psychology, and such violations are often the leading category in ethics cases reviewed by the APA. During 1998, of the 303 letters of intent to file an ethics complaint, 61 resulted in an open case for full review by the APA's ethics office. Thirty-six of these cases fell into the multiple relationship category (seven were nonsexual). Nineteen percent of the total number of membership terminations in 1998 were a result of non-sexual multiple relationship violations (APA, 1999). This number has vacillated between 7% and 40% over the last 5 years. According to Pope and Vetter (1992), multiple relationships are one of the most frequently encountered ethical dilemmas among psychologists in

this country. Their popularity as a topic of discussion may reflect the fact that many psychologists find such behavior blatantly inappropriate (Bennett, Bryant, VandenBos, & Greenwood, 1990; Keith-Spiegel & Koocher, 1985; Stromberg et al., 1988). These strong reactions usually reference multiple relationships that are sexual or exploitative or in some other way harmful in nature. However, because of the constraints of many practice environments, multiple relationships are neither exploitative nor escapable per se, and the majority of these forms of multiple relationship do not result in adverse action by the APA or state and local ethics boards.

Military Psychology

The military psychologist is often placed in the position of adopting unusual and atypical roles as she or he practices within the military environment. This pairing has the potential to result in ethical conflict. Early investigators examined and questioned ethical considerations of military psychology concerning the use of psychological research for so-called psychological warfare, the enhancement of a soldier's war-fighting capabilities, and the application of such research in the development of interrogation strategies (Crawford, 1970; Kelley, 1971; Leuba, 1971; Saks, 1970). Others have taken more political positions and have questioned the APA's organizational role in support of the government and its military actions (Summers, 1992) and described the impact of military organizational expectations on the practice of psychotherapy (Ball & Gingras, 1991). The most frequent commentary has revolved around issues of confidentiality (Howe, 1989, 1997; Jeffrey, 1989; Jeffrey, Rankin, & Jeffrey, 1992; Johnson, 1995; Summers, 1992).

Issues concerning the role duality of the military psychologist and multiple relationship decision-making models have not been well reviewed or discussed in the literature to date. Hines, Ader, Chang, and Rundell (1998) investigated the relationship between high multiple-agency environments and pressures and multiple relationship violations. They compared military and health maintenance organizations (HMO) psychiatrists to non-military and non-HMO psychiatrists in terms of their frequency of multiple relationship violations. The results suggested that engaging in multiple relationships and feeling pressured to engage in multiple relationships are not well associated with actual boundary violations. Hines et al. concluded that military psychiatrists were no more likely to engage in multiple relationship violations than those in low multiple-agency environments. Johnson (1995) reviewed this issue and in doing so urged the APA to collaborate with the Department of Defense (DoD) in the hope that such cooperation might reduce ethical discrepancies and competing expectations.

Decision-Making Models

If one accepts the reality that certain environments will produce occasional, if not ongoing, multiple relationship conflicts, the next logical step is to recognize these environments and prepare for a decision-making model that considers the APA's guidelines while meeting the needs and requirements of the environment itself. Several multiple relationship environments have been identified and discussed by previous investigators, including the following: organizational settings (Anderson, Needels, & Hall, 1998; Glaser, 1961; Lowman, 1998), minority communities (Biaggio & Greene, 1995; Sears, 1990), and the practice of rural community-oriented psychology (Barnett & Yutrzenka, 1995; Brownlee, 1996; Jennings, 1992; Schank & Skovholt, 1997; Stockman, 1990). Models of decision making have been proposed across various multiple relationship domains as well (Epstein & Simon, 1990; Haas & Malouf, 1989; Handelsman, 1991; Kitchener, 1988; Roll & Millen, 1981; Woody, 1990). Each of these models, although varying in complexity and detail, incorporates a systematic process of critical reasoning. However, as Gottlieb (1993) pointed out, each of the proposed models fails to offer content- or context-specific guidance necessary for clinical use. This observation reflects the difficulty in establishing appropriate guidelines. They are often either too specific to provide generalizability to other settings or are so general and vague as to make their application equally difficult. In response to this divergence between approaches, Gottlieb (1993) recommended a decision-making model that expanded on those previously mentioned, integrating these approaches. His model is tri-axial in nature and incorporates relational dimensions of power, duration, and termination. *Power* is defined as the degree of influence over the client. *Duration* concerns the length of time the relationship has had to develop (working from the assumption that power grows greater over time), and *termination* refers to the probability that the individual and psychologist will have future contact. The decision process outlined by Gottlieb proceeds through a five-step analysis consisting of the following: (a) an evaluation of the current relationship across these three dimensions, (b) a similar evaluation of the contemplated relationship, (c) an examination of the compatibility between the roles of each relationship (the degree of agreement between role expectations, obligations, and power differentials), (d) the use of peer consultation and supervision in making the decision, and, finally, (e) client consent to the multiple relationship. Gottlieb's model includes various opportunities to continue or end the relationship at each step along the decision evaluation process (see Figure 1). This approach has been considered an improvement on previous models as it is neither too broad nor too narrow in its scope, it provides specific guidance concerning multiple relationships, and it is believed to be comprehensive enough in its format to be applicable to a variety of environments.

Model Application and Case Examples

Four case examples that are representative of the types of dilemmas psychologists may be confronted with in a military setting are presented. The case examples used are based on actual multiple relationship dilemmas that have been substantially disguised for purposes of illustration. A discussion of each situation and its resolution is reviewed. Gottlieb's model is examined as a potential guide for military psychology. In most of the case examples, the client is considered to be the military or government. The first case involves the military's mission requirements or operational readiness, the second involves flying safety, and the third concerns national security and the protection of top secret information. The final case involves a more commonly experienced form of multiple-agency dilemma: the ill-defined boundaries between the military psychologist and the small community served.

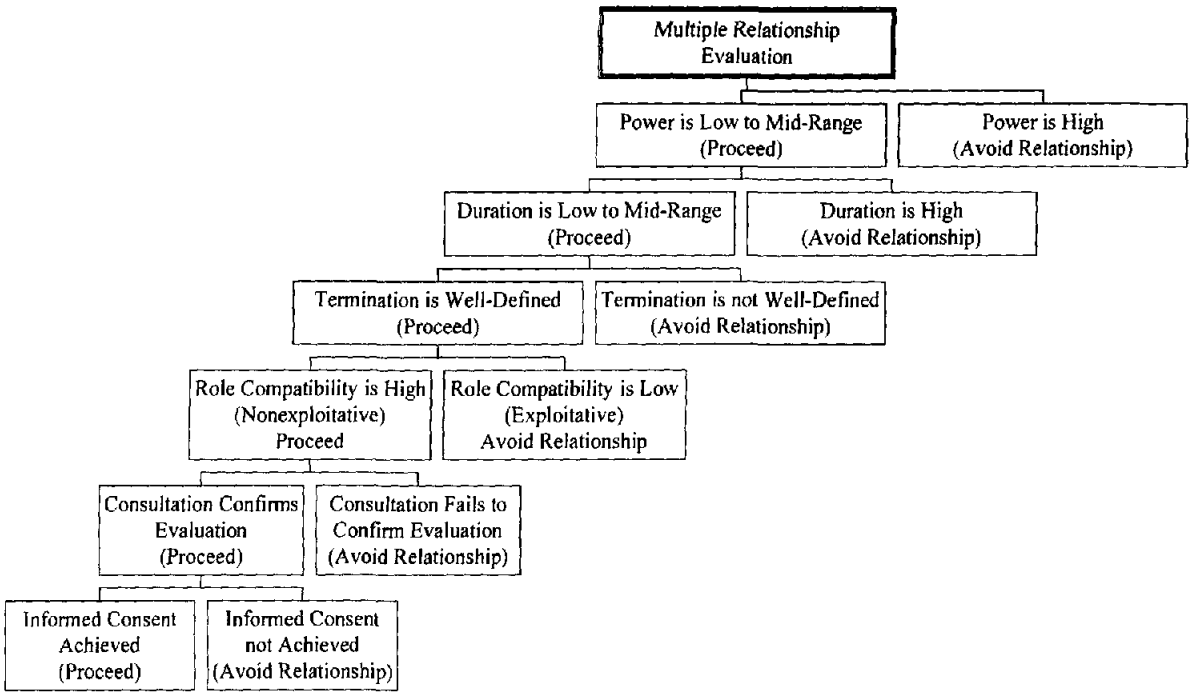

Figure 1. Gottlieb's (1993) decision-making model.

Case 1

A military psychologist evaluated and entered into a treatment relationship with an enlisted member who was referred by her commander because of difficulties in job-related performance. In the military, an individual's commander (designated superior officer) has the ability to compel an individual within his or her command (under his or her direct or indirect supervision) to seek mental health services or evaluation, in accordance with various military regulations (Mental Health Evaluations of Members of the Armed Forces, 1997; Requirements for Mental Health Evaluations of Members of the Armed Forces, 1997). The therapy progressed for 2 months, and issues of prior sexual abuse were revealed and discussed in the context of the treatment. During this time, the psychologist learned of a military field exercise in which the client and psychologist were to be assigned together in the same tent for 2 nights. The psychologist attempted to address the issue with his supervisor, who directed him to discuss the matter with the superintendent of the department. While juggling his commitment to maintain the member's confidentiality, the therapeutic need to avoid the conflict, and the need to comply with the military exercise specifications, the psychologist discussed the issue with the superintendent in an attempt to resolve the dilemma.

Step 1

Power. At the time of the military exercise, the client and psychologist had established a good rapport and developed a significant clinical relationship. The fact that the psychologist is an officer and the client an enlisted member is an additional factor that lends weight to the assertion that there is a significant degree of influence or power present over the client. This situation is compounded by the fact that the client was referred by her commander for evaluation and treatment. In this instance, refusing care or discontinuing treatment without the psychologist's or commander's approval could result in administrative punishment or disciplinary action.

Duration. Because the therapeutic relationship had 2 months to mature and develop, the power differential is considered moderate (not a new relationship but also not long-standing).

Termination. If long-term treatment were indicated, the potential for continued therapy is clearly present. The relationship is still in its early stages of development (2 months into the treatment of past sexual abuse); continued and somewhat open-ended treatment is likely at this point. Termination time frames would not be well established. The fact that the client and psychologist were scheduled to share sleeping arrangements indicates that they were probably from the same military unit or organization. Most military organizations conduct exercises and training together in an attempt to build and foster cohesion among their members. This fact increases the likelihood of future contact in a variety of social and professional situations.

Step 2

The next step in Gottlieb's model is the evaluation of the proposed relationship across these same three dimensions. However, if the initial evaluation indicates that any of the dimensions reflects a mid to high power differential, a mid to high duration, or a mid to high likelihood of continued contact, Gottlieb recommends avoiding the proposed relationship (see Figure 1). Further analysis along the decision-making model (Step 2) is not necessary. In this case, the power differential is high, the duration factor

is moderate, and termination issues are significant. Therefore, the relationship (sharing living quarters) should be avoided. Although not necessary for discussion according to Gottlieb's model, the role compatibility (Step 3) between the current therapy relationship and the proposed relationship is poor. These role incompatibilities are punctuated by the power differential present. The difference in gender between the psychologist and client, the fact that boundary violations (sexual abuse) are significant factors underlying the treatment conditions, and taking into consideration the proposed conditions of the multiple relationship lead one to the conclusion that there is substantial role incompatibility.

The psychologist in this situation attempted to defuse the conflict through Gottlieb's fourth step of decision making (peer consultation or supervision); he referred the issue to his supervisor. His supervisor, however, referred him to his department's superintendent (the individual responsible for scheduling the exercise), failing to bring the conflict to resolution. In this instance, the supervisor should have assisted in advocating for the psychologist's position to the commander in charge of the client or the field exercise. The psychologist in this case could have attempted to elevate his concerns above his supervisor, although this can be seen as inappropriate as it violates the traditional military chain of command (the expectation that one does not "go over the head" of one's direct supervisor unless extreme measures are required). Concerns about the client's confidentiality arise because the psychologist was in the position of revealing the pre-existing clinical relationship to his supervisor (who is not a mental health provider) and then to the superintendent (who also is not a mental health provider). When such conflicts do arise, an attempt to gain the client's informed consent (Gottlieb's fifth step) is clearly indicated. The role of informed consent should not be undervalued in such circumstances. The limitations to confidentiality and risk of multiple relationship dilemmas should be discussed with clients prior to initiating a clinical relationship. This guidance is particularly important in environments prone to dual-agency concerns. Because the provider had some forewarning of the possible conflict, he and the client should have discussed the dilemma, and some form of documented consent to the situation should have been pursued. In the event that such a multiple relationship was unavoidable, a clear definition of the current relationship—outlining role expectations for the situation with the client—and an open acknowledgment of the awkwardness of the situation are recommended. This arrangement would not fall under the concern of fraternization from the military's standpoint, assuming that the behaviors between these members remained appropriate and professional and did not further violate personal boundaries.

Case 2

A military psychologist working in a small remote hospital was requested to evaluate a senior member within his own chain of command (an indirect supervisor). The senior officer, a physician himself, required a routine psychological evaluation for continued flying status. When the psychologist (a junior officer) expressed some initial protest to this arrangement—recognizing the problematic conflict of interest involved—he was ordered by his direct supervisor (who is not a mental health provider) to conduct the evaluation.

Despite conventional wisdom, senior officers cannot force those within their chain of command to engage in illegal actions (violations of the Uniform Code of Military Justice or other civil legal infractions). Such orders are typically issued reluctantly, when clearly in the best interest of the military or its mission, and after consultation with legal authorities. Although the ordered action in this case was not illegal, it was clearly ethically questionable and probably would not have been supported by a third party. Nevertheless, the psychologist at the receiving end of this order was certainly in a compromised position. Psychologists faced with such situations have several avenues of support, including consultation with peers, other medical officers, hospital ethics committees, review boards, and even military legal representation if necessary.

Step 1

Power. The power gradient of the relationship between the local psychologist and the senior physician was clear and well understood; a superior officer and subordinate hierarchy exists from the day of assignment (of either officer) to the day of change of assignment (of either officer). Even when the specific superior–subordinate supervisory relationship (chain of command) no longer exists, both officers are still bound by the generic customs and courtesies that exist between all military members with a rank differential. Power is considered high in this instance, given the nature of the established and enduring supervisory relationship and rank differential.

Duration. The duration of such a relationship is typically well defined and in very few cases will exist for more than 3 years (folk wisdom in the military advises one to tolerate a personality clash as one of you is likely to move on to another assignment soon). The duration of this relationship is unknown, making it difficult to accurately assess its impact.

Termination. Termination of this provider–client relationship is well defined: The relationship would likely exist only until completion of the evaluation. However, such termination would not bring closure to the military supervisory relationship. For example, if the staff psychologist felt no choice but to conduct the assessment, there would be a strong conflict of interest, and it would be difficult, if not impossible, to provide an objective evaluation. For illustration purposes, imagine this evaluation resulted in a negative recommendation because of the presence of a mental health condition. Such an evaluation could lead to a restriction of flying duties, restriction of access to security information, or removal of the individual from his command position. Such a determination would impose financial and possibly even career restrictions on him.

Step 2

In this case, proceeding to Step 2 of Gottlieb's model is not advised. The power differential in the current relationship is very high. In addition, the duration of the relationship is difficult to determine. Although the dimension of termination is low from the standpoint of the evaluation, it is considered to be high when examining the likelihood of continued contact between the staff psychologist and this senior ranking physician. Considering the degree of problematic variables, Gottlieb's model would propose avoiding the contemplated relationship. Steps 4 and 5 are believed

to be important in this case for further examination as they provide valuable tools that could assist a military psychologist faced with this situation.

It is very probable that at least one other officer would occupy a position in the staff psychologist's chain of command. Furthermore, it is likely to be another mental health professional. Consultation might have proven invaluable in bolstering the psychologist's argument against conducting the assessment and aided in resisting entrance into the multiple relationship. Gottlieb's fifth step, informed consent, would be difficult to achieve given that this relationship was apparently consummated, rather than contemplated. It would be recommended in this case that the staff psychologist attempt to discuss his concerns with the requesting senior officer, and if no alternative solution was possible, some form of documented informed understanding regarding the potential risks in the evaluation should have been established.

Case 3

A military psychologist, working in a supervisory position at a research facility, suspected that one of her civilian subordinates in a particularly sensitive position (from a standpoint of the protection of national security information) was suffering from clinical depression, given the observation of numerous symptoms. Her suspicions were confirmed after this employee revealed to some visitors to the facility that she had recently been prescribed an antidepressant by her personal physician for major depression. The supervisor was faced with the necessity, dictated by military regulations, of referring this employee for an evaluation to determine her continued suitability to hold a high-level security clearance. The employee's signed agreement, a condition of employment, held that mental health evaluation or treatment could not take place without the knowledge of the employee's supervisor, in accordance with government security regulations (Personnel Security Program, 1987). The director of the division (the psychologist's non-medical supervisor) and the employee made explicit requests to the psychologist that she conduct the assessment, despite the supervisory relationship, given that she was a licensed psychologist.

Step 1

Power. As the employee's direct supervisor, the psychologist holds a significant power differential in the relationship. Pressures from the psychologist's own supervisor to consent to the evaluation, and possibly treatment, adds an additional element to this power differential.

Duration. The psychologist had been in a supervisory position for a relatively brief period of time, rendering the duration of influence in this instance minimal. The risk of this relationship extending into the future is likely, and this risk factor is addressed under termination issues.

Termination. The probability that the employee will have continued contact with her psychologist supervisor is high. If the supervisory relationship was severed in this case, unlike the previous cases (military to military), no ongoing power imbalance persists (there is no overriding military rank structure that would nullify the termination). However, in this case the supervisory relationship was not severed.

Further Steps

The power differential is considered high, the duration low, and the termination concern high. Gottlieb's model would suggest not proceeding with the relationship, which would thus preempt further consideration. In a brief discussion of Steps 3 through 5, several critical issues are highlighted. The role expectations and obligations in the contemplated relationship are clearly problematic. For example, the standard of care when assessing a client for clinical depression typically involves exploring the source of the depression, necessitating any number of personal or intimate disclosures. A clinical relationship would likely render the supervisory relationship permanently compromised. In this case, the psychologist was asked to perform two incompatible roles. As the employee's supervisor, she had a need to ensure the safety and care of the employee as well as the security of information in her workplace, and by federal law (DoD regulations) she had a need to know about her employees' mental health needs. These requirements are understood given that the government is the client in this case. Informed consent supports this allegiance as the employee agreed to such limitations on employment. Adopting the secondary role of clinician would establish a problematic conflict of interest. A referral for outside care would be the most appropriate course of action to satisfy the needs of both the individual and the organization.

Case 4

A military psychologist was requested to take part in a community task force examining the impact of prevention services on the community. According to the regulations supporting the task force, a psychologist's membership was necessary. After agreeing to join the committee, the psychologist was assigned to a small working group consisting of various members from the community, including a previous therapy client. The previous client was of similar rank and position. The clinical relationship had terminated several months ago under mutually agreed on terms following improvements in a mild depression. Once the committee membership was discovered, the psychologist was faced with a decision to continue to commit to the task force or decline membership and explain to her commander the reason for declining the position.

Step 1

Power. The power dynamic in this case is considered low because the therapy relationship had ended several months prior to assignment to the working group. If significant transferential elements of the relationship were present, the power dynamic would need to be reassessed.

Duration. The duration of the previous relationship was moderate in length; however, because this relationship was formally terminated previously, there is no current relationship under which to consider duration factors.

Termination. Termination of the relationship occurred several months ago and appeared to be well defined. The probability that the previous client will have continued contact with the psychologist (re-enter therapy) is difficult to determine with certainty. Given the nature of the previous care, the fact that there was mutual agreement to terminate, and the understanding that the

client had experienced relative stability since the time of termination, it seems unlikely that continued follow-up care would occur. In any event, a return to treatment could result in a referral to another mental health provider. Termination issues are considered to be low.

Step 2

Because all three dimensions fall to the left of the continuum in Gottlieb's model (see Figure 1) further analysis of the contemplated relationship is recommended.

Power. The power dynamic is considered to be low because the psychologist would not be directly in a position of power over the previous therapy client as a committee member. As comembers, their positions are considered equivalent, and they are of similar rank. There is the potential for residual influence on both client and provider because of their previous relationship; however, this factor is believed to be of minimal impact.

Duration. The contemplated relationship is well defined. The task force was chartered to meet several sessions, provide recommendations to another committee, and then disband.

Step 3

Because the three power dynamics were considered to be negligible in terms of impact in the contemplated relationship, Gottlieb's model suggests proceeding with an analysis of the role compatibility. If the contemplated relationship includes the potential for significant confusion in role expectations or obligations between either party, the proposed relationship should be refused or avoided. In this case, there is no apparent incompatibility noted. Because there is no existing relationship, a significant power differential is not present; the nature of the contemplated relationship is professional and defined; and the incompatibility of expectations is considered low.

Step 4

Consultation with a peer or colleague is always advised in cases of boundary violations. The military psychologist should discuss the situation with a clinical peer, emphasizing sensitivity foremost to the client, and should attempt to err on the side of caution.

Step 5

In this situation, the psychologist should contact the individual prior to membership agreement (or as soon as possible) and gather information on the individual's perception of the potential dilemma. If the individual appears comfortable with the arrangements and the psychologist desires to proceed, documentation of the obtained informed consent is advised.

Summary and Conclusion

Multiple relationships take many forms in the context of military health care. The case examples described, although diverse in nature, represent only a fraction of the actual multiple relationships realized by military psychologists. One area of common concern addressed by each of these examples is that in most instances the client was the military institution, situational forces of a military environment, or military regulations. Although this situation has traditionally been seen as the source of conflict concerning confidentiality, it is the likely source of conflict in most multiple relationships as well. Even in instances where the military is not the client, the member requiring or requesting psychological evaluation or intervention is often complaining of difficulties or dissatisfaction with the psychologist's own employer (i.e., the U.S. government or military command). This condition underscores the inherent conflict in attempting to satisfy the psychologist's traditional clinical role (client advocate) and the role of military officer (organizational support). The ethical implications of this conflict are often reduced through the provision of informed consent. All military members agree to adhere to various military regulations that provide specific standards and guidance as a condition of enlistment or commission as an officer. These standards include a compromise in some individual freedom and rights. Such compromises are generally understood and accepted among military members, and in the case of mental health evaluation, written documentation of this understanding is obtained prior to initiating care. A review of Acuff et al. (1999) is recommended for further discussion of this subject along with specific guidelines in establishing informed consent.

To suggest advocacy against multiple relationships would likely result in psychologists living lives of isolation. Within the military environment and other such small communities, this situation certainly would be untenable as it would not allow for a compromise between ethical boundaries and the demands of the environment. Instead, we recommend awareness of the dangers and risks paired with proper guidance and training in an attempt to minimize these risks. Gottlieb's model of ethical decision making is proposed as a potential guide for military psychology given its advantages over other decision-making models in the literature. We recommend that Gottlieb's model and military-specific ethics education and training be presented at military training sites for psychologists. Although these guidelines do not promise to be all inclusive in their approach to conflict resolution or decision making, they are meant to serve as a sound reflexive framework through which clinicians might structure their decision-making process. Our intent is not to replace critical analysis with a cookbook approach, but instead to propose a model through which difficult multiple relationships can be managed successfully.

We agree with previous encouragement for APA and DoD collaboration in an attempt to better define and protect the provider–client relationship in the military environment. Until that time, military psychologists will continue to tread judiciously across the ethical boundaries that frequent their paths.

References

Acuff, C., Bennett, B. E., Bricklin, P. M., Canter, M. B., Knapp, S. J., Moldawsky, S., & Phelps, R. (1999). Considerations for ethical practice in managed care. *Professional Psychology: Research and Practice, 30,* 563–575.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (1999). The APA 1998 annual report. *American Psychologist, 54,* 537–568.

Anderson, R. M., Needels, T. L., & Hall, H. V. (1998). *Avoiding ethical misconduct in psychology specialty areas.* Springfield, IL: Charles C Thomas.

Ball, J. D., & Gingras, T. (1991). Psychotherapy and its supervision in the U.S. military. *Clinical Supervisor, 9*, 115–134.

Barnett, J. E., & Yutrzenka, B. A. (1995). Nonsexual dual relationships in professional practice, with special applications to rural and military communities. *Independent Practitioner, 14*, 243–248.

Bennett, B. E., Bryant, B. K., VandenBos, G. R., & Greenwood, A. (1990). *Professional liability and risk management.* Washington, DC: American Psychological Association.

Biaggio, M., & Greene, B. (1995). Overlapping/dual relationships. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision-making in therapy: Feminist perspectives* (pp. 88–123). New York: Guilford Press.

Brownlee, K. (1996). The ethics of non-sexual dual relationships: A dilemma for the rural mental health professional. *Community Mental Health Journal, 32*, 497–503.

Crawford, M. P. (1970). Military psychology and general psychology. *American Psychologist, 25*, 328–336.

Epstein, R. S., & Simon, R. I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 54*, 450–465.

Glaser, E. M. (1961). Relationships of the psychological consultant in business and industry. *Journal of Counseling Psychology, 8*, 116–120.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy, 30*, 41–48.

Haas, L. J., & Malouf, J. L. (1989). *Keeping up the good work: A practitioner's guide to mental health ethics.* Sarasota, FL: Professional Resource Exchange.

Handelsman, N. M. (1991, August). An ounce of prevention: Proactive ethical reasoning. In D. J. Lutz (Chair), *Full-time academicians in part-time practice: Ethical and legal concerns.* Symposium conducted at the 99th Annual Convention of the American Psychological Association, San Francisco, CA.

Hines, A. H., Ader, D. N., Chang, A. S., & Rundell, J. R. (1998). Dual agency, dual relationships, boundary crossings and associated boundary violations: A survey of military and civilian psychiatrists. *Military Medicine, 163*, 826–833.

Howe, E. G. (1989). Confidentiality in the military. *Behavioral Sciences & the Law, 7*, 317–337.

Howe, E. G. (1997). Ethical issues in military medicine: Mixed agency. In G. R. Lande & D. T. Armitage (Eds.), *Principles and practice of military forensic psychiatry* (pp. 469–514). Springfield, IL: Charles C Thomas.

Jeffrey, T. B. (1989). Issues regarding confidentiality for military psychologists. *Military Psychology, 1*, 49–56.

Jeffrey, T. B., Rankin, R. J., & Jeffrey, L. K. (1992). In service of two masters: The ethical–legal dilemma faced by military psychologists. *Professional Psychology: Research and Practice, 16*, 385–397.

Jennings, F. L. (1992). Ethics of rural practice. *Psychotherapy in Private Practice, 10*(3), 85–103.

Johnson, W. B. (1995). Perennial ethical quandaries in military psychology: Toward American Psychological Association & Department of Defense collaboration. *Professional Psychology: Research and Practice, 26*, 281–287.

Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology: Professional standards and cases.* Random House: New York.

Kelley, C. R. (1971). In defense of military psychology. *American Psychologist, 26*, 514–515.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling and Development, 67*, 217–221.

Leuba, C. (1971). Military are essential. *American Psychologist, 26*, 515.

Lowman, R. L. (1998). *The ethical practice of psychology in organizations.* Washington, DC: American Psychological Association.

Mental Health Evaluations of Members of the Armed Forces, Department of Defense Directive 6490.1 (October 1997). Washington, DC: U.S. Government Printing Office.

Personnel Security Program, Department of Defense Regulation 5200.2 (January 1987). Washington, DC: U.S. Government Printing Office.

Pope, K. S. (1985). Dual relationships: A violation of ethical, legal, and clinical standards. *California State Psychologist, 20*, 1–3.

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association. *American Psychologist, 47*, 397–411.

Professional and Unprofessional Relationships, U.S. Air Force Instruction 36-2909 (May 1996).

Requirements for Mental Health Evaluations of Members of the Armed Forces, Department of Defense Instruction 6490.4 (August 1997). Washington, DC: U.S. Government Printing Office.

Rinella, V. J., & Gerstein, A. I. (1994). The development of dual relationships: Power and professional responsibility. *International Journal of Law & Psychiatry, 17*, 225–237.

Roll, S., & Millen, L. (1981). A guide to violating an injunction in psychotherapy: On seeing acquaintances as patients. *Psychotherapy: Theory, Research, and Practice, 18*, 179–187.

Saks, M. J. (1970). On Meredith Crawford's "Military Psychology." *American Psychologist, 25*, 876.

Schank, J. A., & Skovholt, T. M. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research & Practice, 28*, 44–49.

Sears, V. L. (1990). Ethics in small minority communities. In H. Lerman & N. Porter (Eds.), *Feminist ethics in psychotherapy* (pp. 204–213). New York: Springer.

Stockman, A. F. (1990). Dual relationships in rural mental health practice: An ethical dilemma. *Journal of Rural Community Psychology, 11*(2), 31–45.

Stromberg, C. D., Haggarty, D. J., Leibenluft, R. F., McMillian, M. H., Mishkin, B., Rubin, B. L., & Trilling, H. R. (1988). *The psychologist's legal handbook.* Washington, DC: The Council for the National Register of Health Service Providers in Psychology.

Summers, C. (1992). Militarism, human welfare, and the APA ethical principles of psychologists. *Ethics & Behavior, 2*, 287–310.

Turner, M. F. (1998). Sex, lies and unprofessional relationships. *TIG Brief, 50*(5), 22–23.

Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. *Journal of Marital and Family Therapy, 16*, 133–150.

Received May 4, 1999
Revision received December 8, 1999
Accepted January 4, 2000 ■