

Multiple-Role Dilemmas for Military Mental Health Care Providers

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Military psychologists and psychiatrists frequently face ethical quandaries involving boundary crossings, or extratherapy contact, and multiple relationships. A multiple relationship is defined as necessarily engaging psychotherapy patients in nonclinical roles, such as coworker, superior officer, neighbor, or friend. In contrast to their civilian counterparts, military mental health professionals must often engage patients in many different contexts and roles. In this article, we consider the distinctive features of mental health practice in the military and offer military providers several practice guidelines for avoiding harm to patients in military settings. This article is also designed to enhance sensitivity to multiple-role risks among nonpsychiatric providers.

Introduction

Clinical psychologist LCDR Steve Jones began a regimen of brief cognitive-behavior psychotherapy with a 19-year-old hospital corpsman who presented to the mental health clinic with complaints of depression and difficulty in relationships. A careful assessment confirmed the diagnoses of dysthymia (mild but chronic depression) and a dependent personality disorder (which had not interfered with performance to date). After 2 months of weekly therapy, the client showed moderate improvement in mood, although he had become increasingly dependent on the support of LCDR Jones. With little notice, both the psychologist and the patient were then deployed for a 3-month period aboard one of the Navy's hospital ships. As a department head, LCDR Jones was in his patient's direct chain of command. He attempted to have the corpsman transferred to a different area of the ship, but his superior officer downplayed the issue of the preexisting therapy relationship. Although they continued with less-frequent sessions to address the patient's mild depression and difficulty with adjustment to the ship, both individuals felt uncomfortable about their new military roles with respect to one another and the more public nature of their occasional sessions. When the patient began to have serious performance problems, LCDR Jones was required to sign formal performance counseling forms. The patient terminated therapy at that point, and his performance further declined. Eventually, the executive officer ordered a fitness-for-duty evaluation. As the only mental health professional onboard, LCDR Jones, despite strong protests concerning his preexisting clinical relationship with the corpsman, was required to perform the evaluation and ultimately to find his patient unfit for duty on the basis of his

personality disorder. The patient was administratively separated from the Navy. He later filed an ethics complaint against LCDR Jones for abandoning his clinical role and moving from provider to supervisor without warning.

Active duty military psychologists and psychiatrists are often faced with ethical quandaries regarding the blending of clinical and military roles with respect to mental health patients. As commissioned military officers bound to place the military mission foremost, these providers often report difficulty avoiding blurred boundaries and maintaining clear professional roles with patients. In addition, an increasing number of military psychologists and psychiatrists are being deployed as members of sea-going medical teams (e.g., on aircraft carriers and amphibious assault ships) and ground combat forces (in Army and Marine assault units). Mental health providers, as embedded members of deployed units, must view every member of the unit as a potential patient, and traditional ethical models of avoiding multiple roles are often rendered irrelevant or unhelpful by the frequent necessity of blurring role boundaries with current patients.¹ In this brief article, we highlight the significance of ethical proscriptions against multiple relationships with psychotherapy patients and describe why such multiple roles can be especially problematic in military environments. We present several brief case examples of difficult multiple-role situations in military environments, and we offer some clear recommendations for military mental health care providers. We also hope to increase sensitivity to multiple-role dilemmas among nonpsychiatric colleagues and medical unit leaders.

What Are Multiple Relationships?

Multiple relationships occur when a provider participates simultaneously or sequentially in two or more relationships with a patient, and potential harm to the patient is exacerbated when there are substantial differences or conflicts between the two roles.² Multiple relationships are also common when a mental health provider is treating a patient and is simultaneously in a relationship (professional or personal) with a person closely associated with the patient or when a provider promises to enter into a different kind of relationship (e.g., business or romantic) with a patient at some future time.³ Kitchener² pointed out that multiple relationships are prone to become harmful when one or more of four conditions are met, i.e., (a) multiple roles cause the patient's expectations about one of these roles to go unmet, leading to surprise or anger; (b) the behaviors or obligations associated with one role are incompatible with the behaviors expected of another role; (c) conflicts of interest arise between the provider's professional obligations and his or her own personal, social, or political interests; or (d) substantial relational power asymmetry makes the patient vulnerable to exploitation. One can easily see how any of these conditions may cause a mental health patient to feel shocked, angered, or manipulated.

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Ethical Perspectives on Multiple Roles in Mental Health Care

Ethical concern regarding the dangers of multiple relationships with patients dates to the Hippocratic oath and continues in contemporary principles of medical ethics.^{3,4} These principles recognize the unique dangers of multiple roles for mental health providers.

While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice. . . . The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus upon the well-being of the patient.⁴

Excellent boundaries between provider and patient are considered essential for the conduct of effective psychotherapy. Clear reliable boundaries provide structure and a sense of safety within which vulnerable or distraught patients can take risks, self-disclose, and engage in the difficult work of personal change; "that the therapy relationship becomes a sanctuary in which consumers can focus on themselves and their needs and thereby receive 'clean' feedback and direction is a model worth rigorously upholding."⁵ Although providers are at times tempted to downplay the potential problems associated with adding new relationship dimensions (e.g., business, romance, or personal friendship) to existing professional relationships, accurate prediction of harm from the addition of new roles is always imperfect. As discrepancies between the provider and the patient in the areas of expectation, obligation, and power increase, the potential for misunderstanding, loss of objectivity, and exploitation increases.⁶

Are multiple-role issues a genuine concern for practicing clinicians? One large-scale survey of psychologists revealed that 17% of all "ethically troubling incidents" involved blurred, dual, or conflicting relationships with patients and multiple roles were the second most frequently cited ethical dilemma among practitioners.⁷ A follow-up study using Air Force psychologists replicated these findings. Twenty-eight percent of the ethical dilemmas reported by Air Force psychologists had to do with multiple-role conflicts.⁸ Not surprisingly, multiple relationships are a major source of ethics complaints filed against psychologists and psychiatrists.² Research on sexual boundary violations reveals that the most common precursor is self-disclosure on the part of the provider. When practitioners create personal or romantic dimensions in a therapy relationship, bilateral intimacy develops and professional roles are more easily ignored.⁹

Although ethical guidelines, survey data, and evidence from professional ethics boards all point to the ethical risks inherent in engaging patients in multiple roles or blurring boundaries between doctor and patient roles, it is essential to recognize that not all multiple relationships need be harmful to patients. Gutheil and Gabbard¹⁰ noted the distinction between boundary crossings and boundary violations. Boundary crossings include all departures from commonly accepted clinical practice regarding professional boundaries (e.g., incidental nontherapy interaction such as standing emergency room watch together on a weekend). These crossings are neither always beneficial nor always harmful to patients and require careful consideration.

Boundary violations are departures from accepted practice that clearly place patients or therapeutic outcomes at risk. Such violations are always considered unethical, and their probability increases with the addition of nonprofessional provider-patient roles.

Multiple-Relationship Dilemmas in Military Practice

It is imperative that members of the military medical community appreciate the manner in which the dual officer and provider identities of military mental health care providers often place them in dilemmas regarding ethical obligations to promote the best interests of patients and to avoid potentially problematic dual roles. In the military, multiple relationships are more common, for several reasons.¹¹⁻¹³ First, the provider and the patient are often members of a small close-knit community. In such small communities, members often want to know details about the lives of others, multiple relationships are expected and seen as normal, geographical isolation results in a limited number of social relationship options for the provider, there is an increased incidence of personal contacts and interactions outside the provider's office, and it is nearly certain that the provider will have multiple roles with some, if not all, of his or her patients.^{9,14} Second, mental health providers are often consultants to military commanders as well as providers to individual patients. As a result, confidentiality may be easily compromised by Department of Defense "need to know" provisions and providers may be required to rapidly shift between clinical and evaluative roles with patients. Third, patients are frequently superior in rank and position to the provider. Fourth, patients can become comrades and comrades can become patients.

Johnson et al.¹ recently delineated several distinctive features of mental health practice in embedded military environments that serve to increase the probability of potentially confusing or harmful multiple relationships with patients. Although providers in other contexts might enjoy the luxury of avoiding multiple relationships more assiduously or terminating professional relationships when multiple roles threaten to undermine therapeutic utility, military providers seldom enjoy these professional freedoms. The following features of military practice milieus frequently raise multiple-role concerns for psychologists and psychiatrists.

As a commissioned officer, the provider's first obligation is the military mission. Embedded mental health providers must promote the fighting power and combat readiness of both individual personnel and the military collectively.^{15,16} Common ethical prescriptions against multiple roles may at times need to be compromised or directly violated to ensure mission achievement.

The embedded provider holds multiple roles with every patient. Because every military mental health professional is both a licensed practitioner and commissioned officer, he or she automatically occupies at least two specific roles with each patient. Military practitioners do not enjoy the luxury of serving exclusively the patient or the organization but must, sometimes precariously, balance those obligations, even when they conflict.^{12,13}

The embedded provider cannot choose to enter or exit clinical relationships. Because they are commonly "solo" practitioners in isolated environments, military mental health providers often have little choice about either commencing a clinical relation-

ship with a friend, colleague, or supervisor or terminating a clinical relationship when other required military roles begin to inhibit the usefulness of the relationship. The case of LCDR Jones at the beginning of this article serves as a good example of this dilemma.

The embedded practitioner cannot easily predict sudden shifts between clinical and administrative duties with clients. In military contexts, psychologists and psychiatrists are often ordered to render administrative or forensic decisions concerning military members who are current or past patients (e.g., fitness for duty, fitness for overseas deployment, or fitness for advanced security clearance). Because it is very difficult to predict when such shifts between clinical and administrative roles will occur, patients and providers are often caught off guard by the sudden change in their respective roles. It is also possible that the practitioner will be required to assume a clinical relationship with a member for whom he or she previously rendered an unfavorable administrative decision.^{13,17}

The embedded provider holds significant power over all aspects of a patient's life. In contrast to the powers of civilian providers, active duty mental health care providers are often able to influence nearly every aspect of a patient's living and working milieu.¹⁸ This power might include living arrangements, working environment, deployability, and fitness for advancement.

Frequent and sometimes intimate personal contact with patients is not only probable but ensured. Especially in smaller military units, providers are certain to encounter and to interact with many, if not all, of their clients outside treatment.^{13,19} Particularly in units that frequently drill or deploy, embedded psychologists and psychiatrists may share dining areas, working spaces, and even sleeping quarters with current patients.

The embedded provider will almost certainly provide services to colleagues, close friends, and supervisors. Active duty mental health providers are frequently required to offer services to other medical professionals, close personal friends, enlisted medical personnel whom the provider also supervises, and higher ranking officers and direct medical community supervisors. Each of these cases involves a potentially uncomfortable dual role and there exists in each case the potential for misunderstanding or added distress on the part of the patient.

In the following section, we offer several real-world case examples of multiple relationships in military settings. These cases exemplify the difficulties inherent in managing multiple roles when the provider is both a practitioner and a military officer. Although details have been modified to protect confidentiality, each case comes from the practice experience of the authors.

Case Examples

While I was serving as the only psychologist on an aircraft carrier, an officer of equal rank, who was a personal friend, began engaging me in informal "chats" over coffee and in the wardroom regarding problems with his marriage. Because the level of his distress was not immediately apparent and because our relationship was primarily social, I offered informal support and dispensed generic advice about managing distant relationships and avoiding depressive self-talk. Rather quickly, however, this "friend's" requests for support and counseling esca-

lated. In addition to seeking me out in the wardroom or in the passageways, he began sending regular e-mail messages reporting the latest upsetting contact from home and seeking guidance. He also began to acknowledge more serious symptoms of depression, and it became evident that his performance was becoming impaired at times. Although it was increasingly apparent that I had effectively acquired a new patient, the officer was adamant about not formalizing our therapy relationship and insisted he did not want any documentation of our contact. Because our relationship had begun informally, I had not addressed issues of informed consent for treatment or confidentiality at the beginning of our contact. I therefore thought it would be unethical to suddenly begin formal documented appointments without the officer's consent. After I confronted him with my concerns about his level of depression, he stopped seeking me out for counsel. He continued to demonstrate distress and erratic performance on the job.

While stationed at an overseas military base, my wife and I became very close to our neighbors, another military couple, with whom we socialized frequently, attended command functions, and even celebrated holidays and birthdays. Because of a mixture of factors, including personal difficulties, marital tensions, the stress of living overseas, work stress, and depression following the attacks on September 11, 2001, "Susan," the wife in this couple, who was a nurse and a colleague in the medical clinic, began to manifest severe symptoms of an eating disorder. She was eventually treated in the emergency room and referred immediately to mental health services. As the only licensed psychologist in the clinic and the only provider with expertise in eating disorders, I was required to conduct an evaluation of Susan's condition and to determine both fitness for duty and appropriate treatment options. Although I was supervising two unlicensed clinicians at the time, both of those providers also knew Susan socially and both expressed concerns about engaging her as a client, because of ethical proscriptions against multiple relationships. Furthermore, because I was supervising those residents, Susan would essentially be my client regardless of who was actually assigned the case. Although I attempted to manage the evaluation and subsequent therapy sessions professionally and sensitively, the arrangement was obviously uncomfortable for Susan, and both couples were saddened by the obvious need to discontinue our social relationship. Several months later, when my wife became pregnant, the only obstetrician available at the time was Susan's husband.

As the only psychologist attached to a small medical command, I began providing regular psychotherapy to my command's executive officer, for mid-life and marital dissatisfaction issues. Although we developed a positive therapy relationship and he appeared to make good progress in treatment, both of us remained cognizant of a level of discomfort in our military relationship. He wrote and screened my fitness reports, conducted inspections of the clinic and personnel, and once had to send me a letter of mild reprimand for missing a duty watch I had forgotten. Six months after our final therapy appointment, the executive officer was accused of fraternization with a junior officer in the command. During preliminary preparations for a court-martial, both attorneys in the case became aware of the officer's previous mental health treatment and demanded copies of all records. When I expressed reservations about providing

records, the commanding officer ordered me to release them under the broad "need to know" provisions of the Department of Defense. Because my patient, the executive officer, strongly protested the release of my records and because it was obvious that some of the disclosures documented in my own notes would be embarrassing and unhelpful to his case if released, I satisfied both attorneys by providing a written summary of treatment. Most of the material in the patient's record was frankly irrelevant to the charges at hand. I did not release my own notes. Nevertheless, my commanding officer was angered by the perception that I had disobeyed the order to release all records. I think that my final performance evaluation at the command suffered in part as a result of this incident.

An officer whom I had treated for stress related to marital difficulty began telling mutual friends and colleagues on board the aircraft carrier about our counseling sessions. During one lunchtime meal in the officer's mess, he began describing our recent therapy conversations in great detail, as a means of amusing others at the table. Although I stayed out of the conversation and was obviously uncomfortable, I listened while his comments degenerated into a somewhat crude round of jokes related to his marriage and our sessions. The officer seemed unconcerned about these disclosures, but I found it very uncomfortable and excused myself as quickly as I could. We discussed the incident in a subsequent session.

These vignettes highlight the myriad ways in which military mental health providers may find themselves in uncomfortable and, at times, unethical, multiple relationships with patients. The embedded, isolated, and intimate nature of many military mental health billets often places providers in multiple-role quandaries that lack elegant resolution. Attempting to walk a tightrope between ethical principles, legal requirements, and military statutes, psychologists and psychiatrists may sometimes find themselves unable to clearly separate clinical, administrative, and military roles with patients. Furthermore, they may have difficulty predicting who will become patients, and they may be unable to offer genuine informed consent for treatment, in that neither the provider nor the patient may be able to fully anticipate what roles they will be required to fulfill in the service of the military. On the basis of previous research and writing in this area, we offer the following recommendations for military mental health providers.^{1,3,12,20-23}

First, strive for a neutral posture in the community. Military mental health providers are well served by avoiding high-profile leadership positions and controversial stands on social, political, or religious issues. Although officers must assume leadership roles in the medical community, it is useful for mental health providers to remain as neutral and "above the fray" as possible, so that potential patients will see them as available and nonpartisan, particularly when occupational conflict contributes to psychiatric disturbance.

Second, assume that every member of the community is a future patient. Because shifts between provider, social, and administrative roles are frequently impossible to predict and because many mental health providers practice in solo billets, one must assume that any member of the local military community may require mental health intervention and that he or she is therefore a prospective patient.

Third, provide immediate informed consent information to all

patients. Ethical guidelines enjoin mental health providers to give patients clear informed consent information about any foreseeable changes in roles. In the military, clinical providers may also become supervisors, forensic evaluators, close-quarter colleagues, and sometimes patients themselves. Potential role changes should be considered and discussed at the beginning of treatment.

Fourth, use stringent interpretations of "need to know" policies. Mental health providers in military settings often struggle with how to balance ethical demands for protection of patient confidentiality with federal statutes that require providers to disclose aspects of a patient's problem, diagnosis, course of treatment, and prognosis in the service of determining fitness for deployment or appropriateness for security clearances. Mental health providers are encouraged to be conservative when determining what information is crucial to the question posed by a command. Safeguarding the provider role requires a combination of informed consent and efforts to protect privacy wherever possible.

Fifth, avoid significant self-disclosure. Because of the danger of uncomfortable and possibly harmful multiple relationships in military settings, providers should be cautious about undue familiarity, bilateral intimacy, and personal disclosures to any member of the military community. Such disclosures may make later provision of services uncomfortable for both the provider and the patient. Although mental health practitioners may therefore be seen as more disengaged relationally at work, this may be an acceptable price for fewer preexisting uncomfortable relationships with service members.

Sixth, consider alternative mental health resources. In worst-case scenarios, such as when a preexisting romantic relationship with a patient exists, mental health providers are urged to consider a referral to other reasonably qualified members of the local military community who might be able to offer appropriate back-up care. Such personnel might include chaplains, general physicians, and substance-abuse counselors.

Seventh, increase tolerance for boundary crossings. Boundary crossings occur every time a provider has extratherapy contact with patients. In small military communities, such crossings are common around base, in the grocery store, and in military housing. Crossings themselves are not unethical and do not suggest boundary violations that are likely to upset or become harmful to patients. Mental health providers who offer clear informed consent information about such crossings and increase tolerance for them are likely to become more effective as both practitioners and officers.

Eighth, actively collaborate with patients regarding management of nonclinical interactions. Because extratherapy contact and various boundary crossings with patients are nearly guaranteed in military settings, it is imperative to collaborate with patients regarding preferred methods for handling such contact before it occurs. Early in treatment, providers should discuss likely places of contact, possible multiple roles, and how the patient would be most comfortable handling these. For example, a provider can feign not knowing the patient or can casually say hello.

Ninth, carefully document uncomfortable multiple relationships. As is always the case when mental health practitioners encounter ethical dilemmas, they must work to resolve them

with the patient's best interest in mind. In military settings, when providers occupy dual roles as practitioners and officers, multiple-role dilemmas may become uncomfortable and their resolution may not ultimately satisfy either patients or some military leaders. For these reasons, it is imperative that providers carefully document awareness of the problem, ethical reasoning, and clear efforts to resolve the dilemmas in the most expeditious and elegant fashion possible. Above all, the patient's best interest should be kept in the foreground.

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