

ORIGINAL PAPERS

The Clients' Perspective – Do military uniform and rank impact on the therapeutic relationship between military mental health clients and clinicians

MM Wilson¹, PD McAllister²

¹Community Mental Health Nurse, Department of Community Mental Health, Catterick, UK; ²Consultant Psychiatrist, Department of Community Mental Health, Tidworth, UK

Abstract

Objective: To measure the perception of military mental health clients of the impact of wearing military uniform on the therapeutic relationship between client and clinician and to ascertain if uniform and rank is perceived as a barrier.

Method: A brief questionnaire was distributed to Departments of Community Mental Health to be disseminated to their mental health clients to measure their responses.

Results: 282 responses from mental health clients were collected over a 30 day period regarding the impact that military uniform makes to the therapeutic relationship with the clinician. 63% (n=178) regarded uniform as negatively influencing their relationship with the clinician, 37% (n=104) responded that it did not. 39% (n=111) believed rank to be a barrier, whereas 61% (n=171) did not believe it affected the relationship.

Conclusion: The majority of military mental health clients regard the wearing of uniform as negative to the therapeutic relationship and a significant minority have similar feelings about rank. Military mental health practitioners should consider the impact of these results on the therapeutic relationship with military patients.

Introduction

Before Departments of Community Mental Health were set up, all mental health personnel, with a few exceptions, wore military uniform. In the last decade this has now changed with many Departments of Community Mental Health (DCMH) staff wearing civilian clothing. The issue has raised comments from clients and other medical professionals that military uniform may have an impact on interactions with soldiers and may subsequently affect the therapeutic relationship. Unlike ward-based staff, there is no coverage of Community Mental Health (CMH) staff dress in Army Trade Dress Regulations [1]. While on Operational postings outside of the UK, all mental health staff team members continue to wear military uniform. This unique environment has not been addressed in this research and the survey did not include staff on Operational tours other than the Department of Mental Health, Headquarters Northern Ireland.

To date the authors have found limited research investigating the mental health clients' perception on the impact of military uniform and rank on their therapeutic relationship with the clinician. In a previous paper, Wilson et al [2] reported on a survey to ascertain the opinions of military mental health staff on whether or not they thought military uniform impacted on the therapeutic relationship

with mental health clients. This follow on study was aimed at highlighting the opinions of the service users, the mental health clients themselves.

Military mental healthcare is unique within the Defence Medical Services in that it is an occupational service for the three services with its own procedures that operates independently from National Health Service Mental Health Services. Therapeutic intervention is an important element of the relationship and of paramount significance between the mental health professional and the client. It is built on faith, perception and good communication, but there are barriers to a positive therapeutic relationship, of which one is possibly the perception of the impact of uniform by the client in a clinical environment. This study is designed to raise awareness of the issues of uniform and rank from the clients' perspective. It is hoped this will instigate further discussion into the subject, possibly leading to more research being carried out to establish best practice.

Methods

A simple questionnaire was compiled based on the guidelines from Hill, Brierley and MacDougall [3] and faxed to all Departments of Community Mental Health to be photocopied and disseminated to all mental health clients who attended Departments of Mental Health within a 30 day period in 2006. All DCMHs were contacted about the research and 17 were sent the questionnaire. Some of the DCMHs in Germany are staffed solely by civilians and it was not felt appropriate for them to participate in the study. Responses were then collated, tabulated and the percentage values calculated for each response.

Corresponding Author: SSgt MM Wilson QARANC RMN, RGN, CPN (Specialist Practitioner), BSc (Hons), Duchess of Kent Hospital, Department of Community Mental Health, Horne Road, Catterick Garrison, North Yorkshire DL9 4DF
Tel: 01748 873058 Email: 5742wilson@armynet.com

Results

Two hundred and eighty two completed questionnaires were received from 11/17 (65%) DCMHs. Six departments did not respond or replied outside of the specified timeframe. A breakdown of the locations and the number of client responses received are shown in Table 1.

Unit	Replies (n)
Brize Norton	45
Catterick	65
Colchester	16
Donnington	17
Faslane	12
Haslar	1
Northern Ireland	21
RAF Kinloss	24
RAF Leuchars & Edinburgh	8
Tidworth	65
Woolwich	8
TOTAL	282

Table 1: Replies from each DCMH

Clients were asked whether or not they felt that military community mental health clinicians should wear uniform when they attended the CMH Departments for an appointment. These findings are shown in Table 2.

Survey Questions	Response			
	Yes		No	
	Number	(%)	Number	(%)
Do you think Military CMH professionals should wear uniform when you attend the DCMH for your appointment?	57	(20)	225	(80)
Do you think Military uniform negatively influences your therapeutic relationship with the CMH professional?	178	(63)	104	(37)
Do you think rank is a barrier to treatment?	111	(39)	171	(61)

Table 2: Survey questions and responses

Discussion

The two most relevant published studies both consider civilian uniform. Chapple et al [4] carried out a case study which was an attempt to evaluate clients' perceptions of changing professional boundaries in primary care services. The results showed that some patients credited the leading nurse as the most highly qualified and perceived the nurse to be a doctor. This conclusion was reached by a number of factors, including the absence of uniform. Conversely, the most important factor was not the perception of professional identity but how the service met the patients' needs. In a civilian environment where uniform is worn, the status or rank of the wearer is less of an issue. However, Graham-Walker [5] states that in psychiatry, including community-based nursing, not wearing uniform may work well if your patients know you, but if there is no established relationship it may be detrimental to the ethos of the appointment. The study seemed to suggest that clients seem to

appreciate the clinician wearing uniform. This reflects the fact that the wearing of uniform and rank acknowledges the relationship and gives it the gravity and respect it deserves, setting the relationship apart from normal business. In this second study, the results showed the opposite, as 80% of the clients reported that military Community Mental Health staff should not wear uniform and 61% believed rank to be a barrier.

It could be argued that the Community Mental Health nurses' attire plays an instrumental role in their communication with clients, inspiring confidence, credibility and evoking respect. On reflection, perhaps it would have been useful to have incorporated in the survey questions the third option of reply "I don't mind" or a fourth "I don't know" thus opening up more possible discussion and gaining more information. There are others who may claim that appearance is a matter of social etiquette and the ability of the health professional is what really matters. This view is also supported by Tham & Ford [6] who carried out a study in 4 adult psychiatric hospitals to assess attitudes of staff and patients and staff dress on psychiatric wards. 36% of patients indicated that the wearing of formal dress made staff less approachable. However, McLean *et al* [7] performed a study to test out the theory that military uniform may alter patients' perceptions of the clinician. The results showed the attire of the clinician in the clients' view did not adversely influence their perception of the clinician.

In the military, both uniform and rank are inextricably linked, as the wearing of uniform also conveys rank. The wearing of uniform by the mental health professional in uniform serves as a powerful, non-verbal symbol that affects communication between client and clinician. This may explain why a large majority of clients responded that they did not think clinicians should wear uniform and rank. The clinical environment is perceived by many as a relaxed, informal environment where military discipline and rules should be left at the door. The inherent military rank structure often conflicts with the rank of clinicians and other clients. It could be argued that military emphasis is established on institutional subservience and this could be detrimental to the therapeutic relationship from a patient's point of view. Johnson [8] states that military officers often report difficulty in avoiding blurred boundaries and maintaining clear professional roles, but on the other hand states that patients are frequently inferior in rank and position to the clinician and this causes the client to perceive the clinician as more powerful and intimidating. Lange [9] believes that clinicians sometimes takes a different therapeutic approach depending on the rank of the client and that it is not uncommon to hear a Sir/Ma'am in response to a statement made by a higher ranking client to a clinician. This is partially supported by Sun *et al* [10] who state that one of the barriers to nursing care in their study was shown to be several psychiatrists were considered to be uncooperative and clients perceived they adopted different approaches to care from the nurses, the outcome of which led to clients not trusting them, emphasising the hierarchical difference between the roles. It would therefore be of benefit for mental health providers to remain as neutral as possible so the client will see them as non-biased, the rank issue minimised and the therapeutic equilibrium balanced as much as possible. The perception of barriers to care among military personnel should therefore be a priority for all clinicians and policy makers to acknowledge and work towards best practice for the client and then the clinician.

Conclusion

We have found that *military* mental health clients differed in their opinions compared to previously reported civilian views of the wearing of uniform. Almost one third of clients did not perceive the wearing of uniform as a barrier to their therapeutic care, and almost two thirds did not regard rank as a barrier. Findings from both studies go some way toward identifying patients' views and needs in relation to their thoughts and feelings about the possible influence of barriers relating to uniform and rank. This can affect

the client-clinician therapeutic relationship and subsequently affect the efficacy of the treatment. Clinicians must continue to ask the client for their views on the care provided in order to enhance and advance their practice and ensure that the client receives the best care possible.

The lack of current research highlights the importance of this study and the need for additional research to broaden our knowledge of the relationship between client and clinician and raises issues about trust and mutual respect between both parties.

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