Fleet Mental Health:  
A discourse analysis of Navy leaders' attitudes about mental health problems

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Abstract

Mental disorders are a significant source of medical and occupational morbidity for active duty military members. The majority of military personnel believe that using mental health services will cause career harm, and over 81% of those with mental health problems do not seek treatment. The literature suggests that stigma and fear of negative career impact are significant barriers to the use of mental health services. Military members have indicated that concern about leaders’ attitudes is a barrier to seeking help. The attitude of military leaders is important because those leaders have authority over both subordinates’ careers and their access to mental health services. Military culture and leaders’ perceptions of mental illness are potential sources of organizational norms regarding mental health service use.

This study used semistructured interviews and military policies as data sources to analyze the language, knowledge, and attitudes of Navy surface fleet leaders about mental illness and mental health treatment using Foucault’s concept of discourse analysis. A discourse is a system of knowledge that influences language, perceptions, values, and social practices. The data yielded by the study showed that fleet mental health, not mental illness stigma, was the dominant discourse of leaders’ attitudes about mental illness and subordinates’ use of mental health services. Leaders expressed frustration with accessing and using mental health resources to ensure that sailors are mentally combat ready. The source of the leaders’ frustration is the fundamental difference between the Navy surface warfare community and the mental health community. Differences between the two communities are aggravated by inconsistent policies, separate organizational expectations, unique knowledge structures, and specialized language.
This study provided an initial look at the attitudes that Navy surface warfare leaders have regarding mental illness and the use of mental health services. The study findings indicate that organizational differences may have a stronger influence on leaders’ attitudes than does stigma. This study provides an elaborated view of mental health knowledge and power within a Navy community. That view can be used to identify practical and concrete implications for further research on stigma in the military and for improvements to fleet mental health services.
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A path will be placed before you. The choice is yours alone.

Do what you think you cannot do.

It will be a hard life ... but you will find out who you are.

~Qui-Gon Jinn~

This study is dedicated to the fleet leaders of the United States Navy. With passion and dedication to their crewmembers, their ships, and the Navy, they are parents, problem solvers, and patriots. More important than the missions completed or medals won is the fleet leaders’ success in developing an incredibly diverse group of young men and women in a way that encourages them to believe in each other and their ability to accomplish the impossible together.
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CHAPTER ONE:
INTRODUCTION

Mental disorders are both common and costly to society. Mental disorders affect over 10% of the world’s adults at any given time and over 25% during their lifetime (Mental health: New understanding, new hope, 2001). The World Health Organization and World Bank study of the Global Burden of Diseases determined that mental disorders are fourth in the ten leading causes of disability for people over the age of five (Murray & Lopez, 1996). Mental disorders and suicide account for 15.4% of all disability-adjusted life-years, ranking second below all cardiovascular disease. By the year 2020, major depression alone is predicted to be the leading cause of disease disability in the world.

In the United States, 7.3% of health care expenditures during 1996, approximately $69 billion, were for mental health services (Mark, McKusick, King, Harwood, & Genuardi, 1998). The inclusion of comorbid drug and alcohol use further increased direct treatment costs by $13 billion (Mark et al., 1998). In addition to direct treatment costs, societal burdens associated with mental illness and substance abuse include violence (Steadman et al., 1998), homelessness (Gelberg & Arangua, 2001), child abuse (Kelleher, Chaffin, Hollenberg, & Fischer, 1994), motor vehicle accidents (Rice, Kelman, Miller, & Dunmeyer, 1990), marital instability (Kessler, Walters, & Forthofer, 1998), and lost worker productivity (Druss, Schlesinger, & Allen, 2001; Ettner, Frank, & Kessler, 1997; Kessler & Frank, 1997).

Despite the pervasive and serious impact that mental disorders have on society and the evidence that efficacious treatments are available for most such disorders, significant unrelieved suffering remains due to the underuse of mental health services.
The 1990 National Comorbidity Study (NCS) demonstrated that 29% of people aged 15 to 54 had an active mental or substance abuse disorder during the past year (Norquist & Regier, 1996). Only half of those with active mental disorders sought some type of help, and only 6% received guideline concordant mental health care. People who do seek help for mental and substance abuse disorders are most likely to receive care in the general health sector where identification and treatment of their disorder are inadequate (Norquist & Regier, 1996). Underuse of mental health services has been associated with inadequate assessment by health care providers, financial burden due to lack of insurance parity, maldistribution of mental health providers, and stigma (Mental Health Report, 1999).

Stigma as a barrier to mental health help-seeking is understudied. Results from the few published studies show that stigma associated with mental health treatment adds to people’s fear of disclosure and social rejection. The belief that stigma interferes with help-seeking is held by both the general public and mental health consumers. In a study of public attitudes toward people with mental illness, Frazer (1994) found that 89% of the general population in Utah believed that social stigma inhibited people with mental illness symptoms from seeking treatment. Community size is related to stigma belief and attitudes toward help-seeking. People who live in smaller rural communities are more likely to hold stigmatized beliefs about mental illness. In particular, men in smaller communities are more likely to delay or avoid treatment for mental illness symptoms (Hoyt, Conger, Valde, & Weihs, 1997). Stigma reduces the likelihood of help-seeking among people who prefer to keep information about mental illness symptoms secret (Cepeda-Benito & Short, 1998). And when people do decide to seek help, they are more likely to use non-mental health services. As a compromise to seeking appropriate mental
health treatment, many people will continue to live with impairing symptoms rather than seeking help or continuing with a full course of treatment (Lee, Gianturco, & Eisdorfer, 1974; Wills, 1983; Windle, Bass, & Taube, 1974). Even when people with mental illness do seek services, they may go to great lengths to conceal that they are in treatment. For example, they may seek treatment outside of their community to avoid being seen at a mental health clinic (Wahl, 1999).

Mental Health Problems in the Workplace

About 18% of employed people between the ages of 15 and 54 have some kind of mental problem (Kessler & Frank, 1997). Within the workforce, mental disorders are more prevalent in clerical workers and laborers than in professionals and managers. Untreated mental health problems result in lost workdays, low productivity at work, increased overall health care costs, and increased disability claims when compared with other, non-mental health conditions (Druss, Rosenheck, & Sledge, 2000; Druss et al., 2001; Kessler et al., 1999; Kessler & Frank, 1997).

Employers purchase more than 93% of private health care insurance in the United States and, thus, strongly influence health plan benefits and choices (Employer health benefits: 1999 annual survey, 1999). An employer's need to keep costs low and beliefs about the effectiveness of treatments in maintaining worker productivity drive decisions regarding health plan benefits. Unfortunately, employers' stigmatized beliefs about the cost and effectiveness of treating such mental illnesses as major depression can act as a barrier to mental health services (Druss et al., 2000). Understanding the true costs and benefits of treatment is often difficult for employers. For example, the costs associated with short-term disability and lost productivity increase when management beliefs or
policies delay treatment or reduce benefits. Few studies have been conducted showing the cost-benefit analysis of the high costs of treatment and including improvements in the productivity of treated workers. Stigma by employers results in the underfunding of treatment by employee mental health plans (Kessler et al., 1999).

Even though more organizations are recognizing the mental health needs of their employees, workers’ employment may still be in jeopardy once mental health services are used. Stigma in the workplace can result in job loss or diminished responsibility for employees who use mental health services. Orvis (2002) evaluated employees’ and supervisors’ factual knowledge about major depression and rated their perceived fear of revealing a diagnosis of depression in the workplace. Both groups demonstrated significant knowledge deficits about the disorder and fear of career harm consequent to disclosing a diagnosis of major depression. Lehane (1995) described the experience of 20 manual laborers and 10 managers who returned to work following inpatient psychiatric treatment. Neither the severity of symptoms nor length of stay was included in the report. Upon returning to work, the laborers described a brief period of curiosity from coworkers that quickly returned to the level of interpersonal acceptance that existed prior to treatment. Managers, on the other hand, experienced a loss of informal position and power within the company. Seven of the 10 managerial subjects received job reassignment or early retirement within three months of returning to work. Other studies showed that workplace stigma of mental disorders reduces the probability of being hired (Brand & Clairborn, 1976; Glozier, 1998), stimulates omission of illness status during job interviews, results in reduction of job responsibilities after disclosure, and increases social distance from coworkers (Wahl, 1999).
Mental Health and the U. S. Military

Mental disorders are the most significant source of medical and occupational morbidity among active duty military members (Hoge et al., 2002). Since 1995, hospital admissions for mental disorders are the second leading cause of hospitalization of members of the active duty military population. Mental disorder admissions accounted for over 13% of all admissions and for 23% of all bed-days. The leading mental disorders are alcohol-related disorders, adjustment disorders, major depression, and personality disorders. Hourani and Yuan (1999) used instruments and methods similar to those of the Epidemiologic Catchment Area (ECA) survey and identified a 40% lifetime and 21% current prevalence of mental disorders in a Navy and Marine Corps population, with more than 81% of those with active disorders not seeking any mental health services.

Occupational stress contributes to mental health problems in the U. S. military. Military service places demands on its members and their families that are different from the demands of most other occupations. There is a constant awareness that military rules and regulations apply both on- and off-duty. Even minor infractions can have swift punitive responses. Routine training for war is a constant reminder of the danger inherent to a military occupation. Unlike a business trip abroad, every military deployment has the potential for armed conflict. In a study by Bray et al. (2000), 23.8% of military members self-reported high levels of life stress. The top five sources of stress identified in the Bray et al. (2000) study were family separation, financial problems, workloads, job-versus-family conflicts, and family changes. High-stress service members had greater risks for low productivity, increased workplace accidents, and maladaptive coping. In the general military population, nearly 25% used alcohol and 4% considered suicide as coping.
options (Bray et al., 2000). Based on the preceding studies, between 21% and 25% of the general military population needs mental health services.

Even though mental disorders account for a significant amount of health care use and occupational risk, many active duty military and their family members are not seeking help. The 1995 Department of Defense (DoD) health beneficiary survey showed that fewer than 19% of respondents with major depression sought treatment (Constantian, 1998). In the general U. S. population, over 30% of NCS respondents with major depression sought treatment within the first year of symptom onset (Kessler, Olfson, & Berglund, 1998). The self-reported need for any type of mental health services was 18% in both the civilian and military workforce (Bray et al., 2000; Kessler & Frank, 1997). While about half of the civilian respondents sought formal treatment, however, less than a quarter of the military respondents used formal mental health services.

Unlike fragmented mental health care in the civilian sector, the structure and process of military health care eliminate both financial and provider availability barriers to mental health services. The military health care system eliminates the beneficiary financial barrier by not requiring co-pays for active duty personnel and only minimal co-pays for family members. The geographic maldistribution of mental health providers in the United States is addressed by mandatory staffing of mental health jobs on the basis of organizational needs versus preferred practice settings. Inadequate assessment by primary care providers may be buffered by required mental health assessment training of military providers. Even with the amelioration of these barriers, however, the underuse of military mental health services remains an important problem.
Significant costs are associated with untreated mental health problems in the military workplace. Some direct costs relate to the replacement of service members who leave or are compelled to leave before completing their contract; others are increased medical care costs associated with delayed treatment and expenditures for military resources to transport patients from remote duty assignments to treatment facilities. Attrition from the military before completion of a service contract is very expensive. For example, it costs the Navy $69,000 to replace just one junior enlisted sailor without technical training (Cost of Manpower Estimating Tool (COMET), 2001). Personnel replacement costs increase dramatically with specialized training and seniority. Delaying treatment directly increases the costs associated with attrition as affected members receive advanced training and promotion.

Inpatient hospitalization is another cost of mental health disorders. For example, the annual price of inpatient treatment for mental illness per patient is seven times greater than that for outpatient services alone (Leslie & Rosenheck, 1999). As symptom severity increases, the feasibility of using lower-cost outpatient treatment and the likelihood of continued military service decrease. Hospitalization also increases the burden in the work environment by reducing the number of people available to meet work goals. Because mental disorders are the leading cause of hospitalization of deployed military personnel, any reduction in the severity of mental illness symptoms will reduce costs for transporting patients to treatment.

Stigma as a barrier to treatment is costly because delays in treatment are associated with increased symptom burden, family disruption, organizational demands, and expenditure of fixed fiscal resources. As in the civilian literature, very few studies of
the military population describe the occupational effects of stigma. Studies do emphasize, however, that most service members perceive that participating in outpatient or inpatient mental health services will harm their military career (Bray et al., 2000; Britt, 2000). At least parts of service members’ perceptions are accurate. Hoge et al. (2002) discovered that inpatient treatment did have a negative career impact. Attrition from the military following hospitalization for a mental disorder between 1996 and 1998 was 61% within 12 months and 74% within 24 months. This investigation did not shed light on the factors that contributed to such high attrition from military service. Unknown are the actual experience of service members upon discharge from the hospital, the level of support or social distance experienced upon returning to work, and the related attitudes and career decisions made by military leaders.

Some of the knowledge gained about stigma in the corporate workplace can provide insights into stigma in the military setting. It is important to recognize, however, that the settings and workers have some significant differences. Compared with large corporations, the military workforce has unique entry and retention requirements that are intended to exclude those with mental disorders. Military group norms and regulations with low tolerance for deviance reinforce behavioral expectations with punitive sanctions. In civilian corporations, employees can reasonably expect to retain the privacy of their medical records and treatment history. In the military setting, in contrast, the commanding officer has the right, and many would argue an obligation, to be knowledgeable about any condition that would affect service members’ ability to perform their duties.
The underuse of mental health services by American military personnel is widespread and contributes to personal suffering, increased family burden, decreased organizational efficiency, increased training expenditures, and increased health care costs (Bray et al., 2000; Britt, 2000; Constantian, 1998; Hoge et al., 2002; Hourani & Yuan, 1999). Stigma and fear of negative career impact represent a significant barrier to seeking help for mental health problems. Delays in seeking mental health services increase the risks of developing mental illness, exacerbating physiological symptoms, and negative career impact. Negative attitudes about mental health problems among leaders and managers are the most likely source of negative career impact. This problem, however, is barely acknowledged in the research and professional literature concerning mental health in the military. With the lack of stigma research in the military culture, part of the current knowledge that mental illness stigma exists in the military comes from the experience of being part of the military and from its oral history that establishes cultural norms and expectations. The expectations of leaders, particularly in regard to mental health issues, produce dramatic differences in the use of mental health services and the outcomes of interventions. This study will address this significant gap in the research literature by describing the perceptions of Navy leaders about psychiatric symptoms and the use of mental health services. The long-term goal is to use the knowledge thereby gained to reduce barriers to seeking mental health services for Navy members and their families.
CHAPTER TWO:
LITERATURE REVIEW

Goffman’s (1963) seminal essay on stigma describes it as a “special kind of relationship between attribute and stereotype” (p. 2) that results in a “spoiled identity.” The spoiled social identity symbolizes an undesired difference from a social norm. Goffman focused attention on the characteristics of the individual in a social context to identify three types of stigma. First is the stigma of physical deformities. Second is character faults — moral weaknesses or willful antisocial behaviors as defined by society. Goffman posits examples of character faults that include criminal behavior, addiction, unemployment, homosexuality, and mental illness. Third are the tribal stigmas derived from membership in a particular group, such as race, nationality, or belief system.

Because stigma is a social construct, the stigmatized often hold the same beliefs about the mental illness stigma as do their social peer group (Corrigan, 2000; Corrigan & Watson, 2002). This self-stigmatizing belief then affects their self-concept and social reactions to others. According to Goffman (1963), the consequences of stigmatized beliefs occur when the stigmatized person is in a social situation with nonstigmatized others. Social tension increases for both parties because stigma changes communication expectations. When stigmatized and nonstigmatized individuals interact socially or in a formal hierarchy such as the workplace, the stigmatized are likely to have poor outcomes, such as being shunned or failing to get a deserved promotion (Bordieri & Drehmer, 1986; Farina & Feliner, 1973; Glozier, 1998; Link, 1987).
Discrimination is the behavior and outcomes emerging from stigmatized beliefs. A person's position in a social hierarchy communicates his or her social power and influence. Self-stigma and other-stigma result in diminished status. Once established, the stigma influences the expectations and perceptions of both the stigmatized and the stigmatizer (Link & Phelan, 2001). Discrimination can occur on both an individual and/or structural level. Individual discrimination occurs when an individual in a position of power denies or rejects a labeled person based on stigma. Structural discrimination systematically limits, or creates barriers to, resources needed by the stigmatized group. The degree to which stigma separates and marginalizes people depends on the level of influence that stigmatizers have in controlling access to education, housing, employment, and health care (Link & Phelan, 2001). In researching stigma, it is important to understand the social context and power relationships that exist along with the experience of stigma.

Social Stigma

Using a social psychology perspective, Jones et al. (1984) expanded Goffman's spoiled identity framework to incorporate findings from stigma research and to refine the concept of social stigma. The social stigma conceptual framework developed by Jones et al. will provide the foundation for this study (Table 1). Stigma is operationally defined as a mark that links the marked person to undesirable characteristics and increases the social distance of that person from others. A mark is a generic term for a perceived deviation from a social norm that might initiate stigma. For example, physical deformities or mental illness diagnoses are considered marks in certain social situations. The mark in this study is the perceived presence of a mental disorder, mental health problem, or
participation in mental health services. A bearer of the mark is a *markable person*. The *marker* is the person who perceives the mark. A *marked person* is one who is the target of a marking. Not all marking behavior leads to stigmatization. For stigma to occur, the mark needs to be a social deviancy that discredits marked individuals and spoils their social identity. For example, Fred is participating in treatment for major depression. He meets Hank, who does not have a mental illness. Fred’s mental illness is a markable condition associated with a deviancy from normal. However, the influence of stigma will depend on whether Hank changes his beliefs about Fred’s personality or capabilities on the sole basis of knowledge of Fred’s history of mental illness.

**Table 1**

Social Stigma Theory Elements

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<tr>
<th>Interaction Types</th>
<th>General Concepts</th>
<th>Dimensions</th>
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<td>Casual</td>
<td>Expectancies</td>
<td>Concealability</td>
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<td>Role-Based</td>
<td>Self-Concept</td>
<td>Course</td>
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<td>Close</td>
<td>Plans and Goals</td>
<td>Disruptiveness</td>
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<td>Stimulus Cues</td>
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Different types of social interaction influence the dynamics of the stigma process. Jones et al. (1984) identified three types of interaction: casual, role-based, and close. *Casual interactions* tend to be spontaneous encounters in public places between strangers or acquaintances. The capacity of a mark to influence a casual interaction will depend on how observable the mark is by others. Easily concealable marks are unlikely to affect
casual interactions. Role-based interactions occur in settings where each of the
participants has a specific role. For example, the health-care provider and patient roles
may be based solely on the mark, whereas employer and employee roles may need to
account for the mark. Role-based interactions are important to understanding the
dynamics of stigma in the work environment. For some, the presence of a mark can
create strain between personal beliefs and expected behavior. For example, an employer
may hold strong stigmatized beliefs on the basis of an employee’s race but is required by
equal opportunity laws to respond to that employee in a socially acceptable manner.
Close interactions occur between intimate social contacts such as spouses, children, and
close friends. Often, the mark is well known by people in close relationships and is
incorporated into that relationship. Frequently, family and close friends will know that a
person has depression or a substance abuse disorder. Within their relationship, they
understand symptoms, triggers, and how to help. In essence, they see a person with a
problem and not a problem that defines a person.

To understand the functional cognitive, affective, and behavioral
interrelationships in each of the three types of interactions, Jones et al. (1984) identified
six general concepts. The general concepts frame the factors influencing the thoughts and
behaviors of the marker toward the markable person; these concepts are expectancies,
self-concept, plans and goals, stimulus cues, perceptions, and attributes. The cognitive
and affective expectations are derived from past experiences, news media, the
entertainment industry, and values of the current social group. The expectancy for the
interaction of both parties influences perception during their interaction. The marker’s
self-concept helps to define initial plans and goals. The interaction may involve specific
plans and goals, as in a medical appointment, or none at all, as in a casual interaction. Depending on the congruence between the parties, plans and goals of the interaction could range from win-win to lose-lose communication. Stimulus cues include appearance, situational context cues, and communication behavior. The preceding general concepts provide the foundation for how the other person is perceived and how attributes (interpretation) are assigned. These general concepts classify the mechanism for how social and intrapersonal variables — such as stigma — influence interpersonal relationships. How stigma affects the general concepts of an interaction depends on six dimensions: concealability, course, disruptiveness, aesthetics, origin, and peril (Jones et al., 1984).

**Concealability**

Concealability determines how observable a mark is to others. Concealability can range from nonconcealable, as in quadriplegia, to fully concealable, as in a history of mental health treatment. Even when a mark is concealable, fear of disclosure can affect the perceptions and social interactions of a markable person. For example, a markable person may experience hypervigilance toward cues of pending disclosure or avoid social situations in which disclosure is likely. Individual stigmatization requires that there be a loss of concealability. As long as a mark remains concealed, the affected individual remains a markable person rather than a marked person. Mental illness can be a concealable mark depending on its seriousness and the need for observable treatment. Concealable marks like mental illness can create tension in the work environment. This tension can develop between the fear of disclosure and the need to disclose in order to gain access to supports and services.
Individuals who attempt to conceal their stigma become preoccupied with stigma-related thoughts and tend to project those thoughts onto others (Smart & Wegner, 1999). The burden of concealment also impacts help-seeking behaviors. Those who self-conceal and do not share distressing intimate information with others are more likely to report needing help but not to seek services; even in the presence of severe distress (Cepeda-Benito & Short, 1998; Cramer, 1999). People who live in small communities and are concerned with loss of anonymity are more likely to identify negative stigmatized attitudes toward mental health services and avoid seeking treatment within their community (Hoyt et al., 1997).

Course

How a mark actually changes or is perceived to change over time constitutes the course of stigmatization. Social rejection is greater with a mark that is progressively disabling, chronic, and incurable, as is true of many mental illnesses. Additionally, as treatment efficacy decreases, the stigma associated with the mark increases. Effective treatments render a mark temporary and less stigmatizing in contrast to incurable marks that are strongly stigmatized. Jones et al. (1984) stressed that stigmatized beliefs about the course of a marked condition, such as major depression, have greater influence than actual symptom outcomes. Beliefs about how the mark had changed in the past as well as the potential for change in the future influence the perception of the mark. A dilemma for most concealable marks is that observable changes or improvements are not readily apparent.

In the case of concealable marks, beliefs by both the marker and the markable about the mark’s course will significantly influence interpersonal interaction. Marks that
are believed to be progressive, chronic, and treatment-resistant place a greater demand on protecting against self-disclosure than do less stigmatizing conditions. These socialized beliefs are internalized before an individual develops the marked symptoms and needs treatment. Upon beginning treatment, individuals must confront their own internal views of what it means to be a marked person and how their relationships to others have changed vis-à-vis the socialized construct of the mark (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Wahl, 1999). If an individual’s internal view is highly rejecting, based on stigmatized beliefs about the mark, that person may avoid treatment or seek indirect services. The beliefs about a mark’s course include the type of remedies that are used. Some remedies, such as mental illness treatment, may bear greater influence on social interaction than the markable condition itself. For example, even though a person is in good mental health, the fact that he or she had participated in mental health treatment may disqualify that individual from positions of trust and authority.

*Disruptiveness*

Jones et al. (1984) described disruptiveness as being dependent on the other five dimensions and contended that conceptually it may have limited usefulness. The disruptiveness of a mark refers to the degree to which it produces interaction strain. A disruptive mark is any condition that increases the uncertainty and unpredictability of an interpersonal interaction. A disruptive mark blocks or distorts normal communication patterns. Usually, disruptive marks are nonconcealable and are independent of attitudes. For example, holding a person who stutters in high or low regard would not change the disruptiveness of the stutter. Mental disorders, however, are marks that are both concealable and disruptive. The degree to which mental disorder behaviors are perceived
as unpredictable increases disruptiveness. Socially, behaviors that are frightening or disruptive elicit rejection and avoidance responses. In particular, symptoms of anxiety and social withdrawal tend to be disruptive of others by increasing communication ambiguity, initiating a hypervigilance response, and increasing social distance.

Social distance is created by stigmatizing labels through emphasizing an “us” versus “them” dichotomy (Morone, 1997). Additional negative attributes are easily assigned when stereotypes become the basis for the belief that negatively labeled people are significantly different (Link & Phelan, 2001). Ironically, as social distance increases, fear increases, which further increases stigma and adds even further social distance. Extreme stereotyping leads to dehumanization of the stigmatized group. Separation is reinforced through using labels that identify people as being what they are labeled (Estroff, 1981) — e.g., referring to a person as a schizophrenic or a psychotic. Social distancing also contributes to status loss and discrimination.

**Aesthetic Qualities**

The aesthetics dimension refers to the extent to which a mark makes the marked repellant or desirable. Aesthetic responses tend to be spontaneous affective reactions to a mark. This first gut response is based on an observable mark, such as scarring from a burn, and precedes cognitive and attributional responses. No direct connection exists between the mark of mental illness and aesthetic response. In the schema of stigma, however, a person who bears both an aesthetic mark and another mark will have increased social burden and stigma. In this way, the dimension of stigma can be additive and can result in varying stigmatizing responses to similar marks in different people.
The origin dimension refers to beliefs about how the mark originated, who was responsible for the mark, and what actions the marked person took to correct the mark. There is a burden of responsibility associated with the mark (Weiner, Perry, & Magnusson, 1988). When the marked person is not held responsible for the mark, as with a congenital condition, social interaction is more likely to focus on supportive behaviors. As the degree of perceived personal responsibility for the mark increases, the social interaction shifts toward punishing behaviors. Unfortunately, most laypersons do not understand that very few conditions have clearly identified causes and burdens of responsibility. In the absence of clear origins, markers form relevant beliefs from what information they do have. Some marks are highly associated with personal responsibility (e.g., addiction, obesity, crime). Ambiguity surrounds the origin of other marks (e.g., mental illness, high-risk sports injuries, misconduct-related injuries). Even though mental health research has described biochemical and neurostructural origins of many mental illnesses, the general public retains a high level of ignorance about the origin of those disorders (National Alliance for the Mentally Ill, 1999).

Marker response will vary depending upon their belief about the labeled group. Two attributes — controllability and stability — in particular are associated with blaming the marked person (Corrigan et al., 2000). Controllability reflects the belief that the stigmatized behaviors are somehow volitional or the result of choices that the person has made. Stability is the belief that the person receives minimal benefit from treatment and is unlikely to change behavior. Perceptions of low controllability and stability tend to
evoke pity and offers of help. Perceptions of high controllability and stability tend to evoke blaming and punishment.

Peril

The sixth dimension is peril. The perceived level of danger presented by the marked person determines the level of peril. The peril dimension is most closely associated with contagious diseases, violent criminals, and the mentally ill. Of the six dimensions, peril is the most likely to result in rejection of the marked person. Public perceptions of mental illness symptoms that are linked with a stereotype of dangerousness stimulate a desire for social distance and rejection of the marked person (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Another type of peril is transfer of the mark to people associated with the marked person. Goffman (1963) called this guilt-by-association phenomenon a courtesy stigma. For example, the loss of professional status of mental health professionals is due in part to their association with the mentally ill. Employers who have programs for hiring the mentally challenged face the risk of loss of business from customers who choose to avoid contact with marked persons. For military leaders, peril could include negative perceptions of their leadership skills when subordinates' behaviors produce negative publicity. For the mentally ill in the workplace, peril goes beyond willful harmful acts. Inattention, distractibility, or behaviors incongruent with organizational norms can cause injuries, failed product quality, or disrupted organizational functioning. The peril dimension represents a range of perceived dangerousness that can include acts of harm, sabotage, or neglect.
Stigma of Mental Illness

Mental illness stigma is a significant problem in the lives of individuals. Stigma can have a profound negative effect on self-esteem (Bradshaw & Brekke, 1999; Estroff, 1989), beliefs about a successful future (Corrigan, 1998), and the use of mental health services; it may also increase depressive symptoms (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001) (Mental Health Report, 1999). Negative mental illness labels have been identified as a basis for the devaluation of, and discrimination against, the mentally ill. Labeling is associated with demoralization, income loss, and unemployment (Link, 1987). When persons with mental illness attempt to protect themselves from the devaluation and discrimination of stigma by using the coping strategies of secrecy, education of others, or withdrawal, they often reinforce feelings of powerlessness (Link, Mirozink, & Cullen, 1991).

The main source of the effects of mental illness stigma on mental health comes from sociocultural beliefs and not from the behavior of the person with mental problems (Link et al., 1991). Specifically, official labeling of a mental disorder explained more variation than psychiatric symptoms in the association between devaluation-discrimination and poor mental health outcomes (Link, 1987; Link et al., 1989). Beliefs about the origin of mental illness symptoms, such as brain disorder, genetics, moral weakness, or inadequate coping, can create an additive burden (Weiner et al., 1988). For example, when mental illness is considered a disease, the marked person is not held responsible and is viewed as having limited behavioral self-control. Once identified with the sick role, marked people are perceived as having limited self-help ability; they are further marginalized and are seen as poor employees and accident-prone (Jones et al.,
1984). Unfortunately, changing how people describe a marked person does not reduce social distance between the marked and marker. Social distance, and the negative effects of stigma, are reduced as interpersonal familiarity increases (Penn & Corrigan, 2002).

Along with increasing social distance, stigma acts as a barrier to the mental health services needed to treat the stigmatized disorder. Stigma prevents the early use of mental health services (Amato & Bradshaw, 1985; Kushner & Sher, 1991). Therefore, people tend to enter the mental health system late, when symptoms are unconcealable and have begun to impact individual functioning. Unfortunately, mental illness symptoms are less likely to respond to treatment and more likely to further impair personal functioning when treatment is delayed.

In addition to prompting increased social distance and delayed help-seeking, stigma keeps people from getting good jobs and advancing in the workplace; it undermines their likelihood of obtaining adequate insurance coverage and results in prejudice and discrimination (Wahl, 1999). According to the former Surgeon General of the United States, David Satcher, “We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down” (Mental Health Report, 1999).

Stigma also influences the choices people make about the types of services they are willing to use. People who do seek help for mental and substance abuse disorders are most likely to receive care from general health sector medical services (6.4%), mental health specialty services (5.9%), voluntary self-help groups or family (4.1%), or human services professionals (3.0%) (Norquist & Regier, 1996). Even when treatment is successful, the mark associated with mental health treatment continues to negatively
impact an individual’s well-being through the burden of being labeled a “mental patient” (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997).

As a social phenomenon, stigma has a particularly strong impact on work relationships and organizations. Mental health problems in the workplace result in time off from work, decreased individual productivity, disruption of work-group productivity, personnel turnover, and increased training costs (Miller, 1998). Kessler and Frank (1997) evaluated the impairment in work functioning associated with mental illness. These investigators showed an average of 6 lost workdays and 31 low-productivity days per month per every 100 workers with mental disorders. These findings suggest that work environments with a high proportion of skilled and semiskilled labor will have significant reductions in productivity associated with mental disorders. In a longitudinal study of over 6,000 employees in three corporations, Druss et al. (2001) found that employees who met the threshold criteria for major depression were twice as likely as their nondepressed coworkers to miss work and seven times more likely to have decreased effectiveness. These studies show that untreated mental illness can have significant effects on workers’ productivity.

Corporate culture and climate can be both a source of employee stress symptoms and a moderator of symptom experience (Jones & Bright, 2001). Effective mental health programs for employees require that organizations demonstrate a positive approach to mental health through policies, procedures, and management decisions that are supportive, not punitive (Miller, 1998). Even though more organizations are recognizing the mental health needs of their employees, a risk to employment still exists once mental health services are used (Orvis, 2002). Stigma in the workplace reduces the probability of
being hired (Glozier, 1998) and the ability of managers to return to their former positions (Lehane, 1995); it leads to omission of illness status during job interviews, reduction in job responsibilities after disclosure, and increased social distance from coworkers (Wahl, 1999).

**Organizational Culture**

Organizational climate and organizational culture are two concepts used to describe the relationship between organizational environments and the individual. Organizational climate is a psychological construct of how environmental stimuli are interpreted by individual organization members (James & McIntyre, 1996). Organizational climate is accessible by direct measures of leadership, role stress, job challenge, and working relationships; it can be influenced by management and administrative activities (James & James, 1989). Organizational culture is a deep and complex construct that is foundational to organizational climate (Schein, 1990).

Organizational culture is defined as:

> . . . a pattern of basic assumptions — invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration — that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 1985, p. 9).

Organizational culture has three distinguishing components: observable artifacts, values, and basic underlying assumptions (Schein, 1990). Artifacts consist of the readily observable characteristics of an organizational environment. Artifacts include physical
layout, dress code, greeting rituals, documents that present mission, vision, guiding principles, and other symbols used to reinforce the organization’s unique identity. Values are deeper than artifacts and can include both overt and covert norms, ideologies, and philosophies. Values are inculcated during the process of orientation and experience with the organization. With reinforcement over time, values develop into deeply held assumptions. Underlying assumptions become nearly invisible in the organizational structure when they are not questioned or identified for discussion. Stigma is a form of underlying assumptions held by individuals and organizations. Leaders play a pivotal role in creating and maintaining organizational beliefs. Schein (1985) differentiates leadership from management by declaring, “[T]he only thing of real importance that leaders do is to create and manage culture[,] . . . the unique talent of leaders is their ability to work with culture,” p. 2. Understanding leaders’ perceptions is important when stigmatizing beliefs are part of an organization’s culture.

**Military Culture**

The organizational structure and culture of the U. S. military — as a subset of the American population — provide a unique opportunity to examine the interpersonal and organizational dynamics of mental illness in a working population. The U. S. military active duty forces comprise approximately 1% of the entire 18- to 45-year-old workforce. The active duty military workforce is geographically, ethnically, and educationally diverse, with stable, living-wage incomes and equal access to comprehensive health care. The nonmilitary workforce has great variation in corporate missions, values, geocultural influences, wages, and health care insurance — all of which confounds the study of stigma in the workplace. In examining the burdens and stigma of mental health problems
in the military population, confounding variables such as insurance parity, socioeconomic status, racial disparities, fluctuations in the labor market, and lack of provider access can be controlled to facilitate an enhanced understanding of how stigma acts in the workplace.

As an organization, the American military shares with the civil culture the values of democracy and the need to respond to changes in the global community. Unlike the civil culture that values individuality, liberty, and freedom of expression, however, the military culture values self-sacrifice, discipline, and conformity (American Military Culture, 2000). Uniforms and ritualized forms of greetings using an organization-centric language are the most clearly observable artifacts of the military culture. Service-specific core values are overt and are used in the training and acculturation of new members. The military culture uses an immersion rite of passage to orient new members to a hierarchical, youth-oriented, up-or-out structure that is dominated by combat leaders (American Military Culture, 2000).

Even though there are common cultural components to the military as a whole, each service has a distinct culture. Core values and underlying assumptions are unique to each service. The level of tolerance that each service has for members who have difficulty adapting to cultural expectations varies on the basis of recruitment and retention efforts. Depending on the available pool of recruits, the manpower needs of a service may conflict with core values and underlying assumptions about the qualities of a good service member by requiring that entry standards be lowered to meet recruitment goals. When entry standards are lowered, an increased number of people with underlying
mental health problems are allowed into the military (Gilmore, 2000; Klimp & Parks, 2000).

Consistent with Schein’s (1985) view of leadership, the responsibility for preserving, protecting, and changing the culture in each of the services is held by the leaders of individual units (American Military Culture, 2000; Beitz & Hook, 1998). The commissioned officers have a significant level of responsibility and authority to ensure that subordinates meet the expectations required in their professional and personal behavior both on- and off-duty. Unit-level commanding officers have direct power over subordinates’ day-to-day work environment and careers. Officers are both individuals and keepers of the military culture; thus, their beliefs about mental illness have a great potential to be reflected in their decision making.

Stigma in the Military

The pathogenesis of mental disorders is the result of a complex interplay between a person’s biological, psychological, and social systems (Engel, 1980). The demands inherent in the military social system can support or destabilize individual biological and psychological factors. Over 23% of active duty military members report high levels of work stress that are associated with lost productivity and increased risk of job-related injuries (Bray et al., 2000). Mental disorders are the leading cause of hospitalization of shipboard sailors followed by digestive illness, accidents, poisonings, and violence (Pugh, White, & Blood, 1989). Inpatient mental health admissions among Navy personnel have longer average lengths of stay compared with admissions for other medical diagnoses (Kilbourne, Goodman, & Hilton, 1988). From 1980 to 1994, 59% of
enlisted Navy personnel who were hospitalized for mental disorders were prematurely separated from the Navy (Gunderson & Hourani, 2001).

Service members experience attrition following hospitalization for mental illness for several possible reasons. Service members with thought disorders are medically discharged from the military. Members with early affective symptoms may delay seeking treatment until their symptoms are disabling. Those who are hospitalized may be systematically different from service members who are able to mask their symptoms in the workplace. Service members who do not adapt well to the military lifestyle may be referred for psychiatric evaluation as part of an administrative separation. Military psychiatric patients have a very high incidence of having co-occurring legal and administrative problems that can result in early discharge. Consistent with Lehane’s (1995) study, posttreatment military members may be downgraded on leadership and teamwork skills in their performance evaluations, resulting in diminished standing for competitive promotions. Finally, some military occupations have specific rules disqualifying anyone who has a mental disorder or who requires psychotropic medications.

The symptoms of mental disorders impair work and social functions, resulting in a burden on the individual, family, and Navy organization. In spite of the significant health impact of mental disorders in the U. S. military, mental health-related programs have not had the same organizational support as those devoted to smoking cessation, physical fitness, motor vehicle safety, and alcohol awareness. Mental illness stigma research with a military population, as a military personnel research priority, is sparse compared with stigma research outside the military. A search of published research and
unpublished military medical research reports yielded seven studies relevant to stigma. Two studies specifically studied stigma (Britt, 2000; Porter & Johnson, 1994). One study included a survey question on stigma (Bray et al., 2000). The remaining four studies had findings or discussions that reflected stigma effects as a potentially influencing variable (Hourani & Yuan, 1999; Knowlan, Arguello, & Stewart, 2001; McNulty, 1997; Rowan, 1996).

Porter and Johnson (1994) surveyed the attitudes of Navy and Marine Corps commanding and executive officers toward service members who had received mental health services. The authors concluded that the respondents were neutral in their attitude about the reliability and competence of those who had used mental health services. Unfortunately, this study has limitations that undermine the authors’ conclusions. The study was a self-report survey using a Likert scale ranging from “never” to “always,” with “sometimes” as the median mark; and it did not include a neutral measure. Theoretically, the authors chose “sometimes” to mean neutral. Yet the phrasing of some of the statements precluded a neutral answer. For example, “Is having had prior mental health care a factor in consideration for promotion?” (p. 604). The scale option of “sometimes” to this statement reflects an agreement with the statement rather than a neutral position. The potential for socially desirable responses by respondents is high given the amount of attention paid to eliminating overt forms of discrimination in the military culture. Additionally, 33% of the respondents included comments in the survey. Of the qualitative statements, 20% were negative toward the survey, and 10% were negative toward health care recipients, indicating that there may be issues not addressed by the survey questions. Finally, we still do not know what attributes military leaders
assign to recipients of mental health services and whether those attributes are used in decision making.

Britt (2000) studied the perception of stigma in Army soldiers returning from a peacekeeping mission. Returning soldiers were required to participate in physiological and psychological screening as part of their transition back to the United States. The findings showed several factors supporting the role of stigma associated with military mental health services. Service members believed that admitting a psychological problem would be more stigmatizing than admitting a medical problem. More than half believed that admitting a psychological problem would harm a military career. Those who screened positive for psychological referral experienced more concern about stigma than those who screened negative. Service members reported a lesser likelihood of completing a psychological referral than a medical referral.

The belief about career harm is an important clue to understanding stigma in the military. Authority over a service member's career resides with the commanding officer of that service member. Peers and immediate supervisors may be able to influence leaders, but they do not have career-level decision-making power. The Britt (2000) study implies that admitting a psychological problem would result in adverse action by service members' leaders.

The 1998 DoD survey of health-related behaviors among military personnel (Bray et al., 2000) identified underuse of mental health services, and it included a question about the potential for mental health counseling to damage a military career. Psychological counseling was an identified need by 18% of the sample. Of those who identified a counseling need, 5% received mental health care and 4% participated in
pastoral care. Regarding the perception of a negative career impact from mental health services, 20% believed that participating in mental health services would be career damaging, 60% were uncertain, and 20% believed that it would not be career damaging. It is unlikely that individuals would take a career-risking action if they were uncertain of the outcome of that action. Without a respondent demographic description, it is not possible to determine whether there were any common characteristics among the 20% of service members who were not concerned about negative career impact.

In a review of Air Force mental health outpatient referral patterns, Rowan (1996) found that self-referral rates were lowest for military students, lower-ranking enlisted, and personnel requiring a special duty status related to weapons or security clearances. Those service members who did self-refer for mental health services had less severe symptoms and were more senior in rank than those with involuntary referrals. Consistent with the differences in symptom severity, there were differences in career impact between self-referrals and involuntary referrals in terms of mandatory treatment (2% versus 94%), recommendation for career change (7% versus 69%), and recommendation for military discharge (5% versus 86%). For some people, increased symptom severity impairs personal functioning so much that they either seek help or are coerced into obtaining services (Lidz et al., 1998). In a military setting, a command-directed referral requires a leader’s concern about the service member’s safety. Hospitalization is appropriate if the presenting symptoms include suicidal ideation or psychosis. If a sailor is hospitalized for mental illness symptoms, an evaluation for continued service suitability is completed, thus yielding an increased risk of career harm.
Rowan recommended that the data can be used to “debunk the myths about mental health and encourage early help-seeking” (Rowan, 1996, p. 328). Rowan does not clearly point out specifically which myths are debunked by this data. The perceived risk of seeking mental health services is more than a myth. The data does support the idea that the risks associated with help-seeking increase with symptom severity. When symptoms are mild and do not meet a threshold of dangerousness, outpatient services can be obtained and the service member sent back to full duty. When symptoms are more severe or deemed incompatible with military service, however, the potential for career harm is significant. Military leaders base their final decision on whether or not symptoms are deemed incompatible for military service on a recommendation from mental health services. However, the beliefs and attitudes of military leaders toward mental illness are a factor in that decision. We do not currently know what beliefs military leaders hold about mental illness or whether those beliefs vary on the basis of the leader’s role and responsibilities.

Hourani and Yuan (1999) found that over 81% of active duty Navy and Marine Corps personnel with active disorders do not seek any mental health services. Highlighting the significant underuse of mental health services, the authors stressed the importance of “removing the stigma or perceived punishment associated with mental illness within the ranks and . . . address[ing] treatment and prevention issues without adverse consequences to a sailor’s or Marine’s military career” (p. 180). The idea of perceived punishment presented by Hourani and Yuan is consistent with leaders’ role in making decisions about subordinates’ careers. Organizationally, punishment decisions are restricted to the commanding officer. For example, a commanding officer can decide to
respond to a suicide attempt as though it were the punishable offense of malingering. Malingering, Article 115 of the Uniformed Code of Military Justice, is strictly a military offense involving avoiding work, duty, or service by faking illness, physical disablement, mental lapse, or derangement or by intentionally inflicting self-injury.

McNulty (1997) discussed the fear of identification as a possible contributor to a low (53.4%) response rate to a survey of Navy nurses in an eating disorder study. McNulty described those sailors with eating disorder diagnoses as having a low probability of remaining on active duty. She states, “Anorexia and bulimia will remain closet illnesses until changes within the military system occur” (McNulty, 1997, p. 706). Even though McNulty does not discuss specific recommendations for systemwide changes, it is clear that she perceives a career risk to military women who disclose an eating disorder problem.

In 2001, Knowlan et al. (2001) reported that the Navy has the capability to treat and retain sailors with a diagnosis of depression. The ability to provide treatment while keeping sailors on active duty was based on the efficacy and the mild side-effect profile of selective serotonin reuptake inhibitors (SSRIs). In addition to the efficacy of the medication, medical department personnel reported a favorable attitude toward prescribing SSRIs to active duty members. Sustained medication management would be unlikely without the support of Navy physicians in the clinics and general practice. A review of the responses by specialty showed that those physicians who are attached to combat commands and who provide medical consultation to commanding officers had the lowest use of SSRIs, and the lowest acceptance of active duty members who needed SSRIs, compared with psychiatrists, neurologists, internists, and family practitioners. The
results of this study highlight a possible disconnect between combat unit and hospital-based providers in their beliefs about mental health patients. Additionally, a favorable attitude by providers toward a prescribing practice does not translate to an acceptance of people with depression by military leaders. Given the importance of military leaders’ influence in a combat unit, the low acceptance and support of SSRI use among combat unit physicians may reflect the unit culture more than their professional beliefs.

There is no conclusive evidence to describe the extent of stigma in the active duty population or among commanding officers. There is enough evidence, however, to suggest that a belief about negative career impact from receiving mental health treatment is one of the factors contributing to the underuse of mental health services by military personnel. It is unknown why highly educated men and women believe that having common and expected mental health problems would put one’s career at risk.

Some insights can be drawn from the few studies of stigma in the workplace. As rank and leadership responsibility increase, so do the risks of seeking mental health services and the incentive to avoid treatment (Lehane, 1995). Service members in elite units with a strong “zero-defect” value system are unlikely to seek services. As treatment is delayed, with a subsequent increase in symptoms, there are increases in seeking general medical care, the number of low-productivity days (Druss et al., 2001), requests for personal time and transfers (Miller, 1998), domestic violence (Kelleher et al., 1994), marital instability (Kessler, Walters et al., 1998), and motor vehicle accidents (Rice et al., 1990). In many ways, places of employment and military commands are like small communities. The informal communication networks in small communities increase the risk of disclosure following use of mental health services (Hoyt et al., 1997). Potential
sources of stigma are found within the social context of relationships in those communities.

Proposed sources of stigma and barriers to use of Navy mental health services include (1) individual beliefs about mental illness and anticipation of stigmatizing responses; (2) command leadership beliefs about the role of mental health services, the competence of former patients, and leadership responsibility to the needs of the Navy (command cohesion and integrity); (3) coworker and first-line supervisor beliefs about and behaviors toward mental health issues; (4) naval personnel and health care policies that use mental health services as a mechanism for administratively discharging "undesirables"; and (5) loss of privacy resulting from a commanding officer’s need to know about their subordinates’ health status. The one potential stigma source that is directly related to the fear of adverse career impact consists of the beliefs of military leaders about mental illness and the role that military mental health plays in maintaining military readiness.

Coinciding with resistance to participation in military mental health services is an increasing body of knowledge indicating that early mental health intervention for stressful and traumatic events reduces the incidence and severity of psychopathology. Increasingly, mental health teams are deployed with combat units. The effectiveness of operational mental health promotion will depend, in great measure, on the beliefs of military leaders about mental health services and of the service members who participate in those services. It is important that military mental health providers and health policy leaders understand the perceptions of military leaders toward mental health services and toward their subordinates who use those services.
Conclusion

The social stigma theoretical framework by Jones et al. (1984) provides a foundation for understanding stigma in the context of social relationships and influencing dimensions. According to Jones et al., the dimensions of social stigma vary according to the type of relationship that exists between people. Hierarchical relationships, such as those in work and military cultures, are role-based and have formal power structures that place one person in authority over another. Theoretically, stigma has the potential to impact individuals and organizations through the leader’s beliefs about mental illness and mental health services. The extent to which a leader’s beliefs result in individual action or corporate policy will depend on the nature of the stigma in the following dimensions: concealability, course, disruptiveness, aesthetic quality, origin, and peril. In this review of the literature, the social stigma theory provided a lens through which to focus attention on the relationship between organizational leaders and the influence of stigma in the workplace.

Stigma has been the focus of study for social scientists since the early 1960s. This body of literature has enhanced understanding of the impact of stigma on marked individuals, interpersonal relationships, and help-seeking. Only recently has the study of stigma in the workplace emerged as a topic of interest (Glozier, 1998; Lehane, 1995; Orvis, 2002; Wahl, 1999). These studies demonstrate that stigma does have a negative impact on workers with mental health problems and the availability of employer-supported services. How stigma becomes transformed from a belief to an organizational action is unknown. The most likely process is through the actions of corporate leaders in their role as managers of the corporate culture. As in the civilian workplace stigma
literature, stigma research in the military is just beginning. What we know from the two military stigma studies is that military members believe that participating in mental health services will harm their careers and that the beliefs of military leaders have not been adequately studied. Given the role that employers have in influencing access to mental health services, it is important that social scientists systematically expand the body of knowledge about stigma in the workplace.

Stigma in the military has its greatest effect on the willingness of those experiencing mental distress to seek out timely and perhaps preventive treatment. Stigma delays help-seeking, and that delay inflates the cost of treatment and increases attrition from the military after hospitalization. The needless suffering of service members with mental disorders and occupational stress will continue to be a major problem as long as most people who need mental health services actively avoid treatment.

Improving access and use of clinical services for even one of the major military mental health problems would have substantial impact. For example, major depression is one of the leading causes of mental illness disability in the military. Treatments for depression are available and have increased efficacy when started early in the course of illness. Civilian studies show that the treatment of workers for major depression results in significant improvements in the number of days worked, work productivity, and job retention. Additionally, disability claim savings reduce treatment costs for most employers. Improving access and clinical outcomes will require organizational change.

The first step in developing strategies to reduce barriers to treatment is to understand the types of barriers that exist and their sources in the military community. The scant literature suggests that fear of career harm is one of the major barriers to help-
seeking in both civilian and military populations. Documenting the beliefs regarding
mental disorders and their treatment of those who hold power to affect the military
careers under their command is one means of determining how well founded this fear is.

This study is significant because it will examine the organizational climate and
acceptance of mental illness at the command level where decisions about subordinates’
careers are made. The following research questions were proposed to understand military
leaders’ perceptions of mental health problems:

1. What are the perceptions of military leaders regarding mental illness and
   mental health treatment in the military organization?

2. What are the perceptions of military leaders regarding subordinates who have
   participated in mental health services?

3. What are the perceptions of military leaders regarding the impact of mental
   health services on a subordinate’s career?

4. What are the perceptions of military leaders regarding barriers to mental health
   treatment?
CHAPTER THREE:

METHODS

The purpose of this study was to analyze the language, knowledge, and values of Navy leaders about mental illness and mental health treatment using discourse analysis. Negative attitudes that stigmatize members of the military are a social problem that affect individuals, family systems, and the Navy organization. In this context, stigma is an ideology linked to the social practices in these institutions. The language, perceptions, values, and social practices that communicate an ideology form a discourse. Discourses provide verbal or written texts that are analyzable material for social research. Discourse analysis will form the methodology for this study.

Design

Discourse analysis is a qualitative method of inquiry based in the theoretical influences of critical social theory, postmodernism, Foucault’s work on social power, and feminism (Powers, 2001; Titscher, Meyer, Wodak, & Vetter, 2000). The method focuses on the sociocultural and political contexts in which text and talk occur. Discourse analysis is concerned with the critical analysis of the use of language and the reproduction of dominant ideologies (belief systems) in a social context. Discourse analysis adds an approach to understanding the relationship between language and ideology by exploring ways that theories of reality (e.g., mental illness) and power relations (e.g., employer/employee dynamics) interact as social practice (e.g., stigma in the workplace).

Discourse analysis is a relatively recent research method and is still developing (Titscher et al., 2000). Currently, procedures of data collection and analysis vary.
depending on the subject and purpose of the research. For example, a discourse analysis using Fairclough’s (1993) method would be a cross-sectional analysis of a discourse in a specific social practice, while a study of discourses over time would use Wodak’s (1996) historical method (Titscher et al., 2000). Foucaultian-based discourse analysis considers how historical and cultural power/knowledge forms discourses. The power/knowledge of a discourse is an active process that gives words meaning, influences perceptions, facilitates comprehension, and guides interaction (Denzin & Lincoln, 2000). This study used Foucault discourse analysis procedures described by Powers (2001) to unveil Navy leaders’ patterns and meanings in text regarding mental health problems and mental health treatment.

Foucault’s poststructural philosophy of discourses is used in this study as a theoretical lens (Dreyfus & Rabinow, 1982; Foucault, 1972; Foucault & Gordon, 1980; Foucault, Rabinow, & Rose, 2003). Foucault described discourses as groupings of signs or symbols (statements) that suggest a consistent pattern in how they function as constituents of a system of knowledge. The patterns of statements form the discursive practices, the actions and objects, in a discourse. The system of knowledge is a form of power that acts as a sphere of influence over language, perceptions, values, and social practices of participants in the discourse. Discourses function to fulfill a social purpose and to maintain social order by authoritatively describing normative expectations propagated by specific institutions. These normative expectations divide the world in specific ways (e.g., medical, legal, psychological) and function as an internal control over what discursive practices are allowable or rejected within the discourse. A Foucaultian discourse analysis aims to enter a discourse in order to determine the rules that govern it.
and to describe various relations among discursive practices. One of the goals of a discourse analysis is to identify new conditions of possibility for social transformation and learning that become available when a discourse is visible and expressible.

Foucault's (1972) own text on discourse formations used descriptions that included sphere, space, surfaces, transformation, and dispersion. A useful metaphor for understanding the conceptual unities that form a discourse is a glycerin bubble. A discourse, like a bubble, can have various dimensions. A single bubble attempts to define itself and maintain its structure by constantly shifting its molecular surface. An outside observer peering through the bubble perceives objects within and beyond the bubble differently than if the bubble were not there. When bubbles meet, they are mutually and simultaneously both attracted and resistant to each other. The surfaces of the two bubbles merge to create a structure that joins and defines a new structure. When we look within or through the bubbles at the point where they merge, the perception is different from looking through one bubble or no bubble. Figure 1 is a representation of the spheres of discursive unity. The surfaces of emergence in the discourse under study are the surfaces where foundational discourses share concepts. These shared concepts are shaped by the subjects of the discourse into the discursive practices of the discourse under study.
A caveat is in order for reading a discourse analysis. Foucault used common words (such as *genealogy*, *archeology*, *power*) in uncommon ways to expand the boundaries of investigation and thought (Foucault et al., 2003). Appendix A is a glossary of key discourse analysis terms used in this study. A Foucaultian discourse analysis will not provide absolute answers to a specific issue. Instead, it enables the understanding of conditions behind the issue to highlight its essence and assumptions. By making the issue's assumptions explicit, the discourse analysis tries to enable us to gain a comprehensive view of the issue and ourselves in relation to that issue. Discourse analysis is meant to provide a greater awareness of the hidden motivations of others and ourselves. Greater awareness enables us to solve concrete problems within the issue, not by providing unequivocal answers, but by making us ask ontological and epistemological questions.
The Powers (2001) method discourse analysis has three components: genealogy, structural analysis, and power analytic. The genealogy emphasizes the foundational discourses that provide legitimacy to the discourse under study. The structural analysis identifies forms of knowledge, authority, and values or justification related to the discourse. The power analysis uses text that describes resistance practices and the web of power relations in the discourse.

**Genealogy**

The genealogy identifies discourses that form the foundation for the discourse under study. The foundational discourses are bodies of knowledge that make the current discourse possible, contribute normative expectations within the discourse, and form the basis for how the discourse exercises its norms (power relations). For example, a discourse on training nurses would include influences from the foundational discourses of medicine, education, and professionalism.

**Structural Analysis**

A discourse's sphere of influence is identified by situating concepts, rules, and authorities in three axes. The axis of knowledge identifies discourse subjects, grids of specification, and discursive practices. The axis of authority identifies who has the right to speak in the discourse and systems of discourse preservation, exercise, and reproduction. The axis of value or justification identifies the "technologies of power" used in the discourse and the influence of foundational discourses identified in the genealogy.
Axis of Knowledge

Foucault uses the term *power/knowledge* to highlight the fact that every description also regulates what it describes (Foucault, 1978). The very terms used to describe something reflect power relations. Discourses promote specific kinds of power relations, usually favoring the professional using the discourse (e.g., lawyer, psychiatrist, professor, doctor). Knowledge is used to participate in webs of power within the discourse. Foucault and others have suggested that subjectivity can be seen in a twofold sense: being a subject and being subjected to. Subjects are people who are participants in the discourse. According to Foucault, the agency of a subject lies in the constant interplay between strategies of power and resistance, not in the self-consciousness of the subject.

The systematic ordering of discourse concepts is called a grid of specification. Taxonomies represent the most readily apparent form of a specification grid. The DSM-IV-TR is an example of a grid of specification in the psychiatry discourse. Grids of specification facilitate the focused application of knowledge within a discourse. For example, people are evaluated by mental health providers using the taxonomy of the DSM-IV-TR when their behavior is not consistent with expected social norms. The label of a particular mental disorder is applied to people whose behaviors match a predetermined pattern in the taxonomy. Once labeled, the person then enters a discourse where options and expectations are expanded (e.g., treatment options) and restricted (e.g., stigma).

Discursive practices are autonomous and rule-governed speech acts that occur at points of choice in a discourse (Foucault, 1972). The discursive practices that emerge in a discourse are limited by the axis of authority. The common characteristics of authority
structures include requirements for membership, structured rules, a body of knowledge and practice, and authority recognized by government, law, and public opinion. In practical terms, discursive practices are concepts that identify points in the discourse where the subjects exercise power/knowledge to influence others. For example, a spouse may suggest marital counseling with a pastor rather than a psychologist to reduce resistance related to stigma while promoting a change in the relationship through counseling.

Dominant discursive practices are identified by examining meaningful speech acts that engage multiple foundational discourses and grids of specification. Specific procedures for identifying discursive practices were not available in the literature. The density of interconnections between meaningful speech acts and discourse structures was used to identify discursive practices. The identification process was completed in two stages. First, categories identified from the interview and policy content analyses were further analyzed for their relationship to the subjects, authority structures, and grids of specification. For a category to be considered as a discursive practice, it needed to show a relationship with at least one subject, authority structure, and specification grid. Second, the dominant discursive practices were identified as those practices that had the highest relationship density. The influence of stigma on leaders’ attitudes about mental illness and subordinates who used mental health services would be considered a discursive practice.

_Axis of Authority_

Authority in a discourse is a form of rule about what can be said and who can speak within the discourse. The discursive rules determine how discursive practices...
appear, who is allowed to speak, and the proper form of discourse concepts. The appearance of discursive practices is influenced by institutionalized text and prohibitions of certain statements (groupings of signs or symbols). Institutionalized text can include the taxonomies identified in the grids of specification, written policies, and organizational norms. Speaking and writing positions in a discourse refer to who can use the discursive practices with authority, speakers' credibility, ways of speaking, and acceptable sites for speaking within the discourse. Speakers do not control the discourse. They are part of the discourse. The third type of axis of authority rule is the proper form that discursive practices must take to be accepted as knowledge and how imperfections in the discourse are resolved. The proper formation of discursive practices depends on the interaction formality. For example, a person will talk about his or her mental health problems differently when talking with a job supervisor than with a close friend or family member.

Axis of Value or Justification

Foucault used the term *bio-power* to refer to people as subjects in a network of practices and discourses (Foucault, 1978). Bio-power is exercised through technologies of power and disciplinary techniques to manipulate the social environment to maintain social norms. The legitimacy of how bio-power is used on people and other discourses is justified by the social value of the discourse. For example, the social value of the medicine discourse is the application of scientific and professional knowledge for the health benefit of people who cannot meet their own health needs (Powers, 2001).

Foucault defines *technologies of power* as disciplinary tools or practices "which determine the conduct of individuals and submit them to certain ends or domination (Foucault, Martin, Gutman, & Hutton, 1988, p. 18)." The concept of tools and practices

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includes the use of social constructs — such as laws, regulations, social class, and professionalism — that leverage human behavior. The disciplinary techniques of biopower function to form people who are obedient to the rules and expectations of the discourse. Disciplinary power is organized around norms and managed by experts who are guided by knowledge from the foundational discourses. Foucault (1995) outlines four disciplinary techniques that forge obedience in institutions such as prisons, schools, hospitals, and the military. The mechanisms through which a discourse exercises discipline include the spatial distribution of individuals, a controlled prescription of activities, organized stages of training, and a general coordination of links between the discursive practices.

*Power Analytic*

In Foucault's conceptual framework, "power is not a thing, an institution, an aptitude or an object (Foucault, 1978, p. 93)." Foucault's use of the word *power*, like his definitions of *genealogy* and *archeology*, is not the common-language use that refers to a concentrated ability to influence or resist others. Foucault rejects what he calls the "juridico-discursive" representation of power, which portrays power as something that restrains individuals and the state (e.g., laws and regulations) and that protects the rights of citizens (e.g., a bill of rights) (Foucault, 1978). Power is a productive network of relations within a discourse that works through people to create norms of what is right or wrong, acceptable or unacceptable; and of what can be considered truth (Foucault & Gordon, 1980). Power as a discourse relation is limited by the discourse boundaries. It is interwoven with other relations (e.g., family, work, peer) and has many forms; it is not limited to reward or punishment, is relatively coherent in support of the discourse values,
and needs resistance. Ultimately, power resides in, and serves to promote, the core discourse values.

Because power relations are adaptive and normative, they are not readily apparent in a discourse. Like the process of identifying an illness, identification of power relations is based on observing symptoms. Resistance reactions represent the symptoms of power. Resistance to a discursive relation is not negation of power but, rather, an exercise of power to challenge or modify the discourse’s normalizing influence. The purpose of the power analytic is to identify the dominant web of power relations and resistance practices in a discourse.

Resistance Practices

According to Foucault, power relations are best understood through the forms of resistance they generate (Dreyfus & Rabinow, 1982). Because power relations are used to normalize thought and behavior in a discourse, resistance can be viewed as an act of autonomy within a structured set of institutions and practices. People respond to power relations that are embedded in situations occurring in their present circumstances rather than to the discourse as a whole. Resistance, then, is a form of creativity of a free person within the discourse that serves the needs of the individual rather than the norms of the discourse. Foucault’s concept of a free person refers to a person in the discourse who has a range of available responses, “...insofar as they are ‘free.’ By this we mean individual or collective subjects who are faced with a field of possibilities in which several kinds of conduct, several ways of reacting and modes of behavior are available...” (Foucault et al., 2003, p. 139). Characteristics of resistance practices in a discourse include a person who
is free to make choices, an expression of autonomy from norms in the discourse, and part of the social network.

Web of Power Relations

Power relations are most evident at the surface of a discourse (known as the web of discursive possibilities) where the discourse represses subjects (Dreyfus & Rabinow, 1982). Repression is not an action of force but, rather, an action of influence toward compliance with the discourse norms. Foucault defines a power relation as “a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on possible or actual future or present actions” (Foucault et al., 2003, p. 137). A power relation has two defining elements. First, the person on whom the power is exercised is free to act and maintains his or her agency within the discourse. Second, the exercise of power is not on the person but on potential actions. A power relation can expand or constrain, facilitate or impede, and incite or inhibit the possible field of actions. Repression as social struggle in a discourse can take the form of domination, exploitation, or submission (Foucault et al., 2003). Domination is an asymmetrical distribution of influence (e.g., ethnic, social, or religious mechanisms) where the conduct of others can be directed in a consistent and replicable manner. Exploitation is the influence that separates individuals from the products of their work and creativity. Submission of subjectivity is influence over individual identity or agency as a subject in the discourse. Foucault claimed that struggles against domination and exploitation have not disappeared, but that the prominent struggle is against the submission of subjectivity.
One of the many challenges in analyzing power relationships in hierarchical organizations, such as the military, law enforcement, or emergency services, is that discourse power relations can include governing (person-on-person) forms of domination and power-over others (Patton, 1994). Governing forms of domination and power-over may or may not be part of the power relations in a particular discourse within these organizations. Domination in a hierarchical organization usually occurs in the form of direct orders by a person with legitimate authority who can compel a subordinate to take a specific action. This is still a form of power relation because the subordinate retains the freedom to refuse to obey or can question the legality of the order. The linguistic and behavioral communication of domination usually has a narrow form with constricted boundaries: I (organizational position of power) order you (clearly stated subject of domination) to stow the fire hoses (definable action or outcome). There is a high degree of reliability that the subject of domination will complete the required action in a specific manner.

Unlike domination, power-over interaction does not always result in modification of the subject’s actions. Common power-over actions can include, but are not limited to, teaching, advising, providing emotional support, or distributing resources (e.g., work assignments, duty schedules, training opportunities). Within hierarchical organizations, power-over interactions tend to be formalized with supervisory roles. Power-over linguistic and behavioral communication does not have a clear form or boundaries. A power-over interaction could include a supervisor’s informal request that a subordinate get a cup of coffee or a highly structured, formal, performance evaluation counseling
session. A person, as an acted-upon subject, in a power-over interaction is free to choose from a wide range of responses that can produce variable outcomes.

Discourse Sampling

The methodology of discourse analysis assumes that concepts, study participants, and the cultural system are bound in a social context (Phillips, 2001). Many forms of sociocultural representations are potential sources of text for analysis — for example, laws, social policies, informational and entertainment media, and people. The text in this study came from semistructured interviews and organizational policies. These two data sources provided sufficient text to enhance understanding of Navy leaders’ patterns and meanings regarding mental health problems and mental health services.

Interview Sampling

In its broadest context, sampling procedures in qualitative studies are either theoretical or purposeful (Coyne, 1997). Theoretical sampling is a process in which the sources of information to be sampled are determined as data is being collected, coded, and analyzed. In purposeful sampling, sources of information are selected according to the a priori aims of the study and their potential as information-rich cases. Several purposeful sampling strategies exist (Patton, 1987; Sandelowski, 1995). This study used purposeful sampling for demographic homogeneity in order to focus on the subgroup of Navy leaders.

Informational considerations, not statistical ones, determine the size of the sample in purposeful sampling. The goal is to maximize the informational content to the point of redundancy (Lincoln & Guba, 1985). The end-point for sampling to data redundancy
occurs when the inductive data analysis process of unitizing and categorizing does not produce any new categories.

The interview sample frame included all Navy commanding officers, executive officers, and command master chief petty officers of surface fleet ships in southeastern Virginia that have between 200 and 1,300 assigned personnel. The geographical area of southeastern Virginia was within the range of feasible travel for conducting the interviews and is the homeport region of the largest concentration of U. S. Navy vessels. As Navy leaders, commanding officers, executive officers, and command master chief petty officers of naval units represent role-based positions that have formal organizational and cultural power over the careers and job assignments of subordinates. This is consistent with the role-based power relationship in the social stigma theory (Jones et al., 1984). These leaders are most likely to translate their beliefs about mental illness and mental health services into command decisions that affect careers (Jones et al., 1984; Schein, 1985).

The interview sample was limited to surface fleet leaders because they supervise the largest population of sailors in the Navy and because their crews range, in occupational skills, from young sailors without technical training to highly skilled senior sailors. Additionally, surface fleet personnel do not have the additional psychological screening requirements of submarine, air, or elite combat unit personnel that may influence leaders' perceptions of mental health problems in those specialized units (Navy Enlisted Occupational Standards, 2003; Navy Officer Classification, 2003).

The direct influence of top leaders in an organization becomes more diffuse as the number of personnel increases and more personnel management decisions are made by
midlevel managers (Gibson, Ivancevich, & Donnelly, 1988). Naval units with less than 1,300 personnel were used to increase the likelihood that the informants in this study were in a position to make direct decisions about subordinates' careers.

Of the ships in the surface warfare fleet, 92% had a crew size of less than 1,300, and that crew size was a natural cutoff for the next larger ships, which have crews of more than 3,000 personnel. Vessels with crews of less than 200 were excluded due to crew screening and mission requirements that significantly differ from larger surface combat vessels.

As of November 2003, there were 50 naval surface fleet units with 200 to 1,300 crewmembers assigned to a homeport in southeastern Virginia, with 40% of the fleet away from homeport (Naval Vessel Register, 2003; Status of the Navy, 2003). Selection bias related to the deployed ships is unlikely because the deployed and homeport ships are not systematically different. The Commanding Officer (CO), Executive Officer (XO), and Command Master Chief (CMC) in each of the 30 remaining fleet units provided a potential informant pool of 90 Navy leaders. The eligible and accessible population for this study was calculated using Porter's method of population estimates (Table 2) (Porter, 1999).
Table 2

Estimate of the Eligible, Accessible Population

<table>
<thead>
<tr>
<th>Parameter for inclusion</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fleet Surface Units in Geographical Area</td>
<td>72</td>
</tr>
<tr>
<td>b. Ships with 200-1300 personnel</td>
<td>50</td>
</tr>
<tr>
<td>c. Not deployed (60% of b)</td>
<td>30</td>
</tr>
<tr>
<td>d. CO, XO, CMC (3 times c)</td>
<td>90</td>
</tr>
</tbody>
</table>

Every effort was made to include women and minority Navy leaders in the sample. Children were excepted. There are few women in senior leadership roles in the fleet because of past federal laws restricting the roles of women in the military (Thompson, 2000). In 1994, women were allowed as crewmembers on selected combat vessels. It was not until 2000 that the first woman took command of a surface combat ship. By 2005, the Navy is projecting that 12% of surface fleet crews will be women. At this time, oversampling of women fleet leaders was not feasible. Minorities make up more than 18% of the Navy officer corps (2001-2002 Military Almanac, 2002). The percentage of minorities available in the sample frame should be consistent with that of the overall Navy population. More precise estimates were not possible because public knowledge of the race or gender of a ship's senior leadership was restricted.

Individual Rights and Safeguards

The University of Virginia Social and Behavioral Sciences (SBS) Institutional Review Board (IRB) review and authorization were obtained before subjects were recruited. In addition to the requirements set by the SBS IRB, this study was reviewed for
compliance with Navy research policies by research coordinators in the Bureau of Naval Medicine and Bureau of Naval Personnel (OPNAVINST 5300.8C, 2002). After obtaining both the SBS IRB approval and verification of Navy policy compliance, a request for approval and endorsement from a senior officer responsible for the participants was obtained. A copy of the approvals and endorsement letter were available to all participants.

Participation in this study was voluntary. All participants received and signed an informed consent (Appendix B). The endorsement by the Navy authority that approved participant recruitment for the study provided proof of authorization and was not coercive. The study description included the SBS IRB approval stamp. All study personnel completed the most recent SBS IRB training in research ethics before IRB approval was requested.

There were two additional safeguards against potential coercion. First, I was not in the chain of command and did not hold positional authority over the participants. Second, the participants represented the senior leadership in their respective commands and organizationally were the least vulnerable to research coercion of the entire crew. Refusal to participate would not result in adverse effects on any participant. I did not know the name of any participant until the participant agreed to further contact. Participant anonymity and personal privacy were guaranteed and safeguarded. Personal descriptive information (e.g., name, rank, command, position) was kept in an encrypted file separate from the collected data. The interview text was identified with a random three-digit code that was not linked to the participant’s identity. The voice recordings
were deleted after verification of the written transcript. No participant chose to withdraw from the study.

Recruitment

Recruitment of the study participants used the Dillman (2000) tailored design method of survey contact. The first contact introduced the study and established the legitimacy of the survey originator. Study participants were removed from the contact list as they volunteered. Initial contact letters were sent to the official electronic mailing addresses of every member in the sample frame whose ship was in the accessible geographic region during the time of the study. The electronic mail included a description of the study, endorsement letters, and how to enroll in the study. The recipients chose to ignore the request or to contact me by electronic mail or telephone to obtain more information about the study, to enroll, or to decline.

Only the initial contact was required due to the enthusiastic response of the participants. Ninety recruitment electronic mail messages were sent, and 11 were returned as undeliverable. Of the 79 delivered electronic mail messages, there were 25 responses, for a 31.6% response rate. There were no follow-up contacts for the undelivered electronic mail messages or for nonresponders.

The final interview sample included 19 Navy leaders: 8 Commanding Officers, 7 Executive Officers, and 4 Command Master Chief Petty Officers. Total years of service ranged from 13 to 29, with an average of 20.21 years. The number of times they had experience in their current role ranged from 1 to 5 times, with a mode of 2 tours. All the participants had at least some college, and 14 had one or more master’s degrees. The majority of participants were married (90%) and male (95%). The participants’ self-
reported racial groups were Caucasian (85%), African American (10%), and Hispanic (5%).

_Policy Documents Sampling_

The sampling strategy for the policy documents started with a keyword search of current, unclassified, public domain Department of Defense (DoD), Chief of Naval Operations (OPNAV), Bureau of Naval Personnel (BUPERS), and Bureau of Medicine and Surgery (BUMED) policies for the following terms: _mental health, psychiatric, psychiatry, psychology, _and_ limited duty_. Unclassified public domain personnel policies are the only policies that would influence surface warfare leaders' decisions about mental health services. The goal of the keyword search was to identify all possible current Navy policies that would provide text related to naval mental health services and the structures of knowledge, authority, and value/justification. *Mental health* is a global term used to identify clinical services and health promotion activities. A preliminary search demonstrated that the term _mental health_ included all policy documents that used the term _mental illness_ or _suicide_. The terms _psychiatric, psychiatry, _and_ psychology identify policies related to the interactions between Navy leaders and mental health providers. Currently, mental health nurses, social workers, and clinically trained chaplains are not authorized mental health providers.

From a pool of 6,113 policy documents, 355 documents met the keyword criteria. After eliminating 66 duplicate documents, 289 documents were obtained for further review. Next, 258 documents were excluded that did not inform or guide Navy leaders about mental health or illness issues for active duty sailors in the fleet. Most of the excluded policies were related to the assignment of mental health personnel, family
programs, and medical practice. Each of the 31 policy documents retained for the study was saved as digital data to facilitate text-based analysis. Appendix C is the list of obtained documents.

Measures

Interviews

Interviews of Navy leaders consisted of semistructured questions, responses to hypothetical vignettes, and demographic questions (Appendix D). The Jones et al. (1984) social stigma conceptual framework formed the basis for the interview questions. The social stigma framework components with the greatest relevance to this study are the leader’s expectancies, plans and goals, perceptions, illness course, and perceived peril. These components therefore have the greatest number of related questions. The component of aesthetic qualities has no associated interview questions because mental illness is a concealable stigma without a characteristic physical disfigurement. Appendix E is a cross-reference between the social stigma conceptual components and the interview questions in Appendix D. The semistructured questions focused on the respondent’s leadership role and beliefs about mental illness without a specific context. Because stigma occurs within a social context, context-free questions can produce a discourse without reference points. This study used vignettes to create common points of reference for the discourse.

In the literature, two types of vignettes are used to assess a subject’s beliefs about mental disorder symptoms. One strategy is to compare responses to vignettes that represent a model case and a contrary case. Glozier (1998) used vignettes of depression and diabetes symptoms to evaluate perceptions of employability by corporate personnel.
officers. Another strategy is to use vignettes of related cases to assess responses within a phenomenon. Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) used randomly assigned vignettes of alcohol dependence, major depression, schizophrenia, drug dependence, and a troubled person in semistructured interviews of the general public to assess recognition of mental illness, beliefs about causality and dangerousness, and desired social distance. The vignettes in the Link et al. (1999) study were developed from Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostic criteria. The vignettes used in this study were modeled after those in the Link et al. (1999) study.

The most frequent mental health conditions in the Navy are alcohol abuse, adjustment disorders, mood disorders, and personality disorders (Hoge et al., 2002). To create a plausible context for the text, the vignettes needed to be consistent with the experiences of a sailor returning to duty after mental health evaluation or treatment. This plausibility necessitated the exclusion of vignettes about people with mental health disorders who have significant impairment of functioning, such as sailors with a thought disorder or severe major depression, and who would not return to duty. Vignettes of abusers of substances other than alcohol were excluded since they would not return to duty because of the military’s zero-tolerance policy on illegal drug use. Even though alcohol abuse is the most prevalent DSM disorder in the Navy, it was excluded as a vignette for this study. Alcohol abuse screening, diagnosis, and treatment in the Navy are culturally and administratively different from those activities for all other mental disorders (Mission of Drug and Alcohol Program, 2002). Alcohol abuse is outside the purpose of this study because it has a unique discourse that is organizationally different.
from those of other mental disorders. For example, the Navy drug and alcohol program has separate facilities, staff, and policies from those of mental health services.

Following the Link et al. (1999) method for constructing vignettes, three vignettes were developed to reflect sailors with a nonspecific personality disorder (Troubled Person vignette), adjustment disorder with depressed mood (Adjustment Difficulties vignette), and major depression (Depressive Symptoms vignette) (Appendix D). Each of the vignettes described symptoms of a mental disorder in a narrative format to engage the interviewee and concluded with the described person returning to active duty. Knowlan et al. (2001) reported that sailors can return to full duty while taking SSRI antidepressants. Specifically, the major depression vignette was modified to include a sailor returning to full duty with a prescription for SSRI antidepressants.

Perceptions of gender, race, age, and socioeconomic status are factors with a potential influence for stigmatizing beliefs (Goffman, 1963; Link & Phelan, 2001). Link and Phelan (2001) randomly varied demographic descriptors in their vignettes to avoid introducing a bias based on race, gender, or education level. Their study found little effect for responses to vignettes with different demographic descriptions. Based on Link and Phelan (2001) findings, the vignettes in this study were written as gender- and race-neutral while holding socioeconomic status constant. The main character in each of the vignettes was a sailor with the generic rank of Petty Officer. The petty officer descriptor was used to represent a person who has some measure of career success and supervisory responsibility and who frequently has had technical training. Furthermore, a petty officer would be viewed as having career potential and would be subordinate to any member in the sample frame.
Face validity of the vignettes was tested with Navy officers and mental health providers. Fleet Navy officers reviewed each vignette for typical case representation as one test of face validity. Frequently, the study participants commented on the accuracy of the vignettes and provided feedback on how to improve them for future use. Vignette content validity was based on review by mental health providers who read the vignettes for closeness of fit to DSM diagnostic criteria.

The demographic questions were the final interview element. Demographic factors that may be relevant to a leader’s perception of mental health services and subordinates’ use of those services included years of military service (i.e., organizational commitment), leadership experience, personal mental health services experience, race, and gender (Corrigan & Penn, 1999; Das, 2001).

Procedures

Interviews

Participants who volunteer to be interviewed in this study were provided full disclosure of the study’s intent, why their participation was desired, potential risks and benefits, permission to record their interviews, and a consent form. All of the interviews were conducted as a face-to-face meeting at a time and location convenient to the participant. All but one of the interviews took place aboard the ship where the participant worked.

Before the interview began, I reviewed the purpose of the study, stated what the participants were expected to do, ensured that a signed informed consent was completed, and solicited any questions about the study. The interview had three phases.
In phase one, the participants engaged in a semistructured interview (Appendix D) in which I asked them to respond to direct questions about mental illness and mental health services. In the second phase of the interview, the participant was presented with the three vignettes. Following each vignette, eight questions focused the dialogue on the cognitive mediators of symptom causality, leader’s response, efficacy of treatment, social acceptance following treatment, and potential career impact issues presented by that vignette. The third interview phase was the collection of demographic and personal data. Throughout the interview, key points were verified with each participant. I paraphrased the main points from the interview and asked the participant if those statements were correct. Additionally, the participant used this opportunity to add or clarify any responses. The length of the interview varied depending upon how much information the participant desired to share. The interviews ranged from 33 minutes to 104 minutes in length, with an average of 60 minutes. At the interview conclusion, each participant was asked if he or she would be interested in participating in a member check of the investigator’s interpretations by reviewing a description of the identified categories and providing a response. Only one participant refused at the time of the interview to participate in the member check.

Data Management

A naturalistic qualitative study produces a significant amount of data. The data management for this study contained four steps. First, obtained documents and interviews were transcribed into an electronic document as soon as possible after they were gathered. This ensured that the data was duplicated for safekeeping, text-searchable, and readily retrievable. The transcription included natural speech patterns of text markers.
(such as *um, ah, like, you know*) for their potential to convey meaning (Fox Tree, 2001).

Second, interview text was compared with the audio recording for accuracy and to add descriptions of language nuances, such as laughter or sarcasm, which carried additional meanings. Third, collected text was systematically reviewed with the iterative analysis process for meaning units and categories as part of the data collection process. Fourth, interview and policy text was imported into HyperRESEARCH 2.6 (ResearchWare Inc., 2003) qualitative analysis software to facilitate coding, recoding, and content analysis.

**Content Analysis**

**Interviews**

Coding raw text data and categorical analysis form the two major steps in preparing interview text for discourse analysis. An ongoing inductive content analysis (Lincoln & Guba, 1985; Patton, 1987) was used to code text into meaning units. A code is a single piece of information that provides a description of meaningful content. I started to form categories as codes were labeled and indexed. Categories comprised codes that appeared to have similar characteristics. The meaning held in a code could apply to more than one category. Rules for categorical inclusion and exclusion were developed during the sorting process. The first text analysis became the foundation for the codebook. The categorical rules were subject to change with each new code that needed to be labeled and indexed.

Each new interview was compared to the collective categories and meaning units of previous interviews. Previously analyzed text was recoded each time the operational definition of an existing code was modified or a new code was added to the codebook. Evidence of data redundancy occurred when the labeling and indexing of a new data set
did not create a new category or modify the rules of an existing category. No further
revisions were made to the codebook after the eighth interview. The codes and categories
comprised the minimum data elements for the discourse analysis.

The iterative process of coding and categorizing was repeated with the policy
documents retained in the sample. The codebook developed from the interview text was
the foundation for the policy analysis. The policy analysis did not create any new
categories or modify the existing operational definition of existing categories that
required recoding of the original interview data. The unitized and categorized data points
from the interviews and policy documents provided the data for the three components of
the discourse analysis: genealogy, structural analysis, and power analytic.

The content analysis of the interview text identified five themes: Mental Illness,
Mental Health, Sailors’ Use of Mental Health Services, Leaders’ Response, and Mental
Health Services (Appendix F). The themes were developed from the iterative analysis
process already described and are grounded in the leaders’ text. The terms used to
describe the categories within the themes were chosen to reflect a synthesis of the
interviews both within and across individual texts. Personal identifiers and descriptors
that could implicate an individual were removed from the exemplars to protect the
participants’ identity.

Policy Documents

The text of the obtained policy documents was entered into qualitative research
software to facilitate rich text discourse analysis. Policy document analysis isolated
meaning units and categories that contributed to the understanding of the genealogy,
structure, and power in the text of Navy leaders’ attitudes about mental illness. The
content analysis of the 31 naval policies produced four categories: suitability and
disability, mental health evaluations, security and reliability, and support and resources.
Appendix C contains a detailed list of the retained policy documents organized by
category.

Rigor

Trustworthiness in qualitative research is determined by the credibility,
dependability, confirmability, and transferability of data collection and interpretation
(Lincoln & Guba, 1985). To address the concern that the data interpretations be credible,
dependable, and confirmable, this study used reflexive journaling, an audit trail, peer
debriefing, and a member check of the interview data coding as described by Lincoln and
Guba (1985).

A peer debriefer independently coded a subgroup of the text and participated in
discussions with me. Peer debriefer coding was used both during the development of the
codebook and while coding later interviews. In addition to coding support, the peer
debriefer reviewed the categories that were sent to participants for the member check.
The peer debriefer provided me an opportunity to discover biases, clarify interpretations,
examine methodological concerns, and identify needed adjustments in data analysis.

As noted, the discussion of the theoretical framework, a Foucaultian discourse
analysis, aims to enter a discourse in order to determine the rules that govern it and to
describe various relations among discursive practices. As an advanced-practice mental
health nurse and a senior naval officer, I was placed inside the discourse as a participant-
observer by my role as a researcher. Being a member of the culture that created the
discourses that I was studying influenced data collection and analysis.
Some of participants in the study volunteered because they wanted to help a fellow officer. The participants knew my role in the Navy, which resulted in transference during interviews. For example, one participant expressed, "It is hard for me when you send me back a sailor who isn’t quite right." Transference was particularly strong when participants expressed frustrations related to mental health services and providers. As I was an officer peer, many of the participants approached the interview in a relaxed and collegial manner. The language used by the participants was thick with Navy acronyms and euphemisms that I understood and so did not require the participant to stop their dialog to explain a phrase. Data collection was also influenced by my ability to gain access to military installations, ships, and the shipboard environment, all of which would have been difficult for a civilian researcher.

Data analysis was influenced in several ways. The descriptions of the shipboard environment, social structure, and foundational discourses were based on observations made during data collection. Interpretation of those descriptions, however, included my experiences. In conducting the interview content analysis, my experiences were part of my thought process and produced a large number of categories that needed further synthesis and reduction. Insights regarding the organizational dynamics of authority structures, leadership roles, and technologies of power were influenced by my experiences within the Navy culture. My observations and experiences that were stimulated by the interviews and participant observations were included in reflexive journaling and peer debriefing.

A member check was conducted by asking (via email) the 18 participants who volunteered to provide feedback to a summary of the interview categories developed.
from the content analysis. The member check document (Appendix F) included the category with an operational definition and interview text exemplars for each category. One document was undeliverable because the participant was transferred. Only 5 of the remaining 17 participants responded to the member check request. A 29% response rate was unexpected given the participants’ enthusiastic response to the interview request; however, the response rate is understandable. The majority of the ships in homeport during the Christmas/New Year holiday were scheduled for a spring overseas deployment. Additionally, two ships with more than one participant each were rapidly mobilized during the week the member check was sent.

All four of the participants who responded to the member check concurred with the categories and operational definitions. One participant requested permission to forward the draft of the results immediately to his superiors because the squadron had just formed a workgroup to begin to address mental health issues. Another respondent included two case examples of mental health events that had occurred since the interview. There was a sixth nonparticipant response. The replacement for a participant who was transferred read the member check document and responded that the categories reflected his view as a leader.

Transferability requires that the research reports contain text sufficient to enable readers to make their own judgments. Transferability is facilitated by the use of data units to support the identified discursive practices and interpretation of discourse structures. The information necessary for comparison is made available to the reader by including the actual text and uninterpreted descriptions in the findings. In this way, the text of the
discourse creates a transparency of analysis that facilitates readers’ ability to draw their own conclusions (Lincoln & Guba, 1985).
CHAPTER FOUR: FINDINGS

Text passages from Navy policies and shipboard leader interviews were analyzed for their contribution to understanding mental health service use in the context of surface warfare ships. It was anticipated that stigma would be the dominant discourse in this study. As a discourse, stigma has the potential to create social relations and normative expectations in the context of mental health service use by subordinate sailors. Text representing stigmatizing beliefs appears in this study. Stigma, however, did not hold a dominant position in forming organizational norms and expectations around mental health problems.

The dominant discourse identified in the text was fleet mental health (FMH). Fleet mental health as a discourse includes text related to mental illness, mental health problems, emotional development, emotional resilience, adaptive coping, psychiatric medicine, nonpsychiatric services, and mental health service use. Fleet mental health is selected as the discourse label in this study because of its central position in the discourse. Fleet refers to the social context of the Navy in the discourse. The term mental health is a broad conceptualization of psychological, emotional, and developmental phenomena. The term mental health does not belong to a profession; its presence or absence is defined by its social context; and it is used as a descriptive component for problems, services, and providers to note a relation to behavior and emotions. The discourse of FMH in this study is limited to the collected policy and interview texts. The analysis of the FMH discourse is conducted to identify normative expectations within the institution of the Navy surface fleet.
The FMH discourse was analyzed for its historic and environmental context (genealogy); knowledge, authority, and justification structures (structural analysis); and patterns of resistance practices and power relations (power analytic). The interview participants are referred to as “leaders” in the analysis text. The term leader is preferred to participant because of the role-bound expectations and responsibilities that dominate the discourse.

Genealogy

The genealogy identifies the foundational discourses that provide essential relationships for establishment of the discourse under study. Each of the foundational discourses has a social purpose, subjects, knowledge structures, and authority structures that can influence other discourses. Foundational discourses of Navy mission, surface warfare community, and Navy psychiatry are the dominant influences of the FMH discourse. Table 3 is a summary of the major components of the three foundational discourses.
Table 3

Summary of Foundational Discourses

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Navy Mission</th>
<th>Surface Warfare Community</th>
<th>Navy Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain, train, and equip combat-ready naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas</td>
<td>A</td>
<td>Accomplish the Navy's seapower mission with maximum efficiency of personnel and materiel resources</td>
<td>Promote, protect, and restore the mental health of sailors, Marines, families, and retired veterans</td>
</tr>
<tr>
<td>Subjects</td>
<td>Active Duty Personnel, Civilian Personnel, Defense Contractors</td>
<td>Sailors, Leaders</td>
<td>Sailor-Patients, Mental Health Personnel</td>
</tr>
<tr>
<td>Knowledge Structures</td>
<td>Regulations, Directives, and Policies</td>
<td>Surface Warfare Qualifications, Ship Classifications, Job Classifications</td>
<td>DSM-IV-TR, Specialty Qualifications</td>
</tr>
<tr>
<td>Authority Structures</td>
<td>Uniform Code of Military Justice</td>
<td>Command Authority, Leadership Competencies</td>
<td>Professional Licensure, Clinical Privileges, Standards of Care</td>
</tr>
</tbody>
</table>

**Navy Mission Discourse**

**Purpose**

The mission of the Navy acts as a foundational discourse to many different discourses within the Navy organization. The social purpose of the Navy mission discourse is to “maintain, train and equip combat-ready naval forces capable of winning wars, deterring aggression and maintaining freedom of the seas” (*Navy Mission Statement*, 2004). A key influence in the FMH discourse is the expectation for combat-ready naval forces. Sailors with mental health problems are at significant risk of not being combat-ready. The loss of combat readiness could be related to symptoms or to training opportunities lost while participating in treatment.
Subjects

The subjects in the Navy mission discourse include all active duty and civilian personnel who work directly for the Navy. Both active duty and civilian workers have social norms they must meet as a condition of employment. An additional type of subject includes Defense Department contractors who engage in ad hoc roles related to particular equipment or services that support the Navy’s mission. As subjects in the Navy mission discourse, all active duty members are required to meet minimum physical and mental health standards that differ from those required of civilian and contractor personnel.

Knowledge Structures

In the Navy culture, groups of sailors who share common organizational goals are commonly referred to as “a community.” The knowledge and authority structures of the Navy mission discourse create a common referent for the varied specialty communities that make up Navy social and organizational components. The leaders in each Navy community are responsible for knowing and appropriately using the regulations, directives, and policies that are relevant to their community. In Foucaultian terms, documents that are responsible for directing human behavior can form a grid of specification — that is, a systematic ordering of discourse concepts. Navy mission discourse mental health policy documents classify behavior, set minimum occupational mental health expectations, and guide leaders’ decisions and actions.

Authority Structures

The Uniform Code of Military Justice (UCMJ) is the main authority structure in the Navy mission discourse. As a Foucault-type technology of discipline, all active duty Navy personnel are subject to the UCMJ. The UCMJ can be exercised in a range of
offenses that span from minor violations of social norms to criminal acts. The main purpose of the UCMJ is to act as a tool for military leaders in maintaining the good order and discipline of subordinates. Within the FMH discourse, the UCMJ provides a source of punishment for any subject who violates mental health policies or whose mental health problem behaviors violate Navy regulations.

*Surface Warfare Community Discourse*

*Purpose*

Many of the dominant social norms in the FMH discourse came from the ideas and thinking patterns that are unique to the surface warfare community. The purpose of the surface warfare community discourse is to accomplish the Navy’s seapower mission with maximum efficiency of personnel and materiel resources. Responsible stewardship of resources is a recurring theme in this discourse. Highly trained sailors represent one of the Navy’s most costly resources, resulting in their productivity and retention having a high organizational value.

*Subjects*

The people who are subject to the authority structures and power relations of the surface warfare community discourse are sailors and fleet leaders who live in the warships of the surface fleet. It is important to recognize that all fleet leaders can be considered sailors but not all sailors are fleet leaders. In the context of this study, the term *sailor* is used to refer to enlisted personnel below the rank of Chief Petty Officer. Some of the sailors’ motivation to participate in this discourse can include access to technical training, promotion opportunities, secondary education financial assistance, and patriotism. Leaders’ motivations for participation can include opportunities for greater
responsibility and influence, rewards of leadership, professional recognition, and promotion — to name a few.

Knowledge Structures

Grids of specification and discursive practices are two types of knowledge structures in the surface warfare community discourse identified in this study. The applicable grids of specification include surface warfare qualifications, ship classifications, and job classifications. The surface warfare qualification is a systematic body of knowledge and competencies for developing expertise in every system and every job specialty onboard a particular ship. Sailors become more costly to replace as they develop greater technical and seagoing expertise. The ship classification taxonomy provides information about ships' mission and resources, including which class of ships have onboard mental health providers or physicians. The job classifications taxonomy identifies which jobs require a higher mental health standard because of security clearance or nuclear program reliability certifications. The discursive practices of shipboard environment and duty expectations originate in the surface warfare community discourse and influence the FMH discourse.

Shipboard environment. Shipboard life and culture are unlike those of any other military or civilian work environment. The main critical difference is that living-space and workspace are commingled. The separation of home and work that allows most people to create social distance between work and social roles does not exist on a ship. Along with commingled work- and living-space, there is a fusion of personal identity with job function in which rank and name are replaced with a job title. Even when a
sailor is "off-duty" on a ship, he or she remains in uniform and must respond to shipboard routine and emergencies. As one leader stated,

"I've got this kid on board, he lives on board, his house is here, all his stuff's here, I can't really send him off somewhere [if he has a mental health problem], because nobody else is going to take him."

The second environmental difference is that a warship at sea is an inherently dangerous place to live and work. As one leader stated,

"This isn't IBM we're working for, this isn't McDonald's or Wal-Mart, ...we know it's dangerous on this ship."

The simple act of walking from one part of the ship to another can be very challenging. A ship rocks from front-to-back and side-to-side with a random rhythm produced by sea and weather conditions. As a complex machine, a ship is dangerous for anyone with impaired concentration, poor balance, or slowed reaction time.

The third critical difference is the degree of relative isolation that most crews experience when out to sea. Many of the ships' in the sample frame of this study routinely go to sea to patrol large areas of ocean without any other support ships or resources. The frequency and duration of time at sea (OPTEMPO [operational tempo]) also create isolation from other resources, especially medical support. It is common for the ships in the sample frame to go to sea for five to ten days and return to port over weekends and holidays. Because of the OPTEMPO, the crew has limited time available to meet personal and routine health needs. For example, medical, legal, and community services are often closed when the ship is in port on weekends and holidays.

Duty expectations. Safely negotiating the challenges of life at sea requires the crew to maintain a strong sense of duty to the ship and to each other. The Navy
organization expects every sailor to demonstrate the core values of honor, courage, and commitment both on- and off-duty. As a context for the FMH discourse, sailors are expected to work diligently and use medical services as necessary, and not as a means to avoid duty obligations. Compliance with core values and Navy norms is reflected in performance evaluations. Positive or negative career impact resulting from a sailor's behavior is reflected in performance evaluations. Medical conditions, including mental health problems, are not officially included in the performance evaluation. Behaviors associated with mental health problems that affect job performance, however, are reflected in a sailor's evaluation. Peer competition is a dominant element within the text of performance evaluations. The relative competitiveness of sailors in their job performance was a context for the FMH discourse. Ranking sailors against peer performance is the responsibility of fleet leaders, and that practice reflects the leaders' perception of sailors' contribution to the mission. One leader described this process:

“It comes down to rankings now, you see kids are ranked against one another and if this guy has a lot that's involved in helping him, ...let's see, you performed for 6 months and you've been sick for 6 months, this other guy performed the whole year. So he's going to be the "early promote" [above 80th percentile peer ranking], you're going to be the "promote" [below 40th percentile peer ranking].”

Authority Structures

The responsibility of the commanding officer for his command is absolute....(Article 0802, Navy Regulations, 1990)

The Navy's institution of command provides for the commanding officer's absolute responsibility for his or her command. The roles of the executive officer and command master chief are in direct support of the commanding officer. As command
leaders, the participants in this study are required by the Navy to demonstrate five core competencies \textit{(Naval Leadership Competency Model, 2004)}. The five core competencies are accomplishing the mission, leading people, leading change, working with people, and resource stewardship. A core assumption of these leadership competencies is that sailors are physically and mentally ready to follow orders and capable of completing assigned tasks. As a context for the FMH discourse, the leaders use their social role authority to facilitate or inhibit sailors' use of mental health services and reintegration into the crew following treatment.

\textit{Navy Psychiatry Discourse}

\textit{Purpose}

The Navy psychiatry discourse provides the medical influences and structures to the FMH discourse. The Navy psychiatry discourse is founded on the discourses of psychiatry and Navy medicine. The term \textit{psychiatry} is used to label the discourse rather than \textit{mental} or \textit{behavioral health} because of the historic and current dominance of Navy mental health services by the medical practice of psychiatry. As a component of Navy medicine, this discourse must respond to simultaneous mental health issues of peacetime health care, noncombat military deployments, and combat operations of both Navy and Marine forces. The purpose of the Navy psychiatry discourse is to promote, protect, and restore the mental health of sailors, Marines, families, and retired veterans \textit{(Navy Medicine Mission Statement, 2004)}.

\textit{Subjects}

The people who are subject to the authority and power relations in the Navy psychiatry discourse are patients and mental health clinical personnel. Specifically in the
FMH discourse, a sailor who needs mental health evaluation or treatment becomes a patient. The neutralization of military rank from one of authority to a personal identifier in the patient role is part of the cultural norm of treatment equality. In the patient role, sailors are expected to submit to diagnostic procedures and honestly self-disclose in the clinical interview. Mental health clinical personnel include a range of professional and paraprofessional clinicians with psychiatric/mental health specialty training. Mental health providers are clinicians who meet minimum knowledge and authority structure competencies to be granted clinical privileges. Mental health providers hold a central role in the FMH discourse.

Knowledge Structures

The DSM-IV-TR (American Psychiatric Association, 2000) is a taxonomy of mental disorders that forms the dominant grid of specification in the Navy psychiatry discourse. The DSM taxonomy is based on a consensus of mental health experts and is not influenced by any Navy discourses. The specialty training that mental health providers receive as they obtain specialty qualifications is used to apply the DSM to sailors' behaviors. Specialty qualifications form another grid of specification that differentiates levels of expertise and clinical competence for making diagnostic decisions and recommendations. Particular Navy psychiatry discourse knowledge concepts that have influenced the FMH discourse include medical environment and the diagnosis and treatment of mental illness.

Medical environment. Navy psychiatry services are predominately located in naval hospitals or medical centers that serve a large catchment area and are not usually located near ships. The physical separation creates additional challenges for sailors trying
to connect with services. Culturally, Navy psychiatry is embedded in the shore establishment culture that is marked by constancy in the work environment and a reasonable ability to predict work demands. Normally it is expected that patients will come to a centralized location to participate in evaluation and treatment.

*Diagnosis and treatment of mental illness.* One of the main psychiatry discourse functions is to identify mental illness, develop a course of treatment, and determine if treatment will be sufficiently effective to enable a sailor to return to duty. The current neo-Kraepelinian nosology represented by the DSM-IV-TR is a collection of disorders and symptoms that have widely varying plausibility and coherence (Double, 2002). A wide range of therapeutic interventions, from talk therapy to medications, is related to the nosologic diversity of mental disorders. The diversity of diagnostic and treatment options creates conditions in which sailors with similar mental health problems can have different treatment strategies and different expected outcomes. Additionally, advances in psychotropic medication formulations have increased the number of mental disorders for which medications are used as a primary or adjunct intervention.

*Authority Structures*

The formal authority structures in the Navy psychiatry discourse apply only to the behavior of medical staff and not that of the patient. Professional licensure, clinical privileges, and compliance with standards of care determine the who, what, where, when, and how of mental health care delivery. These authority structures establish boundaries and expectations for minimal levels of clinical competence, allowable treatment strategies, scope of practice, and treatment delivery. As a context for the FMH discourse, providers must adhere to professional expectations that may appear to conflict with the
purposes of the Navy mission and surface warfare community and with the expectations of patients, sailors, and leaders.

**Summary of Genealogy**

The foundational discourses of Navy mission, surface warfare community, and Navy psychiatry have their own individual spheres of influence, boundaries, and social norms (Figure 2). As expected, a high degree of commonality exists between the Navy mission and surface warfare community discourses. The Navy psychiatry discourse, however, has significant points of separation in each of the discourse components from those of the other two discourses. These differences create tensions between the discourses and the subjects within the discourses. The points of separation in the foundational discourses create a need for another type of discourse that can negotiate and integrate differences in a way that serves the Navy as a whole. The fleet mental health discourse provides that negotiating and integrating function.

Figure 2. Graphic representation of the spheres of discursive unity in this study
Structural Analysis

The genealogy provides an example of identifying discourse components from a position outside a discourse or without the knowledge that emerges from a discourse analysis. The structural analysis of the FMH discourse is written from a perspective within the discourse. The FMH discourse sphere of influence is identified by situating concepts, rules, and authorities in three axes. The axis of knowledge identifies subjects, grids of specification, and discursive practices. The axis of authority identifies speaking positions and rules. The axis of value or justification identifies the discourse’s purpose and strategies for subject compliance. Table 4 is a summary of the FMH discourse components.

Table 4.
Summary of Fleet Mental Health Discourse

<table>
<thead>
<tr>
<th>Fleet Mental Health Discourse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
</tr>
<tr>
<td>To ensure that sailors are mentally capable of performing their shipboard duties while conserving those who are temporarily mentally unfit</td>
</tr>
<tr>
<td><strong>Subjects</strong></td>
</tr>
<tr>
<td>Sailor-Patients, Leaders, Mental Health Personnel</td>
</tr>
<tr>
<td><strong>Knowledge Structures</strong></td>
</tr>
<tr>
<td>Mental Health Policies, DSM-IV-TR</td>
</tr>
<tr>
<td><strong>Authority Structures</strong></td>
</tr>
<tr>
<td>Rules for discursive practices and speaking positions</td>
</tr>
<tr>
<td><strong>Power Relations</strong></td>
</tr>
<tr>
<td>Submission of sailors and leaders,</td>
</tr>
<tr>
<td>Exploitation of foundational discourse authority structures</td>
</tr>
</tbody>
</table>
Subjects

Sailor-Patient. A subject formation that is unique in the FMH discourse compared with the foundational discourses is the sailor-patient. The Navy mission and surface warfare community discourses include the role of sailor but not that of patient. In the Navy psychiatry discourse, and in Navy medicine in general, a patient is referred to by rank and name and may be called client, customer, or consumer; patients, however, are subjugated to the role of receiving mental health treatment. When a sailor engages in clinical services, he or she temporarily becomes a patient. The transition from sailor to patient and back again usually has clear boundaries (e.g., time and place of medical appointments) and is not problematic for minor acute illnesses (e.g., superficial injuries or common infections). The transition of the sailor-patient role becomes problematic when a sailor returns to duty though still in need of treatment. For the remainder of the FMH discourse analysis, the term sailor will refer to the sailor-patient role.

Leaders. Senior surface warfare leaders are career Navy officers and senior enlisted petty officers who have completed minimum education requirements and specialty leadership training. Surface warfare leaders have years of shipboard experience and have completed advanced certification of their knowledge of combat vessel systems and seamanship. The authority of surface warfare leaders is sanctioned by oath of office, naval regulations, and public recognition of military command. Potential FMH discursive practices are limited by this authority to people, activities, or processes related to a surface naval vessel. For example, discursive practices related to sailors attached to shore commands are not included in the FMH discourse.
Mental health providers. In the Navy, mental health providers are clinicians with a specialty in psychiatry, psychology, clinical social work, or mental health nursing. The authority to hospitalize sailors or to determine fitness for duty after treatment is concluded is restricted to doctorally prepared clinicians. The rules for professional practice are developed by professional organizations and sanctioned by state licensure. Mental health providers have the authority to declare the presence of mental disorders and to prescribe treatment. Potential FMH discursive practices are limited by this authority to the subject of a subordinate sailor who was referred to, participated in, or needed mental health provider services. For example, discursive practices for use of non-mental health medical services are not included in the FMH discourse.

Grids of Specification

A grid of specification is a systematic ordering of concepts relevant to a discourse that can be used to focus a particular body of knowledge on a subject or discursive practice. In the FMH discourse, there are seven grids of specification (Table 5). The dominant grids that drive the FMH discourse are the categories of mental health policies. It is important to recognize that no unified mental health policy exists within the Navy. Navy policies originate from widely diverse offices and resemble a collection of ad hoc prescriptions for responding to mental illness issues within specific, and separate, organizational contexts.

The two most influential categories are the suitability and disability policies and the security and reliability policies. Suitability and disability policies set the minimum requirements for sailors to enter the Navy and for disability determination for medical separation from the Navy. These policies reduce the likelihood that a sailor will have a
mental disorder. Security and reliability policies set forth the requirements for sailors whose specialized jobs require access to classified information or nuclear material. These policies provide specific guidance for determining the initial and ongoing evaluation process to certify a sailor as loyal, reliable, and trustworthy. These two policy categories create an expectation of mental health capabilities that may not match actual mental health capabilities of individual sailors in the fleet.

The next influential grids of specification are the ship classification and mental health evaluations. The ship classification grid shows that larger ships have more resources for responding to the mental health needs of individual crewmembers. Greater resources mean that leaders have more options within the FMH discourse. Mental health evaluation policies identify circumstances, behaviors, or events that are associated with mental or emotional distress and that require specific mental health referral procedures. The mental health evaluation policies acknowledge that sailors can be vulnerable to abuse of power; that leaders need to ensure that mental health referrals are used only for mental illness concerns; and that mental health providers must ensure that referred sailors’ rights have not been violated. These two policy categories influence leaders’ referral and posttreatment responses to sailors with mental health problems.

The next influential grid originates in the taxonomy of mental disorders presented in the DSM-IV-TR (American Psychiatric Association, 2000). This grid provides the structural authority to assign a mental illness label, declare occupational fitness for duty, and implement medical intervention. The DSM-IV-TR grid creates two normative expectations in the FMH discourse. First, sailors will be given a legitimate diagnosis if they have a mental health problem. Second, leaders will receive a plan of corrective
action or recommendations from mental health providers to use in dealing with sailors’ mental health problems.

The last two grids that influence the FMH discourse are support and resources policies and job classification. Support and resources policies identify mental health service functions that are related to occupational support and administrative programs for sailors and their families. Leaders are expected to use these resources to assist sailors and families in meeting the demands of the Navy lifestyle. The job classification grid describes, in part, a minimum mental capability for all surface fleet shipboard jobs. It is expected that necessary mental capabilities will vary depending on job requirements. The grids of specification are summarized in Table 5.
Table 5
Fleet Mental Health Discourse Grids of Specification

<table>
<thead>
<tr>
<th>Grid</th>
<th>Specification</th>
<th>Expected FMH Norm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Navy Mission Discourse Mental Health Policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitability and Disability</td>
<td>Requirements on who may enter and remain in the Navy</td>
<td>Sailors will be physically and mentally ready to perform their duties</td>
</tr>
<tr>
<td>Security and Reliability</td>
<td>Requirements for who may have access to classified information or nuclear material</td>
<td>Sailors who have access to classified documents or nuclear material are reliable and dependable</td>
</tr>
<tr>
<td>Mental Health Evaluations</td>
<td>Identifies events or behaviors associated with emotional distress and referral procedures</td>
<td>Sailors are to obtain appropriate mental health services with undue coercion or stigma</td>
</tr>
<tr>
<td>Support and Resources</td>
<td>Identifies mental health service functions related to administrative programs and occupational support</td>
<td>There are resources available for sailors and families to meet the demands of the Navy lifestyle</td>
</tr>
<tr>
<td><strong>Surface Warfare Community Discourse Classifications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ship Classification</td>
<td>Mission expectations, living conditions, available resources</td>
<td>Larger ships have more resources to accommodate sailors with mental health problems</td>
</tr>
<tr>
<td>Job Classification</td>
<td>Minimum expectations for all surface ship jobs</td>
<td>The standard for acceptable mental health problems varies by job type</td>
</tr>
<tr>
<td><strong>Navy Psychiatry Discourse Taxonomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Statistical Manual</td>
<td>Diagnostic label, treatment expectations, and potential occupational functioning</td>
<td>Mental health problems will be appropriately labeled and a clear treatment plan or recommendation developed</td>
</tr>
</tbody>
</table>

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Discursive Practices

Discursive practices are concepts that identify points in the discourse where the subjects exercise power/knowledge to influence others. Six dominant discursive practices were identified. The discursive practices as described by the leaders are fitness for sea duty, mission readiness, malingering, referral decisions, help-seeking, and career impact. It is important to note that one of the many challenges in reporting the findings of qualitative research is finding a way to represent the multidimensionality of text. The discursive practices are presented linearly on the basis of their relative influence in forming the FMH discourse; however, the actual text was not linear. The leaders’ text was a complex juxtaposition of the discursive practices to highlight or modify a particular perspective. Within any given text, the participants would simultaneously connect attitudes about mental illness, their perspective on the sailor, the decisions they would need to make, and the impact of those decisions on themselves or their ship. It is important to recognize that no single discursive practice can stand independent of the influence of other practices or the FMH discourse itself.

Fitness for sea duty.

The leaders’ fitness for sea-duty text was in response to interview and vignette questions about the causes of mental illness, expectations following treatment, and returning to duty after treatment. Little flexibility exists in the shipboard environment for a sailor who is not fit for duty, for any reason. Leaders’ determination of fitness for sea duty following mental health treatment is influenced by six factors: severity of pretreatment symptoms, leaders’ personal experiences, perceived dangerousness, sailor’s job requirements, reliability of the mental health evaluation, and aftercare requirements.
The severity of pretreatment symptoms and the circumstances surrounding the mental health referral were one yardstick the leaders used in determining fitness for returning to the ship. Pretreatment symptoms that were perceived as relatively minor and treatable were the most conducive to returning to sea duty.

“If somebody gets sent to mental health and has no problem or a small problem but it is not a big deal [level of acceptable mental illness symptoms] then he should be able to come back.”

This leader has a narrow view, “no problem, small, not big,” of what type of mental health problem a sailor can have and still be able to return to the ship. The leaders operationally defined mental illness consistent with the security and reliability grid of specification as primarily being a problem in coping with life stressors and social deviancy. Additionally, the leaders expected that, when a sailor was returned to the ship, underlying causes of the original problem had been addressed and the symptoms that precipitated treatment were resolved.

Leaders’ personal experiences influenced decisions about how acceptable it would be to risk retaining a sailor with an identified mental health problem. The text of leaders who had experienced a crewmember’s death due to mental illness was more cautious and reticent to accept a sailor after mental health treatment compared with that of leaders who had only personal experience or family members with mental illness. Leaders who had observed or been impacted by a crewmember suicide while at sea had the strongest response. For example, one leader stated:
"I'm very cautious of the individual, while he is on board and the fact is I can't think of any situations where ultimately I haven't transferred them off the ship. Because a lot of the cases tie back to possible harm to themselves or someone else and that's my threshold.

It's not worth the risk. I have too many sailors in the Navy that don't need Prozac, why would I want one onboard a ship, a warship, at sea that's on Prozac."

In the exemplar, this leader is clear that he will take action. The tone of voice and affect during the interview conveyed the message: "Never again on my ship." The endorsed action is preemptive and is based on his beliefs about sailors with mental health problems and not on his views about a particular sailor. This instance was the most overt evidence of stigma in the interviews. By declaring his "threshold,” the leader indicates that he has zero tolerance for suicidal or homicidal behaviors, statements, or implications. He is additionally stigmatizing sailors with mental illness in his condemnation of those who take antidepressant medication.

Several leaders had personal experience or family members with mental health problems. It is important to note that some of the experiences in this group were traumatic and/or included significant disruption of family functioning. These leaders were more tolerant toward accepting sailors returning to sea duty after mental health treatment; they discussed continued monitoring as a helping behavior and saw medications as an effective adjunct to symptom management.
"I'm just a believer, I mean, if this mental health stuff would be like a religion. You know, I believe that there is, there is a reason that these kind of things happen to people and I believe that they can be treated and helped through them, you know, with the right kinds of treatment and sticking to it on their own afterwards”

“Medication works wonders in a lot of cases. People can function fairly well on medication, depending, obviously depends upon the illness, I would expect them to be able to return.”

The leader in the first exemplar endorsed the understanding that mental illness “happens to people” rather than constituting a personal failing by the sailor. This statement highlights the leader’s perception that mental illness is arbitrary and not under the control of the sailor. The leader in the second exemplar expressed faith in medication as a treatment. His acceptance of sailors with mental illness “depends upon the illness”; he acknowledged that some conditions — his example was bipolar disorder — are incompatible with continued military service.

Given the leaders’ concern for crew and ship safety, they expected that any potential for the sailor to cause harm to self or others was resolved. The leader ends up making a life-or-death decision with every sailor returned to duty if mental health problems are automatically associated with dangerousness.

“It is tough for me [caught between surface warfare community and Navy psychiatry discourses] because the guy that is really hell-bent on killing himself, I take him 100 miles out in the Atlantic, I'm giving him a pretty good opportunity”
This leader went on to explain that the sailor who is “hell bent on killing himself” can avoid mental health referral by hiding or denying symptoms when asked by medical or leadership personnel. The responsibility associated with naval command is evident in the personalized text: “I take him 100 miles out.” It is not the ship or the mission; it is the leader who provides the opportunity, in his view.

“If he was qualified to handle weapons, I would have to remove him from that until I was fully satisfied that everything was taken care of ... I mean, he could harm himself in many other ways on the ship. But handling a weapon increases the probability of him harming somebody else.”

The stigma of dangerousness (Link et al., 1999) may be influencing this leader. He is linking suicidal thoughts with homicidal potential. The leader acknowledges that restricting a sailor’s access to a weapon does not reduce the risk of suicide: “[There are] many other ways [to commit suicide] on the ship.” His role’s authority makes him personally responsible for deciding to allow a sailor to have access to a weapon following mental health treatment. That authority is applied to limiting the performance of a sailor’s duties until the leader was “fully satisfied” that “everything” was resolved. A paradox is created between limiting the sailor’s duties and the leader’s need for assurance. The sailor cannot do his work until the leader is satisfied. The leader cannot be fully satisfied with the sailor’s performance until the sailor can do his job. As long as the sailor’s work is limited, the leader will have doubts about the sailor’s reliability.

A large number of crewmembers need special certifications as a minimum job requirement. The fitness for sea duty text included the expectation that sailors need to be able to resume security clearance or nuclear personnel reliability certification.
“If I have a guy that I think is unreliable,
I have an obligation to [duty to Navy and ship]
pull his security clearance.”

The authority structure in this exemplar is the leader’s judgment of “unreliable.” There is great definitional latitude for the leader. The leaders consistently pointed out that they were required immediately, according to the security and reliability policies, to “decertify” any sailor who needed mental health services. However, the policies do not direct an immediate decertification except for suicidal behavior.

The leaders’ determination of fitness for sea duty was also influenced by their perception of the reliability of mental health evaluations. Lack of clear communication with mental health providers forces the leaders to make their own assessments. When a sailor returns as fit for full duty after mental health evaluation or treatment, there is continued monitoring.

“Cleared by psychiatry and returned to full duty... well, I mean I would like to trust the doctor who said he is ready to go and sent him back, but, you know, once again, on my watch list, the chaplain would be checking on him about every day.”

In this exemplar, the leader does not trust the assessment by mental health providers stating that the sailor is ready to return to duty without additional verification. Part of the lack of trust is related to differences in expectations between the surface warfare community discourse and the Navy psychiatry discourses. The leader expects a combat-ready sailor. For the mental health provider, sailors who are not imminently dangerous do not need a restrictive therapeutic environment and can return to the ship as fit for full duty even if further treatment is recommended. This difference in expectations
results in the leader expending limited resources on what should be an unnecessary function — watching a healthy sailor.

The discursive practice of fitness for sea duty included concerns about the aftercare requirements of follow-up appointments and medication use. Support for follow-up appointments was dictated by the ship’s schedule rather than by leaders’ beliefs about mental health problems. In particular, the need for ongoing aftercare appointments was considered incompatible with a ship preparing for a long-term deployment. In the text about shipboard medication use, the main concern was the crewmember actually following through and taking the medication.

“Staying on his medication, um, that's one of my biggest problems is when people come back from medical, um, yeah, they're adults, they're given the prescription but I'd rather they turn their pills in at the door and have the Corpsman give them to them every day so I make sure I know they take them.”

In referring to medication adherence as “one of my biggest problems,” the leader was referring to all medication and not just psychotropic medication. The most common example provided of medication nonadherence was the sailor who needed antihypertensive medication. Consistently the leaders indicated that they preferred that crewmembers relinquish control of their personal medications to the ship’s hospital corpsman for dispensing. The primary justification for that is that the leader would then have a mechanism for monitoring medication compliance, “so I make sure I know they take them.” The leaders also acknowledged that they were unsure of the rules for psychotropic medications on a ship. The leaders have good reason to be unsure about the
rules: there is no policy guiding the use of psychotropic medication aboard Navy warships.

Mission readiness.

Use of mental health services impacts the leader’s ability to fulfill the mission of the ship by consuming the leader’s personnel management time and reducing available manpower. The impact on mission readiness text was elicited from interview questions about barriers to obtaining mental health evaluation, improving Navy mental health services, and the final request for anything else the leader wished to share.

"Probably 20% of my time is spent [not on the ship’s mission] dealing with these people [sailors with mental health problems], and that only multiplies because, you know, the next guy, the XO that goes up 5% and down to division level, [leaders closest to the sailor spend the greatest time on personal issues] it's a real resource drain as far as tying up manpower."

Time is a precious commodity in the surface warfare community discourse. In this exemplar, the commanding officer spends 20% of his time related to crewmember mental health problems. In his view, the amount of leadership time spent on things related to mental health problems increases at each link in the chain of command, getting closer and closer to direct supervision of the sailor. Spending so much time on mental health issues means the leaders are not spending time on other mission requirements.

"Okay he needs to go to counseling [willing to support] three times a week. ... I am one deep. [no back-up or replacements] When I lose that guy for 6 to 8 hours a week for counseling, I mean that, that really hurts." [cost of support]

This leader is willing to support a sailor who needs ongoing therapy. There is, however, a cost for that support. The phrase “one deep” refers to there being limited
manpower resources aboard a ship. For example, the ship may have only one crewmember with a particular job skill. Sailors need to be able to do their job 100% when they return from any type of medical services. In response to manpower losses, the leaders must use their power and authority to increase the productivity of remaining crewmembers. Given the burden of manpower losses and demands on leaders’ productivity, leaders have an incentive for keeping the number of sailors needing mental health treatment to a minimum.

_Malingering._

The text on malingering was the most broadly elicited text in the interview. In the open interview questions, text about malingering was stimulated by questions about how to identify malingering, a leader’s response to a sailor with mental health problems, and improving Navy mental health services. Malingering was brought up in response to vignette questions about symptom causes, concerns about a sailor’s return to duty, and the open-ended “anything else” closing. Malingering was frequently raised again at the end of the interview when the leaders were asked if there was anything else they wished to share and in responses to the member check.

“You touch a nerve with fleet leaders when you mention malingering. [the label alone evokes a response] We can’t stand malingering, but we absolutely cannot take the risk that someone may in fact intend to harm themselves or others. So often, we choose the lesser of evils [referral as a forced choice] and send the person to the Doc.

_Frustrations mount with the Docs as well, who from our perspective [Surface Warfare Community discourse], should be able to see these guys expeditiously, diagnose, and treat or send back to work._”
The phrase “touch a nerve” evokes the image of a strong, instinctive, protective response to a painful stimulus. For leaders, the painful stimulus associated with mental health problems is malingering. Even though leaders are powerful in the organization, they are also powerless when confronted with malingering in a context that includes the potential for self-harm. The stakes are very high for leaders: “We absolutely cannot take the risk.” If they underreact and the sailor commits suicide, there is needless loss of life, and they are held responsible. In this text, referral for mental health evaluation is identified as an “evil,” something that is very frustrating. One of the perceived costs of sending a known malingerer for a mental health evaluation is the undermining of good order and discipline.

Malingering is a violation of good order and discipline, a punishable offense, and a form of insubordination. The usual response to insubordination is for the leader to punish the behavior in a way that communicates to the entire crew that such behavior is not being tolerated and will not be tolerated. The leaders have the authority to punish malingering as insubordination; however, the authority to determine the presence of malingering belongs to Navy psychiatry. In cases of insubordination possibly presenting as mental illness malingering, the leader must relinquish authority and “send the person to the Doc.”
"Later [after the first evaluation] the guy knows that all he has to do is say that [self-harm] and he will get practically a whole day off while I have him sit in the ER, [he] does it [cry suicide] again and he's gone [for another day from the ship]. That's when you start getting into the malingering, they learn how to play that system [mode of knowledge transfer] because it's so gray on the hospital end [as compared to the clear rules in the surface warfare community]."

In the above exemplar, even if the original evaluation was in response to a crisis, subsequent uses of mental health services are held suspect. Malingering is perceived as inappropriately consuming limited command and medical resources. The leader discovers that sailors quickly learn how to use statements of self-harm as a way to shift power from the commanding officer to the sailor. And there is a shift in blame along with the shift in power. This is not presented as a problem of command climate. The leader blames the sailor for being a manipulator and using limited resources. He blames the providers for missing the obvious and creating the opportunity for malingering through a lack of clear standards within the Navy psychiatry discourse.

**Referral decisions.**

Available resources and Navy policy influence leaders' use of authority in making mental health evaluation referrals. The text on referral decisions was elicited by interview questions about what a leader would do in response to a sailor with a mental health problem; thoughts about a sailor returning to the ship after treatment; and the vignette question about treatment efficacy. Leaders are required to make a series of decisions when presented with sailors' behavior that may indicate a mental health problem. How
the leaders choose to make those decisions depends on their level of knowledge and available resources.

“I understand that I’m not a clinician or a physician, uh, so that there are some, there are just some things that we’re not equipped [lack of knowledge] to make a judgment on.”

The leaders consistently used the disclaimer, “I’m not a clinician,” to convey that they were not qualified to make clinical determinations about sailors’ mental health. Specifically, the leaders identified the risks and frustrations as needing to determine the potential dangerousness of sailors with mental health problems. Even though commanding officers have absolute responsibility for sailors with mental health problems in their command, they need to use other resources (“we’re not equipped”) to exercise that responsibility. Leaders on ships without physicians talked about their personal responsibility for making mental health referral decisions. Many leaders expressed role conflict about having to make clinical decisions while lacking the skill and knowledge to fulfill that responsibility. In contrast, leaders with physicians on their ships talked about sending the sailor with a potential mental health problem to the physician for referral decisions.

“In the Line perspective, [surface warfare community discourse] when somebody comes up [and] says, I’m thinking about hurting myself, [implies willful use of suicidal ideation] I’m very lock-step exactly, [referring to policy requirements] you know, this message has to go, this guy has to be immediately sent, you know, my procedures [by policy] are locked.”

In this exemplar, the leader is clearly distinguishing between his responsibilities (“Line perspective”) and clinical decisions. The leader is required by policy to take
certain referral actions in the presence of dangerousness to self or others, even if he or she doubts the sincerity of the presenting behavior. Mental health evaluation policies require the leader to simultaneously activate medical, legal, and administrative reporting mechanisms. Once initiated, the process cannot be stopped until the mental health evaluation is complete — even if the sailor gives reasonable assurances that the precipitating crisis is over. Another challenge in leaders’ referral decisions is that mental health evaluation policies prohibit linking mental health referral to disciplinary action. Specifically, mental health evaluation cannot be used as a form of punishment, intimidation, or to discredit a sailor.

"[Mental health] problems often manifest themselves related to a discipline problem or performance shortfall. [social deviance from Navy rules] Once that happens, and you know I'm not a lawyer and I'm not a doctor, [not in his power/knowledge domain] but, whatever it is, the Boxer rule, or Boxer law, [mental health evaluation policy] you cannot couple mental referrals with discipline procedures, in that they can't be punitive."

This leader is forced to artificially separate behavior that is a threat to good order and discipline from reasons for mental health referrals. Uncertainty about the presence of a mental disorder makes it necessary for the leader to refer the sailor for mental health evaluation; doing so often forces him or her to delay or suspend punishment. A dilemma for leaders is that other crewmembers may misunderstand and begin to believe that mental health services can be used to avoid punishment or that leaders will tolerate the offending behavior.
Help-seeking.

Interview vignettes were used to explore leaders’ perspectives about what encourages sailors to seek mental health treatment and what discourages them from doing so. The leaders indicated that leader and peer support and available resources are the strongest influence on help-seeking. In response to interview questions about what encourages or discourages help-seeking, one leader responded:

“Encourages?
When they hear it [getting help] from me and everybody else in the chain of command. They're constantly being asked, you know, how are you doing today? Everybody, peers, even subordinates, working back the other way are taking an active interest in each other and I think that encourages it.”

This officer uses his authority to effect the help-seeking behavior of sailors in two ways. First, sailors receive a consistent message from the leader that values early help-seeking and the expectation that other leaders in his command will reinforce that message. Second, with the text, “everybody, peers, even subordinates,” he is advocating that crewmembers are encouraged, through the leadership, to be concerned about each other. The text, “working back the other way,” refers to subordinates taking an active concern in the mental health of their supervisors as well as that of their peers.

Another consistent component of the help-seeking text was the influence of shipmates. In the following exemplar, the leader describes peer influence as having both a deterrent and a supportive role.
“Peer pressure and peer acceptance of the problem is probably the biggest negative, but at the same time, ironically peer interest in trying to help the guy is probably positive, so it’s really all about creating a climate and an attitude and the people are comfortable with bringing their problems forward.”

This leader sees peer rejection as a discouragement to help-seeking while peer acceptance is an encouragement. One of the functions of leadership is to mold the social behaviors and expectations that produce the command climate. The extent to which a crew is rejecting or accepting of a shipmate after mental health treatment is strongly influenced by leaders’ behaviors.

The use of non-mental health services was also described in the context of help-seeking for mental health problems. The leaders’ text identified the diversity of support services as a factor that encourages help-seeking.

“There’s just a whole plethora of other sources [Fleet and Family Support Center, Alcohol Rehabilitation, Fleet Legal Services] if we feel we can pigeonhole it in the right direction and send them there.”

In this exemplar, the presence of a “plethora of other sources” demonstrates that not all sailors with mental health problems [maladaptive coping] need to go to mental health for services. The use of other services, however, can also be viewed as an avoidance behavior of Navy psychiatry. This leader is advocating using the authority of the leaders in his command (“we”) to screen sailors’ problems, to “pigeonhole.” The mental health screening and treatment decision process is normally part of the psychiatry discourse.
Career impact.

The leaders in this study are in positions to impact the careers of sailors directly through performance evaluations and recommendations for promotion. Sailors with mental health problems create a challenge for the leader, who must make sure that evaluations include behaviors that impact work performance while ensuring that the evaluation is not biased. The leaders differentiated potential career effects on the basis of sailors' performance and positions of responsibility.

"The main issue is not why they go to medical, whether it is a mental health problem or not, it is really their performance afterwards.”

In this exemplar, the leader broadened the question from mental health services to any medical treatment. Consistently, the leaders linked the concept of career impact with performance evaluation. Once linked to performance evaluations, the text focused on objective measures of mission support. Behaviors that impact work performance, including symptoms and loss of productivity during treatment, could be used in the evaluation. In the text on career impact and symptoms, the leaders included mental health treatment, with examples of sailors with migraine headaches, high blood pressure, and pregnancy, as having an impact on performance evaluations. Linking mental health treatment with other medical conditions de-emphasized the connection between mental illness and stigma and career impact.

The text on career impact included the relevance of rank and military position. The leaders indicated that mental health problems early in a Navy career have minimal career impact and that the demand for mental stability increases as responsibility
increases. The officer and senior enlisted leaders had differing perceptions of career impact within their peer group. The officer participants, in particular, stressed that mental health treatment had a negative impact on careers of people in their peer group.

"It depends upon what level. I would think yes if it is a position like mine. I think that if I were to seek treatment, for whatever reason, that it would adversely affect my career. And the second part of that is, it should."

In this exemplar, the officer clearly states that seeking mental health services will harm a senior officer's career. By using the phrase, "for whatever reason," this officer leaves no room for any mental health service use, including support for normal life events and developmental transitions. For this officer, even the need for family or personal counseling would negatively affect his career. The implications from the text and other contextual elements surrounding this dialog are that senior shipboard officers need to be held to a higher standard than others in powerful positions. This text highlights that mental health problems are stigmatizing and have a negative career impact in certain contexts.

"For a CO or XO, somebody who has weapons control authority, um, you know, I am concerned with people who have received treatment and then come back."

The officer in this exemplar is stating why commanding officers and executive officers are held to a higher standard. The scope of their responsibility includes access to powerful weapons. The judgment, reliability, and trustworthiness of commanding and executive officers are legitimate concerns. Linking "weapons control" with a history of
mental illness treatment may derive from the stigma of violence and mental illness (Link et al., 1999). Like the leader who would have concerns about a junior sailor having access to [little] weapons, this officer is concerned about senior officers having access to [big] weapons.

Axis of Authority

The authority of a discourse is different from the authority of the naval leaders. The naval leaders' authority is the power to act on behalf of the U. S. Navy. Their authority is set by congressional law and naval regulations. The axis of authority identifies the rules for the appearance of discursive practices, speaking positions, and proper concept forms within a discourse.

Appearance of Discursive Practices

The appearance of discursive practices was influenced by subjects in the discourse and the grids of specification. There are three essential rules for the emergence of the discursive practices. They are the rules of problem recognition, compromised productivity, and required leader action.

For the rule of problem recognition, a sailor's behavior that suggests a mental health problem needs to be part of the leader's conscious awareness. The behavior can be as subtle as degradation of work performance or as overt as statements of suicide. The leaders' minimum threshold is influenced by the security and reliability grid of specification that links mental health problems with an unreliable and untrustworthy sailor. For example, the sailor who has depression symptoms that are not shared with others and that do not overtly impact work performance would not enter the FMH discourse until the leader becomes aware of the symptoms.
In the compromised productivity rule, sailors’ ability to work productively and to resolve their own problems needs to be perceived by leaders or mental health providers as compromised. This rule is important for subjects entering and exiting the discourse. For example, a sailor with suicidal ideation would be identified as having diminished self-care ability and would activate the referral decision discursive practice. After treatment was completed and the sailor was identified by psychiatry as fit for [naval] duty, leaders would consider the sailor as unfit for [sea] duty until a period of continued monitoring had established the return of self-care ability. A sailor cannot leave the FMH discourse until the leader believes that the sailor can be a productive member of the crew.

In the third rule of required leader action, behaviors identified by the preceding rules require the leader to consider or engage mental health services. The requirement for leaders’ decisions or actions activates the surface warfare community discourse. In that discourse, the leaders’ absolute responsibility requires them to respond to any information that could affect the crew or ship. Fleet mental health discursive practices would not enter the discourse if sailors with mental health problems were participating in treatment outside the Navy without the leader’s knowledge or if they did not require the leader to consider a mental health evaluation. In an example of these rules, one leader talked about a sailor he perceived as “not quite right (problem recognition),” who required extra leadership time to stay productive (compromised productivity), and who did not meet the threshold (danger to self or to others, or gravely disabled) for mental health contact until “he spaced out and nearly got hit by a forklift (required leader action).”
Speaking Positions

Speaking and writing positions in the FMH discourse refer to who can use the discursive practices with authority, speakers' credibility, ways of speaking, and acceptable sites for speaking within the discourse. Speakers do not control the discourse as they are within the FMH discourse. There are three speaking positions in the broader FMH discourse: naval leaders, Navy institution through policies, and mental health providers. The dominant speaking positions that were allowed to speak in this study through sampling design were the fleet leaders through interviews and the Navy as an institution through policies.

The leaders' credibility is established by their role in the surface fleet community. Their role conveys both institutional and cultural authority to identify subjects and to use or respond to discursive practices. During the ongoing management of the command climate, leaders communicate the discourse values and norms to other leaders and subordinates. Leaders' attitudes about mental health problems are reflected in their speech and actions. Written elements of the discourse are reflected in the use of referrals for involuntary mental health evaluations, post-suicide attempt after action reports, and manpower documents for sailor attrition.

As an institution, the Navy speaks within the FMH discourse through policies. Not all Navy policies participate in the FMH discourse. Policies that are identified in the genealogy form the speaking position of the Navy in this discourse. The credibility and production of the policies are established by the use of experts as authors and an official signatory. The extent to which mental illness stigma may have influenced the authors of the policies is unknown. The policy text is written in neutral language that reflects the
purpose of the policy. For example, the description of a mental health problem is written in two different styles. Mental health evaluation policies are written using DSM nomenclature and style. Security and reliability policies are written in lay behavioral terms. Mental health-related policies are limited to specific situations and lose authority when they are applied outside those situations.

Mental health providers speak within the FMH discourse from their position as trained professionals with a specialized body of knowledge. Credibility is established by completing specialty training, board certifications, and licensure. Mental health providers speak and write within the conventions established by the DSM taxonomy. Providers are situated in a particular context when they use the FMH discourse. The first context is as clinicians in a professional triad relationship with the sailor as the identified patient and the leader as a privileged significant other. In this context, the provider is limited in the discourse by privacy expectations and case specifics. The second context is as a knowledgeable professional speaking in the public domain through lectures, professional articles, or the popular media. In this context, the provider must speak of the discourse in general terms, avoiding specific subject identification and, generally, in a way that supports the discourse. For example, mental health promotion lectures usually end with the admonishment to seek professional services early.

Proper Concept Forms

The proper form that discursive practices must take to be accepted as knowledge and how imperfections in the discourse are resolved is the third rule type in the axis of authority. In the FMH discourse, proper formation of statements and subjects depends on context formality.
The formal context is where all the subjects are role-bound in the discourse. For example, the sailor has an obligation to the ship and shipmates; the leader must respond to all potential threats; and providers must conduct an evaluation and provide a recommendation. In a formal context, the leaders must use discourse forms consistent with the policies that apply to the situation, and providers must use the DSM taxonomy. The proper formal form of the discourse is behaviorally descriptive and linear; it is stated from the third-person perspective and stated with clearly identified role-bound authority. In the formal context, only the sailor, leader, and mental health provider can participate directly in the discourse. Other professionals, such as lawyers and chaplains, can provide consultation to the leaders and providers but do not speak directly in the discourse. Inconsistencies and imperfections in the discourse need to be negotiated between the provider and the leader. Negotiating positions will vary depending upon the individuals, the presenting circumstances, and organizational goals. Mental disorder diagnosis is the basis for many of the policies that guide the leader’s discourse participation, and the leader is at a disadvantage in terms of knowledge.

The informal context is created when subjects are not in role-bound situations. Examples of non-role-bound interactions include those instances when leaders and providers are combined during varying forms of naval training, in social situations, and in the research interview where decisions and opinions were not binding. The informal discourse form was contextually descriptive (e.g., “We had only been out 6 days when...”), nonlinear, used lay or slang language (e.g., “not quite right,” “crazy”), stated in the first person (e.g., “I had this one kid who...”), and stated as personal experience-bound authority (e.g., “This is what I think...”). In the informal context, the primary
authority voices of the leader and the provider continue to be present. The voice of the sailor is introduced as part of the descriptive context — for example, when a leader stated, “After coming back from psych, this sailor told me....” Imperfections are typically handled by declarations of discourse boundaries or role boundaries. One of the most frequently identified leader boundary declarations was that providers do not understand the needs of the surface warfare community. Examples of mental health provider boundary declarations were not an available text in this study.

Axis of Value or Justification

Within the FMH discourse’s body of knowledge, discursive practices emerged from the interactions of subjects and foundational discourses. In this respect, the exercise of power in the FMH discourse is aimed at people. The social value of a discourse forms the justification for its use of disciplinary tools or practices to subjugate the participants. The social value, the purpose, of the FMH discourse is to ensure that sailors are mentally capable of performing their shipboard duties while conserving those who are temporarily mentally unfit. The FMH discourse mediates the surface warfare community and Navy psychiatry discourses as sailors with mental health problems experience transitions in combat-readiness and move between the two discourses. Shared power/knowledge between the discourses is needed to ensure that sailors are productive and combat ready and to reduce unnecessary losses of trained sailors. Without mentally healthy, productive sailors who can obey orders and perform their duties, the social institution of the Navy cannot meet its mission of projecting seapower.

Disciplinary tools or practices in the FMH discourse include performance evaluations, the Uniform Code of Military Justice (UCMJ), hierarchical authority, and
professionalism. Performance evaluations are the direct link between subjects' behaviors and occupational rewards in the Navy. Sailors who use mental health services can anticipate that behaviors related to the need for treatment and how they participated in the FMH discourse (e.g., a nonemergent request for help compared with a dramatic impairment in job performance) will be included in their evaluations. Leaders' participation in the FMH discourse is reflected in their ability to meet core leadership competencies and their crew attrition rates. Mental health providers' evaluation in the FMH discourse includes number of clinical contacts and fleet support behaviors.

The UCMJ acts as a technology of power in the FMH discourse and as a sanctioned source of punishment for military members who violate norms. Leaders and mental health providers are held accountable for implementing both the letter and the intent of naval policies. A potential sanction for failure to follow mental health policies would be formal charges or official letters of reprimand under the UCMJ. For sailors who use mental health services, the UCMJ can be applied in circumstances of malingering or when failure to report for a scheduled appointment is a violation of a direct order.

Hierarchical authority in the Navy acts as a technology of power by creating orders of precedence in subjects and discursive practices. The clearest example of hierarchical authority exists in the leader/sailor relationship. Leaders have authority over subordinates in their command. This authority includes the power to require sailors to participate in the FMH discourse even when the sailor does not want to participate. Hierarchical authority also creates orders of precedence in the use and application of mental health policies. For example, policies from the office of the Chief of Naval
Operations are subordinate to policies from the Secretary of the Navy which, in turn, are subordinate to policies from the office of the Secretary of Defense.

Professionalism functions as a technology of power in the FMH discourse through its dominance of a special body of knowledge and reinforcing group norms. Leaders, as surface fleet professionals, have a special body of knowledge about ships and sea duty. This body of knowledge is used in the FMH discourse to justify the rejection or acceptance of sailors after their use of mental health services. Leaders' commitment to the ship and crew, expressed as professional obligation and sense of duty, consistently emerged as a reference point when authority was exercised in the discourse.

Professionalism for mental health providers acts to justify labeling sailors with a diagnosis, recommending treatment, and declaring suitability for naval service. Mental health providers are also obligated to their professional standards and organizations for demonstrating and maintaining their competency to speak within the discourse.

Professionalism for sailors acts to reinforce their obligation to their shipmates and the ship. This obligation creates the expectation that they are to help shipmates engage in the FMH discourse as problems unfold. Additionally, sailors are expected to accept additional work while a fellow crewmember is using mental health services.

Power Analytic

The power analytic identifies the dominant power relations within the discourse. The FMH discourse power relations are modes of actions that support the discourse's purpose of mediating relationships between the foundational discourses. The power analytic was conducted in two stages. First, the dominant resistance practices were...
identified. Second, the resistance practices were then used as symptoms that expose the power relations.

Resistance Practices

The dominant resistance practices in the FMH discourse are malingering, continued monitoring, avoidance of Navy psychiatry, and punishment.

Malingering

Malingering was a focal point of naval leaders’ issues about mental problems, mental health services, and mission accomplishment. More than any other discursive practice, malingering evoked the strongest emotive response in the leader interviews. Malingering as a resistance practice has the following characteristics: The sailor as a malingerer is free to choose the use of mental illness symptoms to meet needs that are not being met in other discourses or to accelerate responses in the FMH discourse. For example, sailors who cannot get an authorized exemption from going to sea could use claims of suicidal thoughts to avoid departing with the ship. If sailors perceive that their psychological needs are not being met, or that they are not being afforded the attention they expect, they can choose to stimulate leaders and mental health providers through mental health claims that increase concerns about dangerousness.

Malingering also creates a shift of disciplinary techniques at the surfaces of emergence between the discourses of FMH, surface warfare community, and Navy psychiatry. The leaders identified malingerers as insubordinate and manipulators who should be punished. Once engaged with the Navy psychiatry discourse, mental health providers have the responsibility to determine the legitimacy of the sailor’s complaints and make recommendations to the leaders. The providers have the authority to identify
malingering but not to punish sailors engaging in it. The leaders have the authority to punish malingering but not to identify it. Fluctuation in authority between leaders and providers creates an opportunity for malingering to reach a sustained position in the FMH discourse.

**Continued Monitoring**

The FMH discourse includes the normative expectation that, when a sailor is declared fit for full duty by psychiatry, the leader is not required to respond to the sailor any differently than he or she does to sailors who did not have a mental health evaluation. When a sailor returns to duty after a mental health evaluation or treatment, monitoring by leaders continues. A leader’s choice to continue monitoring a sailor’s behavior when the sailor is medically cleared as fit for full duty after a mental health evaluation or treatment is a resistance practice. The most overt form of resistance occurred when leaders’ and providers’ assessments of duty fitness were incongruent. The resistance practice of continued monitoring was most likely to occur when the leader had difficulty trusting the provider’s recommendation. Lack of trust was related to leaders’ questions regarding the provider’s fleet experience, professional skill level, and unsatisfactory communication between the leader and the provider before the sailor returned to the ship.

**Avoidance of Navy Psychiatry**

An FMH discourse norm is that sailors who require mental health evaluation or services need to be seen by providers whose practice is bound in the FMH discourse. Resistance to that norm occurs in two forms. The first type is for sailors to seek civilian mental health care with the expressed purpose of avoiding documentation in the military health record or provider communication with commanding officers. By going outside
the FMH discourse, the sailor is avoiding the norm that evaluation and treatment should occur within the Navy medical system, and they prevent activating the discursive practices. The second type is the use of administrative and occupational support programs as a surrogate for Navy mental health evaluation or treatment. This resistance practice can be used by sailors and leaders. Counseling and cognitive behavioral therapy provided by Fleet and Family Services and chaplains does not have the same organizational and stigma consequences as do psychiatric services. For example, a sailor with a security clearance does not face the same level of risk of losing his or her clearance by going to see a chaplain as would be the case if the sailor went to see a mental health care provider. Whether or not the use of administrative and occupational support is a resistance practice depends on the choices of the sailor or leader and compliance with discourse norms.

Punishment

Punishment becomes a form of resistance to the norm of appropriate mental health services when treatment options are restricted in the FMH discourse. Punishment as a resistance practice is most apparent among sailors labeled with personality disorders. Providers are excluded by suitability and disability policies from using medical limited duty and medical separation procedures for sailors with personality disorders. In response to those limitations, providers identify the sailor as fit for full duty and recommend an expeditious administrative separation. Leaders then interpret the provider’s assessment and diagnosis in the context of the Navy mission discourse. A medical recommendation for expeditious administrative separation is not sufficient for the leader to act on the recommendation. In addition to the psychiatry recommendation, the leader must document sustained impaired performance. One mechanism for documenting sustained
impaired performance is through punishment. Punishment through the UCMJ can replace medical procedures for the separation of sailors diagnosed with personality disorders.

Web of Power Relations

Power relations in the FMH discourse are identified from the resistance practices. From the resistance practice of malingering, sailors are responding to the social norm that they are to submit their personal needs to the productivity of the ship. In the continued monitoring resistance practice, leaders are responding to the influence that they are to submit their judgment about sailors’ suitability for sea duty to the authority of Navy psychiatry. From the avoidance of Navy psychiatry resistance practice, sailors are responding to the social norm that they are to submit to psychiatric evaluation and labeling of their thoughts and behaviors. The leaders in this resistance practice are responding to the social norm that they are to submit sailors to Navy psychiatry even when that action may result in the sailor’s loss or diminished productivity. In the resistance practice of punishment, the leaders are responding to the social norm that their absolute responsibility for sailors forces them to accept sailors with known mental health problems who are potentially unfit aboard the ship. The dominant power relations in the FMH discourse included the exploitation of Navy psychiatry and surface warfare community authority structures and the submission of the subjects.

The FMH discourse lacks the authority structures that enforce norms in the foundational discourses. To enforce its normative expectations, the FMH discourse exploits (takes advantage of) the authority structures in the Navy psychiatry and surface warfare community discourses. The Navy psychiatry discourse has authority to declare or deny the presence of a mental disorder, declare treatment options, suspend individual
rights for treatment, and declare suitability for naval service. The surface warfare community discourse has the authority to compel sailors to participate in mental health evaluations, show up for scheduled appointments, and use performance evaluations or punishment as responses to sailors' behavior in the FMH discourse. The FMH discourse exploits the authority structures in these two foundational discourses to create power-over and domination influences over the sailors, leaders, and providers as discourse subjects.

To engage with the FMH discourse, leaders can use their authority to compel subordinates to connect with mental health services or mental health providers to evaluate sailors. A sailor can use the FMH discourse to oblige the leader to temporarily remove the sailor from the ship and assigned duties to undergo a mental health evaluation. Once engaged with mental health services, the FMH discourse can use the authority of the leader to coerce the sailor to go to appointments and participate in treatment. The authority of Navy psychiatry can compel the leader to allow the sailor to participate in treatment even when that treatment interferes with the ship's mission. Following treatment or evaluation, the FMH discourse exploits the authority of Navy psychiatry to compel a sailor to leave the Navy if he is labeled as unsuitable or to compel a leader to accept a sailor who is getting better but is not yet combat ready.

The power relation for sailors in the FMH discourse is submission to becoming a subject when they demonstrate or claim disruption of mental health. Once subjugated, sailors' fields of potential action are limited by the FMH discourse domains of mental health evaluation, treatment, and aftercare. Once in the mental health treatment domain, the sailor is subject to providers' labeling of mental disorders, determination for return to duty, involuntary admission, and recommendations of suitability for further service.
Fleet leaders in the FMH discourse are expected to ensure that sailors are productive members of the Navy by being vigilant for potential mental health problems, facilitating access to evaluation and treatment, protecting sailors' rights, and separating unsuitable sailors from the Navy. The power relation for fleet leaders in the FMH discourse is submission to becoming a subject when they need to access the knowledge and authority structures of Navy psychiatry. As subjects in the FMH discourse, leaders have limits and boundaries that restrict potential actions regarding punishment and treatment options. Once engaged in the FMH discourse, leaders are also subject to the authority of Navy psychiatry, the labeling of mental disorders, and limits of treatment. The leaders are limited in their ability to reject a sailor who is a subject in the FMH discourse when the sailor is declared fit for full duty by Navy psychiatry. Another limit leaders face is being restricted from seeking a replacement for a sailor who is a subject in the FMH discourse until that sailor is declared unfit for duty.

Summary

The Navy needs sailors who can do whatever is asked of them. Mental health problems create uncertainty about the mental capabilities of the sailors so affected. The Navy cannot afford to prematurely declare sailors with mental health problems as unfit because sailors are expensive to develop into combat-ready members. From the surface fleet perspective, sailors with mental disorders that render them permanently unfit should be removed from the fleet as quickly as possible. Sailors who are temporarily unfit, however, need some place in the organization to work on their problems until they are combat ready or identified as permanently unfit. A challenge for fleet leaders is that many sailors with mental health problems physically remain on the ships.
The purpose of the FMH discourse is to serve the Navy as an organization and to ensure that sailors are mentally combat ready while preventing premature loss of sailors who are temporarily not combat ready. To achieve its purpose, the FMH discourse exercises two types of power relations. First, the authority structures of the foundational discourses are used to promote the subjects’ compliance with the procedures and expectations of the FMH discourse. Second, sailors and leaders must participate as subjects in a way that shifts some of their autonomy and authority to mental health providers.

The goal of this analysis was to unveil the knowledge foundations, discursive practices, and power relations in the Fleet Mental Health discourse. Discourse structures are unavailable for scientific inquiry and social action as long as they remain hidden. Making these discourse structures visible opens them to a higher level of awareness and understanding. Greater understanding then creates the possibility of identifying concrete problems associated with the discourse and conditions under which social transformation can occur.
CHAPTER FIVE:
DISCUSSION

A discourse analysis using Foucault's theoretical framework is a means to uncover systems of knowledge, power/knowledge practices, and power relations within a social context. Foucault (Foucault & Gordon, 1980) described his work as historical case study research intended to illuminate marginalized (local, popular, and disqualified) knowledge. By focusing on a case of marginalized knowledge, relations of power and knowledge that are overlooked by other research methods could be exposed. Scientific literature regarding mental health services use and organizational culture suggested that mental illness stigma would be a dominant discourse in the context of Navy leaders' beliefs about sailors with mental health problems. The application of a Foucaultian discourse analysis in this study illuminated the presence of a discourse structure related to Navy mental health problems that was richer in context and more dominant than the anticipated discourse on mental illness stigma.

The most important finding of this study is the identification of the FMH discourse. The FMH discourse is a social power structure that emerged by default rather than design in response to surface fleet community and Navy psychiatry discourse incompatibilities. Lacking conscious design, the FMH discourse does not effectively meet the needs of the leaders who must use it to ensure that sailors are combat ready. In particular, the FMH discourse is limited by unclear or conflicted policies, inadequate communication between providers and leaders, slow response to dynamically changing fleet needs, and lack of leaders' knowledge. The FMH discourse limitations frustrate the leaders and undermine their authority. Over the past several years, the FMH discourse
was increasingly being activated because of post-September 11th life stressors, increasing rates of job stress and depression in the military population (Bray et al., 2003), and wartime military service. The leaders subsequently experienced an increased demand for their attention and responsibility related to crewmember mental health problems during a time of increased productivity requirements for ship.

The second important finding is that stigma is not the major influence on use of mental health services from the leaders’ perspective. Leaders’ text showing that a leader’s decisions were based on the mental illness label was considered stigmatizing. For example:

“I’m very cautious of the individual while he is on board. And the fact is, I can’t think of any situations where ultimately I haven't transferred them off the ship.”

Leaders’ text illustrating decisions that were policy based or dependent on job performance was not considered stigmatizing by the leader. For example:

“If I have a guy that I think is unreliable, I have an obligation [by policy] to pull his security clearance.”

It is possible that the use of an overt determination of stigma may underreport subtle stigma that is masked by compliance with policies that support stigmatized decisions. The appearance of stigma behaviors in the leaders’ text is consistent with the leaders’ frustration in trying to manage a difficult problem without clear solutions. Dysfunctional elements in the FMH discourse may promote leaders’ attitudes and behaviors that resemble stigma.

The third important finding is that the mental illness malingering sailor personifies the worst of the FMH discourse. Malingering is a behavior that undermines
leaders' authority and threatens crew cohesion. The FMH discourse policies and social norms prevent leaders from responding promptly and effectively. Leaders' frustration with malingering transfers to mental health providers who represent the ambiguity of the entire discourse.

According to Rabinow and Rose (Foucault et al., 2003), studies based on the works of Foucault should “set out to open things up, not close them down; to complicate, not simplify; not to police the boundaries of an oeuvre but to multiply lines of investigation and possibilities for thought” (p. vii). In expanding the views of knowledge and possibility, it is also important to be able to identify practical and concrete implications for social transformation. This chapter begins with a summary of how the FMH discourse works in the Navy. Next, the practical implications of this study in answering the research questions posed in the study’s development and implications for Navy mental health services are presented. The chapter closes with recommendations for further research and the study’s limitations.

How the FMH Discourse Functions in the Navy

The Navy needs combat-ready sailors to crew the warships of the surface fleet. Mental health problems diminish sailors’ combat readiness. A decrease in sailors’ productivity reduces a ship’s ability to complete its mission. When sailors are not mission-ready, the Navy’s ability to meet its goals is diminished, and other ships must assume the mission burden. The primary responsibility for meeting the surface warship mission of the Navy belongs to the surface warfare community discourse. The purpose, subjects, knowledge, and authority of the surface warfare community discourse are based on the prerequisite that surface fleet personnel are fully productive and competent
members of the ship’s crew. Knowledge and authority structures that are used to develop productive and competent sailors are not effective or applicable when sailors have mental health problems.

Surface warfare leaders must access the subjects, knowledge, and authority of the Navy psychiatry discourse to address sailors’ loss of combat readiness related to mental health problems. Leaders’ access to and use of the Navy psychiatry discourse contains problems. The problem is that the discourse structures of the surface warfare community and Navy psychiatry are fundamentally different. The Navy mission and surface warfare discourses have synchronous goals and objectives that are focused on group outcomes, are mission oriented, and originate in the traditions of the Navy. The Navy psychiatry discourse is focused on individual outcomes and is process oriented, with traditions that originated outside of the Navy. These differences result in meanings and symbols that constitute knowledge and power in each discourse that are not readily compatible or translatable between the discourses.

A discourse that can bridge the fundamentally different components of the surface warfare community and Navy psychiatry discourses is needed to ensure that sailors are mentally capable of performing their shipboard duties while conserving those who are temporarily mentally unfit. The FMH discourse mediates the surface warfare community and Navy psychiatry discourses as sailors with mental health problems experience transitions in combat readiness and move between the two discourses. Fleet mental health discourse mediation acts through discursive practices that can enter all three of the foundational discourses and provide a domain for subjects of the surface warfare community and Navy psychiatry discourses to share power/knowledge. The sharing of
power/knowledge within the FMH discourse is facilitated by balancing authority structures and leveraging knowledge structures. The idea of balancing and leveraging indicates that both surface warfare community and the Navy psychiatry discourse components will have expanded and constricted options. In other words, everybody in the FMH discourse gains and loses something.

Sailors gain the ability to ensure access to mental health services, respite from work stress, and a mechanism by which to leave the Navy. Sailors lose autonomy in the patient role, risk loss of job qualifications, and face a potential mental illness label stigma. Leaders gain access to knowledge and authority structures, shared responsibility for making mental health-related decisions, respite from high-maintenance personnel, and a nonadministrative way to get marginal sailors off the ship. Leaders lose control over the sailor, risk losing a sailor to medical limbo and not getting a replacement, are limited in how they can punish unacceptable behavior, and may be required to administratively (versus medically) separate a sailor who has a mental disorder. Mental health providers gain access to patients, use of leaders’ authority to ensure treatment compliance, legitimacy for funding, and a role in the Navy’s mission. Providers are restricted in their use of treatment options, must share power/knowledge with leaders, must meet both Navy and civilian professional expectations, and are required to return sailors with personality disorders to the fleet for administrative separation.

The result of the FMH discourse mediation is improved combat readiness of shipboard sailors. After engaging with the FMH discourse, sailors with mental health problems either return to the ship to become combat ready or are removed from the surface warfare community discourse. The ultimate determination of combat readiness is
made by the surface warfare community leaders. The FMH discourse gives those leaders the knowledge, tools, and practices to use when a sailor with mental health problems is transitioning back into the role of a fully capable and ready sailor. In part, the FMH discourse gives leaders the opportunity to acknowledge and accept a sailor who is “getting better” rather than rejecting a sailor because he or she is “not better yet.” At the same time, the FMH discourse also provides a process to leaders through which they can remove from the surface warfare community those sailors who will not be combat ready in the near future and request a combat-ready replacement. Ultimately, the FMH discourse exists to serve the needs of the Navy as an organization rather than the needs of individual subjects within the discourse.

Research Questions

One of the study’s functions was to explore the opinions and general feelings of a select group of Navy surface warfare leaders about mental illness and mental health service use. The leaders’ opinions and feelings were explored through the engagement of a peer-based interpersonal dialog in a constructed discourse. Four specific research questions for this study were used as a starting point for data collection and discourse analysis. As a qualitative study, the data was richer in content and meaning than the original questions reflected. The original questions were formulated as a minimum expectation for useful data from the study to address a gap in the literature. The advantage of surpassing minimum expectations is that the existence and power dynamics of the FMH discourse were discovered.

The original research questions were intended to identify the perceptions of military leaders regarding mental illness and mental health treatment in the military
organization; of subordinates who have participated in mental health services; of the impact of mental health services on a subordinate’s career; and of barriers to mental health treatment. Mental illness was perceived by the leaders as impairment in social functioning that is caused primarily by a failure to cope with life stressors. According to the leaders, severity of impairment is influenced by environmental, biological, chemical and genetic conditions. The leaders expected mental health treatment to accomplish three main goals: identify the underlying stressors and make a proper diagnosis, treat the problem as quickly as possible, and ensure that the sailor is fit for sea duty or medically discharge if unfit.

Leaders described mental health evaluation and treatment as complex and ambiguous. Ambiguity about mental health treatment contributed to the leaders’ doubts about treatment efficacy. The broad spectrum of what qualifies as a mental disorder and the fragmentation of services produce great variation in evaluation and treatment outcomes (Norquist & Regier, 1996; Regier et al., 1993). Variability in Navy mental health services is related to the multiple allegiances of mental health providers to the individual patient, family system, shipboard commanders, legal system, managed care productivity, and the Navy. The appearance of inconsistent treatment outcomes and recommendations forces leaders to rely on common knowledge, personal experience, and conflicting policies in responding to sailors with mental health problems. This results in significant variability from ship to ship as to what constitutes a mental health problem, how mental health services are used, and expectations for returning to duty.

This study found that the leaders did not respond strongly to the reliability and competence of generic sailors who use mental health services. This is consistent with the
results of the Porter and Johnson (1994) study where the leaders did not strongly accept or reject the reliability and competence of a generic subordinate after mental health treatment. Once a context was created with the vignettes, however, the leaders’ responses did show strong and consistent doubts about a sailor’s reliability and competence in response to security clearances, personnel reliability certification, and access to weapons. Given the similarities and differences between this study and Porter and Johnson’s (1994) findings, it appears that the context of the sailor who participated in treatment is important to military leaders’ decision making and actions.

The leaders in this study identified that the impact of mental health services use on sailors’ careers are dependent on the context of the services and not the use of services per se. Behaviors or symptoms associated with the need for services, the circumstances surrounding mental health referral, and job performance after treatment are the factors that have significant career impact from the leaders’ perspective. The leaders’ identified that poor job performance and mental health problems were frequently commingled and would have career impact. The leaders’ found that mental health problems would have an immediate career impact for sailors whose jobs required security or reliability certification.

The inquiry about potential barriers to mental health treatment was not particularly fruitful. Leaders perceived the primary barriers to mental health treatment of sailors to be lack of resource access when deployed. The combined effect of the fleet leaders’ empowerment to solve problems and the lack of traditional mental health barriers in the Navy health system may reduce the importance of treatment barriers to the leaders.
Implications

The leaders in the present study responded to the questions and vignettes in the context of their day-to-day lives. By regulation and social expectation, Navy shipboard leaders have complex roles that require absolute responsibility. There are limitations on the scope and depth of knowledge that leaders can reasonably possess in meeting their responsibilities. One leader stated,

“If I participated in all the training that I needed to do my job, I would not be able to do my job.”

In military parlance, the leaders need to rely on knowledge multipliers to be able to meet their responsibilities and complete their mission. Opportunities to improve Navy mental health services exist as a knowledge multiplier for the leaders. The implications of this study are intended to strengthen the FMH discourse’s ability to ensure that sailors are mentally capable of performing their duties and to improve processes used to respond to sailors who are temporarily unfit for duty. Opportunities to strengthen the FMH discourse include clarifying policy ambiguity, facilitating partnerships between fleet leaders and mental health providers, improved training, and increasing leaders’ flexibility to promote sailors’ mental health.

Policy ambiguity creates gaps in leaders’ knowledge and organizational responsibilities regarding sailors with mental health problems. The gaps in knowledge and responsibility cause leaders’ decisions and actions to be influenced by organizational legacy behaviors or personal experience. Policies with the most influential ambiguities are those related to security and personnel reliability programs, fitness for duty, and mental health evaluations of military personnel. The security and personnel reliability
policies clearly show that the presence of a mental health problem or the associated behaviors are grounds for questioning a sailor's reliability. The policies, however, do not provide any guidelines to mental health providers to assist leaders in making the determination of reliability. Mental health criteria for determining reliability and specific administrative statements for use by providers to leaders need to be developed. The mental health fitness for duty policies related to shipboard sailors is long overdue for a systematic review. In particular, behavioral expectations that operationally define fitness for duty aboard a ship and the parameters for use of any medication that is not part of the ship's standard formulary need to be developed.

The cultural split between the surface warfare community and Navy psychiatry discourses creates disparities in access to mental health services and an opportunity for manipulation by malingerers. A major concern for leaders without a shipboard medical officer was continuity of evaluation, communication, treatment, and aftercare. The concept of fleet outreach, mental health liaison, or shipboard mental health visits is not new; it appears to be effective and was well received by fleet officers (Glogower & Callaghan-Chaffee, 1984). Strategies for meeting the full range of mental health requirements on ships without a shipboard medical officer need to be developed and tested.

The leaders in the current study consistently identified a lack of knowledge necessary to make sound and consistent mental health-related judgments. Their current default position is to send the sailor for evaluation if there is any doubt whatsoever about mental competence. The advantage of early referral is to get sailors connected with services. The disadvantage is that many of the sailors referred will not meet clinical
criteria for formal treatment. The low threshold for referral has further implications for increasing the Navy's manpower requirements for mental health providers. Mental health and mental illness are not separate from other activities in the Navy. Wherever existing Navy training content is focused on roles, relationships, or stress, there is an opportunity for integrating the principles of good mental health promotion. Leadership training is one area that could easily integrate mental health issues into the curriculum. For example, the principles of mental health at the junior level focus on self-care and buddy-aid while senior level training focuses on supervisory skills and policy utilization. Improved knowledge about policy utilization could improve referral decisions and reduce frustrations that originate when policies are misapplied or when the leaders talk with mental health providers.

The Navy needs to move beyond responding to mental illness to promoting mental health. Shipboard leaders and the mental health system do not have the resources to wait for the 20% to 25% of sailors who need mental health services to develop impaired functioning before they connect with services. Several leaders advocated for linking routine mental health screening to the Navy's physical readiness cycle to facilitate early problem recognition when more response options are available. Several activities offer programs or services that fall within the continuum of mental health promotion. Some leaders were well versed in the strengths and limitations of the various programs and know how to match sailors' problems with available resources. Other leaders were not sure of what was available or the scope of provided services. A systematic review of available resources, program goals, and referral procedures needs to be completed for each homeport region.
Further Research

This study contributes to the current literature on mental illness beliefs among military leaders. Specifically, this study assessed power relations and discursive practices related to mental health problems and treatment in the context of a hierarchical work setting. Understanding attitudes toward mental health problems among those who hold power over individuals is important to the study of stigma, health beliefs, and mental health service use. The current study also provides data on attitudes toward mental health problems that are common in a workforce rather than the symptoms of persistent severe mental illnesses.

Currently, explication of the FMH discourse is incomplete. This study focused on the leaders as the dominant authority figures in the sailor-leader-provider triad. The text of sailors and providers is absent. The next study needs to analyze text from sailors and providers. A study of the sailors’ text would need to include sailors who used, and did not use, mental health services. A study of the providers’ text would need to include both mental health providers and non-mental health shipboard providers because the leaders identified the shipboard medical officer role as an influencing factor in the FMH discourse. Minor modifications in the vignettes are needed before this study is replicated with sailors and providers. The disclaimer that the described petty officer did not require a security clearance or personnel reliability monitoring was not realistic considering current heightened security expectations and mission requirements in the Navy. The variable of job-specific mental health requirements needs to be added. Vignette elements that were viewed as leadership issues detracted from the mental illness elements. For example, the continued presence of the attacker on the ship in the “Adjustment
Difficulty vignette drew the leaders' attention to managing the command climate and ensuring the attacker was not creating other problems before they could focus on the identified patient's symptoms and issues.

Limitations and Generalizability

The most significant limitation of this study is the absence of text from sailors and providers. A full analysis and understanding of the FMH discourse will not be complete until findings from sailors and providers are obtained and integrated into the discourse analysis. Threats to internal and external validity have less salience for a qualitative study but still present as potential limitations. Internal validity in a qualitative study depends upon the fit of the explanation to the description (Janesick, 2000). Attempts to support the internal validity of this study were the use of a member check and a peer debriefer. An external validity limitation is based on the nature of qualitative research as a method of inquiry. Although this study provides promising data about military leaders' attitudes regarding mental health problems and subordinates who use mental health services, the results are not generalizable. The findings of this discourse analysis are constrained to the participants and the interpretations of the investigator. Specifically, the discursive practices and power relations identified through participant interviews are limited to the participants and cannot be generalized to Navy leaders in a type of command, a region, an officer community, or the Navy in general.

Even with the limitation of generalizability, this study will add to the body of knowledge regarding mental health beliefs in the military. More important, this study will form the descriptive foundation for the systematic development of larger population-based studies that will be able to examine the mental illness beliefs of military leaders.
and subordinates. Because the military lifestyle includes an occupation with high-risk and high-stress potential, it is important to expand our knowledge about the risks and potential benefits of seeking mental health services with systematic and ongoing scientific inquiries.
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APPENDICES
Appendix A

Glossary
Glossary

**Axis of Authority** — A form of rule about what can be said and who can speak within the discourse. The discursive rules determine how discursive practices appear, who is allowed to speak, and the proper form of discourse concepts.

**Axis of Knowledge** — Identifies the discourse core elements of subjects, grids of specification, and discursive practices.

**Axis of Value or Justification** — Identifies how the discourse justifies the use of power on people and other discourses.

**Disciplinary Techniques or Practices** — Social mechanisms, such as controlling rewards and punishment, that are used to encourage subjects to abide by the discursive rules and act in a way that supports the discourse. The concept of tools and practices includes the use of social constructs, such as laws, regulations, social class, and professionalism, that leverage human behavior.

**Discourse** — A system of knowledge that influences language, perceptions, values, and social practices. Discourses function to fulfill a social purpose and to maintain social order through an authoritative way of creating normative expectations.

**Discourse Analysis** — A critical analysis of the use of language and the reproduction of dominant ideologies (belief systems) by exploring ways that theories of reality and power relations interact as social practices.

**Discursive Practices** — Points in a discourse where the subjects exercise power/knowledge to influence others. Dominant discursive practices are identified by examining meaningful speech acts that engage multiple foundational discourses and grids of specification.

**Genealogy** — Identification of the foundational discourses that make the current discourse possible, contribute normative expectations within the discourse, and form the basis for discourse norms.

**Grid of Specification** — A systematic ordering of concepts relevant to a discourse that can be used to focus a particular body of knowledge on a subject or discursive practice. For example, a list of symptoms would be a grid of specification for identifying a disease.

**Power** — A productive network of relations within a discourse that works through people to create norms for what is right or wrong, acceptable or unacceptable, and what can be considered truth.

**Power Analytic** — Identification of the dominant web of power relations and resistance practices in a discourse.
Power Relation — “A mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on possible or actual future or present actions” (Foucault, Rabinow, & Rose, 2003, p. 137). A power relation has two defining elements. First, the person whom the power is exercised is free to act and maintains his or her agency within the discourse. Second, the exercise of power is not on the person but on potential actions.

Power/Knowledge — An active process that gives words meaning, influences perceptions, facilitates comprehension, and guides interaction. Conceptually, the combined influence of power and knowledge in a social system is to describe normative expectations and regulate what it describes.

Resistance Practices — An act of autonomy within a structured set of institutions and practices. Resistance is a form of creativity of a free person within the discourse that serves the needs of the individual versus the norms of the discourse.

Structural Analysis — Identification of the knowledge, authority, and value/justification axes of a discourse.

Subjects — Individuals who are participants in the discourse. The agency of a subject lies in the constant interplay between strategies of power and resistance, not in the self-consciousness of the subject.

Surfaces of Emergence — Points in a discourse where the foundational discourses and the discourse under study share concepts.

Technology of Power — Disciplinary tools or practices which influence the conduct of individuals and submit them to the norms of the discourse.

Truth — The dominant set of discursive practices within a discourse.
Appendix B

Informed Consent Agreement
Informed Consent Agreement

Purpose of the research study:
The purpose of this study is to describe perceptions of Navy leaders about mental illness and mental health services.

What you will do in the study:
Participate in an in-person or telephone interview where you will be asked to describe your personal beliefs in response to interview questions and hypothetical descriptions of sailors who have received mental health treatment. You will be asked to allow an audiotape of the interview to ensure that the interviewer accurately understands your responses. You may be asked to review preliminary study results to check out the researcher’s interpretations.

Time required:
You will spend about 60-90 minutes in the interview. An additional 30 minutes may be required if you are selected for review of data interpretation. Your total participation will require about 2 hours.

Risks:
Research studies involve some risk. The risks of this study are that you may perceive a career risk if your opinions are inconsistent with naval policies and the hypothetical vignettes may closely resemble an actual case before you, which may stimulate disclosure about a non-participant. To address these potential risks, you have the right to stop the interview or withdraw from the study at anytime. If you choose to withdraw, any of your data collected up to the time of withdrawal will be destroyed. Your identity will be protected and not associated with your responses. The researcher will withhold information deemed potentially slanderous or harmful to you or other participants.

Benefits:
There are no direct benefits to you for participating in this research study. The study may help us understand how Naval leaders describe mental illness and mental health services. Additionally, your responses will provide valuable descriptions for the development of future research instruments and interventions to improve access to mental health services in the Navy.

Confidentiality:
The information that you give in the study will be handled confidentially. Your information will be assigned a code number. The list connecting your name to this code will be kept in a locked file. When the study is completed and the data have been analyzed, this list will be destroyed. Your name will not be used in any report. Your audiotape will be transcribed and then erased after verification of the transcript accuracy.

Voluntary participation:
Your participation in the study is completely voluntary.

Right to withdraw from the study:
You have the right to withdraw from the study at any time without penalty. Your audiotape will be erased if you withdraw from the study.

How to withdraw from the study:
If you want to withdraw from the study, tell the interviewer and the interview will stop. There is no penalty for withdrawing.
Payment:
You will receive no payment for participating in the study.

Project Title: Naval Leaders' Attitudes About Mental Illness

Who to contact if you have questions about the study:
Researcher: Commander Richard J. Westphal, NC, USN
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Who to contact about your rights in the study:
Luke Kelly, Chairman, Institutional Review Board for the Social and Behavioral Sciences, 2400 Old Ivy Road, Suite C141, Room 156, University of Virginia, P.O. Box 800392, Charlottesville, VA 22908-0392.
Telephone: (434) [redacted]

Agreement:
I agree to participate in the research study described above.

Signature: ___________________________ Date: ______________

You will receive a copy of this form for your records.
Appendix C

Retained Policy Documents
## Retained Policy Documents

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Appendix D

Interview Guide
Interview Guide

Note: Words in italics are not read nor presented to the participant.

Section 1. Open Interview

Before we begin, I wish to thank you for agreeing to participate in this study. I am going to ask you several questions with regard to mental health, mental illness, and a sailor's use of mental health services. The interview will have three sections. The first section is a series of general questions regarding mental health issues in the Navy. The second section consists of three vignettes with a common core of questions following each vignette. The third section is very short and consists of the demographic questions. To begin:

1. Tell me your ideas of what mental health and mental illness are.
2. What do you think are the causes of mental illness?
3. How would you know if a sailor’s behavior is malingering or mental illness?
4. If you thought that a sailor was having mental problems, what would you do?
5. What are your expectations about what will happen when a sailor gets mental health treatment?
6. To what extent do you think someone sent for mental health treatment should return to active duty?
7. What do you think about someone who has received mental health treatment coming back under your command?
8. As best as you can tell, what encourages or discourages sailors in your command from seeking mental health care, before they get really sick?
9. As a leader, what are some of the barriers you face when you have a subordinate who needs mental health evaluation?
10. In your opinion, can seeking mental health care harm a sailor’s naval career? How?
11. What changes would you recommended to improve Navy mental health services?

Section 2. Vignettes.

Often, it is helpful to use case studies or vignettes when discussing complex issues or situations that do not have clear right or wrong answers. Next, I have three short vignettes that are examples of the most common mental health issues in the Navy. We will use the vignettes to help clarify some of the issues surrounding mental health services. The vignettes describe a Petty Officer whose rating does not require a security clearance or PRP monitoring. I will read the vignette and then ask you several questions to guide our discussion.

Hand participant card with the vignette.
Vignette 1 (Troubled Person)

Petty Officer Smith is a career oriented sailor who reported on board about six months ago. Initially, Petty Officer Smith appeared to be a hard-charger who was effective in completing routine and contingent tasks. Other than poor people skills, Smith seemed to be a good sailor. At first, Smith’s short tempered and abrupt manner was attributed to motivation to get the job done. Smith’s Senior Chief attempted several times to guide the Petty Officer’s management skills by praising the success of the task and suggesting other ways Smith could have lead subordinates to the same results. The Senior Chief was getting frustrated because Smith consistently misinterpreted the guidance as either a personal attack or criticism that the job wasn’t done right.

Recently, Petty Officer Smith became more unpredictable. Smith would yell at subordinates for minor mistakes and was frequently involved in arguments with peers. Off duty, Petty Officer Smith seemed impulsive. Smith had several traffic tickets for speeding, had been seen at an off-limits night-club, and purchased a sports car at a high interest rate. Following an outburst where Petty Officer Smith was angrily disrespectful toward his division officer, Smith confided a long history of trouble getting along with others and controlling anger. Petty Officer Smith voluntarily agreed to a mental health evaluation and returned to duty with a referral for a two-week stress management course.

Vignette Questions
1. In your opinion, what might be some of the causes of Petty Officer Smith’s symptoms or behaviors?
2. Were Smith’s symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Smith?
4. What do you think would happen if Petty Officer Smith did not participate in treatment?
5. What concerns would you have about Petty Officer Smith’s return to the command?
6. What considerations would you give to Petty Officer Smith upon returning to duty?
7. What impact could treatment of a mental health problem have on the Smith’s career?
8. Is there anything else that you wish to discuss in regards to this vignette?

Hand participant card with the vignette.

Vignette 2 (Adjustment Difficulties)

Petty Officer Jackson is a sailor who was assaulted by a fellow crew-member while off-duty. The attacker was found guilty by a court-martial. With a history of positive work performance and support from character witnesses, the attacker was sentenced to a reduction in rank, a fine, and 30 days restriction to the ship. Petty Officer Jackson was angry about the punishment because it meant that Jackson would still see the attacker every day on the ship and the attacker was still senior to Jackson in rank.

Two months after the court martial, Petty Officer Jackson’s work performance began to deteriorate. For example, Jackson would forget details, partially complete tasks, and not adequately supervise the work of subordinates. Petty Officer Jackson appeared sad,
sometimes tearful, and stopped working towards advancement. Conversations with Petty Officer Jackson would often focus on how the command and the Navy legal system were inadequate and a sense of being trapped on the ship. Additionally, the use of Sick-Call for a wide variety of complaints and illnesses increased from before the assault. During a performance counseling session, Petty Officer Jackson stated, “I can’t deal with this anymore” and asked to go to medical. After talking with the Corpsman, Jackson volunteered for a mental health evaluation. Petty Officer Jackson was admitted to inpatient psychiatry for four days and then participated in a two-week intensive outpatient treatment program. Petty Officer Jackson has been cleared by psychiatry and has returned to full duty.

**Vignette Questions**

1. In your opinion, what might be some of the causes of Petty Officer Jackson’s symptoms or behaviors?
2. Were Jackson’s symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Jackson?
4. What do you think would happen if Petty Officer Jackson did not participate in treatment?
5. What concerns would you have about Petty Officer Jackson’s return to the command?
6. What considerations would you give to Petty Officer Jackson upon returning to duty?
7. What impact could treatment of a mental health problem have on Jackson’s career?
8. Is there anything else that you wish to discuss in regards to this vignette?

**Hand participant card with the vignette.**

**Vignette 3 (Depression Symptoms)**

Petty Officer Ray started having marital and financial problems at home about two years ago. Marital counseling with the chaplain helped some, but the relationship remained strained. Working with a command financial advisor, Petty Officer Ray developed a financial recovery plan that would reduce the debt but left little money for non-essential spending. About eight months ago, Petty Officer Ray had several weeks of feeling really down. Ray was not sleeping well and would wake up in the morning with a flat heavy feeling that stuck all day long. During this time, it was difficult for Ray to have fun or experience pleasure. Petty Officer Ray was an avid runner but no longer found enjoyment in running or any exercise. Even when good things happened, like a top-five time for the PRT run, they didn’t seem to make Ray happy. Petty Officer Ray would push on through the days and found that the smallest tasks were difficult to accomplish. Concentrating on any task was hard and Ray’s work suffered due to lack of attention to detail. Even though Ray felt tired, the nights were spent lying awake filled with worry. Feelings of worthlessness and failure were a common theme in Ray’s thinking.

Over the course of two months, family, friends, peers, supervisors, and the ship’s corpsmen began expressing concern for Petty Officer Ray’s well being to Ray and each other. Following a visit to medical for fatigue, the corpsmen referred Ray to mental health. The treatment that Petty Officer Ray required conflicted with the ship’s schedule
and necessitated orders off the ship. Ray participated in six months of limited duty for treatment that included medication, individual therapy, and group therapy. Petty Officer Ray responded well to treatment. According to the treating psychiatrist and the medical evaluation board, Petty Officer Ray is fit for full duty while continuing to take Prozac to prevent relapse and is reporting to full duty on your ship.

Vignette Questions
1. In your opinion, what might be some of the causes of Petty Officer Ray’s symptoms or behaviors?
2. Were Ray’s symptoms worrisome enough to warrant mental health evaluation?
3. To what extent do you believe that treatment will be effective for Ray?
4. What do you think would happen if Petty Officer Ray did not participate in treatment?
5. What concerns would you have about Petty Officer Ray’s reporting to the command?
6. What considerations would you give to Petty Officer Ray upon returning to duty?
7. What impact could treatment of a mental health problem have on Ray’s career?
8. Is there anything else that you wish to discuss in regard to this vignette?

Section 3. Demographics and Personal History

Thank you for your thoughtful answers to the questions and discussion of the vignettes. I have few final questions that will help me to understand your answers in the context of your career and life experiences.

1. How many total years of military service do you have?
2. How many times have you been a (CO, XO, CMC)?
3. For some people, prior experience with mental health services influences how they see those services. Has a social acquaintance ever used mental health services? In what ways did that experience influence the discussion that we have had today?
4. What is your highest level of education?
5. Are you currently married?
6. What racial group do you declare on standard Navy survey’s?
7. Gender M F
8. Would you like to review and comment on the ideas and themes of the study before I write the final results. This review would take an additional 15-30 minutes. Yes No
9. Is there anything else regarding mental health services you wish to share with me?

That concludes the questions that I have for you during this interview. Thank you for sharing with me today your valuable experiences and insights.
Appendix E

Cross-Reference of Conceptual Framework to Interview Questions
Cross-Reference of Conceptual Framework to Interview Questions

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a: Each vignette provides context cues for discourse.
Appendix F

Member Check of Content Analysis
Member Check of Content Analysis

The content analysis of the interviews in this study identified five themes: Mental Illness, Mental Health, Sailors’ Use of Mental Health Services, Leaders Response, and Mental Health Services. Below are the labels, operational definition (OD), and an interview text example (ITE) for the identified themes and categories. The themes and categories should reflect the major mental health related ideas of surface fleet leaders. Feel free to make any comments you think would add clarity or encourage me to rethink any item.

Themes and Categories

1. Mental Illness

   (OD) Mental illness affects people in varying degrees by interfering with their ability to function in a way that is consistent with the norms of society.

   (ITE)
   ... “any condition or disorder diagnosed by the proper medical professional that keeps people from functioning normally in their lives”
   ... “an individual that behaves in some aberrant way that's not normally accepted by society”

1a. Behaviors or Symptoms

   (OD) Mental illness behaviors or symptoms most often manifest as a change from the Sailor’s baseline. Particular behaviors that raise leaders’ concerns are deterioration in job performance, sudden change in personality, emotionally labile or withdrawing, and a loss of future orientation.

   (ITE)
   ... “180 out from the normal personality, stopped working towards advancement”
   ... “losing interest, feeling fatigued, not wanting to do the things that you like”
   ... “the crying, the withdrawing, the sadness, isn't the sign of a healthy sailor”
   ... “not quite giving away personal possessions. But it kind of signals a loss of hope.”

1b. Causes

   (OD) Difficulty in coping with life stressors, especially financial and family problems, are the major influencing factors for Sailors with mental health problems. The negative impact of life stressors are influenced by predisposing biological, chemical, genetic, and family of origin conditions.

   (ITE)
   ... “I think that almost anybody, or all but the very strongest, if you put them in a difficult enough situation, um, you could break them down.”
... "The dominant issue here is life stressors ... marital and financial problems are both things that could easily way heavy on someone's mind."
... "mental illness is manifested through stress at times, undo stress or traumatic event."
... "could be genetic, chemical, it could be environment"
... "likely environment. If people have had a very tough upbringing. It may be hereditary."

2. Mental Health

(OD) Mentally healthy Sailors are self-aware, employ adaptive coping skills, are responsible for their own actions, and behave within normal societal expectations.

(ITE)
... "So the person we would consider to be mentally healthy has some awareness of who he is, an awareness of his surroundings, and the concept that there are other people in the world,"
... "adapting to the requirements around you."
... "The stronger sort of person will make a mistake and say, 'Hey, I made a mistake. I need to pay my penance.' And rarely gets referred further into the system."
... "acting in a sense or in a way that's accepted by society"

2a. Effective Coping

(OD) Mentally healthy Sailors demonstrate effective coping behaviors and maintain a realistic perspective.

(ITE)
... "There are all sorts of things that come to you and just dealing with those in itself is stressful. So you are going to have mental health things to work on as you go through your life."
... "has coping mechanisms to deal with issues. When something comes up that doesn't go quite right for him, then he has a way to work though it."
... "what doesn't kill you makes you strong, so, after he is gone through something like this, depending upon what exactly this is, ... you can keep it all in perspective."

3. Sailors' Use of Mental Health Services

(OD) Sailors' use of mental health services depends on a complex interplay between the needs of the Sailor, positions of authority and responsibility, performance expectations, Naval policies, expectation of peer reactions, and potential career impact.

(ITE) See categories 3a - 3g

3a. Malingering
(OD) Malingering or manipulation of the mental health system is a problem that places increased demands on Naval leaders, the mental health system, and can create an additional burden for Sailors that need mental health services.

(ITE)

...“I think that there are ways for bright people to manipulate the system. I am compelled when somebody says certain things I feel, out of duty to the ship and to that person, that regardless of whether or not I believe them or not, to respond.”

...“malingering is tough. We’ve had a couple of those where we finally got the medical officers to follow up, but only after we sent him through, you know, the million dollar workup”

...“later the guy knows that all he has to do is say that [self-harm] and he will get practically a whole day off while I have him sit in the ER, does it again and he’s gone. That’s when you start getting into the malingering, they learn how to play that system because it’s so gray on the hospital end”

...“when you have so many people, and I say faking it, you know, you overload your system. So I might have someone that legitimately needs to be seen, ... because there are a limited number of resources, my person might not get in until next week. Well, what if we are gone next week.”

3b. Seniority

(OD) The demand for mental stability increases as responsibility increases. Mental health problems early in a Naval career have minimal negative impact versus a senior leader with current mental health problems whose decisions impact the lives of others or national security.

(ITE)

...“If it’s a younger more junior petty officer, you know, particularly the classic Adjustment Disorder that’s getting resolved, there is no [career] impact.”

...“It depends upon what level. I would think yes if it is a position like mine. I think that if I were to seek treatment, for whatever reason, that it would adversely affect my career. And the second part of that is, it should.”

...“for a CO or XO, somebody who has weapons control authority, um, you know, I am concerned with people who have received treatment and then come back”

3c. Returning to Duty

(OD) There is little flexibility in the shipboard environment for a Sailor who is not fit for duty, for any reason. Upon returning to the ship, Sailors are expected to be able to fulfill all their duties. Returning to duty is problematic when the Sailor is perceived to have continuing mental health problems or has a job that requires security clearances or weapons access.

(ITE)

...“If somebody gets sent to mental health and has no problem or a small problem but it is not a big deal then he should be able to come back.”
... "the main issue is not why they go to medical, whether it is a mental health problem or not, it is really their performance afterwards."

... "it is tough for me because the guy that is really hell bent on killing himself, I take him 100 miles out in the Atlantic, I'm giving him a pretty good opportunity"

... "if I have a guy that I think is unreliable, I have an obligation to pull his security clearance."

... "if he was qualified to handle weapons, I would have to remove him from that until I was fully satisfied that everything was taken care of ... I mean, he could harm himself in many other ways on the ship. But handling a weapon increases the probability of him harming somebody else."

3e. Peer Response

(OD) Peer response to a shipmate following mental health treatment has significant impact on returning to the ship.

(ITE) ...

... "I think, peer pressure and peer acceptance of the problem is probably the biggest, negative, but at the same time, ironically peer interest in trying to help the guy is probably positive, so it's really all about creating a climate and an attitude and the people are comfortable with bringing their problems forward."

... "I ended up in the Psychiatric ward ... I was discharged, I went back to my command, they didn't treat me any differently."

... "afraid their peers might find out and then, you know the Navy's a harsh place still, I mean, Sailors are hard on each other, if you're a little bit different, you know, you can quickly become an outcast."

... "the burden of the label is worse than the burden of the disease ... because the rumors, the innuendoes, the perceptions, and all of that makes the person go downhill further and further because they feel, oh, everybody thinks I'm crazy. Well if they think I'm crazy I'm going to be crazy."

3f. Negative Career Impact

(OD) Seeking or participating in mental health services does not have a direct negative career impact. The potential for negative career impact is related to continued poor performance after treatment or from "neutral time" during an evaluation cycle.

(ITE) ...

... "he has been referred to treatment, the failure to follow through with a recommended course of action is very detrimental."

... "if he went to the treatment and didn't do anything about it and came back the same way, he's going to end up where he was before, in trouble."

... "the strategy of doing nothing has not yielded good results, and that's something I look at all the time. You know, staying the course is not the answer."

... "if I have a guy that I think is unreliable, I have an obligation to pull his security clearance. Now that would definitely impact his career if his place requires clearance."
... “no impact, say for the fact that if she was gone from her department, you know, more than a quarter of the time, eventually that would absolutely have to have an effect because you're only getting 75 of the goodness of, of the sailor that you're looking for.”

... “TAD status for six months, it does have an impact, and the way I used to explain it to those folks is, is not an impact in a negative sense, but because he's not performing and competing, there are other people that have outperformed him, so he kind of gets left behind a little bit, ... when they're not here, they're not supporting the mission of the ship same as someone that is here, if during the six months that he was off doing something else. If I have some hard chargers who are performing and doing productive work for the ship, I would be obligated to rank them higher.”

3g. Positive Career Impact

(OD) Participating in mental health services can have a positive impact on a career to the extent that the Sailor makes positive changes in their behavior.

(ITE)

... “If he took the treatment to heart and went with it, I think it'd greatly improve his career.”

... “I would like to say it could only help his career, if he'd been a rising star, he would continue to be a rising star, if he'd stagnated somewhere because the supervisors felt that he was abrasive or didn't deal with other people, then maybe if he fixed that problem it would allow him to continue to be promoted.”

... “you kind of get a get out of jail free card until you're done [with treatment] and then, once you've been trained, or educated, whatever you want to call it, then you choose to go out and do it again, okay, all bets are off.”

4. Leaders' Response

(OD) A leader’s response to a Sailor with a mental health problem focuses on getting the Sailor connected with needed services, continued monitoring, and deciding on the relative risk of keeping the Sailor on board the ship.

(ITE) See Categories 4a – 4c.

4a. Referral

(OD) Available resources and Naval policy influence mental health evaluation referrals.

(ITE)

... “from a shipboard point of view, it's really difficult when we're in someplace else, not here [homeport]. Especially with the size of ship that I'm on, because you just can't fly them off or fly them over [to] the carrier.”
... "I bring my Corpsman into it and usually we sit down and the three of us sit down and talk and after that we make a determination whether he needs to be sent to be looked at, counseling, we use a lot of counseling at the Fleet Family Support Center"

... "I would get them to the experts. We have a senior medical officer in the first place and secondarily the chaplain who helps out with some issues.

... "in the Line perspective, when somebody comes up says, I'm thinking about hurting myself, I'm very lock-step exactly, you know, this message has to go, this guy has to be immediately sent, you know, my procedures [by the Mental Health Evaluation for Service Members instruction] are locked."

4b. Continued Monitoring

(OD) When a Sailor returns to duty after mental health evaluation or treatment there is continued monitoring, even when the Sailor is medically identified as fit for full-duty. Leaders' consistently identified that they are not trained clinicians. Yet, they identified the need to make clinical type assessments of Sailors.

(ITE)

... "I understand that I'm not a clinician or a physician, so that there are some, there are just some things that we're not equipped to make a judgment on"

... "cleared by Psychiatry and returned to full duty... well, I mean I would like to trust the doctor who said he is ready to go and sent him back, but, you know, once again, on my watch list, the chaplain would be checking on him about every day, ...for a while to make sure"

... "they send these guys back, no counseling, whatever, he's, he'll be fine. Okay, what do I do with the guy? I have to watch him"

... "I don't have the capacity to deal with a guy who requires care constantly, or watching him, which is just the bottom line is if they send, if he gets sent back from the hospital as not a harm to himself or others, you know, and I still think he's going to do something"

... "there are times where my opinion may diverge from the professional's opinion, we file the professional's opinion,"

... "he won't have a weapon for awhile until we all are happy again and, I won't give him anything to facilitate him hurting himself or others until I get him back where I'm comfortable with him"

4c. Risk Tolerance

(OD) The level of perceived acceptable risk of retaining a Sailor with an identified mental health problem on board the ship is influenced by personal experience.

(ITE)

Experienced crewmember suicide:

... "I'm very cautious of the individual, while he is on board and the fact is I can't think of any situations where ultimately I haven't transferred them off the ship. Because a lot of the cases tie back to possible harm to themselves or someone else and that's my
threshold. As soon as I see that statement or feel that statement, I will take them off the ship.”

... “It's not worth the risk. I have too many sailors in the Navy that don’t need Prozac, why would I want one onboard a ship, a warship, at sea that's on Prozac.”

Minimal Exposure:

... “There are certain limitations, about what jobs, security clearances and such. I would have to be assured that their performance is up to where it needs to be. We have some of those cases on board here that I am aware of. Yes, they are here and they are doing well.

... “I would have no concerns about somebody that had been through this, is taking some medication like Prozac to kind of moderate their mood swings, and work aboard the ship in a general capacity, I’ve got no concerns about that.”

Personal Experience or Family Member:

... “I’m just a believer, I mean, if this mental health stuff would be like a religion. You know, I believe that there is, there is a reason that these kind of things happen to people and I believe that they can be treated and helped through them, you know, with the right kinds of treatment and sticking to it on their own afterwards”

... “medication works wonders in a lot of cases. People can function fairly well on medication, depending, obviously depends upon the illness, I would expect them to be able to return.”

5. Mental Health Services

(OD) Mental health services have a direct relationship to major issues faced by Naval leaders that include access and barriers to the use of services, support by mental health providers, fitness for sea-duty expectations, needs of the fleet, and the use of psychotropic medications by fleet personnel.

(ITE) See Categories 5a-5f

5a. Access

(OD) Factors that encourage the use of mental health services are having a supportive chain of command, readily available resources, and protecting privacy.

(ITE)

... “Availability of people in the chain of command, having a relationship where you can bring that sort of thing to your supervisor, or chiefs, or Chaplain, or senior medical officer.”

... “Encourages when they hear it from me and everybody else in the chain of command. They're constantly being asked, you know, how are you doing today, everybody, peers, even subordinates, working back the other way are taking an active interest in each other and I think that encourages it.”

... “Portsmouth Hospital is very good about taking folks when we send them over there.”
... "there's just a whole plethora of other sources [Fleet and Family Support Center, Alcohol Rehabilitation, Fleet Legal Services] if we feel we can pigeon hole it in the right direction and send them there"
... "it is more likely that people will seek any kind of medical help when there is some sense of privacy and confidentiality."
... "we guard privacy issues"

5b. Barriers

(OD) Factors that create barriers to initiating, sustaining, or completing mental health evaluation or treatment are lack of knowledge about mental illness symptoms, concern about privacy and career impact, and policy requirements.

(ITE)
... "there's a lot of guys I've talked to who have, who I've thought had mental health issues, didn't think they had a problem."... "people don't recognize signs of mental illness, particularly depression"
... "this barrier that people put up, that says, I will get in trouble if I ask for help"
... "there are a number of folks out there that don't want certain types of problems to be known"
... "I think the primary discouraging factor, ... is the notion that seeking out mental health can be detrimental to your career"
... "confidentiality and access, if you are on a small ship"
... "problems often manifest themselves related to a discipline problem or performance shortfall. Once that happens, and you know I'm not a lawyer and I'm not a doctor, but, whatever it is, the Boxer rule, or Boxer law, you cannot couple mental referrals with discipline procedures, in that they can't be punitive."

5c. Mental Health Providers

(OD) Leaders have difficulty trusting mental health provider assessments. Concerns include mental health provider's reports and recommendations, the reliability of the mental health evaluation, and the mental health provider's knowledge of the shipboard environment.

(ITE)
... "the assessment is going to be a bunch of mumbo jumbo, about this axis and that axis, and so on ... my perception is that the way it is written is that there is a psychiatrist out there who is covering his six."
... "I expect from those guys, to communicate with me better than they do and to tell me the course of treatment. I'll work it out between the ship and the individual's schedules."
... "I just want to know what their plan is. ... I don't want a detailed transcript of what they talked about. But I do want to know what their plan is, how many visits is it going to take, don't leave it up to the individual to schedule his own appointments because he will take that and everywhere that's blue [pointing to underway dates on a calendar], will be an appointment."
... "the best I can do is get them to the ER at Portsmouth, ..., 95 percent of the time plus
the guys return to full duty within, you know, two or three hours, and I doubt
seriously that they even got a psychiatric consult. ... I, don't want to have to wait until
the kid that makes the gesture gets successful because he's stupid, uh, to get him the
help he needs"

... "I'm not so sure what I'm getting for an answer or how qualified that answer is. Is it
some residency individual that saw them, that, it's their tenth patient of the day, and
they just don't have time to deal with it and I'm getting that kind of diagnosis or I'm
getting a diagnosis based on a doctor who's been doing this for 20 years. I don't
necessarily put a lot of confidence in the diagnosis that comes back.

... "make sure the individual doctors are fully aware with what they are doing when they
send a guy back to a ship that is full of hazards, dangers, and goes to sea."

... "I love to take doctors and nurses out to sea just to show them, ... so they get a better
idea of what this kid is going through, but they don't have any perspective to the fleet
unless they get here. ... They don't have to be assigned to a ship, but just come out
every so often and you could do the two things together. I'll bring you for a week and
you just set up shop and I'll cycle them through, that's what I do with the nurse
practitioner.

5d. Fitness for Sea-Duty Evaluation

(OD) "Fit for Full Duty" needs to mean fit for sea-duty. Sailors are returned to
shipboard duty with symptoms, treatment requirements, or aftercare program
requirements that are not sustainable in a shipboard environment.

(ITE)
... "he is sitting there burning holes in his arm ... So here I have this guy who was
dropped from sub school and has all kinds of mental health issues documented and
they send him to a ship. So I spend the next three weeks dealing with this guy and
getting him kicked out of the Navy.

... "But there needs to be some kind of standard, I don't think, I don't see a standard
process ... the line needs to be narrow instead of wide as far, as far as when a person
can come back to the ship"

... "What their criteria is when they come back, I'll leave that to you guys, but, I do
expect when they get back they're pretty much ready to go, don't give me a guy back
who is necessarily, you know, mid-treatment and he's got another 50 visits to go and
they've got to be once a week. Because that guy won't work. There's lots of other
things he can do here on the waterfront, but he may not be ready to go back to sea-
duty."

... "okay he needs to go to counseling three times a week. ... I am one deep. When I lose
that guy for 6 to 8 hours a week for counseling, I mean that, that really hurts."

... "there's a very stamped out aftercare failure criteria on the alcohol side. It might not be
so cut and dry with mental health but, you know, rather than leaving it up to the
command, the untrained, to figure out where that line is, there's an after care thing
and these things happen. ... If a guy goes back and the professional declaring the
aftercare failure, then he's gone. I'm not asking for that decision because I'm not trained to make it. The alcohol one is pretty easy.

5e. Fleet Needs

(OD) Mental health related issues consume a large portion of a leader's personnel management time, create expanded training needs, reduce available manpower, and raise concerns about recruitment screening.

(ITE)

... "probably 20% of my time is spent dealing with these people, and that only multiplies because, you know, the next guy, the XO that goes up 5% and down to division level, it's a real resource drain as far as tying up manpower"

... "I just don't remember anybody [at pre-XO school] waiving their arm and say gents, this is going to be the biggest thing you're going to worry about. ... mental health issues are more significant than the time spent on equal opportunity, sexual harassment, racial strains, or NJP."

... "I think that if I knew a little bit more about what are these axes and what do they really mean. Then when somebody comes to me with a report that says he's got Axis II. Or such, then it would not be as much mumbo jumbo."

... "I have some concerns that we could do a better job, in mental health on board the Navy, in ... training our leaders and understanding them better, and things that are available, and a sense of the medical care that's provided. As I mentioned earlier, perhaps getting them more linked with organizational units instead of, garrisoned in a hospital somewhere, um, and then perhaps more visibility on what's going on in that little black box in the hospital.

... "Right now there's very limited things that I can bring to the ship, ... everything else is pushed to the ships, you know, every maintenance training, this training, that, but not mental health training. ... We do safety stand downs all the time, why not have a health stand down, ... bring the dental van, bring the audiogram van, bring the, the reclining couches and let's just knock all 3, you know, knock them all out at the same time, uh, and then it becomes a normal thing."

... "if treatment is not possible, then limited duty boards need to be held more often and concluded much faster. Because I don't get anybody until the LIMDU board say yes, he is not going to be going back to the ship anymore."

... "with the size of our ship, when a certain NEC, I either keep that guy or I'm looking at anywhere from six months to two years for replacement. That puts a lot of burden on making a decision to let a guy go, but right now we don't have that authority, so we just, the only thing we can do is keep the guy."

... "We need a better screening up front, I'm held to task for attrition, ... I don't take kindly to being held to task for an attrition based on something that was previously known but not waived but he came in through recruiting.

... "I've had two people come that were, you know, civilian diagnosed prior entry service as bipolar ..., somehow make it all the way through boot camp and decide to stop taking their medicine when they get to me, and it's pretty classic, it takes a psychiatrist 5 minutes and tells you to get rid of them. Well, the Navy has just wasted
35 or more weeks in training this guy and you could have solved that right up front and never let him in the door.”

5f. Medications

(OD) There is ambiguity related to psychotropic medication use and administration with concerns related to taking medication as prescribed, medication monitoring, adequate supplies during deployment, and leaders’ responsibilities.

(ITE)

... “my concern would be him taking his medication. That would be my biggest concern. We have, we deal with this on the ship all the time, um, they get there, screw it, I feel better and then they start right down the same road again and we've a lot of issues that we've got to deal with and, I have a guy right now, same thing with blood pressure, he gets all bent out of shape and his blood pressure is through the ceiling and he doesn't take his blood pressure medication”

... “Staying on his medication, um, that's one of my biggest problems is when people come back from medical or whatever, um, yeah they're adults, they're given the prescription but I'd rather they turn their pills in at the door and have the Corpsman give them to them every day so I make sure I know they take them.

... “my only concern is that if we went on deployment that he would have enough medication to last him. And I don't know how long the prescriptions go on that. That would be my concern. How the medication would need to be administered is that they would need to go see the IDC whenever they had to take it. He would issue it and then we would keep track if he got it or not.

... “I should ask him [IDC], because I would like to know that, if there’s anybody that’s on a long-term, you know, medication that if we don’t have it on board, something’s going to happen to him. Am I supposed to know that? I think I’m supposed to know that, if there’s some drug I’m supposed to carry for somebody, I don’t know.

... “my understanding is that Prozac is a pretty potent drug. I don't think people with Prozac can come on ships. Right? I may be wrong. ... A lot of these meds it says, do not operate heavy equipment while taking this medication. Well, 90,000 tons of warship is heavy equipment.”

6. Research (comments about the study)

Many of the participants identified that the vignettes were representative of the most common personnel issues that they face. The disclaimer that the described petty officer did not require a security clearance or PRP monitoring is not realistic with current heightened security expectations and mission requirements. Vignette elements that were viewed as leadership issues detracted from the mental illness elements.

In the first vignette of a “Troubled Person,” the Sailor would most likely end up in stress or anger management classes before his behavior became disruptive to the division.
The issues of poor impulse control, overspending, and disrespect were most frequently seen as most appropriate for leadership intervention.

The continued presence of the attacker on the ship in the “Adjustment Difficulty” vignette drew the leaders’ attention to managing the command climate and ensuring the attacker was not creating other problems before they could focus on the identified patient’s symptoms and issues. The assault description needed to clearly identify if it was a physical versus sexual assault because there are different requirements for sexual assault and harassment cases.

In the “Depressed Symptoms” vignette the continued presence of unresolved marital and financial problems created a dialogue about the need to address underlying causes which prompted the leaders to focus their responses on marital and financial counseling versus the symptoms of depression.

Recommendations for future research included:
- Testing the embedding mental health providers with the RSG to provide mental health support to ships without medical officers.
- Conduct a cost-avoidance analysis to evaluate the potential benefit of more stringent recruitment screening.