Warriors versus Experts: Managing Conflict between Professional Groups for US Army Mental Healthcare

By

Julia Marie DiBenigno

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Abstract

Organizational life is rife with conflict between groups with different interests who pursue different goals. Integrative mechanisms to promote goal alignment do not always work, particularly when conflicts involve professional groups with strong commitments to their professional identities and perspectives. I draw on data from a 30-month comparative ethnographic field study of conflict between US Army commanders privileging their professional group’s goal of fielding a mission-ready unit and mental health providers privileging their professional group’s goal of providing rehabilitative mental healthcare to active-duty soldiers suffering from conditions such as Post Traumatic Stress Disorder. All providers and commanders faced longstanding conflict related to their professional group differences in goals, identities, and perspectives, and all had access to a host of integrative mechanisms to overcome these differences. Yet, only those associated with two of the four combat brigades on the US Army post featured in this dissertation regularly handled these conflicts by co-constructing integrative solutions that accomplished both professional groups’ goals and the organization’s overarching goal to have both mentally healthy and mission-ready soldiers.

I find that an organizational structure that enables what I call “anchored personalization” can help different professional groups overcome identity conflict and entrenchment in their home group’s perspective to align their goals, without becoming coopted by the other group’s perspective from personalized contact with the other group. Anchored personalization resulted from an organizational structure that provided a long-term personal connection with specific members of the other group, while anchoring group members in their home group identity from working surrounded by their fellow group members. Anchored personalization reduced longstanding identity conflict between groups by broadening and expanding each group’s professional identity to incorporate elements of the other group’s perspective, enabling what I call “anchored perspective-taking.” Anchored perspective-taking practices led to the co-construction of integrative solutions to conflicts that aligned seemingly incompatible group goals to achieve the organization’s superordinate goal. This dissertation contributes to our understanding of managing goal and identity conflict between professional groups in organizations and to our understanding of the dark side of personalization without anchoring.
Thesis Committee:

Katherine Kellogg (Chair)
Professor of Work and Organization Studies
MIT Sloan School of Management

Lotte Bailyn
T Wilson (1953) Professor of Management, Emerita
MIT Sloan School of Management

Jayakanth Srinivasan
Research Scientist
MIT Sloan School of Management

John Van Maanen
Erwin H. Schell Professor of Management
MIT Sloan School of Management

Ezra Zuckerman
Deputy Dean and Alvin J. Siteman (1948) Professor of Entrepreneurship and Strategy
MIT Sloan School of Management

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THE PROBLEM

It’s 2:00 a.m. The Army captain is up again. He can barely sleep more than 20 minute stretches since returning from his last deployment. He stirs from the slightest noise. In restaurants, he sits in the back corner of the room—his back to no one. He constantly scans his environment, especially the tops of buildings. He avoids crowds. He wants to “turn it off”, but says he can’t. His wife is worried about him. He says no one comes back from a deployment unchanged and that lots of guys are like this. He tells me officers can’t get care (mental healthcare) because soldiers can’t know their commander is not Superman.

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A mental health provider returns from the memorial service of a private first class who recently killed himself after going AWOL (away without official leave) and driving off a cliff. He had been arrested for a DUI and was facing legal charges. At the suicide review board meeting soon after, his commander exclaimed how he was shocked and that the soldier was “killing it” at work. The mental health provider, who had been treating him for depression for nearly six months, said that she wasn’t surprised at all.

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A staff sergeant smashes his trigger-finger with a hammer in a drunken rage days before his third deployment overseas after his wife threatens to leave him if he misses the birth of another child, their third. He is diagnosed with PTSD (Post Traumatic Stress Disorder) after watching two of his fellow soldiers die from an IED (Improvised Explosive Device) blast to their Humvee in Iraq, which also left him seriously injured with a rod inserted into his leg. He received a Purple Heart and was medically retired, but had the rod removed so he could re-enlist in honor of his fellow brothers who died. After years of self-medicating his PTSD symptoms
with alcohol rather than seeking professional help, he is also diagnosed with alcoholism. His commander initiates criminal proceedings to charge him with malingering, but his mental health provider is eventually able to get this overturned after testifying on the sergeant’s behalf.

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A private first class tried to kill himself after taking twenty OxyContin. His unit and commander said they felt blindsided by what happened since the soldier was considered a ‘stud’ at work. His company commander is berated by higher command for not having adequate ‘situational awareness’ on this soldier since he was not being tracked on his “high risk list”. The soldier is now back in the unit and embarrassed about his recent hospitalization. The commander says the other soldiers are treating him well and that as long as you pull your weight at work, people don’t care. It’s only when you use your condition as an excuse that people start to treat you differently, he says.

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While these soldiers have never met and live hundreds of miles away from one another on four different US Army posts, their lives are connected by their shared experience of suffering from mental health problems while serving in the US Army during the US wars in Iraq and Afghanistan. These are just four of the hundreds of stories shared with me by mental health providers, commanders, chaplains, NCOs (non-commissioned officers such as sergeants), and soldiers I had the honor of spending time with over the course of my fieldwork.
Over the last decade, there has been a dramatic increase in soldier mental health problems in the US Army—notably PTSD and suicide (Srinivasan, 2016; Ramsawh, 2014). Though estimates vary by study, between 15-30% of the 2.7 million US men and women who served during the wars in Iraq and Afghanistan are expected to develop a serious mental health problem (Ramchand et al., 2015). Between 2001 and 2011, there has been a 65% increase in mental health diagnoses across the military. In addition, the suicide rate among active duty service members rose to an all-time, with suicide becoming the second leading cause of death after war injuries since 2010 (U.S. Armed Services Medical Surveillance Report, 2012). Many with PTSD self-medicate with alcohol and drugs rather than seek professional help; it is estimated that 64-84% of veterans with PTSD are alcoholics (Brady & Sinha, 2005). Notably, nearly half of soldiers report alcohol misuse in the year following a deployment to Iraq or Afghanistan (Eisen et al., 2012). Of all the branches of the military, the Army has suffered the greatest increases in suicides and other mental health problems (IOM, 2014).

Numerous theories have been posited to explain the unsettling rise of PTSD and suicide among active-duty US Army soldiers. Explanations include the unprecedented pace and number of Army deployments, the nature and extended duration of the conflicts in Iraq and Afghanistan, prevalence of injury types linked to mental health problems (e.g., head trauma from roadside IEDs leading to TBI (Traumatic Brain Injury) and PTSD), and advances in body armor and medical care which allowed soldiers to survive traumatic injuries they would have died from in the past. For example, improved medical care and protective gear reduced the fatality to wounded ratio for US soldiers from 1:2.6 during the Vietnam War to 1:5 and 1:7.2 in the recent conflicts in Afghanistan and Iraq, respectively (US Army Gold Book, 2012).
The wars in Iraq and Afghanistan have also been unique in that the US military relied upon an all-volunteer force without resorting to a draft, despite severe shortages of soldiers (Korb and Duggan, 2007). To make up for this shortage, soldiers were called upon to deploy more often and for longer periods of time with less time for rest and recovery in between (Bolger, 2010; De Angelis and Segal, 2009). Prior to 2001, soldiers generally were deployed to a combat zone at most once or twice in a career, and had a period of at least two years to recover following a nine month deployment. However, during the height of the wars in Iraq and Afghanistan, soldiers were deployed for 12-15 month tours and were given as little as 9 months at home before deploying again. Many soldiers were deployed multiple times—some engaging in as many as six or seven deployments.

Other researchers have attributed the rise in soldier mental health problems to changes in Army recruitment standards. Historically, the US military has attempted to screen out soldiers with mental health problems or criminal records from enlisting. However, in order to supply enough soldiers for the wars in Iraq and Afghanistan, at the height of these conflicts in 2005, enlistment standards were lowered and more waivers were provided to soldiers who previously would have been ineligible for enlistment (Nock et al., 2014). For example, in 2005, almost 27% of newly enrolled soldiers self-identified as having a prior history of receiving mental healthcare (Srinivasan, 2016).

The Army’s Response

The vast majority of studies published on military mental health are focused on either understanding the underlying causes associated with the rise in mental health problems and suicide among active-duty US soldiers (e.g., Ursano et al., 2014), particularly the effect of
combat exposure on the development of mental health problems (e.g., Shen et al., 2009), or on the patient experience of living with a mental health condition, particularly among veterans (e.g., Finley, 2011). This study is one of the first to analyze the organizational response of the US Army to this disturbing increase in active-duty suicides and mental health disorders. Given widespread agreement that recovering from a mental health condition is most likely when interventions are early (e.g., Anthony, 1993; Bonney and Stickley, 2008; Davidson et al., 2008), it is of vital importance to closely examine the effectiveness of organizational practices related to the provision of mental healthcare while soldiers are still on active-duty.

The unique psychological tolls of the wars in Iraq and Afghanistan first began to receive wide-spread attention in 2007, after the publication of studies noting the increase in soldier suicides and mental health conditions. Most notably, reports by the RAND corporation on “The Invisible Wounds of War” and a Department of Defense taskforce both highlighted these rapid increases in PTSD, TBI, and suicide, along with a critical review of the military’s efforts to address these issues (Tanielian and Jaycox, 2008; Department of Defense Taskforce on Mental Health, 2007). In addition, multiple negative news articles reported on poor health services for soldiers with serious combat-related physical and mental injuries, most notably the 2007 expose of Walter Reed Medical Center, a major military hospital for returning wounded soldiers, which was temporarily shut down after reports of soldier neglect. These reports and scandals brought increased attention to care for soldiers returning from war, and resulted in bi-partisan support in Congress for an unprecedented supplement of over $2.7 billion specifically for PTSD and TBI prevention and treatment programs in the military (Government Accountability Office, 2012).

Since 2007, the US Army has used these and other funds to launch dozens of initiatives to improve mental healthcare services for active-duty soldiers. These initiatives, which enjoy
high levels of leadership support, include: mandatory annual soldier ‘resilience’ trainings, suicide prevention trainings, required pre- and post-deployment mental health screenings and counselling sessions, mental health integration into primary care check-ups, intensive all-day outpatient care programs for PTSD and other related conditions, a suite of preventative programs, and multiple group therapy options ranging from anger management to insomnia, in addition to dozens of post-specific initiatives customized to their populations. Most notably, beginning in 2012, the Army implemented an initiative to build a dedicated outpatient mental health clinic for every brigade on every US Army post across the world. Today, soldiers have a clinic within walking distance of where they live and work and can walk in without a scheduled appointment in addition to attending regularly scheduled therapy appointments. This initiative was part of an Army-wide effort to standardize a system of care that incorporated best practices from across the Army to ensure soldiers had a consistent care experience across posts and did not “slip through the cracks” when moving between posts (Srinivasan, 2016; Hoge et al., 2015).

As a result of these efforts, soldiers are provided the opportunity to recover from a mental health problem while remaining in service in the same way as if they had a physical injury such as a broken bone. They are now offered some of the most extensive rehabilitative mental healthcare services in the world (e.g., a full spectrum of mental health services including regular individual and group psychotherapy sessions, intensive out-patient care, same-day walk-in access to mental health specialists, and case management, among other services). To provide this rehabilitative care, the Army increased the number of mental health professionals by over 300 percent and spent over a billion dollars on initiatives to improve mental health services between 2007 and 2015. Most of the new mental health professionals hired were full-time civilian employees. As a result, the majority of Army mental health professionals are now civilians,
while prior to 2007, the majority were uniformed Army providers (Department of Defense, 2014).

Yet despite this incredible investment of resources, serious challenges remain in getting soldiers to benefit from these new rehabilitative care services. This study suggests that such difficulties stem not from a lack of leadership support or resources (though also necessary and important), but are related to the subcultures of two powerful professional groups that directly affect whether active-duty soldiers seek, stick with, and benefit from using these extensive services—commanders and mental health providers.

Commanders have an enormous impact on whether their soldiers feel comfortable seeking help for mental health problems, and importantly, whether they are able to fully benefit from these rehabilitative services once they seek care. In the Army context, a soldier’s commander—specifically his or her company commander—has discretion over whether to comply with duty-limiting treatment recommendations made by a soldier’s mental health provider considered important for the soldier’s recovery (e.g., whether or not to deploy a soldier with mental health issues, take them to stressful training simulations, comply with workload or work schedule reductions or modifications, etc.)\(^1\). Even though the Army has invested tremendous resources in providing full-spectrum, rehabilitative mental health services for soldiers and encouraging their full usage, company commanders are responsible for fielding a mission-ready force and assessed monthly on the percentage of their soldiers that are medically cleared and trained on mission essential tasks. When soldiers use mental health services, they miss work during the duty day to attend appointments or are sometimes given duty-limiting work

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\(^1\) Commanders can override duty-limiting provider treatment recommendations in which modifications to a soldier’s work activities or work schedule are requested. Commanders cannot override provider recommendations to medically retire a soldier who no longer meets fitness for duty qualifications nor can they override what clinical treatments providers use during a soldier’s mental health appointments.
restrictions by their providers that “take them out of the fight,” making it challenging for commanders to meet their mission-readiness targets. This creates high levels of conflict between commanders, who prioritize their missions, and mental health providers, who prioritize rehabilitative patient care.

This dissertation examines these two professional groups in detail and suggests when and how they can effectively work together to achieve both of their goals, without one goal coming at the expense of the other. In doing so, I aim to contribute not only to our understanding of improving Army mental healthcare, but also to our more general understanding of when and how groups with conflicting goals and different professional identities and perspectives in organizations can align their goals to achieve integrative outcomes.
PART 1: BACKGROUND
CHAPTER 1: INTRODUCTION

It’s 10:00 a.m. and Specialist Smith² is ready to be released from an on-post inpatient psychiatric unit after showing up at the Army hospital Emergency Room because he said he was afraid he was going to hurt himself. After a stay at the hospital, he is medically evaluated by the team of psychiatrists and nurses there. He is deemed no longer at risk of hurting himself and ready to return back to normal soldier life in his unit.

One of the civilian mental health providers who works in the outpatient clinic assigned to Specialist Smith’s combat brigade, Dr. Miller, is scheduled to begin seeing him on a regular basis for outpatient therapy sessions to treat him for depression and monitor his progress. She has a doctorate degree in clinical psychology, and after working for years as an outpatient psychotherapist, started working two years ago at this Army post. She was hired full-time after completing a trial year as a civilian contractor and met the Army’s criteria that she is trained to provide “evidence-based treatments.” Providers with backgrounds similar to hers are increasingly common on active-duty Army posts where civilian mental health providers now comprise the majority of providers Army-wide.

Dr. Miller calls Specialist Smith’s company commander, Captain Rogers, to share her treatment plan for this critical transition. Captain Rogers is a thirty-year old West Point graduate who has deployed twice, and is getting his unit ready for a one-month intensive combat simulation at the Fort Irwin National Training Center that will prepare his unit for an upcoming tour of duty in Afghanistan. He is deeply concerned about Specialist Smith and worries how he will manage to look out for Specialist Smith while also attending to the 120 other soldiers in his unit as they make final preparations for the training exercise. Captain Rogers is especially

² All names used throughout this dissertation are pseudonyms and fully disguised with small details changed to protect confidentiality.
stressed since he was counting on Specialist Smith, who works in a critical military occupational specialty, to play an important role in this upcoming training exercise. However, the Specialist will now have to be replaced and left behind given his recent hospitalization.

Dr. Miller handles this situation the same way other providers in her clinic always did. She makes a conservative treatment recommendation that Specialist Smith be put on “24 hour unit watch,” requiring round-the-clock supervision from the unit, including at night. She justifies this decision based on research on civilian patients that finds mental health patients are at high risk of an “adverse outcome” such as suicide or homicide in the weeks after being released from inpatient hospitalization. She explains: “I think 24 hour watch is great. I mean what else are we supposed to do in these situations? Our number one priority is to keep the soldier safe.”

While Dr. Miller’s genuine concern for her patient’s well-being and conservative approach may appear best for soldier care and safety, I soon discovered that this 24 hour watch recommendation, in practice, often hurt soldier recoveries, exacerbated the negative stigma of seeking care, and damaged commander support for their soldiers using mental health services. During my early days conducting field work, my heart went out to providers like Dr. Miller, who considered themselves staunch patient advocates who put patients and their safety first, regardless of whether it was “convenient” for commanders or the unit. However, after spending time with soldiers and commanders served by these providers, I soon realized that many of their seemingly “professionally pure” recommendations, while well-intentioned, had unintended negative consequences.

Unbeknownst to Dr. Miller, who assumed Captain Rogers had the resources needed to watch this soldier, commanders like Captain Rogers preparing for a training mission did not have the extra manpower to watch a soldier around the clock. As a result, Captain Rogers acts
similarly to other commanders in this situation, and he orders the soldier to remain on a cot next to the unit’s front desk (known as the “Charge of Quarters” or “CQ desk”) since it is manned 24/7, a traditional practice used to respond to unit watch requests.

Soldiers on 24 hour watch placed at the CQ desk reported experiencing humiliation and ostracism from their fellow soldiers, leading to increased mental health problems in some cases. The stigma of seeking care also increased as other soldiers with problems feared that if they came forward, they too would end up the black sheep of their unit on a cot at headquarters for all to see. And commanders reported losing faith in mental health professionals’ judgment when they made such requests, but felt compelled to comply because they would be held accountable if there was a suicide and they were found non-compliant with their written recommendations.

Captain Rogers explained his frustration with this traditional provider practice:

My biggest complaint is with 24 hour unit watch. I've had to do it three different times. It's exhausting on the unit and is terrible for the soldier—they become a pariah in the unit. ...and this has second and third order effects because it makes the unit resent the hell out of them. ...And then the soldier says he's embarrassed, and now that hurts his mental state too.

Other company commanders in Captain Rogers' brigade reported sometimes disregarding provider recommendations for 24 hour unit watch. In one instance, in response to a provider recommendation for 24 hour watch, a commander tried to re-admit the soldier in question to the hospital by taking him to the Emergency Room so they could “babysit” him. Most commanders in Captain Rogers' brigade viewed Dr. Miller and other providers in her clinic as “out of touch” “hippies” who were being duped by soldiers they suspected were faking problems to avoid work and deploying. When soldiers reported to providers how they were treated in these units, such stories further reinforced to providers that commanders were “bullies” who were unsupportive of their soldiers receiving care.
Three weeks later, a soldier from a different brigade faced a similar situation. However, the soldier's provider and commander, Dr. Barnett and Captain Jones, handled this situation quite differently from the prior example. Rather than immediately recommending the soldier go on 24 hour unit watch after being discharged from the hospital, Dr. Barnett first spoke with Captain Jones to gather information about the commander's unit and the soldier's situation. She learned that this soldier had a sergeant and another "battle buddy" with whom he was very close. Dr. Barnett then obtained permission from the soldier to share information about his condition with them so they could provide him additional support and ease his transition back into the unit.

Dr. Barnett also learned that Captain Jones's unit was “stretched thin” preparing for an upcoming training exercise and did not have the manpower available to watch the soldier 24/7. Therefore, Dr. Barnett and Captain Jones designed a plan together to ensure the soldier was discreetly checked on multiple times a day. In addition, instead of having the soldier undergo the public embarrassment of sleeping on the cot in front of the CQ desk as happened to Specialist Smith, Dr. Barnett and Captain Jones arranged for this soldier to sleep over at his sergeant's home for the first few weeks until the soldier had recovered to the point where he could safely spend the night alone.

Dr. Barnett and Captain Jones' skillful handling of this difficult situation was representative of the integrative win-win approach taken by providers from Dr. Barnett's clinic and Captain Jones' brigade. Providers in Dr. Barnett’s clinic noted how they regularly co-constructed solutions like these with the commanders they worked with. One provider explained:

I am willing to make workable solutions with command. When someone comes out of inpatient (hospitalization), there are actually lots of options. It’s not 24 hour watch or nothing. You don't have to stick them at the CQ desk all night, you can move people into the barracks or have them go home with NCOs (sergeants) or have them checked on a few times a day. … You have to know what the unit is all about and who’s who and who can help your patient the most.
Captain Jones echoed these comments and explained how he valued being consulted by providers to co-construct an integrative solution that was helpful for the soldier’s recovery, unit, and the soldier’s standing in the unit. He noted:

Every time we talk, [they say], “Hey, what do you think?” So there is a good dialogue. There’s never like any ultimatums to me as a commander. Like, they will never say, “I want this this and that.” It's more of a dialogue. The providers I've dealt with before were like that and it just doesn't work.

As providers like Dr. Barnett engaged with commanders to co-construct integrative solutions that took into account the needs of the unit and commanders, those providers also relied on their professional colleagues in their clinic to ensure they did not become coopted and avoided giving concessions to commanders at the expense of their patients. One of Dr. Barnett’s clinic colleagues explained:

My team is also big on setting boundaries with command....I also have to maintain the thing of, ‘I'm not just a pawn of the commander.’ I just don't do whatever he says. My job is to make his job easier, but always within the limits of what’s also good for the patient. But again, if you keep on the same purpose, where what you recommend is good for everyone, then anything can get done. My job is not to always do what other people want. You gotta do the hard thing. But I don’t think it’s command wins and the patient loses, or the patient wins and command loses. My job is about what can I do...so we can all win.

Although Dr. Barnett and Captain Jones and other providers and commanders from their clinic and brigade now regularly achieve integrative outcomes for the patient and the unit’s mission, this was not always the case. Dr. Miller and Captain’s Rogers’ strained relationship was more characteristic of relations between all providers and commanders across the Army when I began this study in 2012. However, within a couple years, I observed firsthand how providers and commanders in some clinics and brigades fundamentally changed the way they related to one another and their approach to handling soldier care, regularly achieving integrative outcomes that facilitated soldier recoveries, while also being sensitive to soldiers’ career goals and commanders’ needs to maintain the mission-readiness of their units.
In this dissertation, I set out to understand why some providers and commanders related to one another in new and untraditional ways which ran counter to over a decade of animosity between these two different professional groups. I examine not only how these providers and commanders engaged with one another and what they did, but I also set out to understand what organizational structures could enable these practices and behaviors and why.

Outline of the Dissertation

In Part I of this dissertation, I situate this study historically by providing a brief history of military mental healthcare (Chapter 2). I next provide an overview of the literature on goal conflict among professional groups inside organizations to which my study aims to contribute. I also introduce ideas about identity conflict, personalization and organizational structure which I use to help interpret my findings (Chapter 3). In Chapter 4, I detail my research methods.

In Part II, I begin by describing how despite the presence of a superordinate goal shared by both professional groups—Army commanders and mental health providers—each group prioritized one part of the goal over the other in accordance with their starkly different professional identities and perspectives on how to accomplish this goal (Chapter 5). In Chapter 6, I describe the integrative mechanisms available to all commanders and providers, which current theory suggests should have helped them align their differing goals to achieve the Army’s overall goal of having both mentally healthy and mission-ready soldiers.

In Chapter 7, I demonstrate how the Army’s initiative to co-locate providers in clinics assigned to each brigade failed to improve commander and provider goal alignment. Instead, poor relations persisted between these groups, resulting in suboptimal outcomes for both patient recoveries and mission-readiness. I argue this failed goal alignment was rooted in an
organizational structure that did not allow for personalization or relationships to actually develop between commanders and providers, despite being co-located closer to one another. Without such personalized relationships, intractable identity conflict persisted and these two professional groups were unable to take one another’s perspectives to align their goals.

In Chapter 8, I describe how another Army initiative to fully socialize and integrate some uniformed providers as full-time liaisons to the brigades (rather than work full-time in the clinics), also led to failed goal alignment such that many providers exhibited signs of cooptation and came to privilege the commander’s goals over those of their mental health profession. I argue this is because their organizational structure did not provide a sufficient anchoring in their home professional group identity as providers, and that the personalized relationships afforded by this organizational structure with commanders, without such an anchor, led to cooptation toward the more dominant commander group’s perspective.

In Chapter 9, I describe how another set of providers and commanders in co-located clinics nearly identical to those described in chapter 7, but who operated within an organizational structure that enabled what I call “anchored personalization”, were able to achieve goal alignment that improved both soldier recoveries and mission-readiness through a process I call “anchored perspective-taking.”

In Part III of this dissertation, I end by discussing how my findings contribute to our understanding of group conflict and goal alignment in organizations as well as to our knowledge of identity-based conflicts between professional groups in organizations and the dark side of personalization without anchoring. I conclude by sharing both the theoretical and practical implications of this research.
CHAPTER 2: A SHORT HISTORY OF MILITARY MENTAL HEALTHCARE

While PTSD was not officially recognized by the mainstream mental health community until 1980, the link between exposure to traumatic experiences, such as combat, and negative psychological changes is documented in historical accounts of war. “Nostalgia” and “melancholia” during the 17th and 18th centuries, “soldier’s heart” or “disordered action of the heart” during the American Civil War, and “shell shock”, “battle neurosis” and “battle fatigue” during WWI and WWII were all used to describe soldiers who could no longer fight but had suffered no known physical injury (Jones et al., 2007).

Interestingly, there is little overlap in reported symptoms across these different labels. For example, the principal symptoms of “shell shock”, which included temporary loss of the senses of smell and hearing, differ from those symptoms such as flashbacks and nightmares which are associated with PTSD. Different time periods and contexts are associated with distinct sets of symptoms that are thought to reflect different combat experiences, medical understandings of mental and physical illness, and cultural norms regarding the appropriate ways to express and describe mental and emotional anguish (Jones and Wessely, 2005; Pols and Oak, 2007).

Despite a long history of documented psychological consequences of war, such symptoms were largely considered personal character flaws until the 1970s (Fassin and Rechtman, 2009). Prior to that time, many practicing psychiatrists and psychologists viewed such disorders in service members as signs of weak mindedness, inferior constitution, low intelligence and immaturity (Young, 1997). For example, the head of a prominent British military psychiatric hospital during WWII wrote a doctoral thesis entitled, “The significance of lack of courage in the genesis of psychosis and neurosis” (pg. 89, Jones and Wessely, 2005). Such a view was also reflected in pension decisions in which nearly all psychological illnesses related to combat were compensated only in the short term, as any chronic condition experienced...
by veterans was attributed to a preexisting condition that combat exposure aggravated rather than caused. Conventional wisdom was that soldiers with good character, leadership and discipline should be immune from “shell shock” and “battle fatigue.” Consequently, the British Army banned the diagnosis of “shell shock” during WWII and refused to compensate soldiers for this disorder with a pension out of concern that this diagnosis would inspire malingering (Shively and Perl, 2012).

Suicide and suicide attempts by soldiers were also equated historically with cowardliness. In many Western societies, as recently as WWI, suicidal soldiers were killed because they were viewed as a threat to morale and their suicide attempts considered acts of desertion (Weaver and Wright, 2009). Indeed, suicide was generally viewed in the West as a disgraceful act, and even during the early years of the US wars in Iraq and Afghanistan, soldiers who committed suicide were not given a military funeral and their loved ones did not receive benefits normally awarded to fallen soldiers’ families. Social influences on suicide has long been the source of study by sociologists, beginning with Durkheim who observed variation in suicide rates depending on the level of “anomie” or lack of feeling of belonging to one’s society, finding that Protestants killed themselves at higher rates than Catholics (Durkheim, 1951 [1987]).

The Vietnam War marked a major shift in views about mental health in the military. This war was unique for its unexpectedly low number of psychiatric casualties among active duty soldiers, with less than 2% of soldiers removed from the frontlines for “combat stress” – much lower rates than those observed during WWII and the Korean War. Military psychiatry at the time took credit for what was considered a resounding success, leading one leader to declare that, “Psychiatric casualties need never again become a major cause of attrition in the US military in a combat zone.” (Jones and Wessely, 2005, pg 129). However, this view changed in the late 1960s
and early 1970s as Vietnam veterans displayed psychological problems including anxiety, depression, and high rates of alcoholism and drug addiction that caused widespread alarm across American society, which by then had largely turned against the war (Douglas et al., 1996).

The constellation of mental symptoms now known as PTSD, including hyper-arousal, re-experiencing, and avoidance behavior following exposure to an extreme stressor, was initially known as Post-Vietnam Syndrome, as it was thought to only affect Vietnam veterans (Liebert and Birnes, 2013; Fleming, 1985). In the mid-1970s, a collection of activist anti-war psychiatrists and psychologists, many of whom were Vietnam veterans, lobbied for Post-Vietnam Syndrome to be added to the list of official mental health disorders in the Diagnostic and Statistical Manual of Psychiatric Illness (DSM). The leader of this effort, Dr. Robert Lifton, argued passionately that war causes irreparable psychological trauma and enduring harm long after any physical injuries may have healed (Jones and Wesseley, 2005; Pols and Oak, 2007). The group's efforts were ultimately successful, and in 1980, Post-Vietnam Syndrome was added to the DSM as an anxiety disorder under the revised name “Post Traumatic Stress Disorder” to acknowledge that any trauma, not only that caused by war, could result in the condition (Scott, 1990; Brown, 1995).

Incorporation of PTSD into the major psychiatric canon in 1980 marked the beginning of a dramatic shift in conventional views of mental illness—it was no longer weak people or those with bad genes who succumbed to psychiatric illnesses. Instead, experiences, such as traumatic events, could cause psychiatric illness and strike even those with the “strongest” of characters or best of upbringings. PTSD remains the only mental health disorder to ever be included into the DSM in which epidemiological evidence for the disorder followed rather than preceded its inclusion, and in which the etiology or cause was reflected in the name of the condition, rather
than a description of symptoms, as with all other mental health disorders in the DSM (Young, 1997; Scott, 1990).

Since the addition of PTSD to the DSM, diagnoses and research on trauma both in the military and civilian sectors have exploded. Approximately 7% of the US population is expected to suffer from PTSD during the course of their lifetime\(^3\) (Kessler et al. 2005), while approximately 30% of Vietnam veterans (Kulka et al., 1990) and over half of Iraq and Afghanistan veterans seeking care in the VA were given at least a provisional diagnosis of PTSD or another mental health condition (Tanielian and Jaycox, 2008; Pickett et al., 2015).

It is interesting to note that the increase in PTSD diagnoses and research has been accompanied by a decrease in actual exposure to traumatic events and increased expectations of a risk-free, pain-free life among the general public. For example, two hundred years ago, the average person was far more likely to experience hardship or an early death as a result of higher levels of violence, disease, poverty, and hunger than the average person today. Some have suggested that the relative safety of modern life has been accompanied by a decreased tolerance for risks of all types. Indeed, observers of the lower incidences of psychiatric syndromes among lower class British peasants fighting in the trenches of WWI noted that their day-to-day existence in the trenches was similar to their normal lives in industrial slums (Barnett, 2003). Research on ancient Roman military culture also suggests these soldiers did not view combat violence as especially unusual or “traumatic” given regular exposure to violence in their everyday lives (Melchior, 2011).

Despite this historical variation, there is a movement to “universalize” PTSD and reinterpret ancient literature and texts about veterans in ways that characterize these conditions

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\(^3\) PTSD's prevalence varies significantly by gender in the US, with an expected lifetime incidence rate of 10% for women compared to 4% for men.
and symptoms as ahistorical and timeless human responses to trauma. For example, Shay (2002, 2010) reinterprets classic literary characters like Hercules, Henry the IV and Ophelia as suffering from PTSD. This movement corresponds with the sociological observation of the moral ascendancy of “trauma” and “victimhood” as categories and discourses that command compassion and legitimacy in much of the Western world in ways they did not in prior historical periods (Fassin and Rechtman, 2009).

The influence of cultural and political factors shaping combat-related mental illness is evident in the many strategic name changes for this category of problems. For example, “battle fatigue” and “battle exhaustion” were purposefully changed to “battle neurosis” by the British Army to make the illness sound less desirable since it implied the individual was at fault for being “neurotic” rather than simply “fatigued” from an external stressor outside the individual’s control (Jones and Wessley, 2005). Currently there is also a movement to rename “Post-Traumatic Stress Disorder” as “Post Traumatic Stress Injury” to suggest to soldiers and the public that PTSI is a treatable, temporary injury rather than a chronic disorder. This change is advocated both by uniformed psychiatrists who want to “get soldiers back in the fight” and by many in the public health community in an attempt to destigmatize PTSD so that suffering soldiers and veterans will seek help (Williams and Poijula, 2013).

**Mental Health and Military Culture: The Cult of Character**

Given strong norms of individualism in the US (Sharone, 2013), the idea that war can cause psychological problems is still considered a radical idea by many in the US military. The stigma that mental illness is a sign of weakness and poor character still exists (Greene-Shortridge et al., 2007; Vogt, 2011). It is counter-cultural to believe that an experience can change who
someone is in an environment in which individuals are regularly assessed for their character and held accountable for things outside their control (e.g., what happens to you is a reflection of who you are, your character, versus your circumstances, luck or situation). Experiences of adversity are thought to reveal who you truly are—who breaks and who thrives reveals “what you’re made of.” The idea that combat trauma—an experience—can fundamentally change one’s supposedly immutable character, particularly the character of a soldier already thought to have “good character”, is deeply counter-cultural in an environment that is individually oriented. “Leadership”, “personality”, “character” and Army expressions such as, “he showed his ass”, meaning someone showed their “true colors” to reveal a negative character flaw, dominate the day-to-day language in the Army.

Individualism is prominent in military approaches to preventing and treating mental health disorders. First, through emphasis on individual screenings to weed out those with constitutions thought susceptible to psychiatric weakness. Second, through the dominant approaches of psychiatry and psychology that view mental illness as a biological disease that will respond to medications by changing how the brain operates, or through individual, one-on-one psychotherapy where one’s habitual thoughts and interpretations are challenged and replaced by new, more “skillful” thoughts and interpretations, known as Cognitive Behavioral Therapy. The military’s current emphasis on teaching “resilience” also follows this individual-focused model by often referring to resilience as a quality people inherently possess more or less of. As one General noted, he hoped to “inoculate” his soldiers with resilience. Poor performing soldiers are also often referred to as having “low resilience.”

Although largely ineffectual, mental health screenings of potential enlistees’ susceptibility to mental illness remain common in the military, despite numerous studies finding
the intensity of combat exposure is the most significant predictor of psychiatric problems (Shen et al., 2009). The efficacy of mental health screenings is further compromised as the threshold for the tests are often influenced more by soldier recruitment targets than research. For example, while elaborate psychiatric screenings were employed to cut 7% of otherwise eligible US soldiers from enlisting for WWII, no organized psychiatric screening program was implemented for the unpopular Vietnam War (Glass et. al, 1956; Jones and Wessely, 2005). This pattern is also evident with the wars in Iraq and Afghanistan, where enlistment screening standards were lowered to allow those with criminal and psychiatric histories that would previously have disqualified them from serving to receive waivers to enlist (Alvarez, 2007).

The History of Mental Healthcare in the US Military

Psychiatry and psychology did not exist as disciplines until the early 20th century, as clergymen dominated the professional jurisdiction over the realm of “personal problems” (Abbott, 1980). Psychiatry grew out of neurology research and consisted primarily of conditions other medical specialties could not cure and would attribute to “nerves” (Abbott, 1988). Prior to World War I, psychiatrists worked nearly exclusively in asylums rather than in outpatient settings (Goffman, 1961, 1968).

The efficacy of most mental health treatments prior to the 1970s was poor. For example, in WWI, the most common treatment for mental breakdowns was long periods of sedation where patients were induced into drug-induced comatose states so as to “prevent the chronicity of symptoms being built into the general personality” (Jones and Wessely, 2005, pg 94). Yet despite the limited success of early psychiatric treatments, many psychiatrists under pressure to achieve results in the early-to-mid 20th century are suspected of fabricating reports on positive
results for their patients – particularly those statistics most valued by military leadership such as the rate of soldiers able to return to active duty (Jones and Wessely, 2005; Stone, 1985).

Mental health support in the military has historically been evaluative or of the “quick fix” variety, known as “forward psychiatry” where services are provided on the frontlines and designed to get soldiers back into the fight as quickly as possible. This approach was developed in WWI and WWII and used to this day in active combat zones. Forward psychiatry is oriented around the three principles of the “PIE” method:

1. Provide care in close proximity to where combat is occurring;
2. Provide immediate care; and
3. Provide care expecting the soldier to quickly recover.

Even today, the US Army’s combat stress units and embedded providers (known as Behavioral Health Officers) who provide frontline mental health services to active duty soldiers while deployed follow a similar method, known as the “BICEPS” method of care (Rock et al, 1995). In this model, derogatorily referred to by some mental health professionals as “band-aide psychiatry”, care is provided to give soldiers a short break from combat of no more than three days. Providers are instructed to ensure soldiers continue to see themselves as “warriors” as opposed to “sick people” to facilitate their speedy transition back to the fight (Potter et al., 2009). These tactics have succeeded in achieving their primary objective of quickly returning soldiers to active duty, as measured by high return-to-duty rates (Solomon & Benbenishty, 1986; Solomon et al, 2005).4 One embedded provider explained his recent experience providing mental healthcare on the frontlines (“downrange” or “in theater”) in Afghanistan:

Downrange you administer different, less in-depth treatment. Like I can’t ask about what your relationship is like with your mom, because in theater, you need to keep people going. You

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4 Soldiers unable to return to duty are “med-evaced” (medically evacuated) to their Army post generally back in the United States, a costly and highly discouraged practice done only in extreme circumstances as a last resort.
don't want to open up a can of worms that you can't close. It's not the appropriate environment to get into that.

Prior to 2001, mental health services for active-duty US soldiers when not deployed were limited and primarily evaluative rather than rehabilitative on the Army posts where soldiers train and live in-between overseas deployments. Mental healthcare usage was strongly stigmatized in the Army as a sign of weakness in a hyper-masculine context where soldiers are regularly evaluated on their physical and mental toughness (e.g., Vogt, 2011). Mental health problems were largely considered a career ender. If soldiers had mental health problems that interfered with their ability to perform their jobs, they were typically medically discharged from the Army, rather than sent to professional care to be rehabilitated and retained (Hoge et al., 2002; Hoge et al., 2006). The primary sources of mental health support were fellow soldiers, commanders, and chaplains. However, this changed during the recent conflicts in Iraq and Afghanistan, which taken together, comprise the longest running war in US history.

More robust rehabilitative mental health care was first offered on US Army posts in response to increasing mental health problems surfacing among soldiers who had deployed to Iraq and Afghanistan during the mid-2000s, and so soldiers could be “patched up” for future deployments given the severe shortage of soldiers at the height of these wars. However, even when these wars drew down and there was no longer a shortage of troops, Congress and the American public demanded the “invisible wounds” of mental illness be treated the same way as physical injuries, so that soldiers could remain in their units and keep their jobs while recovering on active-duty. These demands resulted in a massive expansion of rehabilitative mental healthcare services for US soldiers, with an over 300% increase in mental health providers

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3 After discharge from the Army, ex-soldiers with mental health problems could receive mental health care as civilians from hospitals run by the US Department of Veterans Affairs (the "VA").
working on active-duty Army posts. Dedicated outpatient mental health clinics were built within walking distance of each brigade on every Army post. Soldiers can remain in the Army while they undergo treatment, consisting of group or individual therapy sessions and possibly medications, which can last for years. Some patients with particularly acute mental health issues may at times attend daily 4-to-8 hour sessions, while continuing to remain on active duty.

The shift to extensive, full-spectrum rehabilitative mental healthcare in the Army is also bolstered by a renewed sense of efficacy in mental health treatment. Since the 1970s, mental health problems are no longer thought incurable, with multiple clinical trials supporting select “evidence based practices” such as Prolonged Exposure Therapy, Cognitive Behavioral Therapy, and Eye Movement Desensitization Response. These treatments, however, can take months and even years of weekly treatment to be fully effective (Rogers and Pilgrim, 2014).

Yet tension exists over the introduction and expansion of these extensive rehabilitative mental healthcare services on active-duty Army posts. One leader explained:

'It's unfortunate, but the Army is not a rehab institution. If you're not fit for duty, we need to make the tough decision. And will still take care of you with a med board (medical retirement). We seem headed toward becoming a rehab institution versus a set of tools for the Army. ...Some soldiers want to be seen daily and weekly (at mental health services) and I don't mean to have a cold heart, but we are not a rehab institution. If you need daily therapy, then maybe it's time for a new job.

Tensions have also emerged between the mental health professionals who provide this rehabilitative care and the commanders whose soldiers they treat. Given the difficulty of recruiting mental health professionals into active-duty, the majority of providers are civilians, many of whom are working in the Army context for the first time. Traditionally, the Army has been able to socialize professionals from other disciplines such as law, medicine, and theology (e.g., JAG, Army physicians, chaplains) as full active-duty, organizational members who are uniformed and deploy with their assigned units. However, because of the shortage of uniformed
mental health providers and of psychologists and psychiatrists in general, the Army has needed to hire more full-time, non-uniformed civilian providers, many of whom resist acculturation into the Army. As a result, whereas prior to 2001 most Army mental healthcare was administered by those in uniform, currently around 80% of mental health providers on US Army posts are civilians. Today, the remaining 20 percent are uniformed Army providers, either officers who train and deploy with each brigade, or other uniformed personnel who work side-by-side with their civilian counterparts in the same clinical environments on post. In the following chapters, I provide greater detail on the conflict between these mostly civilian providers, who are charged with providing rehabilitative mental healthcare, and commanders, whose primary goal is to field a mission-ready unit.
Organizations are rife with conflict. Labor versus management. Physicians versus hospital administrators. Engineering departments versus Marketing departments (e.g., Kochan et al., 2009; O'Conner et al., 2006; Truelove and Kellogg, 2016). Such conflict is woven into the fabric of organizational life through the division of labor (March and Simon, 1958; Cyert and March, 1963; Strauss et al., 1963). Specialized departments and occupational groups develop their own interests and often pursue goals that conflict with those of other groups and may be at odds with the overall goals of the organization (March and Simon, 1958; Cyert and March, 1963; c.f., Strauss et al., 1963; Dearborn and Simon, 1958; Lawrence and Lorsch, 1967a; Van Maanen and Barley, 1982). Cooperation is thus an ongoing achievement (Cyert and March, 1963; Strauss et al., 1963; Bechky, 2011). Understanding the conditions and processes through which organizations can productively manage these conflicts is one of the central pursuits of administrative science.

Goal Conflict in Organizations

The Carnegie School has long argued that organizations are comprised of coalitions with different interests who pursue different goals (March, 1962; see Gavetti, Greve, Levinthal, and Ocasio, 2012 and Gavetti, Levinthal and Ocasio, 2007 for a review). Even though integrative, overarching organizational goals often exist (e.g., Warner and Havens, 1968), different groups have difficulty seeing or discovering these shared goals due to entrenchment in their own group’s perspective from their distinct position in the organizational structure (e.g., March and Simon, 1958; Dearborn and Simon, 1958; Ketokivi and Castaner, 2004). Such differences lead to
regular conflict between groups charged with coordinating their work and often to suboptimal outcomes for the organization (e.g., Cyert and March, 1963; Bechky, 2003).

Two streams of literature have examined how goal conflict between groups is managed in organizations. The first views conflicts between organizational coalitions as in a constant state of quasi-resolution, managed through mechanisms such as organizational slack (e.g., Cyert and March, 1963), sequential attention to goals (e.g., Greve, 2008), inducements such as incentives or policy prescriptions, and hierarchy so that the more powerful group holds ultimate decision rights, with groups’ relative standing in flux over time as their claim to solve the organization’s most pressing challenges changes as the environment shifts (Cyert and March, 1963; Perrow, 1961; Fligstein, 1987). A second stream of scholarship suggests a host of integrative mechanisms to align the goals of different groups within the organization. These integrative mechanisms include: formal rules and procedures for interaction (e.g., March and Simon, 1958), cross-functional teams, task forces and departments (e.g., Pinto, Pinto, and Prescott, 1993; Turkulainen and Ketokivi, 2012), collaborative incentives such as tying compensation to joint performance (Kretschmer and Puranam, 2008), integrative organizational designs such as centralization, colocation, or matrix structures (e.g., Lawrence and Lorsch, 1967a; Van den Bulte and Moenaert, 1998; Mintzberg, 1980, 1993), integrator roles such as shared bosses or full-time liaison intermediaries that act as boundary spanners (Lawrence and Lorschb, 1967; Tushman and Scanlan, 1981; Galbraith, 1984; Levina and Vaast, 2005), strategic planning that includes participation from both groups (Ketokivi and Castaner, 2004), and the recognition and pursuit of superordinate goals (Sherif, 1958; Pinto, Pinto, and Prescott, 1993).
Identity Conflict, Personalization and Organizational Structure

While these ideas have been essential to our understanding of goal conflict in organizations, many conflicts in organizations have proven immune to such rational attempts at goal alignment (e.g., Jarzabkowski and Balogun, 2009; O’Conner, Fiol, and Guthrie, 2006). Existing scholarship on goal alignment among different groups has not considered how deeply held differences in identities between groups may make these mechanisms ineffective or even exacerbate intergroup relations. Traditional integrative mechanisms may prove ineffectual when identities are implicated in a conflict, making such conflict personal and often intractable (Rothman, 1997; see Fiol, Pratt, O’Conner, 2009 for a review; Rouhana and Bar-Tal, 1998; Coleman, 2003). Scholars of intractable group conflicts involving identity, ranging from those between Hutus and Tutsis in Rwanda to Israelis and Palestinians, suggest that identity differences must first be addressed to promote perspective-taking across groups and cooperation in pursuit of shared goals (Rothman and Olson, 2001; Rothman, 1997). Otherwise these groups are prone to cognitive distortions of another’s behavior, intentions, and communications, limiting their ability to accurately perceive and comprehend the perspective of the other group (Friedman and Davidson, 1999; Northrup, 1989).

Identity refers to how a group collectively defines “who they are,” including their unique beliefs, values, and definitions of what it means to be a “good” or prototypical group member (e.g., Ashforth et al., 2008; Bartel, Blader, and Wrzesniewski, 2012; Petriglieri, 2015). Identities are enacted and often evident through group differences in language, demeanor and even dress (Ashforth, 2011; Pratt and Rafaeli, 1997). Intractable identity conflict between groups is evident when groups use simplifying stereotypes and zero-sum conceptualizations of one another, and define themselves in part by their differences with the other group, known as “dis-identification”
(for a review see, Fiol, Pratt, O'Connor, 2009; Northrup, 1989; Rothman, 1997; Desivilya, 1998; Worchel, 1986; Elsbach, 1999; Dukerich et al., 1998). For example, inviting both administrator and physician groups with different goals (in this case, managing a profitable hospital and providing quality patient care) to a strategic planning retreat without addressing identity differences may backfire and further fuel their conflict over how to run their hospital (O’Connor, Fiol and Guthrie, 2006).

Although early work in the behavioral theory of the firm emphasized how differentiated identities can adhere around organizational coalitions (e.g., Simon, 1947; March and Simon, 1958; Lawrence and Lorsch, 1967a), consideration of how different identities between groups affect goal alignment has largely been absent from this literature. One notable exception is Simon (1947) and March and Simon (1958) who highlighted the importance of promoting organizational identification over subgroup identification, such as through organizational socialization processes (Van Maanen and Schein, 1979; Van Maanen, 1978). However, for groups with strong group identification, such as occupational and professional groups with years of professional socialization and training, privileging organizational over professional identification may not be possible. Such professional groups often have distinct and clashing perspectives on the appropriate way to achieve an organization’s goals in ways that privilege their own professional group’s goals, and are often closed off to considering the alternative perspectives of other groups in the organization (see Anteby, Chan, and DiBenigno, 2016 for a review; Battilana and Dorado, 2010; Turco, 2012; Van Maanen and Barley, 1982; Pratt and Foreman, 2000).

Professional groups are unique in that ‘who they are’ (their professional identity) is deeply entwined with ‘what they do’ as professionals (e.g., Kreiner et al., 2006; Pratt et al., 2006;
Members of professional groups are often strongly committed to pursuing goals and advancing perspectives that align with their professional training, beliefs, values, and identities (e.g., Trice, 1993; Kellogg, 2014; Bechky, 2003; Anteby, 2008; Bailyn and Lynch, 1983; DiBenigno and Kellogg, 2014; Gandal et al., 2005). When Simon (1947) and March and Simon (1958) wrote about organizational socialization as a mechanism for goal alignment between groups, they wrote at a time when occupational groups were less prominent inside organizations, making the problem of how to align goals between different occupational groups less relevant. However, given the dramatic increase in professional and occupational groups working inside organizations (e.g., Goreman and Sanefur, 2010; Noordegraaf, 2007), it is imperative to understand how these groups with strong commitments to their professional identities, goals, and perspectives can broaden their worldviews and identities in service of accomplishing overarching organizational goals.

One promising approach that may help address longstanding identity differences between groups with conflicting goals and perspectives is that of personalization. Distinct from mere contact, personalization involves regular, personalized contact with a member of another group that results in familiarity and knowledge about the other person as an individual (Brewer and Miller, 1984, 1988; Miller, 2002; Hewstone, 1996; Allport, 1954). Personalization has been found to reduce intergroup stereotyping and lead to increased intergroup perspective-taking (Ensari and Miller, 2000; Piaget, 1932; Mead, 1934) from getting to know the other group member as a person, rather than as a stereotyped member of the other group (Cialdini et al., 1997; Sluss and Ashforth, 2007). Perspective-taking, which can be thought of as the logical antidote to entrenchment in one’s own group’s perspective, has been found to increase integrative (win-win) negotiation outcomes (Neale and Bazerman, 1983), increase empathy, and
reduce negative group stereotyping across groups (Vescio et al., 2003; Grant and Berry, 2011; Galinsky et al., 2005; Galinsky and Moskowitz, 2000; Parker and Axtell, 2001; Ku et al., 2015). Taking the perspective of multiple groups is also thought to enhance one’s capacity to take novel action and act in non-traditional ways (Coser, 1975, 1991; Mead, 1934).

Existing scholarship on personalization, to my knowledge, has only explored the positive benefits of personalization on reducing identity-based conflict between groups. However, personalization may have a dark side if such personalized contact with the other group leads to cooptation and indoctrination into the other group’s perspective and loss of allegiance to one’s home group. This may be particularly likely when one group is higher status or more dominant than the other. For example, regulators of large banks are frequently accused of “regulatory capture” in which they get “too close” to bankers and design regulations that privilege the perspectives and goals of bankers rather than the public, or they end up being hired by these same banks (e.g., Katic and Kim, 2013). Other examples abound in organizational life. For instance, the personalized relations between corporate sales personnel and their corporate clients may lead them to provide discounts that may not be in the best interest of their employer. Microfinance loan officers likewise may develop close personal relationships with their clients and make loans that ultimately are bad for the bank (Canales, 2013). “Going native” from personalized contact with other group members has also been observed among diplomats who, after a period of time, pursue the interests of their host country more than their home country, as well as in-house attorneys who come to privilege the goals of their organization over that of the law (Jenoff, 2011). Edelman et al. (1991) likewise found many affirmative action officers acting as “team players” who protect organizations from equal employment opportunity law rather than advocating for the employees the law was meant to protect. Finally, Selznick (1949),
demonstrated how local officials became coopted by close contact with the Tennessee Valley Authority personnel.

While research on personalization has been invaluable to understanding how to improve relations between groups with different identities, scholarship has not examined what specific organizational structures might support the benefits of personalization while mitigating the risk of indoctrination or cooptation. This gap is likely because most research on personalization has been nearly exclusively between members of different ethnic or racial groups rather than professional group members in organizations or conducted in laboratory settings rather than in real organizational contexts. Organizational structures can both enable and constrain the quality and type of interactions members have with other group members inside the organization (e.g., Blau, 1994). In particular, organizational structures can offer opportunities for regular interaction, familiarity, and personal relationships between members of the organization outside one's home group (Uzzi, 1997; Blau, 1994; McPherson and Smith-Lovin, 1987). It remains unknown what organizational structures might promote the benefits of personalization to neutralize identity conflict between groups and promote inter-group perspective-taking to enable the discovery and pursuit of integrative solutions to accomplish superordinate organizational goals, while preventing cooptation from such personalized relations.

This dissertation suggests a novel organizational structure and process for managing conflict between professional groups in organizations, even in the most dire of circumstances, among groups with conflict that involves not only different goals, but also stark differences in professional identity and perspectives. I draw on data from a 30-month comparative ethnographic field study of conflict between US Army commanders privileging their professional group's goal of fielding a mission-ready force and mental health providers.
privileging their professional group’s goal of providing rehabilitative mental healthcare to active-duty soldiers. Even though the organization, the US Army, desired both goals, and ultimately a healthy soldier is in the interest of both groups, only providers and commanders associated with two of the four combat brigades discussed in this dissertation were able to overcome identity conflict and take one another’s perspectives to align their goals to accomplish both mission readiness and soldier rehabilitation. This dissertation addresses the following research question: when and how can integrative solutions in service of the organization’s overarching goal be discovered and pursued by professional groups with differing goals, identities, and perspectives?
CHAPTER 4: METHODS

I collected data over a 30-month period from 2012 to 2015. I spent the first twelve months of data collection as part of an interdisciplinary team at MIT that was engaged to study the US Army’s mental health system where I served as a note taker or co-interviewer for 132 interviews, 46 focus groups (averaging approximately seven participants each), and dozens of informal and formal meetings with mental health and Army stakeholders at all levels of the organization at seven US Army posts. Multiple active-duty US Army officers pursuing advanced degrees at MIT were also a part of the team who provided critical background information. This first year provided an opportunity to learn to “speak Army” and develop my ability to converse with commanders and soldiers, as well as with mental health professionals.

After a year of preliminary fieldwork as part of the team, I spent the remaining 18 months conducting my own dissertation study to uncover mechanisms accounting for differences in provider and clinic effectiveness at improving mental healthcare services for soldiers. I used a relational ethnographic approach (Desmond, 2014) in which I studied the relations between multiple groups mutually dependent on and in conflict with one another—company commanders and outpatient mental health professionals. I also conducted interviews with stakeholders in the broader ecosystem (e.g., chaplains, higher level commanders, and mental health leadership).

The data reported on in this dissertation primarily come from one US Army post (out of seven visited as part of the larger project, and out of 11 possible “force projection platforms” that US troops deploy from), where I spent over 180 hours on post and conducted 69 interviews, 14 focus groups and ten observational sessions, in addition to dozens of informal interviews, observations, and attendance at social events. At this post, I selected four (out of six) mental health clinics to study (Clinics A, B, C, and D) because they were similar on most dimensions,
including those related to subgoal alignment (Table 1). They served brigades of approximately 3,600 soldiers that were part of the same combat division and reported to the same division commander. Each brigade studied was divided into units of approximately 600 soldiers ("battalions", here referred to as "units") and structured similarly in terms of the types of soldiers and the military occupational specialties in their units (e.g. infantry, cavalry, etc.). Since each of the four clinics operated on the same Army post, they shared the same management and organizational structure, were subject to the same pressures and goals, and had the same level of resources and top leadership support.

I first traveled to the post featured in this paper as part of the interdisciplinary research team when this post was transitioning from housing all mental health providers together in one hospital on post to moving providers into smaller free-standing clinics to support each brigade. Relations between mental health providers and commanders were poor at the time, and commanders were resistant to provider recommendations for soldier care. When I returned 18 months later, I was surprised to find that two of the four clinics on post had positive command-provider relations, with commanders at these clinics now supportive of their providers’ care recommendations for their soldiers. I spent the remainder of my time at this post with each of the four clinic teams, as well as the commanders and embedded providers in each brigade, to understand why some clinics and brigades were achieving better outcomes than others. As I will describe below, I came to find that a particular organizational structure accounted for this difference.

My sampling strategy was to interview the majority of mental health providers in each of the four clinics, and a representative sample of sub-unit commanders they engaged with by
interviewing at least one sub-unit commander from each of the six units in each brigade.\textsuperscript{6} I also interviewed the embedded providers assigned to each brigade in addition to mental health and command leadership that oversaw the entire post. Interviews were semi-structured and lasted between one and three hours, with most lasting an hour. When permission was granted, interviews were recorded and transcribed; otherwise extensive notes were taken. Interviews could then be triangulated against one another to corroborate different points of view within clinics and brigades. A summary of my data collection at this post is reported in Table 2.

Insert Table 2 about here

\section*{Inductive Data Analysis}

My inductive analysis (Glaser and Strauss, 1967) consisted of multiple readings of field and interview notes, the writing of analytical memos, and the tracking of patterned activities and issues related to group goal alignment over time. Once I determined that integrative outcomes supporting both goals of improved rehabilitative mental healthcare for soldiers and mission readiness for their units had occurred in Clinics and Brigades A and B, but not C and D or among the embedded providers, I contrasted these cases to identify organizational structures and practices associated with these outcomes. Specifically, I examined how each clinic was organized and interviewed providers and commanders about their experience in different structures over time. I also coded my data to identify specific situations in which the goals and perspectives of Army commanders and mental health providers conflicted. I then compared how providers and commanders in the four clinics and brigades resolved similar types of conflicts, as well as the outcomes of each conflict. I did this by writing a summary of each conflict,

\textsuperscript{6} I chose to interview sub-unit commanders (company commanders), as non-field-grade officers, rather than unit (battalion) commanders or brigade commanders because they were directly responsible for managing and training their units, while higher level officers had more administrative and strategic roles. They were also the level of command that had the most interaction with mental health professionals on the care of their soldiers and influence over whether their soldiers sought and stuck with care.
triangulating accounts from providers, their clinic colleagues, and commanders involved in the same conflicts when possible to create a holistic account of the conflict, provider care decisions in response to the conflict, and the outcome of each conflict. I provide additional detail on my analyses in the findings section below.
PART II: FINDINGS
CHAPTER 5: CONFLICT BETWEEN PROFESSIONAL GROUPS

Commanders and mental health providers, as members of two distinct professional groups within the Army, regularly experienced conflict rooted in their different professional identities and conflicting perspectives on how to accomplish the Army’s over-arching goal of having both a mentally-healthy and mission-ready force. Commanders privileged one part of this goal, namely, fielding a mission-ready force, while providers privileged the other part of the goal, that of ensuring mentally-healthy soldiers. The Army also implemented a host of integrative mechanisms to help these groups pursue this overarching, superordinate goal.

Superordinate Organizational Goal

President Obama, Congress, and top Army leadership dedicated unprecedented resources to improving Army mental healthcare services, including allocating billions of dollars specifically for rehabilitative mental health services and hiring hundreds of mental health professionals. The majority of organizational leaders, defined as “field level” commanders (above the rank of Captain or sub-unit commander) indicated they were supportive of soldiers utilizing mental health services. These higher level commanders were more removed from the day-to-day responsibilities of fielding a mission-ready unit. A healthy soldier should be in the best interest of everyone, commanders and mental health providers alike, from the perspective of these organizational leaders. Rehabilitative mental healthcare services were viewed as an important complement to the organization’s core goal to “fight and win our nation’s wars” and a major component of the Army’s “Ready and Resilient” campaign to promote not just physical readiness for war, but also mental and emotional readiness and resilience (Internal Army document, 2013). In addition, the legitimacy of the Army was threatened by regular negative media coverage of soldier and veteran suicides and increased mental health problems. There were concerns that such negative publicity might hurt public support for the Army and
recruitment of new soldiers. There was little variation in support for soldier mental health services in interviews and observations of these field-level commanders—most variation was observed among the sub-unit commanders below them, those charged with fielding a mission-ready unit, as will be described below (referred to as simply “commanders” throughout).

**DIFFERENCES BETWEEN PROFESSIONAL GROUPS**

Despite the common organizational goal to have mentally healthy, mission-ready soldiers, commanders and providers privileged different aspects of this goal which was rooted in their differing professional identities and perspectives. Conflict regularly occurred between these two professional groups that was not just related to their rational pursuit and prioritization of different aspects of the organization’s goal, but also related to differences in their professional group identities and perspectives on the professionally appropriate way to achieve this goal.

**Differences in Professional Identities Between Groups**

Differences in professional identities between commanders and providers were evident in how they defined themselves, their professional training, demographic profiles, professional jurisdiction, and professional identity displays in terms of their language, demeanor and dress (Table 3). These identity differences contributed to both commanders and providers alike characterizing their intergroup relations as extremely poor for the past decade across the Army. Their interactions exhibited signs of intractable identity conflict (Fiol et al., 2009), meaning they defined themselves by what the other group is not (“warriors” vs. “experts”), stereotyped one another (“bullies” vs. “Berkeley hippies”), and held zero-sum conceptualizations of the other group such that a gain for one group was interpreted as a loss for the other. This meant that when a mental health provider recommended a course of treatment that would “take a soldier out of the fight,” it was not simply viewed as a rational conflict over privileging different goals (in this case soldier rehabilitation over fielding a mission-ready force), but was instead interpreted as a
personal affront to the commander’s authority. And when commanders pushed back or ignored provider recommendations, it was not simply interpreted as a rational response to a conflicting goal, but instead was viewed as a personal affront to the mental health professional’s authority as a doctor or therapist, as I will describe below.

Differences in How They Defined Themselves, Training, and Demographic Profiles. The majority of commanders or “officers” were men in their late 20s and early 30s who had graduated from West Point, Officer Candidate School or ROTC, and deployed at least twice. They viewed themselves as seasoned “warriors” and “leaders” and were skeptical of listening to anyone who had not deployed and had “textbook knowledge” rather than “real-world” experience. One commander explained in regards to a mental health provider:

Who is this person? So you have a PhD? How can you relate to me? …You can get a lot of academic training, but if you don't have the ability to be one of the guys, it won't work. A doctor--generally a doctor went to college, then grad school and has probably been spoon-fed their whole life and never faced real hardship.

In contrast, mental health professionals, who were an even mix of men and women ranging from their early 30s to late 50s, had years of clinical and professional training (masters degrees or doctorates were required), and viewed themselves as “subject matter experts” in diagnosing and treating mental illness. They expressed frustration when commanders did not value their expertise and listen to them. One noted:

It can be frustrating when they don’t follow your recommendations. I try to remind them that, ‘Hey, I have the PhD here, not you!’ I try to remind them that I’m the expert and they’re not.

Commanders tended to view mental health providers, the majority of whom were civilians, as anti-military “Berkeley hippies” who were naïve about military culture, “coddling
soldiers” and easily duped by soldiers they considered faking sick to get out of work. One commander explained his view of providers:

It’s a huge problem. If the soldier has a legitimate problem, they have to go see one of those ladies in <mental health services> with cat pictures all over their walls... Go and talk to Miss Dandelion Hippie Lady!?

The majority of commanders also believed many soldiers using mental health services were “abusing the system” and making up or exaggerating symptoms to get out of work or receive what they considered undeserved medical retirements with benefits. One commander explained this common sentiment:

Some guy got 80% benefits for lying his way through Mental Health\(^7\), and it sickens me. ... But what can you do? Can I hook them to a polygraph? ... If the guy comes in there and describes the scene from a Hollywood movie to a provider, the provider is nodding her head saying, ‘I’m so sorry, honey.’

Providers similarly stereotyped commanders, viewing them uniformly as “bullies” who were “hurting their patients.” They generally assumed commanders were unsupportive of soldiers with mental health problems and that commanders believed soldiers were faking their problems. One of the top reasons soldiers came to Mental Health services was complaints about the Army so providers were bombarded with negative stories of commanders. Mental health providers were acutely aware of the negative perception commanders had of them, as those who treated “invisible,” rather than visible, physical wounds. One provider explained:

There’s also a negative perception of Mental Health (by commanders). On the food chain of MEDCOM (Medical Command), the lowest life form is Mental Health.

**Differences in Professional Jurisdictional Claims.** Mental health professionals and commanders also faced identity conflict over claims to their core professional jurisdiction

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\(^7\) Mental Health services were referred to as “Behavioral Health” in the Army. For ease of reading and given that providers only provided mental health services, “Behavioral” has been changed to “Mental” throughout this dissertation.
regarding their responsibilities as providers and commanders. Commanders believed they were solely responsible for “taking care of soldiers,” while mental health professionals believed they were responsible for “taking care of patients/clients.” Both groups fundamentally believed their scope of professional practice included claiming jurisdiction over the same group of people. These two hyper-paternalistic professional groups believed they each “knew what’s best” for “their soldiers/patients.”

Historically, commanders and the “command team,” including chaplains, had been the primary source of support for addressing soldier problems related to stress, anxiety, and personal and family problems. With the recent influx of more extensive Army mental health services, these formerly “normal” soldier problems handled by the command team were now considered by mental health providers to be medical problems with medical solutions that fell under their jurisdiction, not commanders’. Most commanders, who had full legal authority over their units under the Uniformed Code of Military Justice (UCMJ) (e.g., they were the sole judge and jury on determining misconduct charges, they could over-ride most medical recommendations, they “owned” soldiers), were resentful of such “outside agencies” who they said “took their soldiers away” and sometimes undermined their authority over their units. Commanders believed they knew their soldiers better than mental health providers, while mental health providers believed they knew soldiers better than commanders. Most commanders reported they believed a “good commander” “took care of his own” rather than “punted” his soldiers to outside agencies for help. One commander explained: “I mean we know soldiers best. We see them on a day-to-day basis while they see them what, one hour every few weeks?! So it's hard for them to really know what's going on.” While a provider noted in contrast: “No one wears a sign saying, ‘I have
depression’ or ‘I'm thinking about killing myself,’ or ‘my mom died and I ran through a wall.’

Soldiers keep it inside and command doesn’t know.”

**Differences in Identity Displays.** Observations of these two professional groups also revealed notable differences in identity displays in terms of their language, demeanor, and dress. Commanders were well versed in “speaking Army,” skillfully utilizing the acronyms, jargon, terminology, and idioms common in the Army, so much so that outsiders often described it as a real foreign language (e.g., “I speak a little Army”). Commanders, trained to begin any briefing with the “BLUF” (“bottom line up front”), used a direct and deductive communication style and were generally intolerant of long-winded, inductive and ambiguous speech. In contrast, mental health professionals generally were not fluent in “Army” and used their own technical medical language and an inductive speech style. For example, to a mental health professional, “suicidal intent,” passive vs. active “suicidal ideation”, “suicidal gesture”, and “suicide attempt” all had specific and distinct meanings that an outsider might lump together as “suicide.” The clinical language of mental health professionals also accounted for a complex constellations of symptoms and preliminary diagnoses that evolved over time and for which the criteria were partially subjective, making it difficult for them to make direct, “black and white” statements desired by commanders.

In addition, while commanders were always formally dressed in their green camouflaged “ACUs” (Army Combat Uniforms) with standard regulation hair-cuts and rigid posture, the majority of mental health professionals wore casual civilian attire, carried themselves with a relaxed posture, and looked rather unkempt by comparison. Finally, combat unit soldiers and their commanders were notorious for hyper-masculine displays of bravado as self-described, “alpha males”, who generally portrayed themselves as confident, super-humans, which meant
showing no physical or mental weakness by seeking any kind of help for health problems. One commander noted:

For good order and discipline, soldiers can't see that their commander is not Superman. They need to believe that he is to have confidence in him and the unit. ...I would never tell my soldiers if I had gone to <mental health services>, just like when I broke my foot, I would not wear a cast. You would not catch me wearing that boot!

**Differences in Perspectives on How to Accomplish the Organization’s Superordinate Goal**

Commanders and providers held differing perspectives on how to achieve the organization’s overarching goal of a having a mentally healthy, mission-ready force, such that each privileged one part of the goal often at the expense of the other. These different perspectives, rooted in their different professional group memberships, also led to different traditional professional practices each group believed was most appropriate for pursuing the part of this goal they prioritized in ways that often led to conflict between these groups (Table 4).

--- Insert Table 4 about here ---

**Privileging Different Parts of the Organization’s Goal.** Commanders and mental health providers each privileged the part of the organization’s goal that corresponded best with their professional group’s identity and corresponding worldview or perspective. Mental health providers privileged providing rehabilitative mental healthcare to help soldiers become “mentally healthy”, which they often prioritized over “mission-readiness.” Commanders, in contrast, privileged training their units to be “mission-ready” over ensuring soldiers were “mentally healthy.” Many conflicts between providers and commanders emerged over this difference in prioritization of goals, as each group perceived these goals to be zero-sum such that privileging soldier rehabilitation was seen by commanders as coming at the expense of fielding a mission-ready unit, and fielding a mission-ready unit was seen by providers as coming at the expense of providing rehabilitative mental healthcare to their patients. For commanders, this was because
their soldiers missed work during the duty day to attend mental health appointments. Provider treatment recommendations also sometimes took soldiers “out of the fight” by limiting what they did at work, including performing their regular job duties, and attending important trainings and training deployments essential for meeting mission-readiness levels for the unit to deploy. One commander explained:

First, there is individual live fire training, then its team live fire training, then platoon. The crews are set because we are playing with live bullets and so every time I lose a soldier to Mental Health, it degrades our troops’ ability to accomplish our mission.

Commanders were also regularly assessed on whether their units were at least 90 percent deployable (p-level or “personnel level” of .9) and 85 percent trained on “mission-essential” tasks (t-level or “training level” of .85). P- and t-levels were reported monthly; commanders unable to maintain these levels were removed from command. Many commanders reported frustration when their soldiers sought care for any medical problem because these soldiers “counted against their books” toward meeting their 90 percent goal. One commander explained:

I need to do something with these guys because they are eating up a slot. It's not personal but they're not deployable and they're not there (at work), yet they're taking a paycheck and a slot. If there's no misconduct, they will go to the VA and get some benefits, so it's not like they'll be dropped. But if they're here, they're just not a productive soldier.

In contrast, mental health professionals worried that soldier participation in training exercises preparing them to complete their missions, which often involved being around weapons or operating heavy machinery, might aggravate their mental health conditions or put them at greater risk of harming themselves or others. Mental health providers said they privileged the long-term health and wellness of their patients over the short-term needs of commanders to field a mission-ready unit. One provider explained:

That's my goal right now, rehabilitation. And even if I can’t get him back to duty, it’s also about helping someone become a good human being when they go back to society.
Yet commanders had discretion over whether or not to comply with the soldier care recommendations made by providers that limited what a soldier could do at work, which impacted whether soldiers could fully benefit from provider rehabilitative services. These differences in prioritization of goals created regular conflicts between providers and commanders.

**Different Perspectives on Accomplishing the Organization’s Goal.** It wasn’t just that each group prioritized different parts of the organization’s goal, but that each group held clashing perspectives on how the part of the goal they prioritized should be accomplished, resulting in different traditional professional practices that often led to conflict between the two groups. This difference in perspective on the means of accomplishing the part of the goal they privileged surfaced conflict and resulted in clashing traditional practices in four main areas: 1) sharing vs. protecting patient privacy, 2) individual vs. unit welfare prioritization; 3) enforcing “order and discipline” vs. providing leniency and second chances; 4) instilling mental toughness and resilience vs. reducing the stigma of seeking help.

**Sharing vs. protecting patient privacy.** Providers and commanders had differing perspectives on the appropriateness of discussing a soldier’s mental health treatment progress and status in the service of accomplishing the goal to field a mentally healthy, mission-ready force. Commanders believed they needed as much information as possible about their soldiers’ mental health conditions to make informed decisions about their units’ missions (e.g., can this soldier safely deploy? lead others? manage sensitive security intelligence? operate expensive equipment?), but mental health professionals were trained to protect patient privacy to earn patient trust and adhere to HIPAA laws (Health Insurance Portability and Accountability Act). For mental health providers, protecting patient privacy was not only a legal requirement, but also a sacred part of...
the patient-provider contract for effective therapy so patients felt comfortable opening up and sharing personal and traumatic experiences. One related:

Command wants to know everything. But we were trained to protect patient confidentiality, otherwise patients won’t trust us and they won’t come. …So a lot of conflict emerges.

In contrast, commanders were trained to “know their soldiers,” and have “situational awareness” on all aspects of their soldiers’ lives, which included their health problems, and the Army had rules that formally limited soldier privacy. While a soldier may not want their mental health condition disclosed to their commander, commanders claimed they needed this information to make informed decisions about executing their missions and because they were held accountable for any “negative events” that affected their soldiers (i.e., suicide, homicide, crime, etc.). Under the Privacy Act in the Uniform Code of Military Justice (UCMJ), soldiers waived the right to the same medical privacy protections enjoyed by civilians. Army medical professionals can share information about a soldier’s mental health condition with his or her commander if that soldier was considered at risk of harming themselves or others, or if the soldier’s condition might impact the unit’s mission. But all providers admitted that knowing whether a soldier’s condition affected the mission was an ambiguous, gray area.

These different perspectives on the appropriateness of discussing and sharing soldier health information led to different traditional professional practices, with commanders regularly calling and “pushing” providers to share information, and providers trying to withhold or limit this information sharing by ignoring or rebuffing these commanders, e.g., by not returning their calls.

**Put the unit before any individual vs. put the individual first.** From the commander’s perspective, the needs of the unit came first before the needs of any one individual soldier. This was exemplified in one of the Army’s core values of “sacrifice.” In contrast, mental health
providers were concerned with doing what they considered right for their individual patients’ recoveries, regardless of the impact on the larger unit the soldier was a part of.

These different perspectives on prioritizing the unit over the individual soldier led to different traditional professional practices between providers and commanders. For example, mental health providers often asked for resource-intensive assistance from commanders for certain patients, such as full-time monitoring or an escort to appointments from leaders in the unit, which were often difficult for these units to provide since it took away resources from the rest of the unit. Commanders provided assistance to the extent that it minimized the “burden” on the overall unit, even if it sometimes negatively impacted an individual soldier. For example, as described in the Introduction, providers might ask for a soldier previously hospitalized to be watched 24 hours a day during the few weeks after being medically cleared to rejoin their units. However, commanders preparing for a deployment were generally short-staffed and did not have the manpower to provide a rotating group of sergeants to watch a soldier 24/7. Instead, they often used the resource-conserving practice of putting the soldier on a cot at the unit front desk, which was the only place manned 24 hours a day. Yet this was a humiliating experience for soldiers watched in this way. Mental health providers were often not aware of how their individualized recommendations, which they made in the spirit of being the clinically superior or safest for their patients, often had negative effects on their patients’ careers and standing in their units, as well as on their units’ overall mission-readiness levels. Commanders were often uninformed about how their treatment of soldiers with mental health problems at work might aggravate their conditions.

**Enforcing “good order and discipline” vs. providing leniency and second chances.** While commanders were trained to enforce “good order and discipline” in their units by swiftly (and
often publicly) punishing soldiers who violated any number of the hundreds of Army regulations, mental health professionals were trained to provide leniency and second chances to soldiers. Providers often viewed “indiscipline” as a “cry for help” for an untreated underlying mental health problem. Conflict occurred when commanders wanted to punish a soldier or even “chapter” them out of the Army on a disciplinary charge to remove what they considered “toxic” “problem children” from the unit, while many providers wanted to rehabilitate and treat these same soldiers. This created conflict for commanders, because they said these “bad apples” took up a disproportionate amount of their time and attention, preventing them from attending to the majority of soldiers in their units who do not have (or cause) problems and were considered a peril to the mission.

Providers said they felt a professional obligation to care for and treat all soldiers, regardless of how they affected their unit and regardless of whether they were considered star performers (“studs” who are “squared away”) or poor performers who are unmotivated to improve (“dirtbags” or “problem children”). For example, conflict occurred when a soldier fell asleep while on overnight duty, and command wanted to punish the soldier to enforce discipline in the unit, but the soldier’s mental health provider wanted this punishment waived since the soldier was suffering from insomnia and was on a new dosage of a sleep medication. Commanders often pushed to get these “problem children” out of the Army as expeditiously as possible, while providers were more inclined to give some of these soldiers medical retirements for a mental health condition, leaving them in the unit for an extended period of time for treatment while they awaited a formal disability rating (a process that typically took between 250 to 1000 days). Finally, soldiers with mental health problems may run afoul of the law and commit “misconduct” (e.g., DUI, theft, drug use, etc.), qualifying them to be chaptered out of the
Army with a general or other than honorable discharge with limited (and sometimes no) benefits (e.g., GI bill provisions, healthcare, etc.). Once a chapter violation was initiated by command, the soldier was screened by Mental Health. If a mental health condition was found related to their military service, especially if their condition contributed to their misconduct, they then started treatment and the soldier was evaluated for a medical retirement with full benefits, leaving a soldier who was considered “toxic” (e.g., dealing drugs, showing up drunk at work, getting in fights, etc.) in the unit until the medical board was completed, and who counted against the units’ books. To command, allowing soldiers to go unpunished made controlling the unit more difficult and damaged their impression of Mental Health as a “get out of jail free card” from disciplinary action. One commander explained:

It is hard to keep good order and discipline in the 150 men in my unit when they see this guy drinking and driving, DUIs, popping hot for drugs and all these different things. It looks like we are just looking the other way. I need to take legal action. If soldiers see these people get rewarded with medical retirement (for mental health) when they act out, it sets a bad precedent.

**Instill mental toughness and self-reliance vs. reduce the stigma of seeking help.**

Commanders of combat units were responsible for training a unit of soldiers who were both physically and mentally prepared for the trials of combat. They emphasized mental toughness and self-reliance, and trained their soldiers to “push through” pain and fear and “suck it up and drive on” to develop the capacity to handle difficult situations they may face in combat. This perspective directly conflicted with the perspective of mental health providers who wanted to reduce the stigma around seeking help, which meant acknowledging pain and fear and turning to others for professional help. One commander shared:

We are becoming a ‘kinder and gentler Army,’ but our enemy, like ISIS (Islamic State of Iraq and Syria), hasn’t become any kinder or gentler. Do you think ISIS fighters go to Mental Health? …I have guys who tried to save a friend who was ripped in half and they had to just keep charging on anyway. It is necessary to do the job, to keep going. If we were all getting help, we would be dysfunctional.
Conflict over these different perspectives was especially salient regarding the mental healthcare of 'leaders,' such as officers (like commanders, lieutenants and higher ranking officers) or senior non-commissioned officers (senior sergeants). While providers wanted to reduce the stigma of seeking care, in part by demonstrating that even leaders seek help, for leaders, as role models tasked with instilling mental toughness and resilience in their units, there were unique barriers to getting care. Nearly all commanders and senior sergeants interviewed said they could not openly seek care because it would undermine their status and credibility as leaders who regularly made decisions affecting the lives and welfare of their soldiers. One commander explained how it was not appropriate for leaders to use mental health services and avoided seeking help even when he needed it:

If I talked to my soldiers and I wanted to prove a point that it's okay to seek care, I would say, 'Hey, I'm a Captain, and I went to Mental Health when I had had problems, so there's no stigma.' But part of me thinks guys might think I don't have what it takes to lead. It comes down to the individuals and knowing your audience. If you were to let it be known, they may turn on you. It's up to the individual whether that's (seeking care is) okay or not. ...So I haven't been to Mental Health. ...When I was in Iraq, I called a (suicide) hotline and said I have problems. ...It was over the phone and I felt better. That's the only time I've done that.

Nearly all commanders and senior sergeants shared concerns about being removed from command or passed over for promotion if they sought help, particularly given downsizing in the force which had increased competition for a smaller number of promotions to the next rank. One explained: “The concern is if it's between two guys (for promotion to the next rank of Major) and one’s in Mental Health and one’s not, you’re gonna choose the guy who's not in Mental Health.”
CHAPTER 6: INTEGRATIVE MECHANISMS AVAILABLE TO ACHIEVE GOAL ALIGNMENT ACROSS GROUPS

What makes these conflicts over privileging different parts of the organization’s overall goal to have mentally health, mission-ready soldiers so interesting is that different providers and commanders on post all had access to a host of integrative mechanisms found by the literature to promote goal alignment between different groups in the organization. The integrative mechanisms available to commanders and providers at this post included: new policies and inducements to encourage commanders to support soldier mental health services (e.g., removing automatic security clearance suspension for seeking care, mandating commanders identify and manage “high risk” soldiers, etc.), formal rules and procedures for interaction (e.g., requirements for providers to issue a formal electronic “profile” to commanders listing the work restrictions for soldiers with mental health conditions), strategic planning by leadership from both groups, cross-functional task force/teaming through monthly “Health of the Force” meetings that included both commander and provider representatives, awareness of the superordinate goal of mentally health, mission-ready soldiers through a highly publicized internal “Ready and Resilient” Army campaign that emphasized both physical and mental and emotional health, an integrative organizational design such as co-locating each mental health clinic in the geographical area of each brigade, multiple socialization efforts for providers and commanders, and the use of intermediary full-time liaison roles such as by embedding some providers into the brigades rather than in the clinics.

While certain integration mechanisms described in the literature were not present in this context, their absence was consistent across all clinics and brigades. For example, there were low levels of organizational slack at this and all Army posts given longstanding shortages of soldiers without a draft and given reductions in the size of the force since 2013. The absence of some of
these mechanisms is also typical of many organizational settings where, for example, there is low organizational slack.

Most of these integration mechanisms did not explicitly address identity differences between providers and commanders. However, one mechanism, that of organizational socialization to promote a shared organizational identification in service of aligning the goals of both groups, did address identity differences. In particular, there was an Army-wide organizational socialization intervention to “acculturate” civilian mental health providers to the Army. A special team of uniformed providers were flown in to conduct multiple days of intensive training in “Army 101,” aimed primarily at civilian providers. In addition, all providers were given an onboarding binder upon joining the clinic that included a map of the post, lists of Army acronyms, details on the numerous Army regulations, policies and procedures, especially around determining whether soldiers were medically “fit” of “unfit” for duty, and other information on Army culture. All uniformed providers also underwent a few months of an abbreviated version of officer training. However, these uniformed providers reported that this was very limited training since they are part of the medical organization. As previously noted, professionals are often highly resistant to organizational socialization efforts, since they have spent years being socialized into the identity and perspectives of their profession (e.g., Anteby et al, 2016). Most providers, particularly the civilian providers, reported these socialization efforts made little impact, and were largely rejected by providers who considered themselves clinicians and mental health experts first and foremost over government employees working for the Army.

There were also efforts to modify the organizational socialization practices aimed at commanders to increase their support for soldier mental health usage, such as requiring they conduct 28 hours of “resilience” training with their units, asking commanders to oversee “suicide
stand down days” to educate their units on suicide prevention, and making required reading multiple “leader books” on issues related to “the health of the force” and “suicide prevention.” However, commanders were generally skeptical of the value of these efforts since they took time away from their “real work” of fielding a mission-ready unit.

While additional details on these integration mechanisms can be found in Table 5, it is worth noting in greater depth two integration mechanisms the Army hoped would be particularly effective at promoting goal alignment between commanders and providers. The first was a major Army-wide initiative to move mental health providers out of centralized post hospitals and into free-standing clinics co-located within the geographical “footprint” of the different brigades on post. It was hoped that colocation would allow soldiers to more easily “walk-in” and attend appointments near where they lived and worked, and that commanders and providers could more easily connect and communicate given greater physical proximity to one another. Each clinic was aligned to serve a brigade on post (most posts have 3-6 brigades, with each brigade located in a separate part of the post) and was comprised of a team of mental health professionals including therapists (licensed clinical social workers and psychologists), a psychiatrist for prescribing medications, and a team lead to oversee the clinic. Although co-located near each brigade, clinics were in self-contained buildings apart from brigade personnel. Please see Figure 1 for a visual depiction of this major integration effort.

The second integration mechanism was assigning full-time intermediary liaisons to serve as boundary spanners between the clinical world of mental health and the “line” world of commanders training their units in their brigades. The Army assigned a small number of
providers to work outside of the clinics and fully embedded them into the brigades where they trained and deployed with their brigade. The Army hoped that these embedded providers would be fully acculturated to the unique context of the Army and develop close relationships with commanders, who were fellow officers in their units. According to the current literature, all of these integration mechanisms should have helped commanders and providers align their differing goals.
CHAPTER 7: ANCHORING WITHOUT PERSONALIZATION IN CLINICS AND BRIGADES C/D

One of the most promising integration mechanisms, as described above, was the Army-wide initiative to build co-located clinics in the geographical area of each brigade. In theory, the increased physical proximity from colocation should have improved goal alignment between commanders and providers (e.g., Van den Bulte and Moenaert, 1998). Yet, close observations of providers and commanders associated with two of these co-located clinics, Clinics C and D, revealed that relations between these groups did not change and were just as bad as before the clinics had been built. Strong identity related conflict, including stereotyping, dis-identification and zero-sum conceptualizations across groups continued under this new colocation structure.

Even though mental health providers and commanders in C/D were co-located closer to one another and providers in each clinic were engaging with a smaller subset of commanders associated with one brigade on post, C/D providers still interacted with dozens of commanders, and these commanders dealt with many different mental health professionals treating their soldiers. The existing negative relations between mental health providers and commanders persisted in C/D and their conflict over privileging different goals remained exacerbated by seemingly intractable professional group differences in identity and perspectives.

No Personalization between C/D Providers and Commanders

Because mental health professionals in Clinics C/D engaged with many commanders, they did not develop meaningful personal relationships. For example, commanders were generally unable to name the mental health providers they interacted with. One noted, “I don’t know the people over there (in the clinic). I get a different person every time…I couldn’t tell you their names.” The relations between providers and commanders served by Clinics C/D remained negative, and were similar to relations observed during my initial visit to this post before the
clinics were fully operational. One C/D provider explained how being co-located with one brigade had not led to any notable change in relations with commanders:

Now we serve one brigade, but it’s really not that different than when I sat up in the hospital and saw everyone (all brigades). There’s too many of them to really feel any sense of ownership, which is what I thought the new model (one clinic per brigade) was supposed to promote. So it’s not that different at all.

In the new co-located clinics, despite greater physical proximity, personalized relationships did not develop between C/D providers and commanders. Instead, each group continued to view each other in a stereotypical manner, and dis-identification continued, in which each group, at least in part, defined themselves by what the other group was not. For example, one provider explained how she viewed commanders as not caring about soldiers, unlike providers:

I love my patients, I love my (clinic) team—the clinicians here are all good. (What about command?) Command? Not so much (laughs). Dealing with command is one of the more unpleasant parts of my job. …Commanders only care about the mission; we care about soldiers.

Commanders in C/D also continued to stereotype and exhibit dis-identification with the C/D mental health providers and what they believed they represented. One commander justified his hesitancy to refer soldiers he knew were struggling to the mental health clinic based on his poor impression of the providers there: “I think there is a stigma against these providers. And it's stopping guys from getting help.” Commanders in C/D also continued to largely express skepticism over the value of mental health services, viewing their use as antithesis to their alpha-male warrior identity:

Mental Health is growing like a cancer. And how much money has been spent on it? Billions? I am tired of all the pussies who say they want to go to Mental Health…when I have guys who have really seen and done some messed up shit who wouldn't go near Mental Health.

C/D providers and commanders remained firmly anchored and entrenched in their home group professional identities and perspectives. For example, C/D providers continued to define themselves in opposition to commanders:
To me, first and foremost it’s about my patients. I’m here for soldiers. I’m not paid to do what command wants. I’m paid to use my clinical judgment. That’s what I’m here to use.

While on the surface, the strong commitment of C/D providers to privileging patient rehabilitative care may seem best for patients, the poor relations between commanders and providers in C/D often led to even worse outcomes for patients, as will be explained below.

**Failed Accomplishment of Superordinate Organizational Goal among C/D Providers & Commanders**

Without addressing identity-related conflict, providers and commanders associated with co-located Clinics C/D continued to be mired in conflict over their differing professional identities and perspectives and were unable to discover integrative approaches to handling these conflicts in service of the organization’s superordinate goal to have both mentally healthy and mission-ready soldiers. Instead, each group empathized with and privileged only their home group’s perspective and goals since they assumed integrative solutions to conflicts with the other group did not exist, and pursued only traditional means of achieving their goals that strictly conformed with professional group practices and ways of interacting. As a result, few conflicts were resolved in ways that resulted in integrative solutions which promoted both soldier mental health and mission-readiness, as will be illustrated by showing how these C/D providers and commanders handled common conflicts between them.

**Conflict over sharing soldier health information.** Providers and commanders associated with clinics C/D, like all providers and commanders on post, regularly faced conflict over their differing professional perspectives on sharing health information on soldiers. Commanders generally wanted to know more information about their soldier’s mental health problems than providers generally wanted to share. For example, in one specific case, a patient had a diagnosis of depression and had begun regular therapy along with medication, and the commander asked the provider to share soldier mental health information given that this soldier was also not
Performing well at work. Providers in Clinics C/D took only their home group’s perspective and privileged protecting patient privacy above all else. C/D providers rarely shared any soldier mental health information with commanders. They assumed that no good could come from commanders having this information and assumed commanders had bad intentions. One C/D provider explained:

They think that little rank on their chest gets them a free ticket to get any information they want. …Command will overstep their bounds all the time, and I will say, ‘That’s their private health information; you have no need to know that!’ And it will cause a conflict…

Providers in Clinics C/D handled conflicts over privacy in ways they believed conformed with their traditional practices to not violate their professional ethics and training around protecting patient confidentiality. In this particular case, the provider did not call the commander back in response to the multiple voice messages he left the provider.

While the guarded information sharing of providers in Clinics C/D may have benefited therapist-patient trust, it often led to unintended consequences that negatively affected patient care when the soldier’s support structure could not assist in the soldier’s recovery or make allowances for poor work performance or minor disciplinary infractions related to a soldier’s mental health condition. For example, one C/D commander explained his frustration with how provider’s invocation of professional rules related to HIPAA prevented sharing information he perceived contributed to a soldier’s suicide in his unit:

My number one challenge is HIPAA because it puts up barriers between the person who has the information and the person who needs the information. …For example, I had a <soldier> who had a trauma in Afghanistan and committed suicide. …He had been making appointments on his own and had been seeing shadows and hearing voices and having up to 15 drinks a day. …I’ll tell you, <mental health services> really pissed me off! There is a line somewhere and we were not told because of HIPAA.

Commanders in C/D responded by using their own traditional means of achieving their goals by finding other ways to extract this information, such as by going around the provider and
asking the brigade’s embedded provider or doing what is known as a “command directed referral” where a soldier is ordered to get a mental health evaluation for the purpose of sharing with the commander, a tactic that is often considered humiliating to a soldier (and in which the provider can still limit what is shared to a lesser extent).

**Conflict over prioritization of individual or unit welfare.** All providers and commanders on post were regularly in conflict over their clashing professional group perspectives on prioritizing individual versus the unit welfare. This occurred regularly in situations where commanders perceived provider recommendations for an individual patient to have a negative impact on their unit’s mission-readiness, such as when providers recommended soldiers sit out of important trainings. Providers required the support and compliance of commanders for their soldiers to fully benefit from their rehabilitative treatment plans and to keep soldiers (and their units) safe, particularly when soldiers’ mental health conditions made providers wary of allowing them to carry weapons, engage in stressful activities, or operate dangerous equipment. Commanders had authority over whether and the extent to which they followed provider recommendations made for their soldiers that affected them at work, as previously noted.

In one particular common scenario, a soldier who had “lost buddies in a tank” in Afghanistan began having panic attacks when inside a tank. His unit was about to deploy for a month-long training exercise in “the field” that his commander had been counting on him to attend to be eligible for their subsequent combat deployment. The soldier wanted to attend and did not want to be “left behind.” The mental health provider in C/D privileged the perspective of her fellow clinic peers, and reported that if any soldier was undergoing treatment for Post Traumatic Stress Disorder (PTSD) or any moderate to severe anxiety or depressive disorder, they did not take any chances with aggravating the soldier’s condition and would not allow them to go
to the field. The provider did not consult with the soldier’s commander, assuming that the commander cared more about his mission than what was medically best for his soldier. C/D providers considered commanders’ missions outside the scope of their responsibility to learn about, viewing it as irrelevant and counter to their primary goal of patient rehabilitation and care.

One provider explained:

That’s not my lane (knowing the brigades’ missions). I don’t see how that’s relevant. I’m here for patient care. ...My ‘mission’ is therapy with my client, the patient.

In this case, the provider followed traditional clinic practices and put in writing (in a “profile”) that the soldier not go to the field. While, on the surface, this may seem the safest option for the soldier and unit, in practice, depending on the soldier’s condition and the type of field exercise, automatically leaving the soldier at home in “the rear” and isolating him or her from fellow soldiers often aggravated soldiers’ mental health conditions and scared other soldiers from seeking care. Clinicians in Clinics C/D reported their conversations were often very adversarial when commanders questioned their recommendations not to take soldiers to the field. One C/D provider explained that he believed it was a clinical decision to recommend whether or not a soldier could go to the field, not a decision that should involve commanders, whom he perceived to be only concerned about meeting their mission readiness numbers, rather than about soldier health:

And you’ll see providers (referring to the embedded providers) who will say, wait, we need to talk to the commander before we do a profile...No, it’s not their decision, it’s yours. We lean toward the needs of the patient; command is out for the bottom line.

Providers and commanders in C/D, by pursuing their own goals at the expense of the other group’s goals, often hurt both the ability of their soldiers to recover and mission readiness. For example, I heard of many cases where commanders served by C/D providers ignored providers’ recommendations and took their soldiers to the field for training when they believed the
providers were out of touch with the context of what the field was really like and when they believed that the risks of leaving the soldier behind where there was less supervisory oversight and support were high. In some of these cases, this was a mistake, and the soldier “decompensated” while in the field. In other cases, the soldier was fine, but was unable to fully benefit from mental health provider recommendations designed to support their treatment and recovery. One C/D commander explained how he does not follow mental health “profiles” if he does not agree with them. A profile lists limitations recommended by a mental health provider for a soldier, such as not deploying, attending training events, or being around weapons or requests to modify a soldier’s duties. The commander noted:

If I don’t think a person needs a profile, I’m not gonna do it. I don’t have to follow it. It is just a recommendation and you might not even need a profile.

Another commander served by C/D providers explained: “I think some providers here think that sending this guy to the field is going to be horrific and he’s going to be sleeping on the ground or something.” Another commander noted that he felt the provider recommendations from Clinics C/D were overly cautious and did not take into account the negative effects of leaving a soldier behind:

Many of the profiles overdo it to be overly safe. As a soldier, there are things we need to do, like at a minimum, you need to be able to wear your gear and do training. But we will get profiles from Mental Health (Clinics C/D) that say, “No gear,” basically what we call a “dead man's profile.” The soldier already feels worthless when put on a profile because they will be left behind.

Conflict over instilling mental toughness vs. reducing the stigma of seeking care. Another conflict between the mental health providers and commanders was in regards to their different professional perspectives on commanders’ role in serving as exemplars of mental toughness versus promoting help seeking and reducing the stigma of seeking care. This conflict emerged in the context of officers and non-commissioned officers (NCOs or sergeants) receiving mental
healthcare. All providers and commanders noted that one negative consequence of providing each brigade with its own mental health clinic was that it deterred these “leaders” from getting care due to concerns about being seen by the soldiers they lead in the waiting room (whereas previously they would be with soldiers from across the post from other units when care was delivered in the large post hospital). Conflict occurred when commanders requested that providers make special arrangements to see them or other leaders in their unit, such as asking to see them after hours or in another location other than the clinic.

Providers in Clinics C/D generally handled this conflict by taking only the point of view of their home group to prioritize reducing the stigma of seeking care over the commander’s perspective to prioritize instilling mental toughness. Providers in Clinics C/D generally avoided making special accommodations to treat leaders any differently that junior enlisted soldiers and were generally unsympathetic to commander requests for leaders to avoid the waiting room or receive care in more discreet ways. They said they believed treating all patients equally would help break the stigma of seeking care for junior solders by seeing leaders at the clinic. One provider who worked in Clinic C for six months before moving to Clinic A explained the different approach to care for leaders, as well as its negative effect on whether leaders actually sought and stuck with care:

And that’s a big difference between here (Clinic A) and <Clinic C>. In <Clinic C>, they would say and tell everyone to, ‘leave your rank at the door,’ but not everyone feels comfortable (commanders and senior NCOs), and then they just wouldn't come at all.

While well-intentioned, the decisions by C/D providers to not treat leaders differently than junior enlisted soldiers often back-fired, as many leaders in these units chose not to seek help at all or reported paying out of pocket to get help off post. During the course of this study, several leaders committed suicide at this post, but who had never sought care in Clinics C/D. In one case, it was later found that the leader had called an anonymous suicide hotline. One commander noted: “We
had some suicides in <Brigade C>, and I have to wonder do we contribute to the problem with <Clinic C> by not having a confidential option for officers. We may need VIP care.”
As demonstrated by clinics C/D, the co-location of mental health providers and commanders did not resolve identity-based conflict between providers and commanders, making it difficult for these two professional groups to discover and craft integrative solutions to conflicts in service of accomplishing the Army’s overarching goal of having both mentally healthy and mission-ready soldiers. However, the Army also implemented another promising initiative to integrate some mental health providers into the brigades as full-time mental health liaisons who both trained and deployed with the brigade they were assigned to. These embedded providers were uniformed officer psychologists or social workers assigned to train and deploy with each brigade, but who spent limited time with colleagues in the clinics. They served as liaisons between mental health providers and commanders. They were regularly called upon by commanders to advise them on issues related to mental healthcare for their soldiers, and they also engaged with providers in their brigade’s clinic to relay the perspective of the commanders in their brigade, at a minimum through attendance at the weekly clinic multi-disciplinary team meeting where high-risk patients were discussed.

Liaison roles are thought to allow for effective boundary spanning across groups, such that goals can be aligned more easily through translation and transformation processes (e.g., Galbraith, 1984; Levina and Vaast, 2005). Such liaison roles might also be promising because they may help overcome identity-related conflict by promoting personalization between different group members. Personalization through familiarity from relationships across groups is thought to resolve identity conflict by reducing stereotyping and increasing perspective-taking across groups (e.g., Brewer and Miller, 1984, 1988; Allport, 1954; Ensari and Miller, 2000). However, I found that the high levels of personalization with commanders these embedded providers
experienced, without the same full-time interaction with other mental health providers in their clinics, led many of these providers to become coopted by the commanders’ perspectives whose brigade they were embedded with. My data suggest this is because these providers lacked an anchoring in their clinician identity from spending limited time in the mental health clinics. Without such anchoring in their home group identity, these embedded providers exhibited signs of cooptation.

For example, after a year, most embedded providers did not report even seeing a conflict between the perspectives of mental health providers and commanders because they believed the goals of commanders trumped that of mental health. One embedded provider explained:

To me, we really have one client – the Army. There really isn't a conflict. ...I've never had an ethical dilemma. It's not like that. What's good for the Army is typically good for the soldier.

Embedded providers also exhibited a limited ability to empathize with the goals of other mental health providers in the clinics on post and generally expressed greater empathy for the goals of commanders in their brigades. One embedded provider explained:

Command is your patient. ...We should always be thinking – how do I ease the suffering of command? We need to be viewed as subject matter experts who can be consulted. Commanders care about one thing – am I ready to go to war?

Finally, embedded providers did not remain anchored in their mental health professional identity, but instead came to prioritize their Army identity as officers in the brigade over their clinician identity, which was exemplified in the officer training they underwent. One embedded provider explained:

You learn from day one it’s, ‘Officer first, clinician second.’ You have to keep that in mind in all you do. You are an officer in this brigade first and foremost, then a clinician.

Without an anchoring in their home group’s professional identity from working outside the clinics, embedded providers were observed to shift and convert their clinician identities to privilege the commander’s goals and perspective rather than providers’. For example, most
embedded providers handled the situation most providers found difficult of deciding how much information to share with commanders by erring on the side of sharing whatever information commanders wanted to know in the name of the mission. Embedded providers said they felt obligated to provide commanders with this requested “situational awareness.” They reported sharing this information regardless of whether it was likely to affect the mission or unit safety. When soldiers learned that embedded providers were “lax” with sharing information with command, they reported being more hesitant to seek care.
CHAPTER 9: ANCHORED PERSONALIZATION AND ANCHORED PERSPECTIVE-TAKING IN CLINICS AND BRIGADES A/B

Providers and commanders associated with two other co-located clinics on posts that served brigades in the same combat division as C/D, Clinics A/B, overcame their identity differences and broadened their professional identities and perspectives in ways that allowed for the discovery and pursuit of integrative solutions to conflicts. Clinics A/B were also co-located with one brigade like Clinics C/D. The main substantive difference between A/B compared to C/D was a different organizational role assignment structure that enabled what I call “anchored personalization” and “anchored perspective-taking” practices. In Clinics A/B, each mental health professional was assigned as the point of contact for one or two specific units within their brigade and only worked with soldiers and commanders from those units (~6 commanders per unit) (Figure 2). This organizational assignment structure allowed providers and commanders in A/B to develop a stable, long-term personal connection and relationship with specific members of the other group. This stable connection led to personalization between different group members that reduced identity conflict from increased perspective-taking and reduced stereotyping across groups. At the same time, these commanders and mental health providers remained embedded and anchored in their home group, from working 40+ hours a week surrounded by their professional colleagues who also had stable, personalized connections to specific members of the other group. One’s home group provided collective support to license new ways of interacting with the other group they previously defined themselves against, while also keeping group members anchored in their home group’s perspective to prevent cooptation from increased personalized contact with the other group. Anchored personalization reduced longstanding identity conflict between groups by broadening and expanding each group’s professional identity to incorporate elements of the other group’s perspective, enabling what I
call “anchored perspective-taking” practices, which led them to interact in new and non-traditional ways to collectively develop integrative solutions to conflict.

Personalization rather than stereotyping across groups in A/B. Like the embedded providers on post, and unlike the providers and commanders in C/D, providers and commanders in A/B had opportunities to develop personal relationships with one another. Rather than using only stereotypes to relate to one another as “bullies” or “Berkeley hippies”, the assigned connections between commanders and providers led to personalization. For example, A/B providers and commanders often referred to one another by their first names. By getting to personally know a handful of commanders, mental health professionals started seeing the commanders and their Army units in a more personalized, rather than stereotypical, way. For example, one provider explained the transformation that occurred in how she related to commanders and how they related to her after developing personalized relations with the commanders in her assigned unit:

Now it’s much better... we can get to know command and our own group of soldiers. I’m at the point that I have them all (commanders) on speed-dial and they have me on speed-dial. …That’s how profound it can be. Before (being assigned to specific commanders and units), command and soldiers were hesitant to come to us. …Now you get to know the person as a person. Like he’s John in here with me, not Captain Smith

Another A/B provider explained:

In the past, I’d had some negative interactions with commanders. But things change once you get to know them. I have a much greater respect and understanding of what they do and the pressures facing them.

Similarly, A/B commanders began to view these mental health providers and their services in a less negative and stereotypical light after getting to know the particular provider assigned to their unit. One A/B commander shared:

(Before) I had a pretty negative view of Mental Health... I mean, it's bad, but you think, ‘Oh this guys a dirt bag or can't cut it.’ I had a negative perception--people want nothing to do with it. …You know one guy who’s a shit bag using it to get out of work and you think the
whole thing is full of shamners. And you think the doctors over there just don’t get it...Since working with [first name of his assigned provider], I have a much better view of Mental Health.

**Anchoring in home group’s identity.** Unlike the embedded providers, providers and commanders in Clinics and Brigades A/B were firmly anchored in their home group’s identity from working full-time surrounded by their professional colleagues in either their clinic or brigade area. This identity anchoring from one’s home group had two effects. First, it prevented cooptation into the other group’s perspective despite increased personalized contact with members of the other group. Such anchoring was especially important for providers given that commanders were the more powerful and dominant group in this setting as members of the “line” rather than in a “support” function of the organization. Their clinic “team”, they said, helped “keep you grounded” or “pulled you back” if they saw one another beginning to get “too caught up” with what their specific command counterparts wanted. One A/B provider noted:

> While developing friendships and relationships with leaders (commanders) are important, you need to make sure to distinguish yourself as a professional, and establish clear boundaries, and not become too enmeshed with them. If you don’t keep your boundaries clear, leaders will think of you as a tool ...to get what they want done. ...I advocate for both the Army and the patient. ...it can be easy as you get to know command to start going along with what they want. But your team can help with that. They’ll pull you back when you need it.

Another A/B provider echoed these comments, explaining how his clinic “team” kept him in check and true to his home group’s goals and perspectives even as he developed closer relationships with commanders:

> I had begun to be less objective, but because I get feedback from the (clinic) team, the patient and Army benefited, because otherwise my personal relationship with this (commander) may have clouded my judgment. But because of the team, I was able to stay grounded.

Concerns about cooptation were not an issue for the commanders since they were the more dominant group and engaging with mental health providers was only a very small component of their overall jobs as commanders. No commander, even those with the closest
personalized relations with their assigned mental health provider, expressed concerns about cooptation. Providing mental healthcare services to soldiers and engaging with commanders was the full-time job of providers, while for commanders, engaging with mental health providers on the care of their soldiers was a small, even if important, part of their full-time job.

Second, anchoring in one’s home group also provided group members with collective support and the license to engage with the other group in new, non-traditional ways. This stemmed from the unique organizational structure in which each group member had assigned personalized connections to the other group, such that all group members were in on the same “dark secret” (Goffman, 1959) that constructively engaging with the other group actually helped their soldiers. They were able to engage in these new ways with one another without being seen as betraying their home group’s identity because their home group collectively understood that such interactions actually helped them achieve their group’s goals, as will be explained in more detail in the next section.

For example, among the providers, nearly all expressed that they felt anchored or grounded as a clinician and member of their clinic “team.” One provider explained:

I think that our success is because we (the clinic team) are also like very grounded. We are very solid, you know we have a solid sense of self and clear boundaries… We can, you know, have that support and know it’s a safe place where anybody can conceptualize a case without feeling attacked, you know without any kind of negative consequence. It’s just very, very positive and productive.

Another noted:

Being on the (clinic) team has been wonderful, a real benefit. Hands down, I personally find it highly advantageous especially with all these tensions with the mission and patient care and talking with leadership (commanders). It helps you maintain your professional distance. …I would be afraid to practice independently, because I would lose the opportunity to have this kind of fluid consultation with peers.

Commanders in A/B likewise noted how interactions with the other commanders within their brigade, who also all had assigned personalized connections with specific mental health
providers, helped support them in acting in new and non-traditional ways with mental health providers without it making them appear “soft” or “weak.” For example, commanders in A/B publically supported use of “soft” services like mental healthcare, in part because their fellow commanders also had personalized connections with mental health professionals and realized these services actually helped their soldiers. One A/B commander explained how his fellow commanders also felt the same way about mental health services:

(Name of their assigned provider) is great. I think any of the other guys (commanders) in my unit will tell you the same thing. ...We think it (mental health services) has transformed for the better. The stigma is real. And people do use Mental Health to get out of work. But some soldiers just have bad childhoods...So maybe they never deployed, but you know, actually they need the help. They could benefit from Mental Health, versus thinking, ‘Screw you, you haven’t deployed so you shouldn't be there and you’re a dirtbag.’

Another commander noted how his fellow commanders in A/B were now more supportive and open about talking about mental health in general:

Back then, if you mentioned ‘Mental Health,’ the room would clear out. So now people (other commanders) are more willing to talk about it. There has been a shift.... So the stigma is not there quite as much.

Identity Expansion. Anchored personalization between A/B providers and commanders led them to expand their professional identities to incorporate elements of the perspective of the other group, while still remaining anchored in their home group’s identity. They did this by broadening their definition of what it meant to be a good professional group member in ways that resolved longstanding identity conflict between groups and enabled them to fully engage with one another’s perspective without becoming coopted by that perspective. For example, multiple A/B providers noted how their definition of what it meant to be a good mental health professional had expanded to include not only looking out for their individual patient’s health, but also thinking more broadly about the patient as a soldier, with a career and reputation, who
plays a specific role in his unit and how the larger Army environment shaped their patient’s recoveries and health outcomes. One provider explained this broadening:

It's hard; it really is hard. With civilian training, it's only about the patient—that's really only what you're concerned about, and there's no bigger picture to it. (But after being assigned to a specific unit)...to me the patient still comes first, but the Army is part of it, too.

Commanders also expanded their professional identity to include the perspective of the mental health professionals they had personalized relationships with. They broadened their notion of what it meant to be a good commander who “takes care of their soldiers” to supporting their soldiers in using the services outside the unit in the mental health clinic, rather than handling everything themselves. One commander explained this expansion in his identity and perspective to incorporate supporting his soldiers using mental health services:

In the Army, commanders want to take care of their own, and some think they can handle everything themselves, and do not want to get people help (from professionals). I used to be that way too. But some soldiers do need professional help. Some are dealing with serious stuff like years of abuse, and your buddy just won't get it. So I try to identify people who may need to speak with a professional and encourage them to go...In the military you are responsible to take care of them (soldiers). ...Some commands keep it in house and say I'll try to fix them myself or they'll say, ‘rub some dirt on it and drive on,’ or ‘oh, they'll be ok.’

Commanders’ identity expansion was also evident in the subtle ways in which they now supported mental health usage while still affirming their commander identities as “alpha males.” For example, one commander explained how he now publically encouraged his soldiers to get care, but did so in a way that made seeking help “manly.” He shared:

...I tell my soldiers now, ‘Just because someone’s in Mental Health, just means they’re man enough to get help.’

Anchored Perspective-Taking Practices
Anchored personalization between A/B providers and commanders and the broadening of professional identities it promoted led to a reduction in identity-based intergroup conflict and a dramatic change in how commanders and providers engaged with one another. With reduced intergroup identity conflict, providers and commanders in A/B employed what I call “anchored
perspective-taking” practices to co-construct integrative solutions to conflicts which resulted in outcomes both groups defined as positive and accomplished the organization’s superordinate goal of both mentally healthy and mission-ready soldiers. Anchored perspective-taking involved three sub-processes: 1). empathizing with the other group member’s perspective, while remaining anchored in home group’s perspective. 2). using a broadened repertoire of identity displays during intergroup interactions that demonstrate respect for the other group’s perspective. 3). drawing on one’s personalized knowledge of and relationship with the other group member to collectively craft novel and customized solutions to conflicts that take both groups’ perspectives into account.

**Empathizing with the other group member’s perspective while remaining anchored in one’s home group’s perspective.**

A/B providers and commanders handled similar conflicts facing all provider and commanders on post differently, in part from empathizing with the perspective of the other group while remaining anchored in their own group’s perspective. For example, in a similar situation regarding whether or not to allow a soldier with a moderate anxiety disorder to join his unit in the field for a month-long training exercise, both commanders and providers reported empathizing with the perspective of the other group. One A/B provider noted:

I can see both sides. I feel the pressure they are under when I think about the pressure to deploy, I get that. But the other side of me is a member of this clinic… Clinically, it may not be right for that patient to deploy. So it creates conflict, but I can see it both ways.

In this case, the provider told the commander why she was worried about the soldier’s condition if he went out to the field, and also shared how she understood how much pressure the commander was under to have sufficient manpower for the training exercise. The provider explained how she regularly took the perspective of the commander, or “flipped it,” while remaining grounded in her professional commitment to helping soldiers. She explained:
...I had to try to educate him (the commander) on why it’s best for the soldier. But then then I will flip it to be about what does the commander feel? ...I flip it. I reframe it from the commander’s point of view.

A/B providers also related differently to conflicts over sharing information with commanders on patients. Rather than automatically refuse to pick up the phone with inquiring commanders, they instead listened to commanders’ concerns to learn their perspective. One provider explained how she realized the value of listening to commanders to learn how her soldiers were doing outside the clinic to inform her treatment plans and help commanders feel heard and listened to:

I can call you (commander) and tell you I cannot talk to you about a soldier, but that doesn’t mean I can’t hear your concerns. So it’s just kind of an excuse to say, “Well no, we can’t talk to command because of HIPAA.” No, no...You can say, “I can’t give you any information, but I certainly want to hear collateral data.” How can that not help?

Providers in Clinics A/B were also able to see and respect both points of view on officers and senior non-commissioned officers (“leaders”) getting mental health care. One provider shared:

Now there are two views on officers and leaders getting care. One view is it should be a badge of honor, ‘I’m getting help and you can too,’ rather than a badge of weakness and that your men may lose confidence in your ability to lead them. I can see both sides.

Commanders, through their personalized relationships with specific mental health providers, also came to better understand the perspective of providers regarding the risks of aggravating a soldier’s condition from exposure to stressful situations and regarding mental health provider intentions. One commander noted: “The big difference is now I realize they’re (mental health providers) not trying to screw over my mission. They actually want to help my soldiers.” They also expressed empathy by noting A/B providers were “just doing their jobs” by looking out for what they believed was clinically best for their soldiers when their recommendations conflicted with getting their units mission-ready. One commander explained:

Our job is to train soldiers and when we have soldiers who need help, it takes time to help them, and that takes time away from training. But Mental Health works with us. They know that we can’t stop training, it’s our job. But they need to do their job too.
Using a broadened repertoire of identity displays during intergroup interactions that demonstrate respect for the other group’s perspective.

Mental health providers and commanders in A/B also broadened their repertoire of identity displays to demonstrate respect for the other group’s perspective and preferred interaction style by subtly changing the language they used, their style of speech, and demeanor during interactions with one another. For example, mental health providers in A/B used Army terminology more regularly, and even adjusted their speech style when talking with commanders to curse and speak in a more direct manner. At the same time, they remained anchored in their professional identities, and drew the line to not go too far, such as by not using derogatory Army slang and labels like “shit bag” or “dirt bag” for soldiers. One noted:

I think it helps to use their language. They’re more likely to listen to you. Like I will even say, "roger" instead of “yeah.” … I try to use their language and their words, like "downrange" or "FUBAR" (Fucked Up Beyond All Recognition). I cuss like a sailor around them and they respond to that. ...If they start cussing, I will. Then I know it’s okay. And it helps build rapport… I go in assuming… they think I'm some kind of kumbaya hippie. So I just try to relate to them and be blunt and to the point with them and use their language. I don’t say shit bag. I don’t like that judgmental stuff. But I don’t soften it up what I have to say.

Other A/B providers noted how they toned down their efforts to assert their expert credentials as mental health “experts” with commanders and instead engaged with commanders in a way that demonstrated respect for their position as leaders and officers, while still being true to their professional identity as being “approachable”. One noted:

I come to them not as the expert… I'm <her first name> in here, I’m here to help rather than, ‘I'm a licensed clinical social worker who went to <name of elite graduate school>.’ …And I don't go in there with my tongue ring and sweatpants and snapping gum. ...You go out and show respect. I didn't grow up in the military, so I have to ask and be respectful....But I also don’t act all prissy in a suit and act like you are above them. I am warm and fuzzy, but I will still tell them to buck up, but I will be approachable rather than intimidating.

Commanders also shifted their identity displays by using proper mental health clinical terminology when discussing their soldiers’ mental health conditions. For example, commanders with Clinics A/B used more accurate clinical terminology like “manic episode” in lieu of
language considered ignorant or derogatory by mental health professionals, such as “bat shit crazy.” Many mental health providers also commented on how their commanders “let their guard down” more often with them than in the past, engaging more as “human beings” than as supermen. Many A/B providers noted how their one on one interactions with commanders were dramatically different than when they first started working together—their macho “front’ had come down. One provider noted: “Well (name of commander) is so intimidating…but he’s a softy inside. But he is so stiff when you see him! He's a ranger. He scared me a bit at first. But now I know he’s a class clown, a real funny-guy with a big heart.”

**Drawing on one’s personalized knowledge of and relationship with the other group member to collectively craft novel and customized solutions to conflicts that take both group’s perspectives into account.**

Providers and commanders in A/B handled similar conflicts facing providers and commanders in C/D in markedly different ways that allowed them to craft customized solutions to conflicts that often resulted in integrative (win-win) outcomes.

**Conflict over sharing soldier health information.** When facing a similar conflict over sharing information with a commander inquiring about a soldier who was not performing well at work and seeking care, providers and commanders in A/B handled this situation very differently from those in C/D or the embedded providers. Instead of completely shutting commanders out and not returning their phone calls like the providers in C/D or sharing everything commanders wanted to know like the embedded providers, providers in A/B took a different approach. A/B providers took into account their own knowledge of the different commanders by leveraging their personalized knowledge of them in terms of how they were likely to treat the soldier if they had that information. They also asked their soldiers directly what their feelings were on informing commanders when they thought it could help the soldier’s recovery, such as by allowing commanders to discreetly modify a soldier’s work assignment while in treatment. In a similar
case of a depressed soldier being inquired about by command, the soldier’s provider from Clinics A/B, rather than just refusing to pick up the phone, listened to the commander’s concerns, and asked the soldier to sign a waiver to share his situation with his commander to gain the unit’s support for his recovery by providing background information to account for the dip in his performance and minor disciplinary infractions. She explained:

I was thinking, ‘This soldier is not optimally doing his job’ and now his command is going to be looking at him like, ‘you’re just a sorry soldier’ when in fact I know that your wife just left you and you have depression and clinical insomnia, (I encouraged that soldier to)…sign that authorization to disclose (his situation to command). So, I then said (to command), “I just want to let you know, I am working with so and so and we are working on some issues and if you notice that he’s not on his A game….he has demonstrated the good judgment to access care. …do you have any questions or issues or concerns?”

The provider deviated from traditional practices regarding protecting patient information in ways that she believed ultimately furthered the goal of patient rehabilitation. She further explained that by having the soldier sign a waiver for her to speak with the commander about this soldier, she believed she helped the soldier’s recovery more than if command had not been included. Engaging with the commander also improved the commander’s overall support for soldier care seeking when he saw the positive benefits to both the soldier’s health and the soldier’s performance at work:

(Command) goes, “Oh! Wow! Great! Thanks!” And then they give you information on how the soldier is at work. And so we kind of work together as a team. ... And you know, then you have really good outcomes, which of course then builds on itself because the soldier says, ‘You know what, I went (to the clinic) and she talked to my command and they worked it out, and they understood that if I was late for formation, I’m not a shit bag, and now I feel better.” And command said, “Wow! The soldier went to (the clinic) and actually, everything is good.” ...It builds credibility. It’s no longer being that enemy that we were.

The commander in this case noted how he also changed his traditional practices by no longer “pushing” on mental health providers to tell him more information, because he now trusted that his assigned mental health provider knew when and what information to share from considering both the patient’s needs and the needs of the unit and commander:
As a commander, I get the information I need (from his unit’s assigned provider). Sometimes it’s vague because I can’t be told the details I’m not allowed to know, but I don’t think I need any more than what they tell me. Dr. (name of his assigned provider) gets what I need to know, which is basically: can they do their job or are they going to hurt themselves or someone else. ...Some doctors get confused on being bound by HIPAA… I’m not asking to violate your ethics as a doctor. I am asking because I’m about to put a rifle in his hand.

Providers in Clinics A/B also explained how they were able to avoid cooptation and pressure to share more information with command than needed by drawing on the support and anchoring of their home group of clinic colleagues, such as by running things by one another first. One A/B provider explained:

For me, a lot of communication with command is something I run by my peers first. Before I share with command, I ask someone else. So we will shout ideas back to one another. ...So I ask my colleagues, can you talk? It’s easy to talk to your colleagues...When you aren’t sure, you should talk to them, and even if you are sure (you should talk to them). Because they might have a different point of view...and you can’t make these decisions lightly.

**Conflict over prioritization of individual vs. unit welfare.** When facing the same conflict over prioritization between the welfare of an individual patient and the patient’s unit, A/B providers and commanders resolved this same conflict situation in a different way than C/D or embedded providers who privileged one perspective at the expense of the other. Instead, A/B providers and commanders drew on their personalized relationships with one another and knowledge of one another’s perspectives to craft solutions that often resulted in positive outcomes for both the individual soldier’s mental health recovery and the unit the soldier was a part of.

In a similar case of a soldier experiencing panic attacks before a field exercise like in C/D, providers and commanders in A/B used anchored perspective-taking to develop a customized solution that both helped the patient’s recovery and the unit’s mission-readiness. Providers in A/B leveraged their relationships with commanders to receive invitations to go to the field or firing range to gain a first-hand understanding of what these trainings were like and how important they were for unit bonding and mission readiness. Commanders likewise would
invite their providers to attend important unit meetings. In this particular case, the provider in Clinics A/B first called the soldier’s commander before issuing a formal written “profile” stating that the soldier not go to the field. From the commander, the provider learned what the field exercise would entail and together they brainstormed alternative tasks the soldier could do that would not aggravate his condition but would allow him to participate. The provider also made the field exercise a part of the patient’s therapy, as a next step in confronting his fears to gain useful information about whether this soldier would be able to return to full duty or whether it was time to begin a medical separation for an honorable discharge from the Army. The provider also requested the commander allow the soldier to leave the field after two weeks away to check in at the clinic to be cleared to return again. Better to test a soldier in a training simulation than in an actual deployment, the provider reasoned, and to use it as an opportunity to further the soldier’s recovery. The commander explained his role in co-creating this response:

(Name of POC) contacted me first...before doing the profile (to state the soldier should not go to the field). ...We talked about what the provider wanted and we worked it out because it’s hard for a soldier...to stay behind because they’d feel like they’re betraying (the other soldiers), so we worked something out...so they could still go to the field. ...If the profiles are overly strict, the soldier may not feel part of the unit and may feel isolated because now they’re not with their buddies...and that can make things even worse.

Another commander explained:

<Name of provider> does a good job, I’ve been very happy with them. They don’t know everything about the Army, but they understand us better...They know our unit that makes a huge difference. Like I have the soldier at <name of large inpatient hospital> and they are good at treatment but they don't know about being a soldier. So you are good at the mental health stuff, but you don’t know about being a soldier, and it can cause major problems. Like they are putting him on all these medications that make him non-deployable.

This provider later noted how important her home group of clinic colleagues were in ensuring she remained anchored and grounded in her professional goals associated with improving mental healthcare for soldiers by not becoming too concerned with the commander’s objectives at the expense of soldier care:
I try to look at the case and see, ‘Am I too caught up in it? Am I missing something?’ So it's a good thing for them (colleagues) to come in, and for us to talk. ...I have to maintain my empathy, and the team helps, they pull me back, so it helps being able to consult with others.

The commander involved in this case, likewise looked to his fellow commander peers for validation supporting his non-traditional behavior to support this soldier seeking care by modifying this soldier’s field duties and making special arrangements for him to discreetly leave the field to be checked on. Since his fellow commanders in his unit also had personalized relations with their assigned mental health provider, they were largely understanding and supportive of this new and non-traditional commander behavior in the service of meeting shared goals that helped both the soldier’s health and mission readiness.

**Conflict over instilling mental toughness vs. reducing the stigma of seeking care.** In contrast to C/D providers and commanders who were unable to figure out a way to both reduce the stigma of seeking care and be sensitive to leader’s concerns about seeking care given their role instilling mental toughness in their soldiers, providers in Clinics A/B utilized their personalized understanding and knowledge of these commanders and their units to co-construct customized solutions. Unlike C/D providers who flat out refused commander requests for special accommodations for leaders to receive care, A/B providers took a more nuanced approach from using their personalized knowledge of these units and the very real consequences in terms of status loss and possible negative career ramifications for leaders seeking care. Mental health services was positioned as a service for soldiers, not leaders. Together, A/B providers and commanders found alternative ways for leaders to receive more discreet and sometimes “off the books” care, such as by meeting in leaders’ offices to give the impression that they were there to talk about soldiers or allowing leaders to receive care afterhours, during lunch, or even allowing them to enter through the back door to avoid being seen in the waiting room. One provider explained:
I’ll make time to see the commander late in the day and let them come in the back door or come to their office to meet with them so it looks like a meeting about soldiers....There is a rank-and-file hierarchy, a junior enlisted (soldier) wants to look up to the first sergeant (a senior NCO). They don’t want to be sitting next to them in a waiting room at Mental Health. While you could say, ‘it’s a good thing for the junior soldier to see the senior soldier getting help,’ but that’s not the way the junior soldier sees it. I’d rather the leader get care and come through the back door, than not get help.

An A/B commander shared how he was able to encourage multiple leaders (senior sergeants and two lieutenants) to get care because of how willing the A/B providers were to work out customized solutions to allow these leaders discreet access to their services. He noted:

Overall I am happy with our (name of) clinic. They do a great job. Like I’ve sent more senior guys to them, and told them, ‘I do not want him in the waiting room,’ and they will make it work and get him right in. Like I have a lieutenant I’m sending there (to the clinic) and I don’t want him in the waiting room with the stigma (for leaders getting care).

Some providers in Clinics A/B, in their role as assigned providers for their units, became trusted confidants and advisors to commanders, so that some commanders eventually felt comfortable confiding in providers about leadership and personal dilemmas and their own mental health concerns. Providers able to serve in this role of providing “off the books care” to commanders typically were able to have much greater influence over commanders when they needed their support for other soldiers’ care. One commander explained:

(Name of assigned provider) regularly checks on me as a commander..., and uses that skill set, and will see when you need a little more support. They will say, ‘you can come to my office if you need and I won’t record it.’ As commanders, we deal with a lot of stress. I'm getting divorced now. But can I blame her? I was gone 5 of our 7 years of marriage. So they came and checked on me, and didn’t record anything, and I know they do that for other commanders too and give us the same techniques.

The few commanders reporting actually using mental health services themselves were the ones most open with their soldiers about their experience using these services afterward, which made progress toward achieving the providers’ goal of reducing the stigma around seeking care. One commander explained how he recently decided to be open about his experience seeking help with other commanders and his own soldiers to encourage others to get help:
And I tell my soldiers (about his own struggles with depression and suicidal thoughts). I am open to the troops about what I've gone through. I was at a low point...But you know I'm about the hundredth person to go through this. Lots go through this. So I've talked about it. I don't think my wife knows, but the troops know. I was scared of getting, I don't know, I didn't want to seem like I had problems, but now I am open about it.
CHAPTER 10: OUTCOMES IN CLINICS & BRIGADES A/B vs. C/D

Despite facing the same conflicts between professional groups, goal alignment in which both groups achieved the superordinate goal of the organization occurred among providers and commanders associated with Clinics A/B but not C/D. In A/B, in an organizational structure that enabled “anchored personalization” and “anchored perspective-taking” across groups, both mental health provider goals related to providing rehabilitative soldier mental healthcare and commander goals related to fielding a mission-ready unit were accomplished. Of the 132 situations analyzed in which mental health providers and commanders experienced conflict over their differing perspectives on how to achieve the part of the organization’s superordinate goal they each privileged, providers and commanders in A/B achieved integrative solutions in 89 percent of these situations, versus only 5% in C/D. I define an integrative solution as one that achieved both the goal of the mental health professionals according to the provider most closely involved in the situation (i.e., improved soldier recoveries, reduced stigma of seeking care, and improved commander support and compliance with soldier care recommendations) and achieved the goal of the commanders according to the commander of the soldier involved in the situation (i.e., unit mission readiness, soldier career goals). In contrast, in C/D, these conflict situations resulted in either lose-lose outcomes where both group members defined the outcome as negative (31%), or in outcomes where either the provider or commander defined the outcome as positive, while the other group member defined it as negative, as depicted in Table 6.

Mental health professionals and commanders working in C/D were more likely to pursue their own subgoals at the expense of the other groups’ subgoals. This led to situations where commanders ignored the care recommendations for their soldiers made by mental health providers (e.g., to excuse soldiers from a stressful training exercise). For example, only 10
percent of commanders reported regularly complying with provider recommendations in C/D compared with 86 percent in A/B. To triangulate these accounts, I also analyzed 108 provider soldier care recommendations, and triangulated commander and provider reports of whether these specific recommendations were followed and found that while only 18 percent of these recommendations were followed by C/D commanders, 90 percent of provider soldier care recommendations were followed by A/B commanders. Commanders in Clinics C/D regularly ignored provider recommendations they considered to be “out of touch” or “unnecessary.”

Most notably, as described above, care decisions from providers in Clinics C/D often inadvertently hurt soldiers’ recoveries and desired career prospects according to commanders and embedded provider reports, which often increased the stigma of seeking care and reduced commander support for soldiers seeking care. In contrast, in A/B, providers responded to these same situations by co-constructing integrative solutions with commanders in ways that not only helped soldier recoveries but also protected their desired career prospects, reduced the stigma of seeking care, and improved commander support for mental health care usage, while minimizing negative mission-readiness effects on the unit.
PART 3: MAKING SENSE OF IT ALL
CHAPTER 11: DISCUSSION

All providers and commanders faced longstanding conflict related to their professional group differences in goals, identities, and perspectives, and all had access to a host of integrative mechanisms to overcome these differences. Yet, only those associated with two of the four combat brigades regularly handled these conflicts by co-constructing integrative solutions that accomplished both professional group goals and the organization’s overarching goal to have both mentally healthy and mission-ready soldiers. I draw on these findings to develop a model that explains when and how professional groups can align their group goals to accomplish superordinate organizational goals despite differences in professional goals, identities, and perspectives (Figure 3). I find that an organizational structure enabled what I call “anchored personalization” which helps different professional groups overcome identity conflict and entrenchment in their home group’s perspective, without becoming indoctrinated into the other group’s perspective from personalized contact with the other group. Anchored personalization enables the process of “anchored perspective-taking” across groups, which overcomes entrenchment in one’s professional group’s worldview and broadens one’s perspective and identity in ways that allow for the discovery and pursuit of integrative solutions to conflicts in service of the organization’s overarching goal.

Anchored personalization resulted from an organizational assignment structure that provided a stable, long-term connection and personal relationship with specific members of the other group, while ensuring members remained embedded within their home group. This stable connection led to personalization between group members that reduced identity conflict through increased perspective-taking and reduced stereotyping across groups. At the same time, group members remained anchored in their home group identity from working surrounded by their fellow group members who all had similar personalized connections to the other side. One’s
home group provided collective support to license new ways of interacting with the other group they previously defined themselves against, while also keeping group members anchored in their home group’s perspective to prevent indoctrination from increased personalized relations with the other group.

Anchored personalization reduced longstanding identity conflict between groups by broadening and expanding each group’s professional identity to incorporate elements of the other group’s perspective, enabling what I call “anchored perspective-taking” practices, which led them to interact in new and non-traditional ways to collectively develop integrative solutions to conflict. Anchored perspective-taking involved three sub-processes: 1) empathizing with the other group member’s perspective, while remaining anchored in one’s home group’s perspective; 2) using a broadened repertoire of identity displays during intergroup interactions that demonstrate respect for the other group’s perspective; and 3) drawing on one’s personalized knowledge of and relationship with the other group member to collectively craft novel and customized solutions to conflicts that take both groups’ perspectives into account. Anchored perspective-taking practices led to the co-construction of integrative solutions that aligned seemingly incompatible group goals to achieve the organization’s superordinate goal. This ultimately led to the resolution of a higher percentage of intergroup conflicts that resulted in integrative outcomes that both groups defined as positive.

I contrast the experience of these groups with anchored personalization to those who had either an anchoring in their home group, but no personalization opportunities with the other group, and to those who had opportunities for personalization with the other group, but no anchoring in their home group. I demonstrate how both of these scenarios did not lead to the accomplishment of superordinate goals.
In an organizational structure without anchored personalization, where no stable long-term connection existed between specific members of the other group such that there were no personalized relations across groups, goal conflict, exacerbated by identity conflict, persisted. Without anchored personalization across groups, longstanding conflict between groups remained and intergroup dis-identification and stereotyping prevailed—hallmarks of intractable identity conflict (Fiol et al., 2009). Instead of engaging in anchored perspective-taking practices across groups, group members empathized only their home group’s perspective, utilized only the traditional identity display of their home group, and drew on stereotyped conceptions of the other group to justify traditional responses to conflict that privileged their home group’s goals and presumed integrative solutions did not exist. This led to continued goal conflict in which relatively few conflicts were resolved in ways that achieved the superordinate goals of the organization and outcomes both groups defined as positive.

Finally, group members that had the opportunity for personalized connections with the other group, but did not have an anchoring in their home group, often became coopted by the other group from shifting their identity to privilege the other group’s perspective and goals over their home group’s perspective and goals. These group members also failed to achieve the organization’s superordinate goal, since they largely abandoned their home group’s goals in pursuit of the other group’s goals, leading to suboptimal outcomes rather than integrative outcomes that achieved both groups’ objectives.

**Contributions to Our Understanding of Goal Conflict in Organizations**

I make three contributions to our understanding of goal conflict in organizations. First, while the existing literature suggests a host of ways conflict over goals between different
coalitions in organizations is managed (e.g., Cyert and March, 1963; Simon, 1947; Greve, 2008; see Gavetti, et al., 2012 for a review; Pinto, Pinto, and Prescott, 1993; Turkulainen and Ketokivi, 2012; Kotokivi and Castaner, 2004; Galbraith, 1984; Van den Bulte and Moenaert, 1998), the mechanisms proposed to achieve this integration do not always work (e.g., Jarzabkowski and Balogun, 2009; O’Conner, Fiol, and Guthrie, 2006). This study suggests these rational alignment mechanisms may not be effective when conflicts involve longstanding intractable conflict over differences in professional identity. Groups in organizations may not discover shared goals not only because of differing interests and entrenchment in their own group’s perspective, but also because of identity differences such that each group stereotypes the other, defines themselves by what the other is not, and presumes a gain for one group can only come at the expense of the other group (e.g., Fiol et al., 2009). For example, the integrative mechanism of co-location alone was not sufficient to create goal alignment since it did not address these underlying differences in identities between providers and commanders in C/D. Given that many conflicts in organizations involve groups with differences in identity, particularly between the many different occupational and professional groups growing in number inside organizations who are known to have especially strong professional group identifications (see Anteby, Chan, and DiBenigno, 2016 for a review; Battilana and Dorado, 2010; Turco, 2012; Van Maanen and Barley, 1982; Pratt and Foreman, 2000), conflict between professional groups in organizations is a problem of major practical and theoretical importance. This study suggests that when identity is implicated in a conflict, goal alignment is no longer a straightforward, rational process, since such conflict is personal and an affront to one’s sense of who they are. I find that it is only when these identity conflicts are addressed such that each group’s members expand their identity to encompass
elements of the other group’s perspective, that groups can align interests and take one another’s perspectives to discover and pursue superordinate goals.

These findings may help explain the mixed success of integrative mechanisms proposed by the literature. For example, an integrative mechanism such as cross-functional teaming may not work because it fails to address identity-related conflict since intergroup interactions would occur in a group setting versus one-on-one and hence not lead to personalized intergroup relationships. In other settings, the conflict between different groups may not involve intractable identity conflict (e.g., stereotyping, dis-identification, zero-sum conceptualizations), and such mechanisms may be more likely to work when identity differences between groups are less stark and intractable. My findings suggest that integrative mechanisms need to simultaneously promote both intergroup personalization with specific group members and provide an anchoring in one’s home group’s identity to successfully resolve group intractable identity conflict to set the conditions for subsequent goal alignment.

Second, I contribute a new organizational integrative mechanism which addresses the identity-related aspects of conflict between different groups in organizations — that of an organizational role assignment structure that enables what I call “anchored personalization.” While the existing literature on integration mechanisms has considered organizational structural mechanisms, such as integrative organizational designs like co-location, cross-functional teaming, and matrix structures, to name a few, (e.g., Lawrence and Lorsch, 1967a; Van den Bulte and Moenaerts, 1998; Mintzberg, 1980, 1993) none of these organizational structures supports the needed identity expansion necessary to manage group identity conflict so different group members can align interests and overcome entrenchment in their own group’s perspective. The organizational structure promoting “anchored personalization” addressed identity differences
between groups in two ways. First, by providing the opportunity for stable, long-term personalized relationships to develop between different group members assigned to work with one another, which reduces intergroup stereotyping and increases intergroup perspective-taking. Second, by providing an anchoring in one’s home group identity in which all group members spend the majority of their time together while having unique personalized relationships with members of the other group. Such anchoring provides collective support to license engaging with the other group in new and non-traditional ways without being seen as a traitor to one’s home group, while also keeping one another grounded in their commitment to their home group’s perspective and goals. Together, personalization and anchoring from this unique organizational role assignment structure led to identity expansion where each group incorporated the perspective of the other group into their professional identity, redefining and broadening what it meant to be a good professional and readying the way to engage with the other group in new and more constructive ways.

Third, the literature on goal conflict generally does not specify how different group members actually align conflicting goals. This is likely a methodological artifact since most studies of goal conflict between groups use survey or archival data looking across firms on self-reported usage of certain mechanisms (e.g., cross-functional teams) and outcomes, and do not collect data on the practices actually used by group members to achieve goal alignment. Structures provide opportunities or occasions for people to act in certain ways (e.g., Barley, 1986; Giddens, 1979). They do not in and of themselves align conflicting group goals. By specifying the anchored perspective-taking practices used by commanders and providers in an organizational structure that promotes anchored personalization, I am able to account for how these groups collectively co-constructed solutions to conflicts that led to goal alignment.
It might also be tempting to presume that structure does not matter, and that, for instance, commanders and providers could be taught to use “anchored perspective-taking” practices through a targeted intervention. However, such an organizational structure is also necessary to provide the opportunity for behaving in new ways and promoting use of these practices. For instance, even mental health providers with advanced degrees in therapy techniques that teach perspective-taking with patients/clients like those studied were unable to take the perspective of the commanders they worked with in an organizational structure that did not enable anchored personalization. This suggests, for example, that interventions designed to teach perspective-taking skills or hire those thought to be good at perspective-taking may not work without an organizational structure that promotes anchored personalization.

Contributions to Our Understanding of Identity Conflict and Personalization

I also make a number of contributions to our understanding of identity conflict and personalization between groups. Extant scholarship on intractable identity conflicts has highlighted the importance of addressing identity-related aspects of group conflict, although they have primarily focused on intractable ethnic and national group conflicts, rather than between professional groups in organizations (e.g., Rothman, 1997; see Fiol, Pratt, O’Connor, 2009 for a review; Rouhana and Bar-Tal, 1998; Coleman, 2003). Even those who have studied groups in organizations have not specified what organizational structures might support the management of identity conflict inside organizations (e.g., O’Connor et al., 2006). I find that an organizational structure that enables anchored personalization can help groups overcome differences in identity to discover and pursue shared, superordinate goals. Scholarship on intergroup identity conflict has generally been skeptical of structural solutions, and instead has advocated for various
psychological-based interventions such as “promoting mindfulness” between groups (Fiol et al., 2009). However, these psychological interventions are often found to have only temporary benefits and only work on a small-scale given resource constraints (e.g., Pratt et al., 2012). A structural intervention, in contrast, may have more sustainable effects and apply on a larger scale, given that managing identity conflict is baked into how work gets done and embedded in role expectations, and hence may be more likely to endure even as the original group members turn over. Various organizational structural interventions have also shown promise for creating longer-lasting changes in traditional relations between groups in other settings, whether “team scaffolds” that allow temporary teams to work effectively with one another (Valentine and Edmondson, 2014) or “relational spaces” where those from various levels in the organization’s hierarchy can convene to effectively challenge the status quo to implement reform (Kellogg, 2009, 2011).

For example, Pratt et al. (2012) described a promising intervention to address identity-related conflict among warring professional groups inside a large hospital—in this case, between physicians and administrators—by promoting mindfulness. This intervention, in which members from each group participated in an academic workshop analyzing a conflict between union and management representatives that they then applied to their own conflict, was very successful in the short-term, but did not last (Pratt et al., 2012). This study suggests an alternative, structural approach that may have longer lasting effects, by promoting anchored personalization. In this case, an organizational assignment structure that promotes anchored personalization might entail hospital administrators being assigned to work with specific types of physician groups (e.g., surgery, internal medicine, etc.), while remaining embedded with their hospital administrator group. Such a structure may help resolve identity conflict between group members from these
stable personalized connections to the other group and reduce stereotyping and dis-identification as a result of gaining personalized knowledge about members of the other group.

I also contribute to the literature on personalization by demonstrating that personalization without an anchoring in one’s home group’s identity can have a dark side. Specifically, personalization with another group member can lead to cooptation if one is not firmly anchored in one’s home group identity. While examples from organizational life abound, from reports of “regulatory capture” among regulators of big banks (e.g., Katic and Kim, 2013) to stories of in-house attorneys “going native” (e.g., Jenoff, 2011), personalization research is depicted as having only beneficial effects such as reducing stereotyping and increasing perspective-taking across groups (e.g., Brewer and Miller, 1984; Ensari and Miller, 2006; Shook and Fazio, 2008). This lack of attention to the dark side of personalization may be because most studies are of different racial or ethnic groups aimed at reducing prejudice rather than of professional or occupational groups in organizations attempting to align their goals (e.g., Brewer and Miller, 1984, 1988; Miller, 2002; Allport, 1954). This study suggests that efforts to promote personalization between different occupational groups in organizations should be tempered by efforts to simultaneously ensure a firm anchoring in their home group’s identity.

While much is known about promoting a sense of “we” between groups from developing superordinate or common in-group identities (Gaertner et al, 1999; Gaertner et al., 1996; West et al., 2009), and much is known about identity anchoring in the form of strong in-group allegiances (e.g., Tajfel and Turner, 1979; Brewer, 1979; Mullen et al., 1992), this study suggests the importance of achieving the difficult feat of simultaneously having both personalized relations across groups while also having a firm anchoring in one’s home group. In particular, developing a “we” through a superordinate identity (in this case among embedded providers who
shared an “Army” superordinate identity with commanders), without a firm anchoring in one’s home identity led to an identity shift. While such an identity shift may result in harmonious intergroup relations, it may also result in suboptimal outcomes for the organization (in this case, poorer patient care). Since these identity shifts have been theorized to be important for resolving intractable identity conflicts, but not empirically tested (Fiol et al., 2009), this study is able to extend this important work by demonstrating how identity shifts from developing a superordinate identity between conflicting groups can sometimes have detrimental effects on accomplishing superordinate goals from cooptation without identity anchoring, especially when one group is more dominant than the other. Instead, this study suggests more subtle changes to identity may be necessary to allow groups to resolve identity conflict while not becoming coopted by the other group. In this case, both groups kept a firm anchoring in their home identities (e.g., providers still identified as “providers” and “experts” and commanders as “warriors” and “leaders”) but they each expanded the definition of what it meant to be a good professional to include elements of the other group’s perspectives (e.g., being a good provider meant thinking about how their recommendations affected the patient as a soldier in their unit, and being a good commander meant “taking care of soldiers” by also supporting their mental healthcare usage). This more nuanced and subtle identity expansion, rather than a full out identity shift or development of a superordinate identity or dual identity, may be needed so that groups do not feel their core identity and worldview have been assaulted, making them perhaps more receptive to changing their behavior.

Finally, I contribute to the literature on identity conflict by demonstrating how the resolution of intergroup conflict is an inherently relational process. To date, much empirical and theoretical work on identity conflict between groups uses an individual level of analysis and
theorizes the individual level identity shifts that occur toward improved intergroup relations (e.g., Fiol et al., 2009), despite recent acknowledgements of the importance of dyadic and group-level effects in professional identity work (e.g., Lepisto et al, 2015; Petriglieri and Obodaru, 2016). I show how contact with members of the other group led to identity expansion to incorporate elements of the other group’s perspective into one’s own identity. I also demonstrate how one’s fellow group members granted one another license to incorporate this formerly antagonistic perspective into their identities and also kept one another in check from getting “too close” and becoming indoctrinated by close contact with the other group. While the literature on status and conformity suggests that only high status actors can deviate from professional norms to improve performance (Phillips, Turco, and Zuckerman, 2013), my research suggests an alternative path to achieve this license. In this case, the support of one’s group members can grant collective permission to act in counter-normative ways that improve performance. In some ways, the group may be akin to a holding environment or “identity workspace” (Petriglieri and Petriglieri, 2010) where group members can collectively stretch the boundaries of their socialized professional identities. Thus, this study is also one of the first to empirically demonstrate these group and dyadic-level effects on how identity conflict resolution occurs in practice.
CHAPTER 12: FUTURE RESEARCH, PRACTICAL IMPLICATIONS & CONCLUSION

Future Research

As with most qualitative studies, this study aspires to theoretical rather than statistical generalizability. Future research is needed to test and refine these new concepts of anchored personalization and anchored perspective taking in other settings with different groups. Given the rise of occupational and professional groups working inside organizations with strong commitments to their professional identities and perspectives (e.g., Anteby et al., 2016), it is likely that many organizations face difficulties aligning the goals of different professional groups within them. For example, Nike recently hired an influx of professional sustainability officers in an effort to improve the environmental and social impact of their products. However, this new professional group has faced conflict from apparel designers—a group with different goals, identities and perspectives, as well as higher status in the organization—that strained relationships between the groups (Kaul et al., 2016). My research suggests that an organizational structure that fosters personalized relations between these two groups while ensuring anchoring in their home group’s identity (e.g., perhaps by assigning sustainability officers to specific design departments, but not embedded within them) might enable anchored personalization and perspective-taking practices so that these groups can co-construct integrative solutions that result in the development of both more sustainable and fashionable products. These concepts may also be applicable in other settings where groups have strong commitments to their identities and where indoctrination into the other group’s perspective carries especially negative consequences (e.g., regulators of big banks, safety officers working on oil rigs, etc.).

While this dissertation focuses on the in-depth experience of four combat brigades and their mental health clinics, I also studied an additional fourteen brigades and clinics across three
other Army posts as part of my broader dissertation research. Therefore, I am able to partially assess the naturalistic generalizability of these findings. Across these other posts, six of these additional fourteen brigades and clinics had organizational structures like A/B and also were observed to have achieved anchored personalization and anchored perspective taking to co-construct integrative solutions to conflicts in service of the organization’s goal. I chose to focus this dissertation on the four brigades and clinics from one post because of how comparable they were to rule out plausible alternative explanations for the dramatic difference in goal alignment between providers and commanders in A/B versus C/D.

These findings also raise several additional questions for future research to address. First, the two professional groups studied differ in terms of power and status, with commanders being more powerful than mental health providers since they could override many provider recommendations. This may explain why providers were at greater risk of cooptation and indoctrination into the commander perspective than vice versa, and highlights the especially important role of anchoring for the less powerful group. Future research is needed to understand relations between more equal status groups. However, this asymmetry in power and status likely made goal alignment even more difficult, and makes it all the more notable that an organizational structure promoting anchored personalization and anchored perspective-taking allowed these groups to actually overcome their differences and align their goals.

Second, this study suggests one way of resolving identity conflict between groups so they can then align their goals is through anchored personalization and anchored perspective-taking. Yet, personalized relations which reduce intergroup stereotyping and increase perspective-taking requires that a personalized relationship actually develop. Though not explored in this paper, not every commander and provider dyad had an equally close and personalized relationship. While
the organizational structure provided the opportunity for personalized relations to develop, it did not guarantee such relations would develop. Future work is underway to understand the tactics used to build such personalized relations between groups with longstanding identity conflict and differences in power and status.

**Practical Implications**

This study also suggests a number of practical implications for improving Army mental healthcare. First, while the focus of improving Army mental healthcare has been primarily on the clinical (e.g., developing improved medications, therapies, etc.) and organizational dimensions (e.g., building co-located clinics, implementing new policies and protocols), this dissertation suggests attention is also needed to the relational dimension of the professional groups within the Army that have a major impact on whether soldiers are able to benefit from the significant investments in Army mental health services. The best rehabilitative mental healthcare in the world is meaningless if a soldier’s commander and mental health provider have a poor, conflict-ridden relationship that prevents the soldier from benefiting from these extensive services.

This dissertation suggests efforts to improve command-provider relations should not only be limited to one-off interventions or trainings, but also must be embedded into how work gets done, such as through an organizational assignment structure that promotes anchored personalization. While assigning providers to specific units in this way is part of the Army’s standard operating procedure for running these co-located clinics, it has not received adequate emphasis. Greater attention has been understandably placed on physically building the clinics and staffing them. All clinics on the post studied were short-staffed, yet those that still assigned providers to specific units such that anchored personalization developed were able to use anchored perspective-taking practices to co-construct integrative solution to conflict to
accomplish both the goals of fielding a mission-ready unit and providing rehabilitative mental healthcare. Greater priority is also needed to ensure providers are assigned to specific units and that these relations are maintained and seamlessly transitioned even as commanders rotate out and units deactivate.

Finally, this study suggests that greater efforts are needed to provide increased anchoring to the embedded providers serving as officers in brigades. Innovative strategies, such as assigning these embedded providers to be deputy clinic chiefs – a practice successfully employed at another post visited during this study – may be needed to provide anchoring to these providers to protect them from becoming coopted by their personalized relations with commanders that may sometimes come at the patient’s expense.

**Conclusion**

In conclusion, as organizations continue to employ professional groups with conflicting goals, identities, and perspectives, it is more important than ever to understand how they can effectively overcome their differences to accomplish superordinate organizational goals. This dissertation demonstrates the importance of an organizational structure that allows for anchored personalization between groups such that they have personalized connections to the other group, while maintaining an anchoring in their home group’s identity to prevent cooptation and indoctrination into the other group’s perspective. Anchored personalization can resolve identity-related conflict and lead to the use of anchored perspective-taking practices so groups can co-construct integrative solutions to the conflicts they face in ways that achieve both groups' goals and the organization’s superordinate goals.
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APPENDIX: ADDRESSING ALTERNATIVE EXPLANATIONS

I argue that the difference in goal alignment between commanders and providers in A/B versus C/D can be explained by a difference in the organizational assignment structure that enabled anchored personalization and anchored perspective-taking practices. However, other potential explanations exist for the differences between clinics and brigades, which I address below. Confidence in these results is also supported by replication of these same findings across fourteen other brigades and clinics at three other Army posts visited as part of this broader project. Six of these additional fourteen clinics had command-provider relations like Clinics A/B, and all six also utilized an organizational structure in which providers were assigned to specific units and in which anchored personalization and anchored perspective-taking were also observed. However, these fourteen clinics and brigades did not provide as compelling a matched case comparison as those on the post featured in this dissertation.

One may also wonder why Clinics A/B assigned providers as points of contacts to specific units in each brigade while Clinics C/D did not, and whether the team leads who control these assignments placed a greater priority on building relationships with commanders in A/B than C/D, and it is this relational orientation of the team lead driving these effects. My data suggests this is not the case. First, clinic team leads had very little authority over how the providers in their clinics interacted with commanders and did not formally evaluate the providers in their clinics. All providers were instead evaluated by a senior member of their mental health discipline (e.g., a senior social worker evaluates another social worker) and were also evaluated only on clinical competency such as quality of one’s patient notes and whether or not they were submitted within 72 hours. No providers were evaluated on the caliber of their relationships with commanders.
Second, clinic team leads reported that their decision to assign providers to specific units was made rather casually. As explained above, all Army posts were implementing the same initiative to improve access to mental health services for soldiers by establishing clinics co-located near each brigade on post. Army-wide, a post generally was considered successful if it had physical clinics built and operating and were fully staffed. Less emphasis was placed on how providers were assigned. At the Army post being analyzed in this paper, all brigades had their own separate clinic by the end of 2012 and viewed staffing the clinics as their number one impediment to success. The original guidelines called for assigning one provider to support one unit within each brigade, yet due to Army-wide shortages of mental health professionals, no Army post ever reached full staffing levels (aside from the one post that was the early adopter of this model). However, some clinics still decided to assign providers to units, but had mental health professionals serve two (vs. one) units, as did Clinics A/B. Team leads in Clinics C/D reported that they considered assigning providers to specific units as a “nice to have” but not necessary for running a successful clinic, and claimed they would consider adding POCs when they had more staff (even though they had the same number of staff as Clinics A/B). In addition, there were efficiency gains from not assigning points of contact. Assigning providers to specific units led to inefficiencies in terms of throughput since a clinic can see more patients overall if providers can see patients from any unit and can “cover” for one another, rather than only seeing soldiers from the units they were formally assigned to.

Next, were the providers in Clinics A/B simply more competent providers who had better impressions of command to begin with than the providers in Clinics C/D? My longitudinal data suggest this is not the case. I observed many of the same providers over time, and they behaved differently after being assigned to Clinics A/B, but not after being assigned to Clinics C/D. There
were also two instances in which mental health professionals switched clinics—one moved from C to A and the other moved from B to D. In both cases, the mental health professionals described a shift in how they saw and related to commanders and themselves, and in how they approached conflicting subgoals between them. The transition appeared most difficult for the provider who went from being assigned to two specific units in Clinic B to serving the whole brigade in Clinic D. She explained her frustration at having experienced what she considered “a better way:”

Before (in Clinic B), it was better because we could build relationships (with command), we were reaching out, and in constant contact with them....There’s too many to keep track of and no meaningful relationships so there’s a lot of misunderstandings and frankly it’s one of the least fun parts of my job now, dealing with command. I use to really feel for them, but now not so much. We used to be always talking, going back and forth on how to help a soldier. But now I feel shut out. They don’t return my calls or I find out they went around me and talked to the [embedded provider] instead of me about my patients.

The other provider who later switched to Clinics A/B, explained how she and her former C/D clinic colleagues viewed commanders as “bullies” and “adversaries”:

Before (in C/D), we thought of them (command) as an adversary because they were kind of always on the other side of things, and we’re serving the soldiers. And command—we were trying to keep them more at a distance.

Third, did the provider demographic composition in Clinics A/B differ in some systematic way from Clinics C/D that better explains differences in goal alignment? Comparison of the four clinics reveals no common pattern of provider demographic composition associated with successful subgoal alignment (See Table 7). For example, perhaps clinics with the highest percentage of uniformed providers (e.g., non-civilian providers) might have been better at discovering and pursuing integrative solutions to conflict? However, Clinic B, one of the successful clinics, was comprised of an entirely civilian staff, while Clinic D, which failed, was comprised of 50 percent uniformed providers. Similar comparisons across the four clinics in terms of the percentage of providers who were veterans, white, female, and social workers demonstrate that provider demographics were not associated with success or failure.
Finally, were the units served by Clinics A and B easier to provide mental healthcare to because they had fewer soldiers with serious mental health problems, easier deployment histories, or more supportive commanders than the units served by Clinics C and D? My data suggest this is not the case. First, when I did fieldwork 18 months earlier, nearly all commanders interviewed reported that they had a very negative impression of Army mental health services. It was only when I returned that commanders who had been assigned to specific units in Clinics A and B shared that their impression of Army mental health services had improved, which they generally attributed to their assigned unit provider. In addition, during the study time period, nearly all units had recently returned from similar deployments or extended trainings at the “National Training Center” or the field. In addition, leadership at this Army post was actually most concerned about the mental health of the soldiers associated with Brigade/Clinic A since they had a more accelerated deployment schedule, yet they achieved some of the best outcomes.
TABLES AND FIGURES

Table 1: Comparisons of Clinics

<table>
<thead>
<tr>
<th></th>
<th>Clinic A</th>
<th>Clinic B</th>
<th>Clinic C</th>
<th>Clinic D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size/type of unit served</td>
<td>Brigades of ~3600 soldiers each that were part of the same combat division and reported to the same division leadership</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Deployment history of</td>
<td>All brigades returned from deployment/field within last year with similar levels of combat exposure</td>
<td></td>
<td></td>
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<tr>
<td>Brigade served</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of clinics</td>
<td>Co-located near each brigade served</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting structure</td>
<td>Report to head of mental health for the post, evaluated by professional peers of same discipline</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Team schedule</td>
<td>Daily morning check-ins; weekly team meetings</td>
<td></td>
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<tr>
<td>Full-time/patient load</td>
<td>All full-time providers expected to see ~6 patients a day</td>
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<td></td>
<td></td>
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<tr>
<td>Number of providers</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
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</tbody>
</table>

Table 2: Data Collection Summary at Featured Army Post

<table>
<thead>
<tr>
<th>Data source</th>
<th>Clinic/Brigade A</th>
<th>Clinic/Brigade B</th>
<th>Clinic/Brigade C</th>
<th>Clinic/Brigade D</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Clinic Providers Interviewed</td>
<td>5 of 5</td>
<td>4 of 5</td>
<td>4 of 5</td>
<td>4 of 4</td>
</tr>
<tr>
<td># of Commanders Interviewed</td>
<td>7; 1-2 from each unit</td>
<td>7; 1-2 from each unit</td>
<td>6; 1 from each unit</td>
<td>4; 1 from each unit on post at time</td>
</tr>
<tr>
<td># of Embedded Providers Interviewed</td>
<td>1 of 1</td>
<td>1 of 1</td>
<td>1 of 1</td>
<td>1 of 2</td>
</tr>
<tr>
<td># of Observational Sessions</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Interviews &amp; Observational Sessions</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Other Interviews (e.g., Brigade commanders, other leaders)</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Interviews, Focus Groups, and Meetings 18 months prior, before Clinics began operating separately</td>
<td>19 interviews, 7 focus groups and dozens of informal meetings with 79 stakeholders from across the post, including clinic providers, embedded providers, soldiers, and commanders</td>
<td></td>
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</tr>
<tr>
<td>Total Interviews/ Observational Sessions</td>
<td>69 one-on-one interviews, 7 focus groups and 10 observational sessions; 180+ hours on post</td>
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<tr>
<td>How Defined Themselves</td>
<td><strong>Army Commanders</strong></td>
<td><strong>Mental Health Providers</strong></td>
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<tr>
<td>&quot;Officers&quot; who are &quot;warriors&quot; and &quot;leaders&quot;; Viewed providers as &quot;out of touch,&quot; anti-military &quot;Berkeley hippies&quot; with irrelevant &quot;book learning&quot; messing with their soldiers</td>
<td><strong>&quot;Clinicians&quot; who are &quot;subject matter experts&quot;; Viewed commanders as &quot;brainless&quot; bullies hurting their patients</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| Professional Training and Socialization | West Point, Officer Candidate School, or ROTC graduates | All had masters or doctorate degrees in either psychology, clinical social work, or psychiatry |

| Demographic Profile | All active-duty who had deployed generally at least twice, nearly all male in late 20s to early 30s; mostly White, some Black and Hispanic | Majority civilians who do not deploy, half male and half female ranging from early 30s to early 60s, mostly White, some Black and Hispanic |

| Professional Jurisdictional Claims | As the commander, I know my soldiers best and what’s best for them | As a medical professional, I know my patients best and what’s best for them |

| Professional Identity Displays: Language, Demeanor, Dress | Army language, cursing, macho and confident demeanor, deductive communication style, “be superman,” dress in formal, camouflaged Army Combat Uniform (ACUs) | Clinical language; polite and warm, inductive communication style, “be human,” dress in casual civilian clothing |
Table 4: Conflict Over Different Perspectives and Traditional Practices for How to Achieve Superordinate Organizational Goal

<table>
<thead>
<tr>
<th>Clashing Professional Perspectives on How to Achieve Goal in Different Conflict Situations</th>
<th>Army Commanders</th>
<th>Mental Health Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Superordinate Organizational Goal</strong></td>
<td>Field a mentally healthy, mission-ready force</td>
<td></td>
</tr>
<tr>
<td><strong>Part of Organizational Goal Privileged</strong></td>
<td>Field a mission ready force</td>
<td>Promote soldier mental health and wellness</td>
</tr>
</tbody>
</table>

| Conflict over sharing soldier health information | **Professional Perspective**<br>A good commander “knows his soldiers”, including details of their medical and mental health status as permitted under the Privacy Act of the Uniform Code of Military Justice, to make informed decisions about how to lead their unit and assign tasks to best complete their mission. | **Professional Perspective**<br>A good provider does not violate the sacred provider-patient relationship by sharing patient protected health information to both encourage patient trust and care seeking. |
| **Tradition Practices to Achieve Goal** | Seek out as much information or “situational awareness” as possible about your soldiers. | Protect patient confidentiality and share as little information as possible with others. |

<p>| Conflict over prioritizing individual vs. unit welfare | <strong>Professional Perspective</strong>&lt;br&gt;Put the unit before any individual; A good commander looks out for the broader needs of the unit rather than any one individual soldier | <strong>Professional Perspective</strong>&lt;br&gt;Put the individual patient first; A good provider prioritizes the needs of the individual patient. |
| <strong>Tradition Practices to Achieve Goal</strong> | Make decisions that privilege the unit’s welfare over individual soldier welfare. | Make what consider clinically superior treatment decisions that |</p>
<table>
<thead>
<tr>
<th>Conflict over enforcing “good order and discipline” vs. providing leniency and second chances</th>
<th>Professional Perspective</th>
<th>Professional Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain control over unit by instilling “good order and discipline”</td>
<td>Provide leniency and second chances to patients who may be “acting out” as a result of an underlying mental health condition.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traditional Practices to Achieve Goal</th>
<th>Traditional Practices to Achieve Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforce “good order and discipline” by swiftly punishing soldiers for minor and major transgressions that threaten their authority and control over their unit, including chaptering “problem children” soldiers out of the Army who they consider “toxic” to their mission.</td>
<td>Advocate for exceptions so that soldiers receive treatment rather than punishments, or receive a medical retirement from the Army rather than a general or dishonorable discharge for committing misconduct.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conflict over instilling mental toughness vs. reduce the stigma of seeking help</th>
<th>Professional Perspective</th>
<th>Professional Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instill mental toughness and self-reliance to ensure prepared for trials of combat.</td>
<td>Reduce the stigma of seeking help for mental health problems.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traditional Practices to Achieve Goal</th>
<th>Traditional Practices to Achieve Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push through pain and “suck it up and drive on”; Commanders present selves as “supermen” who do not have medical or mental health problems nor use such services.</td>
<td>Promote care seeking by acknowledging pain and seeking professional help rather than “sucking it up”; Encourage soldiers and commanders to openly get care to set an example to reduce the stigma.</td>
</tr>
</tbody>
</table>
Table 5: Presence of Same Integrative Mechanisms at All Clinics and Brigades

<table>
<thead>
<tr>
<th>Integrative Mechanism</th>
<th>Clinics &amp; Brigades A/B</th>
<th>Clinics &amp; Brigades C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>Dozens of policies have been written or changed to encourage commanders to support soldier use of mental health services (e.g., mental health no longer always removes security clearance, etc.).</td>
<td></td>
</tr>
<tr>
<td>Inducements</td>
<td>Multiple inducements put increased pressure on commanders to prioritize not just mission readiness in their units, but also the health and welfare of their soldiers, including by supporting their usage of mental health services. Commanders were also held increasingly accountable for any “negative events” related to soldier mental healthcare, such as suicides in their unit, and were responsible for identifying and supporting “high risk” soldiers, including those having mental health problems.</td>
<td></td>
</tr>
<tr>
<td>Formal Rules and Procedures for Interactions Between Groups</td>
<td>Formal protocols or “Standard Operating Procedures” were written for all clinics on when and how providers should contact commanders, particularly when issuing a “profile”, an online document listing any work restrictions for their patients (e.g., instructions to sit out a training exercise, not carry a weapon, requirements for number of hours of sleep a night, duty or deployment limiting medications, etc.).</td>
<td></td>
</tr>
<tr>
<td>Strategic planning</td>
<td>At the very highest levels, Command and Medical leadership discuss issues of strategic planning related to both providing rehabilitative mental health services to soldiers and ensuring mission readiness.</td>
<td></td>
</tr>
<tr>
<td>Cross-functional Task Forces/Teaming</td>
<td>“Health of the Force” meetings were implemented in which commanders discuss their “high risk” soldiers in the presence not just of their higher level commander, but also in the presence of representatives from “helping agencies” including mental health providers.</td>
<td></td>
</tr>
<tr>
<td>Awareness of Superordinate Goal</td>
<td>A well-publicized “Ready and Resilient” campaign Army-wide professed the importance of not just physical readiness among troops but also “emotional” readiness from building “resilience” and utilizing professional mental health services.</td>
<td></td>
</tr>
<tr>
<td>Co-location</td>
<td>A dedicated mental health clinic was built co-located in the “footprint” or geographical area of each brigade so that providers</td>
<td></td>
</tr>
</tbody>
</table>
were no longer far away in the one post hospital, but were closer to the commanders and soldiers in their assigned brigade.

<table>
<thead>
<tr>
<th>Organizational Socialization</th>
<th>While commanders are strongly identified with the Army (organization), mental health providers were generally more strongly identified with their profession as clinicians (80% civilian). Multiple attempts were made to socialize providers into the Army, including onboarding programs and a 1 day “stand down” to learn about delivering more culturally competent care at all clinics. A select group of providers were fully embedded into each brigade and spent the majority of their time there rather than in the clinics, to promote full organizational socialization. Commanders were also increasingly socialized into mental health doctrine, such as through mandating commanders provide 28 hours of “Resiliency” training to their units each year, lead suicide prevention training on designated suicide prevention stand down days, and read multiple “leader books” on the health of the force and suicide prevention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time Intermediary Liaison Roles (Integrator Roles)</td>
<td>Uniformed providers who train and deploy with each brigade were embedded into the brigades to serve as liaisons and integrators between mental health and the brigade.</td>
</tr>
<tr>
<td>Organizational Slack</td>
<td>Same low levels of organizational slack given shortage of soldiers without a draft and given reductions in the force. However, high levels of organizational slack in terms of special funding allocated toward rehabilitative mental health provision.</td>
</tr>
<tr>
<td>Sequential Attention to Goals</td>
<td>Previously main goal to deploy as many soldiers as possible and fix them up later (sequential). Now offering rehabilitative care while soldiers remain on active duty in their units; so simultaneously pursuing both goals, rather than pursuing them sequentially.</td>
</tr>
<tr>
<td>Incentives that Reward Joint Outcomes</td>
<td>None, though both benefit from no suicides, though not really evaluated on this. Providers in A/B and C/D evaluated in the same way, by a senior provider of their same mental health discipline (e.g., social work evaluates social work) on the clinical soundness of their notes and on meeting various documentation requirements (e.g., completing patient notes within 72 hours) and not based on any outcomes tied to the soldiers or units they saw.</td>
</tr>
</tbody>
</table>
Figure 1: Army Initiative to Build Co-located Mental Health Clinics For Each Brigade

Pre-Change: Mental Health Providers Work in Post Hospital Serving All Brigades

Post-Change: Mental Health Providers Work in Clinics Co-located By Each Brigade

KEY
- Brigade
- Clinic Provider
- Clinic
- Embedded Provider
Figure 2: Difference in Organizational Assignment Structure between A/B and C/D

Clinic A & B Providers Assigned to Specific Units in the Brigade

Clinic C & D Providers Serve All Units in Brigade
Table 6: Different Outcomes Achieved in Clinics and Brigades A/B versus C/D

<table>
<thead>
<tr>
<th>Outcomes of Conflict Situations</th>
<th>A/B</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of conflicts resolved in which both the mental health provider and commander defined the outcome as positive (integrative outcome)</td>
<td>89%</td>
<td>5%</td>
</tr>
<tr>
<td>Percentage of conflicts resolved in which both the provider and commander defined outcome as negative (lose-lose)</td>
<td>1%</td>
<td>31%</td>
</tr>
<tr>
<td>Percentage of conflicts in which the provider defined outcome as positive, commander as negative</td>
<td>6%</td>
<td>55%</td>
</tr>
<tr>
<td>Percentage of conflicts in which the commander defined outcome as positive, provider negative</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Total number of conflict situations analyzed between mental health providers and commanders</td>
<td>70</td>
<td>62</td>
</tr>
</tbody>
</table>

**Commander Reported Compliance with Duty-Limiting Mental Health Recommendations (e.g., missing training, modifying duties, etc.)**

<table>
<thead>
<tr>
<th>Commander Reported Compliance with Duty-Limiting Mental Health Recommendations (e.g., missing training, modifying duties, etc.)</th>
<th>A/B</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of commanders who claimed to regularly follow duty-limiting Mental Health soldier care recommendations</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Total number of commanders interviewed</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Percentage of commanders who claimed to regularly follow duty-limiting Mental Health soldier care recommendations</td>
<td>86%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Duty-Limiting Mental Health Recommendations Followed by Commanders**

<table>
<thead>
<tr>
<th>Duty-Limiting Mental Health Recommendations Followed by Commanders</th>
<th>A/B</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of duty-limiting soldier mental health recommendations followed by commanders</td>
<td>53</td>
<td>9</td>
</tr>
<tr>
<td>Total number of duty-limiting mental health recommendations analyzed</td>
<td>59</td>
<td>49</td>
</tr>
<tr>
<td>Percentage of duty-limiting soldier mental health recommendations followed by commanders</td>
<td>90%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Commander Reported Mission-Readiness Impact of Mental Health**

<table>
<thead>
<tr>
<th>Commander Reported Mission-Readiness Impact of Mental Health</th>
<th>A/B</th>
<th>C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of commanders claiming Mental Health supported rather than detracted from their unit’s readiness for deployment</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Percentage of commanders claiming Mental Health supported rather than detracted from their unit’s readiness for deployment</td>
<td>79%</td>
<td>0%</td>
</tr>
<tr>
<td>Total number of commanders interviewed</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 7: Demographic Differences between Clinics A/B and C/D Cannot Account for Differences in Level of Subgoal Alignment Achieved

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Clinic A</th>
<th>Clinic B</th>
<th>Clinic C</th>
<th>Clinic D</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Civilian providers</td>
<td>40%</td>
<td>100%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>% Social workers</td>
<td>40%</td>
<td>40%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>% Female</td>
<td>60%</td>
<td>60%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>% White</td>
<td>80%</td>
<td>80%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>% Veterans</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Average Army Tenure</td>
<td>3 years</td>
<td>3 years</td>
<td>3.2 years</td>
<td>3.5 years</td>
</tr>
<tr>
<td>Average Career Tenure</td>
<td>9.4 years</td>
<td>14.75 years</td>
<td>16 years</td>
<td>8 years</td>
</tr>
<tr>
<td>Clinic Team Lead Affiliation</td>
<td>Uniformed</td>
<td>Civilian</td>
<td>Civilian</td>
<td>Uniformed</td>
</tr>
<tr>
<td>Deployment History of Brigade</td>
<td>Accelerated</td>
<td>Similar</td>
<td>Similar</td>
<td>Similar</td>
</tr>
</tbody>
</table>
Figure 3: Anchored Personalization, Anchored Perspective-Taking, and Superordinate Goal Achievement

**Anchored Personalization**
- Stable, long-term connection with specific members of the other group while remaining anchored in one's home group.
  - Personalization of other group
  - Anchoring in home group's identity
  - Identity expansion to incorporate elements of the other group's perspective

**Anchored Perspective-Taking Practices**
- Empathizing with the other group member's perspective, while remaining anchored in home group's perspective
- Using a broadened repertoire of identity displays during intergroup interactions that demonstrate respect for the other group's perspective
- Drawing on personalized knowledge of and relationship with the other group member to collectively craft novel and customized solutions to conflicts that take both groups' perspectives into account

**Achieve Superordinate Goal**
- Co-construction of integrative solutions that achieve superordinate goal
  - High percentage of conflicts resolved in ways both groups defined as positive