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OUTPATIENT PSYCHIATRIC DECISIONS FOR ENLISTED WOMEN IN THE NAVA--ETC(U)
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OUTPATIENT PSYCHIATRIC DECISIONS FOR ENLISTED WOMEN IN THE NAVAL SERVICES

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NAVAL MEDICAL RESEARCH AND DEVELOPMENT COMMAND
BETHESDA, MARYLAND

Outpatient Psychiatric Decisions for Enlisted Women in the Naval Services[1]

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[1]The views presernted in this paper are those of the authors. No endorsement by the Department of the Navy has been given or should be inferred. This research was supported by the Department of the Navy, Bureau of Medicine and Surgery, under Work Unit MPN03.07-3013.

Abstract

Women are playing an increasing role in the functioning of the armed forces. Psychiatric crises account for one tenth of all sicklist admissions for women in the Navy. Navy psychiatrists and psychologists need to ensure that the decisions rules used to treat psychiatric cases result in positive outcomes for women. This study examined the process of psychiatric assessment of naval enlisted women at outpatient clinics. Correlation and regression procedures showed that psychiatric decisions for treatment or returning to work were determined by the woman's expectations. Follow-up data were collected on these women over a four year period. Although 48% of those women who came to the clinic were returned to their jobs, only 12% of these women were successful at follow-up. There were no significant relationships between success and any patient variables or clinical evaluations. This preliminary look at psychiatric assessment highlights the need for guidelines for psychiatric screening for women.

Outpatient Decisions for Enlisted Women in the Naval Services

With increasing numbers of women in the naval services, more women are turning up with general medical and psychiatric problems. About one sicklist admission in ten among women is associated with some sort of psychiatric crisis. What guidelines for treatment and disposition are available to insure that as many women as possible are retained in their useful careers and that norms developed on male populations are not uncritically applied to women ? Masculine bias has been charged in some civilian situations (Broverman, 1970, 1972), and there is an increasing awareness that any guidelines used should be both efficient and sensitive to women's needs and circumstances (Goldman, 1973). It has been adequately demonstrated for male sailors that the application of sound decision rules to psychiatric cases can result in significant gains in the numbers of men performing satisfactorily, (Edwards & Berry, 1972). An equivalent gain can be expected in the treatment and later performance of women if such decision guidelines, tailored to women's situations, can be developed.

The present study examines the process of psychiatric assessment of women referred to outpatient clinics. The sample consists of 70 enlisted women (58 Navy and 12 Marine corps) seen between October 1971 and February 1973 at Portsmouth, Virginia.

Procedure

Before seeing a psychiatrist, the women filled out a questionnaire which covered items on demography, motivation, attitude, and the Health Opinion Survey (Gunderson, et al., 1968). After his interview, the psychiatrist also completed a form which included his perceptions of the woman's motivation for duty, motivation for treatment, and general attitude (Holm, et al., 1973; Edwards, et al., 1973), as well as his diagnosis and recommended disposition. The motivation and attitude scores were scored on a six point scale from 1 (poorest rating) to 6 (best rating) as shown in Table 1.

Table 1, see page 3a.

Data Analysis

The realtionships between patient characteristics and perceptions, and psychiatric perceptions and selected criteria were calculated using correlation and regression procedures. The following criteria based on psychiatric decisions and outcome data were examined:

1. General attitude toward life (Table 2).
2. Motivation for treatment (Table 3).
3. Motivation for duty (Table 4).
4. Disposition from the outpatient clinic (Table 5).
5. Outcome of post-outpatient adjustment in the service, as shown by status four years later.

Table 1

Motivational Indices for Clinical Judgments

General Attitude Toward Life

1. Hates authority - negativistic.
2. Inadequate, escaping from life.
3. Authority problems, excessive dependency.
4. Temporary maladaption.
5. Needs direction.
6. Conforms readily, constructive.

Motivation for Treatment

1. "Fouled up by others" - projecting, externalizing.
2. Sees no need for treatment.
3. Confused - not sure.
4. "They think I need help" attitude.
5. Actively wants help.
6. Early insight, no solution worked out yet.

Motivation for Duty

1. Actively seeking discharge.
2. Hoping to be discharged.
3. Will stay in if coerced.
4. Will stay in if situation improved.
5. Finish enlistment only.
6. Career oriented.

Results

Sample Characteristics

Personal and Service History. The 70 women averaged 20.47 years old (range = 18 to 27) and had been in the service 2.91 years (range = 1 to 7 years). The average pay grade was 2.5 (range = E2 - E6). Only six women indicated that they planned to make the service their career. All but three of the women were Caucasian, two being Black and one Malayan. All but three were high school graduates; the Navy and Marine Corps generally require a woman to be a high school graduate if she is to be allowed to enlist. Fifty of the seventy women were not married.

Medical/psychiatric symptoms. Although most (59%) of the women denied any health problems, they did report a number of physical complaints such as trembling hands, feeling tired in the morning, stomach upset, loss of appetite, and feeling weak. Sleep disturbance was frequently reported. Wondering if anything was worthwhile was a major concern. Contrasted with these complaints, the women reported that they felt in good spirits and felt healthy enough to do the things they liked to do. This mix of frequent symptoms and good spirits presented a provocative picture of healthy complainers.

Patient perceptions. Twenty-seven percent of the women had seen a psychiatrist before, usually for a reason different from the present consult. Most were having a personal problem or having difficulty in their work assignment (80%). Half of the married women reported family problems. Medical screening had been done in many of the cases (43%) and this led to the psychiatric consultation but the patient or the patient's commanding officer also

referred frequently (23% and 17% respectively). Only 38.5% of the women referred to psychiatry expected to be returned to duty as fit for same.

Psychiatrists' perceptions. Nine percent of the women were being screened for a special program (e.g., special assignment or advanced training requiring psychiatric clearance). No women were involved in the drug amnesty program and only one woman was seen as having a drinking problem. Sixteen percent of the sample were having problems with their spouse and family. Major problems were either work related (23.5%) or feared emotional disturbance (23.4%). The women received a slightly positive rating for their motivation for duty (Mean = 3.90, s.d. = 1.82), motivation for receiving treatment (mean = 3.52, s.d. = 1.52), and general attitude (mean = 3.91, s.d. = 1.57). Fifty-nine percent of the women were rated as able to finish their enlistment with one of four of those women rated as career oriented (14.7% of the sample). Forty-three percent of the women were positively seeking help or actively resolving their problems, and 30% of the women were seen as having a temporary maladaption. Thirty-one percent were seen as having a positive attitude which would assist readjustment.

Diagnosis. The diagnoses established for these women were (1) Psychosis, 3.1%; (2) Neurosis, 20.3%; (3) Personality Disorder, 28.1%; (4) Situational Maladjustment, 29.7%; and (5) No Diagnosis, 18.8%. These figures reflect a much lower rate of characterological problems for women and a higher rate of neurosis and situational maladjustment than for men (for men: Personality

disorder-47%; neurosis-7%; situational maladjustment-15%). Psychosis was comparable (3% for men).

Recommendations. Ten percent of the women were recommended for hospitalization. Four percent were not regarded as psychiatric cases. Forty-eight percent were returned to full duty with no further treatment while 21% were recommended for outpatient treatment. The rate of recommendation for outpatient treatment for women was higher than comparable recommendations made for men (11% for men).

Determinants of Clinical Decisions for Women.

The decision to return a woman to duty was analyzed with other psychiatric decisions to define the process leading to the disposition of these cases. Each decision was examined and implications were drawn from the results.

General attitude. The general attitude was related to fourteen variables presented in Table 2.

Table 2, see pages 6a & 6b.

A married service member who manifested any problems was seen has having a generally poor attitude - authority problems and excessive dependency. Overall, the more symptoms a female reported, the poorer the attitude rating she was given.

Table 2

The Relationship Between General Attitude

and Other Dimensions of the Female Sample

Variable	
Demography	
How does your spouse feel about your being in the service? (negative = 1, neutral = 2, positive or not married = 3)	r = .43
Marital status (married = 1, other = 0)	r = -.25
Symptoms (Often = 1, Sometimes = 2, Never = 3)	
Do you feel in good spirits?	r = -.41
Are you troubled by damp and clammy hands or feet?	r = .35
Have you ever been troubled by your heart beating fast?	r = .34
Do you feel you are bothered by all sort of ailments in different parts of your body?	r = .33
Are you bothered by having an upset stomach?	r = .31
Are you bothered by nightmares?	r = .25
Patient Expectations[a]	
What do you expect to be the major result of your seeing the psychiatrist?	
(1) I will be found fit for my special program	6.0[b]
(2) I will be hospitalized or I will be returned to duty or I will be returned to my command for disciplinary action or I will not pass my special screening or I will be treated as an outpatient.	4.1
(3) I will be discharged from the service	3.2
	r = .44

Other Psychiatric Dimensions[a]

Motivation for Duty	r = .60
Motivation for treatment	r = .56
Diagnosis	
(1) No diagnosis Neurosis Situational maladjustment	4.2[b]
(2) Personality Disorder Psychosis	3.1
	r = .44
What disposition did you recommend?	
(1) Not a psychiatric case; referral made R. T. D. as fit for duty. R. T. D. recommending outpatient treatment Recommend admission to the hospital	4.2[b]
(2) R. T. D. for Administrative Separation	2.8
	r = .43
Why did the service member see a psychiatrist?	
(1) Special program, screening required. Therapeutic abortion	4.8[b]
(2) Unable to function at work. Suicidal Adaption problem with serivce Drinking problem Fears she's going crazy Facing disciplinary action Family problems Trouble with her husband Command is considering Administrative Separation	3.6
	r = .41

[a]Categorical variables were linearized by assigning the mean General Attitude Score for each segment to all members in the category and collapsing all categories which were not significantly different on the mean scores. The mean scores for each categorical segment is given and r is computed.

[b]Mean Scores for each category level on General Attitude Scale.

Patient expectations were related to attitude. Diagnosis and attitude reflected similar characteristics of the women.

Those women diagnosed as characterological or psychotic were judged as having a poorer general attitude - having problems with authority or being excessively dependent. Women with personal problems were judged as having a poorer attitude than other women who were seen at the outpatient service.

Motivation for treatment. A summary of the characteristics associated with the assessment of a woman's motivation for treatment is presented in Table 3.

Table 3, see pages 7a & 7b.

Without support from a woman's spouse, if she were married, treatment was not indicated. The desire of the patient for further military service influenced the judgment of the psychiatrist of the woman's desire for treatment. Women who appeared to desire discharge or were having disciplinary problems were not motivated for treatment. Others, including those who expected to be returned to duty, were positively rated as being motivated for treatment. The greater the motivation for treatment expressed by the women, the greater the motivation for duty and the better the general attitude as judged by the psychiatrists. These concommitants reflect an overall congruence about the impressions the women present to the psychiatrists.

Table 3

The Relationship Between Motivation for Treatment

and Other Dimensions of the Female Sample

Variable	
Demography	
How does your spouse feel about your being in the service (negative = 1, neutral = 2, positive or not married = 3)	r = .43
Symptoms (Often = 1, Sometimes = 2, Never = 3)	
Do you feel you are bothered by all sorts of ailments in different parts of your body?	r = .51
Do you feel in good spirits?	r = -.38
Are you bothered by having an upset stomach	r = .35
Have you ever been troubled by cold sweats?	r = .35
Have you ever been bothered by your heart beating fast?	r = .30
Are you bothered by nightmares?	r = .26
Are you troubled by damp and clammy hands or feet?	r = .25
Patient Expectations[a]	
What do you expect to be the major results of your seeing the psychiatrist?	
(1) I will not pass my screening. I will be treated as an outpatient I will be returned to duty I will be hospitalized	4.1[b]
(2) I will be discharged from the service. I will be returned to my command for disciplinary action.	2.3
(3) I will be found fit for my special program	1.8
	r = .48

Other Psychiatric Decisions[a]

Diagnosis

(1)	Psychosis No Diagnosis Neurosis Situational Maladjustment	4.3[b]
(2)	Personality Disorder	2.2
		r = .66

Motivation for Duty Score — r = .62

General Attitude Score — r = .56

Why did the service member see a psychiatrist?

(1)	Unable to function at work Suicidal	5.0[b]
(2)	Therapeutic abortion Fears she's going crazy Family problems	4.3
(3)	Trouble with her husband Special program, screening required Facing disciplinary action	3.3
(4)	Adaptation problems with service. Command is considering Administrative Separation	2.2
		r = .38

What disposition did you recommend?

(1)	Not a psychiatric case; referral made R. T. D. recommending outpatient treatment, R. T. D. as fit for duty. Recommended admission to the hospital	3.8[b]
(2)	R. T. D. for Administrative Separation	2.1
		r = .46

[a]Categorical variables were linearized by assigning the mean General Attitude Score for each segment to all members in the category and collapsing all categories which were not significantly different on the mean scores. The mean scores for each categorical segment is given and r is computed.

[b]Mean scores for each category level on Motivation for Treatment Scale.

Motivation for Duty. A summary of the women's characteristics associated with their motivation for duty is summarized in Table 4.

Table 4, see pages 8a & 8b.

Motivation for duty followed the patterns associated with the other judgments. Poor marital support, administrative problems, characterological diagnosis, or a desire to be separated from the service were interrelated, defining a poor adjustment pattern for continued service.

Disposition. The characteristics of the sample associated with being returned to duty are summarized in Table 5.

Table 5, see pages 8c & 8d.

This decision is most strongly associated with the patients' expectations and desires ($r = .78$), followed by a judgment of motivation for duty and the reason for the referral, both judged by the clinician ($r = .67$ and $r = .63$, respectively), and the diagnosis ($r = .61$). The number and type of symptoms were also related to disposition. Those women who were returned to duty

Table 4

The Relationship between Motivation for Duty and Other Dimensions of Women in Service

Variable	
Demography	
How does your spouse feel about your being in the service? (negative = 1, neutral = 2, positive or not married = 3)	r = .46
Do you plan to make the service a career? (no = 0, yes = 1)	r = .36
Symptoms (Often = 1, Sometimes = 2, Never = 3)	
Are you bothered by an upset stomach?	r = .54
Do you feel in good spirits?	r = -.51
Do you feel you are bothered by all sorts of ailments in different parts of your body?	r = .44
Do you tend to feel tired in the morning?	r = .38
Are you bothered by nightmares?	r = .37
Do you sometimes wonder if anything is worthwhile anymore?	r = .34
Have you ever been troubled by cold sweats?	r = .32
Are you troubled by damp and clammy hands or feet?	r = .35
Patient Expectations[a]	
What do you expect to be the major results of your seeing the psychiatrist?	
(1) I will be found fit for my special program	5.7[b]
(2) I will be returned to duty as fit. I will be hospitalized. I will be treated as an outpatient I will not pass my special screeing I will be returned to my command for disciplinary action.	4.9
(3) I will be discharged from the service.	1.6
	r = .84

Other Psychiatric Decisions[a]

Why did the service member see the psychiatrist?

(1)	Suicidal Special program, screening required	5.8[b]
(2)	Unable to function at work. Therapeutic abortion Drinking problem. Facing disciplinary action	5.0
(3)	Family problems Trouble with her husband Fears she's going crazy	4.3
(4)	Command is considering Administrative Separation	1.9
	Problem adapting to service	1.9
		r = .70

Motivation for treatment score. r = .62

General attitude. r = .60

Diagnosis.

(1)	Psychosis Neurosis No diagnosis Situational maladjustment	4.5[b]
(2)	Personality disorder	2.4
		r = .56

Disposition

(1)	Recommended admission to the hospital R. T. D. as fit for duty R. T. D. recommending outpatient treatment Not a psychiatric case, referral made	4.5[b]
(2)	R. T. D. for administrative separation	1.5
		r = .67

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[a]Categorical variables were linearized by assigning the mean General Attitude Score for each segment to all members in the category and collapsing all categories which were not significantly different on the mean scores. The mean scores for each categorical segment is given and r is computed.

[b]Mean scores for each category level on Motivation for Treatment Scale.

Table 5

The Relationship Between Being Returned to Duty after an Outpatient Psychiatry Referral and Other Dimensions of Women in Service

Variable	
Demography	
How does your spouse feel about your being in the service? (negative = 1, neutral = 2, positive or not married = 3)	r = .53
Symptoms (Often = 1, Soemtimes = 2, Never = 3)	
Are you bothered by an upset stomach?	r = .30
Do you feel in good spirits?	r = -.39
Do you feel you are bothered by all sorts of ailments in different parts of your body?	r = .33
Are you bothered by nightmares?	r = .33
Do you ever feel weak all over?	r = .26
Patient Expectations	
What do you expect to be the major results of your seeing the psychiatrist?	
(1) I will be found fit for my special program.	.83[b]
(2) I will be returned to duty as fit. I will be treated as an outpatient.	.52
(3) I will be returned to my command for disciplinary action. I will not pass my special screening. I will be hospitalized.	.20
	r = .78

Other Psychiatric Decisions[a]

Motivation for Duty	r = .67
Motivation for Treatment	r = .46
General Attitude	r = .43
Diagnosis	
(1) No diagnosis Situational maladjustment	.64[b]
(2) Neurosis	.34
(3) Personality disorder	.11
(4) Psychosis	.04
	r = .61
Why did the service member see the psychiatrist?	
(1) Special program, screening required Therapeutic abortion	.83[b]
(2) Unable to function at work Drinking problem Suicidal Family problems	.45
(3) Trouble with husband Fears she's going crazy	.34
(4) Facing disciplinary action. Command is considering Administrative Separation Problem adapting to service	.21
	r = .63

[a]Categorical variables were linearized by assigning the mean General Attitude Score for each segment to all members in the category and collapsing all categories which were not significantly different on the mean scores. The mean scores for each categorical segment is given and r is computed.

[b]Mean scores for each category level on Motivation for Treatment Scale.

with a recommendation for administrative separation were those women who were judged as having severe authority problems. Those women who received a low motivation score were uniformly recommended for administrative separation (92% of those rated at or below 2.0). Women who received a 3.0 or above rating were generally recommended to be returned to duty from the outpatient service.

A regression analysis indicated that (1) patient expectations (accounting for 94% of the explained variance), (2) diagnosis, and (3) nightmares being reported accounted for the disposition (R = .84). Essentially, women received what they anticipated, or perhaps, wanted.

Outcome. Four years after the study was begun, the military status of the women after psychiatric referral and disposition was determined. Effectiveness of the women was defined as being in the service after four years or being discharged with a recommendation to be eligible for reenlistment. Ineffectiveness was defined as receiving any of the following: (1) discharge as unsuitable, unfit, or bad conduct (courts-martial), (2) a medical discharge for psychiatric reasons, or (3) failing of recommendation for reenlistment. Any other conditions of discharge were not considered in determining effectiveness. For example, six of the women were discharged for reason of "pregnancy/parenthood, and although they were personnel losses to the Navy, were neither counted as

psychiatrically effective or ineffective. The status of six other women could not be clearly determined because all necessary follow-up information was not available. Of the remaining 58 women who had been referred to outpatient psychiatry, 12% served effectively after receiving clinical screening or intervention. Although 48% of the women seen had been returned to duty, none of the data collected had any significant relationships to outcomes. The data indicate that a dispositional decision was determined by the woman's expectations instead of psychiatric judgment based on the woman's characteristics which indicated a good chance of success in the naval services.

Discussion

Personal Characteristics

The women in this study were high school graduates and generally mature. Characteristics commonly expected to be related to adequate performance in the service were noted, yet the incidence rate of women coming to psychiatric clinics is 2.5 times greater than the incidence rate for men in the naval service.

Patterns of Presenting Problems

The women presented a mixed picture of somatic complaints and good health, sleep disturbance, and generally high spirits. Most frequently, the women were having problems with their work assignments. The married

women were receiving pressure from their spouses about the service. Trouble with husbands, and becoming pregnant appear to cause substantial problems. Twenty-five percent of the women were having either marital or maternal problems. No cases of drug or alcohol problems were reported. Women were more likely to be diagnosed as neurotic than men. This difference in clinical profile between men and women indicates a need for a careful study of clinical characteristics, treatment, strategies, and outcome for women.

Judgments of Attitude

In this sample, being married was related to being judged as having a series of poor attitudes about life, treatment, and the service. Dispositions followed from clinical judgments, but the judgments were not related to outcomes. It appears that clearer guidelines need to be developed for women.

Dispositions and Outcomes

Although there was twice the proportion of women treated as outpatients than men, the dispositional pattern for women is different that it is for men. Women are less likely to be returned to duty (women, 48%; men, 67%) than men with comparable characteristics (age, education, length of service, rank, diagnosis). The relationships among clinical decisions (including treatment), dispositions, and outcomes are not clearly defined for women.

Impression

The increasing number of women in the naval services presents a particular problem for Navy psychiatrists and psychologists, as well as for their supervisory personnel: (1) How should behavioral problems be handled? (2) When should psychiatrists and psychologists be used to intervene? (3) What treatment strategies should be used? (4) On what factors or characteristics should a clinician focus his attention in deciding which woman can be returned to duty successfully? Women in the military service constitute a relatively new population for psychiatry and psychology. A wider number of work assignments for women and the fact that they constitute a larger proportion of the work force presents an entirely new set of dimensions for consideration in the practice of psychiatry and good personnel administration. It is the responsibility of Navy psychiatrists and psychologists to assure those women whom they serve that they will ask any woman to take the minimal risk in remaining effectively at duty after outpatient psychiatric intervention.

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Women are playing an increasing role in the functioning of the armed forces. Psychiatric crises account for one tenth of all sicklist admissions for women in the Navy. Navy psychiatrists and psychologists need to ensure that the decision rules used to treat psychiatric cases result in positive outcomes for women. This study examined the process of psychiatric assessment of naval enlisted women at outpatient clinics. Correlation and regression procedures showed that psychiatric decisions treatment or returning to work were deter-

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20. mined by the woman's expectations. Follow-up data was collected on these women over a four year period. Although 48% of those women who come to the clinic were returned to their jobs, only 12% of these women were successful at follow-up. There were no significant relationships between success and any patient variables or clinical evaluations. This preliminary look at psychiatric assessment highlights the need for guidelines for psychiatric screening for women.