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Mental Health in the Military

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Walden University, 2018

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The current qualitative research project explored the lived experiences of senior leaders who have worked with service members known to seek mental health treatment. Despite a large amount of research on the effects mental health has on military members, the scholarly community does not know the experiences individuals face when employing active-duty personnel with known psychological limitations. This phenomenological study aimed to identify senior leadership's lived experiences to identify the barriers and facilitators they faced when employing service members known to have sought mental health treatment. The attribution theory and modified labeling theory were the theoretical frameworks chosen for this study. Five active-duty Navy service members, enlisted ranks E-7 through E-9, participated in semistructured interviews. The findings indicated leaders experienced a lack of knowledge, training, and understanding of how to effectively employ service members. Additionally, senior leadership reported feeling overwhelmed, scared, empathetic, and supportive towards sailors who disclosed their help-seeking behavior. Leadership perceived members to be emotional, anxious, isolated, and experience denial when discussing their issues. The barriers leadership identified were lack of team cohesion from the individual, having to validate their decisions, and having to motivate sailors with psychological limitations. Facilitators included utilizing medical professionals, knowledge, and strong leadership to effectively deal with the situation. Positive social change implications included understanding these potential barriers and facilitators to help educate leadership and policymakers to better prepare individuals to work with service members with psychological limitations.

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Chapter 1: Introduction to the Study

This study's topic was to examine the working relationship between senior enlisted members of leadership who employ service members seeking treatment for a mental health issue. This relationship was vital to explore because it may impact the effective employment of affected members, contributing to perceived discrimination and a less productive working environment. The social implication of this study was by discovering the barriers and facilitators leaders encountered, sharing this knowledge could lead to a better understanding of this working relationship. The information could help educate leaders and prepare them to work with impacted individuals, reduce perceived stigma within the organization, and provide the service member better support during treatment. Improving the working environment may also influence service members to seek treatment when they need help. This chapter provides the background of the research topic, research problem, theoretical framework, a list of definitions and key concepts, and assumptions.

Background

Military members are incredibly susceptible to developing mental health disorders. Long deployments, hazardous working environments, separation from family and friends, failed relationships, and being awarded nonjudicial punishments (NJP) contribute to the high rate of psychological disorders (Pruitt et al., 2019). The disorders include, but are not limited to, posttraumatic stress disorder (PTSD), depression, adjustment disorders, and suicide ideations and attempts (Pruitt et al., 2019). Although this population is high-risk, research has shown that service members tend to underutilize

mental health services. Hom et al. (2017) studied this phenomenon and concluded that only 29.3% of people serving in the military suffering symptoms of a psychological disorder reported using mental health services. One of the main barriers keeping this community from seeking help is stigma (Schreiber & McEnany, 2015). Empirical evidence supports that stigma has several negative cognitive and behavioral impacts on an individual. Impacts include social depreciation, discrimination, nondisclosure, and failure to seek help (Boyle, 2018; Sharp et al., 2015). Factors like these are keeping this community from actively pursuing the psychological help they need to get well.

The study conducted by Hom et al. (2017) on the underutilization of mental health services among U.S. Army soldiers with PTSD concluded that fear of career impacts, logistic barriers to help, and stigma contributed to the lack of help seeking behaviors. Schreiber and McEnany (2015) performed their research on soldiers returning from Iraq and Afghanistan who were victims of military sexual trauma (MST). The group found that fear of being perceived as weak, losing trust among peers, and losing confidence among superiors were effects of organizational stigma and contributed to avoidance behaviors.

Multiple quantitative studies have investigated factors within the work environment that influence an individual's willingness to seek help. Yamawaki et al. (2016) surveyed 108,478 military members from different branches concluding fear of a "hostile work environment, satisfaction with leadership, and job satisfaction" were statically significant predictors of help seeking behaviors (p. 1549). Researchers have also examined how the amount of public educational programs helps mitigate the

perception of stigma among military members. Mohatt et al. (2017) determined that increasing the public's awareness of stigma through the development of Mental Health First Aid (MHFA) training programs could significantly impact service members and veterans.

Research Problem

Individuals in high-risk occupations, like military personnel and first responders, often work in cohesive groups to accomplish difficult tasks. Group unity, trust, and acceptance are characteristics that are vital to shaping the organizational culture and are essential pillars of these social systems (Britt et al., 2020). As a direct result, individuals in organizations that devalue mental health disorders are more likely to perceive stigma when seeking treatment. Stigma is the shame or disgrace people feel that results in discrimination or rejection from societal groups (Britt et al., 2020; Shann et al., 2019; Yamawaki et al., 2016). Researchers have shown that military members often perceive psychological disorders as more stigmatizing than physical issues and, as a result, are less likely to admit they need treatment (Schreiber & McEnany, 2015). Stigmatized service members often choose not to disclose information that has the potential to acquire the label mentally ill. The problem is that these avoidance behaviors are associated with military members' underutilizing mental health services.

While there is a wealth of research on stigma related to mental health among individuals in the military, much of it focuses on the perception of stigma and barriers to care of those who suffer symptoms of a psychological disorder (e.g., Schreiber & McEnany, 2015; Hom et al., 2017). The scholarly community does not know the

experiences leaders have when working with individuals who seek mental health services. In this qualitative study I aimed to understand senior enlisted members' lived experiences when employing military members known to seek treatment for a mental health disorder. The information gathered in his study has direct implications for enhancing the understanding of the working relationship between senior leadership and junior personnel who have psychological limitations. It was essential to identify the experiences of those who employ individuals with psychological limitations to increase leaders' situational awareness when dealing with individuals seeking treatment. This study's findings may be used to help base commanders develop policies, create effective training programs to educate the fleet on the importance of mental care, and encourage treatment-seeking behaviors. These programs and policies could teach members in leadership roles how to effectively employ this population to help mitigate the perception of stigma and discrimination associated with seeking treatment for mental health issues in the military.

Purpose Statement

Stigma can be especially problematic for individuals in the military because of the professional expectation of being physically and mentally resilient. Stigma includes "stereotyping, prejudice, and discrimination" (Shann et al., 2019, p. 2). These actions and behaviors can decrease an individual's self-esteem, causing them to conceal their illness. These actions can result in people not seeking help. Organizational stigma stems from group beliefs and can lead to an unbalance of power within the unit. This disparity allows those in positions of power to stigmatize others by defining what is considered "normal"

and label those who qualify as abnormal according to organizational standards (Shann et al., 2019). These actions can lead to an individual feeling devalued in addition to a possible breakdown of the utility within the organization.

In an organizational culture where the expectations for its members are to "man-up" stigmatizing behaviors can be incredibly impactful (Shann et al., 2019). It is vital that the barriers to employing members with known mental health issues be explored to change the culture and remove the stigma from the work environment. The purpose of this phenomenological study was to explore the lived experiences of senior enlisted leaders employing individuals known to seek treatment for a mental health issue to change the culture of the perceived stigma associated with mental health.

Research Questions

RQ1: What are the lived experiences of senior enlisted leaders who have employed military members who have disclosed seeking treatment for a mental health issue?

RQ2: What are the barriers and facilitators senior enlisted leaders encounter when trying to effectively employ military members who have disclosed seeking treatment for a mental health issue?

Theoretical Framework

Two theories were selected as the theoretical framework for this study, the attribution-emotion model and the modified labeling theory. The creators of the attribution-emotion model hypothesized that individuals may discriminate or prejudge those suffering a psychological disorder because they believe the onset of the illness is

the fault of the individual (Fiske et al., 2009). I used this theory to explain why people can be concerned about being labeled "mentally ill" and why those individuals may fail to disclose their illness. This framework was used to create interview questions that explore the perceptions of leaders who work with individuals who have disclosed seeking mental health treatment. Questions were developed to ask how the individual disclosed their help seeking behaviors. Theorists of the modified labeling theory hypothesized being labeled "mentally ill" could elicit one of three responses: deflection, social withdrawal, or concealment of the individual's illness (Link et al., 1989). This theory was used to help illustrate why people suffering from this type of illness may fail to disclose that they need help. I used the modified labeling theory to create questions related to leaders' experiences with individuals who withdraw from the work environment or social interactions.

Nature of the Study

The nature of this nonexperimental study was qualitative and focused on the lived experiences of individuals who have employed members of the military who were known to seek treatment for a mental health issue. Each participant in this study provided their perceptions of the identified phenomenon through semistructured interviews. I collected and analyzed the data and sought out the barriers and facilitators these individuals faced when effectively employing this population. To capture this target audience, purposeful sampling was used to gather the experiences of senior enlisted members in leadership roles. The qualitative approach aligned with the investigation of the phenomenon of interest of the target audience.

Definitions

Organization Stigma: Organizational or institutional stigma is operationally defined as the shared beliefs among a collection of people used to ostracize individuals in their group who are seen to possess an undesirable characteristic (Fiske et al., 2009).

Public Stigma: Public stigma, or external stigma, is operationally defined as the negative attitudes or beliefs others associate with personnel who have a psychological disorder (Fiske et al., 2009). This type of stigma has multiple adverse conditions and was further broken down in to cognitive and affective responses. Cognitive responses included avoidance behaviors to include a failure to use services, discrimination, and assigning stereotypes while affective responses include emotional responses like depression and anxiety (Fiske et al., 2009). Public stigma was further broken down into groups within the population, which results in organizational or institutional stigma which is stigma experienced within sub populations like the working and organizational environments.

Self Stigma: Self-stigma is operationally defined as the internalization of stigma one places on themselves when seeking treatment for a mental health issue (Crowe et al., 2018). The anticipation of social rejection can lead to adverse emotional reactions and hostile responses to discrimination, resulting in behaviors like withdrawal, nondisclosure, or isolation (Corrigan et al., 2005). External stigma can also have adverse effects on an individual's help seeking behaviors.

Assumption

When I conducted this study, I made the assumption that individuals who work with military members known to seek treatment for mental health experience barriers and facilitators when effectively employing this population. This aspect was necessary to discuss because stigma is still impacting military personnel and contributing to the concealment of their mental health issues. Members not willing to seek help can degrade the service member's quality of life and could adversely impact the military's mission.

Scope and Delimitations

In this study, I focused on the experiences of service members who have directly led subordinates impacted by mental illness. There is much already known about the impact of stigma relating to mental health, but little is known about the impact of mental health on the working relationship between an individual and their employer. The inclusion of this study was purposeful and only involved members of senior leadership who have employed individuals known to seek treatment for a mental health issue. Including only senior enlisted members in the Navy may have impacted the generalization of the study's results because it did not consist of members of other branches of the military or the lived events of those in other paygrades.

Limitations

One challenge associated with this study was soliciting participants. Military members often deploy, take leave, are assigned temporary assigned duty (TAD), and have restrictive mission requirements, which led to a large portion of the Navy being unable to participate. To mitigate this risk, I solicitated participants using social media.

This method was able to draw in enough participants for this study to be effective. Another limitation included the sensitivity of the subject. Mental health in the military is still a taboo subject, and many members may have been unwilling to participate or were subject to response bias. To limit this risk, questions were developed that did not require the member to admit to any inappropriate feelings or behaviors toward the subject of themselves and were tailored to asking only about their experiences leading affected members.

Significance

In this study, I aimed to address the gap in the large amount of literature examining the challenges enlisted leadership had when employing service members with known psychological limitations. To gain a more in-depth insight into this phenomenon, I explored the working relationship between members seeking treatment and those employing them from the employer's perspective. Current research has already identified that stigma in the workplace can influence avoidance behaviors and the reluctance to disclose their situation among those who seek help. Therefore, there is a potential lack of communication between those with limitations and the individuals who employ these people, which may lead to perceived discrimination. Gaining more insight on this working relationship may lead to a mitigation of negative behaviors thus improving the work environment and provide better support to impacted individuals.

Summary and Conclusions

Researchers have discovered the various effects stigma has on an individual, including members of the military. Three types of stigma: public, self, and organizational,

have been identified as influencing an individual's willingness to seek psychological treatment and are the focus of this study. There is a great deal of research that has been conducted on the military population and concluded high-risk work environments, barriers to care, a lack of willingness to seek help, fear of career impacts, and the impact on the work environment can make individuals who perceive stigma reluctant to disclose their mental health issues or use mental health services. It is necessary to understand these individuals' perceptions prior to examining the barriers and facilitators members of leadership experience when employing members seeking treatment. The next chapter provides information on the literature search strategy, the study's theoretical foundation, and a literature review related to key concepts related to the study's phenomenon.

Chapter 2: Literature Review

The focus of this study was mental health in the military to include the stigma associated with this social issue. The aim was to explore the experiences members of leadership had when actively employing a service member known to seek mental health treatment. It was imperative to examine this phenomenon to mitigate the perception of discrimination and prejudice within the military. Elimination of this type of stigma may increase the likeliness service members would seek help if suffering a psychological disorder. In this chapter, literature related to the stigma associated with mental health is presented to include a literature review of studies related to populations and methodologies previously examined. The impacts of public stigma, self-stigma, organizational stigma, and an individual's willingness to seek treatment are presented as well as the theoretical foundation of this dissertation.

There are numerous studies that researchers have published regarding stigma related to seeking mental health treatment amongst the military population. Post 9/11 activities in the Department of Defense (DoD), including campaigns like Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), have made the topic of mental health, stigma, and the underutilization of treatment services a great interest to the research community (see Schreiber & McEnany, 2015; Sharp et al., 2015; Yamawaki et al., 2016; Keller et al., 2020). Stigma involves prejudging individuals or marking them with something wrong regarding their moral character, which may discredit their social identity (Goffman, 1963). This type of misjudgment can be hazardous to individuals and adversely impact their behavior.

There are multiple factors that are commonly associated with stigma related to mental illness. This type of stigma can involve individual and group behaviors, attitudes, and perceptions often related to another's lack of social interaction, slovenly appearance, or label as 'mentally ill' (Penn & Martin, 1998). Stigma can be harmful because it can impact an individual's behaviors, most notably concealing their disorder or not seeking help (Corrigan, 2004). Researchers have shown there are multiple types of stigma related to mental illness. These types include self-stigma, public stigma, and organizational stigma (see Corrigan, 2004). A lack of mental health education fuels the stereotypes and discrimination associated with stigma related to mental illness (Shann et al., 2019). Achieving a better understanding of stigma's impacts on service members was vital to explain the barriers and facilitators leadership encountered when effectively employing this population.

Literature Search Strategy

Selected articles related to the stigma associated with mental health are described here. Keywords searched included *mental health, stigma, military, underutilization of mental health services, organizational culture, perceived stigma, external stigma, internal stigma,* and *organizational stigma.* Educational sources included the SAGE Journals and EBSCO databases accessed through the Walden library database. Google Scholar was also used as a search engine for articles. The majority of articles reviewed and included were peer-reviewed within the last five years. However, historical texts have been included to define and establish the theoretical framework.

Theoretical Framework

The foundation of this research was formed using Weiner's attribution-emotion model (1988) and Link's modified labeling theory (1988). The attribution-emotion model was used to support the theory that public stigma negatively impacts individuals with psychological limitations, including how individuals form their stereotypes regarding mental health. Additionally, the modified labeling theory was used to substantiate individuals' adverse reactions to being labeled 'mentally ill'.

Attribution-Emotion Model

I aimed to expand upon previous research that examined how stigma negatively impacts individual behaviors, including their willingness to seek treatment for mental health issues in the military. Weiner's attributional theory was one of the theoretical frameworks selected for this study. Weiner's theory centered around the belief that responsibility attributions are due to internal and external causes (Fiske et al., 2009). The perception was that if both causes are within an individual's control, they are ultimately responsible for their limitation. Weiner and his team discovered that stigma has various characteristics that are perceived as controllable and uncontrollable. They found that others perceived stigma based on psychical limitations as uncontrollable while mental health limitations were perceived as controllable (Weiner & Magnusson, 1988). Weiner and his team also concluded that the perception of uncontrollable limitations elicited more pity, individuals were believed to be more stable, and more accepting of help. On the other hand, those considered to be controllable caused their limitation, which provoked more anger, were seen as unstable, and less likely to seek help (Weiner et al.,

1988).

The expansion of this theory included the attribution-emotion model of stigma. This theory explains that social stigma associated with psychological disorders derives from the belief that individuals are responsible for the illness's onset (Weiner et al., 1988). Individuals who perceived negative attitudes and behaviors like neglect and anger were thought to be less likely to disclose their mental health issues, while those who perceived more pity were more likely to accept help (Weiner et al., 1988). I used this theory to explain how stigma is associated with psychological issues and why individuals may be reluctant to divulge a significant amount of information regarding their mental health issues and associated limitations. This fact was essential to examine to help support why individuals would be less likely to disclose to leadership their mental health situation and conceal their illness.

Modified Labeling Theory

The labeling theory was developed in the United States during the middle to later part of the 1960s by multiple sociologists to help explain deviant social behaviors as it applied to the study of criminology (Becker, 1963). Becker (1963) applied this theory to the entire field of social sciences and retained the credits for beginning the labeling theory movement. It was not until 1984 that Scheff used this theory in psychiatry and as a theoretical foundation for his research on mental illnesses. The theory was used to better understand the relationship between psychological disorders and social responses during this period.

The modified labeling theory was introduced by Link to explain how individuals

respond to labels, like stigma, socially (Becker, 1963). The theory supports how people develop their beliefs about issues, like stigma related to mental illness, from socialization and social conceptions (Link et al., 1989). The modified labeling model was used to explain how labels impact and individuals. Link and his team concluded that once an individual is socially labeled and subjected to consistent adverse social responses, they will conform to the expectation of being labeled 'mentally ill', resulting in the member assuming this label as their dominant identity.

The modified labeling theory was also used to explain why individuals perceive consequences associated with mental illness. Link et al. (1989) discovered that mental health patients who believed that they were being "devalued or discriminated against" were less likely to interact socially and felt more threatened (p. 400). While the label of 'mentally ill' is not the cause of a psychological limitation, it can incur adverse impacts, possibly exacerbating one's mental health. Theoretically, three critical, predicted reactions impact an individual's coping mechanisms during social interactions:

- They deflect adverse reactions by educating others on the issue
- They withdraw from social interactions
- They avoid discrimination by concealing their mental health disorder

These types of responses from an individual's belief that issues are either socially acceptable or not socially acceptable (Link et al., 1989). Understanding the root cause of why individuals internalize their mental health issues was imperative to explore to gain a deeper understanding of how service members with psychological issues fail to disclose and how leadership's interaction with the individual may influence their willingness to

disclose.

Both theories were integrated to support how service members with mental health issues may react in social settings, like the work environment. Both theories were used as the foundation of this study's data collection process. The questions I created for the interview guide included asking participants about their behaviors when working with junior members known to seek mental health services. It was significant to explore the member's behavior while disclosing their issues to leadership. Additionally, questions regarding leadership's behaviors when a sailor disclosed their mental health status were included to examine whether this was impactful on the individual. It was imperative to explore how leadership reacted to the news about the sailor's help-seeking behavior. This information was used to identify the similar experiences leadership faced when employing military members with psychosocial limitations.

Key Themes and Concepts

High-Risk Environment

Psychological warfare has been gaining a more prominent presence in operational warfare, especially in areas like Hamas and Hezbollah since late 2008 (Klausen, Morrill, & Libretti, 2016). Terrorist attacks, like September 11, 2001, bombings on the World Trade Center, have created an abrupt change in the psychology of warfare and strategy. Conventional warfare encompasses highly identified, uniformed members as enemies or allies. The increase in terrorist acts on civilian populations and growing cells worldwide creates a direct threat to every military member, in and out of uniform. Additionally, high operational tempo, being separated from family, and being deployed to war zones add

unsurmountable stress to people working in this occupation. These stressors are impacting service members negatively.

Williamson et al. (2019) supported this theme. These researchers conducted a meta-analysis study to estimate the number of service members and veterans of the United Kingdom's Air Force suffering from psychological illness between 2001 and 2014. The team used multiple databases, including the Defense Statistics, National Audit Office, and the Ministry of Defense, to obtain data on service members. It was reported that airmen who did not deploy suffered psychological problems due to training, accidents, and off-duty activities. The authors also concluded that individuals who deployed to operational areas, for example, a war zone, reported the highest number of general mental health issues (35%), veteran reservists reported a larger amount of PTSD (9%), and those who had deployed also reported the more alcohol abuse (14%) (p. 64). Keller et al. (2020) conducted a phenomenological study on 14 OIF and OEF service members returning from war to evaluate how their mental health changed post-deployment. They determined that veterans, post-deployment to combat areas, reported changes in their mood and thoughts to include reacting negatively and untrusting towards others. The team reported that 57% of participants experienced a mental health issue, 92% had negative experiences on deployment, 85% experienced disillusionment, and 50% dealt with death (p. 1862).

Suicide is another psychological factor associated with military members returning from deployment. Pruitt et al. (2019) performed a longitudinal study on the suicide rates among military members. They utilized the Department of Defense Suicide

Event Report to examine rates from 2012-2015. The team revealed that 57% of the individuals who took their lives had gone on at least deployment (p. 435). Similarly, Martin et al. (2016) conducted a quantitative study examining the relationship between deployment and predictors of suicide among Army National Guard members. The group found that individuals returning from deployment felt a sense of isolation and depression post-deployment, which increased the risk of suicide (p. 6). They also reported members experienced a lack of social support combined with the absence of military support after returning home, resulting in increased suicidal risk factors.

Current research supports that service members, both active and reservists, are still being impacted by military life, including the high-risk environments during deployments. Those who have experienced combat deployments are reporting more psychological issues. Negative experiences, death, isolation, depression, suicide, and lack of support are all factors affecting military members' mental health.

Impacts on the Individual

Barriers to Care

There is a wealth of research on the various barriers to care military members reported perceiving. One barrier reported was the access to specific providers. Kim et al. (2016) examined the impact of mental health providers and nonproviders on military members' willingness to seek mental health services. The aim of this quantitative study was to see if there was a difference in perceived barriers to treatment between the different types of help available. The authors identified three key barriers to seeking treatment: stigma, negative attitudes towards help, and organizational barriers. They also

concluded that individuals who reported using only nonproviders, like coworkers and chaplains, perceived more stigma than those who sought help from medical professionals. The report supports that service members are concerned about where they obtain treatment and have concerns with the stigma attached to seeking help. Types of providers are not the only barrier experienced by this population.

Tanielian et al. (2016) authored an article on U.S. Army members' barriers when seeking treatment for mental health issues. The aim of this quantitative study was to understand better the experiences Army members had when seeking treatment for PTSD and depression to develop recommendations to increase help-seeking behaviors among this population. The authors concluded that the barriers these service members faced fell into two main categories: structural barriers and institutional attitudes. Structural barriers encompassed long referral time and availability of appointments. Service members reported concerns about provider availability and clinic hours and providers reporting difficulties getting in touch with the service member. Institutional barriers included fear of career impacts due to organizational attitudes and culture. Participants worried about being seen as weak if they sought treatment. Additionally, members admitted to fear leadership's perception and worried about being allowed time to schedule and attend appointments.

A similar mixed-methods study was conducted regarding barriers to care related to the stigma associated with mental health in the armed forces. The team of researchers identified five key themes: failure to disclose, personal belief of mental illness, the anticipation of stigma, concerns about their career, and factors that influence stigma

(Coleman et al., 2017). Non-disclosure was linked to public stigma and the belief that one was supposed to solve problems by themselves. Personal beliefs were associated with thinking they had something wrong with them or were ‘crazy’. Perceived stigma was linked to the fear of losing the respect of fellow service members combined with a fear of guilt or shame from being judged by others. Career concerns dealt with an individual’s fear of having their condition impact their advancement and a reduction in confidence from leadership. Stigma-related factors included finding facilitators to increase help-seeking behaviors of affected individuals, including creating support networks for individuals actively seeking help.

The common theme reported as barriers to care is internal and external to the individual. Internal barriers include the perception of stigma and anticipated career concerns. External barriers involve provider availability and military culture. These barriers explain military members’ difficulties when actively seeking treatment for psychological issues.

Willingness to Seek Treatment

The willingness to seek treatment is the likelihood that individuals would seek mental health treatment if they began to experience a psychological disorder (Bathje & Pryor, 2011). This factor is important to discuss to understand what is impacting members’ help-seeking behavior. Hom et al. (2017) examined the social phenomenon associated with the underutilization of mental health services among military members. The authors created the quantitative study to identify barriers and facilitators service members faced when seeking help for mental health issues. The authors concluded that

barriers to care included career impacts, stigma, structural barriers, and provider-related concerns. Out of the 111 peer-reviewed studies examined, only 29.3% of service members experiencing mental health symptoms reported using treatment services. These barriers have been empirically proven to directly contribute to the lack of willingness to seek treatment and the underutilization of mental health service among the military population.

A similar study was conducted on barriers to seeking care for a psychological disorder within the military by synthesizing 20 quantitative articles related to the phenomenon. Sharp et al. (2014) concluded that around 60% of service members with mental health issues fail to seek help (p. 150). The main factors contributing reducing help-seeking behaviors were fears about stigma and fear of leadership treating the member differently.

Nearchou et al. (2018) conducted a quantitative study examining the impacts stigma related to mental health had on the help-seeking behaviors of 722 secondary students in Ireland. The researchers explored how the perceptions of self-stigma and public stigma were predictors of a youth's willingness to seek help. The team of researchers found public stigma was a statistically significant predictor of the student's willingness to seek help ((4,717) = 13.4, $p < .001$) (p. 87). Public stigma was a stronger predictor than the student's self-stigma.

Bath and Pryor (2011) conducted a quantitative study examining how stigma impacted an individual's help-seeking attitude as it applies to mental health. The team performed a survey on 211 college students exploring how public and self-stigma

impacted their willingness to seek treatment (p. 164). The researchers concluded that attitudes favoring help-seeking behavior mediated the perception of self-stigma and willingness to seek help. Thus, students who received affective responses, like sympathy, for accepting help were more likely to seek treatment for their issue.

Another study examining the perception of unit climate and an individual's willingness to seek help was performed using active-duty personnel. The quantitative study assessed members over a three-month time frame. The researchers concluded that the more an individual perceived a positive climate and support, the less stigma was felt, and the more the member was willing to seek help (Britt et al., 2020). The military has a solid organizational culture that is rich in heritage. This culture has direct impacts on the people working and living within it.

The common theme among these studies is that an individual's willingness to seek mental health services can be dependent upon other's affective responses and perceptions of stigma. Individuals are being impacted by the perceptions of others and the stigma associated with mental health. These impressions are preventing individuals from seeking help.

Fear of Career Impacts

Another theme related to stigma's impact on service members was the fear of adverse career impacts. Anxiety over disclosure, hostile individual attitudes towards mental illness, anticipated stigma, and being discharged from service are all factors known to contribute to the fear of career concerns (Coleman et al., 2017). In addition, individuals also reported concern with possible impacts, including a lack of trust from

leadership. Participants reported being worried about their career progression and a possible discharge from the military. The members believed there would be an absence of confidentiality after disclosing their status, resulting in a change of duty if they did not conceal their need for help.

Bein et al. (2019) conducted a quantitative study on 601 Army National Guard soldiers returning from deployment in Iraq (p. 228). The researchers focused on service member's perception of self and public stigma and their responses to seeking help. The participants of the study were soldiers returning from OIF. The members reported feeling more stigma internally and externally from other military members than they did from other civilians. The service members described being concerned about how their subordinates, peers, and leaders would judge them if they knew their psychological issues. Members feared being perceived as dangerous and inept if they sought treatment. These factors prevented individuals who needed help from disclosing the fact to other military members and felt more secure disclosing to their family due to the worry these types of career impacts.

Tanielian et al. (2016) conducted a qualitative study across 18 Army clinics investigating the barriers to care military members face. The group focused on the military culture as one of the healthcare barrier service members faced when seeking treatment for their mental health. It was reported that 39% of patients were concerned about negative career impacts if they attended appointments (p. 725). Members were worried about the possibility of not advancing and being released from the military.

Fear of adverse career impacts is a theme identified in the literature above. Individuals with psychological limitations do not wish to be seen differently by their command, fear promotion setbacks, and possible discharge from the service. These factors can prevent service members from disclosing that they need help.

Types of Stigma

The label 'mentally ill' carries with it a profound stigma. An individual can be stigmatized not only by being clinically diagnosed with a psychological disorder but also through the act of receiving help (Ben-Porath, 2002). People who are stigmatized can also perceive discrimination and be subjected to stereotypes. It is vital to explore the various types of stigma to better understand how each impacts individuals.

Organizational Stigma

Devers et al. (2009) developed a theory of organizational stigma in which they defined the constructs of this type of stigma to include how this stigma develops. The theory of organizational stigma begins with the connections and bonds that develop. When the individual's values correlate with the company's perceived values, they identify with the company. Conversely, when members fail to align their ideals with those of the organization, they may feel disidentified. The study's authors believed that disidentification does not lead to stigmatization, instead, they lead to antisocial behaviors. Devers and her team defined *organizational stigma* as a collective group perception that devalued specific individuals and disgrace the establishment (p. 165).

Ganz et al. (2021) performed a qualitative study on military culture's impact on stigma related to mental health. The group used the Ganz Scale of Identification with

Military Culture (GIMC) to assess the relationship between cultural beliefs and behaviors. The team reported that members who have deployed to a combat zone aligned their beliefs to the military culture to include feelings of increased loyalty and commitment (p. 10). It was believed that seeking treatment for psychological limitations was contrary to these values. The researchers also concluded that those individuals who did not seek treatment were more likely to abuse alcohol to cope with their symptoms. It was theorized that the high level of commitment and loyalty could contribute to substance abuse as drinking is socially acceptable in the U.S. military.

It is vital to explore the organizational relationship within the military to understand the working relationships better. Research has indicated that there are close relationships within this type of establishment and that they can impact a service member. Organizational beliefs and norms are just a few factors influencing service members.

Public Stigma

Public stigma, also known as external stigma, occurs when an individual is publicly or socially labeled or marked as ‘mentally ill’ (Corrigan, 2004). This societal response can lead to labels that often elicit discrimination and prejudice from members in the community that does not have a working knowledge or understanding of psychological limitations. This type of stigma involves stereotyping and discrimination (Corrigan, 2004). Public stigma can negatively impact an individual to include affecting their help-seeking behavior.

A quantitative study performed by Caldwell and Lauderdale (2018) investigated public stigma’s impact on 262 U.S. veterans. The authors reported that male veterans

with combat-related psychological limitations, like PTSD, are prone to perceiving public stigma. These former service members were believed to be dangerous and invoked fear from others. This stereotypical behavior affected members experiencing segregation and less ascribed because their injuries were incurred during combat. Ultimately this population experienced more negative reactions and less sympathy due to the stigma placed upon them.

Self-Stigma

Self-stigma, also known as internal stigma, is the belief an individual sees themself as flawed, resulting in lowered self-esteem and low self-efficacy (Coleman et al., 2017). Self-stigma can result in an individual feeling shame, fear, and social isolation. The cognitive consequences of this type of stigma are that the person feels like there is something wrong with them or is crazy while the behavioral consequences are that the member fails to get help (Coleman et al., 2017). Reasons for these responses stem from the individual's own negative opinions regarding mental health (p. 1887).

Self-stigma can adversely impact an individual's behavior. Andresen and Blais (2019) performed a study on female veterans who experienced military sexual trauma (MST) (p. 372). The pair examined the relationship between self-stigma and disclosing their trauma. 17.7% of members who did not disclose their issue reported feeling more self-stigma than those who disclosed (p. 375). Survivors reported anticipated stigma from their units and their partners if they disclosed their trauma.

Another behavioral response to self-stigma is not completing treatment. Britt et al. (2015) explored various types of stigma's impact on help-seeking behaviors among

military personnel. The longitudinal study involved 1,652 soldiers on active duty in completing a survey regarding their perceptions of seeking treatment for mental health issues (p. 146). The researchers concluded that self-stigma was the only statistically significant factor related to members dropping out of treatment. It was theorized that the individual perception of others who seek treatment could deter them from seeking treatment. These adversative views associated with mental health and treatment-seeking behaviors are proven to impact an individual's successful treatment completion.

Work Environment

The military environment is unlike many of the current occupations in the United States. In addition to being required to conduct their daily obligations at work, military members are held to a higher moral expectation on and off duty. Cutler (2002) refined the Navy's core values of which every member is required to uphold: values of "honor, courage, and commitment" (p. 9). If any member fails to uphold these values, they are subject to punishment per the Uniform Code of Military Justice (UCMJ) and can ultimately be separated from the service. To help clarify military members' ultimate responsibilities, Dempsey (n. d.) established the "Profession of Arms," a doctrine which states that volunteering to serve in the United States military includes that all members place the needs of the country above themselves (p. 4). In addition to the stress associated with this new moral obligation, a military member's working environment can easily add to the already mounting pressure. Heuristically, military members are expected to encompass the same ethics, standards, and follow regulations established by their branch of service. These requirements can impact members in the workplace and lead to cultural

norms that may result in the perceived discrimination of members who do not fit the model.

Cutler (2002) explained the type of stressful environment military members encounter, while Britt et al. (2020) focused on the impacts of a positive work environment of services members. The researchers discussed how military personnel work in a high-risk environment in which close bonds develop with their peers. This working relationship can strongly influence individuals' attitudes towards mental health. The team conducted a longitudinal study assessing service members over three months. Climate support for mental health (CSMH) is a factor proven to lower the perceived stigma of individuals who seek treatment for mental health issues (Britt et al., 2020). In this study, Britt and his team established that a positive work environment, supportive of individuals seeking treatment, results in individuals perceiving less of an operational barrier and a more positive attitude towards treatment-seeking behaviors. These results support the theory that a work environment that fosters positive beliefs associated with mental health, the fewer barriers a member faces when requesting help.

Jones et al. (2018) reached similar results when assessing the perception of strong leadership and team cohesion had on perceived stigma. The researchers conducted a longitudinal study on United Kingdom (U.K.) service members. The data were gathered post-deployment and four months after deployment. The researchers conducted team cohesion was significantly associated with willingness to seek health care for psychological issues, which supports the results from Britt et al. (2020). It was also

reported that solid leadership also helped to reduce the perceptions of stigma and barriers to care for affected personnel.

Similarly, Yamawaki et al. (2016) performed a study on military members examining the effects of the stigma associated with mental health services on the work environment. The authors wanted to examine what aspects of the work environment impacted an individual's willingness to seek help. The population explored was the Army, Navy, Marine Corps, and Air Force, increasing their results' generalization. The team conducting this exploratory study concluded that hostility in the workplace, lower satisfaction from leadership and coworkers, and the impacts on an individual's organizational roles were all issues resulting from the perception of organizational stigma and a lack of help-seeking behavior. The team also reported that social support, team cohesion, positive moral, and strong leaders in the work environment facilitated help-seeking behaviors (p. 4).

In the military, individuals are expected to perform to a high ethical standard and place their country before themselves. Within this organization, sailors often spend a significant amount of time with their colleges, for example, being on a long deployment. These living conditions make it important for these members to feel accepted and supported. An individual's working environment can defiantly negatively impact their mental health and willingness to seek help.

Summary and Conclusion

The information presented in this chapter included an explanation of the attribution-emotion model and the modified labeling theory, which was the framework I

used to explain the focus of this study and to develop the interview questions used in this research. Also included was a review of literature related to critical concepts involving stigma's impacts on military members and the barriers they face when seeking psychological treatment. This information clarifies what is known in the scientific community. High-risk work environments can exacerbate psychological disorders, while stigma, barriers to care, unwillingness to seek treatment, fear of career impacts, and the work environment can adversely impact a member suffering a mental illness. The research community does not know the experiences leaders encounter when employing these individuals and the barriers they face in the work environment. This study aided in understanding the gap in current research and included the experiences leadership encountered when employing service members with known psychological limitations. Chapter 3 discusses research design and rationale, the role of the researcher, methodology, and issues of trustworthiness.

Chapter 3: Research Method

The purpose of this phenomenological study was to explore the lived experiences of senior enlisted leaders employing individuals known to seek treatment for a mental health issue. I aimed to gain a better understanding of these experiences to change the culture of the perceived stigma in the workplace. This chapter includes a discussion related to the phenomenon of interest, a description of the study's approach, the role of the researcher, methodology, and issues of trustworthiness.

Research Design and Rationale

The phenomenological approach complemented existing research that discussed the impact stigma has on service members with mental health issues (see Patton, 2015). Current studies have already identified that stigma can inhibit help seeking behaviors when associated with mental illness. While there are adequate quantitative data to support this claim statistically, there is a lack of understanding about the lived experiences of those individuals who employ members regarding this phenomenon. The phenomenological approach helped me gather these experiences and provided richer data to help understand the perspectives of individuals impacted in addition to understanding the culture in which they perceive this stigma (see Patton, 2015). Allowing leaders the opportunity to relive their experiences through storytelling has provided a more in-depth insight into the working relationship as well as the barriers and facilitators individuals within the military encountered when actively seeking treatment for a mental health issue. The research questions answered were "What are the lived experiences of senior enlisted leaders who have employed military members who have disclosed seeking

treatment for a mental health issue?" and "What are the barriers and facilitators senior enlisted leaders encounter when trying to effectively employ military members who have disclosed seeking treatment for a mental health issue?"

Description of Approach

The approach selected for this qualitative study was the phenomenological approach. Phenomenology was used to gain a richer understanding of the meaning of the individuals' experiences (Patton, 2015). Researchers use this method to explore how people "transform experiences" into awareness on an individual basis and through shared meanings (p. 115). This method involved understanding how people perceived, judged, felt, remembered, and made sense of life experiences (p. 115). The phenomenological approach was used to define, explain, and understand the sensory experiences of the phenomenon to develop common concepts and themes associated with the barriers and facilitators senior leadership faced. Everyday experiences are better understood and have the potential to change social practices using this reflective approach (Phenomenology, 2008). The personal descriptions of experiences were gathered to describe the phenomenon of interest without "causal explanations or generalized interpretations" of the researcher (p. 7). This type of approach also aided in developing more reliable results.

Role of the Researcher

The roles of a researcher included keeping current on scholarly literature, maintaining awareness of critical issues, understanding the parameters of qualitative research, proposing a feasible research project, ensuring research was conducted appropriately and ethically, and ensuring the research was meaningful and pertinent to

supporting social change (Researcher Roles, 2008). As an active-duty military member, it was imperative that I conducted this study ethically and without bias. To mitigate the risk of bias, the interview questions were thoughtfully created, the interview process was carefully carried out, and data analysis were empirically performed. Limiting bias began with the development of the interview questions. Ensuring the questions were not leading and were open-ended helped to deter response bias (Researcher Roles, 2008). Being mindful of body language also helped mitigate bias. Avoiding nods of agreeance when the participant spoke of negative aspects of stigma, boosting their self-esteem, or trying to comfort someone when becoming emotional when sharing a strong personal experience were all forms of nonverbal behavior that may have influenced the participant's responses (see Researcher Roles, 2008). These actions could have blurred the lines of the research and blend more into the role of a counselor unintentionally. These nonverbal cues were limited during the interview process. Another way to ensure the interviews were conducted without bias and maintain transparency with participants was to disclose my professional background in the military. Military protocol was not followed making the interviews more personal and not military related.

Methodology

Population

Participants for this study were solicited from the Navy chief owned and operated Facebook page with approval from the site's owner. At the time the study was conducted, the site had over 4,000 members and was restricted to only active duty and veterans of the enlisted grades E-7 to E-9. Solicitation for participation included both male and

female Navy service members ages 18 years and up. The criterion included individuals of all different ages, ethnicities, years in service, and ratings. The exclusion applied to those members who are not enlisted ranked E-7 to E-9. Using a purposeful sample helped make an inference on the Navy senior enlisted leadership experiences from all over the world and from various commands and was used to generalize results applicable to the entire naval senior enlisted population.

Sampling and Sampling Procedures

The sampling method selected for this study was a nonprobability, purposive sample. This method was carried out by taking samples from an information-rich population who had a high probability of sharing some experience dealing with the phenomenon of interest (see Patton, 2015). The sample size for this study was five participants. Baker et al. (2012) suggested this sample size was well suited for graduate students as it can contain enough participants to be useful for a study but not too large that it bogs a student down with enormous amounts of data to process. A sample pool of five senior enlisted leadership members was adequate to meet the *saturation point*, the point at which no new information is being collected (Rubin & Rubin, 2012). In-depth interviews were ideal when gathering life experiences through the stories participants share (Patton, 2015). This data collection method aligned with the phenomenological research design of this study.

Procedures for Recruitment, Participation, and Data Collection

Recruiting Procedures

Solicitation for participants was accomplished through an invitation posted on the Navy chief owned and operated Facebook page. An email link to my personal account was included in this invitation and interested members responded using their personal email account to accept the invitation. The invitation included a brief personal introduction, the study's background, purpose, informed consent form, and what to expect from their participation to include the interview guide. Only those who have had experience with the phenomenon of interest and completed the informed consent form were selected to participate.

Data Collection

Members meeting the inclusion criteria participated in a one-on-one, in-depth interview. Due to the restrictions of COVID-19, the interviews were conducted virtually via the Microsoft Teams application. This application has been approved to conduct work-related meetings, used military-safe emails, and has been directed for use among military communication as per guidance given by Force Readiness Analytics Group Commander, Naval Air Forces provided April 2, 2020 (Kohler, 2020). Once the individual provided the personal email, it was verified they have the military Microsoft Teams access, and a meeting was scheduled and created in the Microsoft Teams application. The interviews were conducted virtually on the date set between interviewer and participant. An interview guide was used during the interviews to promote smooth transitions between questions and probes. The duration of the interview was scheduled

for approximately 60 minutes. Each interview was recorded using a personal laptop via the Microsoft Teams application recording device. Every participant was briefed on the topic of the interview, and it was reiterated that their participation was voluntary, and the interview could be ended at any time. Each participant was asked for permission to record the interview. After the interview concluded, the participants were debriefed on what to expect next. They were informed that the recordings from the interview were to be transcribed and used as part of a dissertation at Walden University. They were also sent a copy of the transcript for validation purposes. It was stressed that the information collected will be protected and their privacy maintained as the data does not include personally identifying information and was not shared with anyone outside of the university.

Instrumentation and Operationalization of Constructs

Interview Guide

The interview guide I developed for this study contained a list of predetermined questions and probes to ask participants during the interview. Using this guide during the interview helped to standardize each session. The guide was used as a checklist to ensure that all pertinent topics and subjects were addressed (see Patton, 2015). The interview guide developed for this study contained open-ended questions to obtain relevant information applicable to this study. The research questions were created to solicit data regarding areas including the perceptions of organizational stigma, employment concerns, impacts on group cohesion, barriers, and facilitators to employing individuals.

Data Analysis Plan

The qualitative data analysis approach was utilized to code and theme the one-on-one, virtual interviews, which aligned with the chosen thematic method of analysis. The use of personal interviews is a highly structured way of capturing and managing essential research data (Meyer & Avery, 2009). The thematic approach was selected because it involved focusing on the collection, description, and interpretation of an individual's perspective. Using a thematic analysis aligned with the phenomenological approach because it allowed me the ability to provide more in-depth insight into the phenomenon studied instead of focusing on the development of theories.

The framework approach allowed multiple aspects of the phenomenon studied to be captured. This method consisted of three main phases: data management, describing accounts, and explaining accounts (Smith & Firth, 2011). During the first phase, the development of codes, concepts, and themes immerged. The process of coding involved the creation of ideas and perceptions from "raw data" (Sage Publication, 2008, para. 1). It was a systematic approach to arrange "code, concepts, and themes" found in data (para. 1). Coding was performed by identifying interesting "events, features, phrases, and behaviors" and setting them apart with labels (para. 3). This process was important because it led to the identification of special incidences, meanings, activities, or phenomena that were similar to another individual's account (para. 3). The framework approach utilized "in-vivo codes," which use key phrases from the participant's own words (Smith & Firth, 2011, p. 56).

Once codes were developed, the next step was to assign them to concepts or "relationships or patterns," communicating any conclusions (Sage Publication, 2008, para. 3). After codes and concepts were created, the sorting process began. This step included collecting labels that were the same across interviews and compiling them into one file. The next step was to generate themes. Themes were created by identifying and grouping related concepts that helped answer the research questions (para. 3). This process included identifying themes that were placed into larger groups, themes that caused or were consequences of another, or themes that opposed each other. Once this information was consolidated, a review of the information summarized the results.

The next phase in data analysis was to develop descriptive accounts. This process involved a summary and synthesis of the codes by "refining the categories and initial themes" (Smith & Firth, 2011, p. 59). Links between codes, concepts, and themes were also conducted. The last phase was to explain the "concepts and themes in terms of the participant's experience" (p. 59). The nature of the phenomena was described through the identification of these critical concepts.

Issues of Trustworthiness

In this section of the dissertation, the study's credibility, transferability, dependability, and confirmability is provided. Included is a brief description and strategy to establish each aspect of trustworthiness. In addition, the ethical measures that were taken during the conduct of this study are presented.

Credibility

Credibility is the internal validity of a study's results (Patton, 2015). Due to this being a phenomenological study based upon collecting the experiences and perceptions of participants, credibility was dependent upon the accurate transcription of the participants' interviews. It also included the accuracy with which the information was analyzed, interpreted, and presented. To increase the credibility of this study, the transcriptions of the interviews were reviewed for accurateness. Additionally, participants were required to recall information or events that occurred a long time ago, challenging the exactness of their memory, which may compromise the study. To mitigate this risk, participants were asked to clarify any comments that were confusing or unclear. Also, the questions were open-ended to allow the individual to better explain their perspective and were allowed ample time to answer each question.

Transferability

Transferability is the study's external validity (Patton, 2015). It involves the way in which the researcher generalizes the phenomenon in terms of "case-to-case transfer" (p. 685). The researcher is responsible for providing enough information about the individuals studied that the reader could establish similarities between participants and those to which the findings might transfer. To increase the study's external validity, the interview questions were carefully developed to include gathering information relevant to the study. This process involved ensuring questions were focused on lived experiences of the phenomenon of interest and not the participant's opinions or beliefs.

Dependability

Dependability can be described as a study's reliability (Patton, 2015). This process included the researcher's responsibility to ensure the entire process was "logical, traceable, and documented" (p. 685). Keeping copious notes and saving all documentation regarding the study's conception, development, implementation, and results helped increase the dependability of this study. All electronic files, notes, and documents regarding this study have been saved on a personal laptop that is password protected. All paper documentation was saved in a folder with the course number written on the cover and will be stored at a personal residence for five years. All documentation will be destroyed or deleted at the expiration of five years.

Confirmability

Confirmability can be described as the study's objectivity (Patton, 2015). Objectivity helps to reaffirm the fact that the data and its interpretation are real and not created from the researcher's imagination. During the analytic process, links between "assertions, findings, interpretations of data" were made obvious to the reader and documented in the results section of this study (p. 685). It was also essential that the individuals who participated were knowledgeable about the topic under examination (Rubin & Rubin, 2012). Content credibility was increased by observing verbal and nonverbal cues of those who participated. Conducting observations, collecting documentation, or politely asking for "firsthand experience" were several ways of requesting this information (p. 65). When dealing with members of an organization, there was a potential for members to put on a brave face when discussing controversial issues.

Creating questions that avoided “formalistic replies,” evading questions regarding organizational norms, rules, or responsibilities helped mitigate this risk (p. 65). Lastly, military jargon was kept to a minimum, and formal protocol was not the focus of the interview to enhance the credibility of the interviews.

Ethical Procedures

Specific ethical procedures were followed to protect those who participated in this study due to the sensitivity of this study. Data collection did not commence until the Institutional Review Board (IRB) reviewed and approved the application to conduct the research. The ethical procedures were strictly followed. Information and background on the topic were provided to the participants to include the interview questions ensuring they were willing to participate fully and prepared to discuss the sensitive subject matter. Additionally, while recruiting participants, none of the individuals were pressured to volunteer (see Rubin & Rubin, 2012). Before the interviews commenced, individuals were briefed on what to expect during the interview, including reiterating they may choose to end the session at any time. During the interviews, the primary focus was to “do no harm” to the volunteers (p. 89). This process included providing members with an informed consent form that was required to be signed prior to participation. After the sessions ended, each participant was debriefed on where the information from the interview will be kept, with whom it will be shared, and when it will be deleted to reaffirm their privacy would be maintained. Personal identifying information collected for this study was not shared with anyone outside of Walden University and was not included in the research results. The data was kept on a personal password-protected

laptop, to which the researcher has exclusive access. Additionally, all electronic and paper copies of consent forms, data collection, and other information relating to the identification of the participants will be destroyed or deleted after five years.

Summary and Conclusions

This phenomenological study was designed to capture the lived experiences of military leaders who employ service members actively seeking treatment for a psychological issue. The population of interest was active-duty Navy members in the enlisted grades E-7 through E-9. Purposive sampling was chosen to ensure individuals interviewed had experienced the phenomenon of interest. Virtual, one-on-one interviews were performed with the use of a carefully developed interview guide to help increase credibility, transferability, dependability, and confirmability. IRB approval (Approval Number: 02-23-21-0369310), expiring February 22, 2022, was verified before any participant solicitation or data collection began. All interviews were conducted with strict ethical procedures and the safety of the participant was paramount. The next chapter includes the study's setting, demographics, data collection, data analysis, evidence of trust worthiness, and results.

Chapter 4: Results

The purpose of this phenomenological study was to explore the lived experiences of senior enlisted leaders employing individuals known to seek treatment for a mental health issue. The information obtained from this study may be used to change the culture of the perceived stigma associated with mental health in the Navy. Those individuals who participated in this study provided their experiences and perspectives of the barriers and facilitators associated with working with military members seeking mental health services. An interview guide was used during data collection to ensure only information relevant to this study was collected. This chapter provides elements used to collect pertinent data, a description of participants, data analysis, concepts, themes identified during analysis, evidence of trustworthiness, and results.

Study Setting

Approval from the institutional review board (IRB) was obtained (Approval Number: 02-23-21-0369310), expiring February 22, 2022, before data collection occurred. Data collection began by soliciting participants on the Navy Chief Petty Officer (CPO) Facebook page. This website was used to post the interview invitation, consent form, and interview questions to ensure only those who qualified for this study were included. Participant names were withheld from this study and were referred to as Participants 1, 2, 3, 4, and 5.

Individuals who were interested in participating in the study sent me a message via personal email to schedule a time and date to conduct the virtual interviews on Microsoft Teams. All participants who qualified for the interview were sent an electronic

invitation, a consent form, and the interview questions. The consent forms were signed by each of the participants and sent back to me through Microsoft Teams, which were verified for signature before the commencement of the interview.

Demographics

Five participants were selected for this study representing both active-duty and reserve Navy sailors. All participants were E-7 – E-8 in positions of leadership. In the Navy, individuals with the rank E-7 through E-9 are senior leaders within the enlisted community (U.S. Military Rank Insignia, n.d.). The participants varied in paygrade, ratings, and command experiences. The demographic information is summarized below.

Table 1

Participant Demographics

Participant	Rank	Gender	Years in Service	Affiliation	Geographical Location
Participant 1	E-8	Male	19	Active-Duty	Okinawa, JP
Participant 2	E-8	Female	16	Selective Reservists	San Diego, CA
Participant 3	E-8	Male	22	Selective Reservists	San Diego, CA
Participant 4	E-8	Male	23	Active-Duty	Norfolk, VA
Participant 5	E-7	Male	20	Active-Duty	Whidbey Island, WA

Data Collection

Participants in this study included five active-duty and reserve Navy enlisted leaders. Each participant was met virtually via the Microsoft Teams to record the one-on-one interview in a private setting. Before the interview began, the consent form was

signed by each individual and forwarded back to me via Microsoft Teams and saved on a personal, password-protected laptop. Each interview was conducted using an interview guide comprised of 15 questions. Every participant was debriefed at the end of the interview. The length of the interviews varied from 25 minutes to 1 hour and 2 minutes. The recordings were transcribed, coded, and themed. Personnel identifying information was removed from the transcriptions and was not included in this study. Data collection was conducted as outlined in Chapter 3, noting no variations or unusual circumstances factoring into the study.

Data Analysis

Codes and Coding from Sage Publications (2008) was referenced during the review of the transcripts to identify relevant information from the data. The terminology used in the participant's statements and an examination of the interview content was reviewed for key themes among the participants. This process aided in the identification of commonalities among individuals.

Concepts and Themes

The transcripts were reviewed for codes, concepts, and themes. The process began with identifying participants' own words to identify event occurrences. Each question was evaluated along with the participants' response. Phrases that pertained to the question were selected and isolated from the rest of the transcript. All five participants' phrases were documented and examined. Next, concepts were formed to capture key information. Concepts were ideas represented in a noun or noun phrase (Rubin & Rubin, 2012). Participant's jargon was used to accurately identify key concepts. Metaphors were

also examined to identify embedded concepts within the transcripts. Lastly, themes were developed. Themes were established to explain the phenomenon the participants experienced. A master list of codes and concepts was developed from all five sets of data. Themes were created by linking multiple concepts together and empirically reasoning how they all fit together.

Evidence of Trustworthiness

Credibility

Credibility depended largely upon the accuracy of which the study was conducted. Transparency was paramount and performed by ensuring the reader understood the process by which the study was conducted (Rubin & Rubin, 2012). Credibility was maintained during data analysis by accurately reviewing the transcripts ensuring all the participant's words were used and the information collected was accurate. Also, during the coding process, direct phrases from the participants were used. The use of quotations during the coding process allows the reader to identify terms used by the participant and not the researcher. Additionally, the detailed step-by-step process identified in data analysis reaffirms to the reader the information used was not fictional or was the perception of the researcher (Rubin & Rubin, 2012).

Transferability

Transferability or external validity can be defined as the extent to the findings of the study could be used in further studies or the generalization of the research (Merriam &Tisdell, 2016). For this study, transferability was maintained by carefully developing

the interview guide and strictly adhering to the questions and prompts on the guide. Any information outside the scope of this study was omitted.

Dependability

Dependability, also known as the reliability of the study, was maintained by saving all documentation, including the conception, development, implementation, and results of this study (Patton, 2015). All electronic files were maintained on my personal laptop, which is protected with a password. All documents may be retrieved at any time if the dependability of the study comes into question. The documentation obtained during this study will be destroyed or deleted at the expiration of five years.

Confirmability

Confirmability or objectivity is necessary to reiterate the data and its results were not the perceptions of the researcher (Patton, 2015). To ensure confirmability, each participant was provided the background information of the study to ensure they were knowledgeable about the purpose of the study. Observations during interviews, including firsthand knowledge of the topic, were objective ways of obtaining data. The interview guide I used avoided questions dealing with military protocol to help mitigate bias from the participant. Formal protocol, including addressing individuals using rank and rate, was avoided to allow the participants to speak freely and focus on their experience instead of military customs and traditions.

Results

RQ1: What are the lived experiences of senior enlisted leaders who have employed military members who have disclosed seeking treatment for a mental health

issue?

This qualitative research question was designed to collect the perceptions of Navy enlisted leaders to gain a better understanding of the working relationship between those who employed sailors with mental health issues and those who were directly impacted by mental health issues. Key concepts collected were a lack of understanding of how to deal with the sailor, lack of team cohesion, leaders not recognizing an issue with the sailor, a feeling that the leader's training had failed, and experiencing an intensity from their sailor. Themes developed were a lack of knowledge of how to deal with the sailor among leadership, sailors were reluctant to disclose their situation, leaders reduced sailor's workload, and relied on medical professionals for assistance. Additionally, leaders felt overwhelmed as well as supportive and empathetic to affected sailors. Senior leadership also reported the sailors seemed grateful after disclosure as well as untrusting and isolated. Members of Navy leadership who have employed sailors with physiological limitations wished their peers had a better understanding of how to deal with this population, had more awareness, trust, and guidance on how to handle this issue. Lastly, leaders advised their peers to be patient, open-minded, and supportive of the sailor while relying on the training they did receive.

RQ2: What are the barriers and facilitators senior enlisted leaders encounter when trying to effectively employ military members who have disclosed seeking treatment for a mental health issue?

This qualitative research question was included to identify factors that enhanced the working relationship between leader and subordinate and what factors inhibited the

working relationship. The interview questions and participant responses were analyzed to include identifying concepts and themes. Key concepts to barriers identified were lack of cohesion, sailor needing validation, engagement, motivation, and the sailor's denial of the severity of the situation. Key concepts for facilitators identified were reducing a sailor's workload, assigning the sailor a less demanding position, leadership relying of medical professionals for assistance, using strong leadership, relying on their knowledge and experience with these types of situations. The themes developed towards barriers were leaders struggled with ensuring cohesion, the sailor exhibiting a lack of confidence, the leader having to foster the sailor's engagement, motivation, and observing the sailor break rules as an act of denial. Themes identified for facilitators were that leaders were able to reduce the workload of the sailor and were able to get medical assistance for the individual helping them navigate the situation.

Table 2

Coding Matrix

Interview Questions	Participant No.	In-Vivo Codes	Concepts	Themes	Results
1) Tell me about the first time you knowingly employed a service member(s) known to seek mental health treatment	*1*	"blinded..."; "directly from the Sailor…"; "I had no idea how to deal with the Sailor."; "We were looking for a warm body, but we don't understand what's going on with the sailor."	understanding	lack of knowledge	Leadership experiences a lack of leadership's understanding about the sailor's situation, how to deal with the situation, sharing their own experiences to get the sailor to open up, noticing a change in performance.
	2	"the member have some kind of hesitations in a lot of areas when it came to just leadership roles but also integrating and being more a part, I don't want to say that they weren't a part of the team but actually feeling included to be able to be inserted into a team environment. And then as I would work with this member, this member then divulge they did have some assistance within their mental capacity that was helping them being	hesitation	change in performance	

		able to work with this environment, that they were in from a profession and personal environment."			
	3	"sailor didn't realizing they were having a hard time"; "it was me sharing with them, my personal bouts"; "they took my advice to seek help"	sharing	leader sharing own experience	
	4	"taboo to seek mental health…", "hasn't been alarming…", "wasn't a culture shock…","being trained or knowing how to handle those…was a little bit alarming…didn't feel like I was as prepared…"	handling	lack of knowledge	
	5	sailor became "more intense"; "his mom called …said he was trying to kill himself"	performance	change in performance	
2) How did the individual(s) seeking help disclose their help seeking behavior?	*1*	"directly from the sailor…"	sailor	self-disclosure	Individuals will self-report, families can contact leadership and leaders can identify a problem.
	2	"the member did open up…";"I feel I need to bring this up to you so that you have situational awareness as this might impact my duties and responsibilities."	sailor	self-disclosure	
	3	"extreme drop in personality"; "fairly interactive person…went dark"; "that started the conversation"	leadership	leadership identified problem	
	4	"sailor told me…"	sailor	self-disclosure	
	5	"wasn't seeking treatment until it was too late"; "we knew because we made him go"	family	family notified leadership of problem	
3) What was that experience like for you?	*1*	"no idea how to deal with that situation with the sailor…"	understanding	lack of understanding	Leaders can experience a lack of understanding, being thankful, being scared, excited, and feeling guilty,.
	2	"A blessing…"	blessing	thankful	
	3	"exiting"; "how do we solve this puzzle"; "when the weigh to it hit it was a little harder"; "scary to be honest"	emotional	scared and excited	
	4	"guilt…", "feel so horrible pushing the sailor…", "am I really equipped and prepared to handle a situation…"	guilty	guilt	
	5	"rough", "I didn't know what to do"; "didn't know if he was going to get in trouble"; "I was troubled"	troubled	lack of understanding	

4) Describe the behaviors of the individual while they were disclosing their help seeking behaviors.	*1*	"Very frustrated."; "Shaking…";"You could see the anxiety in his face." "He was very slow to speak…"; "fidgety, moving back and forth…";"gathered himself. Deep breaths, and covering his face, even burying his face in his hands."; "He was uncomfortable…"; "he definitely had to dig deep."; "Torn."	anxious	reluctant to disclose	Sailors were observed to be reluctant to disclose, shut down, become isolated, and denial.
	2	"person was worried that it would impact them to be able to continue to support the military and their profession."; "reserved…"; "could not make eye contact"; "emotionally draining"; "body was not closed off"	emotional	reluctant to disclose	
	3	"took some coaching"; leverage a strong relationship"; "sailor stop communicating"	reluctant	shut down	
	4	"very emotional…", "felt like they weren't part of the team…"	emotional	isolated	
	5	"denial", "was standing on the corner of the roof"; "thought [mom] was over reaching"	denial	denial	
5) What challenges did you encounter when trying to effectively employ the individual(s)?	*1*	"cohesion"; "getting everybody to understand"; "explaining to other sailors why you're doing what you're doing without violating these medical protocols"	cohesion	ensuring cohesion	Sailors experience lack of cohesion, confidence, lack of motivation and denial.
	2	"the individual was very insecure of their decisions…"; "they need a lot of validation"; "they could become too assertive"; "couldn't find a balance"	validation	lack of confidence	
	3	"keep them engaged"; "augmented by other people (collateral duty)";"Military One Source"	engagement	foster engagement	
	4	"how do I motivate a sailor…", "have them feel supported and not ostracized…", "how do I continue to make them feel like they are part of the team…."	motivation	motivation and making them feel a part of the team	
	5	"denial"; "he went to his hometown and refused to come back"; "Us…looking after him too much"	denial	denial, breaking rules	
6) What were some of the facilitators that aided in effectively employing the individual(s)?	*1*	"move his work center and put him in a less demanding work center"; "removing him for the watch bill"; "active communication"	responsibilities	reduce responsibilities, assign less demanding position.	Reducing work responsibilities, using medical and strong leaders are all facilitators.
	2	"medical professionals"; "trying to help the person load balance"	professionals	medical professionals	
	3	"strong leadership";	leadership	strong leadership	

	4	"experiences….", "education…", management and leadership courses…", "learning a different way to handle employees…"	knowledge	experience, education and training.	
	5	"can't think of any"; "training the Navy gave me went out the window"	nothing	nothing	
7) What kind of tools did you have available to you or that you employed while working with individual to get them to perform to the most capability?	*1*	"PHOP" [Psychological Health Outreach Program]; "getting advice and understanding"; "getting educated"	professionals	medical professionals	Medical professionals, support structures, and education are tools leadership had to deal with sailors.
	2	"administrative"; "writing a list…how to prioritize"; "load balance personal and professional life"	balance	finding balance	
	3	"support structure"; "peers"	support	support structures	
	4	"education.."	education	education	
	5	"medical…chaplain"	professionals	professionals	
8) Describe the behaviors that you exhibited while actively employing the individual.	*1*	"walking the floor, speaking to him, and then talking in private"; let the individual "unload and vent"; "nerve wracking"	support	supporting sailor	Leaders support sailors, can feel overwhelmed and empathetic dealing with sailor.
	2	"overwhelmed"; "I take on someone else's, their load or burden'"; "felt worthy; "we don't get taught how to deal with these situations"	overwhelmed	overwhelmed	
	3	"saw a lot of myself in him"; awarding every opportunity to recover"	support	letting sailor time to recover	
	4	"empathy…", "relate.."	empathy	empathy	
	5	"more cognitive what he was saying"; "paying more attention"; "tip-toeing around"; "changed day-to-day business"	attention	paying more attention to sailor	
9) How did these behaviors, that you exhibited impact the working relationship between you and the individual?	*1*	"talking to him in private"	communication	one-on-one communication	The working relationship can grow by bonding and communication, but can also create agitation for the leader.
	2	"helped this working relationship between the individual grow."; "tighter bond grew"	bonding	bond grew between leader and sailor	
	3	"COVID"; "telework…did not strengthen the relationship"; "communication"	communication	communication	
	4	"awkward at first…", "felt like I was walking on eggshells…", "avoid pressing…", "didn't understanding their trauma…", : unpreparedness to deal with something like that…"	avoidance	walking on egg shells	
	5	"way we would speak"; "his work ethic went down, motivation has gone down", "I felt angry"; "agitation"; " irritation"	anger	work ethic and motivation declined	
10) Describe	*1*	grateful; "positive"	grateful	grateful	Individuals can

the behaviors the individual displayed when you found out they had a mental health issue.	2	"willing to support"; "willing to take on taskings and always willing to be a part of the team"	team player	cohesion	display positive behaviors, being grateful and team player; as well as negative behaviors, isolation and untrusting.
	3	"fairly successful"; "good"; "open"	good	positive	
	4	"very emotional…", "felt like they weren't part of the team…"	isolated	feeling not a part of the team	
	5	"lack of trust"; "lost touch [as friends];	lack of trust	lack of trust	
11) Where there any behaviors that you did not anticipate from the individual?	1	"gratitude"; "appreciation"	grateful	grateful	Leaders were not expecting sailors to feel grateful and be successful.
	2	"no"; "just moments of insecurities"	no	NA	
	3	"complete recovery and success"	success	success	
	4	"brought more clarity to how they were reacting or responding.."	clarity	clarity	
	5	"no"	no	NA	
12) What is your greatest concern about employing individuals who seeking mental health treatment?	1	"lack of knowledge from leadership.", "leadership in not being informed…", "managing sailors rather than leading…", "unit cohesion…", "perceived favoritism...", "lack of knowledge from leaders to employ a sailor…", "only triad know the problem…", "disconnect of expectations..."	knowledge	lack of knowledge	Lack of knowledge/training, sailor discrimination and self-disclosure are all concerns of leadership.
	2	"that those around that person that is seeking the help don't understand what's going on with that individual."; "there is a worry about being judged"; "the person doesn't voice that they are actually needing help"; "society does not allow that actually person to overcome their issues"	judgement	discrimination	
	3	"feedback from either the professionals or from them showing some type of improvement"; "not trained (as leaders) to identify improvement)."; "fear - not knowing if the member is truly ok. "it is difficult to employ somebody that is not getting help"	training	leaders not being trained	
	4	"how do I handle that…how does the Navy provide…of training…", "I don't have any formalized training…", "don't teach chief petty officers how to lead sailors with mental health issues…", "taboo to seek mental health…"	training	no formalized training for leaders	
	5	"[sailors] willingness to come out and actually admit they have a mental health issue"; "definitely hard to get appointments"	disclosure	willingness to discloses	

13) Based on your experiences, what do you see as the biggest obstacle with the working relationship with people that are seeking mental health treatment?	1	"stigma of receiving help", "sailors may not go into detail.", "leaders may not understand…what's going on", "sailor not wanting to regurgitate the information", "no way to be more intrusive…with mental health issues…"	stigma	stigma, leadership understanding	Obstacles include stigma and leading.
	2	"I think that those people because they worry that they will always be judged based off of their situations, they will not open up enough in order to be a part of the team unless there is somebody there that they can confine in to help mold them";" the person would have withholdings to be open"; "those around the individual...won't be able to recognize...triggers"; "understanding the different environments that mental health can be wrongly triggered, even rightly triggered"	stigma	being judged	
	3	"stigma"; "not focusing on mental health"	stigma	stigma	
	4	"balance between letting my superiors know…"	balance	notifying superiors	
	5	"maybe as leaders we throttle back on the duties we allow them to do or ask them to do"	responsibilities	leadership	
14) What do you wish your colleagues knew about this type of working relationship between working with or employing members with mental health issues?	1	"have all…resources at their fingertips", "taking it seriously…", "understanding how to deal with the situation", "showing empathy", "understanding how not to cross lines between perceived…fraternization or unfairness…", "reaching out to the ones who experiencing..."	understanding	having resources, reaching out, and understanding	Leaders should have an understanding, awareness, trust and guidance of the situation.
	2	"it can happen to any of us"	awareness	it's real	
	3	"need very specific guidance from medical profession"	guidance	use medical professionals	
	4	"colleagues would have….same kind of experience…"; "ask the tough questions…"	ask	ask questions	
	5	"divulge [information] as minimal as possible just to make them [leadership] aware"; "wish we could share more information";	awareness	share necessary information	
15) Do you have any advice for someone employing an individual	1	"patience…", "educating yourself…", "readjust…", "following up with them…", "diligent consistent…"	patience	patience, education, diligence	Be patient, open minded, support the sailor and use your training.
	2	"patience"; "don't directly attack them"	patience	patience	

seeking mental health treatment?	3	"open mind"; "push back negative stigma 'rubbing sand on it'"; "listen to training and understand people"; "learn the red flags-be intrusive"; "have critical conversations"	open minded	being open minded
	4	"bridge the gap in how they feel they're being treated versus how everyone else is being treated.", "formal training…"	training	use formal training to bridge gap
	5	"listen"; "don't brush them off…take their issues seriously"; "give them time"; "be approachable…trustworthy"; "send them to medical, get them taken care of soon as possible"; "don't belittle"	support	listen, give time, get care ASAP

Emerging Themes

Interview Question 1

Tell me about the first time you knowingly employed a service member(s) known to seek mental health treatment. Concepts identified were understanding, hesitation, sharing, handling, and performance. Themes developed included leadership having a lack of knowledge, noticing a change in the sailor's performance, and sharing their own experiences with the sailor. The results concluded that leadership experiences included a lack of understanding how to deal with the situation, sharing their experiences with the sailor, and identifying a change in the sailor's performance.

Interview Question 2

How did the individual(s) seeking help disclose their help-seeking behavior? Concepts identified using this question were sailor, leadership, and family. The themes identified were sailor's self-disclosure, leadership intervention, and family intervention. The results concluded are that individuals had self-report, leadership identified a problem, and families notified leadership of an issue.

Interview Question 3

What was that experience like for you? Concepts identified using this question were understanding, blessing, emotional, guilt, and troubled. The themes that emerged included leadership had a lack of understanding, being scared, excited, thankful, and feeling a sense of guilt. Results concluded members of leadership had a lack of understanding of how to deal with the situation, had feelings of fear, excitement, and guilt that they did not know how to deal with the situation. There was also a report of being thankful that the sailor disclosed their issue to that member so steps could be taken to help the individual.

Interview Question 4

Describe the behaviors of the individual while they were disclosing their help-seeking behaviors. Concepts identified were anxiety, emotion, reluctance, and denial. Themes identified included sailors were reluctant to disclose, shut down, became isolated, and experienced denial. The results formed were the individual behaviors while disclosing included the sailor being reluctant to disclose, the sailor feeling isolated/withdrawn, and denial.

Interview Question 5

What challenges did you encounter when trying to effectively employ the individual(s)? Concepts included cohesion, validation, engagement, motivation, and denial. The themes that emerged were challenges that existed in ensuring team cohesion, handling a sailor's lack of confidence, leadership fostering engagement, motivation, and

the sailor experiencing denial. The results reached were sailors experience a lack of team cohesion, exhibit a lack of confidence, lack of motivation, and be in denial.

Interview Question 6

What were some of the facilitators that aided in effectively employing the individual(s)? Concepts retrieved were responsibilities, professionals, leadership, and knowledge. The themes developed were reduction in sailor's responsibilities, medical professionals, strong leadership, and experience. The results concluded facilitators leaders had where reducing the workload/work stressors of the sailor, referred individuals to medical professionals, and relying on education, and experienced leadership.

Interview Question 7

What kind of tools did you have available to you or that you employed while working with the individual to get them to perform to the most capability? The concepts identified were professionals, balance, and education. The themes created were leaders use of medical professionals, finding work/life balance, and education. Results included the tools leadership had to employ in this community were medical professionals, using support structures, and leaderships' education.

Interview Question 8

Describe the behaviors that you exhibited while actively employing the individual. Concepts obtained were support, overwhelmed, support, empathy, and attention. The themes created included supporting the sailor, the leader feeling overwhelmed, being empathetic, and giving the sailor more attention. The results were that the Navy leaders exhibited supportive, empathic, and attentiveness to sailors with

known mental health issues. They are also reported feelings of being overwhelmed with the situation.

Interview Question 9

How did these behaviors that you exhibited, how did they impact the working relationship between you and the individual? The concepts identified were communication, bonding, avoidance, and anger. The themes developed were one-on-one communication, bonds becoming stronger, walking on eggshells, and noticing a decline in sailors' work ethic and motivation. The results indicated the working relationship between leadership and sailor was impacted negatively through the leader not knowing how to approach the sailor and a continuing declination in the sailor's work performance. The positive results showed an increase in communication and bonding between the leader and the effected sailor. The results indicated the working relationship grew and enhanced after disclosure but also created stress for the leadership.

Interview Question 10

Describe the behaviors the individual displayed when you found out they had a mental health issue. Concepts included grateful, team player, good, isolated, and lack of trust. The themes that emerged included gratefulness, cohesion, positiveness, and a lack of trust. The results concluded individual behavior included positive behaviors such as the sailor being grateful, expressing cohesion, but also a lack of trust for leadership.

Interview Question 11

Were there any behaviors that you did not anticipate from the individual? Concepts included gratitude, success, and clarity. The themes created were the sailor's

expressed gratefulness, were successful, and the leader gained clarity of the situation. Results concluded that leaders were not expecting sailors to feel grateful and or be successful.

Interview Question 12

What is your greatest concern about employing individuals who are seeking mental health treatment? Concepts developed were knowledge, judgment, training, and self-disclosure. The themes created included lack of knowledge, discrimination, leaders not being trained, and the willingness for sailors to disclose. Results concluded leadership was concerned about the lack of knowledge/training they had to deal with these situations, sailors feared discrimination, and were not willing to disclose they have an issue.

Interview Question 13

Based on your experiences, what do you see as the biggest obstacle with the working relationship with people that are seeking mental health treatment? The concepts identified were stigma, balance, and responsibilities. The themes that emerged were the biggest obstacles with the working relationship were the sailor's perception of stigma, leadership's lack of understanding, and finding the balance of which to let leadership aware of the situation. Results obtained were stigma and leadership's knowledge were the biggest obstacles in relation to the working relationship between leaders and sailors affected by mental health issues.

Interview Question 14

What do you wish your colleagues knew about this type of working relationship between working with or employing members with mental health issues? Concepts included understanding, awareness, guidance, and ask. The themes created were leaders reaching out for help/utilizing their resources, having awareness, using medical professionals, asking questions, and sharing information with leadership. The results concluded leaders should have an understanding of their sailor's issues, mental health issues do exist in the military, and they must be aware that they may lead individuals with mental health limitations, rely on medical professionals to help, and share this information regarding the situation with leadership.

Interview Question 15

Do you have any advice for someone employing an individual seeking military mental health treatment? The concepts identified were patience, open-mindedness, training, and support. The themes that emerged were leaders need patience, education, diligence, to be open-minded, use formal training, listen, and provide care. The results concluded leaders advised their colleagues to be patient, open-minded, supportive, listen and rely on training to effectively employ a service member with physiological limitations.

Summary

There are barriers and facilitators members of senior enlisted leadership experienced with employing sailors with known mental health issues. The problem is there is little research to support what barriers and facilitators impact military leadership.

The purpose of this study was to explore the lived experiences of senior enlisted leaders employing individuals known to seek treatment for a mental health issue. Five participants volunteered for this study who had first-hand experience with the topic of the study. The design was phenomenological, and data were obtained from one-on-one, virtual interviews.

Research question one asked what are the lived experiences of senior enlisted leaders who have employed military members who have disclosed seeking treatment for a mental health issue? The answer to this question was leaders feel they had a lack of knowledge and experience to accurately deal with the situation. Additionally, it was also revealed that sailors were unlikely to disclose they have an issue. Challenges for leaders included sailors feeling a lack of cohesion, lack of motivation, and experienced denial. Leadership relied on medical professionals and support structures to help the affected sailor. Leadership also felt overwhelmed, undertrained, unprepared, and frustrated when dealing with these individuals. It was also noted that once informed, leadership increased communication and patience with sailors to create an optimum working relationship.

Research question two asked what are the barriers and facilitators senior enlisted leaders encounter when trying to effectively employ military members who have disclosed seeking treatment for a mental health issue? Barriers to employing these individuals included the sailor's disengagement in cohesion, lack of trust, motivation, confidence, and being in denial about the severity of their situation. Some of the facilitators identified included leaders being able to reduce the workload of the sailor and were able to get medical assistance for the individual.

The results of this chapter provide amplifying information on the barriers and facilitators senior members of leadership faced when employing service members with known mental health issues. The evidence captured in the interviews supported the findings that Navy leadership encountered barriers and facilitators when effectively employing service members with mental health issues. The findings also provide a better insight into the perceptions of leadership when dealing with these situations. Chapter five includes a discussion, conclusion, and results of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

In this qualitative study I explored the lived experiences senior enlisted leaders had while employing individuals with physiological limitations. Five Navy senior enlisted personnel participated in this study. The objective of this research was to capture data on the perceptions this population had while employing members with known mental health issues to identify barriers and facilitators within the working relationship. The data were transcribed, analyzed, and coded to obtain themes pertinent to the purpose of this study. In this chapter a detailed description of the interpretations of findings, the study's limitations, the researcher's recommendations, the study's implications, and conclusions are provided.

Interpretation of Findings

The findings in this study have the potential of helping the military community understand the challenges to in turn aid members of senior leadership when employing sailors with known mental health issues. The findings may be valuable in developing training and education among military members to better prepare them for dealing with situations like the ones captured in this study. The literature review in Chapter 2 provided information on how mental health illnesses can impact a military member. The impacts on sailors identified were barriers to care, individual's willingness to seek treatment, fear of career impacts, and impacts on the work environment. The findings in this study empirically support those assessments.

Previous scholars have identified three main barriers military members faced when seeking treatment for a mental health issue: stigma, negative attitudes towards help,

and organizational barriers (see Kim et al., 2016; Tanielian et al., 2016; Hom et al., 2017; Nearochou et al., 2018; Caldwell & Lauderale, 2018; and Britt et al., 2015). In the present study, three out of five participants identified the fear of anticipated stigma as one of the biggest obstacles impacting the working relationship with a sailor. Participants 1 and 2 identified that stigma receiving help and the fear of being judged prevents the affected sailor from opening up to the leadership about their situation (Participant 1 and 2, 2021). The current study also reported that leadership had a lack of knowledge and training to adequately employ individuals who seek mental health treatment. It was stated that discrimination could also be a concern for leaders dealing with this population. Participant 2 reported a lack of understanding of how to treat these members and the "worry about being judged" can contribute to members not seeking treatment (Participant 2, 2021, question 12). Furthermore, current research supports that self-stigma, public-stigma, and organizational stigma can impact an individual's help-seeking behavior (see Shann et al., 2019; Coleman et al., 2017; Britt et al., 2015; and Ganz et al., 2021). In the present study, three of five participants stated stigma as the biggest obstacle impacting the working relationship when employing military members with known mental health issues.

Current literature also supports the fact military members underutilize mental health service (see Hom et al., 2017 and Sharp et al., 2015) . The present study supports a reluctancy when observing the member's behavior while disclosing they had a mental health issue. Only three of the five participants self-reported their issues. Two of the five had their need for help identified by leadership or the individual's family. Additionally,

the behaviors observed while the members were addressing leadership about their issue were a reluctance to disclose. Behaviors observed by leadership included the member being frustrated, shaking, a lack of eye contact, and anxiety. It was also found that a loss of communication with leadership and the sailor expressing denial about their situation were also contributing factors. The leader who had to coach the sailor to disclose lost the personal relationship with the sailor and the sailor whose family reported the fact they needed help continued to be in denial about the severity about their situation. These factors can all be associated with a sailor's failure to disclose their need to for help.

Additionally, researchers have concluded military members fear that they would be viewed as being incompetent if they disclosed their need for mental health assistance (see Bein et al., 2019 and Tanielian et al., 2016). In this study, it was found that leadership experienced a lack of knowledge of how to effectively employ individuals with known psychological limitations. Participant 1 felt they were handed a "warm body" and had no understanding of what was going on in the sailor's life (Participant 1, 2021, question 1). Participant 1 also stated they were unprepared to deal with the situation. In addition to a lack of knowledge of the leadership, these individuals reported fear of perceived favoritism with the individual due to a lack of situational knowledge both about and below the chain of command. Participant 3 identified a fear of not knowing if the member was ok and being unable to identify improvement amongst the sailor's behavior (Participant 3, 2021). A leader not understanding how to effectively employ individuals in this type of situation can be a contributing factor to the fear they have for being viewed as incompetent. Not knowing how to appropriately lead individuals with

psychological limitations in combination with not being able to fully know their limitations and not being able to communicate those limitations with the work environment could influence the leader to withdraw too many of the sailor's responsibilities, in hopes of helping the situation, but in actuality making the situation worse.

Current research exists that supports there are several factors that contributed to the career concerns of military members with mental health issues. They concluded anxiety over disclosure, hostile individual attitudes, stigma, and being discharged from service were all contributors to career concerns (see Coleman et al., 2017; Bein et al., 2019; Tanielian et al., 2016; and Yamawaki et al., 2016). In this study, anxiety was reported during disclosure, as well as an individual reported as being worried about the possibility of continuing their military career. It was also reported that reducing the service member's responsibilities facilitated the leadership when employing the individual. Additionally, the lack of leadership's knowledge on how to employ these individuals in combination with not knowing the sailor's entire situation and limitations could lead to the sailor feeling excluded and discriminated against. Participants reported the sailor's sense of cohesion, insecurities, lack of engagement, and a feeling of being ostracized as challenges when employing individuals impacted by mental illness.

Researchers have also reported that a positive work environment and support could result in individuals perceiving less stigma (see Britt et al., 2020; Jones et al., 2018; and Yamawaki et al., 2016). In this study, it was found that leadership exhibited supportive, attentive, and empathetic behaviors to sailors dealing with mental health

issues. Information in this study supports the 2020 findings as it identified that observed behaviors from the sailors included them being grateful for disclosing, being a team player. Supportive leadership has proven to lead to positive behaviors and improved working environments when executed.

Research Question 1

The first research question was "What are the lived experiences of senior enlisted leaders who have employed military members who have disclosed seeking treatment for a mental health issue?"

Lived Experiences

My data analysis concluded members of leadership knowingly employing Navy service members seeking mental health treatment experience a lack of knowledge and understanding when effectively employing these members. Leaders also felt senses of being overwhelmed, scared, empathy, and yet supportiveness towards the sailor effective. Leadership was known to observe a decline in the sailor's performance and a change in attitude before the member disclosed they had an issue. Senior leadership has experienced sailors self-disclose they have a mental health issue in addition to both command and family intervention.

When disclosing a mental health issue, leadership has experienced members to be reluctant to disclose, including being emotional, anxious, feeling isolated, and being in denial of their situation. The data shows the leaders' behaviors include being supportive, being attentive, and empathetic towards the sailor after disclosure. It is also evident leadership could feel overwhelmed by the situation. Once aware of the situation, the

working relationship between leader and sailor resulted in enhanced communication, and greater bonding as with the leader as well.

Research Question 2

The second research question this study addressed was "What are the barriers and facilitators senior enlisted leaders encounter when trying to effectively employ military members who have disclosed seeking treatment for a mental health issue?"

Barriers

The data collected indicated that barriers or challenges for leaders who employ individuals seeking mental health treatment are that the sailors seeking treatment feel a lack of cohesion, need to have their leadership validated, need to be motivated or engaged, and may be in denial about the severity of their situation. Additionally, the lack of training and knowledge leaders must deal with these types of situations is also a known factor.

Facilitators

Participant data reflected that facilitators included relying on medical professionals and other professionals like the chaplain for support. Also, tools aiding in effective employment include leadership having the knowledge and strong leadership to effectively deal with the situation. Lastly, the reliance on peer support was also identified as a facilitator to these types of working relationships.

Limitations of the Study

One limitation noted in this study was its generalization. The size of participant sampling and inclusion of only Navy members are factors that can impact the

generalization of this study's results. Utilizing only Navy members of senior leadership does not represent other branches of the military or the lived events of those in other paygrades. Due to these limitations, the results are restricted to only representing Navy senior enlisted leadership. Additionally, participants had to recall events from the past, so there could be an issue with the accuracy of which they recalled the events. The data is solely dependent upon the participant's ability to retrieve these past experiences and communicate them to the researcher. Some accounts may have been misrepresented by the participant or not accurately recalled.

Recommendation

In this study, the experiences leadership had when employing service members with known psychological limitations was explored. Results identified were the barriers and facilitators experienced by these leaders while working with this population. Due to the lack of generalized results of this study, it is recommended future research include members of other military branches. The inclusion of other services could impact the results by comparing the experiences members in services have and the barriers and facilitators they perceive. Additionally, including the experiences and perspectives of members of all ranks may help to clarify this working relationship. The inclusion of junior personnel and officers could provide amplifying information and detailed accounts to better explain this phenomenon. Lastly, this researcher recommends using a larger sample size. A larger sample size could yield richer results by including more perspectives and experiences.

Implications

In this study, the findings offer implications that may help educate and train senior members of leadership who work with members seeking treatment. The findings from this study have the potential to enhance these working relationships by creating a better understanding of the situation, potential barriers, and facilitators. Sharing the results of this study with members of leadership and policymakers may better prepare individuals who work with service members with psychological limitations.

A policy could be established to mandate the creation of training programs, educational resources, and develop support groups to increase leadership's knowledge regarding these situations. One of the main findings in this study was leadership had a lack of understanding of how to effectively deal with an individual seeking mental health treatment. Voicing these barriers to members of the Department of Defense and policy makers may ultimately lead to the creation of a stronger relationship between medical professionals and military leadership. Allowing communication between these two entities may help to foster a work environment which better supports impacted sailors. Permitting medical providers to provide leadership with individual limitations may also help the working relationship between leader and subordinate by increasing the knowledge regarding an individual's situation and how to appropriate lead and employ them. The more knowledge leadership is provided, the better able they can be to support the individual without the perception of discrimination.

Conclusion

It as been discussed that military members are prone to developing psychological issues. The stressful working environment places this population at high risk, yet they still underuse mental health services. The failure of this population to seek help was of great interest to this researcher in addition to gaining a better understanding of this phenomenon. The purpose of this study was to explore the lived experiences of senior enlisted leaders who employ individuals known to seek treatment for a psychological issue.

Previous research focused on members suffering from a mental illness and excluded the standpoint of those members who employ these individuals. It was important to gain the perception of those who lead impacted members to gain a better insight into this working relationship. The findings in this study prove there is a lack of knowledge and understanding of how to effectively deal with these sailors from the leadership's perspective. Additionally, participants indicated sailor's reluctance to disclose, among other behaviors. The data collected helps to gain a better understanding of the barriers and facilitators leadership encountered and has the potential to aid others in developing a better working environment for everyone.

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Appendix A: Invitation

Invitation

Military members face numerous life stressors unique to their occupation. Multiple deployments, long absences from family and friends, stressful and dangerous working environments place service members at a high risk of developing mental health disorders (Hom, Stanley, Schneider, & Joiner, 2017). Even though this is a high-risk population, there is an underutilization of mental health services. Recently, it has been found only 29.3% of service members suffering symptoms reported using mental health services (p. 61). Researchers have shown that military members often perceive psychological disorders more stigmatizing than physical issues and, as a result, are less likely to admit they need treatment (Schreiber & McEnany, 2015). Stigmatized service members often choose not to disclose information that has the potential to acquire the label ‘mentally ill.’ The problem is that these avoidance behaviors are associated with military members’ underutilizing mental health services.

This qualitative study aims to understand senior enlisted members’ lived experiences when employing military members known to seek treatment for a mental health disorder. This study has direct implications for enhancing the understanding of the working relationship between senior leadership and junior personnel who have psychological limitations. It is essential to identify the experiences of those who employ individuals with psychological limitations to increase leaders’ situational awareness when dealing with individuals seeking treatment.

The data gathered from this study will be used to identify common themes in experiences to better understand the barriers and facilitators members of leadership encounter when employing individuals seeking mental health treatment. My intensions are to solicit United States (US) Navy service members, E-7 through E-9, who have employed individuals known to seek mental health services. Individuals are asked to voluntarily participant in a 1-hour, virtual, semistructured interview to tell their story and personal experiences. An informed consent form is required to be read and signed prior to the start of the interview.

Appendix B: Interview Guide

Interview Guide

Provide the participant with a brief introduction of the study's purpose.

Before we begin discussing your experiences, please tell me a little bit about yourself. Where are you from? How long have you been in? Why did you decide to join the military?

Thank you for sharing your story.

1) Tell me about the first time you knowingly employed a service member(s) known to seek mental health treatment.

- How did you find out they were under treatment/had a diagnosed psychological limitation?

2) How did the individual(s) seeking help disclose their help seeking behavior?

- How did you feel when you found out?

3) What was that experience like for you?

- What emotions did you experience?

4) Describe the behaviors of the individual while they were disclosing their help seeking behaviors.

- Can you give me a specific example?

5) What challenges did you encounter when trying to effectively employ the individual(s)?

- Can you describe some of the influential factors?

6) What were some of the facilitators that aided in effectively employing the individual(s)?

- What other facilitators where there?

7) What kind of tools did you have available to you or that you employed while working with individual to get them to perform to the most capability?

- What other resources did you have?

8) Describe the behaviors that you exhibited while actively employing the individual.

- What other behaviors did you notice?

9) How did these behaviors, that you exhibited, impact the working relationship between you and the individual?

- How else was the relationship impacted?

10) Describe the behaviors the individual displayed when you found out they had a mental health issue.

- What nonverbal and verbal ques did you notice?

11) Where there any behaviors that you did not anticipate from the individual?

- What other behaviors did you notice?

12) What is your greatest concern about employing individuals who seeking mental health treatment?

- What are other concerns you may have?

13) Based on your experiences, what do you see as the biggest obstacle with the working relationship with people that are seeking mental health treatment?

- What additional obstacles are there?

14) What do you wish your colleagues knew about this type of working relationship between working with or employing members with mental health issues?

- How else could you aid another leader in this similar situation?

15) Do you have any advice for someone employing an individual seeking mental health treatment?

- Any additional advice you could provide?

Thank you for taking the time and sharing your experiences with me today. After all we have discussed, do you feel there were any topics missed? Do you think there is something else I should pay attention to? Is there anything else you would like to share before we end the interview? Thank you very much for your participation.