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A Qualitative Study on Mental Health Resource Utilization of Enlisted Airmen During the COVID-19 Pandemic

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A QUALITATIVE STUDY ON MENTAL HEALTH RESOURCE UTILIZATION OF ENLISTED AIRMEN DURING THE COVID-19 PANDEMIC

by

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DEDICATION

For my amazing wife Krystal, and my outspoken son Khari. Krystal has supported me through thick and thin, never allowed me to waiver, and never failed to give me honest feedback. Khari has saved my life through some dark times by merely existing. Seeing this young man smile wipes away all bad in the world and reminds me that everything will be ok.

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ABSTRACT

This qualitative action research study examines the impact of COVID-19 on Airmen serving in the aircraft armament systems career field, while also studying the utilization of mental health resources among those same Airmen. Nine Airmen chose to participate in interviews, received an intervention in the form of a resource guide outlining mental health resources offered on-base, and received a second interview to measure any changes in attitude. Respondents found COVID-19 impacted their workload negatively, and adversely affected their personal lives. Culturally, there is an unenthusiastic viewpoint on mental health assistance, which leads many Airmen to suffer in silence and not seek the help they need. Although the resource guide had no immediate impact on the likelihood of the participants using mental health resources, they felt it would greatly benefit their peers. Further research is needed to study the long-term effects of a resource guide for other Airmen in aircraft maintenance occupations.

Keywords: Air Force, COVID-19, mental health, confidentiality, social constructionism, symbolic interactionism, culture

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CHAPTER 1

INTRODUCTION

Throughout my 20-year career in the U.S. Air Force as an aircraft armament Airman, I have personally experienced mental health crises and observed the symptoms of negative mental health in fellow Airmen. These crises occurred while stateside, overseas, in deployed environments with live munitions, in training environments with inert munitions, and both on and off duty. Many of us have healthy ways to cope with our stress, like rigorous exercise, relying on faith, talking to friends and family, or any number of positive outlets. Unfortunately, some manage their symptoms through more unhealthy means like alcohol and drug abuse, isolation, violent behavior towards friends and loved ones, or a poor diet. These difficulties remain even after separation or retirement from the military, and for many they result in lifelong battles and ongoing treatment.

The pressure to perform and not let your wingman down is immeasurable, and oftentimes the nature of our work prevents us from seeking assistance when in need. That pressure can often manifest in feelings of guilt when putting your family or personal needs before the needs of the mission. Even still, there is a culture of hesitance bordering on active discouragement from utilizing mental health resources. In the age of COVID-19, getting help when needed is even more important.

From the outset of our military service and beginning in Basic Military Training, we are stripped of our individuality, creating a sense of community. The hair on our head

is shaved to the same length, our clothing is removed and replaced with identical uniforms, our names are replaced with the title of "trainee," and the only time we spend alone is when we use the bathroom. If a trainee gets sick or injured, resulting in an extended absence from their "flight" (in this context, a group of about 50 trainees), that trainee is then removed from their flight and placed into another. Losing a brother due to injury discourages some others from disclosing a sickness or injury. Additionally, our instructors were extremely hard on us and purposely created an adversarial relationship. If one of us improperly made our bed and failed to create hospital corners with our sheets at the right angles, all of us were punished with strenuous physical work and aggressive verbal correction. When our instructor left for the day, we took it upon ourselves to berate anyone who failed us that day. Every one of these aspects served as our introduction to military life and for better or worse, instilled a sense of brotherhood, a desire to perform for your wingman, and the withholding of injury or mental health struggles.

Drawing upon my own experiences with deploying to a combat zone while ignoring my mental health, there were moments where I should have sought help but did not. While in Afghanistan as a young Staff Sergeant, I was responsible for two Airmen assigned to my load crew. We placed missiles and bombs on jets, those jets took off and accomplished their mission, and then they proceeded to return without any bombs. This reality conflicted me internally. An empty jet meant someone just lost their loved ones or their livelihood, but also that we saved American lives. That conflict also manifested with the sense of accomplishment and pride I felt in my crew doing our job. That struggle was something I thought about upon returning to my room at the end of every 13-hour shift

for six, sometimes seven days a week. This cycle of pride and shame occurred daily for over six months, in-between regular mortar attacks from the enemy. I resisted the urge to tell anyone of my thoughts knowing if I was unable to work, I would impact the mission and the hundreds of servicemembers "outside the wire" who were depending on me to get these bombs loaded quickly, efficiently, and safely. I showed up to work every night as if I was thriving and happy to be there. Again, this idea of being reliable to your unit and accomplishing the mission, no matter the cost, began from day one of my military career.

One moment that stands out vividly occurred on Christmas Day. One of our co-workers served in the Air Force for approximately seven months, and this was his first time away from family. He had a wife and two toddlers, both girls. I was sitting next to him reading about sports on the internet, and I could not help but overhear his conversation. His daughter asked why he was not home with them opening gifts and asked when he would be coming back. I could hear his voice crack in his response, and it hurt me so much to know he was missing a key moment in his children's lives. I had to leave the room and go for a walk outside so I could cry alone. I did not want anyone to see me distraught for fear of appearing unable to do my job and adversely impacting the mission.

Furthermore, being away from home during the holidays is especially difficult. During that deployment, I spent July 4th, Thanksgiving, my sister's birthday, Christmas, and my brother's birthday all thousands of miles away. Individually, those holidays do not mean much, but collectively, missing that many key days can have a tremendous negative impact on one's mental health. Making things even more difficult is knowing that on those days, our adversaries attack more frequently. It's a surreal feeling when you

are celebrating Christmas Day with your unit and seeing your family smiling and opening gifts on social media in one moment, and in the next, you are in the freezing cold taking shelter in a bunker because you are under attack. Our squadron leadership would try their absolute best to make holidays just like they were back in America. They would encourage us to buy each other gifts, remind us that we are a family and how all we have in this moment is each other, and we would have holiday meals together between bomb loads. While I would appreciate their efforts, Sergeant Brown serving potato salad with raisins could never replace my mother's meatloaf.

Upon returning home to Georgia after my deployment, I felt numb. Family and friends would ask inappropriate questions. "What's being deployed like? Did you kill anyone? Have you seen anyone killed?" Loud noises would startle me, and I would fight the urge to reach for my imaginary M-16 rifle while directing my crew to take cover. There was no imminent danger in Lawrenceville, GA, but my mind would not accept that reality. To cope with that perpetual discomfort and inability to reconnect with my loved ones, I would isolate myself, drink alcohol excessively, and text other Airmen who deployed beside me and just experienced what I had. I would never get specific on what I was going through, but I think we all understood. With time, I was better able to manage my emotions and enjoy those precious moments with family. No one knew what I was going through because I had become so accustomed to concealing my feelings, but my wife knew something was amiss.

An often-overlooked aspect of military duty is the impact our service has on our family. In another incident during a deployment, my wife and I were video chatting over Skype. Depending on how busy my days were, or what her class schedule was for the

day, we would often go a few days without hearing each other's voice. Considering we had been married slightly over a year, those days where we could Skype meant so much to our relationship. Within 10 minutes of us starting our conversation, there was a loud explosion, and the base alarm rang throughout our facility. In a panic, I quickly cut my wife off mid-sentence, said "I love you," and slammed my laptop closed. The base lost internet access for about 24 hours so I could not contact my spouse to tell her we were alive, and everything was mostly fine. When my wife and I were finally able to talk again, she was visibly upset and was unsure of what happened over all that time. She heard the explosion, didn't hear my last words, and saw the video cut out during our call.

I contracted COVID-19 in November of 2021. My wife and I had been exceptionally safe; we wore our masks in public or when we had strangers in our house, washed our hands several times a day, and sanitized high traffic areas in our home. We avoided recreational public exposure like restaurants, movie theaters, concerts, and sporting events. Even at work, when mask use was not enforced despite base policy, I still wore mine and made sure those around me did too. My wife and I were both fully vaccinated and received our first shot before they became mandatory for government employees and military members. However, one day I had become extremely fatigued, had prolonged migraines, and felt like I was coming down with the flu. My wife suggested I go and get medication to treat my symptoms and although reluctantly, I did. Base policy requires a COVID-19 test before treating any other suspected symptoms, and I was surprised when I received a call later that evening saying I tested positive. This meant I lost my most meaningful stress outlet in utilizing the fitness center to manage my mental health, making me feel overwhelmed and depressed. Again, I felt like I let my

fellow Airmen down by not being able to serve next to them, although it was only for a week. Fortunately, my wife did not test positive. To mitigate that feeling of letting the squadron down due to my sickness, I asked a co-worker to bring a government laptop to my home, and I continued to perform my duties. I did this even though I could hardly find the energy to shower or brush my teeth.

COVID-19 has had a negative effect on the mental health of almost every person on Earth. There were over 3.5 million lives lost to COVID-19 related illnesses as of June 1st, 2020, worldwide (World Health Organization, 2021). Many young adults have had to navigate the passing of loved ones, be it a family member or close friend. Restrictions placed upon local communities meant no gathering in large groups, no dining in, and no concerts or sporting events. People no longer had their previous outlets to relieve stress. Young Americans are more likely to develop depression, anxiety, and other negative mental health characteristics due to COVID-19 (Kujawa et al., 2020), with young adults in the military among that group.

Work as an enlisted member of the military is extremely stressful. Long hours, irregular shifts, lack of personnel, shortage of equipment, and working with hazardous materials all lead to increased stress for enlisted military members. Suicide rates among enlisted military personnel outpace the suicide rates of their civilian counterparts (Serino, 2019). Enlisted military members also suffer from higher rates of post-traumatic stress disorder (Vasterling et al., 2015). There is a critical intersection of both enlisted military members and Americans affected by COVID-19. Enlisted military members already operate in a highly stressful environment, and factors related to COVID-19 act as a

multiplier to those stressors. Even still, Airmen find ways to overcome those stressors and perform for the sake of the mission and for fear of letting down their wingman.

Air Force Structure

Compared to the civilian sector, the U.S. Air Force has a unique organizational structure. The overall base is called a Wing, run by a Colonel or Brigadier General. Within the Wing, you have several distinct groups (i.e., Maintenance Group, Mission Support Group, Medical Group) run by a Colonel or Lieutenant Colonel. Within each group, there are squadrons run by a Lieutenant Colonel or Major. For example, the typical Maintenance Group could have a few Fighter Generation Squadrons, each assigned with 23 fighter aircraft. Inside the Fighter Generation Squadron would typically be specific flights operated by a Master Sergeant or Senior Master Sergeant, and each flight is responsible for squadron functions like aircraft armament, radar and flight control systems, engines and general flight equipment, and other overall aircraft responsibilities (see appendix A). When a squadron deploys, an estimated 75% of the Airmen in that squadron deploy with a large portion of the equipment and jets accompanying them. Any manning shortfalls are filled with qualified Airmen from other squadrons.

The Airman tier of the enlisted force consists typically of high school graduates with little to no formal college education, between the ages of 17 and 25, and between the grades of E1-E4. This group is not only the largest population group in the Air Force, but also arguably the most important. The next group in the enlisted force is the non-commissioned officer (NCO) tier, comprising of grades E5 and E6. The final tier of the

enlisted force is the senior non-commissioned officer, with grades between E7-E9 (Stiehm, 2020). The research problem for this paper is the study on the effect of COVID-19 on the mental health of enlisted military members in the aircraft armament occupational specialty (See Appendix B). One of the key components of enlisted rank structure is that you must serve in the previous grade for at least two years before the opportunity to progress to the next grade. I retired as a Master Sergeant, or E7, and would use that experience to remind the junior Airmen for whom I was responsible that I intimately understand their struggles and stressors because I experienced the same difficulties years ago.

The squadron superintendent is the highest-ranking and most experienced enlisted Airman in the squadron and acts as the squadron Commander's right hand. They advise the Commander on all matters within the unit, both positive and negative. A special duty position only offered to SNCOs is that of First Sergeant, also known as "First Shirt" or "Shirt." The role of the Shirt is to advise the squadron Commander on all matters involving the health, morale, and conduct within the squadron. More importantly, the Shirt is a visible leader, relaying any issues within the unit to the Commander to act upon. The Shirt is the squadron's focal point for information on mental health resources, Sexual Assault prevention, promotions, awards and recognition, or any personal matter facing an individual (Callander, 2008). Their role is akin to a coordinator who can point you to specific agencies to solve whatever issues arise within the unit. Moreover, all Airmen who in-process within a new unit are required to visit their Shirt for a brief sit-down and outlining of expectations. The Commander, superintendent, and Shirt all make up a triumvirate of leadership within the squadron. When speaking of squadron leadership, it

is usually in reference to all three positions. Squadron leadership can create an environment that encourages Airmen to prioritize self-care for that Airmen to better meet the needs of the mission or prioritize taking care of aircraft at the cost of the Airman's health.

The Air Force classifies its enlisted Airmen into occupations called Air Force Specialty Codes (AFSCs). These codes consist of an alpha-numeric set of five characters. The first character is the career group, second character identifies the career field, third character recognizes the career field subdivision, the fourth character signifies the proficiency of the Airman within that AFSC, and the fifth and final character signifies the specialty within the career field subdivision (Department of the Air Force, 2021). All Airmen within the aircraft armament occupation share the AFSC of 2W1X1, with the X character in place of the skill level. For example, my AFSC while serving in the Air Force was 2W171. Every AFSC serves an important role in the Air Force, and each contains their own unique culture. Under the umbrella of aircraft maintenance, Airmen are expected to take care of Aircraft first and foremost.

Skill levels, which are the fourth character in an Airman's AFSC, show how capable an Airman is at their duties, of which there are five. The 1 skill level is titled helper, the 3-skill level is titled apprentice, the 5-skill level is titled journeyman, the 7-skill level is titled craftsman, and the 9-skill level is titled superintendent (Air Force Personnel Center, 2020). As an aircraft armament Airman's rank and skill level increase, so do the scope of their responsibilities and performance expectations. Furthermore, as the skill level rises that Airman performs less manual work on aircraft and equipment and performs more administrative duties (see appendix C). Like rank structure, Airmen must

have experience in the previous skill level before progressing to the next, with some unique exceptions.

The aircraft armament occupation is what we would call the "tip of the spear." Our job has a direct impact on our country's warfighting and defense effort through our roles as bomb loaders. The specific specialty summary outlined in the Air Force Enlisted Classification Directory (AFECD) states,

> Loads and unloads nuclear and nonnuclear munitions, explosives, and propellant devices on aircraft. Manages, controls, maintains, and installs aircraft bomb, rocket, and missile release, launch, suspension, and monitor systems; guns and gun mounts; and related munitions handling, loading, and test equipment. (Air Force Personnel Center, 2020, p. 190)

This means we place conventional (non-nuclear) and in some cases non-conventional (nuclear) weapons on aircraft, maintain associated weapons equipment on and off the aircraft, and monitor them for expected functionality. The requirements for selection into this occupation are high school diploma or equivalent, meeting the minimum mechanical and electronic score on the Armed Services Vocational Aptitude Battery (ASVAB), no record of emotional instability, normal depth perception, normal color perception, completion of background check, completion of credit check, fulfilment of 8.5 weeks of Basic Military Training (BMT), and between the ages of 17 and 39 (Aircraft Armament Systems, n.d.). This occupation may appear glamourous and fulfilling, however, conventional Air Force wisdom would not call the occupation desirable.

The Airmen assigned to the wing under research are in the Southeastern United States, falling within a specific Air Force command, which identifies the base's role. There are nine major commands in the Air Force which are: Air Combat Command (ACC), Air Education and Training Command (AETC), Air Force Global Strike Command (AFGSC), Air Force Materiel Command (AFMC), Air Force Reserve Command (AFRC), Air Force Special Operations Command (AFSOC), Air Mobility Command (AMC), Pacific Air Forces (PACAF), and U.S. Air Forces in Europe (USAFE). The ACC is a collection of wings whose role is the "primary force provider of combat airpower—fighter, conventional bomber, reconnaissance, battle management, and electronic combat aircraft." Key membership bases within this command are JB Langley-Eustis in Virginia, Seymour Johnson Air Force Base in North Carolina, Shaw Air Force Base in South Carolina, Moody Air Force Base in Georgia, and Robins Air Force Base, also in Georgia (Major Command and Reserve Components, 2012). These bases also frequently deploy to hostile locations all over the globe. Out of my 20-year career, I have spent approximately 10 years in ACC, 4 years in AETC, 1 year in PACAF, and 5 years in USAFE.

Considering we work with conventional weapons and have the potential to work with nuclear weapons as well, there are several requirements Airmen in the aircraft armament occupation must meet. An extensive background check looks for associations with foreign governments, extensive debt, crimes, family history, and more. The purpose of this background check is to identify risk factors against an Airman's reliability and overall trustworthiness. Once this check is completed and passed, that Airman is awarded with a security clearance, often a Secret but up to a Top-Secret level. With a security

clearance, there are significant occurrences that can be viewed negatively and can result in the loss of your security clearance.

When working near or in direct contact with nuclear weapons or nuclear weapon components, we must perform those duties under the personnel reliability program (PRP). This means we are not allowed to work alone under any circumstances. We work under close observation from trusted authorities and Airmen armed with small-arms weapons, every action must be verified by another party, and more extensive operational checks must be performed on the equipment and nuclear weapon. In essence, loading a single 1000-pound conventional weapon may take a total of five minutes, while loading a single nuclear weapon can take hours. To emphasize the importance of background checks and PRP, "Nuclear weapons require special consideration because of their policy implications, military importance, destructive power, and the political consequences of an accident or an unauthorized act" (Department of Defense, 2022).

There are several reasons you could lose PRP privileges or a Top-Secret clearance. Among those reasons are taking medications that alter your mood or make you drowsy, marrying an individual from an adversarial nation, diagnoses with extreme mental health disorders, excessive adverse administrative actions, or substance abuse (Department of Defense, 2022). More importantly, removal from PRP duties and the revocation of a Top-Secret clearance does not prohibit an Airman from performing their job, however, that Airman is no longer allowed to work with nuclear weapons, their components, or other sensitive weapons systems. As identified earlier, loss of these qualifications feeds into the idea of community over self, leading to many Airmen avoiding the notification to leadership of the previously discussed adverse factors.

Base, or assignment selection for enlisted Airmen is a process high on the list of priorities for military members. This determines the base that Airman is assigned to. Assignment at a base can last anywhere from one year to an entire career exceeding 20 years. For the Airman, programs for base selection are accessible through the Assignment Management System (AMS), allowing the Airman to update their base of preference (BOP), and identify base openings on the Enlisted Quarterly Assignments List (EQUAL). Each Airman is assigned a priority based on factors like their current job or current assignment. Furthermore, any opening at the preferred base must match the Airman's rank and skill level. While the assignment selection team tries their best to match the Airman to their preferred base, the needs of the Air Force come first (Assignments, n.d.). Without the ability to earn the necessary level of security clearance or capability to earn PRP, Airmen are prohibited from being assigned to bases that require more responsibility, including bases located overseas.

Statement of the Problem

There is a lack of research concerning COVID-19 and the impact of additional strain on the mental health of enlisted military members, and mental health research utilization among Airmen in the aircraft armament occupational specialty. My research aims to address that void. While there are quantitative studies relating enlisted personnel to an outbreak of COVID-19 on an aircraft carrier (Marcus et al., 2020), and the methods used to reduce the risk of spread in BMT, there is little to no qualitative data on enlisted Air Force Airmen, the relationship of COVID-19 to mental health, and mental health resource utilization. The role of the purpose statement is to indicate to the reader why the

study should occur, and what the study is intended to achieve (Creswell & Creswell, 2018). The purpose statement also gives the reader a preview of what to expect in the work. The intent of this action research study is to explore the impact COVID-19 has on enlisted aircraft armament Airmen in at an Air Force Base in the southeast United States, and to also determine what effect, if any, COVID-19 has had on their perception of mental health resources, the utilization to those services, and their access to those mental health resources.

Purpose of Study

The purpose of this action research study is to examine the effects of COVID-19 on the mental health of Airmen, study overall attitudes towards mental health resources, implement a mental health awareness intervention that makes members aware of the resources available to them, and see if this leads to an increased number of Airmen seeking these services out. This study is qualitative and will use social constructionism and symbolic interactionism as its theoretical frameworks. The intervention will be a resource guide that has simple to read directions on what mental health services are offered, along with explaining implications of using these services. I believe our Airmen have unfounded fears of negative occupational consequences from utilizing mental health resources, and this resource guide will address those fears and concerns. Some benefits of improved mental health are lowered suicide rates, increased productivity, and healthier relationships. These benefits are also advantageous to Airmen even after their service in the military.

Prior to COVID-19, our Airmen had access to mental health services at the Airman and Family Readiness Center, at the on-base mental health clinic, and tele-counseling services with Military One Source. Due to factors such as staff availability and reductions in face-to-face opportunities, Airmen have had to find other means to navigate difficulties with mental health. COVID-19 restrictions placed on off-base establishments also limits potential activities to reduce stress, which may have an adverse effect on mission effectiveness. Undoubtedly, the pandemic has discouraged an already reluctant group of Airman from getting the help they need through opportunity from seeking help, and the reduction of options to attain that help.

Research Questions

Research questions are developed and guided by the theoretical framework, which in this case is social constructionism and symbolic interactionism. Given that this is a qualitative research paper, the questions are qualitative. They were individually developed in the hopes of addressing the cultural obstacles surrounding mental health, and how to eliminate those obstacles. As an insider to the group under study, I have my own answer to these queries, but the Airmen would have better answers collectively. The key phenomenon of this study is COVID-19's effects on the mental health of enlisted aircraft armament Airmen, attitudes towards mental health, and both the access and utilization of mental health services.

1. What improvements, if any, does an intervention have on Airmen's handling the demands of military work while balancing the fears and mental challenges of COVID-19?

2. What is the relationship, if any, between COVID-19 restrictions, mission effectiveness, and the mental health of enlisted Airmen?
3. What methods would be effective in counteracting perceived negative consequences to utilizing mental health resources?

Theoretical Framework

Like many occupations, the military has its own unique culture and sub-cultures. We address each other by rank and last name, we wear our hair in mostly conservative styles, emphasize physical fitness, and have a strong sense of community. These would be viewed as positive aspects of military behavior, but there are negative aspects as well. Attitudes toward a subject change along a spectrum of perspectives within that culture as well. For example, driving under the influence of alcohol was acceptable behavior and would result in a slap on the wrist in 2002. However, current attitudes toward that behavior are of zero tolerance and Airmen could be discharged for it. One of the questions this study looks to address is adverse attitudes towards mental health services.

The strong sense of community that accompanies military life gives servicemembers a network of people to rely on. There are relationships I have made over 20 years ago in BMT that I still maintain to this day. Whether it's your first time buying a home, questions about an overseas base, concerns about the responsibilities that come with a new position, or seeking employment after military life, you can turn to your side and ask your brother or sister. The downside of that is misinformation tends to spread quickly and becomes widely accepted as true, despite information to the contrary.

Considering the nature of mechanic work, pressure to perform on and off-duty, political conflict within the United States, and the COVID-19 epidemic, mental health is as important now as it's ever been. Oftentimes, military members rely on their wingman for advice or guidance on whatever is burdening them. Those same military members are not trained counselors or therapists, leading to that burdened member not receiving the quality assistance they need. The next step would be to seek professional help from the mental health clinic, Military Family Life Consultant (MFLC), military One Source, Chaplain, or the Behavioral Health Optimization Program (BHOP).

Unfortunately, Airmen in need are often steered away from these services for fear of the impact it would have on their career. Airmen are discouraged at all levels, from their peers to squadron leadership. For example, if an Airman were diagnosed with bipolar disorder and prescribed medication for treatment, that Airman could potentially be "worldwide disqualified" meaning they could not serve in overseas locations or deploy to an overseas environment. Additionally, some Air Force occupations require enrollment into a system called the Personnel Reliability Program (PRP). Airmen under this program come into proximity with nuclear weapons or nuclear components and must meet the highest standards of integrity and trustworthiness. Some mental health diagnoses could result in the suspension or revocation of PRP, resulting in that Airman potentially having to re-train into a new occupation. These experiences are rare, but they still prevent Airmen from seeking professional assistance.

The theoretical framework used for this study is social constructionism and symbolic interactionism. Social constructionism theory believes that groups socially construct and assign value to experiences, and that value becomes widely accepted as

accurate (Andrews, 2012). Zhao (2020) found, "Social constructionism is a sociological theory according to which knowledge and meaning are historically and culturally constructed through social processes and actions." Additionally, social constructionism theory believes that reality is a complex result of multifaceted forces, that we assign importance to (Zhao, 2020). Relating to the problem of practice within this study, military members typically have a negative view on mental health services. This is due to a mostly male demographic, perceived negative consequences to one's career, prioritizing the mission over mental wellness, and an overall misunderstanding of services offered. Over time, these factors have compounded, culminating in today's negative perceptions on mental health assistance. Social constructionism accredits this thought process to shared narratives among individuals that then become communal. Furthermore, military members oftentimes place more value upon their occupation and their wingman, as opposed to their own personal well-being. This manifests itself at every rank, AFSC, base, skill level, age, race, or religion.

Symbolic interactionism is a theory that operates under the belief that social realities and other aspects of life are manipulated through person-to-person exchanges and symbolism (Quist-Adade, 2019). These realities become generally espoused within groups and accepted as fact. In other words, "Based on the idea that social reality is constructed in each human interaction through the use of symbols – words, gestures, and communicating through language. Studying social interaction is key to understanding human behavior" (Quist-Adade, 2019, p. 20). Symbolic interactionism is conventionally used in qualitative research but may be used in quantitative research as well (De Nooy, 2009). The symbolic interactionism framework correlates with this research by

identifying the means through which aircraft armament Airmen have established the idea that utilizing mental health resources will negatively impact one's career. Few, if they have ever seen an Airman in their unit suffer career consequences from utilizing mental health resources, know the actual circumstances behind the decisions their squadron leadership make. This leads to the spreading of stories that result in more extravagant and extreme details and promoting fear.

Overview of Methodology

In examining mental health as it relates to COVID-19 and Airmen, there should be a structure to answering the research questions and solving the problem statement, referred to as the methodology. The methodology was developed with the intent of identifying if there is a relationship with COVID-19, the mental health resource utilization of Airmen, and the cultural factors surrounding those relationships. This research will be conducted through observations and interview questions. The next aspect of methodology development sought to determine the magnitude of negative attitudes held toward mental health resources, and resource utilization rate, also answered through observations and interviews. After aggregating, reducing, and analyzing all data, participants will be issued a resource guide that outlines mental health services offered, along with the potential impact on an Airman's career. Follow-up interviews will be conducted with select Airmen who received the resource guide. In interviewing the Airmen, this study will determine if their attitudes towards mental health resources changed after receiving the information.

As the researcher, I then drew upon participant observation conducted throughout my 20-year career to gain more insight on COVID-19's impact on mental health and mental health utilization. In participant observation, the researcher is involved in the day-to-day activities of the research participants (Sharpe, 2019). In this case, I have acted as the direct supervisor, Shirt, or peer when making these observations. I also have personal insight to the work-related impacts from these factors, considering I have served in each of their ranks and skill levels.

In this qualitative action research study, thematic analysis was the most appropriate method for data analyzation. Thematic analysis works well because there is no qualitative information to measure, and this study gathers non-tangible information. This methodology examines qualitative data collected by the researcher for themes or patterns that then allow the researcher to develop a theory surrounding that data. Supporting this idea, Alhojailan (2012) claims, "It allows the researcher to associate an analysis of the frequency of a theme with one of the whole content. This will confer accuracy and intricacy and enhance the research's whole meaning" (p. 40). In other words, a thematic analysis within this research will search for relationships between the data points and an intervention. The most important aspect regarding thematic analysis as the chosen methodology in relation to this research is through coding and categorizing data. In presenting qualitative data using thematic analysis, the researcher must gather large amounts of data to accurately reflect whatever repeated themes or patterns are present (Alhojailan, 2012).

Significance of the Study

This research is significant because it could have a direct impact on our country's national defense through the care of the Airmen assigned to protect it. One of the Air Force's many missions is to protect the United States and its allies from all enemies, both foreign and domestic. COVID-19 is still an enemy, although unseen. The Air Force also transports supplies quickly and over great distances and has played a significant role in the movement of bulk COVID-19 vaccines.

COVID-19 has altered the mental health landscape for military members and veterans through the limiting of options for care, and appointment availability for the mental health resources accessible, leading to self-medication through unhealthy means (McFarlane et al., 2020). With the pandemic comes increased isolation, leading to anxiety, stress, and post-traumatic stress. Over time, this will likely lead to more instances of depression and suicide among military members (Han et al., 2020). Also, political leaders in the United States stress the importance of our country's military, but the perception does not match reality. It would be more appropriate for increased investment in mental health resources, not less.

Furthermore, based on an extensive review of the literature concerning COVID-19's effect on the mental health of young, enlisted Airmen, there is little in the way of qualitative data on this group. The information gathered from this study can also be used in other high-stress, essential occupations, like nursing, childcare, paramedics, and law enforcement. The data collected in this study could also assist mental health care professionals in designing interventions that prevent suicide and self-medication among service members. While this research was done using active-duty Airmen as its subjects,

this study could also potentially guide other researchers in examining the mental health challenges for separated or retired Airmen.

Limitations of Study

With any study, there are limitations to consider, which would further guide other researchers in their own studies. This study is focused on Airmen within the Aircraft Armament occupation at a base in the Southeast. COVID-19 has impacted cities and bases in different ways, meaning the findings in this study may be unique to this specific base and this specific group of Airmen. Other researchers should focus their efforts on Sailors, Marines, Soldiers, and Guardians. Other researchers could also do their studies on Airmen, but outside of aircraft maintenance occupations.

There are restraints unique to the selection of qualitative research to conduct this study. The results of a qualitative study are difficult to duplicate by another researcher and the information gathered is heavily influenced by both specific experiences, and the research ability of the investigator. Furthermore, my presence as the researcher has the potential to influence study participation and the responses I receive during the data gathering stage. The possibility exists for complications regarding confidentiality while presenting the data. Finally, qualitative data can be problematic when trying to present findings visually (Anderson, 2010).

Definition of Key Terms

1st Sergeant- A Senior Non-Commissioned Officer responsible in conjunction with the commander and superintendent for the health, welfare, safety, and morale of their squadron.

Air Combat Command (ACC)- Major command of the U.S. Air Force, comprising of several bases in the continental U.S.

Air Education and Training Command (AETC)- Major command responsible for the formal training of Airmen, to include Basic Military Training.

Air Force Global Strike Command (AFGSC)- Major command responsible for maintaining our nations bomber fleet of aircraft and deploying both nuclear and non-nuclear munitions.

Air Force Material Command (AFMC)- Major command responsible for the testing and procurement of advanced aircraft and munitions.

Air Force Reserve Command (AFRC)- Major command responsible for the management of the Air Force's reserve Airmen and equipment.

Air Force Special Operations Command (AFSOC)- Major command responsible for the quick and worldwide deployment of Airmen and aircraft to unique locations.

Air Force Specialty Code (AFSC)- A five-character code categorizing Airmen by their occupation and skill level.

Air Force Enlisted Classification Directory (AFECD)- A guide outlining the responsibilities of each enlisted occupation, and its requirements.

Aerospace Ground Equipment (AGE)- Powered and non-powered equipment used in the maintenance or servicing of aircraft.

Air Mobility Command (AMC)- Major command responsible for the transportation of Air Force cargo.

Airman- Term referring to all members of the Air Force, whether enlisted, officer, civilian, or contractor.

Assignment Management System (AMS)- Online system, accessible through the Air Force Portal, allowing for Airmen to apply for their next assignment preference.

Armed Services Vocational Aptitude Battery (ASVAB)- An evaluation grading prospective enlistees on their capabilities and used to assign occupations.

Behavioral Health Optimization Program (BHOP)- A program offered by the mental health clinic that specializes in helping Airmen obtain healthy coping mechanisms.

Basic Military Training (BMT)- An 8-week initial skills course, teaching trainees basic information about the Air Force and Airmanship.

Base of Preference (BOP)- An Airman generated list of eight CONUS and eight overseas bases they would favor as their next assignment.

COVID-19 (Coronavirus disease 2019)- is an infectious disease caused by the SARS-CoV-2 virus (World Health Organization, 2021).

Enlisted Quarterly Assignment Listing (EQUAL)- A quarterly listing of base openings, organized by rank and skill level.

Flightline- Concrete parking ramp housing dozens, sometimes hundreds of aircraft and pieces of AGE equipment.

Military Family Life Counselor (MFLC)- A certified civilian mental health provider.

Military Treatment Facility (MTF)- A clinic on or near a military installation that provides medical care to its military members in the general area.

Non-Commissioned Officer (NCO)- An Airman at the grades of E5 and E6. Typically, a front-line supervisor.

Pacific Air Forces (PACAF)- Major command responsible for each base located in and around the Pacific Ocean, including wings in South Korea, Japan, Alaska, and Guam.

Personnel Reliability Program (PRP)- A program used to evaluate the trustworthiness and manage Airmen in sensitive occupations relating to the handling of nuclear weapons and associated equipment.

Senior Non-Commissioned Officer (SNCO)- An Airman between the grades of E7-E9. Usually responsible for many personnel.

United States Air Forces in Europe (USAFE)- Major command responsible for each base located in Europe, including wings in England, Italy, Belgium, and Spain.

Veteran Affairs (VA)- A nationwide organization tasked with providing care to veterans.

Chapter Summary

In this chapter, I identified my personal reasoning as to why mental health is so important while also detailing my struggles with deploying and contracting COVID-19. Necessary background information on items such as enlisted tiers, ranks, grades, responsibilities, the aircraft armament AFSC, skill levels, PRP, and the assignment selection process was also defined within this chapter. Essential information was also

provided on the statement of the problem, research questions, the theoretical framework, purpose of the study, overview of methodology, significance of study, limitations, and a list defining key terms.

The remainder of the chapters in this dissertation are organized as follows. Chapter 2 contains the literature review, which is an overview of all relevant information involving this research. Specifically contained in Chapter 2 is literature concerning the relationship between COVID-19 and the military, COVID-19's impact on mental health, mental health educational materials, the military and its relationship to mental health, and the theoretical frame works of social constructionism and symbolic interactionism. Chapter 3 details the methodology of the research, meaning the research design, description of context and participants, the instruments and data sources, procedures, researcher's background and role, ethical considerations, and expected findings. Chapter 4 contains a more in-depth description of the participants while also specifying the findings of this qualitative research study. Finally, Chapter 5 explains and assigns meaning to those findings through a summary, while also containing recommendations for further research and next steps in advancing the topic. Brief closing remarks will also provide context to the findings of the study at the conclusion of this research.

CHAPTER 2

LITERATURE REVIEW

The purpose of this study is to examine the impact of COVID-19 on Airmen serving in the aircraft armament systems career field, while also studying the utilization of mental health resources among those same Airmen. The theoretical framework used in this research is a combination of social constructionism and symbolic interactionism. Furthermore, this study looks to survey the impact a resource guide containing relevant mental health resources would have on those same Airmen. The purpose of Chapter 2 in an action research study is to provide the reader with a literature review, which is defined as "a summary and synthesis of research put forward by others that is pertinent to your own inquiry" (Efron & Ravid, 2013, p. 17).

An essential function of the literature review is to identify the research already completed on a topic and identifying gaps within that collective literature to validate the completion of your study. On the weight of the literature review, "The review of literature is considered evidence that the doctoral student has sufficiently examined the theoretical writing and research publications as a conceptual base for the proposed study" (Stake, 2010, p. 104). A key consideration in conducting this study was when developing this literature review and seeking other writings related to this topic, I had to ascertain that the military uses a specific set of jargon that often does not directly correlate with civilian terms. This meant I initially had difficulty finding other studies that were relevant to this research.

These challenges led to the development of a concept map to aid in developing this literature review. A concept map assists in the planning of a research study, may be formal or informal, and gives the researcher a visual aide to further develop the study (Stake, 2010). Concept mapping helped me in identifying terms and literature in fields unrelated to the military. I wrote down key terms to my research relating to COVID-19, the military, mental health educational materials, and mental health resource utilization, defined and classified synonyms to those terms, and constructed database search phrases based on those synonyms. This technique eliminated the roadblocks I initially encountered in performing this literature review.

A conceptual literature review was the most appropriate type of analysis, considering the amount of research specific to this study on Airmen in the aircraft armament occupation was difficult to find. A conceptual literature review expands the research into unrelated but relevant fields, eschewing specific literature that may be limited or completely absent (Stake, 2010). For example, medical providers and police officers face similar stressors to enlisted military members. These occupations may be unrelated, but any research conducted on these groups will inform my own. While conducting this study, I found myself returning to the literature review and adding more information that I discovered, even past the completion of Chapter 5.

This literature review opens with an examination of texts pertaining to COVID-19's impact on the U.S. military. The next portion of the review identifies writings on COVID-19's impact on the mental health of young adults. The third portion of this literature review seeks texts on mental health and enlisted military members. Subsequently, this chapter pinpoints literature on the theoretical framework used to

conduct this study, which is both social constructionism and symbolic interactionism. Chapter 2 concludes with a chapter summary, then a foreshadowing of the contents enclosed inside Chapter 3, Chapter 4, and Chapter 5.

COVID-19 and the Military

There are many relevant studies that cover the broad spectrum of issues related to COVID-19's impact on the military, and its impact on mental health. The U.S. military has always been at the forefront of vaccine adoption to prevent the spread of viruses among its members, in-turn bolstering our nation's defense and COVID-19 vaccines have been no different. In fact, in 1776, George Washington mandated the first mass immunization against the contraction of smallpox, after half of his army contracted the disease (Adams et al., 2022). President Biden enacted a similar mandate almost 250 years later with his vaccine mandate for federal employees, including members of the U.S. military. As of May 11, 2022, there are 1,676,121 fully vaccinated members of the U.S. military with 476,757 of those belonging to the U.S. Air Force (Coronavirus: DOD Response, 2022).

Wilén (2021) found three key elements in relation to the COVID-19 pandemic and the military. They find the military is especially vulnerable to outbreaks due to working and living in close quarters with other military personnel, while also leaving the opportunity for military personnel to spread the virus to their civilian counterparts. The second key element is that while the pandemic has had minimal impact on the military's mission, that impact will likely increase overtime, due to logistic, operational, and human resource concerns (Wilén, 2021). Finally, "the higher visibility and closer connection

with the civilian population during the current pandemic has confirmed the last two decades' development of military institutions toward being highly versatile organizations with increasingly important domestic roles" (Wilén, 2021, pp. 21-22).

While the reputation of the U.S. military may be of warfighting and conflict negotiation, they also play a major role in providing aid to countries in need of assistance. This is expressed through the deployment of servicemembers to foreign hospitals that are under-staffed and overrun with patients due to the COVID-19 pandemic. The military also plays a key role in the testing of vaccines and the manufacturing of personal protective equipment (Kalkman, 2021). For example, the French military serves as a key stakeholder to Pasteur Institute's development of many vaccines and medical treatments, the U.S. military contributed to the development of the anti-malarial drug (chloroquine) during World War II, and U.S. Army surgeon Major Walter Reed's research led to the eradication of Yellow Fever. During the West Africa Ebola pandemic that occurred from 2014-2016, military medical support was provided to the region from France, Germany, the United Kingdom, China, Canada, and the United States. This international response was viewed as the deciding factor in mitigating the challenges in providing aide to the region, given the shortcomings of local governments and traditional humanitarian aid (Gibson-Fall, 2021). Furthermore, militaries transport medical supplies to other countries, and transports patients to hospitals more suitable for treatment (Kalkman, 2021).

There are many factors that determine whether the military is deployed in response to a disaster. The first of those factors is the disaster's scope. To further accentuate this point, "Other things being equal, the greater the scale of the disaster, the more likely it is to overwhelm civilian capacity and to initiate the mobilization of military

resources, particularly to provide logistics and boost healthcare capacity" (Erickson et al., 2022). The scope is significant in that it determines a country's ability to maintain order, as outlined in the United States Department of Defense Authorization Act, written in 2007. The purpose of this act is to deploy armed forces when a local government is incapable of maintaining order or becomes overwhelmed by a public health emergency. Other factors to consider when deciding to deploy military units are that military's capabilities, the country's capability in providing goods and services to its citizens, and that country's ability to enforce its laws. The capabilities of a military are in direct correlation to a country's investment into its defense, with the United States as the worldwide leader in defense spending (Erickson et al., 2022).

A key role the U.S. military played during the pandemic is through providing security for locations that have a poor ratio of essential health-care worker to patient (Kalkman, 2021). This reflects the idea that in some countries, the military handles the primary response to any health crisis, as opposed to a civilian led solution or blended resolution. Countries where their respective local military was responsible for the initial reaction to a health crisis include Indonesia, Sri Lanka, Myanmar, Thailand, and the Philippines. Meanwhile, Argentina, Brazil, Mexico, Chile, Uruguay, Ecuador, and Peru, used a hybrid approach to the COVID-19 pandemic (Gibson-Fall, 2021). Even still, some military responses have caused political complications. Where the initial COVID-19 response was civilian led in Iran and Pakistan, that civilian response has given way to a military response due to perceived inadequacies by local leaders. Gibson-Fall (2021) found, "In these settings, the pandemic further encroaches military presence into domestic civilian affairs." There is some concern as to whether these militaries will

relinquish the power they gained back to the local government after the pandemic (Gibson-Fall, 2021).

Some find a more appropriate approach requires the cooperation of many different entities. The North Atlantic Treaty Organization (NATO) has encouraged its member nations to collaborate to mitigate any social threats that arise due to COVID-19. For instance, "This comprehensive non-military-centric preparedness approach means governments, militaries, businesses, and civil society work together against emerging threats (such as disinformation campaigns)" (Gibson-Fall, 2021). This approach allows all stakeholders, including militaries, local governments, citizens, and business owners collaborate and exchange information on lessons learned and minimizing any threats to recovery.

One study, titled "An Outbreak of Covid-19 on an Aircraft Carrier" (Kasper et al., 2020), examined the impact of COVID-19 on the military. This quantitative paper follows the steps taken to mitigate the spread of COVID-19 among sailors in the small spaces of an aircraft carrier. Key information includes the following: 26.6% (1271 crew members) of the carrier's sailors tested positive, 572 (43%) were asymptomatic, and the cases were fairly distributed across sex, race, and ethnic group. A huge majority (90%) of the cases on this carrier were with enlisted personnel, and those working near one another (Kasper et al., 2020). There is also information on the steps taken by the Air Force to mitigate the spread of COVID-19 among classes of 50 students living in proximity at Lackland Air Force Base, TX. Based on the data collected, the Air Force was successful in limiting the opportunity for the virus to spread among its members in BMT but does not contain information on the mental health risks on the intervention (Marcus et al.,

2020). The pandemic has had a negative impact on vulnerable populations, to include military veterans. McCarthy et al. (2022) found that COVID-19 manifests itself among veterans through increased cases of insomnia. COVID-19 has also had an immense effect on essential workers, like healthcare professionals and law enforcement (Gaitens et al., 2021). There is a correlation between essential workers and enlisted military in that they are racially diverse, earn low wages, and work in proximity with others.

To gauge opinions on vaccines, a survey was issued to 816 personnel on Wright Patterson Air Force Base, OH. The survey found that an Airman's age and occupation were the biggest factors in determining vaccine hesitancy. The parallel is that Airmen 30 years old and below are more hesitant to receive their COVID-19 vaccine, while Airmen above age 30 are not. Surprisingly, Airmen serving in medical occupations were more likely to be vaccine hesitant than any other AFSC. This study shows that the main concerns surrounding vaccine hesitant Airmen were the short and long-term medical effects of the vaccine (Theis et al., 2021). In the opinion of the researchers, this is because of misinformation. "These findings, especially if consistent across military installations, are concerning as there exists a high potential to directly negatively impact military readiness" (Theis et al., 2021).

The stressors associated with prior service in the military are amplified by the COVID-19 pandemic. Hill et al. (2021) examined data from the National Health and Resilience in Veterans Study, surveying 3078 military veterans. The researchers screened for psychiatric issues prior to the COVID-19 pandemic and compared those problems among the same veterans during the pandemic. They discovered that there was a 9.4% increase in positive screens for general anxiety disorders while positive tests for major

depressive disorder and PTSD remained relatively constant. Additionally, 13.2% of respondents surveyed claimed to have a meaningful intensification in stressors (Hill et al., 2021). Those stressors exhibited themselves in the form of social loss, housing instability, and work-related difficulties. In their conclusion, the researchers find regarding their observations, "However, they also highlight disparities in the effects of the pandemic and the resultant need for targeted interventions to protect those at risk of deteriorating mental health, particularly middle-aged veterans and veterans with low social connectedness" (Hill et al., 2021).

There has been research on the effect certain health behaviors have on COVID-19 hospitalization among Airmen serving in the U.S. Air Force. While physical fitness level, body-mass index, and disease history show to have a large impact on how ill someone gets from contracting COVID-19, there are other factors as well. This study was conducted by assessing Periodic Health Assessment Questionnaire's (PHAQ), taken annually by all Airmen, and fitness data derived from the Air Force Fitness Management System II (AFFMS). This data was taken from all active-duty Airmen who contracted COVID-19 between March 5th, 2020, and March 10th, 2021, and were hospitalized. The researchers found less than adequate sleep and consumption of sugary beverages and sodas in large amounts increase the likelihood of hospitalization or death due to COVID-19 infection. Airmen in maintenance occupations often suffer from poor diets and inadequate sleep due to working extended hours and lack of opportunity to eat healthily (Webber et al., 2021).

Also of importance to this study is the military response to COVID-19 for U.S. servicemembers located outside the United States. Unlike most military installations in

the United States, many foreign military bases do not have their own Military Treatment Facilities (MTFs) (Gillis et al., 2021). In a study conducted by Gillis et al. (2021), researchers observed the COVID-19 related challenges faced by a foreign military base located in Bavaria, Germany. Typically, these MTFs provide care to military members and their dependents located in and around the installation. If the MTF is unable to provide care for more unique or intense medical issues, the military member or dependent is directed to seek care at a host nation facility.

COVID-19 had an immense impact on the local area around this region, resulting in the German state of Bavaria being one of the two hardest hit regions in the entire country. A constraint faced by this base was when the MTF reached 90% capacity of hospitalizations due to COVID-19, new cases were sent to other larger bases after the expiration of their 72-hour quarantine. Depending on the base a servicemember was assigned to, that larger and more capable MTF was located at the Landstuhl Regional Medical Center, up to 378 kilometers (234.9 miles) away. Of course, this moving of personnel due to limited availability at smaller MTFs served to complicate treatment and created logistical challenges for healthcare providers (Gillis et al., 2021).

Furthermore, installations had to consider two sets of restrictions when considering their COVID-19 response. MTFs had to implement restrictions based on German law, and implement guidance put into place by the U.S. Centers for Disease Control. Among the restrictions put into place were the limiting of travel to essential functions only, like medical care, food, and work. Even more limiting was the application of a restriction-to-base measure, meaning any servicemember residing on-base was restricted from leaving base, unless there was an emergency. To conserve personal

protective equipment, hospital beds, and other essential resources, MTFs had to take drastic measures, meaning outpatient treatments and elective surgeries were canceled (Gillis et al., 2021). The pandemic placed an immense burden on extremely capable healthcare systems, but that strain was even larger for healthcare systems in rustic locations, due to many factors.

Mental Health Materials

Web-based mental health applications accessible through mobile devices were used with adults aged 17-29 in a study conducted in 2020. An initial survey measured the likelihood of participants to seek mental health assistance at three months, then again at six months. This research shows that there was no significant change in resource utilization through the mobile application. However, the research does show that women in this age group are more likely to seek help from formal resources while men were more likely to use informal resources (Wiljer et al., 2020).

Pamphlets can be an effective way to communicate health information to vulnerable groups and helps combat hospitalization. Resource guides and other educational materials assist in the messaging of risk factors, identifiers, treatment options, and other comprehensive health information. It is essential that these materials are written and verified for accuracy by subject matter experts, while also providing follow-up options for more data. Pamphlets provide a quick reference, accessible before symptoms or after. Educational materials such as these also allow individuals to see signs of unwellness in others, which is an essential part of what it means to be an Airman. Air Force Technical Orders (TOs), which are used as manuals to assist Airmen in the

accomplishment of complex tasks, are written at a 12th grade reading level, under the assumption that all enlisted Airmen have at least a high school diploma or equivalent. Research shows that medical resource guides should be written at a 6th grade level to avoid conflict with the literacy levels of its recipients (Samimi et al., 2019). Samimi et al. (2019) found, "Readability and suitability are two criteria used to assess the quality of written instructional subjects. In this regard, readability refers to factors, such as using words and the length of the sentences that have effects on success in reading."

Where would the most optimal location be to display pamphlets and other materials on mental health and mood disorders? This study identifies the usage rates of various resource guides based on locations in physicians' offices. The researcher concludes that health materials placed in common areas like waiting rooms have a lower frequency of handling than health materials placed in exam rooms. Patients were more likely to read and take materials when they felt they could do so privately and with the ability to ask questions about information within those materials (Craven et al., 2005).

Gujral et al. (2020) identified a lack of advertisement in mental health resources available to those affected by COVID-19, and the potential long-term effects from the underutilization of those resources. There has been an 200% increase of calls to the Project HopeLine suicide prevention hotline for April 2020 (Gujral et al., 2020). There has also been an attrition of available resources available to young adults due to COVID-19, specifically self-harm reduction services. The virus caused a reduction in staffing for self-harm services, reduced supply availability, and less opportunity for face-to-face interaction in Boston (Noyes et al., 2021). This study is thorough and can also be used to

guide research on the limiting of resources available to Airmen throughout the duration of the epidemic.

COVID-19 and Mental Health

The COVID-19 pandemic unquestionably has a negative impact on mental health. Among those who have contracted the virus, people have shown increased levels of depression and posttraumatic stress symptoms (PTSS). Among those with mental health issues prior to contracting the virus, some patients claimed their condition worsened during the pandemic. Moreover, there is an increased likelihood of symptoms among healthcare workers, which is analogous to enlisted military based on responsibilities, stress, and expectations within the workplace. Researchers also witnessed a decrease in mental health wellness in the general populace, further indicating the impact of COVID-19 on mental health (Vindegaard & Benros, 2020).

COVID-19 restrictions have been extensive in some areas, directly impacting the mental health of Americans. Examples of these restrictions can take the form of limited travel, reduced tables and opportunities to dine-in, closure of movie theaters, shut down of night clubs, and teleworking from home. Losing these activities has had a direct negative impact on the mental health of many Americans (Courtemanche et al., 2020). In fact, although researchers can project the effect on mental health these restrictions can have, the long-term impact is currently unknown (Ammar et al., 2020). Furthermore, COVID-19 restrictions have led to an increase in alcohol consumption, particularly among men (Rehm et al., 2020). Men also happen to be the larger demographic among Air Force Airmen.

Pandemics historically have a greater unseen impact than a tangible one. According to Ornell et al. (2020),

> During epidemics, the number of people whose mental health is affected tends to be greater than the number of people affected by the infection. Past tragedies have shown that the mental health implications can last longer and have greater prevalence than the epidemic itself and that the psychosocial and economic impacts can be incalculable if we consider their resonance in different contexts.

With this information, it is essential to increase our investment into mental health resources to potentially mitigate the long-term impacts surrounding the COVID-19 pandemic, which is difficult considering we are still within the pandemic. Those who have tested positive for COVID-19 have exhibited increased occurrences of anxiety, loneliness, fear, boredom, insomnia, and anger. Those emotions potentially lead to depression, psychosis, paranoia, and suicide. Furthermore, individuals who have been quarantined have higher rates of these negative mental health attributes for fear of infecting others or their own death. Medical care for COVID-19 patients has been focused on the treatment of physical symptoms as opposed to the mental anguish associated with infection or quarantine (Ornell et al., 2020).

One of the essential foundations of COVID-19 mitigation is social distancing, but that introduces other issues. With social distancing comes isolation and a greater reliance on social media or other internet resources for social interaction. That dependence on virtual interaction leaves individuals open to misinformation online, further accelerating mental health complications. To counteract these issues, people in isolation due to quarantine should be encouraged to spend less time online, limit their interactions online

with family and close friends when utilizing social media, and utilizing tele-med or other mental health resources (Amsalem et al.2020). According to Amsalem et al. (2020), "In the midterm, there should be a focus on the development and dissemination of innovative brief online contact-based interventions to encourage healthy lifestyles (e.g., physical exercise, balanced diet) and anxiolytic-like activities (e.g., meditation, mindfulness)."

The need for mental health providers during the COVID-19 pandemic is of paramount importance. While there are over a million deaths due to COVID related symptoms as of June 2022 (The New York Times, 2022), some estimates believe that there could be an additional 75,000 deaths related to COVID-19 related mental health issues, like substance abuse and suicide. With a medical infrastructure already stretched thin due to physical complications derived from contraction of COVID-19, there may not be enough of a foundation in place to handle mental health needs as well. The pandemic has forced many mental health providers to adopt a different approach to helping their patients, utilizing teletherapy services and virtual appointments. Unfortunately, this has negative connotations for many, "Numerous respondents indicated teletherapy fatigue, and many disclosed feeling dissatisfied with work or questioning the meaningfulness of their work" (Fish & Mittal, 2021). Furthermore, in their own research, Fish and Mittal (2021) found that 81% of the 137 mental health providers they interviewed felt COVID-19 negatively affected their ability to perform. This is due to the same COVID-19 related stressors providers felt as their patients, resulting in providers feeling distressed, depressed, anxious, isolated, and fearful (Fish & Mittal, 2021).

U.S. Military and Mental Health

Although on the surface healthcare workers and military service members may not have much in common, there are several similarities between essential workers and enlisted military. The first likeness between the two fields is that of selflessness. Military members operate out of a call to service to their country and a responsibility to their partner in arms. Healthcare workers operate out of a call to help others and a responsibility to patients under their care. The expectations of both occupations call for long hours, shift work, and extended time away from family. As both a registered nurse and a Soldier in the national guard, Roggensack (2020) finds, "Getting to the point of forgetting oneself and completely giving everything to others, whether they be patients or soldiers, is a unique and surreal place to be in, and it's where soldiers and nurses both live when they show up to work." Both occupations require solving unique and complex problems, requiring quick thinking in life and death scenarios.

Mayo et al. (2013) found that there is a direct relationship between one's occupation in the military and mental health conditions. This study examines military members who had no diagnosed mental health issues prior to deployments to Iraq, Iran, and Afghanistan. This research mostly focuses on Sailors and Marines working as combat specialists, compared to Sailors and Marines working in support functions (Mayo et al., 2013). There are some parallels between this study and my research on mental health resource utilization among Airmen in the aircraft armament specialty, in that both examine high stress jobs among deployable service members, and how the occupations contribute to negative mental health. There is also an interesting correlation between auditory issues and adverse mental health conditions.

As previously identified, work on the flightline for aircraft maintenance Airmen is highly stressful, with noise being a large contributing factor. Multiple jet engines operating simultaneously, jets departing the runway at full throttle, and AGE operating at proximity to an Airman's ears are the culprits to the loud noises on the flightline. Airmen are required and issued two sets of hearing protection. One set of foam hearing protection is placed inside the ear canal, and another set of hearing protection is placed over the ears. The idea is that these measures will reduce the likelihood of hearing loss. Unfortunately, due to operational pressure, inability to communicate with other Airmen effectively, and traveling to and from the flightline make 100% hearing protection use impossible. Auditory problems, like hearing loss or tinnitus, are the most common disabilities found in retired or separated veterans of military service. Those who suffer from auditory problems are also more likely to socially isolate themselves and have more difficulty finding employment post military service. These elements contribute to a military member developing depression and anxiety. Many tinnitus sufferers abuse alcohol to self-medicate from their hearing issues (Parker et al., 2021).

Airmen belonging to the unit under research annually deploy to combat zones in the southwest region of Asia, which includes countries like Afghanistan, Iraq, Qatar, and the United Arab Emirates. By some measures, service members returning from deployments in this region are diagnosed with posttraumatic stress disorder (PTSD) at a rate of 5-20% (Farmer et al., 2014). Those with military occupations that potentially involve direct exposure to combat scenarios suffer from PTSD at an even higher rate (Farmer et al., 2014). To alleviate this risk, the Marine Corps implemented a program called the Operational Stress Control and Readiness (OSCAR) program (Farmer et al.,

2014). This initiative sought to help Marines in managing their mental health through embedding mental health professionals into combat units and increasing the counseling capabilities of their senior NCOs and commissioned officers. Farmer et al. (2014) finds, "To this end, select officers and senior NCOs at the battalion and company levels attend a one-day training course that delivers instruction on OSCAR principles, as well as the recognition, intervention, and referral of marines with potential stress injuries." To my knowledge and based on my research, the Air Force has not implemented this type of initiative.

This same study also finds that among Marines who have experienced combat, 79.3% have used a mental health resource and 88.7% have recommended a fellow Marine to use a mental health resource. The most used mental health resource used in the context of this research is a fellow Marine, which 71.9% of respondents claim to have used (Farmer et al., 2014). For my own study, I do not consider a fellow Airman to be an adequate mental health resource in dealing with mental health issues.

Suicide among military members is always a hot-button issue and involves several factors. Unfortunately, the military model of mental health care is inconsistency among service members, low number of qualified mental health professionals serving in or with the military, and contradiction from senior military leaders. Additional issues facing suicide and mental health within the military include the following:

> Service members are leery of the diagnosis of a mental disorder because of its potential career implications. Patient confidentiality for service members must be enhanced to approximate civilian standards except when there is an imminent threat to combat-related mission. Military mental health clinicians must leave

> behind the age-old and empirically unsupported military mental health view that a diagnostic label reduces service members' will to recover and function. (Engel, 2013)

The Department of Defense's approach used to combat suicide is contingent on the belief that suicide is a mental health disorder. As a mental health disorder, research had been geared towards the identification of demographics and characteristics of those who have or are likely to commit suicide. For some, this tactic is not without its shortcomings:

> While understanding suicide from the medical perspective has no doubt saved lives, it has inadvertently created a circular loop in the continued national and military policy responses of suicide as being largely understood in the context of mental health pathology controlled and privileged by mental health professionals requiring continued mental health problem solving overlooking other perspectives, in this case service members' perspectives of military mental health policy and suicide prevention efforts. (LeFeber & Solorzano, 2019)

LeFeber and Solorzano (2019) recognized that this approach to suicide and mental health among servicemembers was not comprehensive and took a narrative approach to gaining insight on suicide in the military. The researchers interviewed seven service members, ranging from two years of service to more than 20 years. The sex of the participants was three women and four men, ranging in age from early 20s to late 40s across numerous military occupations. The narrative approach to this problem provided the researchers with internal solutions as opposed to external or purely clinical ones. It

allows participants to assign their own meaning to their experience in contrast to a researcher conveying their own. The researchers identified many themes while analyzing and categorizing information gathered from their interviews. Some of these themes provide a preview of what to expect in my research. The first theme is a perceived lack of confidentiality within the workplace. The nature of some occupations requires the notification of a mental health issue to the member's supervision or chain of command. One participant spoke to his suicidal ideations stemming from a feeling of isolation. When his chain of command was notified, he was unable to fly or perform his duties, further isolating him from his unit. One member served as a Green Beret and felt that much of his unit avoiding reporting any mental health issues because of the fear of losing their security clearance and being removed from the team. Another prevalent theme found in this research was the quality of mental health services provided by the military. One participant felt her diagnosis of depression was delivered without empathy and expressed in a way that portrayed her as unable to do her job because of the diagnosis. The participant felt depressed for a long period of time and had only received outstanding performance reports and many awards from her work. In another case, a military member claimed she was diagnosed as suffering from schizophrenia and an avoidance disorder. Due to this diagnosis, she was prescribed medication and discharged from the military. Veteran Affairs (VA) conducted follow-up appointments with her, and the doctors documented a noted improvement in her behavior due to the medication. She claims she stopped taking the medication and felt as if she was misdiagnosed. The researchers found that this puts many veterans in the precarious position of choosing between their life and their career (LeFeber & Solorzano, 2019).

Suicide is a leading cause of death of Airmen, and one of the programs the United States Air Force uses to alleviate suicide among its junior enlisted force is through Wingman-Connect. Among active-duty U.S. military servicemembers, the rate of suicides is 24.8 for every 100,000 personnel. A trial was performed using a random selection of 1485 Airmen within 215 training classes from a two-year period, occurring from October 2017 to October 2019. The intervention within the program occurred for approximately six-months, from the time the Airman entered technical training, to the time the Airman left for their first duty station. The intervention itself consisted of group-based instruction centered around giving Airmen skills to help with their resiliency. The intervention included three sessions lasting two hours each. Results were scored using the following two methods: the suicidal ideation and depression scales of the Computerized Adaptive Test for Mental Health, and data sourced from an Airman's annual Personal Health Assessment (PHA). Upon completion of the Wingman-Connect intervention, Airmen were given $50. The program reduced symptoms of depression and suicidal ideation among its participants while actively in the program, and for one month after. After that one-month period, there were negligible benefits for depression and suicidal ideation. Based on the results of this study, researchers recommended the program be expanded to include other installations, other tiers of Airmen, and occur annually (Wyman et al., 2020).

Several classes that I personally taught were selected for participation in the Wingman-Connect program. Because our class schedule was so strict with timing, losing students for two hours of class time meant that time would have to be made up the next day with accelerated pacing or on a weekend. Initially, I would ask my classes what they

thought of the program and the majority had negative attitudes towards Wingman-Connect. The top complaints were that it made their workday longer, and they did not like talking about their mental health with strangers.

Although unintentional, aircraft armament Airmen, like most Airmen assigned to aircraft maintenance occupations on the flightline, experience some of the same concepts used to extract information from terrorists through torture. Work on the flightline occurs outdoors under all weather conditions, including extreme heat. Airmen in these occupations can work extremely long hours, in some cases resulting in a 16+ hour workday, resulting in partial sleep deprivation. "Historically, sleep deprivation has been used for a number of different objectives but, primarily, to cause stress and duress for the purpose of coercing information and confessions" (Cakal, 2019, p. 13). These long hours result in less time spent at home or in contact with loved ones. Flightline work is also shift work, requiring 24-hour coverage during the week, and some weekends depending on aircraft fleet health. Depending on the shift or time of day an Airman is tasked to work, they may get minimal exposure to the sun. Sensory overload also occurs through the extremely loud noises produced by jet engines and running aerospace ground equipment (AGE). Stress positions ensue from prolonged periods of standing, and the manual transporting of large and heavy AGE equipment. Considering the pain caused by the prolonged significant manual labor, partial sleep deprivation serves to magnify physical ailments (Pérez-Sales, 2017). Combined, the effects of the flightline environment can be debilitating for some, with Leach (2016) writing, "Each single factor may not be considered tortuous, however, if deliberately structured into a systemic cluster may constitute torture under legal definition." All these elements of aircraft maintenance

occupations, while arguable necessary, have a negative effect on the mental health of the Airman.

Further exacerbating this issue is the strain placed on mental health providers. Civilian mental health professionals have a low ratio of provider to patient resulting in an excessive workload, an unsupportive culture, ethical clashes, and seclusion from other mental health professionals (Hall et al., 2007). Their military counterparts share the same issues with their civilian peers. In addition to the strain identified previously within this paragraph, military mental health professionals also must balance the needs of their branch of service versus the needs of their patient, resulting in internal conflict (Johnson & Wilson, 1993). In addition to their role as mental health providers, military mental health professionals also serve as consultants to base leadership and various base entities charged with maintaining good order, discipline, and readiness (Johnson, 2008).

While many military members are perplexed at the confidentiality rules surrounding certain mental health resources, mental health providers face ambiguous rules to confidentiality as well. Conventional mental health professionals highlight and prioritize the confidentiality of their patients in all aspects, with three exceptions: child abuse, imminent harm to others, immediate harm to self (King & Snowden, 2020). Military mental health providers have additional mandatory reporting items:

> The Instruction identifies nine circumstances in which providers are required to notify clients' commanders, including when a client: poses a serious risk of harm to self, poses a serious risk of harm to others (including child and domestic abuse), poses a serious risk to a specific military mission, is assigned to sensitive duties (e.g., nuclear, flight missions) and is impaired, initiates or terminates

> inpatient care, has acute medical conditions interfering with duty, initiates or terminates substance abuse treatment, or undergoes a command-directed evaluation. (DoD, 2011)

Studies also show that the COVID-19 pandemic has led to an increase in alcohol dependency among the general American population and certain groups within the U.S. military show an even larger increase. 3,078 military veterans were surveyed from 2019-2020 through the National Health and Resilience in Veterans Study prior to the pandemic and during the pandemic, to measure the prevalence of Alcohol Use Disorder. Results show that younger servicemembers, having served in combat roles, and have more COVID-19 related stressors in their daily lives are more susceptible to Alcohol Use Disorder (Na et al., 2021). Members of the unit under observation for my research all meet the criteria outlined in Na et al.'s (2021) study for vulnerability to alcohol abuse.

When the mental health needs of military members are not met by military resources, many servicemembers turn to options outside of the military. Among the many reasons for seeking care from a third party as opposed to the military are fear of reprisal from the chain of command, mistrust of leadership, insufficient and unresponsive services, or military sexual trauma. This research shows that military mental health resources still hold a responsibility to their respective branch of service and sometimes prioritize the mission instead of the individual. Additionally, military mental health providers have a high volume of patients, causing a reduction in access to care and quality. Civilian mental health resources have no obligation to a military branch and potentially provide individualized and higher quality care (Waitzkin et al., 2018).

The COVID-19 pandemic has also caused a very small increase in suicidal ideations and suicide attempts among veterans of the U.S. military. This study investigated the prevalence of suicidal ideations and suicide attempts using the same data collected from 3078 prior military members in the National Health and Resilience in Veterans Study in Na et al.'s 2021 research (Nichter et al., 2021). While the researcher's results only identified an increase of 2.6% of new suicidal ideations and suicide attempts, that number was significantly higher for veterans who contracted and tested positive for COVID-19 (Nichter et al., 2021). Later studies should research the mental health for veterans who tested positive versus those who did not to find a relationship between adverse mental health and COVID-19.

Essential Workers and Mental Health

There are direct comparisons that can be made between military work and essential work, like nurses, mechanics, police, transportation professionals, and other similar occupations. Essential workers have similar concerns with mental health, due to the nature of their job. Within the general population of Americans surveyed in March of 2020, 45% reported having increased levels of stress or worry, related to COVID-19. Healthcare professionals already had higher levels of stress prior to the pandemic, due to potential increased contact with COVID-19 positive patients and inadequate personal protective equipment (Guerrini et al., 2020). Researchers polled 1,123 health care professionals who had not previously utilized mental health services prior to the COVID-19 pandemic, and 51% of those polled expected to take advantage of those services for pandemic related mental health issues.

Among the issues causing concern for essential workers is the view of poor workplace protections against infection. Essential workers must fulfill the responsibilities of their job to ensure the general populace has access to the vital services needed to take care of their families and ensure their safety. On the apprehensions workers face due to the pandemic, Mayer et al. (2022) report, "Frontline essential workers face elevated risks of exposure to COVID-19 because of the interactive nature of their jobs, which require high levels of interaction with the general public and coworkers." Furthermore, there are increased stressors with essential workers outside of the health-care field. These workers have even less availability of personal protective equipment, less training on how to mitigate the transmission of COVID-19, have less education, and work for lower wages. Where this manifests in mental health for essential workers is that employees with a poor opinion of safety measures taken by their employer are more prone to unsafe risks within the workplace and find themselves less motivated to follow safety guidelines (Mayer et al., 2022).

The nature of essential work requires increased collaboration with customers, patients, and coworkers, while also putting the families and friends of essential workers at risk as well. As previously identified within this literature review, non-healthcare essential workers are unable to take advantage of mitigation efforts to reduce the spread of COVID-19 and infection. One study within a grocery store tested 102 employees for COVID-19 and found six positive cases, with four of those cases being asymptomatic. Close daily interaction with customers, reliance on public transportation and ride sharing, mean these employees were unable to practice social distancing which resulted in increased anxiety and stress (Fan-Yun et al., 2021).

While there is a plethora of research on the impact COVID-19 has on essential workers, there is a gap in research on the impact COVID-19 has on the families of essential workers. Adolescent girls and gender non-conforming children of essential workers, under the age of 13, were more likely to have a significant mental health event (i.e., self-harm, suicidal thoughts, or substance abuse) when compared to the same groups or children under the care of non-essential workers. Race also contributes to increased risk factors for the children of essential workers. According to Sugg et al. (2021), "Additionally, Hispanic children of workers reported higher rates of stress/anxiety, whereas African American children of workers had higher rates of abuse and depression."

Social Constructionism

The roots of social constructionism rest with the originators of modern social sciences. Those founders are Emile Durkheim, Max Weber, and Karl Marx. Durkheim believed that the framework for categorization reflected the cultures and societies where they happen. Weber's contributions to social constructionism were more abstract in nature, owing his influences through the inspiration of later sociologists like Alfred Shutz, Karl Mannheim, and Jurgen Habermas (Weinberg, 2014). Interestingly, when talking about the origins of social constructionism and how its ideas are rooted in Marx's ideologies, Weinberg (2014) found, "Marx developed this concept to suggest how people can suffer from a false consciousness that renders them complicit in their own oppression."

Social constructionism is the idea that what some believe to be facts are shaped by society and are based on one's perspective through which those facts are viewed (Kang et al., 2017). This theory normally applies to undeniable concepts like sexuality, race, and gender (Kang et al., 2017). Here, I am applying social constructionism to the cultural beliefs held by Airmen in the aircraft armament occupation. To reiterate, it has become a fact among some Airmen that utilizing mental health resources will have an adverse effect on that Airman's career. Culturally, they have assigned this meaning to mental health resources that is not true. Lane and Kolack (2020, p. 21) stated, "Looking into military culture, social constructionism would state that a problem does not exist socially until it has been defined by some agent as an actual social problem." A key term to social constructionism is "culturally relative." I believe the idea that utilizing mental health resources will be harmful to an Airman's career is specific to Air Force members with occupations within the aircraft maintenance field and that idea may not be shared by other supporting AFSCs. Supervisors and leaders at all levels within a military installation and above should take a more proactive role in promoting the benefits of mental health resources, because their words and actions hold power. Lane and Kolack (2020, p. 23) emphasized, "In military context, this theory takes a closer look at how acts are limited and restrained by the system of power relationships, and how the resulting behaviors from this system can either reproduce or reinforce that learned system."

I interpret social constructionism as the way all members of a group classify things and ideas is based on the circumstances that group finds themselves in, authentic or imaginary. Furthermore, social constructionism believes that people create information

from social interaction. While this case examines gender formation, it also does an exemplary job of identifying how ideas become accepted as fact over time.

> For example, practices such as encouraging girls to be docile or admonishing boys not to cry help to disseminate and perpetuate constructed "knowledge" about gender. This type of knowledge stems more from current connotations about femininity and masculinity (which are social constructions in their own right) than from preexisting, "natural" characteristics of human beings. (Allen, 2005, p. 36)

Social constructionism and mental health intersect in a meaningful way. There are frameworks or structures within mental health fields of practice that directly inhibit those who need assistance.

> This study addresses the issues of power, labeling, and the media as they relate to the quality of mental health care that the individual receives and how the power that resides within various cultural systems impacts the identity and experiences of consumers of mental health care. (Onofrio Babb, 2014)

Mental health professionals have a counter-intuitive culture that can misrepresent patients, leave them vulnerable, and actively thwart the use of mental health services (Onofrio Babb, 2014). The social constructionist view to mental health uses narratives to tell an individual's story. Llewellyn-Beardsley et al. (2019) expressed, "A sense of identity, in this approach, is not discovered in but actively constructed by the act of telling stories, with the construction of personal narratives providing opportunities to change an individual's view of reality." Moreover, therapists using the social

constructionist approach find individual stories as more of an overarching narrative on cultural ideologies (Llewellyn-Beardsley et al., 2019).

Symbolic Interactionism

Symbolic interactionism became a tenet of sociology in the 1960s but was first mentioned in 1937. That year, Herbert Blumer wrote a book called Symbolic Interactionism. Other key contributors to the theory were George Herbert Mead, Charles Horton Cooley, and William Isaac Thomas (Quist-Adade, 2019).

The main concept of symbolic interactionism is that social exchanges create communal definitions which are then used to identify behaviors in dynamic patterns of work, commerce, family, worship, and play. The three basic perceptions of symbolic interaction are that people extensively use symbols; people assemble their social realities through interaction and role assignment; and that interaction, people, and the societies they belong to are intimately linked. Symbols are defined as verbal communication, written language, and body language (Quist-Adade, 2019). In summary, "Symbolic interactionists assume that social reality is not something out there, already existing, but rather it is created when people engage one another in communication" (Quist-Adade, 2019, p. 21).

As previously stated within this research, the military community is extremely tight knit. Military relationships last no matter the elapsed time, distance, branch, or status. There are things about military culture that cannot be communicated to outsiders who have not experienced it. That bond comes with a high level of trust and is explained by symbolic interactionism. If you ask a wingman for advice in dealing with a sensitive

mental health issue, and they advise against using a particular mental health resource, that advice becomes law. Over an extended period, those ideas become ingrained into that culture and unraveling those ideas becomes extremely difficult.

Summary

When looking at the results of these studies in the context of the research for this literature review, the studies support previous theories about the COVID-19's impact on the military, COVID-19's impact on mental health, the development of mental health educational materials, and the utilization of mental health resources. Additionally, this literature review identified writings on social constructionism and symbolic interactionism as the basis for the theoretical framework. Although there is no direct connection to enlisted aircraft armament Airmen in many of the studies examined for this literature review, the groups and results are comparable and appropriate. This literature review also guided the research in identifying areas that require further exploration. Chapter 3 details the methodology used in developing this research and collecting data. Later, Chapter 4 will outline the findings of this research and Chapter 5 contains the summary, recommendations, and conclusion.

CHAPTER 3

METHODOLOGY

Action research dissertations are intended to outline the methodology behind the research. The term methodology refers to the path taken within one's research to discover findings. By many accounts, the methodology behind a study is the most important aspect in that it determines the quality of your research and allows others to repeat your research design (Herr & Anderson 2014). The crucial factors involved with action research are the improvement of practice or a social change, and the addition of knowledge to a practice. Action research also asks the researcher to consider the social and historical context behind their subjects' motivations (Efron & Ravid, 2013). The benefits of this approach are that it has the potential to offer tangible outcomes that benefit the participants, participants could feel emboldened by the study, and it generates new knowledge for the field (Herr & Anderson, 2014). Moreover, action research is performed by insiders within the organization or group under study (Efron & Ravid, 2013). Action research is appropriate for this study because I am an insider and a member of the group under study, the study meets the intent to improve that group through assistance with mental health resource utilization and managing COVID-19 related stressors and adds to the knowledge base regarding enlisted Airmen and their mental health.

A key component of action research is improving one's professional practice, community, or organization. This study accomplishes that in many ways. As identified during the literature review, there is very little written on this specific topic regarding

Airmen in aircraft maintenance occupations, which improves the professional practice. The 2W1 weapons community is potentially improved through the intervention, providing Airmen with a comprehensive resource guide for them to refer to for themselves or another Airmen. The squadron I belonged to is improved due to the participants potentially getting the help they need without having to ask a third party for contact information or consequences for using specific mental health resources. I have seen first-hand, the strain placed on enlisted Airmen in aircraft maintenance career fields. Many of these Airmen either ignore those issues to continue their role within the mission or are unaware of their options to seek assistance. Furthermore, with improved mental health comes improved effectiveness on the job and alleviating cultural pressures to perform on the job at the expense of one's health.

The purpose of this action research study is to examine the effects of COVID-19 on the mental health of Airmen, study overall attitudes towards mental health resources, implement a mental health awareness intervention that makes members aware of the resources available to them, and see if this leads to an increased number of Airmen seeking these services out. Furthermore, this study looks at cultural obstacles preventing Airmen from disclosing their mental health struggles and seeking help. In Chapter 2 of this action research study, I identified many studies related to this research. Although many of the studies in the literature review did not explicitly convey the exact topics contained in this research, their data was still essential to conducting this study.

The research questions involved in action research stem from events, problems, or professional interests that the researcher finds worthwhile, with the overall goal being to improve the professional practice, community, or organization. The research questions

focus the study, defines the area of research under investigation, and guides the methodology (Herr & Anderson, 2014). The design of this research allows for the research targets to describe the issue in their own words, interpreted by the researcher. The research questions were written in a manner to capture qualitative data in a narrative form. Guided by the theoretical frameworks of social constructionism and symbolic interactionism, the research questions are as follows:

1. What improvements, if any, does an intervention have on Airmen's handling the demands of military work while balancing the fears and mental challenges of COVID-19?
2. What is the relationship, if any, between COVID-19 restrictions, mission effectiveness, and the mental health of enlisted Airmen?
3. What methods would be effective in counteracting perceived negative consequences to utilizing mental health resources?

This research was designed using several parameters. The study was to be conducted using action research, to occur within the researcher's place of business or educational institution and involve an intervention. Action research, also known as practitioner research, is a reflective inquiry conducted by researchers within the setting they belong to, to advance their practice and improve their organization or community (McKernan, 1988; Wood, 2020). The process starts from the bottom and moves up the chain—meaning the research begins at the lower levels of the organization and moves up the ladder of responsibility. There were additional steps required in conducting this research, considering that both the research participants and the researcher are Department of Defense employees.

Research Design

Prior to data collection, both the U.S. Air Force's Human Resource Protections Office and the University of South Carolina's Institutional Review Board approved the methods and procedures for this study. I also had to gain approval from my direct supervisor, the 1st Sergeant, Squadron Commander, Squadron Superintendent, and Group Commander. The Squadron Commander also insisted that I reach out to the Medical Group Commander to ensure my research was ethical and did not put any Airmen in danger. Essentially, each level of approval asked for changes to the research design, which then drove amendments to the research, submitted to both the U.S. Air Force's Human Resource Protections Office and the University of South Carolina's Institutional Review Board. Participants in this study were recruited during "roll call," which occurs before every shift. Each Airman was given a brief overview of the study, to include my background, the purpose of the study, and the extent of their participation, if the Airman chose to assist. Furthermore, direct subordinates were not considered for this research.

A phenomenological approach to this qualitative study was appropriate due to the nature of the research, which is studying the potential effects of COVID-19 on the mental health of enlisted Airmen, and the lack of qualitative research concerning COVID-19 and the mental health of Airmen. Phenomenological methods collect data from the perspective of the individual, or in other words, examines a particular problem from the viewpoint of the participant (Qutoshi, 2018). In this qualitative action research study, structured interviews with open-ended questions and observations were the most appropriate means of data collection (Creswell & Creswell, 2018). Participants were

interviewed over email, received an intervention in the form of a resource guide outlining mental health resources, then participants were emailed for a second time to measure any changes in perspective. This approach gave the perspective on COVID-19 and mental health within the work section, along with perspectives on mental health resources. Furthermore, this approach allowed for participants to potentially be contacted after the second set of interviews for follow-up questions to further collect data.

Another key to this research is participant observation. One aspect of participant observation is to view the research targets in a variety of settings. In this case, participants were viewed both on and off-duty, while working, and while on break. As the researcher, I drew upon my 20 years of experience in supervising both Airmen and NCO's, repeated narratives among Airmen, and my intimate knowledge of the mental health struggles Airmen faced while I was a 1st, Sergeant. Sharpe (2019) said, "PO was historically associated with a form of research in which the researcher resides for extended periods of time in a small community."

The type of study a researcher conducts determines the type of data collected for the study, which in this case were themes and narratives (Efron & Ravid, 2013). Finally, the report write-up contained qualitative data that provided a snapshot in narrative form on how COVID-19 affected the mental health of Airmen, and their utilization of mental health resources. A thematic analysis was used to sort the data and placed in Chapter 5 of this study. Thematic analysis was appropriate because the type of data collected is qualitative, which is difficult to express with charts and graphs.

Description of Context and Participants

The setting for this research was an Air Force base located in the Southeastern United States. The base was in Air Combat Command. The unit was within the Maintenance group, and the section was an Armament section. The unit had two large hangars that typically housed two large fighter jets. There was an assortment of powered Aerospace Ground Equipment and running aircraft, making for a high level of noise. Thankfully, between the hangar bays were offices that provide areas where conversations regarding this research could be held while talking at a reasonable volume. On the flight line, where most of the assigned aircraft are located, there were sunshades that protect Airmen from the sun on most parking locations. Otherwise, Airmen conducted their work in all types of weather.

The population of interest was enlisted Airmen between the grades of E3-E7 (Airman First Class, Senior Airman, and Staff Sergeant, Technical Sergeant, and Master Sergeant) within the 2W1X1 Air Force Specialty Code. The expectation was a target sample of ten (10) participants from a population of twenty-six (26) personnel. The aircraft maintenance section under research for this study has a total of twenty-six (26) Airmen, determining the population, with a potential pool of eighteen (18) that meet the criteria of enlisted Airman. Convenience sampling was used to select the participants from the population of eighteen (18), and the stratification requirements are: assigned to the Air Force base from January 2020 to June 2021, and between the grades E3 and E7. The Airmen in this group are normally between the ages of 18 and 40. In a convenience sampling, participants are selected based on availability and willingness to engage (Creswell & Creswell, 2018).

The hours worked were anywhere from 8-13 hours a day, on three periods called mid shift, day shift, and swing shift. Many of the elements that occur in this setting were like what interrogators use to acquire information from the enemy: long hours, minimal nourishment, sleep deprivation, isolation, and loud noises. Although squadron supervision tries to allot Airmen time to eat a meal during their shift, those opportunities are determined by aircraft fleet health, flying time slots, and that Airman's individual workload. These factors induce high stress, depression, and other negative mental health diagnoses (Halperin, 2014). These considerations directly impact the willingness of enlisted aircraft armament Airmen to engage in this study, leading to the selection of convenience sampling.

The section level of a unit is traditionally a tight knit group, relying on each other for advice or guidance on personal or professional issues, which led to the selection of social constructionism and symbolic interactionism as the theoretical framework. Based on observational evidence from personal experience, Airmen within the 2W1X1 career field have a culture of ignoring their mental health issues, self-medicating with alcohol and other vices, and encouraging others to do the same. The research will occur outside of its natural setting, to minimize ethical concerns and to curtail distractions. Distractions could occur in the form of jet noise, Airmen interrupting the interviews, or even supervisors influencing the interviews. Conducting the interviews over email will eliminate these factors.

Intervention

The intervention utilized for this research, referred to a resource guide within the study itself, is intended to help Airmen identify the mental health resources afforded to them, how to contact those resources by phone or email, where they are physically located on the base, and any additional notes or confidentiality agreements offered by the resource (See appendix D). It was designed to be easy to read, pocketable, shareable, and low cost. At the start of the intervention, I met with Airmen individually and asked if they knew of the mental health resources offered by the Air Force. After talking with each Airman, I provided them with a pamphlet that outlined the mental health resources available to them. After providing Airmen with the resource guide, I observed them for the next four weeks, looking for any signs of distress or abnormal behavior. During my observation, if I noticed that an Airman exhibited anything that I thought might be mental health related, I reminded the Airman to review the guide that I provided for them. The focus behind its implementation was to give Airmen a quick reference if they find themselves personally in a mental health crisis, or if a fellow Airman or family member needs assistance. I personally contacted the resources to verify their contact information and confirm their rules around confidentiality. Throughout my career, I have observed and seen many Airmen not know who to contact for help, and supervisors not know who to direct their subordinates to for assistance.

Instruments and Data Sources

The instruments used to collect data for this research were interviews and observations made by the researcher himself. Interviews gave data from the research

targets, enlisted Airmen, on how COVID-19 has impacted their mental health and how it affected their likelihood to utilize mental health services while also giving the researcher the opportunity for more in-depth responses and follow-up questions. The observations were drawn upon by the researcher over a 20-year career, serving the very same target group the participants were a member of. The data sources were from the researcher-participant and the research participants.

Procedures

Described below are the steps that occurred to conduct this research written in chronological order.

The researcher piloted interview questions asked later in the data collection process. These questions were open-ended, allowing for follow-up questions, and prompted thorough responses. Special attention was paid to not reopen any previous trauma. The interview questions were submitted to both the U.S. Air Force's Human Resource Protections Office and the University of South Carolina's Institutional Review Board, and key members within the researcher's wing. Below are the interview questions that were asked to the Airmen prior to the intervention.

1. What has been your experience with COVID-19, personally? Professionally?
2. If you had any difficulties, were you aware of the mental health resources afforded to you? If aware, how did you hear about them?
3. Have you utilized those resources? If not, what made you hesitant? If so, were those resources helpful in what you were going through?

4. Overall, how would you describe the viewpoint your peers have towards mental health resources in the military?
5. If a peer came to you with a significant issue that they were unable to handle themselves, how would you assist them?
6. How effective is the current messaging to notify service-members of the benefits versus the consequences of utilizing mental health resources?
7. Are there any other barriers to aircraft maintenance service-members seeking help?

The second interview occurred one month after the Airmen received the intervention. The second set of interview questions were reviewed in the same manner as the first set. Below are the interview questions that will be asked to the Airmen post-intervention.

1. Were you aware of all the resources on the resource guide? If not, which ones were you unaware of?
2. Does having the resource guide benefit change your view on mental health resources? Does it change your likelihood to utilize them?
3. In terms of cultural attitudes toward mental health resources, what impact do you think a resource guide would have for your peers?
4. Has there been any change in your perception on how COVID-19 has affected you personally or professionally?

The researcher also created an informed consent document. This document serves multiple purposes. It gives the research targets a preview into the context of the study, allows potential participants the opportunity to opt out of the study, and protects the

researcher from liability. The informed consent document was written using a template from both the University of South Carolina's Institutional Review Board and approved by the U.S. Air Force's Human Resource Protections Office.

Following IRB approval, I then recruited 10 potential participants from a population of 26 during roll call for this study. The recruiting occurred during "roll call" on a Monday, and the population had approximately two weeks to reply, with a reminder at the one-week point. The potential participants were between the grades of E3-E7 and assigned to the Air Force base from January 2020 to June 2021. This aligns with the same age group of those who most had their mental health affected by COVID-19.

Next, I then sat with the potential participants and gave them the consent form, while verbally explaining the study. The expectation was to acquire at least ten (10) positive responses from those eligible to participate. If there were more than ten (10) who chose to partake in the study, ten (10) would be randomly chosen. Subjects were then interviewed using previously piloted interview questions. Participants received a list of questions over email, while the researcher asked follow-up questions for clarity. Communications did not occur on any government issued computer or mobile device, and government affiliated e-mail accounts were not used, to prevent any potential legal issues.

After the initial interview, subjects received an intervention in the form of a resource guide (see appendix D). The resource guide outlines mental health resources, their contact information, and the confidentiality the mental health resources offer. This resource guide is small enough to fit in the Airman's pocket and is intended to be used as a quick reference for themselves or for another Airman in need. Along with the resource

guide, the interview subject also received a verbal briefing on each item contained on the resource guide, presenting the subject with the opportunity to ask any questions. To prevent other Airmen from identifying research participants, targets received the resource guide in private. After a month with the resource guide, Airmen were asked follow-up questions which are identified above.

Following both sets of interviews, I then sorted and organized data using a thematic analysis, then interpreted that data to answer research questions and draw conclusions. By coding, the data was perused for repeating or significant findings. It is important to accurately capture the responses from the target audience in this study. Failure to do so will result in skewed or improper results from the study. I took particular care in sorting through the data without bias, preventing any influence from potential findings.

Then, I drew upon my own experiences as a supervisor. Over my 20-year Air Force career, I have struggled with my mental health on occasion, and witnessed others struggle with their mental health extensively. Using those experiences and conducting participant observations will provide another perspective on COVID-19's impact on mental health and mental health resource utilization. In this instance, avoiding bias is not possible, because I am the researcher, and I am using my own understanding.

Lastly, I wrote the final report and informed the participants of their individual contribution to my findings. I ensured I captured the participant's responses accurately, and they saw my interpretation of their replies. Allowing participants to view the study's findings and provide feedback ensures the validity and reliability of the results. Triangulation confirms the accuracy of any findings through multiple data sources

(Creswell & Creswell, 2018). Interview data will be triangulated with historical data and observations to confirm the veracity of the findings.

Researcher's Background and Role

Positionality is the relationship between the researcher, their participants, and their setting (Efron & Ravid, 2013). It gives a snapshot to the lens in which the researcher is viewing their subject matter. I served as a Master Sergeant stationed at the same base and working in the same unit as the research participants, and my duty title was Non-Commissioned Officer in Charge (NCOIC) of Loading. I directly supervised four Technical Sergeants, and indirectly supervised or managed an office of approximately 70 Airmen. Before my assignment to that position, I worked as a Technical Training Instructor and Instructor Supervisor at an Air Force base in Texas for four years. As a Technical Training Instructor and Instructor Supervisor, I directly supervised six NCO's and 80 Airmen in training. Also, while stationed at the base in Texas, I was the Associate 1st Sergeant for a year and a half, responsible for hundreds of Airmen. Prior to that, I served in various roles within the 2W1X1 AFSC, like the roles of the target audience. I was an Airman working under a Staff Sergeant supervisor, then became a Staff Sergeant supervising Airmen, then became a Technical Sergeant who supervised Staff Sergeants. Positionality slides across a spectrum, changing throughout the course of one's research (Herr & Anderson, 2014). This makes me an insider, because I am researching the very organization I am a member of, through the lens of someone who has had similar experiences with COVID-19, faced mental health challenges, and directly observed the difficulties faced by Airmen due to the pandemic. I have extensive knowledge of the

AFSC and supervising Airmen within the AFSC at multiple grades. My biases surface through my personal and professional relationships with the participants, passion about mental health issues, and my own experiences and challenges due to COVID-19. To counteract these biases, I standardized all interview questions and prevented my personal relationships from skewing my interpretation of the data.

Ethical Considerations

One of the many roles of the researcher is to protect their participants, gain their trust, act with integrity, and prevent reprisal against the participants from their organization (Creswell & Creswell, 2018). Reprisal is of high importance, because this study involved Airmen who may supervise or be subordinates of other Airmen. In relation to this study, there are a few ethical considerations for all participants to be aware of. Both the U.S. Air Force Human Research Protection Office, and the University of South Carolina's institutional review board approved this research study.

The researcher-participant relationship is the first consideration of this study. As an insider and researcher for this study, there may be barriers to accurate information. I am a Master Sergeant and a workplace supervisor within a maintenance section of the squadron. Junior enlisted Airmen may be uncomfortable talking about mental health with an authority figure and may not give valid responses based on Air Force rank structure. Rank structure and an inherent respect for Airmen higher in grade could lead to lower ranking Airmen being hesitant to refuse participation (Yambo et al., 2015). Because of my position within the group under research, I may be the source of a mental health stressor for an Airman, resulting in a conflict of interest. Junior enlisted Airmen may also

fear negative consequences from their feedback. According to some, "The inherent power imbalance between the parties and the ethical concerns pertaining to this imbalance are commonly dwelled upon, with particular attention to the predetermined asymmetric roles between the researcher and the researched" (Råheim et al., 2016). I believe conducting these interviews over email are the best course of action to build a positive researcher-participant relationship.

There are ethical concerns regarding what data is being collected, what that data is used for, and the protection of participants' identities (Sanjari et al., 2014). Privacy is of the utmost importance when researching military populations, considering if participants are identified as having given information that would be detrimental to a higher-ranking individual, that participant could face significant punishment (Schuman et al., 2021). To prevent unauthorized access of participant names, their identities will be stored on a password protected laptop. Additionally, it is essential to provide consent information prior to collecting any data, allowing the subject the option to participate or decline (Sanjari et al., 2014). To prevent any confusion, a written document will be provided to the Airmen that outlines the purpose of the study, questions asked during the study, and how their responses will be applied to the study. This document along with participation in the study will provide informed consent.

Another ethical consideration is sampling. It will be important when conducting this study to carefully select participants and not use the researcher's direct subordinates. If someone experienced issues related to mental health and professional performance throughout the duration of the COVID-19 pandemic, selecting them for the study could cause them to feel targeted. If the issue was not disclosed to supervisors, it would be

challenging to avoid this. This can be avoided if the purpose and opportunity to participate in the study is shared widely. Given the first ethical consideration related to hesitations and the stigma behind mental health issues, clear communication regarding the study should avoid this issue.

Finally, my role as a mandatory reporter for sexual assault, suicidal ideations, and harm to others must be taken into consideration by participants as well. If during an interview an Airman were to disclose thoughts of suicide due to COVID-19 related stressors, I must notify the Shirt and escort that Airman to a mental health provider. Airmen are already aware of mandatory reporting requirements for all Airmen at or above the grade of E5, but I will remind them of my disclosure responsibilities.

Summary

The purpose of this chapter was to provide the reader with an insight into the methodology behind the research for this study. A phenomenological approach to research design was selected to capture the cultural thought processes behind attitudes held by Airmen in the 2W1X1 AFSC towards mental health services. The research design also was scrutinized by two review authorities and several key members of the researcher's squadron, group, and wing. Research targets were chosen based on period assigned to the Air Force Base and rank. Participants were asked a series of questions, received an intervention in the form of a resource guide, and then asked a second set of questions. Chapter 4 outlines the findings derived using this methodology and Chapter 5 summarizes the findings.

CHAPTER 4

FINDINGS

The purpose of this qualitative research study was to explore the impact COVID-19 has had on enlisted maintenance Airmen at an Air Force Base in the southeast part of America, their view of mental health resources, their utilization of those services, and any cultural obstacles surrounding mental health assistance. Social constructionism and symbolic interactionism provide the theoretical framework guiding this study. The phenomenological methodology for this qualitative action research study is to interview Airmen between and including the grades of E3-E7, gathering data on their experiences with mental health, giving them an intervention, and interviewing them for a second time to identify if any change in their attitude occurred. The researcher also draws upon observations obtained throughout their 20-year career serving various roles and ranks as a 2W1 Airman. This chapter ends with findings and a summary of the data collected.

As stated earlier, my positionality within the context of this research is that of an insider. I was a member of the unit under observation and worked in proximity and interacted daily with many of the participants. The relationships I shared with the participants were purely professional in nature, although some of the relationships began years ago, and I avoided recruiting any of my subordinates. There were no other researchers who assisted with this study in any way, although many individuals within the squadron and group required changes be made to the methodology. These changes

were made to protect the Airmen from harm, prevent any legal issues for the researcher, and alleviate any ethical or moral concerns.

Participants

From a pool of twenty-six (26) Airmen assigned to the aircraft maintenance section, there were eighteen (18) that met the criteria, which was they were assigned to the Air Force base from January 2020 to June 2021 and between the grades of E3 and E7. Subordinates of the researcher were also removed from consideration for this study due to ethical concerns. The reasoning for the timeframe for Airmen assigned to the base is because this was during the peak of the COVID-19 pandemic, so these Airmen have specific knowledge relating the pandemic to their occupation within aircraft maintenance. There were no gifts offered for participation in this study, and participants were allowed to decline participation at any time. After the intervention, one Master Sergeant participant removed themselves from the study, so their data was removed from consideration in this research. No reason was given for their refusal to further participate. Furthermore, all participants were grouped based on their rank and grade to assist in the thematic analysis of the findings (See Table 1). A total of nine (9) Airmen chose to participate in the study, meaning I did not reach my target sample of 10 research targets.

Table 4.1 Demographic Information of Participants

Demographic Information of Participants				
Participant	Group	Rank/Grade	Age	Time in Service
A	1	A1C/E-3	21	3
B		SrA/E-4	21	3
C		SrA/E-4	25	4

D		SrA/E-4	26	4
E	2	SSgt/E-5	26	5
F		TSgt/E-6	33	10
G		TSgt/E-6	33	15
H	3	MSgt/E-7	38	12
I		MSgt/E-7	41	22

Pre-Intervention Findings

The following table provides a quick reference to the overall themes present from each group in their response to the pre-intervention questions (See Table 2). The rest of this section will discuss the themes more in depth.

Table 4.2 Pre-Intervention Themes

Pre-Intervention Themes			
Question	Group 1 Theme	Group 2 Theme	Group 3 Theme
1) What has been your experience with COVID-19, personally? Professionally?	Positive COVID-19 tests resulted in an increased burden for those left behind.	Respondents unsure of who would be available on day-to-day basis due to COVID-19 quarantines.	Difficult to maintain healthy manning levels to meet mission requirements. Increased stress on those who did not test positive.
2) If you had any difficulties, were you aware of the mental health resources afforded to you? If aware, how did you hear about them?	No shared theme.	No shared theme.	No shared theme.
3) Have you utilized those resources? If not, what made you hesitant? If so, were those	Most did not express using resources for various reasons.	None expressed using resources for various reasons.	None expressed using resources for various reasons.

resources helpful in what you were going through?			
4) Overall, how would you describe the viewpoint your peers have towards mental health resources in the military?	Shared negative perspective on mental health resources.	Shared negative perspective on mental health resources.	Shared negative perspective on mental health resources.
5) If a peer came to you with a significant issue that they were unable to handle themselves, how would you assist them?	No formal experience in handling issues but would take a personal approach, providing a peer to talk to.	Formal experience. Would take a professional approach by listening and referring the peer to the appropriate resource. Did not have contact information readily available.	Personal and formal experience in handling significant mental health issues. Had some contact information for some resources, based on previous use by subordinates.
6) How effective is the current messaging to notify service-members of the benefits versus the consequences of utilizing mental health resources?	Poor messaging of resources by Air Force in general, while also failing to counteract negative perspectives.	Felt messaging was poor because those needing assistance were unclear on the consequences on using mental health resources.	The resources and their contact information are there for those who truly need help. It requires investment by both the individual and their supervisor.
7) Are there any other barriers to aircraft maintenance service-members seeking help?	No shared theme.	No shared theme.	No shared theme.

Prior to the intervention, there were several themes present, based on the rank and time in service of the Airman. Participants A, B, C, and D were all at the grades of E-3 and E-4, with an average age of 23, and consisted of group 1. This group of participants

also has an average time in service of 3.5 years. In their reaction to question 1 (What has been your experience with COVID-19, personally? Professionally?), most participants from this group felt that the most significant impact COVID-19 had on their lives was in terms of manning within their work center. This meant when an individual tested positive, they were out of work for up to two weeks. In a work center of this size (26 Airmen), working three shifts, one person testing positive for COVID-19 means that entire shift is also potentially positive, given that they work in proximity. This means the other shifts must rearrange their personnel to compensate. Additionally, if too many Airmen test positive, the unit is unable to maintain three eight-hour shifts and must turn to two 12-hour shifts. According to participant D, "Professionally we are under the constant stress of infection across the workplace and the same requirements remain; in an already low manned, high stress scenario, packing more work on less people has taken its toll on us all."

Group 2 comprised of participants E, F, and G, at the grades of E-5 and E-6, with an average age of 28, and a mean time in service of 10 years. This group had a similar perspective, that COVID-19 placed a greater strain on manning issues, while also adding in more context to the struggles presented by COVID-19's impact on them personally and professionally. The responsibilities of this group places them as front-line supervisors of younger Airmen; their stressors stem from the difficulty in managing the ever-changing rules surrounding COVID-19, and personnel management. Participant F says, "I think that my experience has been devasting, confusing and somewhat laughable due to rules and regulations constantly changing. Professionally, it has been very difficult. Difficult to get the job done while dealing with COVID protocol." Participant F has also

filled the roles of lower ranks and extended their own hours to prevent the entire shift from working extended hours. Doing this has caused additional strain on the participant's household.

Constituting group 3 were participants H and I, at the grade of E-7, age averaging at 39, and time in service averaging 17 years. This group of Airmen were tasked with managing the entire work center and coordinating with other entities to accomplish their mission. The responses to question 1, which asked about the impact of COVID-19 both personally and professionally, closely reflected those of group 2. The shared idea between all groups was that COVID-19 stretched their personnel thin, meaning those who were not testing positive had to work longer hours to compensate for absences. Participant H found,

> It has been incredibly difficult keeping manning levels manageable while still keeping up with military mission requirements. Close contacts were getting quarantined sometimes and other times they weren't. Randomly people would be positive, but weren't symptomatic and could effectively work, but were unable to do so.

Participant H also suspected that there were instances where their subordinates had symptoms like those of COVID-19 but did not get tested for fear of missing work and extending everyone's hours.

Question 2 asked, "If you had any difficulties, were you aware of the mental health resources afforded to you? If aware, how did you hear about them?" The responses were scattershot, and I identified no pattern based on grade, age, or time in service. Some participants knew of all the mental health resources offered by the base, while others only

knew of one or two. Notification about these resources was varied as well. Some knew of the resources based on personal utilization, having to refer a friend, a mass briefing held at the base theater, or word of mouth from a peer. I anticipated the higher grades being more aware of mental health resources compared to lower grades, but based on the responses to this question, that was not the case.

Question 3 asked about mental health resource utilization, reluctance, and the effectiveness of those resources: Have you utilized those resources? If not, what made you hesitant? If so, were those resources helpful in what you were going through? Out of nine participants, only one used a mental health resource while the other eight did not for several reasons. Key responses were as follows: participant A had concerns about the impact seeking mental health assistance would have on their career, participant C did not trust their supervision to keep their information confidential, participant E had a good support system in place and did not need additional assistance, participant F had concerns about taking time away from work and the impact that time away would have on the workplace, and H identified moments where they felt uneasy mentally and found other methods to reduce their stress. This question is where the potential existed for responses to be dishonest based on my rank and position within the unit.

Next, question 4 asked the Airman their opinion on how others view mental health resources in a cultural context. The overwhelming theme shared by all participants is that their peers think mental health assistance will negatively impact their careers. That impact could mean a loss of security clearance, inability to change bases, removal from performing their jobs on aircraft and placed on administrative duties, being viewed as a liability by peers, or the withholding of promotions. Interestingly, participant C gave the

most poignant response, claiming, “Peer to peer might be the most accepting level of use considering they are there with you to experience the constant stress. It is not said but often obvious that supervision would rather throw your mental health under the bus to get some jets up in the air. It is shown in their actions and a constant problem for our young core of workers in the military.” Participant I felt as if the stigma was slowly changing, while also feeling as if there is still progress to be made, saying,

> The viewpoint associated with the resources at hand are growing more positive overall I feel. The stigma mental health has on a career is diminishing amongst peers with the realization mental health concerns are as impactful if not more, as a broken arm.

Based on the groupings of responses to this question, more experienced and higher ranked Airmen had a more negative view of the cultural attitudes surrounding mental health assistance in the Air Force.

Question 5 asked research targets to gauge how each participant would respond if a peer were to present the participant with a significant mental health issue. This question is essential because Airmen are more likely to disclose any mental health difficulties to their peers, instead of a higher-ranking individual. The answers here were more aligned by the respondent’s grade and time in service, like question 1. Most of group 1 claimed they would take a personal approach while seeking outside assistance if completely necessary. Only participant B gave the names of specific entities, proclaiming, “I would refer my peers to counselors, chaplains, supervisors and like resources. First, I would offer an ear as maybe they need to simply vent.” Experience in handling mental health

issues is likely the most significant factor in these answers, and group 1 has little to no formal experience.

Group 2 took a more professional approach, mostly saying they would listen to the details surrounding the mental health issue, then refer the peer to the appropriate resource for assistance. Participant F stated, "By listening, first of all. After listening, I would ask them a few questions to see where their head space is. Then I would find a list of possible places to refer them to." No participants in this group had contact information on hand or specific resources in mind for this scenario. Group 2 has had formal military training on assisting peers and subordinates with mental health crises, and that training reflects in their responses. However, they should know specific resources.

Group 3's responses showed an even more professional approach than the previous two groups, while also focusing on the immediate health of the Airman needing assistance. Participant H and I were both in the military for an extensive amount of time while also having an average age of 39. The responses here reflect that broad experience. Participant H feels,

> I constantly have an open chair next to my desk that people know is there for them to come and talk about any number of things. If I can network them to a professional or a better resource, then I will guide them. If it happens to be a problem that I am unsure of, I will help them research what potential avenues are available to handle that problem.

Many supervisors claim to have an open-door policy, but Participant H seemed to embody the idea of being a supportive figure for their Airmen.

Question 6 posed, “How effective is the current messaging to notify service-members of the benefits versus the consequences of utilizing mental health resources?” In group 1, all respondents felt the messaging was grossly ineffective. This stems from a failure to counteract the perceptions surrounding the consequences of using mental health resources, or the simple knowledge of what those resources are. Within this group, the messaging was spread by word-of-mouth among peers. Participant A found, “Mental health doesn’t really do a good job with putting the message out there about their resources and the positives of them. They also don’t really try to break the stigma that comes with mental health. A lot of the stories you hear from people who have had experiences with them are usually negative.” Junior Airmen receive briefings for a day in BMT, over two days in Technical Training, and over two days upon arrival to their first base. The messaging was being delivered to young Airmen, but I’m not sure if the delivery method was helping the Airmen retain that information.

Group 2’s responses mostly reflected those same opinions with another layer of complexity. Participant E said,

> I don’t think it’s as effective as it could be because some Airmen may want to vent to you about certain issues because they feel comfortable and trust you with the things they may be going through without realizing as a supervisor you’re a mandatory reporter which could put you both in an awkward situation.

Being a mandatory reporter means there are certain topics that trigger a chain of events that supervising military members must follow. For example, if an Airman confided in their supervisor at a bar that they were sexually assaulted, that supervisor

would then have to notify proper channels of the details of the sexual assault. That Airman could have been merely looking for a friend to confide in while also trying to maintain confidentiality. Participant E felt those rules are not commonly known or understood. Concerns about the impact a disclosure of mental health issues has on the career of an Airman prevents that Airman from seeking mental health assistance.

Group 3's opinion was different from the other two. Overall, the information is available to those who need it, but it requires reiteration from supervisors and active listening from subordinates. Furthermore, this group identified opportunity as an obstacle to utilizing these resources, regardless of how effective the messaging is. Participant H responded,

> The messaging is out there, but the delivery of the information relies heavily on supervisors and leadership to continue to update maintainers. Not every maintainer is able to log in to a computer every day and see updates and are given less time to explore and quietly look for resources.

Unfortunately, the mission takes precedence over getting help, preventing Airmen from utilizing mental health resources.

Finally, question 7 asked if there are any additional barriers preventing Airmen from utilizing mental health resources. The responses here showed no all-encompassing theme based on rank, age, or time in service, but the reactions were similar. Among the barriers identified to seeking mental health assistance are time, manning, perceived lack of support from leadership, no centralized source for mental health contact information, deficiencies in appointment availability, impact on job and career, loss of security clearance, and fear of judgement. Participant F feels that the biggest barrier, however, is

the perception from peers, stating, “Peers are often the reason people don't go seek help. They're too worried about what people will say about them.” The perception from others has a duality in that the Airmen want to be available for their peers at work and would like to maintain a semblance of privacy regarding mental health.

Post-Intervention Findings

The intervention is a resource guide outlining the resources available to Airmen at this base. The resource guide details the location of the resource, how to contact them, the confidentiality offered by the resource, and any other helpful notes. The resource guide is on paper, 4.5 x 2 inches in size, and intended to be folded and placed in the Airman’s wallet, pinned to a wall or cork board, or attached to a computer monitor. This assists both the supervisor and the subordinate in the event of a mental health crisis by giving them information they can quickly reference. Participants overall had a positive impression of the resource guide and liked the amount of information. The only critiques I received on the resource guide were that the Airmen would have liked an area for them to write their own personal notes, specific names within the mental health resources they could contact, and for the resource guide to be laminated.

Post-intervention, additional questions were asked to gauge any change in attitude the intervention produced in the Airmen. For this portion, the participants are assigned to the same groups as they were during the pre-intervention data collection, because their demographic information had not changed. Some questions had answers that were similar, regardless of group. Other questions were vastly different, depending on the rank

and time in service of the participant. The table below outlines the overall themes present from each group in their response to the post-intervention questions (See Table 3).

Table 4.3 Post-Intervention Themes

Post-Intervention Themes			
Questions	Group 1 Theme	Group 2 Theme	Group 3 Theme
1) Were you aware of all the resources on the resource guide? If not, which ones were you unaware of?	Mostly aware.	Mostly aware.	Fully aware.
2) Does having the resource guide benefit change your view on mental health resources? Does it change your likelihood to utilize them?	No change in perspective but resource guide serves as a good reminder.	No change in perspective but the resource guide is beneficial as a quick reference.	No personal change in perspective but can foresee the resource guide being more beneficial for younger Airmen.
3) In terms of cultural attitudes toward mental health resources, what impact do you think a resource guide would have for your peers?	Extremely beneficial for young Airmen and their supervisors.	Extremely beneficial for young Airmen and their supervisors.	Extremely beneficial for young Airmen and their supervisors.
4) Has there been any change in your perception on how COVID-19 has affected you personally or professionally?	No change in perception.	No change in perception.	No change in perception.

The first question asked if participants were aware of the resources on the resource guide and whether they utilized any of the resources on the resource guide after the initial interview. All respondents, regardless of group, claimed to have been mostly aware of the resources outlined on the intervention, although most of them failed to give specific examples of those resources in the initial interview questions. The most interesting response came from participant C, stating, "I often forget what the services available to us, probably due to my own lack of usage. I haven't found a need for any of them I would say. I know of all these resources; I just have never used them and often forget they exist. I have never used any of these resources."

The next question is, "Does having the resource guide change your view on mental health resources?" Airmen in group 1 mostly responded that the card serves as a good reminder of the services offered, although they were already aware. The key is the confidentiality/notes section, because not everyone is mindful of their protections. The Airmen in this group could mostly recall the names of these resources but were unable to detail their confidentiality or recall methods to contact the resources. Participant B said, "Having the resource reference card definitely reminds me of the multiple different options available for help. Also having the confidentiality notes is very helpful."

Group 2 had a mild reaction to the intervention, mostly due to having accumulated the knowledge on these services and what they offer over their careers. Through formal training courses, word-of-mouth, and personal experience, group 2 has an adequate level of experience with mental health resources. However, one respondent did find the resource guide to be a good reminder. Participant F declared, "I believe the

pamphlet does change my view. Because although I knew about all these options, I also forgot about them. So having a quick reference is very helpful."

Group 3's responses trended towards the resource guide being less beneficial for them personally, but more helpful for younger Airmen. This group has extensive experience in the Air Force and had built up a knowledge base of mental health resources and knew where to find the contact and confidentiality information quickly. Other groups did not have this experience to rely on. Additionally, this group feels the intervention would be beneficial if a younger Airmen was afraid to ask their supervisor for contact information for these services. They view their role, with respect to the intervention, more as a facilitator with other Airmen, as opposed to something they would use for themselves. Participant H said,

> The quick reference card does not change my view on mental health resources, but instead gives me an easier reference for airmen that may approach me with a given type of issue. It takes some of the pressure off of them to blindly dial a number for help and additionally shows that security forces is listed, making potentially any SF member a quick point of contact if the need should arise. It does not change my likelihood of utilizing these resources, but I feel it would have a beneficial impact on younger airmen.

Question 3 measures the cultural impact the intervention would have on Airmen with aircraft armament systems occupations. The resource guide was designed to counteract the negative attitudes surrounding mental health assistance within the community. Outside of participant D, all felt the resource guide would be beneficial to their peers and increase the likelihood of someone getting help when they need it. For a

different perspective, participant D said, “Culturally, I don’t think the card will have an impact. The card only appears to offer a ‘quick reference’ when in need. The thing is that anyone who wants to utilize the resources will put the work into finding them whether they have a card or not. The stigma is still there, card or no card.” To counteract that opinion, participant E claimed,

> I think a personal quick reference card to keep in your wallets/in close reach would be beneficial for everyone to have. Especially individuals who are a little more private and would like to go directly to the source which having this card would provide vs asking someone for this information which could potentially shy them away from seeking help all together.

The final question posed post-intervention asked if any Airmen experienced any change in how COVID-19 has affected them personally or professionally. All respondents claimed that there was no change since the initial interview. At the height of the COVID-19 pandemic, quarantine and exposure rules changed frequently and served as a source of frustration for the more experience Airmen in groups 2 and 3. The only significant response to the question came from participant G, who said, “I’m just ready for this COVID phase to end so I can get back to a somewhat normal life.”

The following table synthesizes the overall themes present from each group in their response to both pre- and post-intervention questions (See Table 4). Chapter 5 further discusses the conclusions and implications surrounding all findings.

Table 4.4 Overall Group Themes

Overall Group Themes			
	Group 1 Theme	Group 2 Theme	Group 3 Theme
Pre-Intervention Themes	COVID-19 presented manning challenges that left those available to work with an increased burden. Most in this group claim to have never used mental health resources. The career field holds negative attitudes towards seeking mental health assistance. They would take a personal approach to help their peers but would not refer a peer to a specific resource. Poor messaging on resources overall, and a failure to counteract negative attitudes towards mental health.	Pandemic and quarantine rules made day-to-day managing of availability extremely difficult. None claimed to have used mental health resources in the past. The community has negative perceptions on mental health assistance. When helping an Airmen in crisis, they would also take a personal approach while also referring that Airman to a specific resource, although they did not have the information readily available. Messaging on resources is poor, mostly due to a failure by leadership to explain the consequences of using resources.	The reality of COVID-19 testing, and quarantine procedures led to increased difficulty in meeting the needs of the flying mission. This group had alternate methods to handle their stressors and had never felt the need to use official resources. The career field has always had negative attitudes towards mental health resources, although the perception is improving. When helping other Airmen, this group took a professional approach and could name some specific resources and their contact information. The messaging is effective for those who need the help and are willing to do the work to find it.

Post-Intervention Themes	This group was mostly aware of the resources on the intervention, but the guide served as a good reminder. The resource guide would be extremely beneficial to their peers and supervisors.	This group was mostly aware of the resources available on the guide but could not recall specific details. They also felt that the guide may not be beneficial for them individually, they could see the guide helping young supervisors and junior Airmen.	This group was almost fully aware of the resources on the guide, due to their second-hand experience with them. They felt the guide would greatly benefit younger Airmen, although this group personally already knew the information.

Observations

As a new SSgt supervisor, one of my subordinates received a phone call from home while we were on break. My subordinate went outside to take the call and returned after approximately 30 minutes. Upon returning and appearing distraught, he had just been notified by family that his uncle had passed away. I did not know what to do or say despite the training I received before becoming a first-time supervisor. I did what I thought was best, and that was to send him home for the night so he could grieve privately. After releasing him home, I let my supervisor know what I had done, and my supervisor verbally reprimanded me and demanded that I call my subordinate back to work so we could keep a close eye on him. In a state of panic, I had jeopardized his wellbeing to save him the embarrassment of crying while at work. That supervisor had the Airman back at work placing bombs and missiles on aircraft, a choice that I did not agree with. I was concerned about him being distracted and harming himself or someone else.

While stationed overseas, a member of my unit was sexually assaulted after work on a Friday. The culture in this unit encouraged heavy drinking at the end of the duty day to relieve all of the stress built up during the work week. That female SrA was sexually assaulted by a male, married, MSgt. He boasted about the encounter to our co-workers and in the SrA's presence. The two of them got into an argument and she verbally accused him of sexual assault, triggering an unrestricted report with the Sexual Assault Prevention and Response (SAPR) office. She was unaware of her rights or that she said these words around several mandatory reporters for sexual assault or suicidal ideations.

At another overseas assignment in Europe, I was a SSgt, and my subordinate was an A1C. He was a very hard worker and extremely professional around me. We bonded over our love of music, specifically connecting over the artists Mac Miller and Kendrick Lamar. Other people in our squadron would tell me how immature and disorderly he could be off duty but that was not what I saw. After about six months together, he was alone in his room, drinking heavily, and decided to attempt suicide. He was found by his roommate in the shower unconscious and bleeding, and that roommate immediately called the police. I stayed by his side while he was hospitalized and got to know him better. He explained that he had gone through a lot as a child and used alcohol to cope, which leads to him losing control and feeling depressed. Talking with squadron leadership, we all agreed that he should seek help for alcohol dependency and visit mental health to better manage his struggles. To support him, I quit drinking as well.

One year passed, and things went mostly smoothly with this subordinate. One day, he asked me if I would be alright if he got together with some people in our shop and went wine tasting. I told him I did not think this was a good idea, but if there was a

responsible SSgt there, then I would be fine with it. He went out drinking that night. I got a phone call early that morning at maybe 0300 from that SSgt asking me to rush to his house because my subordinate was behaving erratically and trying to jump from the SSgt's 12th floor balcony to commit suicide. I jumped out of bed and asked that SSgt if he had called the police or notified our leadership, and he said no. He did not have the numbers saved in his phone, and overseas emergency numbers operate differently than those in the United States. On my drive over, I called the local police and gave the address poorly in the broken native tongue. Thankfully, the police had a translator on shift who understood perfectly. When I arrived, the SSgt and two other Airmen were outside on the balcony, laying on top of my subordinate so he would not jump. While my concern in that moment was the health of my subordinate, I was also upset that he had not already notified the authorities. I still struggle thinking about what would have occurred if I had not answered my phone. My SSgt peer was unaware of the appropriate mental health resource to contact, contacted me instead, and lost precious time in the process of trying to save a life. That SSgt peer used a personal approach where a professional one was more appropriate.

As a TSgt instructor, I prided myself on being aware of how my students were doing and recognizing any change in their behavior. One of my more talkative and humorous students spent this entire class day disengaged and isolating himself. At the end of the day, I called him into the office to see where his head was. Simply asking him how he was doing caused him to cry hysterically, and that's when I noticed cuts on his forearms. He refused to say what caused him to react so emotionally. I asked him directly if he had hurt himself or if he had any plans of hurting himself. That student then quickly

said no, and I told him the cuts on his arms said otherwise. The conversation went in circles for a while, but we eventually got to the root of the issue. He and his girlfriend back home had just broken up, and he threatened suicide to try and convince her to stay. More than his personal health, he was more concerned with keeping his job and not losing his assignment overseas. I notified the 1st Sergeant and dorm leaders, and that Airman missed the next week of class. That Airman was placed in the care of mental health professionals to give him better tools to manage his stressors. When he returned, I asked a spare instructor without a class to catch that student up with the rest of his class. It was important to me that he understood he would not be punished for doing the right thing and speaking up.

Between BMT and technical training, Airmen get minimal time seeing their family. In our 2W1 weapons community, the most amount of time an Airman spends between BMT and technical training is nine months, depending on the aircraft they are assigned to. Airmen are allotted the opportunity to visit home upon completing technical training, depending on how many days of leave they have accrued during their short careers. Often, they have saved up around two weeks of leave. During the initial and worst stages of the COVID-19 pandemic, we did not allow any Airmen to travel home on leave. They would go right from technical training to their first duty assignment. Although this was to keep the Airmen and their peers safe, this resulted in a huge negative as well. When I arrived at my next base after performing instructor duty, I met many Airmen who had not seen their family or visited home for over a year. This left many Airmen feeling defeated, depressed, and unmotivated to perform on the job.

While stationed at a previous base as a MSgt, I took on the role of assistant First Sergeant. Because of the size of our squadron, we employed two SNCOs to fulfill the duties of one Shirt. Additionally, because this was a pipeline training unit, we managed new Airman that recently graduated from BMT. Most of these newer Airmen, called trainees, were between the ages of 17-23. This experience in technical training was their first extended time away from home. While giving an in-processing brief, an Airman pulled me aside and asked if she could speak to me in private. I found a secluded area, and the Airman confided that her six-year-old daughter just accused her husband of sexual abuse, and she did not know what to do. Although I did not know what specific resource to call to provide this Airman the assistance they needed, I knew I could contact the Sexual Assault Response Coordinator (SARC), and if they did not know the answer, they could point us in the right direction. I canceled my portion of the in-processing brief and escorted that Airman directly to the SARC. When I arrived in her office, she was already on the phone with the military legal office to find a way to help this Airman and her daughter.

Summary

Chapter 4 presents the findings using the methodology outlined in Chapter 3. The methodology was phenomenological in nature, using interviews and observations to draw conclusions from the perspective of the researcher, positioned as an insider. Findings show Airmen felt COVID-19 placed a stress on both them and the workplace, and they felt equipped to handle using their own stress relief techniques. Findings also show that regardless of rank most Airmen felt COVID-19 impacted them professionally though the

lack of consistent messaging surrounding quarantine procedures and low manning. Furthermore, a resource guide outlining mental health resources is an effective way to counteract negative connotations associated with mental health resource utilization, combined with an increased push from unit leadership. Chapter 5 provides a summary of the findings, a conclusion, and recommendation for further research.

CHAPTER 5

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

The purpose of Chapter 5 is to summarize the findings from data collection contained in Chapter 4, provide a discussion surrounding those findings, and offer recommendations for future research. The data for this study was conducted using researcher piloted interviews and researcher observations. This chapter also contains an overview of the purpose of the study, research questions, literature review, and findings. Chapter 2 contained the literature review, Chapter 3 outlined the methodology, and Chapter 4 detailed the findings.

The purpose of this study was to explore the impact COVID-19 has on enlisted maintenance Airmen at an Air Force Base in the southeast, to determine what effect COVID-19 has had on their view of mental health resources and their utilization of those services, and cultural viewpoints surrounding mental health within the 2W1 weapons community. The research questions this study seeks to answer are:

1. What improvements, if any, does an intervention have on Airmen's handling the demands of military work while balancing the fears and mental challenges of COVID-19?
2. What is the relationship, if any, between COVID-19 restrictions, mission effectiveness, and the mental health of enlisted Airmen?
3. What methods would be effective in counteracting perceived negative consequences to utilizing mental health resources?

The literature review performed in Chapter 2 identifies studies that support previous theories about the COVID-19's impact on the military, COVID-19's impact on mental health, the development of mental health educational materials, and the utilization of mental health resources. Because there was very little research related to COVID-19 and aircraft maintenance Airmen, I searched for analogous occupations during the literature review. The methodology used to conduct this study is phenomenological, using social constructionism and symbolic interactionism as its theoretical framework. Participants were interviewed, given an intervention in the form of a resource guide, and then re-interviewed for a second time. Finally, conducted with interviews and observations, data collected from Chapter 4 was coded using a thematic analysis.

Discussion

Several themes emerged through thematic analysis of the findings. Group 1 felt the biggest impact COVID-19 had on their lives was through the uncertainty of not knowing who would be available to work and having to compensate for absent peers. Groups 2 and 3 echoed those sentiments with more context from a management perspective. These groups felt that with the everchanging rules surrounding COVID-19, it was very difficult to manage schedules, project leave, and set shifts due to who was available. It was also challenging to message subordinates on how many days to quarantine or if they should quarantine based on close contacts testing positive for COVID-19. The theme present was workplace strain due to shifting pandemic guidelines and the cultural pressure to perform for your peers. COVID-19 had not substantially

affected their mental health, but the mission implications of a positive test were more significant.

Interestingly, participants either knew all the resources available to them outlined in the resource guide or had no idea what the purpose of the specific resource was. No participant had the contact information for mental health resources on hand and would have to ask another party or search for the information online. There was no theme surrounding prior knowledge, regardless of rank, age, or time in service. The responses to this question showed the need for a resource guide or guide to mental health services for all Airmen.

For previous utilization of mental health resources, only one (1) participant claimed to have used a mental health resource. Some Airmen were concerned about the impact using a mental health resource would have on their career, while other Airmen had other ways to relieve stress, and another had concerns about confidentiality with squadron leadership. I believe that some participants did not truthfully disclose whether they used a resource or not for fear of me using that knowledge against them and hurting their career due to my rank and position. The theme present was that there are many personal obstacles with Airmen using mental health resources, but many Airmen have their own outlets for help.

The cultural view respondents had on mental health resource utilization proved extremely valuable to this study. Participants overwhelmingly felt that their peers had career concerns preventing them from using mental health resources. Those career concerns manifest in the form of promotion consideration, loss of assignment, suspension from PRP or Top-Secret clearance, shame from peers, or being placed on administrative

duties. Respondents felt more comfortable seeking help from a peer if they needed help with a sensitive topic. The downsides of this approach are that peers may not be trained or equipped to handle significant issues, and this perpetuates Airmen not seeking professional help. This is the crux of the issue from a cultural lens, and these responses support the beliefs I shared, which are based on personal observations throughout my career.

In a scenario where a peer would need help, participants responded appropriately, based on their rank and time in service. Airmen in group 1 would take a personal approach and listen to an Airman in need and ask an authority for help if the issue felt direly serious. Airmen in group 2 would also listen with the intent of directing them to a mental health resource, although only one member of group 2 named a specific entity. The Airmen in group 3 would also take a personal approach, knew specific resources to take the Airman in need to, and would also escort them to the appropriate location. The theme here is that Airmen know what to do but may not know the specific steps they need to take or the entities to direct Airmen in need to. I believe the resource guide would be helpful to all groups in this study, for them personally or to get other Airmen the appropriate help for their mental health issue.

Groups 1 and 2 feel as though the methods the Air Force uses to get the messaging about mental health resources is ineffective. Information about mental health resources for Airman in BMT or technical training is overwhelming, and the Airmen have nothing tangible to refer to. Not only do most Airmen not know the resources offered to them, but they also do not know the specific details surrounding the resources they are aware of. For example, Airmen may not know the difference between restricted

and unrestricted reporting when notifying the appropriate entities of a sexual assault. The more experienced Airmen in group 3 feel that the messaging is available, but direct supervisors and squadron leadership need to take a more proactive approach in promoting mental health resources. Unfortunately, a more proactive approach may have a negative impact on aircraft productivity, making squadron leadership less likely to champion those resources.

According to respondents, there are additional obstacles preventing their peers from utilizing mental health resources. From the perspective of the research participants, those obstacles are time, manning, perceived lack of support from leadership, no centralized source for mental health contact information, deficiencies in appointment availability, impact on job and career, loss of security clearance, and fear of judgement from others. This reflects the previously identified theme of Airmen being reluctant to seek mental health help because of perceived career repercussions. Furthermore, Airmen appear to be more concerned about how their lack of productivity due to time missed for mental health appointments would impact the mission.

After receiving the mental health resource guide, participants were asked questions on its impact. While they may have forgotten about the specific resources outlined on the resource guide and their details, the Airmen had heard about the resources at one point or another. The resources were mentioned during formal training activities, through word-of-mouth, or through experience. Most did appreciate having a centralized product that provided all the details on mental health options. The theme here is that there was some knowledge on the information contained in the resource guide, but the resource guide provided an easily referenceable form.

The overall reaction to the intervention was mostly dependent on the group each participant was assigned to, categorizing the Airmen by rank and time in service. The Airmen in group 1 thought the resource guide was incredibly beneficial, in that it allowed them to bypass their supervisor and squadron leadership for help with their mental health. Privacy appeared to be a primary concern among Airmen in this group. Groups 2 and 3 mostly already held the knowledge but again, appreciated something they could use as a quick reference. These groups already had techniques and resources to help themselves. Mostly, group 3 acknowledged how beneficial the resource guide would be for younger Airmen. Some preferred the resource guide had an extra column for personal notes, specific contact names within the organization, or for the guide to be laminated.

On the general cultural impact the intervention would have on other Airmen, almost all felt the resource guide would have a positive impact. The biggest benefit in the eyes of the study participants is that it allows for some privacy in a time of need, allowing Airmen to contact the resource directly as opposed to asking for a supervisor or NCO contact number or location. Another benefit is that it allows supervisors to respond quickly with resources when their subordinates need assistance, instead of having to search online or call the Shirt. With many mental health crises, every lost second leaves the potential for escalation. The themes here confirm the positive impact a resource guide would have on Airmen in the aircraft armament career field.

Participant observations reflect the same themes identified from data collected during interviews. As a new supervisor, I was unaware of mental health resources to assist my subordinates and because of that, I made bad decisions for them. Other new supervisors also made similar poor choices regarding their subordinates, in one case, a

SSgt contacted me instead of contacting the local police. The Airmen themselves were also unaware of their options for mental health resources or the details surrounding them, sometimes shouting critical information, and forcing an unrestricted sexual assault report. Airmen who joined the Air Force just prior to, or during, the COVID-19 pandemic have had extensive struggles attributed to the virus due to them being prevented from visiting loved ones.

Social constructionism and symbolic interactionism both explain how the career field has grown to accept negative consequences surrounding the utilization of mental health resources. These ideas have been widely accepted over decades, although few of today's Airmen have directly had negative career impact from these resources. Social interactionism specifically believes that social exchanges spread communal definitions (Quist-Adade, 2019).

Based on the findings, below are the answers to the research questions posed in Chapter 1.

What improvements, if any, does an intervention have on Airmen's handling the demands of military work while balancing the fears and mental challenges of COVID-19?

After the initial adjustment period and shock of life due to COVID-19, Airmen have mostly adjusted to the demands of military work while balancing the fears and mental challenge of the pandemic. COVID has made professional life more difficult through the shifting quarantine requirements of positive tests and close contacts. Furthermore, not knowing who would be available to work a particular time made

projecting manning especially difficult for supervisors in the NCO tier and increased the burden on Airmen available to performing their duties. Airmen mostly use their peers as a resource while forgoing professional help because of perceived career consequences. Using peers and rejecting formal mental health options perpetuates those negative cultural perceptions within the career field toward professional mental health assistance. There are hesitations held by Airmen and other service members regarding the impact the use of mental health resources will have on their career. Those hesitations can come in the form of fear of being unable to perform their job, loss of security clearance, and ultimately letting the team down (LeFeber & Solorzano, 2019).

Many participants, mostly those junior in grade and with less experience, felt the resource guide would be effective in assisting them personally with their mental health struggles and with balancing their professional work in the face of mental challenges produced by COVID-19. Most participants, regardless of experience and rank, felt the resource guide would be beneficial for others facing challenges, whether COVID-19 induced or otherwise. The most significant improvement is having access to mental health information on hand and readily available through the mental health resource guide, without having to seek that information from another source. Groups 1 and 2 both felt the messaging surrounding mental health resources was severely lacking, and both were unsure of the confidentiality surrounding the use of these resources. A potential reason for the confusion surrounding the confidentiality is that providers are unsure of what the rules are themselves (King & Snowden, 2020).

What is the relationship, if any, between COVID-19 restrictions, mission effectiveness, and the mental health of enlisted Airmen?

COVID-19 restrictions have had an adverse effect on mission effectiveness and the mental health of enlisted Airmen. Because many young Airmen have been unable to take leave and see family between graduating from technical training and their first permanent assignment, Airmen have suffered from increased stress and reduced opportunities to relieve that stress. For many, that increased stress has negatively impacted their job performance because of an inability to stay focused. Missing work due to COVID-19 or utilizing a mental health resource was also a stressor for many Airmen.

As previously identified, not knowing who would be available to work on a day-to-day basis because of COVID-19 positive tests puts a strain on Airmen tasked with the management of aircraft armament sections. Airmen who are available for duty are unable to take leave or have their leave canceled and must work longer hours to compensate for their peers who are absent, further increasing the stress of those managers and the Airmen who are present. On some occasions, NCOs tasked with managing their aircraft armament section are forced to perform the tasks of their subordinates to prevent everyone having their duty hours extended. This is in addition to the personal stressors faced by those same Airmen in management positions, and their own desire to take leave. Culturally, Airmen feel beholden to their brothers and sisters-in-arms. This attitude is also shared by healthcare workers (Roggensack, 2020). It results in a reluctance to get tested for COVID-19, thus putting the needs of the mission before one's own health.

The implications coincided with the literature review, in which Wilen (2021) found that working in proximity left military communities more vulnerable to a COVID-

19 outbreak. Over time, the pandemic has had a greater impact on military members through logistic, operational, and human resource concerns. Unfortunately, due to the nature of the work performed by enlisted Airmen in aircraft maintenance occupations, typical measures to reduce the impact of COVID-19 (e.g., social distancing, mask wear, remote work) cannot be implemented. This reflected the findings of Kasper et al. (2020) in their research on the pandemic challenges faced by Sailors on an aircraft carrier. Furthermore, the pandemic amplified already present stressors for military members, which increased the need for mental health assistance (Hill et al., 2021).

There has always been a negative attitude toward mental health among Airmen in the aircraft armament occupation, and COVID-19 further exacerbated those issues. Previously, if Airmen had an issue with their mental health, due to pressures from work or problems at home, Airmen still had several resources to take advantage of. Many of those resources offered the option for face-to-face assistance. With the onset of the COVID-19 pandemic, many military bases shut down offices, reduced hours, and reduced personnel. While many Airmen declined to utilized mental health resources, some did extensively. COVID-19 robbed them of the opportunity and potentially drove them to self-medicate or avoid a positive solution altogether. Furthermore, COVID-19 robbed Airmen of the social activities to manage their mental health. Movie theaters were closed, restaurants had less available seating, there were no concerts or tours, and sporting events either did not allow spectators or had limited availability to promote social distancing. These factors led to increased feelings of isolation and loneliness. The COVID-19 pandemic undoubtedly had an exponentially negative effect on the mental health of our Airmen.

What methods would be effective in counteracting perceived negative consequences to utilizing mental health resources?

An intervention in the form of a resource guide would be effective in counteracting perceived negative consequences to utilizing mental health resources. This resource guide would give all Airmen a reference for themselves and for their peers, in the event of a mental health crisis. While a pamphlet is effective in increasing knowledge on mental health resources, a mobile app-based approach would be more beneficial for young adults between the ages of 17-29 (Wiljer et al, 2020). Two groups in this study (group 1 and group 2) overlap with this age range.

The effectiveness at this point is limited to the armament section under research in this study. However, if this became adopted by the entire squadron, group, and wing, the positive impact would be more substantial. Some benefits of utilizing a resource guide are the low cost, ease of carry, quick accessibility, reduced response time to an immediate crisis, and elimination of the need for a third party to get information. It is also critical to have any resources, to include pamphlets, in high-traffic, centralized locations for ease of access (Craven et al, 2005). The resource guide must be designed by professionals intimately familiar with those mental health resources (Samimi et al., 2019), issued upon assignment to a new unit and verified for accuracy by the First Sergeant, and with more support from Shirts, superintendents, and most importantly, direct supervisors.

Marines felt more comfortable using a peer as a mental health resource, as opposed to a more formal resource (Farmer et al., 2014). This idea directly correlates with group 1's approach of using themselves as a resource instead of referring an Airman

to an outside resource. To circumvent any reservations, an expanded resource guide that focused on trusted third-party resources would be beneficial (Waitzkin et al., 2018). This would also lessen the personnel constraints felt by on-base providers.

Additionally, more support for mental health resources from direct supervisors and squadron leadership would also counteract negative attitudes. The messaging must surround the benefits and dispel any negative ideas surrounding the career impact of utilizing mental health resources. This support should come in the form of more visibility from personnel in offices associated with the mental health resource. Examples are, monthly visits to the unit from the SARC, mental health office, or another medical professional on the base.

Limitations

This study is limited in scope for many reasons, with one being the size limitations of the population sample. With the size of the researcher's unit in mind, there were not many Airmen that fit the research criteria. My rank and position also likely had an influence on responses from the participants. Most claimed to have never used mental health resources but also claimed a general distrust in sharing mental health problems with higher ranking individuals, including some within squadron leadership. This caused me to question the cooperation of the sample in fully answering the interview questions. Research targets could have also used more time with the intervention, between the initial interview questions and post-interview questions. This would give a more accurate assessment of the benefits surrounding the pamphlet through allowing more time for it to be put into use. The generalizability of these results is accurate for other Airmen working

on the flightline in aircraft maintenance occupations but may not be acceptable for non-essential Air Force AFSCs.

One area where the findings of my research differ from those conducted on other groups is with the mental health impact COVID-19 has had. Ornell et al. (2020) found that while social distancing helps slow infection rates, it also leads to increased isolation, loneliness, and depression. Because the participants of this study were unable to social distance due to the type of work they perform, none reported any significant mental health issues due to COVID-19, although this may be due to barriers due to rank or confidentiality. This research on enlisted 2W1 Airmen directly correlates with the mental health challenges faced by nurses, mechanics, police, transportation professionals, and other essential workers, considering these occupations all share similar characteristics (Guerrini et al., 2020), but further research should be done specifically targeting these groups.

Implications for Future Research

This study can guide other researchers to drive their practice forward. Further research is needed to determine if a mental health resource guide would be effective for other career fields within aircraft maintenance, for other support AFSCs, or for other military branches. Additional research can be done to determine how effective a similar intervention would be on analogous occupations outside of the military, like nursing, law enforcement, security guards, or factory workers. A separate study should be performed on counseling techniques taught in professional military education activities like Airman Leadership School, Non-Commissioned Officer Academy, and the Senior Non-

Commissioned Officer Academy. Supervisors are taught what to do in the event of a subordinate facing a mental health crisis while attending these courses, but some are still unprepared and unable to apply the skills they were given. Further research should also be conducted on the impact COVID-19 has on the family members of military service members. The dependents of military members, to include their children and spouses, are also affected by COVID-19 and the mental health of their loved ones serving in the military. More research could also be conducted on mental health research utilization for retirees, members who are separated from the military due to injury or disability, and for those who simply leave for a less stressful life.

To improve other studies, a more focused approach that concentrated on the viewpoints held by women towards mental health resources would be useful. Women feel more isolated in the military, and other studies should exclusively research how cultural attitudes affect their mental health resource utilization and how they feel it impacts their career. Another question is the overall quality of the resources (LeFeber & Solorzano, 2019). Some military members feel they are unable to get the help they need with a mental health issue due to availability of appointments. There are also questions surrounding the quality of these resources. This could be explained by the large strain placed on mental health providers due to a low patient-to-provider ratio (Hall et al., 2007). Additional qualitative research should examine what limiting factors affect the quality and availability of mental health resources.

Admittedly, I have personal biases that inform the lens through which I view the findings of this research. As discussed earlier, I have had personal struggles with my own mental health, and those struggles make me passionate about the topic. I had challenges

adjusting to the military lifestyle, I've lost fellow Airmen to suicide, I've witnessed peers pour themselves into the mission to avoid an unfavorable family environment, and I've witnessed Airmen prioritize the needs of the Air Force over their own physical health.

Implications for Practitioners

Here are the implications derived from the findings contained in this study. Younger Airmen and many NCOs are either unaware of the mental health resources afforded to them or hesitant to use those resources because of the perceived career implications. Also, many Airmen are not equipped to handle the mental health challenges that come with their occupation as aircraft armament Airmen. They rely on their peers for guidance, which can be both harmful and helpful. COVID-19 has amplified the challenges faced by Airmen through increased workload and less opportunity to relieve stress. The major barrier preventing Airmen from seeking professional help is the potential impact on their career, although these fears are mostly unfounded and stems from a cultural attitude of discouragement.

The resource guide is beneficial to all Airmen regardless of rank for two reasons. The first reason this benefits younger Airmen is that it gives them the information they would normally have to ask a supervisor for and protects their sense of privacy. The benefit for Airmen with more experience is that it reduces reaction time when a subordinate or peer is having a mental health issue and gives them specific contact information and a location so that experienced Airman can escort a member in need.

Conclusions

As a result of this study, there are steps that Airmen can take to help themselves or other Airmen in need. Regarding the mental health resource guide, the mental health clinic, MFLC, a Military One Source representative, BHOP, base Chaplain, security forces, and command post should all collaborate to develop and verify the accuracy of the information contained on the resource guide, making the information more comprehensive. Shirts from all squadrons should also be involved in the design process, knowing the unique needs and concerns facing the Airmen in their units. Moreover, the Shirts can consolidate all the information from these resources and shrink it down to a pamphlet or card size and laminate enough copies for their entire unit. Because all Airmen, regardless of rank, must visit their Shirt upon arrival to the unit, the Shirt will be the single point-of-contact for issuing the resource guide. It would also be beneficial to have extra resource guides in common areas like break rooms, shared offices, posted in unit cork boards, and in bathrooms. Before their shift begins, Airmen are sent to the support section to check out any tools or equipment they need for their duty day. Having extra resource guides in the support section would be advantageous as well. Supervisors and squadron leadership should verify that all Airmen have the resource guide readily accessible at regular intervals, particularly before long weekends or holidays. Many of these procedures, like in-processing through the Shirt or supervisors and squadron leadership interacting with their subordinates prior to a long weekend, already occur and would not add to the workload of the stakeholders involved in the process. To ensure the information on the resource guide is up to date, an annual review of the guide should be done by the Shirts, or the guides should be updated whenever the information changes.

I can personally attest to the benefits of utilizing multiple mental health resources. While serving as an aircraft armament instructor at a previous base, I had to make an adjustment to my new role. I deployed multiple times, visited countries all over the world, experienced so many different cultures, loaded live bombs and missiles, loaded practice nuclear weapons, loaded in steamy and uncomfortable gear (including gas masks), ultimately feeling as if I had fulfilled my responsibilities to my country. I felt as if I served an almost perfect career as a weapons troop, and I had the ribbons and decorations to reflect that. I checked every box at my rank and exceeded all our conventional cultural expectations. Now, my job was to teach new Airmen from BMT basic information such as what the difference between what a common screwdriver was and what a #4 offset screwdriver was. After fourteen years of being so close to the fight, I could not find myself further away, resulting in a deep depression. That depression led me to cope with several unhealthy behaviors and affected me both at home with my wife and on-duty with my fellow instructors. I resorted back to what I thought was best, which was attempting to hide my suffering. Further adding to my difficulties was the internal conflict of not wanting to directly contribute to the death of any enemy, while yearning for the opportunity to deploy and load live munitions.

My wife noticed a change in me and suggested I go talk to someone. I talked to a trusted friend of mine, and they suggested I try and talk to the military family life consultant (MFLC). After searching the internet, I was able to find a good contact number and I set up an appointment for the next week. The MFLC, a licensed counselor, gave me some tips to better combat my stress, which altered my perspective on my new role in the Air Force. Although I was no longer personally loading live weapons in

combat locations, I was training the next generation of Airmen to do the same thing. Upon further reflection and using tools the MFLC gave me, that feeling of training other Airmen and seeing them solve problems on their own was more fulfilling than doing it myself. I was able to refocus my efforts from jets and bombs, and completely dedicate myself to helping my fellow Airmen. Teaching became a passion of mine, and I relished the opportunity to mentor young adults. In fact, the experience of teaching and wanting to mentor young adults was a major factor in me pursuing an Ed.D.

Unfortunately, I was not fully cured of my mental health struggles. A recent promotion to Master Sergeant and a new prominent role within the schoolhouse placed new pressures on me, which resulted in new negative ways to cope with those expectations. I had a new rank and a new position, which both came with new problems I was unprepared to face. Again, my wife suggested I talk to someone but with regular visits. I went to the mental health clinic on base, despite all the harmful consequences that I heard come with it during my extensive career. Unfortunately, they explained that what bothered me would not be appropriately treated by that mental health resource, while also failing to provide me with alternative options. I was turned away in a time of need and not directed to a more appropriate mental health option.

As my behavior worsened and I felt like I was losing control, I became desperate and researched civilian therapists in the area. I made sure that they would not report our conversations back to base leadership and assured them that I could pay myself without using my military insurance. I met with that therapist two days a week over a two-month period and I was able to get to the root cause of what my issues were. That therapist also helped me to reflect on any behaviors I may unintentionally exhibit that show me

reverting to poor coping skills. Talking to a professional may have saved my life and because of that, I committed myself to championing other Airmen to seek help with their mental health, when they are comfortable. Interestingly, the therapist told me that many of his patients were in the military, and they all wanted to pay with their own money, instead of with their insurance. In his view, this was because his patients were concerned with career consequences for seeking help.

After leaving that base in my role as instructor, I returned to my conventional duties as a MSgt, 7 skill level, aircraft armament Airman. My wife and I looked forward to being close to family and hopefully getting back to traveling the country. Working as an instructor for those four years left me lacking the valuable and necessary experience within my career field held by other 7 skill level MSgts. I felt wholly unequipped to perform my duties and my supervisor made work life difficult and my expertise was in education and training, not bombs and jets. I reached out to other MSgts in my position for their guidance on my new duties and they helped to the best of their ability. Considering my unit was grossly understaffed and our aircraft were timeworn and malfunctioning, our Airmen needed time away. The long hours, uncooperative jets, and tense environment were taking a toll on the Airmen within our unit. I encouraged them to look at our shop calendar and try to find an opening in our schedule so they could take leave. I advised those Airmen did not have leave scheduled to come see me, and we would come up with leave dates together. In doing this, I left our unit slightly more undermanned. My supervisor took great issue with this and issued me the first adverse administrative in my 19-year career. I was devastated because I thought I was doing the right thing. I thought I was fulfilling my duties as a SNCO by promoting responsible

behaviors. This administrative action left me with workplace anxiety and triggered a deep depression within me. I could not be in the same room with squadron leadership, found myself being outwardly disrespectful toward higher ranking Airmen, and became combative. I felt my career was over so I would do all I could to continue fighting for the younger Airmen, even if it hurt my career further. At this point, I needed to speak to a professional on short notice. The mental health clinic at this base also said they could not help with what was bothering me mentally but did refer me to a more appropriate resource with the contact information. I used that resource, for an hour, found the conversation to be both relieving and constructive, and subsequently requested I be moved to another unit. The squadron I was in had become toxic and unsustainable. Within a month, I was moved and in a better mental headspace.

Now that I am retired from the Air Force, I still face major mental health challenges. The transition from the extremely rigid and structured military life to my complete and utter freedom, has been challenging. I made several disability claims from injuries sustained during service, along with all the proper medical documentation, only for the Department of Veteran Affairs to deny my claims. I have spent an extensive amount of time seeing other medical professionals to validate my claims. I hoped that with my managerial experience, educational background, and overall professionalism, I would have extensive employment opportunities very quickly. Initially, my job seeking experience was the exact opposite of that. I found my untraditional background to be a hinderance to the type of job I was seeking. Thankfully, I changed my approach, broadened my search, and I was able to find employment. Adjusting to the way people communicate and working conventional hours has been difficult. Using the tools I have

received from utilizing mental health services, even after retirement, I have been able to recognize when I am not myself, cope in healthy ways, and manage my expectations for myself.

Despite the beliefs from fellow Airmen, using the MFLC, visiting the mental health clinic, utilizing a civilian therapist, and sitting with a BHOP counselor had no negative effect on my career. I still performed my job under PRP duties, still managed to be deployable, was fairly considered for promotion opportunities, earned a second Meritorious Service Medal, and maintained healthy professional relationships. By most measures, I have had a successful military career and I attribute a large portion of that triumph to finding the will to get help with my mental health. Had I not utilized those resources throughout my career, and now that I understand that I suffer from mood depressive disorder and anxiety, I'm not sure I would be here to share my story.

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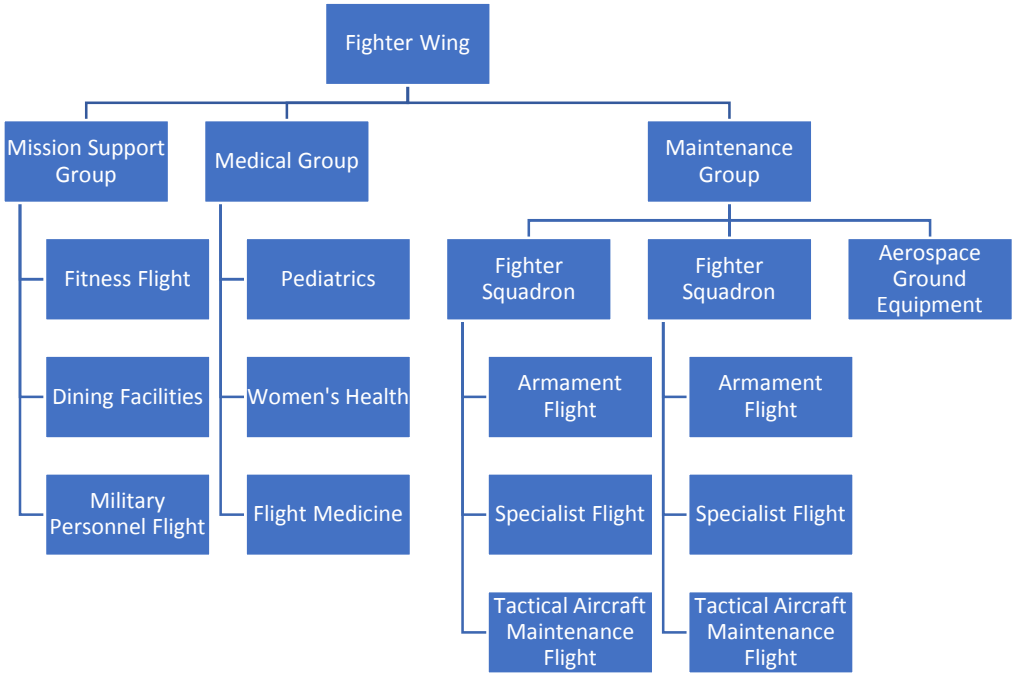
APPENDIX A: FIGHTER WING STRUCTURE



APPENDIX B: RANK AND ROLE RESPONSIBILITIES

Rank and Role Responsibilities			
Grade	Rank	Tier	Responsibilities
E1	Airman Basic (AB)	Junior Enlisted Airman	Demonstrate what it means to be an Airman in the profession of arms. Detect and correct behavior that may place themselves and others at risk. (Department of the Air Force, 2018).
E2	Airman (Amn)		
E3	Airman 1st Class (A1C)		
E4	Senior Airman (SrA)		
E5	Staff Sergeant (SSgt)	Non-Commissioned Officer	Lead and develop subordinates while exercising effective followership. Willingly own and explain leader's decisions. Stay professionally engaged with subordinates, both on and off-duty (Department of the Air Force, 2018).
E6	Technical Sergeant (TSgt)		
E7	Master Sergeant (MSgt)	Senior Non-Commissioned Officer	Epitomize excellence, professionalism, pride, and competence, while serving as a role model. Help leaders make informed decisions. Promote responsible behaviors in all Airmen (Department of the Air Force, 2018).
E8	Senior Master Sergeant (SMSgt)		
E9	Chief Master Sergeant (CMSgt)		

APPENDIX C: AIR FORCE SKILL LEVELS

Air Force Skill Levels		
Skill Level	Title	Rank Spread
1	Apprentice	AB-SrA
3	Helper	AB-SrA
5	Journeyman	SrA-TSgt
7	Craftsman	SSgt-MSgt
9	Superintendent	SMSgt-CMSgt

APPENDIX D: MENTAL HEALTH RESOURCE GUIDE

Mental Health Resource Guide		
Resource	Contact Information/Location	Confidentiality/Notes
ADAPT/Mental Health	919-722-1883 2803 Medical Place, Goldsboro, NC, 27534	Partial confidentiality. Information kept in medical records. Can prescribe medication.
Chaplain	919-722-0315 1505 Vermont Garrison St, Bldg 3720, Goldsboro, NC, 27534	Full confidentiality and no records kept
Command Post	919-722-1973 1330 Cannon Ave, Goldsboro, NC, 27534	Mandatory reporter for suicide and sexual assault.
Security Forces	919-722-1211 1330 Cannon Ave, Goldsboro, NC, 27534	Mandatory reporter for suicide and sexual assault.
Military Family Life Counselor	919-886-3346 1500 Vermont Garrison St, Bldg 3801, Goldsboro, NC, 27534	Mandatory reporter for potential or planned crimes, spousal abuse, and child abuse
Sexual Assault Prevention and Response (SAPR) Hotline	919-920-7272 1010 Vermont Garrison St, Goldsboro, NC, 27534	Partial confidentiality. Member has the option of restricted or unrestricted reporting. Texting is an option.
National Suicide Hotline	1-800-273-8255 https://suicidepreventionlifeline.org	Full confidentiality and no records kept. Online chat is an option.
Military One Source	1-800-342-9647 https://www.militaryonesource.mil	Full confidentiality and no records kept. Online chat is an option.