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**SOCIAL INFLUENCES AND BARRIERS TO SEEKING HEALTHCARE FOR MENTAL HEALTH PROBLEMS AMONG UK MILITARY PERSONNEL
QUALITATIVE AND QUANTITATIVE INVESTIGATIONS**

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SOCIAL INFLUENCES AND BARRIERS TO SEEKING
HEALTHCARE FOR MENTAL HEALTH PROBLEMS
AMONG UK MILITARY PERSONNEL: QUALITATIVE
AND QUANTITATIVE INVESTIGATIONS

Thesis submitted for the Degree of Doctor of Philosophy
in Psychological Medicine by:

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ABSTRACT

Approximately 60% of UK military personnel who experience mental health problems, do not seek help. Typical demographics of military personnel provide one explanation for this, as help-seeking is lowest in young males in the general population. There are, however, further issues concerning the military, such as heightened stigma concerns and the effect of military culture on help-seeking behaviours.

The overarching aim of this thesis is to determine the main social influences, barriers and facilitators of help-seeking for mental health problems in UK military personnel (Service Personnel, Reserves and ex-Service personnel). The thesis is comprised of three studies and utilises a mixed methods approach. The two qualitative studies examine factors which were barriers and facilitators of help-seeking for mental health problems. The quantitative study explores how social support, military characteristics, attitudes towards mental health treatment, and stigma are associated with help-seeking.

All studies utilise male only samples. The first qualitative study sample (N=16) of non-help-seekers and help-seekers is taken from *phase two* of a longitudinal cohort study of UK military personnel. The second qualitative study sample (N=10) was recruited from help-seeking beneficiaries of Combat Stress, an Armed Forces mental health charity. In-depth semi-structured telephone interviews were conducted for both qualitative studies and analysed using thematic analysis. The quantitative study sample (N=453) is taken from a clinical telephone interview study investigating help-seeking behaviours from a sample of respondents in *phase three* of the military cohort study. Descriptive analyses exploring the relationship between help-seeking and stigma/barriers to care are presented.

Key findings show that public stigma, self-stigma, attitudinal preferences for self-management of problems, and poor social support are barriers to seeking help. The main facilitator of help-seeking was supportive social networks. The research compares findings with existing literature in military and general populations. Recommendations for future research and policy implications are discussed.

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ABBREVIATIONS

AOR	Adjusted Odds Ratio
AUDIT	Alcohol Use Disorders Identification Test. A health outcome measure assessing for alcohol misuse
AUDIT-C	Alcohol Use Disorders Identification Test – Modified Short-Form Test
BACE	Barriers to Care Evaluation – A measure to assess barriers to accessing care for mental ill health
CI	95% Confidence Interval
CMD	Common Mental Health Disorders
CO	Commissioned Officer: A military rank of the highest authority deriving authority directly from a sovereign power. This rank is gained through Direct Entry (DE Officers) via officers training, or Late Entry (LE Officers) having been commissioned from senior NCO ranks. DE and LE Officers often work in different roles. CO ranks include Field Marshal, General, Brigadier, and Major.
DASA	The UK Ministry of Defence Analytical Services and Advice (now called UK Defence Statistics)
DMS	Defence Medical Services
GAD-2	Generalised Anxiety Disorder-2 Item Scale
GAD-7	Generalised Anxiety Disorders-7 Item Scale
IBM	Integrated Behavioural Model
KCMHR	King’s Centre for Military Health Research
MOD	Ministry of Defence
MODREC	Ministry of Defence Research Ethics Committee
MSPSS	Multidimensional Scale of Perceived Social Support
n	Sample size
NHS	National Health Service
NCO	Non-Commissioned Officer. A military rank with some degree of authority. This rank is gained through promotion from within the non-officer ranks. NCO ranks include corporal, sergeant, and warrant officer
NVivo	Qualitative Coding Software

OR	Odds Ratio
PCL-5	Post Traumatic Stress Disorder Checklist for DSM-5
PC-PTSD	Primary Care – Post Traumatic Stress Disorder Screen
PHQ-2	Patient Health Questionnaire-2 Item Scale (Depression)
PHQ-9	Patient Health Questionnaire-9 Item Scale (Depression)
PSBCPP-SS	Perceived Stigma and Barriers to Care for Psychological Problems- Stigma Subscale
PTSD	Post-Traumatic Stress Disorder
RAF	Royal Air Force
RBL	The Royal British Legion
RN	Royal Navy, including Royal Marines
SPVA	Service Personnel and Veterans Agency (UK)
STATA	Data analysis and statistical software
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
TRiM	Trauma Risk Management (Training/Practitioners)
UK	United Kingdom
US	United States
VRMHP	Veterans and Reserves Mental Health Programme
WHO	World Health Organisation
95% CI	95 per cent confidence interval
%	Per cent

TERMINOLOGY

Active duty	US equivalent of Regular personnel in the UK Armed Forces.
Civvy Street	Colloquial term used by military personnel to denote civilian life after leaving Service.
Combat Stress	UK Armed Forces mental health charity providing treatment and support for ex-Service personnel.
Deployment	Movement of Armed Forces on operations around the world to war and conflict zones. Operational advised tour lengths for UK troops - six months deployed, with 24 months in-between deployments.
Defence Medical Services	Healthcare services provided by the MOD for Service personnel and mobilised Reserves when in Service.
Ex-Service personnel	Those who have left the Armed Forces, also termed as veterans.
Help-seeking/care-seeking	The act of seeking help or care.
Help-seeking pathway/routes	The passage or track an individual may take when seeking help for their health.
(Positive) Mental Health Case	Individuals considered to have a probable mental health diagnosis as measured by mental health screening measures.
National Guard (NG)	A Reserve military force in the US similar to the UK Reserve force. The majority have full time jobs while serving part time as a National Guard member. The National Guard are part of the US Reserve component
Op HERRICK	The UK military codename for operations in Afghanistan
Op TELIC	The UK military codename for operations in Iraq
Other ranks	Ranks below NCO. Other ranks includes Able Seaman in the Royal Navy, Private in the Army and Royal Marines and Aircraftman in the RAF
Regular Service Personnel	Regular personnel are employed by the military in a full-time capacity.
Reserves	UK Reserves can include those in the Army, Navy or Royal Air Force Reserve. They provide support to Regular UK military forces at home and abroad. They hold civilian jobs and train part-time.
TRiM Practitioners	Trained military personnel on a peer level that undergo specific training in the identification and management of Service personnel after traumatic incidents.

Veterans

Individuals who have left the military – also termed ex-Service personnel

STATEMENT OF CONTRIBUTION

My thesis is part of a series of studies being conducted at the King's Centre for Military Health Research (KCMHR), King's College London, where I have been enrolled for completion of my PhD. I designed and carried out my systematic review and meta-analysis. I specifically extracted and analysed the data for this review. I was not involved in the design, ethics, or data collection of phase 1 or 2 of the KCMHR military cohort health study. My first qualitative study included participants who were recruited through phase 2 of the KCMHR military cohort health study however; I designed the first qualitative study, submitted the ethics amendment, gained ethical approval, and also collected, coded and analysed the data. My second qualitative study recruited beneficiaries from the Armed Forces charity, Combat Stress. I designed the study, submitted the ethics amendment and gained ethical approval, and finally collected, coded and analysed the data. My quantitative study used data collected by a KCMHR clinical telephone interview study, which recruited participants from phase 3 of the KCMHR cohort military study. I was not involved in the ethics or data collection of the KCMHR clinical telephone interview study, however I was partly involved in the design of the stigma and barriers to care section of the study. I did, however, plan and design my quantitative study additionally cleaning, coding and checking the data, and conducted all analyses in the quantitative study. All work undertaken as part of my thesis was supervised by Professor Nicola Fear, Dr Laura Goodwin, with the additional support of Professor Christopher Dandeker for the qualitative aspects of the PhD.

STATEMENT OF AUTHORSHIP

Marie-Louise Sharp carried out the drafting and preparation of this thesis under the supervision of Professor Nicola Fear and Dr Laura Goodwin. Professor Nicola Fear and Dr Laura Goodwin read and commented on the entire draft. Professor Christopher Dandeker read and commented on chapter 3 (qualitative methods). The systematic review and meta-analysis chapter is an adapted version of a published version of this work (included in Appendix 1); the draft of the published version was read and commented upon by all named authors.

Thesis Structure

Chapter 1 introduces the PhD and presents an overview of the relevant literature in this field. This chapter includes a discussion of the limitations of the existing literature, the rationale underpinning my PhD, the objectives, aims and hypotheses of this thesis.

Chapter 2 presents my systematic review and meta-analysis of the military literature assessing the relationship between stigma and help-seeking.

Chapters 3-5 contain an overview of my two qualitative studies, a description of my methods and the results of these studies. The two qualitative studies involve in-depth semi-structured interviews, assessing barriers and facilitators of help-seeking for mental health problems for military personnel. The two studies were conducted with non-help-seeking and help-seeking participants from the King's Centre for Military Health Research Cohort Study (KCMHR) and help-seeking beneficiaries from the Armed Forces Charity, Combat Stress.

Chapter 6 provides a summary of the results from my two qualitative studies.

Chapters 7-8 present my quantitative study. These chapters provide an overview of the quantitative study, including the specific methods and results, and a summary of the main quantitative findings.

Chapter 9 is composed of the main discussion for this PhD. It includes discussion concerning results from my systematic review/meta-analysis, and my qualitative and quantitative results. This discussion is set within the context of the most recent research findings (including research published after the literature review was conducted).

Chapter 10 considers the strengths and limitations of this PhD.

Chapter 11 concludes this PhD. It examines the main implications and conclusions of the research findings, offers proposals for future research in light of Armed Forces healthcare policy, and suggests possible interventions for this population to improve health outcomes.

Chapter 1 – Introduction and Literature Review

1.1 Overview

This chapter presents a review of the existing literature that assesses the social influences and barriers to seeking healthcare for mental health problems relevant to United Kingdom (UK) military personnel. The background information includes the most current statistics on the UK Armed Forces to provide an overview of the population in terms of the prevalence of mental health problems and healthcare utilisation. The review includes published literature up to early 2014 (when the review was completed). The review includes literature on international militaries where the data is useful for understanding the global context of help-seeking in the military for mental health problems. The review also includes help-seeking literature in UK general populations where these data are appropriate for contextual comparisons with the UK military.

The literature review will help inform the direction of my thesis in the design and analysis of my qualitative and quantitative investigations. It discusses findings thematically, by the most prominent barriers or facilitators of help-seeking. These include stigma, attitudes towards mental health care or mental health treatment, self-perceived need for care, social networks, logistic or practical barriers, military culture and gendered help-seeking.

The initial literature review prompted a more in-depth assessment of the barrier to care of ‘stigma’, that was cited in many military studies as a focal point for investigation in terms of its effect on help-seeking. This systematic review and meta-analysis was subsequently conducted in early 2014, and published in *Epidemiological Reviews* in January 2015 (Sharp et al., 2015). Chapter 2 is therefore based on this publication, which can be found in Appendix 1. Following the literature review, the limitations of the literature are presented and form the basis of the rationale for this thesis. The thesis aims and hypotheses are then presented.

1.2 Background

There are estimated to be 2.3 million ex-Service personnel in the UK, with an additional 2.1 million dependent adults (including spouses and widows) and 1 million dependent children (UK Household Survey of the Ex-Service Community, 2014¹). Regular and Reserve Forces approximate 182,500 (UK Armed Forces Annual Personnel Report 2014, UK Reserve and

¹ <http://www.britishlegion.org.uk/about-us/campaigns/household-survey-2014>

Cadet Strengths 2014²), with 23,000 leaving Service in 2013-14 (UK Armed Forces Annual Personnel Report 2014).

Military personnel who have deployed are at high risk of experiencing traumatic events (Hoge et al., 2004), particularly those who deploy in a combat role. UK research has found an association between holding a combat role and Post Traumatic Stress Disorder (PTSD) (Rona et al., 2009, Fear et al., 2010). There is an increased risk of PTSD and relationship problems in deployed Reserve personnel compared to non-deployed Reserves (Harvey et al., 2012). The prevalence of common mental health disorders (CMD) in the UK Armed Forces is estimated at 20%, alcohol misuse 13% and PTSD 4% (Fear et al., 2010). Few studies have directly assessed the prevalence of mental health problems in the UK military compared to the UK general population. Previous studies have shown a mixture of results; Iversen et al. (2009) research suggested the prevalence of neurotic disorders (depression, generalized, anxiety and panic) in the military, was similar to the prevalence of neurotic disorders from the Adult Psychiatric Morbidity Survey (McManus et al., 2009). However recent research by Goodwin et al. (2015) comparing UK Service personnel and the English working general population suggests that odds of probable CMD were double in the military compared to the general population. This approximates Royal British Legion (RBL) research that found depression at 10% in the ex-Service population compared to 6% in the UK Population (RBL UK Household Survey of the Ex-Service Community, 2014).

Help-seeking for mental health problems is low in both the UK general population (McManus et al., 2009) and UK military population (Iversen et al., 2010, Hines et al., 2014a). In the Adult Psychiatric Morbidity Household Survey in England, 2007: only 24%, 28% and 14% of individuals with probable CMD, PTSD and alcohol dependence respectively, were receiving formal/professional treatment (McManus et al., 2009). The military population in comparison may have better access to mental health services, through the Defence Medical Services (DMS) (when in Service provided to Service personnel and mobilised Reserves) and through the specific services for ex-Service personnel on the National Health Service (post-discharge provided to ex-Service personnel and demobilised Reserves) compared to the general population (Clark et al., 2012). The Government since 2010 through the Murrison report, 'Fighting Fit', has specifically focused its policy and funding on providing improved mental health services for the UK military and ex-Service personnel. Some of these services aim to encourage early intervention, increased access points and more funding for new services, such as setting up the 24hr Veteran Mental Health Helpline and specialised services such as the NHS commissioned intensive PTSD treatment

² <https://www.gov.uk/government/statistics/mod-national-and-official-statistics-by-topic>

service delivered through the Service charity Combat Stress (For more information on Government military mental health policy and healthcare services please see Appendix 2). Despite these apparent advantages in access to treatment, the military population remains reluctant to seek help for mental health problems.

In a UK military sample including Service personnel, Reserves and ex-Service, only 23%, 50% and 64% of those with alcohol problems, depression/anxiety and PTSD respectively had sought professional help (Iversen et al., 2010). A recent UK military study, Hines et al. (2014a) found that out of 888 military personnel who reported a stress or emotional problem as a result of deployment, only 42% were seeking any help and only 29% seeking formal/professional help. Help-seeking for alcohol problems in this study (n=291) was again even lower with only 31% seeking any help and 17% seeking formal/professional help. In the UK military therefore, 46% - 83% of individuals with probable mental health disorders do not seek help and of those who do access help, most help sought is from informal sources (Iversen et al., 2010, Hines et al., 2014a). This is also comparable to US Service personnel where an estimated 56% - 77% of individuals with mental health problems do not seek professional treatment (Hoge et al., 2004, Kehle et al., 2010). There are also concerns in the US that up to 60-70% of veterans with a mental health diagnosis do not receive adequate treatment within a year of their diagnosis (8 or more sessions) (Seal et al., 2010, Rosen et al., 2011).

The typical demographic of the military provides one explanation for why help is not sought, with help-seeking lowest in young males in the general population (Oliver et al., 2005). However, there are further issues relating to the military. Contemporary international research has examined the barriers that impede help-seeking behaviour and engagement with treatment in military populations; these have included **stigma** (Greene-Shorridge et al., 2007, Britt et al., 2008, Pietrzak et al., 2009, Langston et al., 2010, Gould et al., 2010, Kim et al., 2010, Iversen et al., 2011, Rosen et al., 2011, Gibbs et al., 2011, Kim et al., 2011, Sudom et al., 2012, Ben-Zeev et al., 2012, Momen et al., 2012, Held and Owens, 2013a, Osório et al., 2013a), **practical or logistic barriers to care** (Iversen et al., 2011, Brown et al., 2011), **negative attitudes related to mental health problems or mental health treatment** (Kim et al., 2011, Vogt, 2011, Sudom et al., 2012, Forbes et al., 2013), **poor recognition of the need for treatment** (Iversen et al., 2005, Sareen et al., 2007, Fikretoglu et al., 2008, Britt et al., 2012, Momen et al., 2012), and the **effect of social networks or military leadership** (Warner et al., 2008, Harpaz-Rotem and Rosenheck, 2011, Pfeiffer et al., 2012, Britt et al., 2012) on help-seeking. In addition, research has discussed the effect of **military culture and**

gendered (masculine) help-seeking on help-seeking outcomes (Iversen et al., 2005, Jakupcak et al., 2006, Langston et al., 2007, Burns and Mahalik, 2011, Alfred et al., 2014).

The following sections assess these main barriers, present available evidence to ascertain what social influences or barriers to seeking help for mental health problems in the UK military are of primary interest, and what areas of research may be lacking.

1.3 Stigma

1.3.1 Stigma Definitions

Stigma is a complex and contested construct with many theoretical facets. Whilst there are competing definitions, I describe some of the most relevant and most commonly used terms below. Stigma is frequently conceptualised as a belief relating to an ‘attribute that is deeply discrediting’, that reduces the target, whether it be the self or other, ‘from a whole and usual person to a tainted, discounted one’ (Goffman, 1963). Theoretically stigma can occur at individual, interpersonal (interactions among dyads or groups), and sociocultural levels (across societies or cultures) (Chaudoir et al., 2013). Stigma that occurs at the sociocultural and interpersonal levels has been termed, ‘public stigma’ or ‘enacted stigma’. The process of stigmatisation follows when groups with power, stereotype, hold prejudice and discriminate against a group that has been labelled as separate or different (Link and Phelan, 2001, Rüsche et al., 2005, Thornicroft, 2008). This stigmatisation is related to shared, cultural beliefs held by the general public about the attributes of those with mental illness, that can lead to explicit acts of discrimination and hostility resulting in ‘enacted stigma’ (Steward et al., 2008).

At the individual level, one facet of stigma has been described as ‘felt normative stigma’, which is the individual’s belief about the prevalence of stigmatising views among people in their community (Steward et al., 2008). Additionally, ‘anticipated stigma’ has been termed, the extent to which people believe they personally will be viewed or treated in a stigmatising way if their mental health problem or related help-seeking becomes known (Britt, 2000, Earnshaw and Chaudoir, 2009). Self-stigma alternatively, reflects a stigmatised individuals’ internalisation of actual or perceived negative societal beliefs towards those who have mental health problems. Self-stigmatisation can lead to feelings of shame and inadequacy, which may affect an individual’s self-worth and confidence to seek help (Corrigan et al., 2005, Vogel et al., 2006). Stigma at all of these levels interact with each other and can act as barriers to help-seeking (Vogel et al., 2007a, Chaudoir et al., 2013).

1.3.2 Mental Health Stigma and the Military

Military organisations may engender certain stigmatising beliefs in relation to help-seeking for mental health problems that may also persist into civilian life (Langston et al., 2007, Greene-Shortridge et al., 2007, Vogt, 2011). These beliefs may be related to military culture, rules and conduct learnt and experienced in Service. For example, the value placed on the actions of the group to achieve military objectives above all else, the cultures of reliance upon each other, masculinity, self-sufficiency and the stigmas of ‘going sick’ or ‘shirking work’ have been noted to affect help-seeking behaviours (Iversen et al., 2005, Gibbs et al., 2011, Simmons and Yoder, 2013). The requirement for operational readiness through good health, conflicts with the direct availability of mental healthcare provided by the military for Service personnel. The Armed Forces is one of the few careers where your employer is also your healthcare provider. In this sense, personnel are faced with a choice between disclosure of health problems in order to access care and the potential negative effect upon their operational effectiveness, and thus their careers. Hence military objectives, healthcare, structures and cultures may interact to create barriers to seeking help for mental health problems and personnel may therefore elect not to disclose mental health problems (Greene-Shortridge et al., 2007, Warner et al., 2008).

Across the literature when considering mental health help-seeking from formal/ professional or medical sources, stigmatising beliefs are reported at consistently greater levels than practical or logistical barriers to care, irrespective of whether personnel are full time Regular, Reserves or veteran/ex-Service (Hoge et al., 2004, Britt, 2000, Britt et al., 2008, Iversen et al., 2011, Osório et al., 2013b). Research has also consistently found that personnel reporting more mental health symptoms perceive greater levels of stigma and barriers to care than those with sub-threshold symptoms (Hoge et al., 2004, Pietrzak et al., 2011a, Kim et al., 2011, Ouimette et al., 2011, Osório et al., 2013b, Iversen et al., 2011, Warner et al., 2011, Jones et al., 2013).

1.3.3 Public Stigma Prevalence and Association with Help-Seeking

Specifically in UK military literature one of the most common reasons evidenced as to why UK Service and ex-Service personnel indicate they would not or have not accessed mental health services, was the influence of anticipated public stigma associated with consulting for a mental health problem (Gould et al., 2010, Iversen et al., 2011, Osório et al., 2013a, Jones et al., 2013). Some of the top concerns endorsed in these studies were; (a) being seen as weak, (b) concerns members of their unit or work colleagues might have less confidence in them, (c) concerns unit leaders or work bosses would treat them differently if they sought help and, (d) it being too embarrassing to seek help.

UK military studies have mainly utilised adapted versions of the Perceived Stigma and Barriers to Care for Psychological Problems Stigma Sub-Scale (PSBCPP-SS) developed by Britt (2000), Hoge et al. (2004), Britt et al. (2008) to measure anticipated stigma. Most UK studies have only measured barriers related to hypothetical help-seeking, i.e. what barriers '*might*' be of concern, '*if*' the respondent ever had a problem and needed to seek help. Only one UK study, Jones et al. (2013), has assessed stigma and its association with care seeking propensity (i.e. interest in receiving help). In this UK sample of Regulars and Reserves they found a positive association between stigma and care seeking propensity i.e. those who were interested in seeking help were more likely to endorse high stigma concerns regarding help-seeking compared to those not interested in seeking help, after adjusting for mental health status. The positive association between public stigma and interest in receiving care in Jones et al. (2013) may be related to modified labelling theory (Link et al., 1989), where the actual process of thinking about accessing care and help, may engender stigmatising perceptions or beliefs and make individuals more aware of stigma from others.

Jones et al. (2013) conducted a reanalysis of these data to assess the relationship between stigma and actual health service utilisation (based upon self-reported use of services). In this sampler-analysis, they found no association between public stigma and utilisation of mental health services for those with probable mental health problems. The finding of no association between stigma and health service use in the Jones et al. (2013) study does not immediately cohere with the high stigma prevalence and general assessment of stigma as a barrier to mental healthcare, widely documented in the military literature examined here. In light of the sparse evidence in UK military literature, I looked to US military literature, however I also found that few studies internationally had assessed the association of public stigma and help-seeking propensity or actual health service use (Vogt, 2011).

The systematic review by Clement et al. (2014) assessed the impact of stigma on help-seeking in 144 studies. They found a small, negative relationship between stigma and help-seeking, with self-stigma and treatment stigma (stigma associated with receiving mental health treatment) being most often associated with reduced help-seeking. They did not find an association between public stigma and help-seeking. It is clear that stigma was an prominent barrier to help-seeking in these studies, as it was the fourth highest ranked barrier (across stigma types), however it is also apparent that specific types of stigma may be more important than others in affecting help-seeking decisions.

1.3.4 Other Military Stigma Findings

Iversen et al. (2011) found that those with alcohol problems, compared to other diagnoses, were more likely to cite stigma as a barrier to care. Gibbs et al. (2011) found qualitative support for this with evidence from a US Regular Army sample. This sample cited heightened public stigma towards alcohol treatment, compared to mental health treatment, as soldiers placed more fault and responsibility on the individual having an alcohol problem. There is also evidence for a potential culture of silenced or controlled disclosure of mental health problems in the military. Fear et al. (2012) found a statistically significant effect on the increased reporting of sub-threshold/probable PTSD and certain stigmatising beliefs when a UK military sample used an anonymous, compared to an identifiable survey questionnaire on mental health.

Reasons for disclosure concerns are also well documented in US research, which utilises the PSBCPP-SS scale for much of its research. Again Regulars, National Guard/Reserves and ex-Service personnel cite high levels of concerns about unit members losing confidence in them, unit leaders treating them differently or concerns about embarrassment and weakness (Hoge et al., 2004, Gould et al., 2010, Kim et al., 2010, Gorman et al., 2011, Kim et al., 2011, Warner et al., 2011, Hoerster et al., 2012, Pietrzak et al., 2009). Confidentiality of medical records and the influence on career advancement are ranked high in US literature (Gorman et al., 2011), with these concerns persisting into veteran life (Vogt, 2011).

1.3.5 Self-Stigma

Despite self-stigma being highlighted in general population literature as distinct from anticipated or public stigma (Corrigan et al., 2006), no quantitative studies have been conducted in UK military research that measure self-stigma and its association on care seeking propensity or healthcare service utilisation. Self-stigma negatively affects people's decisions to receive mental health care in general populations (Vogel et al., 2006); it has also been linked to negative attitudes towards mental health services, and to reduced care seeking propensity to seek different forms of mental health treatment (Vogel et al., 2007a, Conner et al., 2010). Additionally, those who endorse greater self-stigma are less likely to engage with treatment after an initial visit (Wade et al., 2011). Finally the systematic review by Clement et al. (2014) assessing stigma and help-seeking in a mixture of different populations found it was specifically self-stigma that presented a small and consistent negative association with help-seeking.

From the evidence available, one UK military study qualitatively investigated pathways to care for Service personnel with PTSD (Murphy et al., 2014). One of the themes identified

described how individuals had to overcome self-stigma to be able to seek help, this included overcoming feelings of shame about experiencing mental health difficulties and the effect on self-esteem of being prescribed psychiatric medication. From US military research, one study examined a sample of National Guard/Reserves and found that self-stigma was negatively related to help-seeking intentions (Blais and Renshaw, 2013). As yet in military literature there is little research that addresses the effect of this type of stigma.

In light of the findings: that there are many studies assessing stigma in military populations; that most studies assess anticipated public stigma only; and few studies measure the association of stigma on actual service use; I deemed a systematic review and meta-analysis would be able to provide an overall assessment of the relationship of stigma and help-seeking. I wanted to be able to assess the prevalence of stigma and clarify knowledge of the association of stigma with help-seeking propensity (i.e. interest in receiving help) and health service utilisation, in military populations with mental health problems. Conducting this systematic review therefore became one of the first supporting aims of the PhD. The systematic review and meta-analysis assesses the relationship of stigma and help-seeking in military samples and is presented in Chapter 2.

1.4 Attitudes and Expectations towards Mental Health Treatment

Mental health illness related beliefs and specifically negative beliefs about mental health treatment have been explored as constructs in general populations, in their effect on mental health service use (Rüsch et al., 2011, Mojtabai et al., 2011). In terms of attitudes towards mental illness, negative beliefs may include negative stereotypes of individuals with mental health problems, such as views that individuals with mental health problems are dangerous, or that they lack self-discipline (Rüsch et al., 2005, Angermeyer and Dietrich, 2006). Negative attitudes towards mental healthcare treatment might entail beliefs such as a lack of trust in mental healthcare professionals, views that treatment doesn't work, or that treatment would necessarily involve pharmacological medication. These beliefs have also been identified as important for help-seeking populations in the military because of the effect of the role that military culture, masculinity and career prospect concerns play in creating these attitudes (Vogt, 2011).

In UK military studies, Forbes et al. (2013) conducted a comparison of UK military attitudes towards mental illness compared with the UK general population. The study showed that the majority of respondents from both populations showed positive attitudes towards mental illness. The military held more negative attitudes about the job rights of those with mental

illness; 57% of the UK military sample vs. 68% of the general population sample agreed that, *'People with mental illness have the same rights to a job as everyone else'*. Additionally there were less positive attitudes in young military males between the ages of 16-34, compared to the young males in general population; 33% vs. 23%, regarding the statement, *'Mental illness is an illness like any other'*. The UK military had more positive views compared to the general population about the causes of mental illness, with 81% of the UK military sample disagreeing with the statement, *'One of the main causes of mental illness is a lack of self-discipline and willpower'*, compared to 62% of the general population. This study did not aim to connect these attitudes with help-seeking behaviour, so it is not possible to tell the effect these views would have had on healthcare service utilisation.

In the available evidence in UK studies, negative attitudes towards mental health care do not seem to be prevalent in the military. In Iversen et al. (2011) study assessing barriers to care, including negative attitudes to mental health care or providers, endorsement of negative attitudes were in the bottom third of concerns for the UK military sample (including Service personnel, Reserves and ex-Service personnel). For example only 14% of the sample endorsed that they believed their visit would not remain confidential, and only 4% endorsed that mental health care doesn't work. However, this study did not measure the effect of these barriers on actual service use.

With few UK military studies to draw evidence from, it is helpful to analyse general trends from US and Canadian military studies. Brown et al. (2011) found in a US Regulars sample, that negative attitudes towards mental health care such as, *'Mental health care doesn't work'*, were associated with a lower likelihood of interest in receiving help in those who had screened positive for a mental health problem. Similarly a large study of Canadian soldiers found that negative attitudes towards care had negative associations with care seeking propensity (Sudom et al., 2012). A large cohort study of US soldiers, previously deployed to Iraq or Afghanistan found those who reported negative attitudes towards mental health treatment such as, *'I do not trust mental health professionals'*, *'Psychological problems tend to work themselves out without help'* and *'Getting mental health support should be seen as a last resort'*, were almost 40% less likely to use any type of mental healthcare (Kim et al., 2011). Stecker et al. (2013) interviewed 143 US Service personnel who had PTSD but were not in treatment. The most commonly endorsed barriers to care were concerns or negative attitudes regarding treatment (40% endorsement overall), such as the concern that treatment would necessarily require prescription of a medication (26%). Additionally in a US veteran sample, Pietrzak et al. (2009) found that negative beliefs about mental health care such as,

'Therapy is not effective for most people', were associated with stigma, barriers to care and a decreased likelihood of utilisation of mental health counselling.

The literature shows some evidence of the negative association of negative attitudes towards mental illness or mental health treatment and help-seeking intentions or healthcare service use. However as Vogt (2011) review notes, there is still a lack of attention in this area that measures the association of mental health related beliefs and actual service use. Equally studies have not delineated clearly the separate effects of personal beliefs about mental illness as opposed to personal beliefs about mental health treatment and its subsequent effect on help-seeking and service use.

1.5 Self- Recognition of a Mental Health Problem

A distinct barrier to seeking help is an individual's recognition that they are experiencing a mental health problem and that they could concurrently benefit from treatment. In a UK military sample (including Service personnel, Reserves and ex-Service personnel), 44% of individuals with a PHQ probable diagnosis (depressive/ anxiety disorder, alcohol misuse or PTSD) did not endorse (or recognise) that they were experiencing a stress, emotional, alcohol-related or family problem (Iversen et al., 2011). Recognition of the need for care differs across diagnoses in UK military studies with those with alcohol problems being the least likely to recognise a need for care. In Iversen et al. (2010) study only just under half of Regular Service personnel who had probable alcohol misuse problems (46%), perceived they had a problem. Additionally in another UK military sample (Hines et al., 2014a), only 14% of those who scored 16-19 on the Alcohol Use Disorders Identification Test (AUDIT) reported an alcohol problem following deployment; the AUDIT advises a case positive cut off score of 8, where scores of 16-19 would require an intervention of advice plus brief counseling and continued monitoring (Babor et al., 2001).

In Canadian military research, Sareen et al. (2007) found it was those with alcohol dependence who had the lowest likelihood of reporting a perceived need for treatment. Fikretoglu et al. (2008) (utilising the same data source as Sareen et al. 2007) also showed in that Canadian military sample that 80% of those who might benefit from mental health treatment failed to recognise their own treatment needs and consequently, did not seek help.

Certain factors have been shown to obscure individuals' perceptions of need for care. Research has found that individuals' self-sufficient desire to manage mental health problems on their own, affects their recognition of the need for care. In Iversen et al. (2005), UK ex-Service personnel's most common reason for not seeking help was a sense of resilience and

stoicism, citing –*It's a problem I should be able to deal with by myself*. In more recent UK military research, 62% of Regulars endorsed the statement, *I would prefer to manage problems on my own*, when asked about their views on personal responsibility for mental health management (Jones et al., 2013). In other US military literature, the most commonly cited belief was that mental health problems should be handled by the individual on their own (Britt et al., 2012, Momen et al., 2012). This finding has also been replicated in a US population study that found 73% respondents who recognised a need for treatment, subsequently did not seek treatment because of their desire to handle the problem on their own (Mojtabai et al., 2011).

Other research has sought to explain what factors might be relevant for individuals recognising their need for care. Some studies look at impairment as a predictor of mental healthcare utilisation, where individuals' self-perceived need for treatment only becomes actualised when impairment becomes too great. Hines et al. (2014a) found in a UK military sample that medical help-seeking was associated with individuals who had two or more mental health problems and increased severity of functional impairment. International research reflects this; Sudom et al. (2012) found in a Canadian Regular and Reserves sample that those with an increased severity of mental health problem were more likely to be interested in receiving mental health care. In a US veteran sample Rosen et al. (2011) found that initiation of mental health treatment was more likely if the veteran was more impaired. Hoerster et al. (2012) found that prospective use of US Veterans Affairs mental healthcare services was positively associated with increased severity of PTSD and depression symptoms. In these cases individuals were essentially forced to recognise their need for care when their illness became too much to cope with.

Hence factors that obscure individuals' ability to recognise that they may be experiencing a mental health problem act as barriers to help-seeking; whilst severity of illness may be a precipitating factor in recognition of problems and subsequent help-seeking and appears relevant for the UK military population.

1.6 Social Support and Networks

Having supportive social networks are potentially enablers in encouraging individuals to seek help. The term social network refers to the mesh of social relationships that surround an individual. Social networks influence health in various ways, including the facilitation of exchange of social support (Heaney and Israel, 2008). This social support can come in the form of emotional, instrumental, information and appraisal (affirmation/constructive feedback) support (House, 1981). Social networks are important in that they provide the

social resources that enhance or restrain access to information and opportunities that can affect health behaviours and attitudes (Berkman et al., 2000). In Albert et al. (1998) review of social networks and mental health service utilisation, they found smaller social networks were associated with an individual's increased service use. They concluded that ensuring adequate size and quality of social networks would reduce the likelihood of hospital admission, facilitate access to services and help avoid adverse pathways to mental health care. Thoits (2011) work in general population samples found that increased social support generally reduced the likelihood of treatment entry, but when an individual's mental health condition was more serious, supportive relationships raised the probability of mental health utilisation. Hence both high and low network density may be related to the use of professional services, however this relationship may be modified by the quality of support (Albert et al., 1998), severity of illness (Thoits 2011) and attitudes within the social network (Kogstad et al., 2013). For example, Vogel et al. (2007b) looked at the influence of social networks on individuals seeking help from a mental health professional. They discovered that being prompted to seek help and knowing someone who has sought help were related to positive expectations about mental health services and positive attitudes about seeking help. Research has also looked at the effect of social support on stigma. Lower levels of social support were linked to higher levels of public stigma, self-stigma and lower levels of recovery and quality of life for those with mental health problems (Chronister et al., 2013)

There is no UK military research that assesses the association of social support and its influence on help-seeking behaviours. However, in UK military samples Iversen et al. (2010) and Hines et al. (2014a) find the majority of those who endorsed they were experiencing a problem, had only made use of informal sources of support such as a spouse or friend, rather than seeking professional help. This was despite the individuals concerned being probable 'cases' on mental health measures who could have benefited from professional treatment. Hence there could be several ways informal support (and by default the individual's social network) influences help-seeking behavior. This informal support may prevent help-seeking in providing adequate support to the individual at lower levels of severity of problem, or by preventing help-seeking if the attitudes found within the social network were negative attitudes towards mental health and deterred the individual from seeking help.

From US military research, Warner et al. (2008) found one of the most influential factors for overcoming barriers to seeking care was having 'family and friends strongly encourage' soldiers to get help. Additionally, Pfeiffer et al. (2012) found in a sample of National Guard soldiers that tightly connected, supportive peer networks had the potential to decrease stigma related to mental health problems and encourage treatment. They also found that soldiers in

loosely connected peer networks or those in networks with competing cliques, were much less likely to seek mental health treatment based on interaction with their peers. Hence whilst social networks may provide positive informal support, the effect of attitudes within the network will moderate whether this support lends itself to future positive help-seeking behaviour. Therefore, the strength of social networks may not act as a constant on help-seeking propensity and it is necessary to look at the characteristics and quality of the social network.

The impact of leadership and unit cohesion within the military is important as these factors affect the culture and attitudes within a social network. From US military research, Harpaz-Rotem and Rosenheck (2011) found a positive association between greater unit support and utilization of mental health services. Britt et al. (2012) found that US Commissioned and Non-Commissioned Officers positive leadership behaviours were predictive of individuals positive decisions to seek mental health treatment. Pietrzak et al. (2009) found that decreased unit support predicted increased public stigma and barriers to care in a US Reservist and National Guard sample. Hence this research exemplifies the effect of attitudes within networks, influenced by leadership and the resulting effect on help-seeking.

Finally, it is widely noted in military literature that supportive social networks act as a buffer against stress and mental ill-health. Good leadership and unit cohesion has been associated with lower levels of CMD and PTSD in a UK military sample (Jones et al., 2012). Additionally, there is evidence that social support from within the military acts as a buffer against stress and mental health problems (Smith et al., 2013). Harvey et al. (2011) found in a UK sample that low levels of social support outside of the military for Reserves was associated with increased reporting of CMD, probable PTSD and alcohol misuse. Jakupcak et al. (2010) and Pietrzak et al. (2010) both found in US veteran samples that greater social support was negatively related to suicide ideation, however Pietrzak et al. (2011b) later research, questions the protective effect of social support on suicide ideation for individuals with more severe mental health impairment. We can therefore conclude that social support may be a protective factor against mental health problems by providing informal support that allows a positive environment where problems can be disclosed and individuals' supported (emotionally and practically) in addressing difficulties.

From the findings in US military samples, social support has been evidenced to be an enabler in encouraging individuals to seek help. From the broader literature it is also possible to conclude that the size of social network, quality of support and attitudes towards help-seeking within the network may play a role in individual's decisions to seek help. UK

military research is however at a deficit in investigating these factors.

1.7 Logistic/Practical Barriers

Many studies have assessed logistic or practical barriers to seeking care in military populations, however most have found these barriers to be less important than social or psychological barriers. In Iversen et al. (2011) UK military study, practical barriers to care were in the bottom half of the list of concerns relating to seeking help for a mental health problem. For example, 29% endorsed, *'It's difficult to schedule an appointment'*, 19% endorsed, *'It would be difficult to get time off work for treatment'* and only 16% endorsed that they didn't know where to get help. In this study, Reserves were more likely than Regulars to endorse practical barriers. This may align with some of the difficulties of providing joined up healthcare services to Reserves through the separate healthcare systems provided by the Defence Medical Services, when mobilised, and the NHS or the Veterans and Reserves Mental Health Programme (VRMHP) when demobilised. Additionally in this study, ex-Service personnel were more likely, compared to Regulars, to endorse that they didn't know where to go to get help. This may also reflect the situation where ex-Service personnel possibly do not know the services available to them on the NHS having little experience of negotiating NHS healthcare services in their lifetime. Again in UK military research of Regulars, practical barriers to care such as, *'I don't know where to get help'* and *'Mental health services aren't available'* were only ranked 9th and 11th out of 11 statements pertaining to concerns they had about seeking help for a mental health problem (these statements included items on stigma and barriers to care) (Jones et al., 2013). Osório et al. (2013a) found in a longitudinal study of a sample of UK Regulars that the most commonly held practical barrier to care across the time period (2008-2011) was difficulty in getting time off work for treatment, yet stigmatising beliefs were more frequently endorsed over every time period in all their deployed and post deployed samples.

International military studies have also explored practical barriers to care such as lack of adequate transportation, difficulties in taking time off work/scheduling appointments, knowing where to seek help and cost of medical care. Kim et al. (2010) study found that active duty soldiers were significantly more likely than their National Guard counterparts to report difficulties in scheduling appointments and getting time off work for treatment, however the National Guard sample compared to the active duty soldiers were significantly more likely to report that mental health care was too expensive. In several international military studies, the two concerns of having difficulty in finding time to schedule appointments and getting time off work for treatment are endorsed as the most important practical barriers. Despite this the majority of studies, including Kim et al. (2010), find

endorsements of these practical concerns less important than stigma/attitudinal views or find no association with help-seeking or receipt of treatment (Hoge et al., 2004, Pietrzak et al., 2009, Gould et al., 2010, Kehle et al., 2010, Britt et al., 2011, Gorman et al., 2011, Kim et al., 2011, Ouimette et al., 2011, Warner et al., 2011, Hoerster et al., 2012, Sudom et al., 2012).

1.8 Military Culture/Gendered Help-Seeking

Commonly stated in the UK literature is reference to the military culture of stoicism and masculinity that negatively affects help-seeking behaviours for mental health problems (Iversen et al., 2005, Langston et al., 2007, Iversen et al., 2011). Military training has been described to encourage conformity to Western masculine norms (Alfred et al., 2014). These norms include personal self-reliance, emotional stoicism, dominance, warrior ideals emphasising violence, toughness, heterosexual desire and risk taking. These masculine norms within the context of the military are thought to promote personal survival, mission completion, resilience and domination of weakness in order to earn the right of passage to become a soldier (Jakupcak et al., 2014, Alfred et al., 2014). In several studies, male military personnel have reported high levels of conformity to dominant western masculine norms (Kurpius and Lucart, 2000, Jakupcak et al., 2006). Brooks and Good (2001) argue that military personnel's adherence to masculine norms may produce a fixed and heightened masculine identity that remains with individuals throughout their lives affecting gender-related attitudes and behaviours. Although aspects of these masculine norms may promote successful soldiers, strict adherence to masculine norms may lower psychological well-being (Alfred et al., 2014) and delay treatment seeking for mental health problems (Addis and Mahalik, 2003, Yousaf et al., 2013). Jakupcak et al. (2014) found that US veterans who endorsed emotional toughness (e.g. not showing stress, not talking about difficult emotions and self-reliance) were also more likely to screen positive for PTSD and depression. Hence it is the very population that may need to seek help, who may be disinclined to ask for help due to adherence to masculine norms.

Burns and Mahalik (2011) emphasise that men's gender identities within the military are key to understanding help-seeking and suicide risk. They argue that adherence to self-reliance and emotional control may cause servicemen to go to great lengths to cope with their problems on their own, as asking for help may be akin to admitting weakness and can elicit feelings of failure and shame from the individual. In concurrence with this Vogel et al. (2011) research in US general population samples found that heightened masculine norms led to increased self-stigma and consequently decreased positive attitudes towards seeking help for mental health problems. In Vogel et al. (2007a) previous work, they found men were

more likely than women to internalise public stigma and self-stigmatise. As previously discussed in the stigma section of this review (Pg.24), self-stigma is also an important predictor of help-seeking behaviour (Vogel et al., 2006, Pederson and Vogel, 2007). Hence this research highlights the importance of the mediation of self-stigma between masculine norms and help-seeking attitudes. Men who have internalised masculine norms may believe help-seeking goes against principles of self-reliance and emotional control, and therefore needing or asking for help may create feelings of inadequacy or shame that additionally work against positive help-seeking behaviours.

Evidence for decreased help-seeking in male military personnel is found in Iversen et al. (2010), where UK Reservist females were more likely to seek help than males for mental health problems. In Hines et al. (2014a) medical help-seeking was associated with being a female. In a US veteran sample, women were twice as likely to receive treatment for serious psychological distress compared to males (Golub et al., 2013). These findings reflect similar data in the UK general population, which suggest women are more likely than men to seek help (Biddle et al., 2004, Galdas et al., 2005), and that men in the general population also experience prominent barriers created by masculine norms when seeking help for a mental health problem (Yousaf et al., 2013). There is evidence in US military and general population literature that masculine norms negatively affect help-seeking behaviour. There are, however, no UK military studies that measure masculine norms, their effect on male and female personnel, or association with help-seeking.

1.9 Application of Help-Seeking Models

Much of the research on determinants of help-seeking for those in the military with mental health problems has been atheoretical with researchers identifying descriptive labels for factors that might be barriers to care with limited use of help-seeking theory (Britt et al., 2011). Hence I believed it was important before conducting this research to have a broad overview of the possible help-seeking models that could be applied to the military population. I present a brief description of different help-seeking models below.

1.10 Theory of Reasoned Action and Theory of Planned Behaviour

The Theory of Reasoned Action (TRA), which was then extended in the Theory of Planned Behaviour (TPB) were developed to understand relationships between attitudes, intentions and behaviours (Fishbein, 1967, Fishbein and Ajzen, 1975, Ajzen and Fishbein, 1980, Ajzen, 1991). The theories focus on constructs concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour and have (among other

applications) been employed to understand health service utilisation (Montano and Kasprzyk, 2008). TRA contends that the most important determinant of behaviour is behavioural intention. Determinants of behavioural intentions are 1) **attitudes** towards performing a behaviour and 2) **subjective norms** associated with the behaviour. TPB adds to the model 3) **perceived control**, taking into account situations where individuals may not have control or free choice over a behaviour (see Figure 1).

Attitudes are determined by beliefs about the outcomes or attributes of carrying out a behaviour (behavioural beliefs). Hence an individual who holds strong beliefs that negative outcomes will result from a behaviour, will have a negative attitude toward that behaviour.

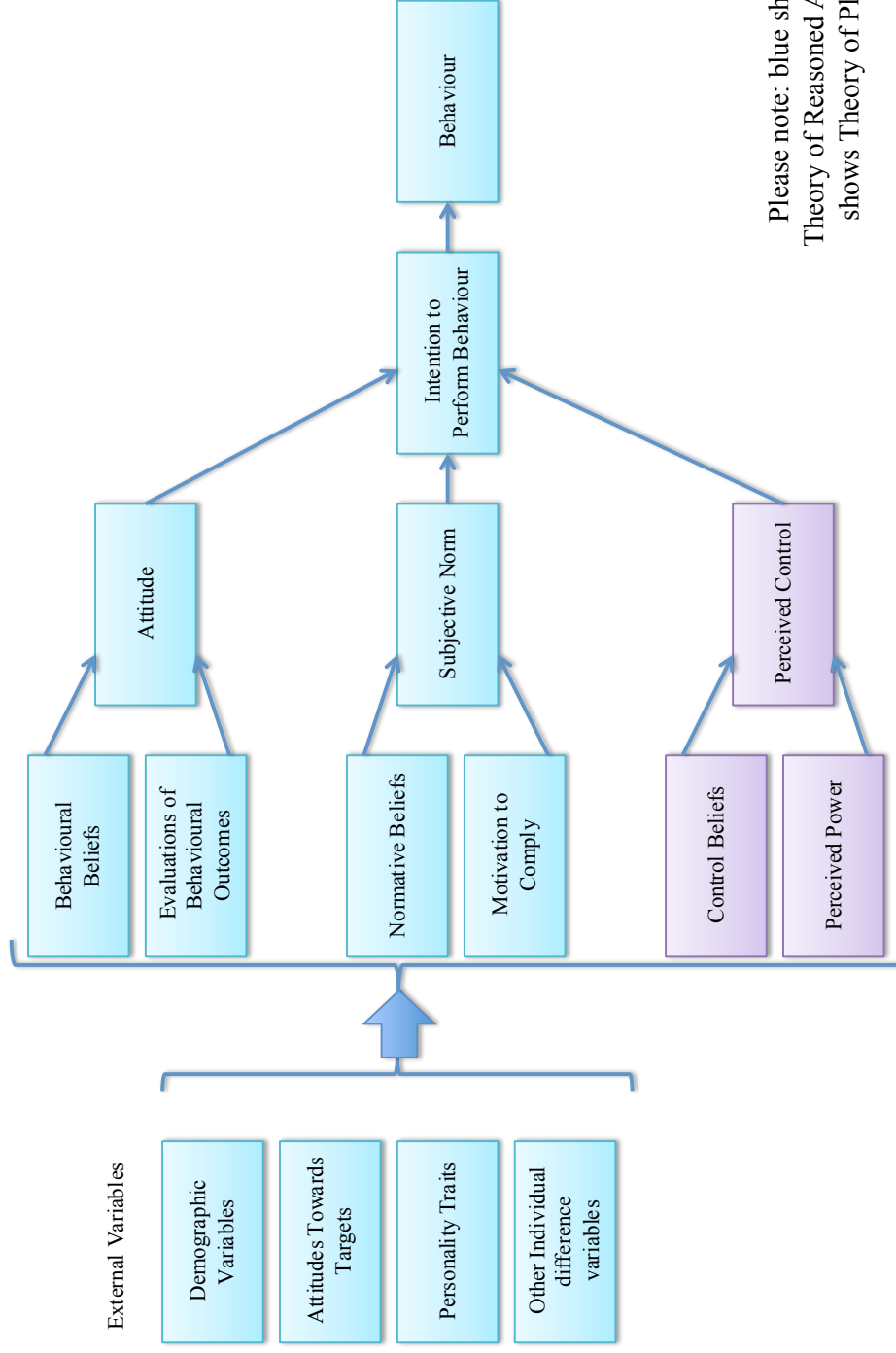
Subjective norms are determined by normative beliefs. That is, whether important individuals in relationship to that individual approve or disapprove of the behaviour in question, additionally weighted by the individual's motivation to comply with those referents.

Perceived control is determined by control beliefs. These concern the presence or absence of facilitators or barriers to performing a behaviour. Hence TPB adds to TRA, that it is not only the intention to perform a behaviour that is important, but also the ability of the person to carry out that action. A person's perception of control over an action (their volition) together with intention is expected to have a direct effect on behaviours.

TRA and TPB assume a causal process that links behavioural beliefs, normative beliefs and control beliefs to behavioural intentions and behaviours via attitudes, subjective norms and perceived control. The model additionally adds other factors such as demographic and environmental variables that are assumed to operate through the model constructs and not independently.

Relating this to military populations and help-seeking for mental health problems, TRA and TPB would posit that intentions to seek help would be affected by 1) attitudes towards help-seeking through the expected outcomes of help-seeking i.e. (for example) the possible negative affects on career, 2) subjective norms i.e. awareness of public stigma from colleagues or friends of seeking help for a mental health problem, and wish to avoid this stigma and, 3) perceived control, whether the individual believes they could help-seek i.e. do they have the information and resources to know where to seek help from and do they have time for appointments.

Figure 1 - Theory of Reasoned Action and Theory of Planned Behaviour. (Montano and Kasprzyk, 2008)



Please note: blue shaded boxes show Theory of Reasoned Action; entire figure shows Theory of Planned Behaviour

1.11 Integrated Behavioural Model

The integrated behavioural model (IBM) builds upon the TRA and TPB theories whilst also adding additional elements of theories from other behavioural models. IBM was developed from the Institute of Medicine report (2002) 'Speaking of Health' (Century and Populations, 2002).

The model posits the most important determinant of behaviour is, intention to perform the behaviour. There are four other components that include: knowledge and skill to carry out a behaviour; few environmental constraints that make behaviour difficult/impossible; the behaviour must be salient; and experience performing the behaviour may make intention less important as behaviour becomes habitual.

The model then constructs three categories through which these components are operationalized, these categories include, 'Attitude', 'Perceived Norm' and Personal Agency'. These are described below:

Attitude toward behaviour – this is made up of *experiential attitude* i.e. an individual's emotional reaction towards performing a behaviour and *instrumental attitude* i.e. an individual's beliefs about the outcomes of behavioural performance.

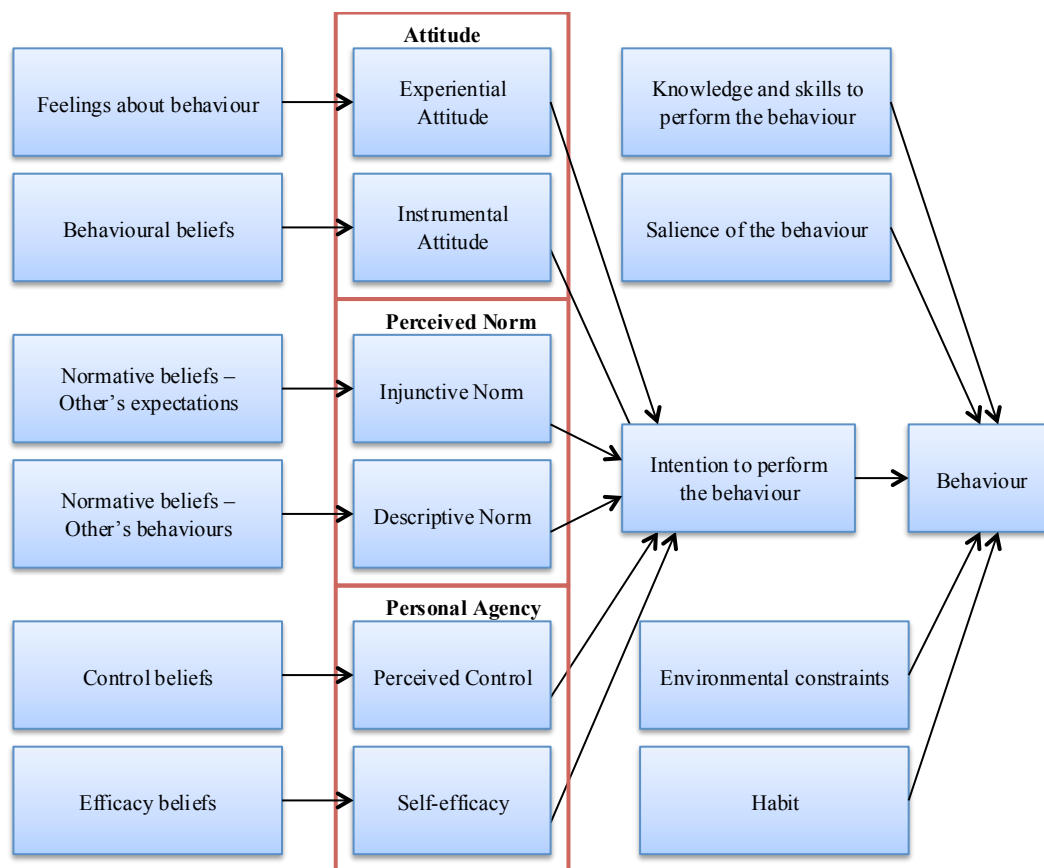
Perceived Norm – reflects the social influence or pressure individuals feel to perform/not perform a behaviour – this is made up of *injunctive norms* i.e. individuals beliefs about what others think one should do and motivation to comply and *descriptive norms* i.e. perceptions about what other people in the individual's social network are doing. This captures instances of influence through networks and populations who have a strong social identity.

Personal Agency - an individual's own influence over their functioning and environment – this is made up of *self efficacy* i.e. one's degree of confidence in the ability to perform a behaviour and *perceived control* i.e. an individual's perceived control over behavioural performance and the perception of the degree to which environmental factors make it hard/easy to take an action. (please see Figure 2 for the full operationalised diagram)

All of these constructs feed into underlying beliefs, that if used in help-seeking models would be important factors in affecting help-seeking decisions. The model also highlights that the relative importance of the three categories may vary for different populations and behaviours. The model also notes that demographic and other environmental influences may

be associated with behaviours but only indirectly working through the attitudinal, perceived norms and personal agency constructs.

Figure 2 - Integrated Behavioural Model (Montano and Kasprzyk, 2008)



1.12 Other Models

1.12.1 Anderson model of health service utilisation

The model consists of four broad categories: 1) **predisposing characteristics** (socio-demographics), 2) **enabling factors** – this relates to external circumstances that can facilitate or inhibit someone’s use of healthcare services. These could include, social support, waiting times, work and family commitments etc., 3) **need factors** – these describe someone’s motivation and need for treatment, 4) **environmental factors** – these include ease of access to healthcare services (transport, cost, availability).

1.12.2. Approach-Avoidance Conflict

Decisions to seek help are conceptualised as an approach-avoidance conflict (Kushner and Sher, 1989, Kushner and Sher, 1991). Individuals are more likely to approach treatment

when they have positive attitudes towards seeking professional help. Avoidance factors conversely decrease the chances individuals will seek help. Hence psychological and external barriers to treatment seeking, and avoidance factors, are pitted against the sum of various motivations to approach treatment to assess help-seeking outcomes.

1.12.3 Prototype/Willingness model

This model suggests that health-related decisions may involve social reaction processes that influence one's willingness to seek help (Gerrard et al., 2008). It extends TRA and TPB reasoned choice models by proposing two pathways to behaviour. One is a reasoned deliberative path that impacts behaviour through intention. The second is a social reaction path that impacts behaviour through willingness. This pathway involves spontaneous decision making, rather than a planned intention, which presents a willingness to engage in behaviour, given the right circumstances. For example, individuals may have no specific plans (intentions) to seek help for their depression, however when the opportunity presents itself they may be willing to do so. Willingness has been shown to be a better predictor of behavioural decisions than intentions, when behaviour is unfamiliar, undesirable and involves emotional processes (Gibbons et al., 2003, Gibbons et al., 2006).

In summary, there is benefit in understanding these models to be able to interpret my research under the possible lenses of some of these different approaches. I believe intentions are important to help-seeking behaviours (as described by TRA/TPB/IBM), but there may be other factors affecting help-seeking in situations where intentions might not marry with help-seeking behavioural outcomes (as offered by the prototype/willingness model).

1.13 Limitations and Rationale

Whilst there is much agreement that help-seeking is low in the military (Hoge et al., 2004, Iversen et al., 2005, Sareen et al., 2007, Iversen et al., 2010, Blais and Renshaw, 2013), there are multiple explanations as to why this is the case. Overall, more research is needed that focuses on the factors that enable and facilitate help-seeking in the military and not just barriers to care. Primarily, the military help-seeking literature explored here, focuses on potential barriers to care. Military studies such as Sayer et al. (2009) and UK general population studies such as Rüsçh et al. (2011) provide evidence that positive enabling factors may be more important in determining help-seeking behaviours than simply addressing barriers on their own, and therefore facilitators of help-seeking are an important aspect for future investigation

There is a need for research to connect attitudes and intentions to seek help with actual service utilisation. As noted several times in this literature review, few studies measure the association of barriers to help-seeking with service utilisation (Vogt, 2011). Hence studies deal with hypothetical help-seeking situations, asking respondents what they would do in a given situation, without confirmation whether that hypothetical behaviour does or does not turn into reality. Healthcare service utilisation data is an essential variable to measure in barriers to care, as intention-behaviour relationships cannot be assumed. In addition, there is a need to incorporate help-seeking models and theory into discussions about military help-seeking to provide theoretical grounding to help understand and develop research findings.

I have noted throughout conducting this literature review that there is a huge variety research that focuses on public stigma and help-seeking in the military, yet there is no, one systematic review that brings all of this evidence together in a coherent fashion. Clarity on the available evidence in this field is an essential starting point for any new military help-seeking study. I believe it is also important to focus on the data that measures stigma and help-seeking in military populations that have a mental health problem, as, from the literature, this population is the most likely to endorse or experience stigma, and are a group most in need of treatment.

From the literature review there is a need to discuss the concept and measurement of help-seeking. Studies should be explicit about whom they consider 'help-seekers' and 'non-help-seekers', and why they consider them to be in the categories chosen. For example, many studies consider individuals to be help-seekers if they have crossed the threshold of seeking help from a professional or medical source. However, there is a need for research to assess help-seeking in terms of successful health outcomes and engagement with treatment. Many studies measure help-seeking in terms of 'one moment' of help-seeking, for example, by asking respondents of their service use within the last three months, however few studies measure the broader conception of help-seeking that includes adherence to treatment and/or successful completion of a number of courses of treatment. In practical terms, measuring one moment of help-seeking encourages one to think of help-seeking in linear terms which narrows the purview of the help-seeking experience. In reality individuals' help-seeking pathways are complicated and simply having sought professional help once, does not mean an individual will receive adequate treatment or necessarily improve their health status. Studies that measure their help-seeking group in terms of one help-seeking interaction with professional services, may overestimate the number of help-seekers in their sample, with some 'help-seekers' being more like 'non-help-seekers' if they have interacted with formal services once and have no future plans to engage further. Consequently, studies need to take

a broader and longer-term view of the help-seeking process. Military help-seeking should not be seen as an end, but adherence to treatment and successful health outcomes should be an item of real interest (Rosen et al., 2011). Equally, as the majority of studies are cross-sectional, they also fail to capture the relationship between informal and formal help-seeking and in what circumstances informal help-seeking aids formal help-seeking. In future studies, research needs to be more nuanced in how they think about and measure help-seeking.

Research must be extended that compares different enablers/barriers to care for different service types (i.e. Regular, Reserve or ex-Service) and different types of diagnosis (i.e. differential stigma/barriers to care for CMD, compared to PTSD or alcohol problems). Service personnel, Reserves and ex-Service personnel interact with several different healthcare systems over their lifetimes that may elicit different barriers to help-seeking at different points. Just as research has found that those with increasing severity of mental health problem experience increased stigma and barriers to care (Jones et al., 2013), those with PTSD endorsed more stigma (Iversen et al., 2011), and those with alcohol problems may be less likely to identify their own health needs (Hines et al., 2014a). There may also be different barriers that are more important depending on mental health diagnosis.

Finally, more research should utilise qualitative research methods. Only a handful of military mental health and help-seeking research pieces use qualitative methods (Gibbs et al., 2011, Stecker et al., 2013, Sayer et al., 2009). Qualitative research in this field has the potential to generate new insights into the help-seeking process or for refining concept measurement. It is apparent that quantitative studies have relied heavily on previous concepts and consensus, without seeking to explore or understand whether these concepts are truly meaningful for the current military populations that they examine.

Considering the various limitations within the current literature, there is a need for more research that is able to address the reasons why a large proportion in the UK military do not seek help, particularly in light of the recent UK mental health policies and services (see Appendix 2). This PhD will add to existing research by providing more data on help-seeking pathways. The research will add to the current literature by utilising qualitative methods to inform the latter quantitative study. It will specifically connect attitudes and intentions of help-seeking with service utilisation and engagement with treatment. It will address factors that facilitate help-seeking as well as barriers to care. This PhD will conduct a systematic review and meta-analysis to clarify the evidence available on stigma as a barrier to seeking healthcare in the military for those with mental health problems. Finally my research will add to mental health policy knowledge both within DMS and the NHS, and improve

understanding of barriers to care to increase access to services. It is imperative for individual and public health, that routes to help-seeking are better understood to enable timely mental health interventions to those who need care.

1.14 - Thesis Aims

The overarching aim of this PhD is to determine what the main barriers and facilitators of help-seeking are for individuals in the military with mental health problems (including Service Personnel, Reserves and Ex-Service Personnel). Four aims underpin this overarching aim and will be examined using a mixed methods approach. The first aim will be addressed by conducting a systematic review and meta-analysis, aims two and three are addressed by qualitative methods and the fourth aim is addressed by quantitative methods (Figure 3).

Systematic Review and Meta-Analysis (Chapter 2)

Aim 1 – To systematically review published research available on stigma as a barrier to seeking healthcare for those in the military with mental health problems.

Sub-aims – to examine:

- What types of stigma have been explored in military studies that examine medical/formal help-seeking behaviours for those with mental health problems?
- What is the prevalence of stigma measured in military populations of those experiencing mental health problems?
- What is the direction and strength of association between stigma and medical/formal help-seeking intentions and mental health service use among those with mental health problems?

Qualitative Study Aims (Chapters 3-6)

Aim 2 - To examine qualitatively the issues related to not seeking help for mental health problems and to uncover additional issues that have not been previously investigated.

Aim 3 - To examine qualitatively the experiences of help-seekers, exploring the barriers that were overcome and personal experiences of the healthcare services received among those who have sought help for mental health problems.

Quantitative Study Aims and Hypotheses (Chapter 7-8)

Aim 4 - To examine quantitatively social support, military characteristics, attitudes towards mental health treatment, and stigma as associations of healthcare seeking.

Hypothesis 1: Increased barriers to care will be associated with non-help-seeking.

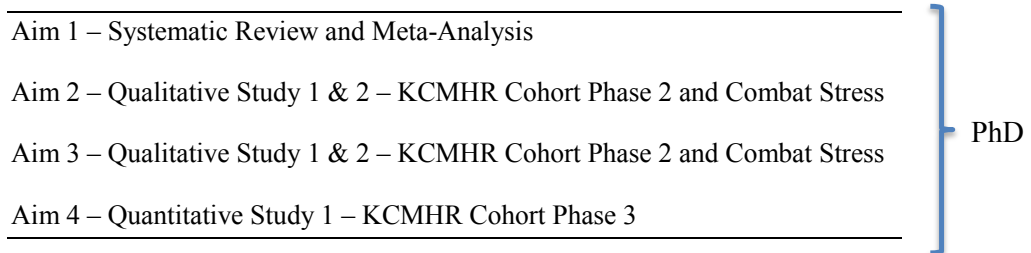
Hypothesis 2: Mental health ‘caseness’ (i.e. if individuals have a probable mental health diagnosis) will be associated with increased barriers to help-seeking.

Hypothesis 3: Socio-demographic factors, for example, age, sex, educational status, will be associated with help-seeking.

Hypothesis 4: Military characteristics, for example, rank, service branch, service status, deployment status, will be associated with help-seeking.

Hypothesis 5: Increased social support will be associated with help-seeking

Figure 3 - Overview of Thesis Aims and Associated Studies



1.15 Mixed Methods Approach

I have adopted an approach to this research utilising methods from both qualitative and quantitative disciplines. This is because the combination of both approaches will provide a better understanding of this research problem than either approach could alone. Using terminology from Clark and Creswell (2011) and their mixed method research typology, I aim to conduct an explanatory sequential, qualitative dominant, mixed method design. My initial qualitative study will inform some measures utilised in the latter quantitative study, therefore my qualitative study 1 and quantitative study are not independent from each other. The timing of my qualitative study 2 means it cannot inform measures utilised in the quantitative study, however its findings will be used in comparison with my first qualitative study and my quantitative findings. The qualitative studies will form the larger part of this PhD and aim to explicate the most current and important barriers and facilitators of help-seeking in the military population with mental health problems. My quantitative study will

then test the findings from my qualitative studies on a population level to see whether barriers and facilitators of help-seeking are replicated from a thematic qualitative level, to an epidemiological quantitative level.

In this specific research case there is a need to lead with qualitative research, as much of the previous military literature is quantitative and has not explored whether the current measures are appropriate for the military population it currently researches. The quantitative study will therefore be enriched in its measures and design by utilising certain factors uncovered in the first qualitative investigation. The two qualitative studies build upon each other and overall the different data from both qualitative and quantitative investigations will be able to be compared for confirmation, generalisation, explanation and further detail on findings (Guest et al., 2011). Certain unexplained quantitative findings may be able to be explained by qualitative in-depth description and explanation found in the data. Finally as Greene et al. (1989) report, quantitative and qualitative methods used together lead to elaboration, enhancement, illustration, and clarification from one method to another. I aim to achieve this clarification and illustration by leading with qualitative investigations to then test these findings on a quantitative level.

Chapter 2 - Systematic Review And Meta-Analysis – Stigma And Help-Seeking

As described in my literature review there is a large proportion of research that has primarily examined the impact of stigma on help-seeking behaviours and the role that it plays in decisions to seek help for those in the military. (Greene-Shortridge et al., 2007, Britt et al., 2008, Pietrzak et al., 2009, Gould et al., 2010, Kim et al., 2010, Langston et al., 2010, Gibbs et al., 2011, Iversen et al., 2011, Kim et al., 2011, Rosen et al., 2011, Ben-Zeev et al., 2012, Held and Owens, 2013b, Momen et al., 2012, Sodom et al., 2012, Osório et al., 2013a). There had not previously been a systematic review that collates this vast military literature together. This systematic review and meta-analysis was published in *Epidemiological Reviews* in January 2015. Please see Appendix 1 to view the published paper.

The aims of this systematic review were to address:

- What types of stigma (such as anticipated public stigma or self-stigma) have been explored in quantitative military studies that examine formal/medical help-seeking behaviours for those with mental health problems?
- What is the prevalence of different types of stigma measured in military populations of those experiencing mental health problems?
- What is the direction and strength of association between stigma and formal/medical help-seeking intentions and mental health service use among those with mental health problems?

This systematic review and meta-analysis focuses on quantitative military studies. This is because the literature review in Chapter 1 revealed very few qualitative studies that assessed the relationship between stigma and help-seeking (Vogt, 2011). Only one UK study assessed this relationship (Murphy et al., 2014) and hence there was not a desire to repeat qualitative literature into a systematic review that has already been discussed. As the breadth of this military literature has not been systematically assessed before, there is a need to focus on certain areas of interest to make the review manageable in the context of a PhD. Specifically I aim to focus on quantitative literature so I can fulfill my original review aims of examining prevalence of stigma and assess the direction and strength of association of stigma and help-seeking (both of which require quantitative assessment). The systematic review focuses on assessing data in military research literature on different ‘types’ of stigma, as it was not immediately clear from my original literature review what types of stigma have been most

commonly assessed in international literature (rather than UK literature alone). Therefore there was a desire to approach the breadth of the literature on stigma in a systematic way.

This review focuses on those in military populations who have probable mental health problems, as they are the group most in need of mental health care. Their help-seeking behaviours are important to understand in terms of their need to access mental health care and the associated evidence that they experience a higher stigma prevalence compared to healthy military populations (Hoge et al., 2004, Kim et al., 2011, Iversen et al., 2011, Ouimette et al., 2011, Pietrzak et al., 2011a, Warner et al., 2011, Osório et al., 2013b). Questions regarding (hypothetical) help-seeking will also be more salient for individuals with a mental health problem, than to those without. This review focuses upon medical or formal help-seeking rather than support from family and friends or welfare officers/chaplains/charities with no associated medical/formal input. This is to assess access to medical/formal services for those who are unwell who could most benefit from that access.

Additionally, this review focuses on recent military populations – primarily those who have been active during the Afghanistan and Iraq conflicts from 2001 onwards. This decision was made so my systematic review would be relevant to understanding my proceeding qualitative and quantitative study samples. The samples investigated in Chapters 4, 5 and 7 have all been active during Afghanistan and Iraq conflicts. There was not a desire to confuse historical help-seeking barriers that different ex-Service populations may have experienced in the context of their specific deployment and healthcare structures/services experienced many years ago. By conflating international stigma data from current groups, who may be negotiating present day healthcare systems, it should be possible to assess the most relevant contemporary military mental healthcare barriers, that are most important for informing policy decisions in the current environment.

In summary, this review is important, as there is a need to systematically assess and collate the available evidence about stigma and its relationship with medical/formal help-seeking and mental health service use in military populations with mental health problems. There is a need to review the methods, methodologies and research designs used in the military studies in this research area to allow an assessment of the robustness and quality of results in this field of research.

2.1 Method

2.1.1 Search strategy

The literature search was conducted in February 2014. Relevant studies published since 2001 in peer-reviewed journals were identified through electronic searches on MEDLINE, PsycINFO, EMBASE, Web of Science and SCOPUS databases.

Key search terms were combined with Boolean operators. These included:

1. 'mental health' OR 'mental illness' OR 'mental disorder' OR 'psychological distress' OR 'common mental health disorders' OR 'anxiety' OR 'stress disorders' OR 'acute stress' OR 'posttraumatic stress disorder' OR 'PTSD' OR 'depression' OR 'alcohol' OR 'substance misuse' OR 'substance abuse', combined with,
2. 'help-seeking' OR 'help-seeking behaviour' OR 'help-seeking attitudes' OR 'help-seeking intentions' OR 'barriers to healthcare' OR 'healthcare seeking' OR 'treatment seeking' OR 'healthcare utilisation' OR 'healthcare utilization' OR 'service utilisation' OR 'service utilization' combined with,
3. 'stigma' OR 'self-stigma', combined with,
4. 'military personnel' OR 'military' OR 'service personnel' OR 'armed forces' OR 'armed services' OR 'veterans' OR 'ex-service personnel' OR 'reserves' OR 'national guard' OR 'navy' OR 'marines' OR 'air force' OR 'soldiers', using the AND operator.

Duplicate papers were removed and the reference lists of all eligible studies were checked for additional studies. Dissertation abstracts were reviewed to check whether the authors' work had been published in peer-reviewed journals. My supervisors were also asked to view the reference list and indicate any other possible missing studies.

After full text articles were accessed to assess eligibility, authors of any studies that were deemed eligible but did not report the relevant data were followed up. Additional data was received from, Iversen et al.2011(Iversen et al., 2011), Jones et al.2013 (Jones et al., 2013), Kehle et al. 2010 (Kehle et al., 2010), Osorio et al. 2012 (Osório et al., 2013b) and Pietrzak et al. 2009 (Pietrzak et al., 2009).

2.1.2 Inclusion criteria

1. Studies using quantitative methodologies.
2. All studies published in peer-reviewed journals.
3. Populations including international military populations (Regulars, Reserves (or international equivalents), National Guard and veteran/ex-service personnel).
4. Recent military populations studied since 2001.
5. Studies which measured mental health – this included common mental health disorders (depression and anxiety disorders), post-traumatic stress disorder (PTSD) and alcohol problems (hazardous drinking, misuse, abuse, dependence).
6. Studies that measured the association between stigma and medical/formal help-seeking for those in the military experiencing mental health problems. This included attitudes/intentions to seek medical/formal help and actual mental health service use. Medical/formal help-seeking was defined as; medical/formal help-seeking for mental health problems resulting in service use (in-Service and ex-Service mental health services) e.g. primary care, secondary mental health services, psychotherapy, psychologist, psychiatrist, counseling.
7. Studies that used stigma as measured on a scale or sub-scale utilising established and/or validated measures of stigma.

2.1.3 Exclusion criteria

Papers were excluded that:

- 1) Addressed stigma as a help-seeking barrier in other populations such as the general population, non-military occupational studies, military contractors, military spouses, prisoners, and homeless individuals.
- 2) Measured help-seeking intentions or service use but did not measure stigma.
- 3) Measured stigma and help-seeking intentions but did not stratify their sample by mental health status, or control for mental health status in statistical models (unless data could be obtained from authors).
- 4) Where prevalence of stigma OR association of stigma and help-seeking intentions/service use was not reported and data could not be obtained from authors.

2.1.4 Data extraction and analysis

Data extraction was conducted by myself. Data from 20 papers were extracted which included information on: author, title and date of publication, overall study sample size, sample size of those with mental health problems in the study, country study originated from, study design, sample selection criteria, service status (i.e. Regulars, Reserves, National Guard, veteran/ex-Service), when data were gathered in relation to deployment, empirical

measurement of stigma including associated stem questions and Likert scale treatment, internal reliability of stigma scale used (Cronbach's alpha scores) and key variables measured (Appendix 1 – Web Table 1).

Data was also extracted including information on: prevalence of stigma items of those with mental health problems (Appendix 1 – Web Table 2). The numerator (the number of individuals endorsing stigma items) and the denominator (the sample size or number of participants who had mental health problems and responded to the item) were entered into the review database. Studies did not however consistently report numerators, denominators or prevalence, hence these data were calculated from available data in the paper, or additional data was obtained from the authors.

The prevalence (%) of endorsed stigma items, standard errors and 95% confidence intervals (CI) were calculated for meta analyses to produce weighted averages for the six most common stigma items measured in samples across the 20 studies. Stata statistical software, Release 11 (StataCorp LP, College Station Texas), was used for the meta-analyses.

1. The metan command was used to produce forest plots (Figures 5-10), displaying the prevalence of endorsed stigma items, 95% CI and weights for each sample, and the overall weighted average and 95% CI.
2. Fixed effects models were initially run for each stigma item, however random effects models were then fitted to account for high heterogeneity between studies samples after assessment of I^2 , which is an estimate of the variability in results across studies that can be attributed to heterogeneity as opposed to chance (Higgins et al., 2003). Heterogeneity measured through I^2 ranges from 0% -100% and benchmarks high heterogeneity at >50%.
3. Meta analyses for each stigma item were stratified by the country of United States and United Kingdom to assess sources of heterogeneity further.

Additional data were also extracted from papers on measures of association between stigma scores and help-seeking intentions/mental health service utilisation including other key findings of note (Appendix 1 – Table 1 and 2).

2.1.5 Quality analysis

The review assessed the quality of the eligible papers utilising the following guideline question areas; method of sample recruitment/selection, response rates, clarity of aims, appropriateness of design to stated objectives, sample size justification, measurement validity and reliability, adequate description of statistical methods, adequate description of basic data, assessment of statistical significance, adequate discussion of main findings, selection basis, interpretation of null findings, reporting of all important results, generalisation of results, comparison of results to previous literature, implications of the study for policy and practice (Crombie, 1997). Issues of quality are noted in the study characteristics (Appendix 1 – *Web Table 1*) and commented upon in the discussion section.

2.2 Results

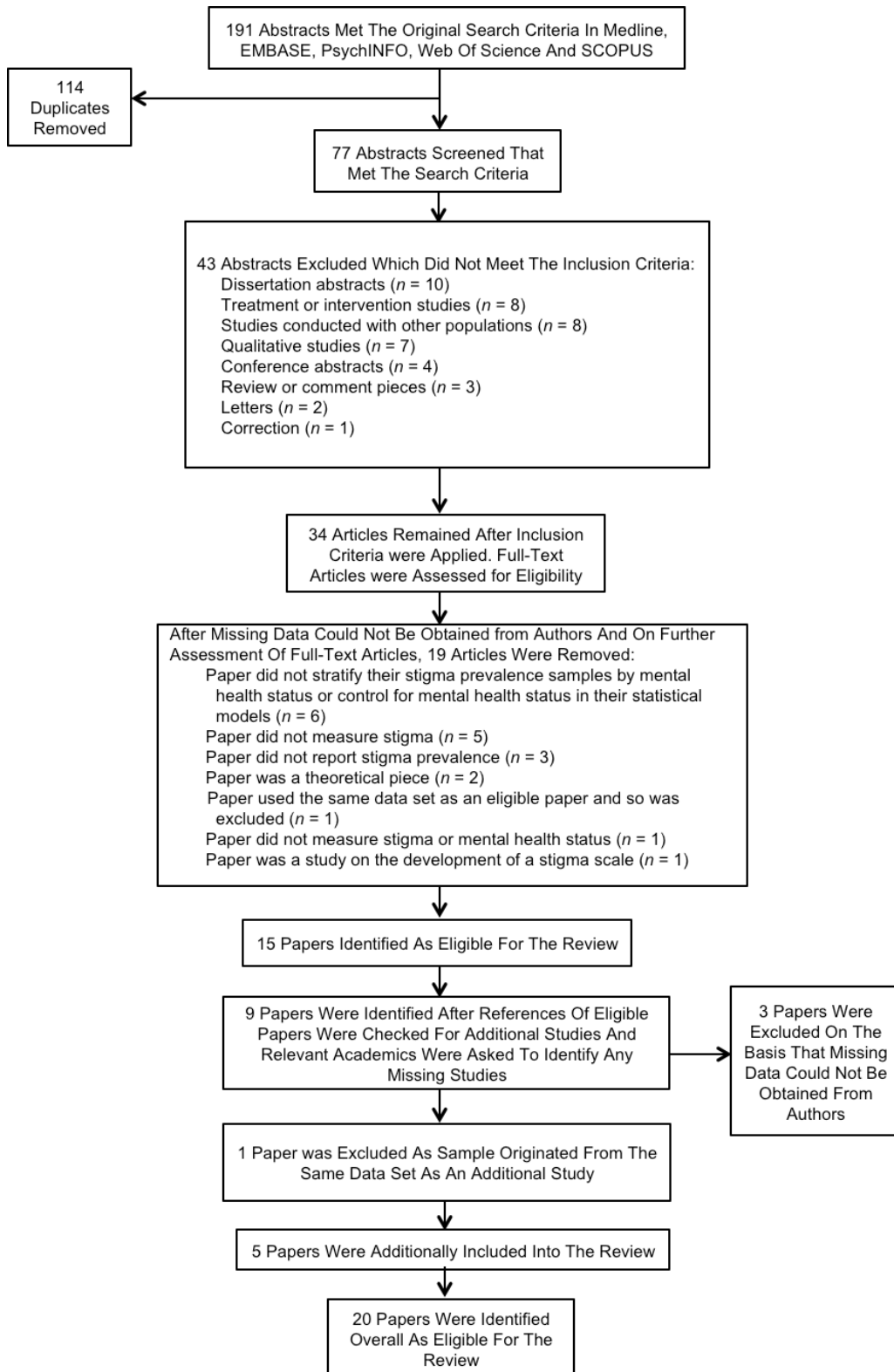
2.2.1 Study Selection

Initial searches returned 191 abstracts that met the initial search criteria (see Figure 4). 114 duplicates were removed leaving 77 abstracts. Forty-three abstracts were excluded that did not meet the inclusion criteria

Thirty-four articles remained after inclusion criteria were applied. The 34 full text articles were then accessed for eligibility, and 19 articles were removed (see Figure 4 for details of exclusions).

Fifteen papers were eligible for inclusion. After reviewing the references of the 15 eligible papers and sharing the list with my supervisors (Professor Nicola Fear and Dr Laura Goodwin), a further nine papers were identified. After review of the full text articles of the additional papers, six extra papers were considered eligible for inclusion into the study, the other three additional studies were excluded, and one further paper (Arbisi et al., 2013) was removed as it originated from the same dataset as a newly included paper that had a larger study sample (Kehle et al., 2010).

Figure 4 - Study Selection Flow Chart



2.2.2 Overview of studies

Twenty papers met the review inclusion criteria. Eighteen of the 20 studies were cross-sectional and two papers used a prospective design (Hoerster et al., 2012, Harpaz-Rotem et al., 2014). Out of the 20 eligible papers, the Ouimette et al. (Ouimette et al., 2011) and Rosen et al. (Rosen et al., 2011) papers utilised the same dataset but the former reports on stigma prevalence and the latter on the association of stigma with mental health service use. Similarly, Hoge et al. (Hoge et al., 2004) and Brown et al. (Brown et al., 2011) used datasets that overlapped but the former reports on stigma prevalence and the latter on the association of stigma and help-seeking intention.

The studies were carried out among the military populations of the United States (N=14), United Kingdom (N=4) and Canada (N=1). One paper additionally assessed the United Kingdom, United States, Australia and New Zealand militaries in a comparative study. Five papers assessed samples where all participants had probable mental health diagnoses and 15 studies assessed broader samples including those with and without probable mental health problems. The largest study sample size of those with mental health problems was 2,520, the smallest was 30. In one paper, the sample size of those with mental health problems was not reported (Blais and Renshaw, 2013). Seven papers researched Service personnel/active duty soldiers, five papers ex-service personnel/veterans, three papers National Guard, with five papers researching a mixture of Service Personnel, National Guard/Reserves and ex-service personnel. All papers contained research participants who were deployed to recent Iraq or Afghanistan conflicts, except three papers that also included as part of their sample those deployed to Timor Leste (NZ participants (Gould et al., 2010)) and veterans of the Vietnam era (Ouimette et al., 2011, Rosen et al., 2011).

2.2.3 Measurement of Stigma

The majority of papers (N=18) assessed anticipated stigma using a core six-item stigma subscale measuring anticipated stigma and its effect on decisions to seek treatment for psychological problems in military populations (Appendix 1 – Web Table 2). This was achieved through the use of the ‘Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale’ (PSBCPP-SS), developed by Hoge et al. (Hoge et al., 2004) and Britt et al. (Britt, 2000, Britt et al., 2008). Of these 18 papers, seven add additional items to the scale (Kehle et al., 2010, Brown et al., 2011, Gorman et al., 2011, Kim et al., 2011, Sudom et al., 2012, Jones et al., 2013) and five of these papers select and measure fewer items than the core measure (Gould et al., 2010, Langston et al., 2010, Warner et al., 2011, Hoerster et al., 2012, Osório et al., 2013b). Blais and Renshaw (Blais and Renshaw, 2013) added, ‘Perceptions of Stigmatisation by Others for Seeking Help’ (PSOSH; (Vogel et al.,

2009)) and ‘Self-Stigma of Seeking Help’ (SSOSH;(Vogel et al., 2006)) in addition to the core measure of PSBCPP-SS. Jones et al. 2013 (Jones et al., 2013) also add items from the, ‘Reported and Intended Behaviour Scale’ (RIBS;(Evans-Lacko et al., 2011)). Rosen et al. 2011 and Ouimette et al. 2011 measure a mixture of stigma facets including discomfort with help-seeking and concerns for social consequences (anticipated stigma) using a stigma subscale developed from Mansfield 2005(Mansfield et al., 2005) and Vogt 2011(Vogt, 2011).

The measurement of help-seeking intention was either through the endorsement of different stigma items and their effect on decisions to seek treatment e.g. *‘rate each of the possible concerns that might affect your decision to seek treatment for a psychological problem (e.g. a stress or emotional problem such as depression or anxiety attacks) from a mental health professional (e.g. a psychologist or counsellor)’*; or through questions assessing care seeking propensity e.g. *‘Are you currently interested in receiving help for a stress, emotional, alcohol, or family problem?’*; or additionally through self-report of mental health service utilisation e.g. *‘Respondents were asked to indicate whether they had received help for a stress, emotional, alcohol or family related problem from a treatment provider in the last ‘X’ months’*, or alternatively by assessing medical records. Three studies assessed ‘adequate’ service utilisation or ‘completion of treatment’ (by reporting the count of visits to mental health services with 8-12 visits representing adequate treatment) (Rosen et al., 2011, Hoerster et al., 2012, Harpaz-Rotem et al., 2014).

2.2.4 Prevalence of anticipated stigma and intentions to seek help

Fourteen studies reported anticipated stigma prevalence per endorsed stigma item. Ouimette et al. (2011) use a different stigma measure assessing ‘discomfort with help-seeking and ‘concerns about social consequences’, and so cannot be directly compared to other studies prevalence findings; however the study found these stigma related barriers were more salient than institutional factors (not fitting into VA care, staff skill and sensitivity logistic barriers). The 13 studies that were comparable by their use of items on the PSBCPP-SS had high levels of variability in prevalence of endorsed stigma items. Across studies, over the six stigma items, I^2 ranged from 96.8% to 98.3%. Studies were additionally stratified by country, grouping together United States and United Kingdom studies to investigate whether this accounted for heterogeneity. Stratification by country had little effect on the high heterogeneity. For example the I^2 for United States and United Kingdom studies for the stigma item, *‘It would be too embarrassing’*, remained at 94.2% and 91.6% respectively. Hence meta analyses here are reported across all studies and stigma items.

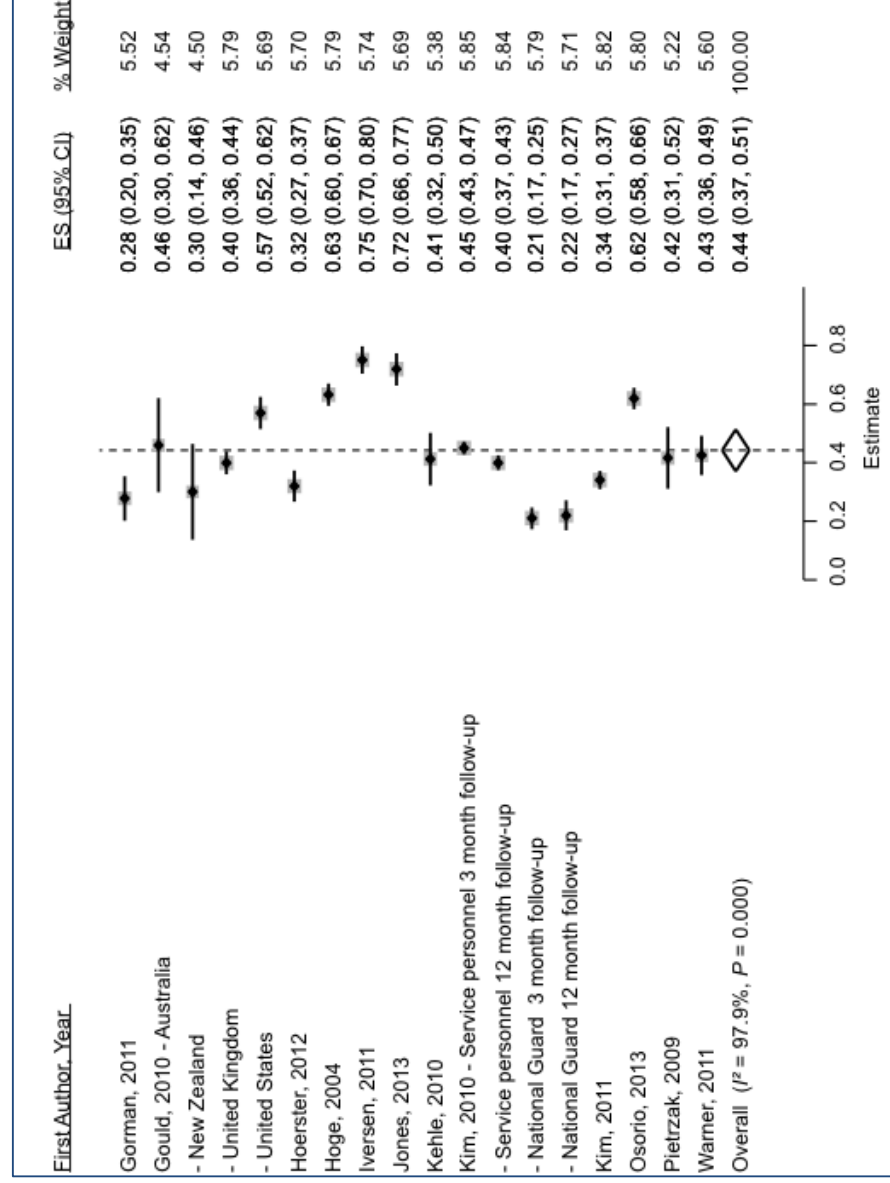
When rank-ordered by weighted prevalence (Table 1) and the forest plots (figure 5-10), the most frequently endorsed of the core six stigma items was being treated differently by leaders and the least frequently endorsed was being blamed for having a mental health problem.

Table 1 - Item Weighted Prevalence Using the PSBCPP-SS (Britt, 2000, Hoge et al., 2004, Britt et al., 2008)

Stigma Item	Prevalence (%) and 95% CI
<i>'My unit leadership might treat me differently'</i>	44.2 (37.1 – 51.4)
<i>'I would be seen as weak'</i>	42.9 (36.8 – 49.0)
<i>'Members of my unit might have less confidence in me'</i>	41.3 (32.6 – 50.0)
<i>'It would be too embarrassing'</i>	36.1 (29.0 – 43.2)
<i>'It would harm my career'</i>	33.4 (27.9 – 38.9)
<i>'My leaders would blame me for the problem'</i>	25.5 (18.6 – 32.5)

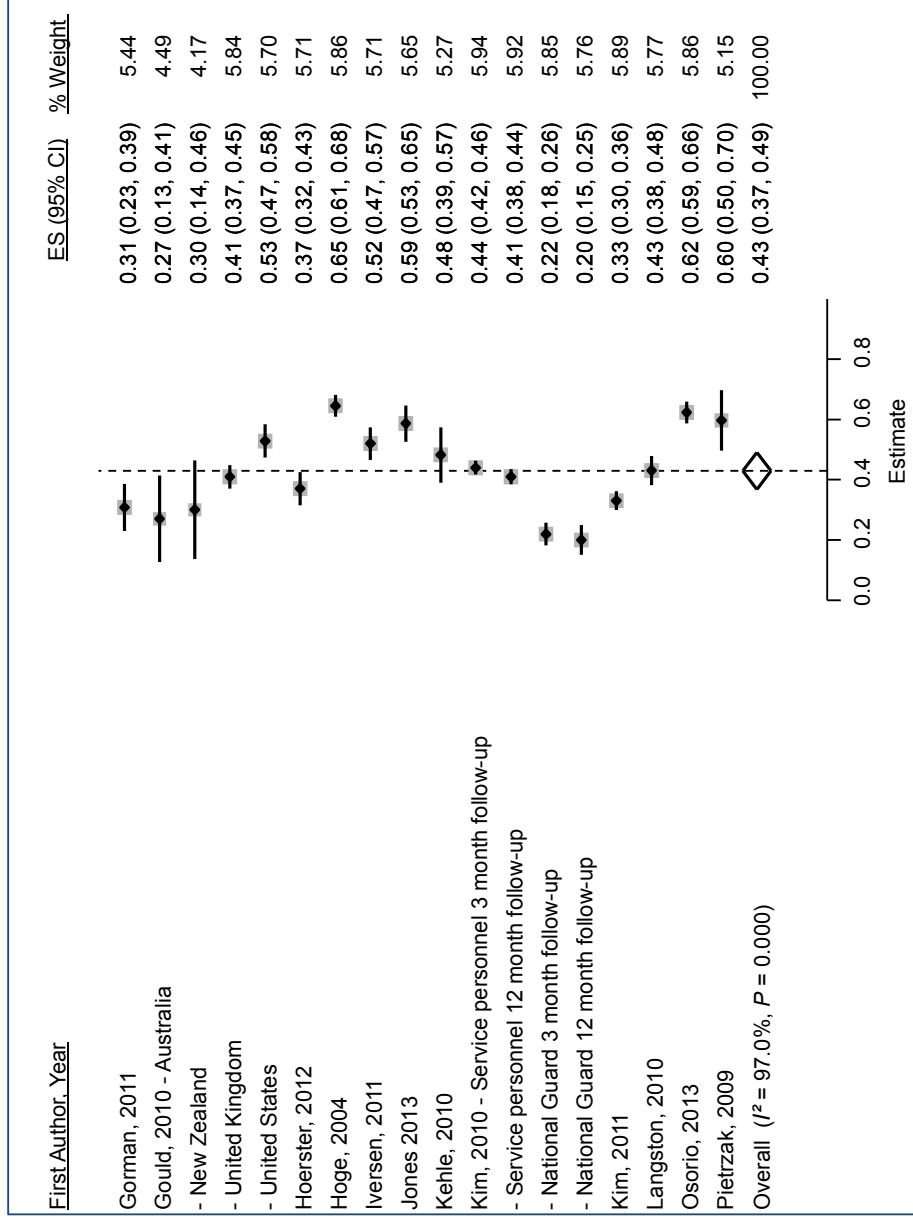
Several studies across the majority of stigma items were consistently above the overall weighted average prevalence percentage (Hoge et al., 2004, Pietrzak et al., 2009, Langston et al., 2010, Iversen et al., 2011, Jones et al., 2013, Osório et al., 2013b) and several studies were consistently below the weighted prevalence average over the majority of stigma items Kim et al. (2010) and Gorman et al. (2011) National Guard samples, Gould et al. (2010) Australian and New Zealand samples, Kehle et al. (2010), Kim et al. (2011) and Hoerster et al. (2012).

Figure 5 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSBCPP-SS "My unit leadership might treat me differently"



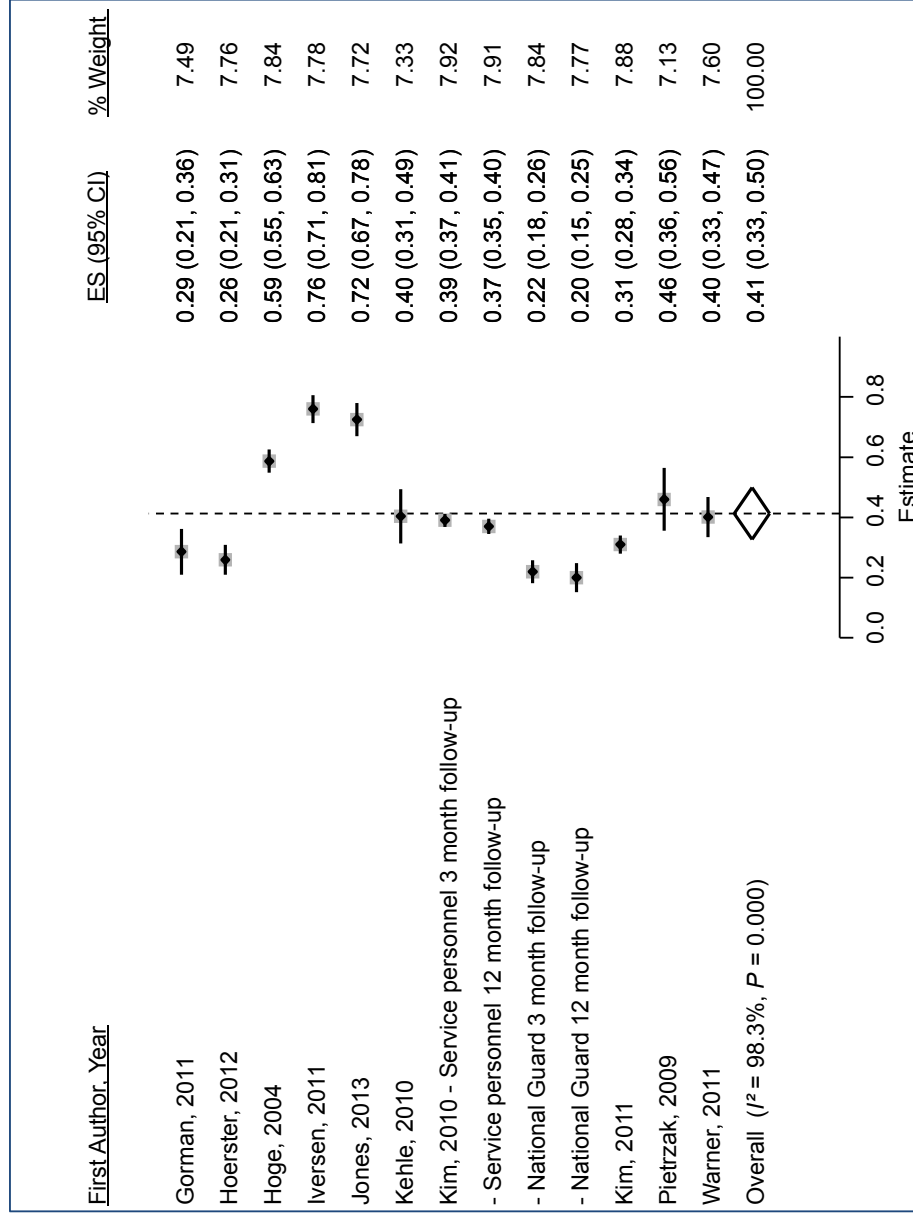
N.B Weights are from random-effects meta-analysis.

Figure 6 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSBCPP-SS "I would be seen as weak"



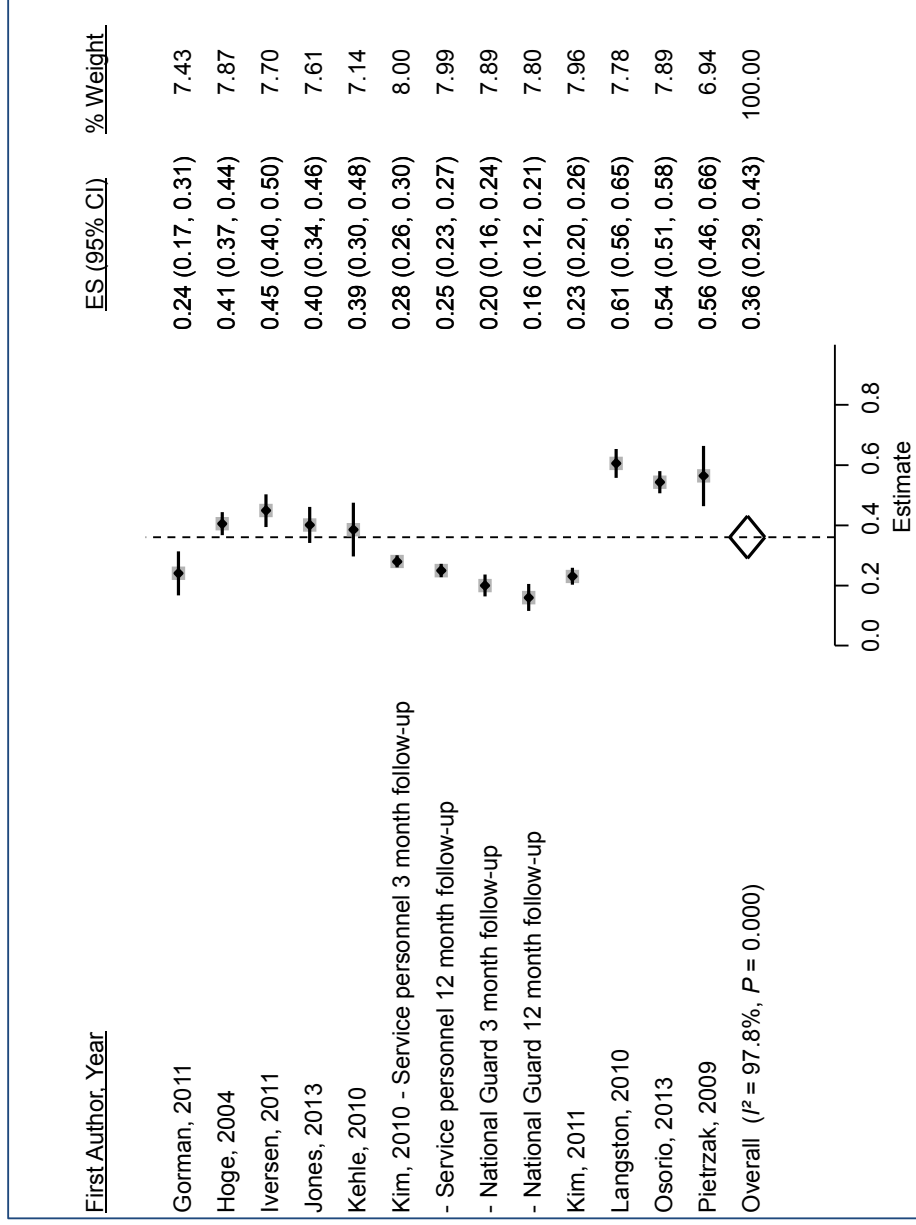
N.B Weights are from random-effects meta-analysis.

Figure 7 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSBCPP-SS "Members of my unit might have less confidence in me"



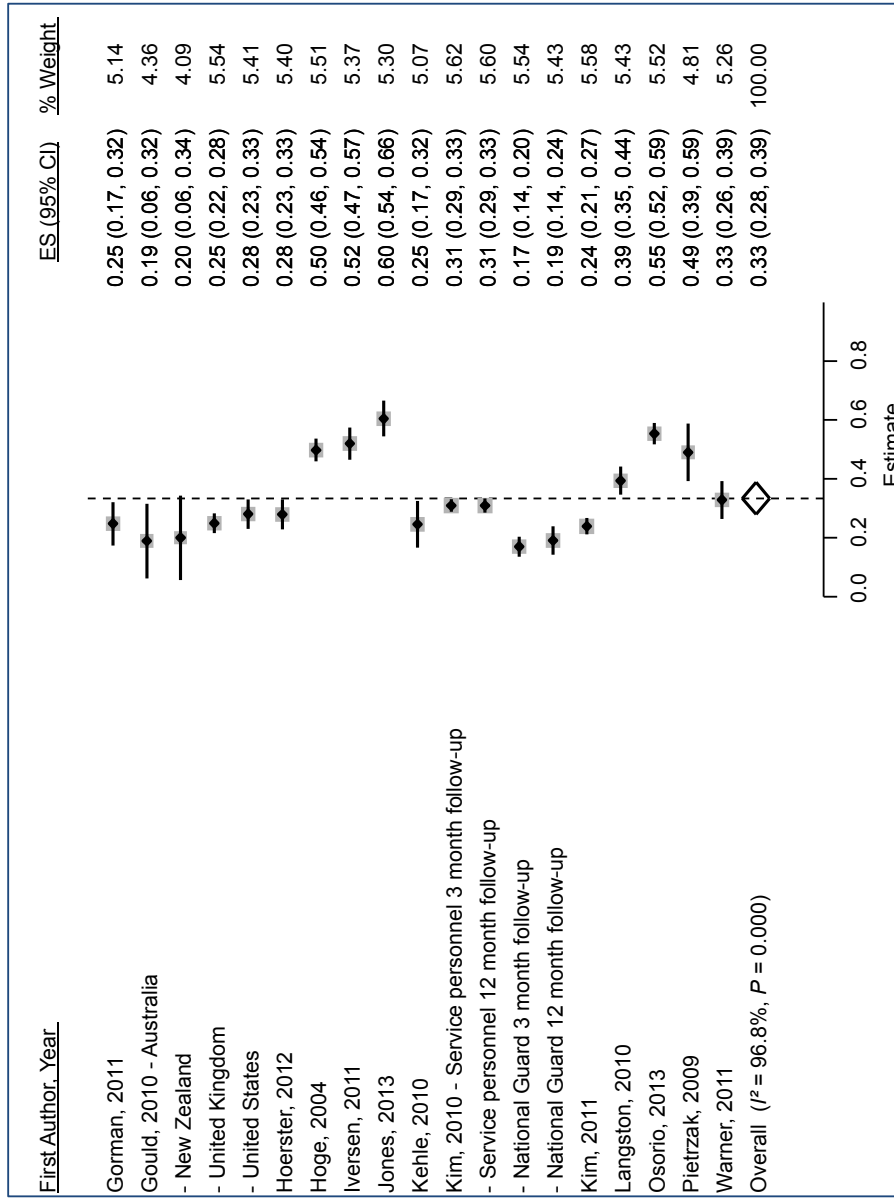
N.B Weights are from random-effects meta-analysis.

Figure 8 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSBCPP-SS "It would be too embarrassing"



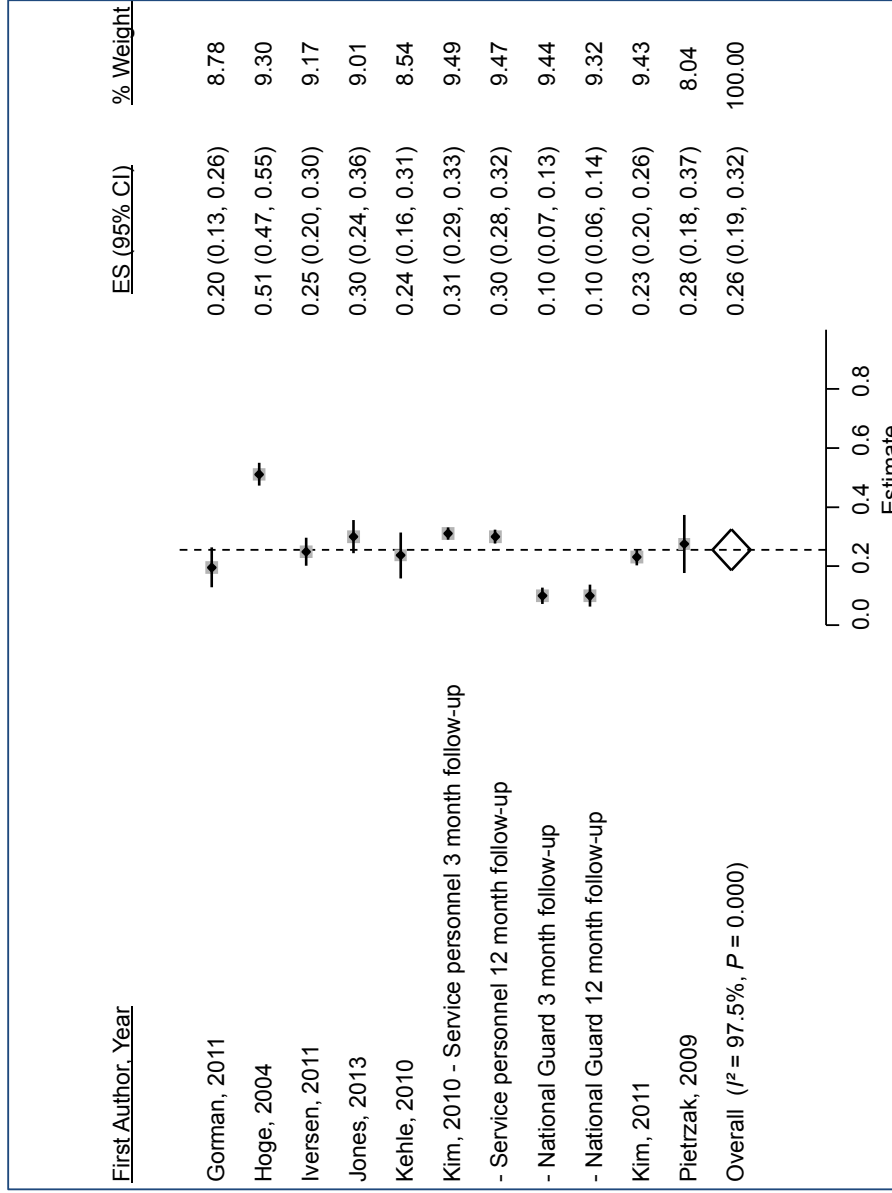
N.B Weights are from random-effects meta-analysis.

Figure 9 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSBCPP-SS "It would harm my career"



N.B Weights are from random-effects meta-analysis.

Figure 10 - Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the PSB CPP-SS "My leaders would blame me for the problem"



N.B Weights are from random-effects meta-analysis.

2.2.5 Association of anticipated stigma with mental health service utilisation (Appendix 1 – Table 1)

Seven studies found no association between endorsed anticipated stigma and mental health care service utilisation, initiation, or completion of treatment. Two studies found positive associations between endorsed anticipated stigma and mental health care service utilisation, however the effects seen were small. For example there was a positive association found between anticipated stigma and utilisation of mental health services by combat medics in general (male and female) and male combat medics (**AOR 1.61**, 95% CI not reported, $P=0.01$ and **AOR 1.58**, 95% CI: 1.09-2.30 respectively) (Elnitsky et al., 2013). In Rosen et al. (2011), a positive association was found between stigma and completing eight or more PTSD psychotherapy visits (**AOR 1.51**, 95% CI: 1.00-2.28, $P<0.05$) and a positive association found between reporting stigma and retrospective reports of use of veteran centre counselling services (**AOR 1.69**, 95% CI: 1.24 -2.30, $P<0.01$) (Rosen et al., 2011).

2.2.6 Association of anticipated stigma and self-stigma with mental health care seeking propensity (interest in receiving help) (Appendix 1 – Table 2)

The findings with regard to this outcome were varied. Two studies found no association between anticipated stigma and care seeking propensity i.e. stigma was not associated with interest in receiving help for mental health problems (Sudom et al., 2012, Blais and Renshaw, 2013). Two studies found a positive association of anticipated stigma and care seeking propensity i.e. those who endorsed stigma items were 2-3 times more likely to be interested in receiving help (Brown et al. 2011 - **AOR 2.29**, 95% CI: 1.46-3.59, $P<0.05$ and Jones et al. 2013 - **AOR 3.19**, 95% CI: 1.80-5.65, $P<0.05$) (Brown et al., 2011, Jones et al., 2013). Lastly one study found a negative association between self-stigma and intentions to seek help (Blais and Renshaw 2013 – structural equation modelling - paths from self-stigma to individuals' help-seeking intentions from both a mental health professional and medical doctor were significantly negative, standardised coefficient = **-0.34**, $P<0.001$ and **-0.20**, $P<0.01$ respectively) (Blais and Renshaw, 2013).

2.3 Discussion

There are a number of key findings from this systematic review. There are a substantial number of studies on stigma and barriers to care with few studies examining how stigma is associated with actual mental health service utilisation. A quarter to just over two-fifths of those in the military with mental health problems, across countries and across those of different serving status, endorse anticipated stigma as factors that might affect their decision to seek help for mental health problems. Despite the fairly high and consistent prevalence of anticipated stigma, the majority of studies found no association between anticipated stigma

and mental health service use or intentions to seek help; and the minority of studies found a positive association. Hence those that endorsed high anticipated stigma still utilised mental health services or were still interested in seeking help. These findings seem at odds with the majority of evidence in civilian literature, i.e. that stigma negatively affects help-seeking from medical/formal sources for those with mental health problems (Clement et al., 2014). There could be several competing explanations for these findings, which I will address in this discussion.

2.3.1 Stigma Prevalence

The prevalence of anticipated stigma concerns amongst those in the military with mental health problems are consistently highest in relation to concerns about unit leadership treating them differently, being seen as weak, and unit members having less confidence in them if they seek help for a mental health problem. These results highlight the importance of individuals' perceptions, be they correct or not, and the influence of prevailing military culture that may dissuade them from seeking help or disclosing mental health problems (Greene-Shortridge et al., 2007, Warner et al., 2011). Individuals in the military can be medically downgraded and taken off weapon handling, particularly if they are put on medication for mental health problems. This can act as a barrier to help-seeking and may be reflected in the anticipated stigma concerns associated with leadership and unit members. However these public stigma concerns may also be a result of safety critical industries similar to that of the fire service, police or airline pilots, where team safety may rely on high performance and health of other team members and where mental ill health may be perceived to affect this functioning (Pinfold et al., 2003, Pasillas et al., 2006, Britt and McFadden, 2012). Additionally the public stigma concern that individuals may be seen as weak for seeking help, may be an extremely ingrained stigmatising belief associated with the masculine culture of militaries. Studies have noted this masculine culture in military populations and its negative effects on help-seeking behaviours for mental health problems (Iversen et al., 2005, Langston et al., 2007, Iversen et al., 2011, Simmons and Yoder, 2013). Cultures, beliefs and behaviours learnt in service may be pervasive into civilian life and continue to affect stigmatising beliefs (Vogt, 2011).

When assessing studies that sat consistently above or below the overall weighted prevalences across the majority of stigma items, it can be inferred from high heterogeneity, that different studies sample structures and contexts may be factors that interact to affect prevalence outcomes. Prevalence in studies could be affected by service status. Active Service personnel have been shown to endorse higher levels of anticipated stigma compared to National Guard or veteran/ex-service personnel samples (Kim et al., 2010, Iversen et al., 2011). Additionally

the Gorman et al. (2011) and Kehle et al. (2010) (to a lesser extent), National Guard samples in this review sat consistently below the weighted average across stigma items. This difference in public stigma may reflect differences in healthcare provision and community cultures whilst in Service between active Service personnel and National Guard/Reserves. National Guard or Reserves may endorse fewer stigmas as they can access local mental healthcare when demobilised without the same visibility or anticipated stigma from their military community compared to those in active Service. The type of mental health problem measured in the sample group could also affect high prevalence. Those with probable PTSD have been shown to endorse stigma items at higher levels than those with depression (Iversen et al., 2011). Hence studies that utilise more expansive measures for their group ‘screening positive’ for mental health problems, may lower their overall prevalence results. Stigma has also been evidenced to be an moving entity that changes over time, with Service personnel reporting higher anticipated stigma whilst deployed compared to post deployment, hence studies may differ in stigma prevalence depending on when surveys were taken in relation to deployment (Osório et al., 2013a). Prevalence could also be influenced by country. The majority of UK studies show consistently higher endorsed anticipated stigma than the majority of US samples. Further comparative work on public stigma in the UK and US militaries may be worth investigation to explain these differences.

Lastly there is a lack of studies that measure the association of stigma with actual mental healthcare service utilisation. The majority of papers only measure the effect of stigma on help-seeking intentions i.e. whether a barrier to care ‘might’ affect seeking mental healthcare, with an assumption that intention would lead to an action. However it is not possible to cannot say from these prevalence figures whether potential barriers to help-seeking do transpose into help-seeking inaction (or action) and therefore the outcome of interest may not be adequately measured.

2.3.2 Association of stigma and help-seeking intentions/service use

The findings that anticipated stigma in the majority of studies was not associated with help-seeking intentions or mental health service use and in the minority of studies was positively associated, seems a non-intuitive outcome if considering public stigma a barrier to help-seeking. Despite individuals in these studies endorsing anticipated stigma, it did not deter their intentions to seek help or affect their actual mental health service use. Several explanations could account for these findings.

It may be that there is an ‘intention gap’ between the intention/non-intention to seek help and the subsequent action or inaction. When looking at intention-behaviour relations, Sheeran’s

empirical review finds it is the ‘inclined abstainers’ that make up the large majority of the intention gap i.e. those that want to act but choose not to, rather than the ‘disinclined actors’ i.e. those that do not want to perform an act but subsequently do so (Sheeran, 2002). However, in the case of individuals in these studies they would be defined as ‘disinclined actors’ i.e. individuals who note their anticipated stigma, but some of whom subsequently seek help. Other factors may uphold a theory of ‘disinclined actors’ such as the repeated findings that the severity of mental health problems are positively related with help-seeking intentions and mental health service use (Rosen et al., 2011, Hoerster et al., 2012, Sudom et al., 2012, Harpaz-Rotem et al., 2014). Hence it may be that individuals endorse anticipated stigma, however the severity of their mental health problem, which may lead to crisis points in their lives or functional impairment, overrides the barrier to care of anticipated stigma, causing them to seek help as their mental health problem can no longer be ignored or coped with successfully (Hines et al., 2014a, Murphy et al., 2014). Jones et al 2013 also uphold the notion that concealment of a mental health problem in Service may be difficult due to close health supervision and therefore individuals may be compelled to seek help by the chain of command when behavioural or psychological disturbances are present (Jones et al., 2013). Lastly the use of self-report for measuring service utilisation may not be a robust way to measure this outcome as individuals with high levels of stigma may not disclose mental health service use (Jones et al., 2013).

In addition to this, it may be that facilitators of help-seeking are more powerful than barriers to care (Sayer et al., 2009, Rüscher et al., 2011). Warner et al. (2008) found one of the most influential factors in a US military sample for overcoming barriers to seeking care was having ‘family and friends strongly encourage’ soldiers to get help. This is also supported by the ‘Theory of Reasoned Action/Planned Behaviour’, that intentions to perform an action are shaped by the perceived social pressure to perform/not perform a behaviour (Ajzen and Fishbein, 1975, Ajzen et al., 2012). Indeed some studies in this review found a positive association between greater unit support and utilisation of mental health services (Harpaz-Rotem et al., 2014) and found that decreased unit support predicted increased stigma and barriers to care (Pietrzak et al., 2009). These findings have also been supported in research that found US Commissioned and Non-Commissioned Officers positive leadership behaviours were predictive of individuals’ positive decisions to seek mental health treatment (Britt et al., 2012). Hence social support could explain how individuals, who are disinclined to seek help, subsequently seek help and could be an important variable to include in future analyses.

Additionally it should be noted that stigma may simply not be associated with help-seeking intentions or service use if individuals have not recognised or linked their symptoms with the need for medical help. Fikretoglu et al. 2008 showed that 80% of those who might have benefited from mental health treatment failed to recognise their own treatment needs and consequently did not seek help (Fikretoglu et al., 2008). Equally those with alcohol problems were the least likely in military studies to recognise their own treatment needs (Sareen et al., 2007, Jones et al., 2013, Hines et al., 2014a). Hence the impact of stigma on mental health service utilisation, may not be truly measured if individuals do not perceive they have a problem that might require accessing mental health care.

Alternatively a positive relationship between stigma and help-seeking intentions/service use could be related to ‘modified labelling theory’, i.e. that having an interest in receiving mental health care makes respondents more aware of stigma from others (Link et al., 1989). Hence the process of thinking about, or receiving help makes individuals think more acutely about, or experience, the repercussions of seeking help, and hence service use or interest in care causes higher stigma rather than stigma causing service use.

Lastly three studies found that negative attitudes towards care were negatively associated with help-seeking intentions/mental health service use (Pietrzak et al., 2009, Brown et al., 2011, Sudom et al., 2012). This finding is also supported by other research, which found the most commonly endorsed barriers to care for non-help-seeking service personnel with PTSD, were negative attitudes towards treatment (Stecker et al., 2013). It may be that negative attitudes towards mental health care are more important barriers to help-seeking in the military than anticipated stigma and may need future focus in terms of interventions and policy decisions.

2.3.3 Stigma – Types, Measurement and Methodology

In these military studies, anticipated stigma was the most commonly assessed, with the majority of studies utilising the same stigma scale (PSBCPP-SS). Intuitively this form of stigma may be salient for military populations; previous research has shown that disclosing a psychological problem in the military is perceived as more stigmatising than having a physical medical problem (Britt, 2000), and that military personnel may choose not to disclose a mental health problem to avoid being ‘labelled’ as different from ‘normal’ soldiers as dictated by norms and cultures within their militaries (Corrigan and Matthews, 2003, Langston et al., 2007).

However there have been recent methodological questions explored in the literature as to whether the PSBCPP-SS scale measures anticipated stigma effectively with some authors utilising alternative scales such as the PSOSH (Blais and Renshaw, 2013, Blais et al., 2014a) or the 'Endorsed and Anticipated Stigma Inventory (EASI)' tool for military populations (Vogt et al., 2014a). Hence the lack of association found between stigma and help-seeking intentions or service use, may be a function of the PSBCPP-SS tool. Recent studies such as Blais et al. 2014 (subsequently published after the systematic review was conducted) have found a negative association between anticipated stigma and intentions to seek help using the PSOSH tool (Blais et al., 2014a). Some studies used the PSBCPP-SS tool on veteran/ex-service study samples with stigma items referencing 'units members' and 'unit leadership'. These points of reference may not be valid for individuals who have left service, which could have affected responses to these studies. Additional research assessing the comparative validity and utility of stigma scales in military populations would benefit the evidence available in this field.

In the studies included in this review, it is unclear why anticipated stigma was the main construct explored. Only one paper measured self-stigma and found a negative effect upon help-seeking (Blais and Renshaw, 2013). Self-stigma appears to be a discreet psychological construct that is unlike public stigma or anticipated stigma (Corrigan et al., 2006). For instance, individuals may endorse public stigma, but may not then internalise this stigma. Self-stigma has been shown to be a considerable deterrent to receiving mental health care in general populations (Vogel et al., 2006), it has also been linked to negative attitudes towards mental health services, and to lower intentions to seek different forms of mental health treatment (Vogel et al., 2007a, Conner et al., 2010). Additionally, those who endorse greater self-stigma are less likely to return for further mental health treatment after an initial visit (Wade et al., 2011). From this review, it is largely unknown whether self-stigma has an impact on mental health service use or help-seeking intentions in the military, and it could potentially be an important facet of stigma that may act as a barrier to help-seeking that needs future exploration.

Finally there are some methodological quality issues that may have affected studies outcomes. Three papers that found no association of stigma and mental health service utilisation drew their samples from treatment-seeking or help-seeking samples, i.e. individuals who were able to be sampled because of an initial engagement with Veteran Affairs services or health screening events (Rosen et al., 2011, Hoerster et al., 2012, Harpaz-Rotem et al., 2014). These samples of help-seeking individuals may not be generalisable to the key population of interest, i.e. military populations that do not seek help for mental

health problems. Those who have taken the step to attend a health screening event, may be more likely in the future to use mental health services and at the same time endorse high anticipated stigma because of their interaction with mental health services. Hence current (and future) military cohort studies are best placed to address recruitment of large enough samples of those experiencing mental health problems, who are non-help-seekers and help-seekers, selected on a random basis, for assurance of robust results.

There is inconsistency in the use of language used to describe stigma. For example, some papers use the language 'self-stigma' or 'internal stigma' (Langston et al., 2010) when referring to items assessed using measures of anticipated stigma. Hence there is a need within military studies for more clarity in stigma descriptions, definitions and conceptual frameworks used to explain different forms of stigma (Britt et al., 2011, Ben-Zeev et al., 2012). The current study suggests that modified versions of the scales used to assess stigma are widely utilised. This may impact upon the validity and reliability of the scales, though many studies do report alphas for the modified scales.

2.3.4 Strengths and Weaknesses

This is the first systematic review and meta-analysis of the military literature that I am aware of that generates an overview of stigma prevalence, its relationship to mental health problems, and its association with help-seeking intention and service use. A strength of this review is that it focuses on the effect of stigma on help-seeking of those with mental health problems and stratifies on this basis. This is important, as previous research has shown that those with a mental health problem are more likely to perceive higher stigma and barriers to care and it is specifically this population that could benefit from treatment but may be the most reluctant to seek help. Therefore they are the most pressing group that we must seek to understand their barriers to care.

Weaknesses of this review include the fact that not all data could be obtained from authors and therefore data that could have contributed to findings may have been missed. A further limitation of this review is that some sub-groups such as age, gender, ethnicity and diagnosis were not analysed. This analysis was not done because very few studies stratified by these sub-groups and therefore the studies that did stratify by gender (Elnitsky et al., 2013) or diagnosis (Iversen et al., 2011) could not be compared to other studies. A limitation of this review is that only the terms, 'stigma' and 'self-stigma', were included as stigma related search terms in the search strategy. I felt these terms would incorporate most papers that assessed different types of stigma, however additional terms, such as 'stereotype' or 'discrimination' may have expanded the papers returned in the search. I feel however that

my review of bibliographies of included papers and discussion with my supervisors to identify additional papers, was satisfactory in identifying all relevant papers. Finally a weakness of this review is that studies included in the review, had very high heterogeneity. The different effects of this heterogeneity are detailed at length in the discussion (Section 2.3, Pg.64). High heterogeneity however makes analyses of the relationship of stigma and help-seeking difficult as there are different effects of factors in study samples such as, 'time since deployment', 'service status' and 'mental health casesness inclusion criteria', all that affect interpretation of stigma prevalence and its association with help-seeking. Hence the un-picking of these relationships is difficult and may render studies difficult to compare, unless taking specific account of these differences.

2.3.5 Implications and Conclusions

This study's key findings have shown that whilst anticipated stigma prevalence is high in military populations with mental health problems, the majority of studies found that anticipated stigma was not associated with help-seeking intentions or mental health service utilisation, and the minority of studies found a positive association of this relationship.

I propose these findings may be related to an intention-behaviour gap where individuals who are disinclined to seek help are compelled when reaching a crisis point, or enabled to seek help by positive facilitators of help-seeking, such as supportive family/friends/unit, to overcome stigma. More research would be valuable on the role of social networks and their interaction with stigma in the help-seeking process. From the information gathered in these studies we cannot tell how long someone has been 'disinclined' for before they 'act' to seek help. Delays in treatment may create additional negative impacts to individuals' long term health outcomes, relationships or families. Further research could usefully address delays in treatment-seeking associated with stigma. Policies therefore could be aimed to encourage early help-seeking and sustained engagement with mental health services to avoid the high social and economic costs of individuals seeking help at crisis points.

It is evident that certain stigma concerns have remained prevalent to varying degrees across studies, time periods, countries, for those in Service and for those who have left the military. It is also an issue for concern that individuals may experience stigma as a result of their help-seeking, as research indicates that the stigma of mental illness can often be more damaging than the mental illness itself (Thorncroft, 2006). Questions must be asked regarding anti-stigma campaigns for military populations, whether they are able to have a large enough affect on stigma concerns and additionally if veteran/ex-service populations can be reached effectively in the promotion of anti-stigma messages. There may be a need to learn from

successful anti-stigma campaigns aimed at general populations, to then adapt these methods to the context of military populations.

I also suggest that the lack of association between stigma and help-seeking may be a result of methodology. This review highlights the differing language, terms and scales used in stigma research. Whilst these terms, scales and models of stigma are contested, it may be difficult for the field to progress in a cohesive fashion. It is suggested that future theoretical work is needed to inform methodological approaches and stigma scales, which would bear much utility in addressing these issues.

Finally, there may also be the need for research to focus on other potential barriers to help-seeking in military populations such as self-stigma, negative attitudes towards mental health treatment, or individuals' own recognition of need for mental healthcare, to help further understand the low proportion of help-seekers for mental health problems in the military.

Chapter 3 – Overview of Qualitative Studies

The following Chapters 3-6 present my two qualitative studies. The purpose of these studies is to examine the help-seeking behaviours of military personnel with mental health problems and assess prominent barriers and facilitators of help-seeking. The first qualitative study sample is drawn from the KCMHR cohort study including non-help-seekers and help-seekers. The second qualitative study's help-seeking sample is recruited from the Armed Forces charity, Combat Stress. The qualitative studies employ in-depth, semi-structured telephone interviews, which are analysed using thematic analysis. These interviews explore the help-seeking pathways of participants, investigating barriers that prevented or delayed them from help-seeking and factors that encouraged them or made it easier to seek help for problems they were experiencing.

Chapters 3.1-3.2 incorporate information and justification of the use of my main analytical methodology – thematic analysis, and my main method – telephone interviews. The two qualitative studies build upon each other's findings to create an overall thematic map of help-seeking for the two different studies. The research findings are then compared and contrasted in Chapter 6.

3.1 - Qualitative Method – Thematic Analysis

This chapter seeks to define and explore what thematic analysis is and what it entails. It additionally aims to describe my specific approach and decisions made with regards to applying this method. This chapter delineates the overall approach I have used with thematic analysis for both qualitative studies. Where the qualitative studies have specific methodological differences in terms thematic analysis, these are identified in the Chapters 4 and 5 detailing the specific methods of each qualitative study.

3.1.1 Definition, Background and Epistemological Underpinnings

Thematic analysis is a method for identifying and analysing patterns (themes) of meaning in a qualitative data set (Braun and Clarke, 2006). As a primary goal it can describe and understand social phenomena, including individuals' behaviours within a particular context, relative to specific research questions. Thematic analysis organises codes at its lowest level, into sub-themes, themes, super-themes and supra-themes to its highest level.

Whilst thematic analysis is rooted in the tradition of content analysis, it is demarcated from this method, as it moves beyond counting explicit words or phrases and focuses on identifying implicit and explicit ideas in qualitative data (Guest et al., 2011). It was developed to provide an in-depth method of analysis to go beyond plain observable data to

explore more tacit themes and structures in datasets (Merton, 1975). Joffe (2012) explains how contemporary thematic analysis is able to utilise the systematic elements of content analysis, but also allows the researcher to combine the frequency of codes, with analysis of codes' underlying suggested meanings, allowing a more complex interpretation of social phenomena. Depending on certain decisions made by the researcher, thematic analysis can apply inductive methods of coding akin to grounded theory methods, but it can also assess perceptions, feelings and lived experiences in a thematic structure, like phenomenological/hermeneutic traditions (Guest et al., 2011). Whilst many academics have employed thematic analysis in psychology (Aronson, 1994, Boyatzis, 1998, Attride-Stirling, 2001, Joffe and Yardley, 2004, Tuckett, 2005); Clarke and Braun (2013) argue it is only recently that it has achieved 'brand recognition' like other methodologies such as grounded theory and interpretative phenomenological analysis.

Thematic analysis however is a flexible method in that it is not tied to one epistemological viewpoint and so can be utilised when using a range of theories and approaches (Joffe, 2012, Braun and Clarke, 2006, Clarke and Braun, 2013). Thematic analysis holds both positivist and interpretivist characteristics by combining a rigorous and (often) inductive set of procedures to identify, analyse and interpret themes from qualitative data whilst providing a transparent account of process (when reported correctly), to enable external audiences to assess its findings' validity, credibility and reliability within the context of individuals' experiences.

3.1.2 Justification of Use of Method

Thematic Analysis is a method that is suitable and beneficial to utilise in terms of my research area, my epistemological standpoint, my research questions and the type of qualitative data collected in this work. I approached this work with a critical realist/(broadly) constructionist epistemological approach and a participatory research paradigm. This approach essentially means that one is mindful of the explicit meaning imparted in participants' interviews, however one equally makes allowances for implicit interpretation of meaning (reading between the lines), and that overall, the meanings participants give to certain behaviours or experiences are socially constructed and must be understood from the context of their lives and communities. Hence from this standpoint, a researcher needs a method that can address explicit and implicit data whilst also being able to couch this in participants' broader context of lived experiences (in this case the experience of military Service). Thematic analysis as described above is capable of providing these different lenses with which to analyse qualitative data.

I was keen to approach the analysis of interviews from the standpoint that an interviewer cannot be neutral in their analysis but plays an active role in the identification of patterns and themes. Thematic analysis can produce an 'audit trail' through its process steps that specifically highlight the role of researcher and hence provide legitimacy and clarity on where certain analytical decisions were made that affect the findings of research. Thematic analysis is also adept in framing participants as collaborators and not just interviewees (Braun and Clarke, 2006). I wanted to approach interviews with this idea of collaboration in mind, because of my views on the role of the researcher, but also because of my views of the place of the participant i.e. that the participant too collaborates with the researcher and that the participant should be empowered to tell their experiences and offer their expertise on the research matter (This is discussed in more detail in Chapter 3.2).

Due to the nature of my overall research aim, i.e. to explore the main barriers and facilitators of help-seeking in military populations with mental health problems; thematic analysis can usefully summarise fundamental features of large bodies of data whilst also being able to offer in-depth description of certain aspects of the data. Additionally it can produce results that are easily translated into comparative analyses within and between groups, highlighting similarities and differences. As I aimed to interview and compare three discrete groups of interviewees, thematic analysis was a suitable method to employ. Additionally as my topic guide questions were comparable across groups, this lent itself well to applying thematic analysis and presenting results in a comparative manner (Guest et al., 2011). If used in an inductive way, thematic analysis also has the ability to generate unanticipated insights (Braun and Clarke, 2006). This was particularly relevant for the work, as my research questions specifically aimed to encourage participant led interviews. Here questions asked were semi-structured and open-ended so participants could introduce topics that were important to them, rather than myself simply dictating areas of inquiry I believed to be of interest. Lastly my research typology and design lent itself well to thematic analysis. The mixed methods research design needed an analytical method that could be exploratory in nature so the initial qualitative study could inform some measures in the proceeding quantitative study. Additionally, both qualitative studies needed also to be explanatory in design to be able to offer extended insights regarding certain phenomena. Overall thematic analysis was able to provide the appropriate tools to match my research design and my specific aims.

Braun and Clarke (2006) note that thematic analysis can be useful for producing qualitative analysis that is suited to informing policy development. This is because of its thematic nature, its accessibility in terms of data presentation in thematic modelling/maps, and the

strength of data taken from quotes. Hence to be able to achieve this impact, thematic analysis again was an appropriate tool for creating data that could inform policy development.

3.1.3 Data Analysis Processes

Whilst there are different iterations of processes of thematic analysis, I followed the steps presented in Braun and Clarke (2006) (see Table 3). Before describing these specific steps, I will discuss the specific analysis choices I took so there is clarity and transparency in the approach I have taken to this method.

Inductive thematic analysis

I approached the coding of data and themes in an inductive ‘bottom up’ manner. Inductive analysis is a process of coding the data without trying to fit the data into a pre-determined ‘top down’ coding frame. The topic guide created for the interviews was semi-structured and asked open-ended questions without mentioning pre-determined areas of interest. The topic guide (in summary) asked participants about why they had/hadn’t sought help and was there anything that made help-seeking harder/easier (Please see Appendices 8 and 13 for KCMHR and Combat Stress topic guides respectively). Hence as the collection of data was as undirected as possible to specific themes, it meant the inductive coding of data could allow for coding and themes to be created that were strongly linked to the raw data themselves. This was with the aim of producing findings that were participant led as far as was possible, so I could assess matters of interest *currently* important to military personnel in terms of their help-seeking for mental health problems.

What counts as a theme?

‘A theme captures something important about the data in relation to the research questions and represents some level of patterned response or meaning within the data set.’ (Braun and Clarke, 2006).

‘Themes come in all shapes and sizes. Some themes are broad and sweeping constructs that link very specific kinds of expressions. Other themes are more focused and link very specific kinds of expressions’ (Ryan and Bernard, 2003)

I approached coding with one clear main research question. ‘What are the main barriers and facilitators of help-seeking?’ Hence when coding transcripts, I coded segments of data that I assessed to describe an aspect of a barrier or facilitator of help-seeking. Additionally I realised that the definition of ‘help-seeking’ could not just refer to one initial moment of help-seeking, but that it had to refer to ‘continued help-seeking’ particularly in the case of help-seekers who might have experienced several different help-seeking pathways. I therefore extended the definition of help-seeking to also include the sub-question addition,

‘What are the main barriers and facilitators that hinder or enable *successful* help-seeking’ that is, engagement with health services and treatment.

From the codes, I justified what was classed as a theme in terms of its prevalence across the data set as a whole, and/or whether a theme identified something significant about the research area (therefore not just using prevalence as a marker of importance). Prevalence was assessed by; 1) how many participants noted a theme (or an aspect of a theme) and 2) overall how many times this theme was referenced by all participants. Of these two markers, I deemed the prevalence of how many participants noted a theme (even just once), to be more important than the overall number of references. This was because I felt it would be more relevant if 10/10 help-seekers and 10/10 non-help-seekers mentioned a theme rather than 3/10 help-seekers mentioning a theme many times.

I also created themes when I judged segments of data to capture critical aspects of evidence vital to the research question. Braun and Clarke (2006) note, ‘*more instances do not necessarily mean the theme itself is more crucial*’. Hence a theme may have only been mentioned by one or two participants and only a few times, but it could be extremely important in revealing aspects of evidence that furthered understanding of the research issue. Hence the importance of a theme did not rest solely on quantifiable measures of prevalence.

Latent themes

Lastly in line with my critical/realist, constructionist approach I conducted thematic analysis at the latent, interpretative level, as opposed to just the semantic level (Boyatzis, 1998). Therefore I aimed to go beyond the surface level of the data and assess the underlying ideas, assumptions and contexts that have formed or shaped the data. In this case I took the backdrop of my understanding to arise from the cultures and structures experienced in the military; for example, the experience of deployment, life in Service, life after leaving the military, masculinity cultures, identities and social networks formed from the military occupation and how behaviours learnt in Service may influence behaviours after having left Service. I developed this contextual understanding both from the raw data available in the interview texts and from previous literature discussing these issues in Hockey (1986), Jones and Wessely (2005) Langston et al. (2007) and Forbes et al. (2013). Hence the development of themes involved interpretative work and the analysis produced is couched in these broader assumptions of military life and culture identified as underpinning what is articulated in the data. Each qualitative results chapter is therefore preceded by a depiction of the context of military life and culture described by interviewees. This context, therefore, is decisive in

understanding and interpreting latent themes and provides the backdrop of the social world individuals' construct their help-seeking behaviours within.

Phases of Thematic Analysis

I followed the phases of thematic analysis as detailed in Braun and Clarke (2006) (see Table 3), with the addition of creating a codebook as advised by Guest et al. (2011). However, it is pertinent to note that analysis was not a linear process, but a recursive process, therefore there was an element of moving backwards and forwards throughout the phases as was appropriate to the analysis. I used the coding software NVivo 10. (NVivo qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012)

In phase 1, I first familiarised myself with the dataset. This included transcription of some of the interviews, but it always involved listening to all interviews at least twice. I then read and reread interviews, whilst noting down ideas and compared these ideas to notes I had made at the time of interviews.

In phase 2, I began generating initial codes for the specific dataset of interviews; these codes referred to the most basic level of coding and captured something interesting about the dataset. After I had generated initial codes for the specific dataset of interviews, I moved onto phase 3, where I collated codes into potential themes and gathered relevant codes together. I also merged codes that were the same and deleted codes where it became apparent they were irrelevant to the research question. Phase 3 moved the analysis up to the level of sub-themes or themes, where I began to analyse how different codes potentially combined to create themes. Here I utilised the NVivo function of coding trees to organise codes into themes/sub-themes additionally giving a basic visual map as to the hierarchical status of codes and themes. At this point I began to think about the relationship between codes and themes at their different levels. Additionally, I created a place to house codes under 'miscellaneous codes' that did not seem to fit in anywhere, in case they became useful at a latter point.

Over the iterative phases 2, 3 and 4, I created a codebook. Codebook development helps to systematically sort codes into categories, types, and relationships of meaning. It helps to define and refine themes, and also provides a consistent reference point as to when (and when not to) to use certain codes. Coding is hence as logical and consistent as possible. During phase 2, 3 and 4, the codebook definitions are refined, as codes and relationships are refined. Hence at the end of phase 3, I had created candidate themes to be analysed further.

Please see an example of a code in Table 2. For additional examples of codes in my codebook, please see Appendix 3.

Table 2 - Codebook Example

<u>Doesn't want to take medication</u> <u>(child sub-code of participant negative attitude/expectation of mental health treatment)</u>	
Code description	Describes non-help-seekers and help-seekers negative attitudes/expectations towards pharmacological treatment
Where to use the code	Use where participant expresses a reason for not seeking help being their concern that they would be offered pharmacological treatment (most commonly anti-depressants) and they do not want to take medication for their problem. Often imbued idea that they would have little choice over their treatment. Potentially related to stigma.
Where not to use the code	Not to be used where individual does not want to participate in other forms of treatment (e.g. counselling, CBT, anger management etc.)

From phase 4, I began reviewing candidate themes. I firstly reviewed all the collated extracts under sub-themes and themes. I considered whether the coded data formed a coherent pattern. If data extracts did not fit a certain theme, the data segment was uncoded and either recoded or left. Additionally at this point I continued to refine themes, by merging or collapsing codes that were similar and reorganising codes to sit under sub-themes or themes that were appropriate. As the reviewing and refining of themes progressed, I was able to create a thematic map in NVivo using the modelling function. This aided my visualisation of sub-themes and themes. After an initial thematic map was created, a second review process was initiated, whereby I assessed whether my candidate thematic map accurately reflected the dataset as a whole.

Phase 5 involved defining, refining and finally naming themes. Here I continued to identify what the essence of each sub-theme and theme was about. Using my codebook, I determined what aspect of the data each theme captured and refined a definition for each theme. The main test for clearly defining what a theme was and what it was not, was whether the scope and the content of each sub-theme or theme could be described in a paragraph or a couple of sentences. Descriptions that were longer than this were further refined to be succinct and as clear as possible.

After phases 4 and 5, I returned to the thematic model created at phase 4. After further defining and naming themes, it became clear that certain barrier and facilitator themes mirrored one another. These themes were hence brought together and organised under

overarching supra-themes (For an example of this model progression, please see Appendix 4).

Finally, phase 6 proceeded as I wrote up my results for each qualitative study. I opted to present overall thematic models, followed by descriptions of supra-themes, themes (barrier and or facilitator themes) and sub-themes. Under the description of these themes and sub-themes I provide a coherent account of the story the data tell, using vivid quotes to demonstrate evidence for the theme and embed this within an analytical narrative presenting the results.

In brief, thematic analysis is an excellent tool for the needs of the qualitative research in these studies. In this chapter I have presented my overall approach and process when applying thematic analysis to my qualitative studies to enable a transparent evaluation of my qualitative method. Specific processes of coding relevant to the different qualitative studies are further delineated in Chapters 4 and 5.

Table 3 - Phases of Thematic Analysis - Braun and Clarke (2006)

Phase	Description of the process
1	Familiarisation with data: Transcription of interviews, reading and rereading the data, noting down initial ideas.
2	Generation of initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes: Checking themes work in relation to the coded extracts and the entire data set, generation of a thematic map/model of the analysis.
5	Defining and naming themes: On-going analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6	Production of the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, production of a scholarly report of the analysis.

3.2 - Justification Of Use Of Qualitative Telephone Interviews

For the purpose of the qualitative study, I opted to conduct semi-structured qualitative telephone interviews. There is a combination of reasons for this decision based on the most current qualitative interview research literature addressing interview modes and the experience of the KCMHR group in previous studies.

Academic tradition and methodology textbooks have most commonly sided with the assumed advantages of face to face interviews over telephone interviews when dealing with semi-structured qualitative interviews, particularly interviews that may need to broach sensitive subjects (Rubin and Rubin, 1995, Legard et al., 2003, Gillham, 2005). Some authors have described how there is a lack of interaction between the interviewer and interviewee, where this may lead to the inability to create rapport to enable the discussion of sensitive subjects (Weiss, 1994, Shuy, 2003, Trochim and Donnelly, 2007), that telephone interviews are more fatiguing and likely to be shorter (Gillham, 2005), that breakdowns in communication are easier over the telephone simply because of the fact of being apart (Hermanowicz, 2002) and that important nuances could be lost because of absence of visual cues (Fielding and Thomas, 2008).

Recent research has begun to assess the use of telephone interviews and often concluded that telephone interviews are a highly acceptable and successful options in comparison to face to face interviews, even when dealing with traumatic or sensitive issues (Wilson et al., 1998, Sturges and Hanrahan, 2004, Holt, 2010, Trier-Bieniek, 2012), and have yielded good quality data that varies little in content or depth when compared to face to face interviews (Greenfield et al., 2002, Sturges and Hanrahan, 2004).

3.2.1 Justifying Knowledge, Justifying Method

Good quality qualitative research attends to the internal consistency of epistemology, methodology and methods (Carter and Little, 2007). Using Carter and Little's framework, epistemology is seen as 'justification of knowledge', methodology as, 'a theory and analysis of how research should proceed' and methods as, 'techniques for gathering evidence'. Espousing a certain epistemology can influence methodology and methods, determine researcher-participant relationships, affect the type of data gathered and impact the means and context with which data can be analysed.

In the research I take a critical realist/ (broadly) constructionist epistemological approach, utilising thematic analysis as my methodology and qualitative semi-structured telephone interviews as my method, which ensures internal consistency within these choices. The mode of qualitative telephone interviews, therefore, fits into and benefits this approach.

When assessing the alternative to telephone interviews, there is an implicit assumption made in face to face interviewing that face to face contact will produce more a 'truthful' experience or create a more 'natural' encounter (Shuy, 2003). In setting out a top line epistemological view of qualitative interviews, I disagree with such a positivist, realist account that an interview can ever be (or come close to) a 'natural encounter'. I also disagree with the proposition that an interviewer can be an objective observer who facilitates the interview encounter, where facts somehow 'emerge' or are 'uncovered' about the participants' life. Instead, as described in Rapley (2001), I take the interview to be a specific local interaction whereby the interviewer and interviewee create data together. By taking a critical realist approach to the interview encounter, I am able to pay due attention to my role and influence over the interview.

I also take a critical realist approach to the knowledge imparted by a participant. That there is no such thing as a pure truth or experience a participant can relay to researchers at face value, evidence or facts. Instead, I would promote the concept that interviews provide an account of participants' experiences from their perceptions of the world, that are truly felt and experienced by the individual from their particular perspective (Willig, 2013). I also contend that individuals' perceptions and views are socially influenced and constructed on an individual level and a macro level in social epidemiology (Krieger, 2001, Krieger, 2011). This epistemological position matters when discussing the benefits of mode choices in interviews. This position cannot accept the argument that one mode 'trumps' another because it creates more factual data from a more 'natural' experience. From a critical realist approach, all data is important and no type of data is more truthful than another, because all interview data is based on perceptions that are individually socially constructed.

Instead, the critical realist approach causes the researcher to thoroughly question the 'sender-receiver' dynamic of interviews (Shuy, 2003), so as to understand power balances in an interview, and decide accordingly which mode best mitigates the undue influences of these power balances. This approach also encourages the researcher to accept that no one mode can be perfect and focuses them to analyse their own role in the construction of data.

Telephone interviews can offer benefits that counteract some of the difficulties posed by the power balances created by face-to-face qualitative interviews. A researcher can structure their interview to meet the needs of the participant, minimising stress, and empowering the participant to talk about sensitive topics. This approach has been successfully demonstrated in the work of Trier-Bieniek (2012) who conducted qualitative telephone interviews with women who had experienced trauma.

3.2.2 Interview Power Balance

The use of telephone interviews helps to silence, in part, some of the more obvious power balance relationships and allows both parties to have more control over their social space (Stephens, 2007). Whilst the interviewer and participant would know the sex of the other, contextual and ethnographic details, such as living circumstances of the interviewee, what each party looks like or how they are dressed, is unknown. This is valuable in helping to level the power relationship, so assumptions about each party are not made at face value. Holt (2010) describes how telephone interviews help to reduce the intensity of the ‘surveillant other’ by not intruding on the participants’ home. Additionally telephone interviews allow the participant to control when and where they have the interview, ideally so the participant can feel safe, uninterrupted and private.

3.2.3 Sensitive Subjects and Anonymity

Tourangeau and Yan (2007) discuss three different meanings of the concept of sensitivity in survey literature. Some sensitive questions can be regarded intrusive or an invasion of privacy regardless of the answer, e.g. questions on income. Secondly, sensitive questions are ones that can elicit the threat of disclosure, that is concerns about the consequences of giving a truthful answer should the information become known to another, and lastly, sensitive questions are ones that elicit answers that are socially unacceptable or undesirable, e.g. the disclosure of drug use.

All three types of sensitive questions had the potential to be broached in my qualitative interviews. Hence anonymity and confidentiality was especially important to aid high quality data in this circumstance. Anonymity and confidentiality was critical for the specific sample group when disclosing information on mental health. Fear et al. (2012) found a statistically significant effect on the reporting of sub-threshold and probable PTSD and certain stigmatising beliefs when using an anonymous compared to identifiable questionnaires, with the anonymous questionnaires resulting in a higher prevalence of PTSD and increased reporting of three stigmatising beliefs.

In my particular research circumstance the interview sample group was purposefully selected on the basis of military employment (past or present), including those who may have experienced trauma, may hold stigmatising views or have felt stigmatised themselves, and may feel protective or defensive about disclosing information because of fears this information could harm their career (Langston et al., 2007, Iversen et al., 2011). In tandem, many in the sample group were expected to have high levels of mental health literacy from mental health education policy drives in the MOD. Hence there was a possibility that some in the group would have more of a tendency to answer in socially desirable ways because of their knowledge of the correct institutional answers on mental health and stigma (Forbes et al., 2013). Hence the importance of anonymity and confidentiality was considered paramount for these interviews and telephone interviews were seen to aid this.

In addition to this evidence, Fenig et al. (1993) highlight that subjects who agree to be interviewed about sensitive topics may prefer the anonymity of the telephone compared to a face to face interviews and that telephone interviews may reduce embarrassment involved in responding to emotionally or socially laden questions. Greenfield et al. (2002) work suggests that telephone interviews increase respondents' perceptions of anonymity. In Sturges and Hanrahan (2004) comparative work of sensitive interviews, they asked respondents why they chose face to face interviews, or telephone interviews. Respondents who opted for the telephone interviews reported that they took the option because it was more private and that they did not want others to know that they were taking part. Separately there is evidence that computerised self-administration increases the reporting of sensitive information (Tourangeau and Yan, 2007). As one of the qualitative telephone interview samples was selected through an online self-administered screening tool (see Chapter 4), the online screening tool was also intended to instil a prior confidence of anonymity and more open reporting to then be built upon in the telephone interview.

3.2.4 Hard to reach groups

Creswell (1998) suggests that telephone interviews may provide opportunities to obtain data from participants who are hard to reach in person. Telephone interviews cut through the difficulties of the practicalities of face to face interviews and associated costs, giving access to otherwise unheard voices, whilst also offering the interviewee control of place and time. Holt (2010) research shows how flexible telephone interviews can be in allowing participants the power to reschedule interviews with little embarrassment. Telephone interviews may reduce the stress of an interview for an individual living with a mental health disorder, that if at the last minute, the individual does not feel up to the interview, the

interview does not have to be disbanded or carried through under circumstances that would not be conducive to obtaining good quality data, but can be rescheduled.

Within the particular interview sample, many individuals have busy lives, live in disparate areas of the UK and will be living with a mental health condition. In this situation telephone interviews enabled the participation of potentially hard to reach individuals and decreased the stress of participation to allow the participant control in being able to fit the interview around their lives and schedules.

3.2.5 Non-verbal data, ethnographic info, rapport

One issue regarding the use of telephone interviews was the potential loss of non-verbal communication between the interviewer and interviewee that could aid understanding and rapport. The main question considered was whether the lack of visual cues was critical to data quality. Scott (2004) and Sturges and Hanrahan (2004) proffer that previous communication builds rapport. In this specific case the sample group had prior communication with the researcher through mail or e-mail invitation, a self-administered screening tool/online survey (for qualitative study 1), an introductory telephone call to invite the selected group to take part in the telephone interview and finally, the telephone interview. Hence the rapport that one loses in not being face to face was built in prior communication channels.

Other benefits of telephone interviews are that they offer the interviewer the opportunity to take notes or note down follow up/probe questions without interrupting the flow of the interview, which would not be possible to the same extent during a face to face interview. The interviewer in a telephone interview can conduct 'intense listening practices' (Trier-Bieniek, 2012) and focus on verbal cues such as hesitation and hurried answers that could be lost amongst non-visual cues in face to face interviews. Lastly Holt (2010) advises that the lack of facial or ethnographic information allows analysis of the data to stay at the level of the text and the issues the participant orients themselves towards, which in turn would be better for a critical realist approach to research.

3.2.6 Evidence from other KCMHR studies

Several other studies from the KCMHR group (Iversen et al 2009, 2011 Mental Health Service Utilisation and help-seeking Study (REC approval reference 05/Q0703/155), Military fathers study (REC approval reference 08/H0808/27) and Blind Veterans UK study (Social Care Research Ethics Committee Approval Reference 12-IEC080032)) had utilised telephone interviews and found the mode to be acceptable and successful concerning the

specific study group when interviewing participants on potentially traumatic or distressing subjects.

3.2.7 Consideration of risk and well-being of the researcher

As these interviews were to be conducted by myself, potentially with participants discussing difficult/distressing experiences or potentially with the need to enact the risk protocol, my supervisors and I considered the need to provide certain measures to ensure my own well-being. From a clinical perspective, the on-call mental health professional (who was available in relation to the risk protocol for participants) was available to myself if I needed to discuss anything I found difficult to process regarding my participant interviews, or if I felt my own well-being was being compromised by the interview process. Additionally as part of my training, I received advice from the mental health professional on good coping mechanisms and strategies to encourage my own good mental health (such as exercise, diet, social support etc). At my supervisor meetings over the interview period, my supervisors also specifically enquired about the interviews and provided support. Hence with these mechanisms in place, I was content that my own well-being was provided for.

From this evidence presented in this section, I deemed telephone interviews to be appropriate and beneficial to my qualitative studies and participants. The proceeding Chapters 4 and 5 detail the specific methods and results associated with each qualitative study.

Chapter 4 - Qualitative Method Study 1 – King’s Cohort Specific Methods

4.0.1 Participants

The King’s Centre for Military Health Research’s health and well-being survey of members of the UK Armed Forces cohort study identified a subsample of 1071 military personnel who reported stress/emotional or alcohol related problems as a result of deployment in 2007-2009 (based on data from ‘phase two’ of the cohort study) (Hines et al., 2014a). The quantitative study reported on the health and healthcare seeking status of the military cohort group amongst those deployed to Iraq or Afghanistan (Fear et al., 2010). The cohort offered access to a unique longitudinal representative sample of both help-seeking and non-help-seeking individuals with mental health problems.

Participants were recruited specifically from the group of 1071 military personnel who reported stress/emotional or alcohol related problems as a result of deployment in the 2007-2009 data collection.

The sampling method took place in two stages. The original data from the 1071 individuals was initially screened to identify young males (a group least likely to seek help) and the most likely sample of individuals who would currently be experiencing problems (approximately five years on since the original collection of the phase two data). The criteria used for the first sample stage was:

1. Those who were case positive on the mental health screening measures for depression or anxiety - GHQ-12 (Goldberg and Blackwell, 1970, Pevalin, 2000), Post Traumatic Stress Disorder - PCL-C (Bliese et al., 2008), and alcohol misuse/abuse - AUDIT (Babor et al., 2001) using a score of 16 cut off
2. Those who were male.
3. Individuals in January 2013 who would have been between aged 18-35.

After the first eligibility criteria were applied, the group was reduced to 282 individuals (Please see Figure 11 for the sample selection flow chart). In the second stage of sampling, these eligible participants were invited to participate in an online survey/screening tool (in May 2013) to enable the recruitment of participants who currently (within the last year) endorsed they were experiencing a stress/emotional or alcohol related problems and who were current non-help-seekers or help-seekers seeking formal/professional help. Participants

who met the inclusion criteria (detailed below) were invited to take part in qualitative telephone interviews. I aimed to recruit:

- 10 participants who currently (within the last year) **did not report** seeking any formal/profession/medical help for their stress/emotional and/or alcohol related problems;
- 10 participants who currently (within the last year) **did report** seeking formal/profession/medical help for their stress/emotional and/or alcohol related problems.

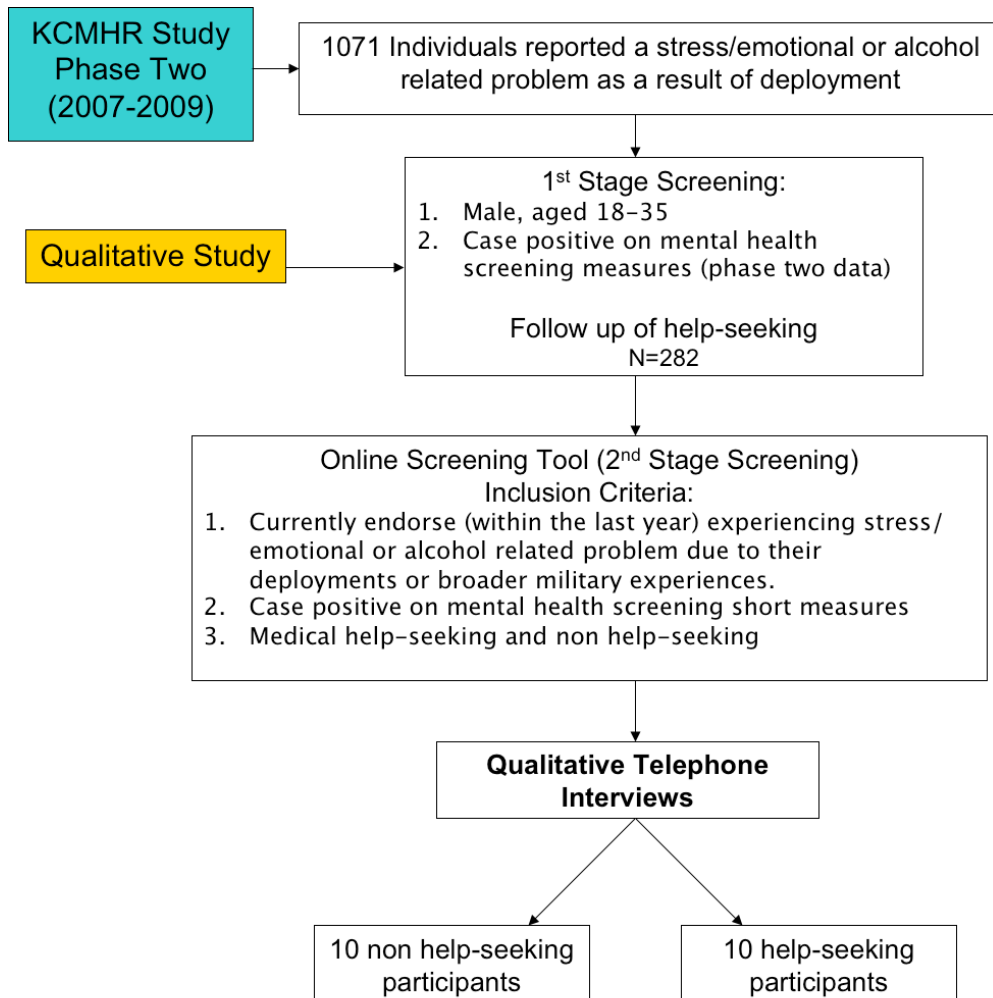
4.0.2 Telephone Interview Inclusion Criteria

In order to ensure homogeneity of participants for the qualitative semi-structured interviews, a number of inclusion criteria were applied:

1. Individuals who endorsed through the online screening tool, that they were currently experiencing (within the last year) stress/emotional or alcohol related problems;
2. Individuals who were identified through the screening tool as having a probable mental health problem and;
3. Individuals who identified themselves as help-seeking (formal/professional/medical treatment) and non help-seeking (receiving no professional help for the problems identified).

These inclusion criteria were applied so the qualitative study could recruit those in possible need of treatment (hence use of mental health screening short measures), those who could talk about their reasons for non-help-seeking or help-seeking (and therefore they had to recognise they were experiencing a problem), and those I could categorise into non-help-seeking (no formal/professional help sought) or help-seeking (formal/professional help sought). Here I explicitly categorised help-seekers as those seeking formal/professional help. This was because there was a need for a salient categorisation of help-seeking groups. I am however also aware the resulting in-depth interviews may give more detail as to the intricacies of an individual's help-seeking status. The screening tool (discussed below) also asked participants whether they had sought informal help from family/friends/others. In this way I believe I will be able to identify the subtleties of individuals help-seeking pathway both from the screening tool and from the proceeding in-depth interview.

Figure 11 - Qualitative Study 1 - Sample Selection Flow Chart



4.0.3 Recruitment Procedure

The Invitation Letter and Participant Information Sheet (see Appendix 5) detailed information on the study and informed participants that their participation was voluntary, confidential, that the information they gave would remain anonymous, unidentifiable, and that they would be able to opt-out at any stage. In addition, participants were given an internet link <http://www.kcl.ac.uk/kcmhr/participants/helpseeking.aspx>, only accessible to those who had the link (i.e. not able to be viewed on the public KCMHR website without knowledge of the link). This link took them to the associated website page for the help-seeking study on the KCMHR website for participants to access the survey and study materials (see Appendix 6 for the survey).

The Invitation Letter invited participants to complete a secure online or hard copy survey (screening tool) that took approximately 5-10 minutes to complete. Each individual was issued with a unique identification number related to their survey so that no personal information was entered over the internet, or written on the hard copy. The letter also detailed to participants that if they wanted to participate further, individuals could identify that they would be willing take part in a telephone interview and that they would be reimbursed as a thank you for their time. All individuals who took part in the online screening tool were sent a signposting leaflet detailing mental health services, support and welfare services either by electronic form or hard copy (Please see Appendix 7).

Over the recruitment period, May – July 2013, potential participants were sent a study Invitation Letter and Participant Information Sheet by electronic copy and/or hard copy by post depending on the contact details available in the database. As part of the recruitment strategy, those participants with personal e-mail addresses were contacted first, as it was felt this mode of contact would produce the most efficient responses in completing the online survey. Where e-mail addresses were found to be out of use by e-mail bounce backs, and if contact numbers were available for participants, participants were contacted by telephone to ask for an update to their e-mail information to be able to get in touch with them electronically about the study. If no e-mail or telephone contact could be made, participants were put on the hard copy mail out list. If there was no contact from participants by way of opting out or in completion of the online survey, participants were sent another e-mail reminder one week and two weeks after the original e-mail was sent out.

The required recruitment numbers were not met through issuing the study invitation only through the e-mail contacts available. Hence Invitation letters and Participant Information Sheets were sent out directly through postal mail outs to potential participants on the database who:

- Had no personal e-mail address;
- Had no working e-mail contact (i.e where e-mail bounce backs were received) and where they could not be contacted by telephone to update electronic e-mail records; and
- Where no contact had been received (either in completion of the study or opting out) from the e-mail invitation, including the e-mail reminders, three weeks after the original e-mail was sent.

Individuals who completed the online survey, who were eligible under the inclusion criteria and who indicated that they would be willing to take part in a telephone interview, were then contacted by telephone, to arrange a suitable time to conduct the telephone interview. Contact was made with participants within a week of their completion of the online survey and interviews were conducted as soon as was possible, usually within a week after telephone contact was made. After a date and time was agreed for the interview, a confirmation e-mail was sent to the participant, where they were also advised that at the time of taking the interview call they should aim to be somewhere they felt was private and comfortable. Additionally the Participant Information Sheet was sent again to the participant at the confirmation point to ensure they had read the information sheet and would be able to give informed consent at the time of taking the interview. Participants were then texted the evening or morning before their interview as a reminder and also offered a change of interview time should their availability have changed.

Telephone interviews and consent were recorded. Participants were also asked to confirm that they had received the signposting document and were offered it again in electronic or hard copy versions. Participants were also asked to confirm the best address to send the financial reimbursement for taking part in the interview. Participants were then informed that they could get in touch with myself if they had any further thoughts on the interview questions, or further questions about the study.

Survey/Screening Tool

The screening tool was administered through 'Survey Monkey'. It was a short 5-10 minute screening tool that assessed the current health and help-seeking status of potential participants (Please see Appendix 6 or follow this link for access to the preview mode of the survey/screening tool. Please enter 0001 as your identification number and any date of birth: <http://www.surveymonkey.com/helpseeking>.)

The survey/screening tool also used the short form measures listed below:

- Patient Health Questionnaire-2 (PHQ-2), a 2-item version of the PHQ-9 (Arroll et al., 2010) used to assess the presence of a depressed mood and a loss of interest or pleasure in routine activities. (Cut off PHQ-2 score used ≥ 3)
- Generalised Anxiety Disorder-2 (GAD-2), a 2-item version of the GAD-7 designed as a brief screener to detect anxiety disorders (Cut off GAD-2 score used ≥ 3) (Skapinakis, 2007)

- Primary Care-Post Traumatic Stress Disorder Screen (PC-PTSD), a 4-item screen that was designed for use in primary care and other medical settings and has been used to screen for PTSD in veterans at the United States Veteran's Agency. (Cut off PC-PTSD score used ≥ 3 (Prins et al., 2004)
- Alcohol Use Disorders Identification Test-C (AUDIT-C) is a shortened version of the AUDIT (Babor et al., 2001, Isaacson et al., 1994). It uses the first 3 questions only of the AUDIT test. Using a cut off ≥ 4 the Audit-C has a sensitivity of 86% of patients with heavy drinking and/or active alcohol abuse or dependence with a specificity of 72% and can be used to assess frequency and consumption of alcohol. (Cut off AUCIT-C score used ≥ 4) (Bush et al., 1998, Bradley et al., 2007).

4.0.4 Ethical Considerations

The main KCMHR cohort study (including phase one and phase two of data collection) received full ethical approval from the MOD Research Ethics Committee and the King's College Hospital Research Ethics Committee (NHS REC reference: 07/Q0703/36). This qualitative study was approved by the King's College Hospital Research Ethics Committee as a substantial amendment to the original cohort study ethics application. (April 2013 REC Reference: 07/Q0703/36 Sponsor Reference: CSA/07/006).

Consent, Confidentiality and Anonymity

Only participants who agreed to be re-contacted in the main cohort study questionnaire were considered for inclusion in the study. The Invitation Letter and Participant Information Sheet gave participants' a contact number and e-mail address via which they could ask any questions. The online survey asked participants to confirm that they understood that their participation was voluntary and that they were free to withdraw at anytime without giving a reason. The online survey would not allow participants to progress with the survey until they had confirmed that they had read and understood the Participant Information Sheet and that they had been given the opportunity to ask questions. The survey also offered two opportunities for participants to re-read the Participant Information Sheet before beginning the survey to ensure they understood the requirements of the study.

After participants had completed the online survey and after telephone contact was made to arrange a telephone interview, participants were encouraged to ask any questions about the study and were informed that consent would be recorded at the beginning of their telephone

interview. Participants were also re-sent the Participant Information Sheet in the confirmation e-mail sent detailing the appointment time of their telephone interview.

Individuals were informed that by taking part in the survey they consented to KCMHR being able to use their data but that the data would be anonymised and would not be linked to any personal identifiers. Furthermore, participants were free to ask questions at any time during the interview and the interviewer was able to determine whether the participant understood the requirements of taking part. Participants were also encouraged to identify a time and place where they could be interviewed in private when they were unlikely to be disturbed. Participants were informed that they could ask for their interview recording to be destroyed, and that they could remove their data from the study up until one month after the interview, as after data were transcribed and coded, it would be difficult to link it to a specific individual. Participants were informed that the interviews would be recorded, that the recordings would not be linked to any personal identifiers, and that after the recordings are transcribed, they would be deleted.

Participants were informed that all information would be kept strictly confidential. Data was stored securely, and was only accessible to the research team and would not be shared with anyone outside of the research team. Participants were also informed that the only exception to their confidentiality was if they told the researcher something that made them concerned about the participants' safety or the safety of others.

4.0.5 Potential for Participant Distress and Risk Protocol

Independent Medical Officer

The study provided an Independent Medical Officer to all participants should they have had any general concerns or distress about the study. The Independent Medical Officer was available to give impartial advice. Their sole function was to ensure participants safety and well-being whilst participants took part in the study.

If participants reported suicidal ideation or experienced acute distress during the interview, I could enact the risk protocol. In this situation a call back would be offered from the KCMHR on call medical officer to ensure individuals were not left in a vulnerable position. After the participant had a discussion with the medical officer, the medical officer would then get in contact with the participant's General Practitioner, responsible medical officer or their welfare officer to highlight the distress experienced and enact appropriate support mechanisms.

Although participation in the study was not anticipated to result in any adverse effects, the nature of the questions involved in the interviews had the potential to cover emotive and distressing topics. In light of this I took advice from colleagues in my research group who had conducted similar interviews. They advised that the interview process often acted as an opportunity for disclosure/release for an individual who might be struggling in some way with their wellbeing. However, in addition to this I searched the literature and found no evidence to support the assertion that interviews which explored sensitive and intimate concerns posed a risk to participants. For example, Jacomb et al. (1999) examined participants reports of distress following participation in a mental health survey and reported that while 5% reported feeling distressed, 3% depressed and 3% concerned about privacy, 35% reported 'feeling good about themselves' as a result of the survey. Griffin et al. (2003) studied the impact of participating in research that asked about trauma including domestic violence (n = 260), rape (n = 108), and physical assault (n = 62). Results indicated that participants generally found that the assessment experience was not distressing and was, in fact, viewed by most as an interesting and valuable experience. Boscarino et al. (2004) examined the reactions of a sample of New Yorkers caught up in the events of September 11th (n=2,368). Results indicated that 15% found some of the survey questions stressful, however, less than 2% reported being upset at survey completion and more than 70% of participants expressed positive sentiments about participation.

Specifically amongst veterans, there were two key papers that demonstrated that talking things through, even for those who had been traumatised, was not harmful and may be beneficial for some. Halek et al. (2005) examined spontaneous reports of emotional upset among veterans with PTSD after receiving a survey which addressed mental health and trauma specifically. Content analysis of spontaneous comments suggested that spontaneously disclosed episodes of emotional upset were unusual. Parslow et al. (2000) randomly selected 641 Australian veterans who agreed to participate in an epidemiological survey. Participants were asked about distress experienced during the interview when traumatic events were raised. Significant distress during the interview was reported by 75.3% of those with current PTSD, 56.5% of those with past PTSD, and 20.6% of those with no PTSD diagnosis. However, distress did not affect participants' use of medical services following the interview nor did it affect their willingness to continue participating in the study. The research team concluded that research interviews about trauma may cause short-term distress, but found no evidence of long-term harm. Hence after this review of the literature, I was content with regards to ethical considerations to proceed with interviews with the additional use of the risk protocol if required.

Signposting

All participants who took part in the online survey were sent a signposting leaflet that documented relevant mental health, support and welfare services. (Please see Appendix 7)

Financial Reimbursement

Participants who completed a telephone interview were reimbursed for their time. This was in the form of a £15 cheque.

4.0.6 Interview Structure

The semi-structured interview questions guide was compiled on the basis of existing qualitative research (please see Appendix 8). Questions asked were open ended such that broad topics were introduced by the interviewer; however these particular interviews were designed to be fluid in structure which would allow the participant to lead and focus on areas they deemed most important and pertinent to their experiences, following the form of a fluid interview script (Fontana and Frey, 2003, Trier-Bieniek, 2012). The semi-structured interview also allowed the possibility of new themes to emerge from the participant that had not been identified by current research. Those who had not sought help were asked about barriers and facilitators of help-seeking. Those who had sought help were asked questions within the themes of barriers overcome, types of help sought, service utilisation, engagement with treatment, and satisfaction with treatment outcomes. Additionally, the interview included questions on the acceptability of the mode of interview through telephone interviews. These questions were intended to gather data to build upon research in this area assessing the benefits and limitations of face to face versus telephone interviews.

4.0.7 Pilot Interviews

Prior to the study, three telephone pilot interviews were conducted to evaluate the interview schedule. These participants were recruited through colleagues at the KCMHR who had knowledge and experience of the subject area. The pilot participants were informed of the purpose of the interviews and were given roles to play including different permutations of potential stress, emotional or alcohol problems, different service status' (such as Serving, Reserve or Ex-Service) and whether they were help-seeking or non help-seeking. The interviews were not recorded but participants were reimbursed for their time with a £15 cheque.

4.0.8 Qualitative Software and Coding

Interview transcripts were coded through the software NVivo 10.

4.0.9 Transcripts

I transcribed four interviews. The remaining 12 interviews were transcribed by a professional transcriber who had worked with KCMHR on a previous military study (Blind Veterans UK study - Social Care Research Ethics Committee Approval Reference 12-IEC080032). A confidentiality agreement was signed by the transcriber, that information in the interviews and identification of individuals could not be shared with anyone else. The transcriber had knowledge of the subject area and military language. The transcriber was employed to allow the efficient production of transcripts to enable analysis to proceed in a timely fashion. The use of a transcriber had no impact on the analysis and interpretation of results because of the methods I employed to immerse myself in the qualitative data. For example, when transcripts were received back from the transcriber, I checked them for accuracy by re-listening to the interview and correcting any text that had been transcribed incorrectly. Each interview was given equal attention to assess the interviews for participants' tone of voice, gaps in answers, coughs/laughs or other non-spoken details that would add evidence to the meaning and experience of the interview for both the participant and myself.

4.0.10 Reflexivity

For my interviews I followed certain procedures to allow the possibility that I could be critically reflective on the interviews I conducted. I wanted to be able to assess my role or influence in the interview, and to enable myself to have in-depth understanding of each interview to allow a fair and balanced coding of interview data that followed.

To create this outcome, during each interview I would make notes on important details or language used by the participant, where I aimed to reflect the same language back to the participant in follow up questions. This method was followed so particular points could be expanded upon without myself introducing language or themes that had not been offered by the participant. I aimed as far as possible to let the participant lead the interview and introduce topics of interest, so my own research interests or beliefs were not directive in the interview. At the end of each telephone interview, I would note down my initial thoughts about the interview. This included themes of barriers/facilitators of help-seeking that I thought had been most striking in discussion, general feelings I had about the participants attitude or any emotions/difficulties/un-spoken evidence (laughs/coughs tone of voice etc) expressed during the interview.

I followed this method to provide an initial record of my impressions of interviews to be able to compare this with my later assessment of the same interviews when re-listening to them. I listened to interviews a minimum of two times, once when assessing the accuracy and detail of transcription and again when making further broad notes and general impressions of interviews before the coding of interviews began. This was to ensure I had a good understanding of the interviews but also to allow me to reflect on my own role in the interview. I was able to highlight areas where I may have introduced ideas unwittingly that did not originate from the participant or where I missed opportunities to ask follow up questions on interesting points that participants offered. This whole method of reflexivity allowed a balanced and fair assessment of interview. It also allowed me to reflect on my skills as an interviewer and make notes on where improvements or adjustments could be implemented for use in future interviews.

4.0.11 Analysis

Thematic analysis was used in analysis of the qualitative interviews. Please refer to section 3.1 in Chapter 3, for a broad overview of the analytical method used in these qualitative interviews and for specific detail in methodological choices I made within the utilisation of thematic analysis. As detailed before, it is an appropriate method for identifying, analysing and reporting patterns (themes) within data, with the ability to describe and interpret various aspects of the research topic.

The non-help-seeking participant group and help-seeking group were analysed as independent groups, the codes and themes generated from the two groups were then analysed comparatively - allowing for analysis within and across groups. The analysis for each group followed the six phases of thematic analysis (Appendix 9). When both the non-help-seeking and help-seeking groups had been analysed up to steps four and five, using comparative analysis, I began to create an overall 'thematic map/model' to collate the data from both groups into one analysis. Phase 6 then began during the write up stage for this study using data from both groups in one model of help-seeking.

4.1 - Qualitative Results Study 1 – King’s Cohort

4.1.1 Study Recruitment Selection

The first stage inclusion criteria were applied to the original sample group of 1071 individuals from the KCMHR phase two study data. The inclusion criteria were males, aged 18-35 who were case positive on at least one mental health screening measure of the GHQ-12, PCL-C and the AUDIT (using a cut off of 16). The potential study sample group of 1071 individuals was reduced to 282 potential participants (Please refer to Figure 12). Over the recruitment period, May – July 2013, the 282 potential participants were sent a study Invitation Letter and Participant Information Sheet by electronic copy and/or hard copy by post, depending on the contact details available in the database. Of the 282 potential participants, 107 individuals were initially contacted through e-mail. Three weeks after initial invitations were sent out electronically to participants, and two reminder e-mails had been sent out, the study had received 13 responses. The remaining 94 participants who had not responded from electronic contact were added to the hard copy mail out list.

Overall, 269 individuals were sent out hard copy invitations to the study using postal addresses in the database. The online screening survey received 30 responses overall from both electronic and hard copy postal contact. From the 269 invitations sent out by post, 68 postal returns were received back to KCMHR where the addressee was no longer known at that address.

An overall response rate was difficult to calculate as it was hard to ascertain whether electronic contacts through e-mail and post had reached recipients. After excluding the 68 postal returns, the overall response rate was 14.0% (30/214).

Please refer to Table 4 for eligibility details of the 30 individuals that responded to the online survey.

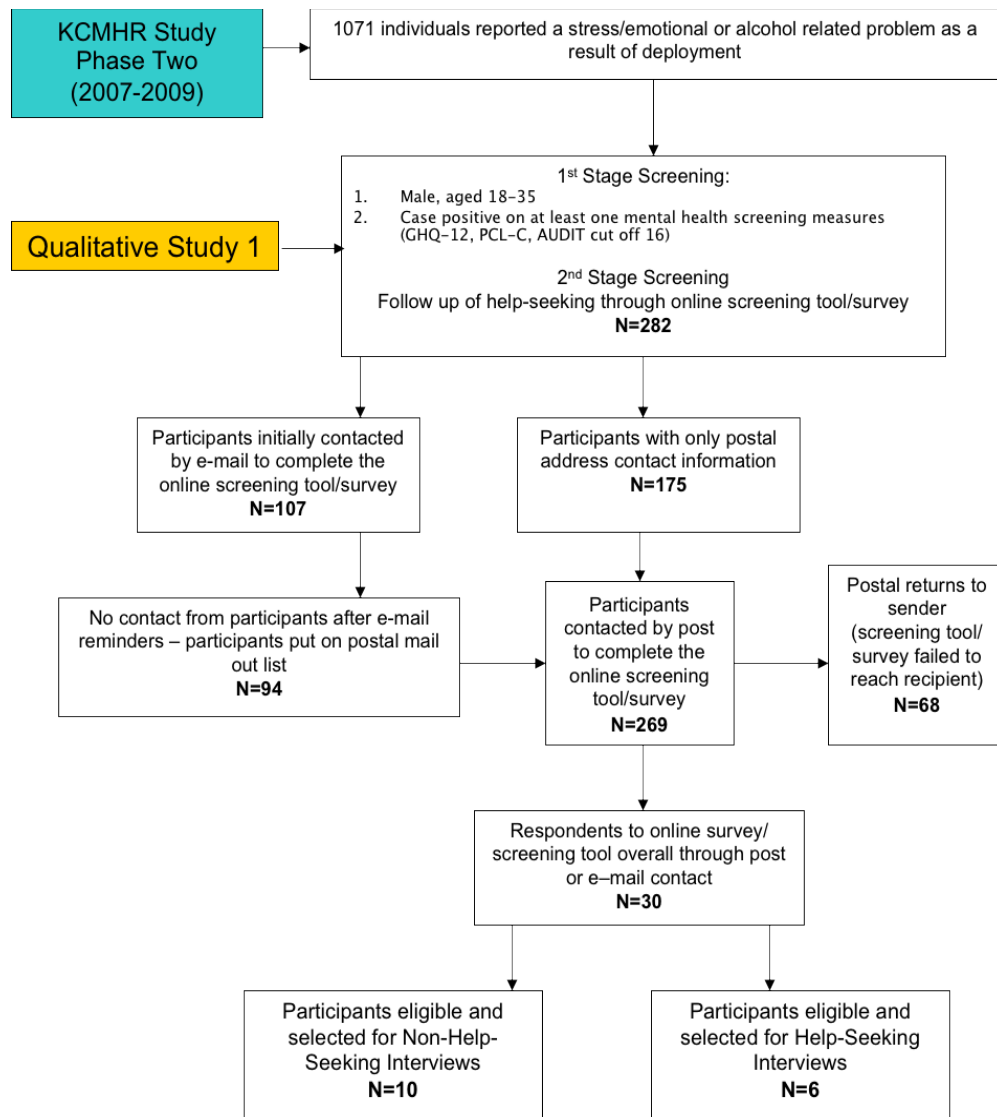
Table 4 - Screening Tool/Survey Respondents Eligibility Status

Participant numbers	Eligibility status (✓/✗/?)	Details of Eligibility/Help-Seeking Status
6	✓	Help-Seekers
14	✓	Non-Help-Seekers
1	?	<ul style="list-style-type: none"> • Endorsed experiencing a stress/emotional problem • Borderline case positive on mental health screening measures • Help-Seeker
7	✗	<ul style="list-style-type: none"> • Did not endorse experiencing a stress/emotional or alcohol problem • Case positive on mental health screening measures • Non-Help-Seekers
1	✗	<ul style="list-style-type: none"> • Fitted all eligibility criteria • Did not want to participate in a telephone interview • Non-Help-Seeker
1	✗	<ul style="list-style-type: none"> • Endorsed experiencing a stress/emotional problem • Did not meet threshold for a positive case on mental health short measures • Non-Help-Seeker

Interviewees were selected on the basis of eligibility and on a first come first serve basis. Hence 10 interviews were carried out for the non-help-seeking interview group, however only six interviews were carried out for the help-seeking group. Originally the study had aimed for 10 participants in each group, however out of the participants who responded, there were few who were eligible for the help-seeking group and an over-subscription of responses that were eligible for the non-help-seeking group.

Due to the lack of respondents who were eligible for the help-seeking group, I made the decision to include one participant who was borderline on being case positive for a mental health short screening measure. The participant endorsed they were experiencing a problem, and identified themselves as a help-seeker. I made the decision to include the individual on the basis that they were in treatment and therefore his symptoms may have improved because of the treatment received. I also felt that his help-seeking experience would be valuable to the study. Therefore there were potentially seven individuals in the help-seeking group. Interviews were completed with six out of these seven participants. One eligible participant did not take part in an interview after five unsuccessful attempts to schedule an interview.

Figure 12 - Study Sample Selection Flowchart Results



4.1.2 Study Sample Characteristics

Please refer to Table 5 for an overview of the study sample characteristics. This table details;

- Participants names (please note all names have been changed from participants real names);
- Age;
- Service status (Serving, ex-Service or Reserve);
- Whether they endorsed experiencing an alcohol problem;

- What the participant believed their problem was related to or caused by (Deployment, General Military Service, Non-Military Related Circumstances or Don't Know);
- Help-seeking status (Help-Seeking or Non-Help-Seeking);
- Informal help-seeking status (Whether the participant identified they were seeking informal, non-medical help from a Padre, Social Worker, Welfare Officer);
- Mental health screening short measure scores (PHQ-2, GAD-2, PC-PTSD, AUDIT-C);
- Participants response to the general health question, 'In general, how do you rate your health? With answer options ranging from 'excellent', 'very good', 'good', 'fair', 'poor'.

16 males, aged 18-35 years, who endorsed they were experiencing a stress, emotional or alcohol problem within the last year, and were seeking formal/professional help or were non-help-seeking, were recruited. The median age of the participants was 32.5 years. Five participants were Service personnel, 10 participants were ex-Service personnel and one participant was a current Reserve.

Participants were asked what they believed their problem was related to or caused by. The most commonly endorsed option was 'general military service' followed by 'deployment'. From the mental health short screening measures (PHQ-2, GAD-2, PC-PTSD and AUDIT-C) more non-help-seekers were case positive on three or more measures (5/10) compared to help-seekers (2/6). Overall between the two groups, the majority of participants were case positive most commonly on the AUDIT- C with a cut off ≥ 4 (12/16). The majority of individuals (13/16) ranked their health 'good', 'very good', or 'excellent'.

Whilst only 7 out of 16 participants were case positive on the PC-PTSD measure, 14 out of 16 participants responded 'yes' to the Pre PC-PTSD screen question which asked: *'The next few questions are about bad experiences that might have happened to you at any time in your life. When I use the term "bad experience" I mean things like seeing bad things in a combat situation, seeing someone killed or seriously injured, a serious car accident, having a loved one die by murder or suicide, or any other experience that either put-you-or-someone-close-to-you-at-risk-of-serious-harm-or-death.'*

Table 5 – Qualitative Study One Sample Characteristics Overview

Participant	Age	Service Status	Endorsed Alcohol problem (Yes/No)	Believe their problem is related to:	Help-Seeking Status	Informal Help-Seeking (Yes/No)	PHQ-2	GAD-2	PC-PTSD	AUDIT-C	General health self-report
Liam	32	Ex-Service	N	DK	N-H-S	N	2	3	4	5	Fair
Steven	30	Ex-Service	N	D & GMS	N-H-S	N	4	3	4	5	Good
Carl	33	Serving	N	GMS & NMRC	N-H-S	Y	6	6	2	2	Good
Owen	30	Serving	N	GMS	N-H-S	Y	0	0	1	9	Good
Edward	32	Ex-Service	N	D & NMRC	N-H-S	N	1	1	2	8	V. Good
Alex	35	Ex-Service	N	DK	N-H-S	N	2	6	2	1	V. Good
George	33	Serving	N	NMRC	N-H-S	N	2	0	0	7	Excellent
Tom	33	Ex-Service	Y	GMS & DK	N-H-S	N	5	4	4	11	Good
Gary	29	Ex-Service	N	D	N-H-S	N	3	4	4	6	Good
John	28	Ex-Service	Y	D & GMS	N-H-S	N	6	6	4	7	Fair
Robert	31	Serving	N	D	H-S	Y	0	2	1	0	V. Good
Jake	32	Ex-Service	N	D & NMRC	H-S	N	0	2	1	6	V. Good
Mark	35	Reserve	N	DK	H-S	N	1	2	1	6	V. Good
Ben	27	Ex-Service	N	D	H-S	N	1	5	4	5	Good
Ryan	34	Ex-Service	N	GMS & NMRC	H-S	N	0	3	0	0	Poor
Peter	28	Serving	N	GMS	H-S	Y	6	6	4	8	Good

Key:

Cause of problem: DK = Don't know; NMRC = Non-military related circumstances; GMS = General military service; D = Deployment

Help-Seeking Group: N-H-S = Non-help-seeking; H-S = Help-seeking

Please Note: shaded boxes denote positive case on mental health short screening measures

4.1.3 Context and Background of Experiences

To help understand the context of results and particularly in relation to the occupation of the military, this section details the study sample's deployment experiences, descriptions of military life and culture, causes of the problems they experienced and a summary of the symptoms most commonly experienced in relation to their problem.

Deployment experience

All participants described deployments to Iraq or Afghanistan, with a minority describing deployments to Northern Ireland or other conflict areas; a large minority had completed multiple tours. The majority discussed deployment as an intense time, with extreme pressures in terms of hours worked or things seen or endured during operations. These included heavy physical and psychological tolls, such as working seven days a week, poor sleep, not believing they would survive their tour and having 'close calls' in relation to combat experiences that threatened their lives.

'...we were told our life expectancy if we got out the vehicle was two point something seconds, you kind of start to think, you get used to the fact, you are going to die' (Liam - Pg 6, Line 302)

There were also many descriptions of traumatic events experienced during tours. These included having friends killed by gunshots or IED's, high casualty rates and seeing Afghanistan children who had been killed. One participant described the responsibility he felt for the deaths of soldiers he was in command of:

'...but at the end of the day these were my two guys, they were under my control and I told them "Right this is the way we're going" They went that way and then they got blown up. So regardless of who you are and whoever's telling you, time and time again that "It's not your fault" "It's one of them things that happens" ... They got blown up so that you know what I mean there's no one else to blame but me. And it... that's something that plays on my mind constantly.' (Peter - Pg 9, Line 428-436)

Military Life and Culture

Many participants remarked on the pressures of the military occupation. As well as the high tempo of operational tours experienced, there were difficulties described such as stresses placed on relationships and family life because of moving locations frequently and periods of separation during deployments and training.

'I mean you know service life is stressful as it is. You know it's not just a job where you go to work, do your job and go home and that's it. It is twenty-four hours of it seven days a week. So you've always got that on your head.' (**Robert** – Pg.4, Line 193)

Despite these pressures there were many comments from participants that they loved their occupation or their time in Service. There were descriptions of how military life and training created its own culture and social bonds separate from those in civilian life. A 'them' (civilians) and 'us' (those in Service) mentality was described whereby military training created strong social networks or a 'brotherhood' and a strong identity of who an individual was and where they belonged. It was also described by some, how on leaving Service, individuals lost many of their military friends, had few civilian friends, and in turn felt isolated from their previous life.

'And when I did leave, I did actually think about trying to go back. Even though I had a crap time in Afghanistan, all the time that I've had in the army apart from that was brilliant. It's the best time of my life.' (**Ryan** – Pg.21, Line 1014)

'...it's like when you go through training, they take you... they strip you down so they take all the civilian out of you and they build you up into a military soldier.' (**Peter** – Pg.14, Line 666)

'So you're taught to hate everyone, but the people you work with... it's obviously makes for better fighting soldiers, but in... the way they do that is to say that every single other person in the world is the worstest like piece of dirt. Like civvie scum and all that.' (**John** – Pg. 22, Line 1059-1093)

'I would say band of brothers (when asked about his friends in service), you know, you're like that close aren't you?' (**Tom**, Pg.16, Line 803)

Participants also described a normalised intense drinking culture, which also added to social bonding and identity in Service.

'Soldiers on the whole are ridiculous binge drinkers, either they're in an absolute mess or they don't drink, regular drinking isn't really something that most soldiers do in my experience in sort of 15 years, it is binge drinking to excess' (**Owen** - Pg.8, Line 407)

Lastly a macho military culture was described where aggression, strength and bravado were common features, and individuals' understanding of their roles in service were combined with masculine understandings of what it was to be a soldier.

'... in the infantry it is a complete macho environment' (**Owen** - Pg.11, Line 591)

'... you're not meant to just be physically hard, you're meant to be mentally hard as well.' (**Peter** – Pg.9, Line 440)

'Marines you're seen as a ... how shall I put this. It's like a bunch of arsenal has been put together' (Carl – Pg.14, Line 755)

'... but you know there is a lot of bravado, you wouldn't see many officers for example admitting for example they are stressed or overworked you know' (Edward - Pg.5, Line 241)

Causes of problems experienced

Participants detailed what they believed their problems were related to, some of these causes were military specific, but many also reflected issues experienced in normal daily life, these included:

- Deployment
- Transition to civilian life
- Bullying in service
- Relationship breakup
- Relationship, family difficulties
- Work pressures
- Unhappiness in job
- Personal finances

Symptoms experienced

Participants were asked how they had realised they were experiencing a stress, emotional or alcohol problem. The most common two symptoms or behavior changes described was heightened aggression and heavy drinking. Another very common feature were descriptions by participants that their personalities had changed from being happy to an array of negative descriptions.

'... I was drinking a lot and things like that. Drinking too much to be honest with you affected the relationship I was in at the time. You know I was drinking until I was out of control and you know... You know I wasn't as happy-go-lucky as I once was.'
(Gary - Pg.2, Line 67)

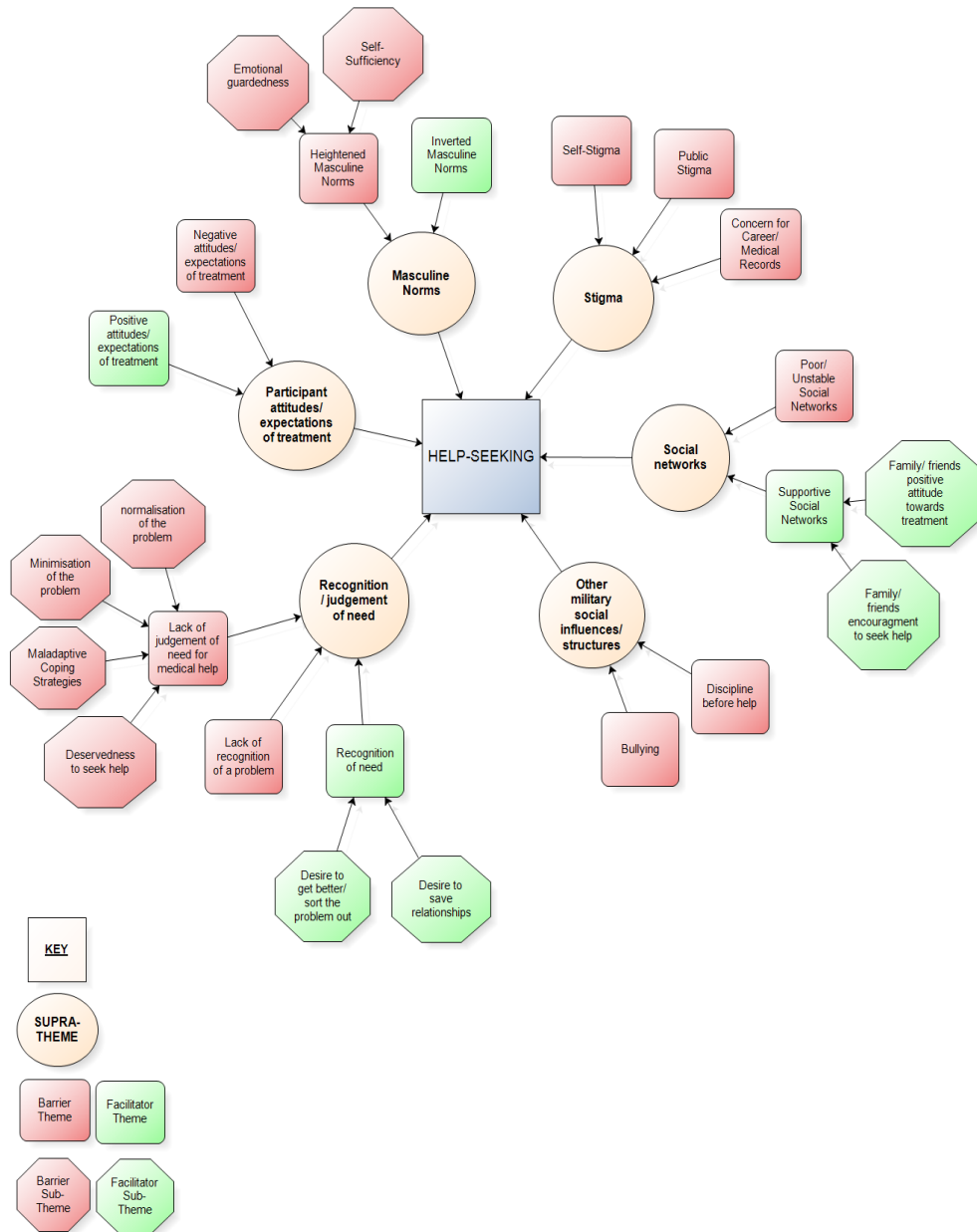
'... because until I got back from Afghanistan I'd never actually felt that sort of anger. It was really weird like my blood was just boiling and the slightest little thing that somebody could say to me would just tip me over the edge and I would actually notice half way through screaming at somebody that 'Oh my God! What... this isn't me!' (Ryan – Pg.8, Line 380)

4.1.4 Help-Seeking Summary Model

Barriers to help-seeking were widely evident across both help-seeking and non-help-seeking groups. All participants reported multiple and interacting barriers. Some barriers reflected military specific barriers that negatively affected help-seeking for those both in Service and ex-Service, however some barriers reflected issues that potentially could be experienced in the general population. All barriers were also influenced by the military experience and behaviours learnt in Service that endured into civilian life. Facilitators of help-seeking in the help-seeking group were described infrequently and the quality and success of help-seeking in terms of engagement with treatment was relatively poor.

Figure 13, 'Qualitative Study 1 – Detailed Theme Model' provides a diagrammatic overview of themes generated from this study. It presents the largest or most important, sub-themes that feed into overall themes that finally feed into overall supra-themes.

Figure 13 – Qualitative Study One – Detailed Theme Model



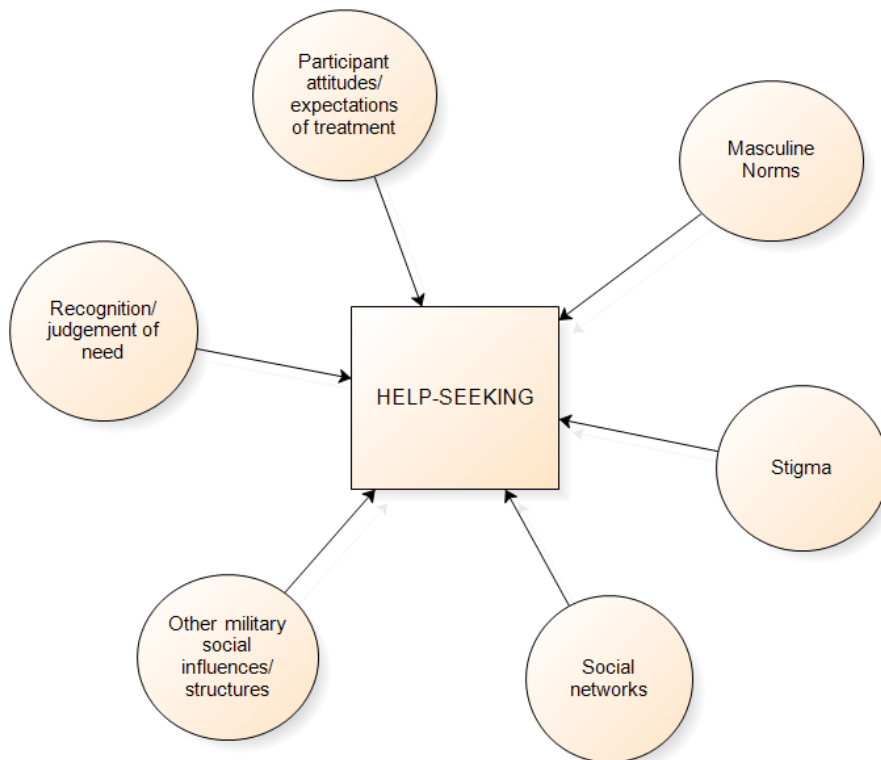
When summarising themes up to their highest level, both barriers and facilitators of help-seeking fall into six groups. Some barriers to help-seeking have a mirror opposite facilitator of help-seeking. For example the theme, ‘Unstable/poor social networks’ is mirrored by the facilitator theme of ‘Supportive social networks’. The supra-themes included:

- Recognition/judgement of need
- Stigma

- Masculine norms
- Social networks
- Participants attitudes or expectations toward mental health treatment
- Military social influences/structures

An overview of these supra-themes is depicted in Figure 14.

Figure 14 – King’s Cohort Supra-Themes Overview



4.1.5 Help-Seeking Barrier and Facilitator Themes

The proceeding sections present the detailed results of different themes highlighted in Figure 13. For a numerical overview of the themes please see Appendix 10. This table includes quick reference to the definition of themes and provides information on the number of non-help-seeking and help-seeking participants that made reference to a theme. The table also provides information on how many times overall a theme was accumulatively mentioned by participants.

4.1.6 Supra-Theme – Recognition/judgement of need

This supra-theme encapsulates the notion that whether an individual recognises their problem or not, is key in terms of help-seeking. Many individuals in this qualitative study simply did not recognise they had a problem and therefore help-seeking was never an option explored. Additionally this theme encapsulates whether an individual, on recognising they have a problem, also recognise that they may need professional help. This theme highlights that simple recognition of a problem does not necessarily precipitate help-seeking. Whether an individual judges their problem to be one that needs professional help, is key in terms of influencing whether participants sought help or not.

Barrier Theme - Lack of Recognition of a problem

Within this theme, participants had endorsed they were experiencing a stress, emotional or alcohol problem, however when asked in hindsight about points of recognition or realisation of their problem, participants described how for periods before this, they did not believe anything was wrong, despite experiencing symptoms of mental health problems. Seeking help with a professional was therefore never a primary line of thought they entertained. **4/10** non-help-seekers and **4/6** help-seekers referenced a lack of recognition of their problem at some point in their help-seeking pathway.

Steven, a non-help-seeker, when asked about how he realised he was experiencing a stress or emotional problem, described first experiencing physical symptoms such as heart palpitations and therefore had believed for a time that his problem was physical rather than mental:

‘to me in my head there was nothing wrong, it was just my body felt weird, I felt that I was having a heart attack’ (Pg. 3, Line 109)

Owen, a non-help-seeker, describes different occasions where incidents happened after his deployment in terms of fights, extreme aggression and lack of enjoyment in his job, however

he did not currently believe anything was wrong and therefore he was not going to seek help with a doctor:

'I never thought, apart of the reports written from that problem said that they believed I had PTSD... then saw the Commanding Officer for a telling off he told me he wants me to see a professional, and I said OK Sir, but I never have, I don't see the need to, I don't think there is anything wrong with me whatsoever' (Pg. 7, Line 331)

Peter, a help-seeker, described a battle with himself in recognising his problem before he eventually sought help:

'It plays on your mind that you're thinking 'Well there's nowt wrong with you, just get on with it' and just try and bury it'. (Pg.6, Line 292)

In terms of the reasons discussed for the difficulty in recognising a problem, participants cited the busy nature of life in Service which interrupted time for self-reflection or served as a way for some to ignore some of the problems they were experiencing.

'... if you were busy you wouldn't even notice it [symptoms of stress]. You know what I mean like. If you were... imagine if I'd stayed in the army like, how the hell would you... you wouldn't have the time. It's like quiet now I go back and you know I've got really no pressure... going like why am I getting stressed out? (Jake, help-seeker, Pg.18, Line 866)

'...well I think when I was in the army, one you don't really recognise it... but no you didn't really recognise it at the time just swept up on the conveyor belt' (Edward, non-help-seeker, Pg.4, Line 170)

This was also combined with participants own thoughts on the difficulty they had in self-examination and understanding their own behaviour at the time when symptoms of mental health problems were manifesting:

'As I said I'd walk off and just get some quiet time by myself and at that time you sit down and think 'What the hell is happening? Why am I doing this? What's...? You were questioning why I've reacted that way and then you start sort of hunting for the reason.' (Robert, help-seeker, Pg.4, Line 175)

Overall an important barrier to seeking help was participants simply not recognising that they had a problem and not relating behaviour changes or symptoms experienced as something that would indicate that they had a mental health problem.

Barrier Theme – Lack of judgement of need for professional/medical help

This theme describes how participants whilst endorsing their current experience of a stress, emotional or alcohol problem, then justified or explained the reasons why they didn't need to seek medical help. Much of this explanation is based on the judgement of their own need and the tactics employed, consciously or unconsciously, to cope with and manage their problem without seeking professional help. This theme does not describe or include individuals who deny they have a problem at all. The sub-themes that create this theme include: minimisation of the problem, normalisation of the problem, deservedness to seek help and maladaptive coping strategies. Overall **10/10** non-help-seekers and **6/6** help-seekers all referenced this theme. This theme was mentioned the most times by participants (284 times), compared to any other theme in this study.

Barrier Sub-theme - Minimisation of the Problem

This sub-theme describes how participants qualify the size of the problem they are experiencing to be minor. Therefore in judgement of their own need, participants concluded that they did not need to seek professional/medical help for problems that were small. The minimisation of their problem stands in stark contrast to the severity of symptoms and function described by participants and the selection criteria used by the mental health screening measures. **7/10** non-help-seekers and **4/6** help-seekers referenced this sub-theme.

John (non-help-seeker): *'Because to me it's not too big a thing like because I've been to Iraq and all that and I'm a bit more nervous now and yeah I get you know... weird dreams and all that, but to me... and everyone keeps telling me that it's a big thing and like I've changed so much. But I don't see it as a problem really.'* (Pg. 11, line 536)

Jake, a help-seeker, when asked what his problem was related to responded:

'That's related to the anxiety, just anxiety really and kind of not serious. I wouldn't say this is something serious that would ruin my life or change it.' (Pg.2, line 90)

However **Jake** goes on to describe in his interview how he had experienced panic attacks over the last six months, was unable to sleep, experiencing heightened aggression, hyper-arousal and a decreased ability to cope with stress. This seemed to stand in contrast to the judgment he made on the severity of his problem.

Steven, a non-help-seeker, described his problem as being in the *'low category'* (Pg.1, line 4&8) he described how he was diagnosed with PTSD a few years before, after experiencing

panic attacks that severely limited his functioning. He then described how he currently experienced adrenaline rushes, anxiety and interrupted sleep patterns, however he remarked:

'in comparison to what I was like a while ago, PTSD, I suppose, it's a controllable anxiety' (Pg.1, line 30).

Steven goes on to explain that he has not sought help because he felt he was in a better state than he was previously.

Overall barriers to care were created when individuals minimised the extent of their problem that resulted in them underestimating their own need to seek professional/medical help.

Barrier Sub-theme - Normalisation of the Problem

This sub-theme describes participants' judgement of need in relation to the extent they believe that their problems are normal, everyday life stresses, that everyone experiences. In this case participants do not seek help because they do not count their problems as something over and above what other people have to deal with in life. Within this sub-theme is also a tacit acceptance by the participant that this is just the way their life is and therefore their problems are also normal for them. Whilst this sub-theme includes ideas of minimisation of the problem, the key difference is that participants' achieve their judgement of need through normalising their experiences and symptoms. **9/10** non-help-seekers and **2/6** help-seekers referenced this sub-theme.

Tom, a non-help-seeker, was asked to give brief details on the problem he was experiencing; he described getting wound up easily, combined with aggression and drinking heavily. He went on to normalise each of these problems in relation to army culture and stresses that were normal for people in the army:

'Like the aggression, but that's just life in the army, isn't it?' (Pg.4, line 154)

'Yeah I could drink way too much yeah, I know. Everyone in the army's just like that...' (Pg. 5, line 241)

'I mean everyone probably gets stressed out like me...' (Pg.15, line 742)

'Anybody whose looking at me would say "That's life... everyone gets stressed out".' (Pg.22, line 1077)

Edward, a non-help-seeker, describes the main stress he is experiencing to be related to work. When asked about why he hadn't sought medical help, one of the reasons offered is a

normalisation of the work stress experienced throughout his career, as well as demonstrating an acceptance that this is what he expects from life:

'I don't know, 14 years, 15 years, being stressed and busy and all that sort of stuff is part and parcel of life, and subconsciously that's what I expect life to be like' (Pg. 6, line 303)

Alex, a non-help-seeker, describes in his interview how his stress and aggression has arisen from the change to 'Civvy' life from leaving Service, and the work pressure or work insecurities the 'Civvy' job market brings with it. He describes several times how the stress he experiences is normal and not a medical issue:

'I don't see it as a big problem. You see that's how I see. I think I'm normal' (Pg.9, Line 427)

'It's not really a medical issue, it's something that can be solved with one or two jobs' (Pg.16, Line 796)

In the context of **Alex's** friends discussing with him his personality change, **Alex** commented:

'They tell me [talking to him about his problem] and I think 'No I don't see anything wrong with that it's normal.' (Pg.5, Line 240)

Lastly both **John** and **Gary** (both non-help-seekers) who were case positive on all the mental health screening measures, normalise their symptoms in relation to their own personalities and therefore rationalised why there wasn't a need to seek medical help:

John: *'But I have like dreams and nightmares and stuff sometimes, but it's nothing to do with anyone else. It's just me and that's just the way I am'* (Pg.17, Line 816)

Gary: *'I feel like I said I'm a bit of a bad tempered bugger like now. But you know I think that's because I'm thirty and I'm growing... I think it must be... you know having no patience and being grumpy is probably easy to explain. But it could be hereditary as well, my dad's a bit grumpy'* (Pg.7, Line 319)

Barrier Sub-theme - Deservedness to seek Help

This sub-theme describes how participants' judgement of need for professional help is based on their own view of their deservedness to seek help. This judgement is usually made in comparison to military colleagues who they deem to have experienced worse events and therefore assess their current problem not deserving of attention. **6/10** non-help-seekers and **3/6** help-seekers referenced this sub-theme.

Gary, a non-help-seeker, referred to his deservedness to seek help;

'I felt... personally I felt like I wasn't worthy of the you know... not the treatment and what have you, but you know I didn't feel that what my experience was severe enough to warrant going down that route... That's how I look at it. Because you know even though I was in a difficult location, you know we're getting mortared every day and you know people getting hurt and stuff. I felt that there were people in a much worse situation than I was in and that.' (Pg.7, Line 350)

Alex, a non-help-seeker who scored the highest score on the GAD-2, suggestive of a possible anxiety or panic disorder, explained how his problem was not a big problem and goes on to relate this to others in the military worse off than him:

'Some of these guys they will join the army at the age of sixteen and they have haven't seen anything yet. So I think this is more of a problem than mine.' (Pg.9, line 453)

Mark, a help-seeker, described how he had received a leaflet from an Armed Forces charity with a help number and had thought about using the number, however he didn't in the end and remarked:

'I'd also thought at the back of the my mind there's people out there that have seen more, done more, are in a worse state than I am... there's always somebody worse than me sort of scenario so let them have it [the medical care]' (Pg.9-10, Line 454-466)

Ben, also a help-seeker, recalled that he had put off help-seeking for a long while, one of the reasons he states for this delay was comparing his need to others:

'I feel there's other people that need help more than I do, and I don't really feel that my situation is terribly awful. I mean I can get through things, but there's a lot of things I'd like to do that I don't do' (Pg.7, Line 287)

Barrier Sub-theme - Maladaptive Coping Strategies

Participants described many maladaptive coping strategies that enabled them to manage or avoid, and therefore cope with their mental and physical health symptoms associated with their problem. These strategies allowed the participants to ignore psychological distress they were experiencing and in doing so meant individuals believed they were coping with their problems and therefore did not need to seek help. In help-seekers these maladaptive coping strategies may have delayed professional/medical help-seeking. The most commonly

described maladaptive coping strategies included, heavy drinking, emotional avoidance and social avoidance. **8/10** non-help-seekers and **6/6** help-seekers referenced this sub-theme.

Participants regularly described trying to avoid thinking about some of the problems they were experiencing:

Edward (non-help-seeker): *'you try not to, I don't know, subconsciously find myself deliberately not trying to think about it'* (Pg.6, line 309)

Gary (non-help-seeker): *'...I don't dwell on it anymore or I try not to'* (Pg. 4, line 167)

There was also a distinct worry identified by participants that if they did seek help, they would have to discuss their problems, which might bring up memories or emotions that would make them feel worse. Hence participants wanted to avoid this possibility and therefore did not seek help or declined treatment. For example **Ryan**, a help-seeker, was offered counselling by his GP, however he turned down the treatment twice commenting:

'Again it would have just wound me up. I think for me personally the best thing that I could have done is just to try and forget about everything that happened...But you sort of dredge it all up, would just wind me up even more!' (Pg.14, line 696)

Liam (non-help-seeker): *'I'm getting along and obviously I have down days but obviously if I got someone involved emotion might get brought up and end up feeling even worse.'* (Pg.2, line 64)

Gary, a non-help-seeker when asked about talking to a medical professional about his problem replied:

'...to be honest with you... I don't know how I'd benefit from dredging up the past.' (Pg.12, line 574)

Heavy alcohol consumption was often described as a way to escape dealing with issues and emotions:

Mark (help-seeker): *'I went on the self-destructive route with alcohol, lot of alcohol and maybe four or five in the morning. Get up, have a bit more, a few more drinks but then some nights I would come in and say 'What the hell am I doing?... and then go out at maybe three in the morning for a run...Because I wasn't sleeping and I'm thinking 'This is ridiculous!...So I was up at all hours, any time of the day I was either drinking or going on a gym spree...'* (Pg.11, line 558)

Robert (help-seeker): *'so in my situation at the peak of its time the issues I was having I was like drinking a lot and I was like heavily into just sort of trying to forget everything just by getting drunk.'* (Pg.14, line 670)

Social avoidance and withdrawal were other tactics used by participants to cope with the symptoms they were experiencing:

Ben (help-seeker): *'I think I'd adapted my life to live around it and it's only... I've been with my girlfriend for about a year and a half now... But she says a lot of the things I sort of do aren't normal and aren't sort of healthy... And if we're out at night sort of thing, and there's people coming and I'll sort of hide until they've gone, and things like that.'* (Pg.12, line 520)

John (non-help-seeker): *'but the thing now I've figured... to counteract sort of violence and stuff, I've become more of a recluse.'*

Overall maladaptive coping strategies were a barrier to help-seeking and treatment in that they enabled the individual to manage their problems, albeit often in unhealthy ways, that allowed them to cope and function to a certain extent in their daily lives. This delayed intentions of help-seeking, as individuals could avoid addressing symptoms and emotions and judged their ability to cope as evidence that they did not need to seek help.

Facilitator Theme: Recognition of need

This theme describes how help-seeking participants were able to seek help when they recognised their own need and recognised that the problem they were experiencing warranted seeking professional/medical help. This facilitator theme, mirrors the opposite theme, 'Lack of recognition/judgement of need'. Under this theme sit the sub-themes, 'Desire to get better/sort the problem out' and 'Desire to save relationships'. The participants 'desire to get better' or a wish to 'sort the problem out' were sometimes precipitated by participants reaching a point that brought to the fore the severity of their problem in terms of their own daily functioning or the effect on their family and children. Often participants' recognition of need was, in part, precipitated by spouses, family or friends identifying to them that they believed there was a need to seek medical help. Within this theme participants have moved on from their previous acceptance of the status quo and coping their life, with a realisation that their health and lives can be lived differently and with an understanding that professional/medical treatment might help them to improve their situation. This theme and the associated sub-themes were not discussed by any non-help-seekers. Overall 4/6 help-seekers referenced this theme.

Facilitator Sub-theme – Desire to get better or sort the problem out

This theme encapsulates participants' rejection of the status quo and their desires to improve their health and their current living situations with a recognition that help-seeking could provide the support that they need. This theme also demonstrates the help-seeking decision process as a weighing scale where participants weight up the costs and benefits of seeking help. The impetus to change their situation acts as a catalyst to override other concerns or barriers to help-seeking. This sub-theme was not identified within the non-help-seeking group. **0/10** non-help-seekers and **4/6** help-seekers referenced this sub-theme.

Robert: *'I mean you sit down and you weight up the pros and cons and the pros definitely outweigh the cons, you know. And I could be tagged with that domestic violence person, I didn't care about that as long as I got it sorted. And you know I could show people that I'm not just someone that shy's away from any problems I have. I will seek help and sort it out'* (Pg.6, Line 281)

Jake describes how contemplation of the problems he was experiencing (panic attacks, hyper arousal) and his time in Afghanistan, helped him to understand why these issues might have arisen, which in turn engendered the idea that the issues might be able to be dealt with or it would be detrimental to his health in the long-term:

'Then you kind of see it. And then you kind of realise why and so then maybe I should go and talk or whatever because that will get rid of it'. (Pg.17, Line 859)

'I think if you identify these things you've got to kind of deal with them or whatever. Otherwise it's like carrying round a splinter' (Pg.19, Line 924)

Ben also commented on his desire to improve his current situation:

'Well I'm sort of in two minds about it. But I'm willing to go and speak to someone... and I would like to be in a better position...' (Pg.12, Line 490)

'And the thing that really motivated me to do it [seek help], was a lot of things that my brother would like to do, that we'd like to do together, and my girlfriend, and I don't want to sort of hold her back from not doing things with her.' (Pg.7, Line 295)

Facilitator Sub-theme - Desire to save relationships

This theme highlights the process of recognition of need through participants' relationships with spouses/partners. In this theme participants come to the realisation that their behaviour has a detrimental and possibly a terminal effect on the future of their relationship. Alternatively, participants' spouses/partners discussed with them the negative effect of their behaviour. Lastly, ultimatums were issued by spouses/partners that if they didn't change or seek help, then they could not continue in the relationship. These situations caused

participants to move from the status quo, to a place where they needed to sort out their problem in an attempt to save the future of relationships that were important to them. Again this facilitator sub-theme was not discussed by non-help-seekers. **0/10** non-help-seekers and **2/6** help-seekers referenced this theme.

Robert was asked what was the most important thing in enabling him to seek help, he responded:

'Just the relationship between my wife and I. It got to the point where I valued... I actually did value that more than my job, so if I lost my job but kept my wife then that was... so be it sort of thing' (Pg.16, Line 806)

Peter's spouse had discussed with him the effect of his behaviour, which caused **Peter** to think about the future of his family life:

'And that like brought a light to me thinking 'I need to see someone, I need to get some sort of balance to... You know that so that you don't ruin another relationship. It doesn't and not only that I've got two young boys and I don't want my problems to inflict on them. Especially when I'm out of army. And I don't want them to think that I'm a bad dad. I don't want them to you know have to go through me being horrible to them or anything like that.' (Pg.7, Line 337)

In summary, the supra-theme recognition/judgement of need and its associated barrier and facilitator themes and sub-themes, highlights the importance of individuals recognising that they have a problem, judging their problem to be one that needs professional/medical help and lastly having facilitators of help-seeking that move them from the status quo to a position where they wish to improve their situation and health by seeking professional/medical help.

4.1.7 Supra-Theme – Stigma

This supra-theme encapsulates participants' references to the stigma of mental health problems as a barrier to help-seeking. This supra-theme includes the barrier themes of 'public/anticipated stigma', 'self-stigma' and 'concern for career and medical records'. It includes participant's references to stigmatising beliefs concerning the effect of disclosing a mental health problem on their career and medical records. There was no concurrent facilitating theme that mirrored the barrier of stigma. Overall when participant references to these themes were aggregated, all non-help-seekers (10/10) and help-seekers (6/6) discussed issues relating to stigma. Stigma was the second most referenced theme out of all the themes in this study with 196 references made overall. Non-help-seekers made 133 of these references and help-seekers 63 references.

Barrier Theme – Public/Anticipated Stigma

In this barrier theme the participant described a barrier to care as being the anticipated effect of public stigma for seeking help for mental health problems from family, friends, colleagues, and doctors. This theme includes a desire from participants not to be labelled as 'mad', 'bad' (in relation to domestic violence or a 'bad soldier', including cowardice), 'lying' (about having a problem), or be labelled as 'weak' by others. It also includes participants own stigmatising beliefs that they held about people with mental health problems. All non-help-seeking (10/10) and help-seeking (6/6) participants made reference to anticipated public stigma.

Participants were particularly concerned about what other people, their friends, family and colleagues would think or say about them if they sought help for a mental health problem. Additionally participants did not want to be treated differently by others, which became a barrier to disclosing a problem or seeking help. When I asked **Mark** (a help-seeker) whether there had been anything that put him off seeking help he replied:

'The biggest thing is obviously it's being judged by others' (Pg.14, Line 670).

Gary (a non-help-seeker) was also concerned about his colleague's perceptions of him:

'I didn't want to go to the MO or anything because you know what the forces are like, people gossip. I didn't want it to affect like promotion or what my peers' perception was of me' (Pg.6, Line 302).

Jake (a help-seeker) who had left Service, also did not want his help-seeking disclosed to friends because of anticipated stigma:

'I mean you know mental ill health has a stigma about it, you know, itself. So to be... seen to be not sort of normal mentally has a potential potentially... you know this is just the norm isn't it ... and if you aren't in the normal then you're outside and there's a bit of stigma about it. (Pg.13, Line 625)

'...certainly your mates it could affect how they see you and stuff like that... But they'd look down on you, they'd feel sorry for you probably. I'm sure they're pretty good at looking after PTSD, the army and navy. But it's still not the kind of thing you'd want to do if you could avoid it.' (Pg.13-14, Line 658-666)

Throughout the interviews participants emphasised the desire not to be labelled by others. Participants wanted to avoid being marked as 'mad' or 'dangerous':

Gary, (non-help-seeker): *'I didn't want people thinking I was a bloody nutcase! Like my friends, do you know what I mean? I didn't want... you don't want your innermost... you know what the army's like? You know what the army's like with going sick? You know there's stigma of people going sick. If you were to say "I'm going sick" you know "Why?" "Oh, I'm going to go and see the head doctor" "Oh right OK" It's like "We've got one of those!"'* (Pg.8, Line 372)

John, (non-help-seeker): *'Going to see a mental health professional is like, "That guys nuts!"... So just that would be another thing that I probably wouldn't do it for [seek help for].'* (Pg.14, Line 697-702)

John also described how he didn't want his friends or family's opinion to change of him, and when asked what his close friends and family would think if he sought medical help, he responded:

'It would turn me into like a person that people would be afraid of probably. Because of the command I have, you know that that's person's seen seeking mental help would probably scare some people' (Pg.15, Line 723)

John then gave the analogy of the worry people might have around him:

'Yeah, like even like a dog... even though you know the dog's perfectly nice and it gets on great, but you wouldn't leave it in a room with a kid just in case.' (Pg.16, Line 781).

Some participants explained that they wanted to avoid being labelled as a violent person, a bad soldier or a coward and therefore explained why they or others were put off seeking help:

'that sort of that whole thing of being tagged with you know the... There's a big thing about domestic violence here and it's not just the physical side of it, it's the verbal side as well and mental side. And I just didn't want to get tagged with that type of you know that personality.' (**Robert**, help-seeker, Pg.6, Line 265)

Owen (a non-help-seeker) explained to me where the stigma of seeking help for mental health problems came from. He related this to previous individuals who had sought help, which had given help-seeking for mental health problems a 'bad name', because these previous men in his (and others) opinions were bad soldiers or cowards:

'... the stigma is is that some of the most appalling soldiers we've had, the constant cases, people who are always in trouble, people who aren't very good soldiers in the first place, that is I'm sorry, the people who go and see the community psychiatric nurse and get signed off work for months on end, and get full pay, and not be in work and people have to cover their guard duties etc etc , 'whereas he [the good soldier who needs help] doesn't want to go see a CPN because she'll rattle off the names of blokes who have been to the CPN, who were never good soldiers in the first place' (Pg.8, Line 400)

Owen went on to describe an example of this,

'I'll give you an example again from erm, that is still talked about, we have a Sergeant, who to all intensive purposes was a coward, didn't want to be there, didn't want to do the job... he then went on his RnR, his platoon commander was killed... he refused to come back, um we were all taking bets and joking that he wouldn't come back when he left... he went to a CPN, and he was kept in the army and this and that and his name is now used as an example, oh you're like him are you...and that just created a huge stigma, because the man was a coward and therefore there was a link of cowardice attached to a mental health problem.' (Pg.14, Line 751)

Other participants when asked why they hadn't sought help or what things put them off seeking help described help-seeking as a sign of weakness and did not want to be labelled as such:

'because you're meant to be like I say hard in head and hard in hand. It's like people almost think 'Oh he's weak as hell' (**Peter**, help-seeker, Pg.13, Line 656)

'you know it'd probably just be the stigma of it and being a young lad you don't want to show any weakness do you?' (**Gary**, non-help-seeker, Pg.12-13, Line 607)

Edward, (non-help-seeker): *'... so you know I would see it very much as a weakness to see a doctor'* (Pg.4, Line 182), *'and people look at you and that would be seen as a huge weakness if the boss had a wobble'* (Pg.8, Line 423), *'They [colleagues] would look at it as a weakness, there is that stigma to it'* (Pg.9, Line 457)

There was also the continued assertion from **Edward** that individuals may be lying about their mental health problem to get out of work or military employment, and therefore he didn't want to seek help so he could avoid being lumped in this same group:

'... there is a reason I don't do anything about it now is probably an element of self pride, one of the frustrations I have at work is people who go off for stress you know and for every 10 people only one's probably genuinely got it, unfortunately people abuse it, and so I think it's got quite a stigma attached to it and I certainly wouldn't want to tar myself entirely with that same brush' (Pg.4, Line 178)

'back in the day people used to pretend to be gay because you weren't allowed to be in the military and gay, but then they let them in, I guess the natural progression is, ok what is the next best way to get out is pretend to be stressed or depression and pretend to commit suicide' (Pg.6, Line 278)

Barrier Theme - Self-Stigma

This barrier theme captures where participants voiced self-stigmatising personal beliefs. These beliefs demonstrated some level of personal acceptance of the characteristics of negative mental health stereotypes and attributed them to themselves. This barrier theme includes references where participants described a lack of self-efficacy or self-worth because of their problem, and therefore these negative views about themselves acted as barriers to seeking help. **9/10** non-help-seekers and **5/6** help-seekers made reference to self-stigma.

Peter (help-seeker) remarked: *'A big thing with the army is that I feel sometimes that you've got to hide it because you've just got to get on with it. If you highlight a problem, it feels almost as if everyone's looking at you saying "He's a problem", "He's a problem child", "He's a problem case" You know and it almost makes you feel like scum. Like that's the sort of outlook that they put on you, it makes you feel like you're a lesser person.'* (Pg.13, Line 641)

Gary's lack of self-worth and embarrassment had prevented him from help-seeking:

'But basically what it was, I didn't feel at the time worthy of... and you know also felt embarrassed that I'd have sort of seeked help. I would have felt like a bit of a maggot if you know what I mean?' (Pg.3, Line 119)

Ryan and **Carl** both described feeling weak needing to seek help:

Ryan (help-seeker): *'Oh I just thought it was sort of a weakness, me a fully grown man in the doctors crying like a baby.'* (Pg.11, Line 547)

Carl (non-help-seeker): *'Well you know it may feel as being weak [individuals seeking help in service] to be honest for a start. You know it's something that's looked down on'* (Pg.14, Line 750)

Lastly **Owen** (non-help-seeker) would have counted help-seeking as a weakness in himself and therefore it was not an option he would have considered;

'...I wouldn't want them to see I couldn't cope with something, I would see that in myself as a personal weakness' (Pg.12, Line 627)

Barrier Theme - Concern about Career and Medical Records

This barrier theme includes participants' concerns about seeking help for a mental health problem and the negative impact they believe it would have on their careers. Participants also described the desire not to have their mental health problem retained on their medical records which they felt would negatively affect their career prospects in the future. These beliefs were set in the background of anticipated stigma and anticipated discrimination that they believed might be a potential result of disclosure of their mental health problem. **9/10** non-help-seekers and **4/6** help-seekers made reference to concern about career or medical records.

Robert (help-seeker) described how there was a general fear in Service over medical discharges particularly in light of Armed Forces restructuring and redundancies. He also went on to cite one example where a friend was medically discharged for a mental health problem:

'Well certainly the military environment. Everyone is protective over their job. They, you know, a lot of people will not seek medical help even for the smallest ailment because you know a lot of people can be in fear that they can be medically discharged for any reason. And it's getting more... especially now they're drawing down the manpower numbers. A lot of people think that all they'll need is one small reason to get rid of you and they'll get rid of you.' (Pg.15, Line 709)

'You know there's been a friend of mine... he was unable to carry out any of his duties that involved holding a live armed rifle because he'd had a mental illness. And that was under observation and eventually he got discharged from the air force, medically discharged.' (Pg.16, Line 790)

John (ex-Service) and **Owen** (in Service) both non-help-seekers wanted to avoid seeing the doctor, as they were concerned of being signed off work, and being excluded from employment:

'I don't want to be sort of written off as a... because that would be devastating for me. I've got to work you know what I mean?', 'and is that kind of a real fear that you know... so you've got your work and you enjoy kind of working hard and the fear that it might you know, if you went to the doctor, kind of you don't want to get signed off or you don't want to be' (John, Pg.10, Line 504)

'But, it would put me off going to see somebody if they were to then sign me off work and then people think well whatever we do we can't send him on operations again, people would think we can't send him on ops' (Owen, Pg.12, Line 635)

Tom, a non-help-seeker who had left Service, was also concerned that if he sought help, he would have to disclose this to his employers and that could mean losing his job:

'Plus you'd got to explain to your work, people and your bosses in work. And the company I work for, they won't think twice of getting rid of you' (Pg.8, Line 397). 'One of the blokes he had actual counselling you know. And six months later they got rid of him' (Pg.9, Line 408)

Many participants when asked why they hadn't sought help for their problem commented on the concerns they had that it would have affected promotion prospects:

'...you know stuff like that could affect your promotion as well, as you... but if you've got issues stopping you from being promoted so... you know how can you lead, You know if you've got obvious problems...' (Carl, non-help-seeker, Pg.15-16, Line 821)

'I didn't want it to affect like promotion' (Gary, non-help-seeker, Pg.6, Line 303)

'if he takes time out for a problem [a soldier with a mental health problem], it will in effect, it will be a career break, if he's junior and he's not quite right, I'll say right, you're not quite right, you're not really fit, look have a break, go away and do recruiting for 6 months, you don't want to promote in that six months, other people will then get ahead of him, he'll come back probably when I am probably no longer there, regain the trust, we're now talking a year, 18 months, two years and it's the career that suffers.' 'it will affect their career and it will affect their, I won't say career, I'll say immediate chance of promotion' (Owen, non-help-seeker, Pg.13, Line 701)

Edward, (non-help-seeker): *'...you know I wouldn't do it, you'd limit your career', (Pg.8, Line 385) 'when it came to the promotion board you wouldn't be surprised when you didn't get the top profile job, because you couldn't hack the pressure of the job before sort of thing' (Pg.8, Line 394), 'the unspoken word is that it would be career limiting...you wouldn't put someone in charge of a brigade if they'd had a wobble from an operation a few years before.' (Pg.8, Line 399)*

Many participants also explained that they did not want mental health problems or associated medication, marked on their medical records, as they believed it would have a detrimental effect on future job prospects:

'Anything you want you go to see the GP it immediately goes on your record, and that can be a problem as well because they are jobs and other stuffs like that and people can see your GP report' (Alex, non-help-seeker, Pg.7, Line 309)

'I didn't want anti-depressants on my record anyway' (Pg.9, Line 442), 'there are certain roles that I've looked in services that would still check stuff like that on your medical records' (Steven, non-help-seeker, Pg.12, Line 630)

Finally, **Peter** (help-seeker) believed this information on his records could be used against him:

'You know it'd be on my med records and then Court asking for my med records and seeing if I'm you know mentally stable enough to have the children' (Pg.4, Line 180)

In summary, the supra-theme of stigma and its associated themes emphasise the concerns individuals had about the effect of disclosing a mental health problem and the concurrent stigma or discrimination that they believed could be experienced as a result of this. Participants highlighted the desire to avoid stigmatising labels from family, friends or colleagues, whilst also voicing the internalisation of this stigma. Participants were concerned that disclosing a mental health problem would negatively affect their career and this therefore influenced them not to seek help.

4.1.8 Supra-Theme – Masculine Norms

This supra-theme covers the concept of masculine norms and how these affect help-seeking behaviours in both negative and positive ways. Masculine norms for the purposes of this supra-theme are defined as dominant western male gender roles that prescribe beliefs about masculine behaviours, which in turn affect individuals' approaches to help-seeking.

Masculine norms may include ideas from western culture that men are strong, should be in control of their emotions and should be able to handle problems self-sufficiently without having to ask for help (O'Neil, 2008, Wester et al., 2012). Within the supra-theme, participants described adherence to dominant male gender roles, behaviours and characteristics. Participants directly or indirectly linked adherence to these masculine norms with their help-seeking behaviours. Masculine norms were found to be both a barrier and facilitator of help-seeking.

Barrier Theme – Heightened Masculine Norms

This theme describes how participants adhered to dominant masculine norms and directly or indirectly linked these beliefs to their lack of help-seeking for the problem they were experiencing. This theme was highly influenced by the male environment of military Service and military training. In this barrier theme, asking for help stood in contradiction to participants' beliefs in terms of what they understood was required of them to be a 'man'. Additionally sub-themes within this theme encapsulate participants' descriptions of the facets of masculine norms such as emotional guardedness (dislike of discussing emotions) and self-sufficiency. **10/10** non-help-seekers and **6/6** of the help-seekers made reference to heightened masculine norms. Heightened masculine norms were referenced 163 times overall, with non-help-seekers discussing this theme 99 times and help-seekers 64 times.

Owen, a non-help-seeker, was asked what his friends/family would think if he sought medical help, he directly related being a man with the ability to cope, where he believed deviation from this would result in others seeing him as weak:

'I wouldn't want anyone to think anything less of me from a man's perspective, I wouldn't want them to see I couldn't cope with something, I would see that in myself as a personal weakness, I wouldn't want anyone to think that of me.' (Pg.12, line 627)

Ryan, a help-seeker, had many examples scattered through his interview of adherence to masculine norms. A background of this culture was reinforced through his friendships and family relationships that influenced his help-seeking. **Ryan** associated talking about

problems (and therefore seeking help) as something that men didn't do and therefore justified why he hadn't sought help earlier when he first experienced problems:

'I don't think it would have helped me at all to just talk about something. I mean I'm not being funny, but it's more of a girl thing I think!' (Pg.19, Line 955), *'... Because blokes don't do that, do they? They just sit there and keep quiet!'* (Pg.20, Line 961)

Ryan also believed that if he had disclosed his problem to his military friends they wouldn't have taken him seriously:

'To be honest most of the time if I'd told any of my mates that I had a time when I was going to do all that sort of stuff and you know talk about my feelings and past events and things like that. They would have just taken the piss and said "Oh you're queer"' (Pg.20, Line 974)

Other non-help-seekers connected help-seeking with weakness or a lack of competency and again did not want others to have a different view of them that deviated from dominant masculine norm, which in turn acted as a barrier to help-seeking:

Gary, (non-help-seeker): *'It was male pride that stopped me going really [to the GP]'* (Pg.7, Line 346);

George, (non-help-seeker): *'I suppose there's a natural resistance to it [help-seeking] from a male perspective'* (Pg.4, Line 185)

John, (non-help-seeker) *'... don't want to be seen to be going to see a doctor as well! ... because my people around me see me as a solid guy'* (Pg.14, Line 680), *'... You know ex-squaddie. You know get the job done. That would go if anyone you know... the stereotype would just ruin...'* (Pg.15, Line 717)

Additionally many participants described masculine norms associated specifically with their identity in military service and what it meant to be in a certain role or branch of the forces.

'It's just the way that it makes you feel like. I'm a combat infantryman. You know we're in front line, we're meant to be hard. And it feels like you're breaking down, it's just feels like you're like you're not that man anymore...' (**Peter**, help-seeker, Pg.6, Line 288)

Interviewer (M-LS): *'So it's quite hard for people to, is it accept? or put your hand up and say hey I need a bit of help? You said it's the pride?'*

Liam (non-help-seeker): *yeah particularly obviously in the Army where you are seen to be strong and then when you get [mental health problems] you're not seen like that, you can't really go back, and takes a long time to think actually yeah I do need help'* (Pg.6, Line 265)

Owen, non-help-seeker: *'I would be very upset for people to know that [if he were to seek help], because I think people would initially think that its weakness, because in*

the infantry it is a complete macho environment and so to admit there is something wrong is, giving up physically at a task is weak, you don't give up and to say and to admit you've got a problem and you can't deal with it, it does feel like you are almost giving up, so it is difficult to do' (Pg.11, Line 590)

Theme - Emotional Guardedness

This theme describes how participants' made reference to how they preferred to keep emotions or problems to themselves. They described their dislike of discussing or disclosing personal feelings or problems and how they put up a guard against others. This theme is closely related to ideals of masculine norms, in that participants believed that men should be stoic and private with their emotions. Emotional guardedness acted as a barrier to help-seeking as it stopped the process of disclosure of talking about mental health problems, and in turn may be interrelated with delays in self-realisation and acceptance of a problem. **9/10** non-help-seekers and **4/6** help-seekers made reference to emotional guardedness.

Mark, a help-seeker, had not disclosed his help-seeking to his family or partner. Whilst it had not stopped him from initially visiting the GP, he had not successfully continued to seek help and described his emotional guardedness in relation to being a man:

'I'm just a typical bloke. I'm just, why should I break down in front of somebody?'
(Pg.14, Line 691)

He also described masculine norms when asked why he hadn't talked to his family about the problems he was experiencing. Here, **Mark's** ideal of a man was providing for and protecting his partner. His wish not to be vulnerable caused him to erect emotional guards which acted against the disclosure of problems:

'... I wouldn't let my guard down either. It's one of these a man should be a man and you're there. I'll provide and protect her [his partner] so if I'm now the vulnerable one...' (Pg.19, Line 926)

Throughout, both non-help-seekers and help-seekers interviews there were references to emotional guardedness that acted as a barrier to disclosure of problems and seeking help:

Ben (help-seeker): *'...I think in general I don't really talk about my emotions that much. Just dealing with it. I'm that sort of person that stays sort of closed'* (Pg.9, Line 358), *'It wouldn't take a lot to put me off... to seeking help. I mean... it would have put me on the defence to see a doctor and talk'* (Pg.20, Line 846)

Edward (non-help-seeker): *'What I find is getting, um, a constant feel that because of the stress, I am always on guard and almost having to put a face on things and you know being very sort of, not defensive as such as snapping at people, but having*

to put a front up that you don't, don't want to let people in, discover your inner weaknesses' (Pg.3, Line 144)

Alex (non-help-seeker): *'I try to keep things to myself' (Pg.7, Line 326), 'But my very, very close friends I don't think I will allow them to get too much into my personal issue' (Pg.13, Line 630)*

Theme - Self Sufficiency

The theme self-sufficiency encapsulates participants desire to cope with problems on their own, without the help of medical professionals and often other people. Sometimes imbued in the idea of self-sufficiency was the notion that the participant did not want to burden people with their problems. The behaviour or personality trait was described across both non-help-seeking and help-seeking groups and acted as a barrier to help-seeking. Some of the reasons for traits of self-sufficiency are bound up in ideas of masculinity that men should be able to deal with problems on their own. All non-help-seekers (10/10) and 5/6 help-seekers made reference to self-sufficiency.

George, a non-help-seeker, was asked why he hadn't gone to see a medical professional regarding his problem, he responded:

'Well I suppose I prefer to deal with these things alone in some ways' (Pg2, line 87), and later remarked: '...and you know I very much see it as for me to get through, and deal with.' (Pg.7, line 313)

Other participants' remarks when asked this question responded:

John (non-help-seeker): *'Well it's that I've sort of learnt to cope with my problems you know.' (Pg.10, line 494)*

Alex (non-help-seeker): *'I just try to cope in myself' (Pg.7, line 325)*

Despite seeking some form of medical help, the help-seeking group still echoed the language of self-sufficiency and the tensions experienced when thinking about their current problem and future help-seeking:

Ben (help-seeker): *'it's just sort of, I like to keep things to myself, and I'm a very private person, and I like to deal with things on my own' (Pg.7, line 278)*

Peter (help-seeker): *'It's like now, I still think I can deal with it myself, but I know that other people are telling me that I have to go out and seek help....' (Pg.15, line 724)*

Embedded within the idea of self-sufficiency was also the participants desire not to burden others with their problems, which acted as a barrier to disclosure and help-seeking:

Tom (non-help-seeker): *'I just think, Yeah basically don't want any hassle... that's all I want... I can do it myself because I'm thinking I don't want to hassle anyone.'* (Pg.11, line 551)

Gary (non-help-seeker): *'...my mum's not sound of mind herself so I wish I couldn't ... I didn't want to burden her with my problems.'* (Pg.6, line 273)

Mark (help-seeker): *'It's difficult for me if my mother found out something like that to be sort of on my case going "Now have you been to see the doctor again?" "When's your next appointment?" "Do you want a lift there?" "Is there anything we can do for you?" It's just that "I'm not physically disabled mum, just leave me alone"... Yeah. I don't want to burden.'* (Pg.16, line 808)

Participants rationalised their situation as one in which they wanted to be self-sufficient and cope with, deal with, or 'fix' the problem on their own. Frequently, this behaviour was associated with emotional guardedness and concepts of masculinity.

Facilitator Theme – Inverted Masculine Norms

This facilitator theme describes how help-seeking participants described and adhered to the same masculine norms as non-help-seeking participants, however, in the case of help-seekers these beliefs and characteristics associated with masculinity were used to positive effect. Participants described how they were propelled to seek help, often describing help-seeking as 'brave' (rather than 'weak') and therefore help-seeking became something that did not interfere with their identity as a man. In turn this facilitated help-seeking behaviour that helped to overcome other barriers to help-seeking. **4/6** help-seekers made reference to masculine norms having positive effect on help-seeking, in contrast, only **1/10** non-help-seeker referenced this theme. There were only seven references in total to this theme, however these inverted masculine norms and use of language when describing help-seeking was important in understanding help-seeking behaviour.

Mark was asked whether there was anything that encouraged him or made it easier to seek help with his GP, he responded:

'... literally sort of growing a pair of balls and said "Actually I need to see somebody"' (Pg. 11, Line 525), *'...Nothing more than just actually manning up to something and saying "I've got to go"'* (Pg.11, Line 530).

Robert's wife had urged him to seek help:

'... you know we both said that I had to have the courage I suppose to go and speak to someone.' (Pg.12, Line 558).

Ryan was asked what he thought his friends thought of him seeking help, he replied:

'I think most people do understand. I mean most people that know about it they say "Oh well done for going" "You're a braver man than I am"' (Pg.17, Line 825).

Peter's problems stemmed from bullying in Service. The action of help-seeking and disclosure of problems, he cites as an action needing strength:

'if people aren't strong enough to talk about it they just... well they'll stay quiet.' (Pg.22, Line 1074)

In all these cases, the language used cites help-seeking as an action that is brave and something that affirms their identity as a man in the military. **Gary**, a non-help-seeker, with hindsight describes help-seeking as an action as one that would have needed 'moral courage':

'... it's probably safe that if I'd had the moral courage to go [to the doctors]... If I'd had had the backbone to go and sort of face my demons at the time...' (Pg.8, Line 405).

In summary, heightened masculine norms that see help-seeking as a brave, masculine activity, invert masculine norms from a barrier, into a facilitator of help-seeking.

Overall participant's adherence to masculine norms, influenced by their military service, was key in determining their behaviour and beliefs about help-seeking in relation to their identity as a man. Heightened masculine norms negatively affected help-seeking whilst inverted masculine norms seeing help-seeking as 'brave', encouraged participants to seek help.

4.1.9 Supra-Theme – Attitudes/expectations towards mental health treatment

This supra-theme encompasses participants' attitudes and expectations towards mental health treatment. These attitudes and expectations acted as barriers or facilitators of help-seeking depending on whether the participant had positive or negative attitudes about mental health treatment. These attitudes or beliefs may be based in the reality of experience or may be perceptions held by participants. These attitudes or expectations covered beliefs about the help-seeking process, the medical profession, medication and recovery prospects.

Barrier Theme – Negative attitudes/expectations towards mental health treatment

This barrier theme collates the incidences where participants noted their negative attitudes or expectations towards mental health treatment, directly or indirectly citing these beliefs as barriers to seeking medical help. **6/6** help-seekers and **8/10** non-help-seekers made over 100 references to negative attitudes/expectations towards mental health treatment. Many participants were apprehensive about the help-seeking process and how they would be treated; this concern elicited a plethora of different negative attitudes towards mental health treatment and help-seeking.

Tom, a non-help-seeker, was worried about disclosing a problem if nothing was wrong with him:

'for me that would be making a step out, and that could be nothing' (Pg.12, Line 581).

Peter, whilst classified as a help-seeker (he had sought help but was only offered sleeping pills for his problem), was worried about disclosing mental health problems in his upcoming medical board (in Service) as he felt he might not be believed, *'like I'm making it up or something like that'* (Pg.8, Line 380), and hence was concerned about seeking further help. **Alex** wanted to avoid his problem being made into a *'serious medical issue'* (Pg.10, Line 485) and believed seeking help would medicalise his problem, which was an outcome he didn't want. **George** felt that seeking medical help was a last resort:

'Something I wouldn't consider at first hand unless things absolutely required it.' (Pg.8, Line 367).

Lastly three help-seekers **Ryan** (ex-Service), **Robert** (in-Service) and **Mark** (Reserve), all commented that they did not believe visits to the Doctor in Service would remain confidential:

'I think it always plays on their minds [individuals in Service, seeking help] because obviously the GP... You can't obviously tell everyone what's going on, but then it can be relayed up to the SMO, the Senior Medical Officer...And then he or she has obviously fingers in both pies....So that's where the crossover happens and that's where most of the barriers they're hard to get over.' (**Robert**, Pg.15, Line 748-759)

'And you're telling them [the Doctor] something very personal and obviously confidentiality, yeah it's there. But do they go home and like most people that are married or have partners, "Well I had such and such on, this person in who did this, this and this" Obviously you don't mention names and stuff, but its... that for me it's still there bothering.' (**Mark**, Pg.15, Line 721)

'they're obviously not allowed to, but... I think an army doctor... I think they would tell somebody' (**Ryan**, Pg.13, Line 631)

Participants also had concerns about treatment or medication. Some participants cited theirs or other people's previous bad experiences with seeking help, which had put them off continuing or initiating medical help-seeking. Some help-seeking individuals had previously been offered medication and were against this route of treatment. **Ben** (ex-Service) noted his desire to seek help only through the military, as he had negative experiences previously in the NHS:

'GP sort of has been a bit baffled by it and he sort of speaks about prescribing anti-depressants and all of that. And I didn't really think that was the way forward.' (Pg.9, Line 373)

John (non-help-seeker) had been assessed for a War Pension and had discussed his nightmares with assessor:

'Well I told the last person I did... as of... in their sessions... she gave me like a list of drugs, like antidepressants or something. I've never even contemplated going to get them' (Pg.17, Line 823).

No further referral or signposting for treatment had been offered to John and he felt that since he had been assessed, and medication was all that was offered, he did not want to seek help any further.

Peter had poor experiences of help-seeking in Service which had created negative views of what mental health treatment could offer:

I didn't find it easy at all to book to see him. And then the way that it made me feel during the time of being "Oh yeah I don't think you're depressed or anything like that, just take some sleeping tablets" just made me think 'Well there's no point in me coming back here'. And the thing is that what made it worse is there were no follow-up to it.' (Pg.6, Line 264)

Participants also had negative views or concerns about the medical profession, which acted as a barrier to help-seeking. **Mark** (help-seeker) and **Alex** (non-help-seeker) both described the doctor as a stranger which put them off seeking help:

'if you can't talk to your family, really so you're going to go to a stranger?' (**Mark**, Pg.14, Line 708).

Other participants did not believe their GP would be able to understand their problem because of their Service history,

'I wouldn't necessarily open up to my GP about it because he's about twelve and he wouldn't have a clue. He wouldn't have the slightest idea you know about what I'm talking about' (**Gary**, non-help-seeker, Pg.11, Line 542)

'it's like I've said before the fear of me going to the doctor and me telling him that I was in Iraq and I was involved in armed conflicts and stuff. You know sort of like and then him not having a clue what that's really like and then just signing me off as "You're a dangerous person" or something like that', 'so I need someone to understand exactly how I am' (**John**, non-help-seeker, Pg.18, Line 886)

Participants also cited their lack of confidence in doctors or felt that their doctors weren't interested in them:

'...you know you go back and you give them this copy [of his military medical records] and they [his NHS GP] are not interested....They don't care.' (**Alex**, Pg.11, Line 522)

'... well because I know people who've gone through this and they've been through similar problems and gone to the doctors because... and they [the doctors] just say "Well what do you want me to do" basically. No one really, wants to help, it's quite hard really...' (**Tom**, Pg.8, Line 371)

'one thing you know, going to a GP, I don't have huge faith in GP's per se...part of it I see as the whole medical system [NHS] being pretty woeful' (**Edward**, Pg.6, Line 300)

Negative beliefs were prevalent in terms of participants' thinking that doctors would not be able to help them. There was either a lack of understanding of what treatment could provide,

or previous participants' attempts to seek help had not improved their situation and therefore put them off further attempts:

Ben, (help-seeker): *'but I don't know to what extent it would change things. I mean I've been twice now'* (Pg.6, Line 238), *'Well I'm sort of reluctant to commit to spending time [seeing a Doctor]... I just don't particularly enjoy it. And I'm not sure what benefit it would have after having it before.'* (Pg.12, Line 497)

John, (non-help-seeker) *'They wrote down what was wrong and they gave me this money [from the Armed Forces Compensation Scheme] and then that's it. There's... So if I went to a doctor again, it's the same thing but... it'd be the same thing surely?'* (Pg.13, Line 632), *'I just don't see what they could possibly bring me'* (Pg.13, Line 659).

'... the way I feel now I don't think that I would get any benefit from going back to the doctor' (**Gary**, non-help-seeker, Pg.7, Line 316)

'I just can't see what they're going to do for me' (**Carl**, non-help-seeker, Pg.9, Line 499)

'I don't really know what they can do to help me' (**Alex**, non-help-seeker, Pg.7, Line 350)

'I don't know, if there is anything anybody can do' (**Steven**, non-help-seeker Pg.11, Line 544)

Additionally some participants were concerned about their treatment outcome or prospect for recovery and so were fearful they might not get better, or hesitant they might waste their time:

'I'm sure it would help, but whether it would actually change the way I sort of avoid feelings and things like that... Whether it would actually have an impact.' (**Ben**, help-seeker, Pg.6, Line 228)

'I was also concerned that if it didn't work [counselling] there was nowhere to go from there' (**George**, non-help-seeker, Pg.5, Line 240)

Facilitator Theme – Positive attitudes/expectations towards mental health treatment

This facilitator super-theme captures where participants noted positive attitudes or expectations towards mental health treatment that facilitated their help-seeking. This facilitator theme was referenced infrequently (nine times overall) but did represent a different attitude in help-seekers compared to non-help-seekers that may have encouraged their help-seeking. This facilitator theme mirrors the opposite barrier theme 'negative attitudes or expectations towards mental health treatment'. **0/10** non-help-seekers and **3/6** help-seekers made reference to the theme.

Robert, (help-seeker) remarked: *'Obviously when you're speaking to a doctor it's all in confidence anyway. So I mean nothing would... It wouldn't go to anyone else. It wouldn't affect my career. It wouldn't affect you know anything that I held dear, if you know what I mean so... And it was only going to be a positive outcome.'* (Pg.5-6, Line 251-258)

'And I know that there's medication out there that can, as I said you don't have to soldier on in silence all the time you know. , But if my mental health deteriorated either way I wouldn't have a problem... going back really.' (**Jake**, help-seeker, Pg.7, Line 354)

In general, participants' attitudes or expectations towards mental health treatment were important influences over their decisions to seek professional/medical help. The majority of participants held negative attitudes or expectations towards mental health treatment that affected their decision not to seek help. Positive attitudes or expectations towards mental health treatment were in the minority, but where they were held by participants, these views or perceptions enabled them to seek help.

4.1.10 Supra-Theme – Social Networks

This supra-theme encapsulates how the nature and strength of participants' social networks were important in terms of facilitating or creating barriers to help-seeking. Both non-help-seekers and help-seekers described military structures and transition to civilian life that created disjointed social networks and affected social support. This had a detrimental effect on the strength of social support both in Service and after having left Service. Many participants also discussed supportive social networks that were important structures around them that enabled help-seeking or made help-seeking a more likely outcome.

Barrier Theme – Poor/Unstable Social Networks

This barrier theme describes where the participant highlighted the fractured nature of social networks in Service and/or the disconnect with the military and friends after leaving Service. This structure worked against the facilitating nature of good social networks that may support an individual to seek healthcare for a mental health problem. This barrier theme also includes incidents where participants indicated loneliness or social withdrawal/isolation. This barrier theme should be assessed under the context of military identity, the strength of brotherhood created in Service and the depth of problems experienced when these close social support networks are fractured. This fracturing of supportive social networks also works against an individual having trusted social networks within which they feel they can disclose the problems they are experiencing. Non-help-seekers more frequently described poor or unstable social networks – **8/10** non-help-seekers and **5/6** help-seekers referenced poor or unstable social networks. Non-help-seekers referenced this theme twice as much as help-seekers (54 times compared to 23 times).

Participants described the experience of deployment and life in the military where intense relationships and experiences occurred during deployment. However when units returned home they were split up and redeployed ready for the next operation. This had negative effects on individuals' supportive networks of shared experience and friendships:

'so we've built this tight knit family cohesive unit and then we split them up [after deployment]' (Owen, non-help-seeker, Pg.9, Line 462)

Jake, (help-seeker): *'And the other thing is you know... all your mates you know. And all the guys who worked so close with, then the second you're back then the teams broke up',* (Pg.21, 1029) *'And it's a bit of shock as well, you know. That's when you're out there it just you and the guys, yeah? And then suddenly... and that's what you're fighting for and then you come back and everyone's broken up from... sure it's great to see them, you bump into them around the place, but it's changed'* (Pg.21, 1053)

Alex, Ryan and Ben all describe how after leaving Service there were few friends' they had left that they could talk to about their problems:

'I've tried to not involve myself in too much with people of that personal level' (Alex, non-help-seeker, Pg.13, Line 627), '...since I left the Army I don't really think I have very, very close friends' (Pg.13, Line 632)

'I think it's a lot more difficult seeking help once you've left. It's a lot more difficult to talk to anybody because the people that you were around aren't there anymore, in your everyday life sort of thing...I don't think that I could tell people certain things unless they've been there, experienced it... I don't think I could be talking to people who don't know... don't know about it.' (**Ben**, help-seeker, Pg.19, Line 810)

Ryan, (help-seeker): *'Nobody really said to me you know "You're acting like an idiot" or "You need to go to find some help" or "You need to go and do this" because I didn't really have anybody there at the time to say anything like that.'* (Pg.10, Line 476), *'...apart from the friends that I had in the army at the time, I didn't really have any. And once I left the army they didn't want to know me, and to be honest I didn't want to know them. So that was friends out of the window'* (Pg.16, Line 762)

Other non-help-seekers simply indicated that they were lonely or felt isolated:

'... towards the end of my service, I started finding myself withdrawn from even my closest friends in there. That's what eventually led me to release myself from the military... Then I found that I was even more alone... And after you know like left behind' (**John**, non-help-seeker, Pg.4-5, Line 196-206)

Carl, (non-help-seeker) *'I know there are other people around, but you know you still feel alone'* (Pg.4, Line 201).

'I think nobody cares where I've been. That's what I feel that nobody cares' (**Alex**, non-help-seeker, Pg.13, Line 616)

Facilitator Theme - Supportive Social Networks

This facilitator theme includes when participants described family or friends support/encouragement to seek help or described family or friends positive attitudes toward mental health treatment that facilitated help-seeking behaviours. This facilitator theme, mirrors its opposite barrier theme of 'unstable/poor social networks'. Whilst this facilitator differentiated the help-seeking group from the non-help-seeking group, there were overall few references to social support. Additionally non-help-seeking participants referenced the potential support they imagined they would receive from family and friends if they disclosed their problem; however this potential support had not impacted on their help-seeking status. Help-seekers described supportive social networks more frequently – **5/6** help-seekers and **4/10** non-help-seekers referenced family/friends encouragement to seek help. Counter-

intuitively, more non-help-seekers (8/10) referenced family or friends potential positive attitudes towards mental health treatment compared to help-seekers (3/6).

Facilitator Sub-Theme - Family/friends encouragement to seek help

Help-seeking participants often described their spouses or partners encouragement to seek help. Some of this encouragement was positive, however some of the 'encouragement' came in the form of ultimatums:

Ben (help-seeker): *'it's progressively sort of having quite an impact [his problem]... it wasn't really my decision...my girlfriend sort of talked me into going to see someone, so I went back to the GP'* (Pg.4, Line 155)

Peter (help-seeker): *'she [his girlfriend] said it's probably the best thing to do [to seek help]'* (Pg.10, Line 485), *'because what she's said has made me try and seek help to try and get rid of a problem so that I'm not taking this problem with me'* (Pg.21, Line 1016).

Robert, (help-seeker): *'that first time when my wife turned to me and said "You need to go and sort yourself out because this is getting too much now" Not so much an ultimatum but she said that "I'm not happy" (Pg.5, Line 218), 'she was supportive of it but there was still that side of her that was like you know if you don't sort yourself then you're out the door.'* (Pg.11, Line 549)

John, was a previous help-seeker (despite his current status being non-help-seeking), he described how his mum and friend were crucial in him making the decision to first seek help:

John: *'but my mum was quite...was quite shocked in the difference in my personality and stuff. And I think that was probably one of the reasons I went because obviously everyone listens to their mum when she's upset or something like that! So...*

Interviewer (M-LS): *Yeah, yeah. And you said that's one of the reasons that you went?*

John: *Probably yeah, yeah. But my friend telling me and discussing it with him and him telling me where to go and that was it.* (Pg.13, Line 641-649)

Facilitator Sub-Theme - Family/friends positive attitude towards treatment

Some help-seeking participants described family or friends positive attitudes towards treatment, which had encouraged them to seek help:

Jake (non-help-seeker): *'and they said [his parents] "Look why, what's the point in kind of you know soldiering on you know if you could maybe get a prescription that takes the edge off things a bit"'* (Pg.6, Line 262)

Many non-help-seekers when asked what their close friends and family would think of them if they went to get professional help often described family and friends positive attitudes

towards treatment and potential encouragement to seek help; however this knowledge in itself was not enough to elicit help-seeking behaviours:

Alex, (non-help-seeker): *'Yeah girlfriend obviously, yeah. I think she'd be really happy [if he was to seek help]'* (Pg.12, Line 570).

'I think my Mum would be made up' (**Tom**, non-help-seeker, Pg.17, Line 844)

'My wife would be very supportive' (**Edward**, non-help-seeker, Pg.8, Line 420)

'My Mum and Dad would be over the moon' (**Liam**, non-help-seeker, Pg.3, Line 153)

In summary, social networks and the strength of support given by these networks were discussed by participants, directly and indirectly, as important factors influencing help-seeking behaviour. Supportive social networks were important in creating the right environment where an individual felt able to seek help. Supportive social networks also created an environment where participants were more likely to disclose mental health problems or have these problems highlighted to them by family or friends. The nature of the military experience negatively affected social support for both Service personnel and ex-Service personnel. Poor social networks seemed to uphold other behaviours such as non-disclosure and self-sufficiency that worked against help-seeking.

4.1.11 Supra-Theme – Military Social Influences/Structures

This supra-theme comprises of social influences and barriers that were specific to the context of participants currently Serving in the Armed Forces. These include the barriers of ‘discipline before help’ and ‘bullying’. Whilst there were only one or two mentions of these themes, they represented a specific and important barrier to seeking help, enforced by the structural and cultural context of Service in the military.

Barrier Theme – Discipline before help

This barrier theme encapsulates how the discipline system in the military was described as being quicker to react to incidences of aggression, violence or hazardous drinking, than the welfare or medical system. It captures situations where Service personnel found themselves in fights or late to duty from drinking too much, and these circumstances were seen as issues of discipline and not warning signs that the Service personnel in question may need mental health support or treatment. This barrier theme includes where participants made reference to themselves or others being seen as ‘problems’ or ‘bad soldiers’ if they were to seek help. This theme represents structural and cultural barriers to help-seeking engendered by the discipline system in Service. **1/10** non-help-seekers and **2/6** help-seekers referenced this theme.

Owen (a non-help-seeker) explained that the most obvious sign for him of a mental health problem was when a good soldier’s behaviour suddenly changed, usually including excessive drinking:

‘this cracking lad all of a sudden becomes a bit of a drama, um that’s when like I say in the past, I think you should go and see someone about it, the problem is the army discipline system is sometimes quicker, so getting in a spiralling world of trouble before getting seen to there is something wrong...’ (Pg.8, Line 410)

‘I have seen one case where I genuinely thought something was wrong with an officer and the discipline side caught up with him first’ (Pg.10, Line 497)

There was also distinct language used by participants that Service personnel are put into brackets of ‘good soldiers’ and ‘bad soldiers’, with ‘bad soldiers’ being ones in need of discipline, and by default, not identified as needing mental health support:

‘Yeah it covers a sort of, this blokes a bad bloke who is always in trouble, let’s keep and eye on him, keep up on the disciplinary action and eventually if we get to the point we’ll kick him out of the Army, so he’s got no career, he’s got no career course and he’s in that circle, and there’s almost as soon as a guy, that’s off the path of being really good he get’s pushed into that circle as one of the bad guys’ (Pg.8, Line 424)

Other participants confirmed that their help-seeking was difficult because they wanted to avoid being put in the bracket of being a problem or a bad soldier. **Mark** who was a Reserve had not disclosed his help-seeking to his chain of command:

'I actually do believe if I'd met people, tell them this [about his mental health problem] that they would then look at me as a problem child' (Pg.27, Line 1342)

Peter who was still in Service had disclosed his mental health problem, but as a result had not had a good reaction from his colleagues and unit:

'A big thing with the army is that I feel sometimes that you've got to hide it because you've just got to get on with it. If you highlight a problem, it feels almost as if everyone's looking at you saying "He's a problem", "He's a problem child", "He's a problem case"' (Pg.13, Line 641)

Barrier Theme - Bullying

This barrier theme describes how those in Service did not want to disclose the mental health problem they were suffering with because the cause of the problem originated from bullying by their own unit leaders. This barrier to help-seeking arose from the fear of potential backlash that disclosure of the problem might cause in terms of formal procedures against the perpetrator and potential backlash from unit colleagues. Participants here made reference to delayed help-seeking and experience of further bullying/stigmatisation when formal complaints were eventually made. **0/10** non-help-seekers and **2/6** help-seekers referenced this theme.

Ryan had been attached to a unit deployed abroad and began to experience specific and extreme physical and psychological bullying which precipitated his symptoms of extreme aggression and anxiety. After months of enduring the bullying, he eventually reported the incident to the Royal Military Police. This then caused a situation of backlash from the unit he was attached to. When home from deployment he sought help through an NHS civilian doctor (whilst still in Service). The main barriers to help-seeking was the fear of backlash from the unit, which ultimately delayed help-seeking:

'I think she [the doctor in-service] could tell that people were bullying me or picking on me or beating me up and things like that. And when she... she did later flat out ask me "Have people been bullying you or giving you a hard time?" And I just paused and I think she took that as confirmation that they were, but I didn't actually say "Yes" because I didn't want to sort of grass people up and make things worse... Because that's pretty much what happens if you do go to the doctor. You know and

say "Oh people are bullying me" because it sort of makes things worse, and it sort of discourages you from asking for help.' (Pg.12-13, Line 601-614)

'They all [his unit] just made my life hell because they were saying to me "Oh my God, what... you've grassed him up" "You're a grass" and "You've probably just fucked up his career" "You've fucked up his family"' (Pg.8, Line 360)

Peter describes physical bullying by his unit leader. He eventually reported a Forces complaint, but he then faced social backlash from the rest of his unit. He received a threat to his life, which precipitated him asking to leave the Armed Forces. Throughout this situation he sought help from a doctor in Service but was offered no mental health support or follow up support and was only offered sleeping pills.

'I was getting bullied...and this went on for four and a half months before I actually made a formal complaint. Once I'd made the formal complaint it felt like the battalion were looking at me in like disgust or shame sort of thing.' (Pg.2, Line 63)

'so the individual got removed from the battalion... but still that didn't remove the problem from my head. It don't resolve it and not one person has given me any support or asked how I'm dealing with this situation or anything like that.' (Pg.2, Line 92)

'The big thing is there's people get bullied and don't tell anyone, and they just... that's it, they end their life... And there was times where I felt like that' (Pg.18, Line 871-876)

In summary, two themes were apparent that fell under the supra-theme 'Other Military Social Influences/Structures'. The themes of 'discipline before help' and 'bullying' were key factors in delaying help-seeking for the help-seeking participants. Whilst these themes were referenced only a few times, they were important examples of barriers to help-seeking, specific to the military experience.

4.1.12 Final Summary

Overall, several barriers to seeking help for mental health issues were apparent in both non-help-seeking and help-seeking groups. Facilitators of help-seeking were infrequently mentioned, however the facilitators identified in the help-seeking group contrasted with the absence of these facilitators in the non-help-seeking group. The quality and success of the help-seeking in the help-seeking group was poor. Many help-seekers within the interview group had only visited their GP once and were not engaged in further treatment.

The most common barriers preventing or delaying help-seeking were a lack of judgement of the need for medical help, stigma (both public and self-stigma), concerns relating to career,

and heightened masculine norms. The most common facilitators of help-seeking (albeit referenced infrequently) were supportive social networks and recognition of need.

Chapter 5 - Qualitative Method Study 2 – Combat Stress Specific Methods

My second qualitative study builds upon the previous qualitative study and focuses on help-seekers. It aimed to determine qualitatively, what the main barriers and facilitators of help seeking for mental health problems were in UK military personnel who had sought help from Combat Stress. The study also specifically examines participants' facilitators of help-seeking, barriers that were overcome and personal experiences of the healthcare services received.

5.0.1 Study Design

Ten ex-Service help-seeking individuals were recruited through the Armed Forces charity Combat Stress. In-depth semi-structured telephone interviews were conducted assessing barriers and facilitators of help-seeking.

5.0.2 Inclusion Criteria

In order to ensure homogeneity of participants for the qualitative semi-structured interviews and to ensure comparisons could be made with the KCMHR qualitative study, a number of inclusion criteria were applied:

1. Males aged 18-35 years.
2. Individuals currently seeking help with Combat Stress (within the last year) for a mental health related problem.
3. Beneficiaries of Combat Stress for more than three months and had received an initial assessment or treatment.
4. Individuals not going through intensive mental health treatment currently.

These inclusion criteria ensured that an individual's help-seeking experience with Combat Stress was recent and that they were engaged with a treatment plan at Combat Stress. As I did not want the interviews to interfere with any intensive treatment that Combat Stress beneficiaries were receiving, I consequently excluded individuals who were in intensive treatment. Please see Figure 15 for a diagram of the Combat Stress recruitment flowchart.

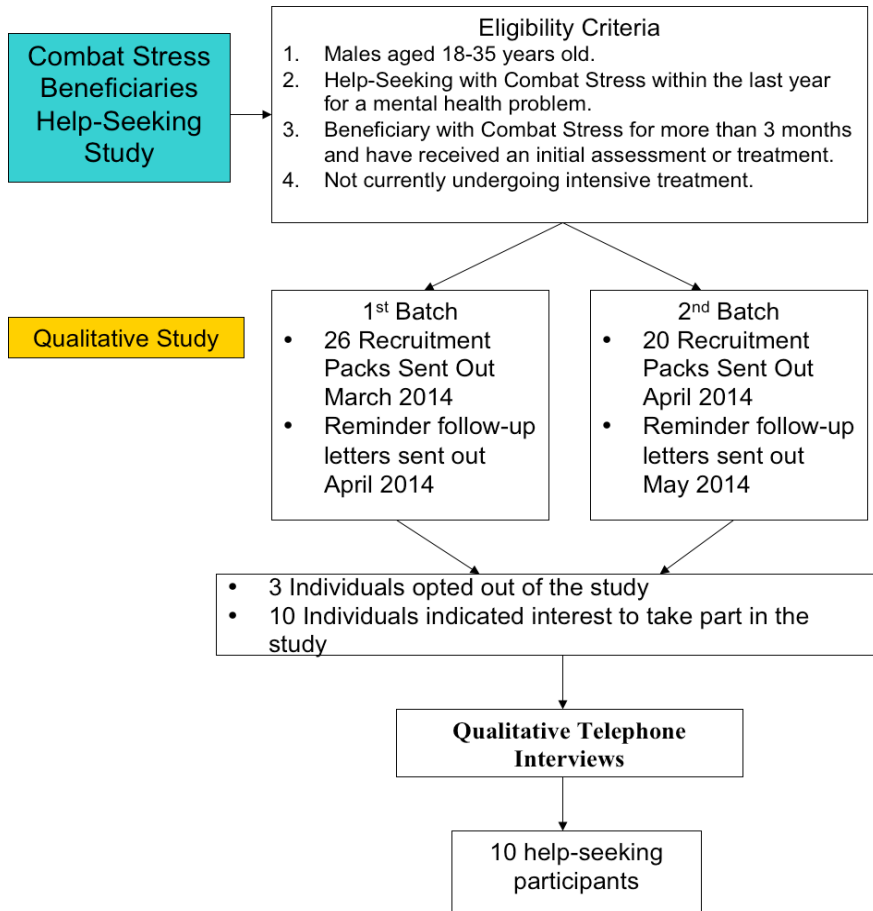
5.0.3 Recruitment Procedure

I worked closely with Combat Stress to recruit 10 participants. Over the recruitment period March – June 2014, Combat Stress sent eligible beneficiaries a hard copy (by post) Invitation Letter and Participant Information Sheet on behalf of KCMHR and myself. The Invitation Letter and Participant Information Sheet detailed information on the study and informed participants that their participation was voluntary, confidential, that the information they gave would remain anonymous, unidentifiable, and they that they would be able to opt-out at any stage (see Appendix 11).

The Invitation Letter was printed out on Combat Stress headed paper to ensure to beneficiaries that Combat Stress supported the study and to create confidence in the postal communication. The Invitation Letter invited participants to take part in a telephone interview and provided contact details with which to contact KCMHR to identify their interest in taking part in the study. The Participant Invitation Letter encouraged individuals to read the Participant Information Sheet for more detail on the study. The letter also detailed to participants that Combat Stress would not have knowledge of who took part in the study (unless they wanted to discuss their participation with Combat Stress) and if they wanted to participate they would be reimbursed as a thank you for their time. Lastly, the letter detailed how to contact either KCMHR or Combat Stress if they did not wish to participate. All individuals who took part in the telephone interviews were sent a hard copy Signposting leaflet detailing mental health services, support and welfare services (see Appendix 12).

Over the recruitment period, 46 potential participants were sent a study Invitation Letter and Participant Information Sheet. Postal communication was sent out in two batches. 26 potential participants were sent Invitation Letters and the Participant Information Sheet in March 2014 and the remaining 20 participants in April 2014. Postal reminder letters were sent out to the first and second batches of participants in April and May 2014 respectively, to individuals who had not made contact with KCMHR or Combat Stress to participate or to opt out. During the recruitment period, 10 participants identified their interest to take part in the study, three individuals opted out of the study, and by June 2014, 10 interviews had been completed with Combat Stress beneficiaries (see Figure 15). The response rate was therefore 21.7% (10/46).

Figure 15 - Combat Stress Study Recruitment Selection Flow Diagram



5.0.4 Interview Procedure

Interviewees were selected on a first come, first serve basis. Interviews were scheduled within a week of their contact with myself. After a date and time was agreed for the interview and contact details confirmed, participants were advised that at the time of taking the interview they should aim to be somewhere they felt private and comfortable. Participants were also advised that they would be sent a reminder text on the night or morning before an interview confirming the time of the interview and offering a rescheduling opportunity if their availability had changed. Participants were also encouraged to read through the Participant Information Sheet before the interview and told they could contact myself at any point to discuss any queries they had about the interview or the study. Telephone interviews and consent were recorded. Participants were asked to confirm the best address to send the Signposting document and financial reimbursement for taking part in the interview. Participants were then informed that they could get in touch with myself after the interview if they wanted to discuss anything further about the study.

5.0.5 Interview Structure

The basic interview structure utilised stem questions, as closely comparable as possible, to the previous qualitative study to allow a basis for comparison (Please see Appendix 13 ‘Combat Stress Interview Topic Guide’). The semi-structured interview question guide was compiled on the basis of existing qualitative research and the literature’s suggestions for further research investigations. Questions asked were open ended such that broad topics were introduced by myself. However, these particular interviews were designed to be fluid in structure which would allow the participant to lead and focus on areas they deemed most important and pertinent to their experiences. Each interview followed the form of a fluid interview script (Fontana and Frey, 2003, Trier-Bieniek, 2012). The semi-structured interview also allowed the possibility of new themes to emerge from the participant that had not been identified by current research. The help-seekers were asked additional questions within the themes of barriers overcome, types of help sought, service utilisation, engagement with treatment, and satisfaction with treatment outcomes. Additionally, the interview included questions on the acceptability of the mode of interview, through telephone interviews in order to add to previous data.

5.0.6 Combat Stress

Combat Stress is the leading voluntary sector organisation in the UK that provides specialist clinical treatment and welfare support to military personnel (Serving and ex-Serving) who have mental health problems. They are commissioned by the NHS to provide a specialist PTSD Intensive Treatment Programme and a 24-hour mental health helpline for ex-Service, current Service personnel and their families. They provide short stay clinical treatment, occupational therapy, community and outreach services to ex-Service personnel. They also have a Reserve Forces Liaison team working directly with Reservists and military staff to raise awareness of mental health issues in the Reserve Forces. As of January 2015, Combat Stress supported approximately 5,600 ex-Service men and women across the UK aged 19 to 101 years. They are currently treating approximately 662 Afghanistan and 960 Iraq ex-Service personnel, however the majority of the veterans they treat have Served in Northern Ireland (n=2984). The majority of their beneficiaries are male (~97%), ex-Army (~84%), with a PTSD diagnosis (~73%) and comorbid diagnoses such as depression (~62%) and alcohol problems (20-27%) (written correspondence from Dr Walter Busuttill – Medical Director, Combat Stress). Combat Stress beneficiaries have taken between 2 - 13 years to seek help after discharge from the Armed Forces (van Hoorn et al., 2013)

5.0.7 Study Rationale

The Combat Stress beneficiary group offered unique access to ex-Service help-seekers, who potentially had some of the most complex and acute needs in the Armed Forces community. For example, a study of veterans living in Wales randomly selected veterans from the different groups of Combat Stress, the Service Personnel Veterans Agency (SPVA) and the KCMHR cohort. This study found Combat Stress beneficiaries, compared to SPVA and KCMHR groups, had higher levels of PTSD diagnoses of 73% v 10% and 3%, lifetime suicide attempts 44% v 6% v 1%, probable alcohol dependence 27% v 2% v 6% and major depression 62% v 13% v 4% respectively (Welsh Affairs Committee Written Evidence from All Wales Veterans' Health and Wellbeing Service 2011³).

This beneficiary group have often experienced many different pathways to help-seeking through DMS, NHS and voluntary sector services. It was therefore, important that the entire variety of the help-seeking experience was captured, including individuals who are ex-Service, some of whom may have taken a long time to seek help, some who may have acute mental health diagnoses, and have experienced current mainstream and voluntary sector mental health services. Combat Stress has a population whose younger beneficiaries' experiences of help-seeking have not been qualitatively researched. Recent research has suggested that ex-Service personnel who deployed to Iraq and Afghanistan present to Combat Stress earlier and at a younger age than previous ex-Service personnel, which may suggest different help-seeking patterns. (van Hoorn et al., 2013).

Hence with this context, I felt extending the previous qualitative study to focus on help-seekers would provide new qualitative data on barriers and facilitators of help-seeking, focusing on those who are potentially the least likely to seek help with acute mental health conditions. Additionally, fewer help-seekers were recruited than expected in my previous qualitative study. This study, therefore, also offered the opportunity to focus specifically on help-seekers to assess this group in more detail than had previously been possible. In addition there were interesting initial findings in the KCMHR help-seeking group that indicated a poor quality of help-seeking and engagement with treatment, which needed further investigation by focusing specifically on a help-seeking group of participants.

5.0.8 Ethical Considerations

Ethical approval was received from the Combat Stress Research and Ethics Committee, November 2013. The main KCMHR cohort study received full ethical approval from the

³ To view the written evidence please follow this link:
<http://www.publications.parliament.uk/pa/cm201213/cmselect/cmwelaf/131/131we03.htm>

MOD Research Ethics Committee and the King's College Hospital Research Ethics Committee (NHS REC reference: 07/Q0703/36). This qualitative study was approved by the King's College Hospital Research Ethics Committee as a substantial amendment to the original cohort study ethics application (November 2013 REC Reference: 07/Q0703/36 Sponsor Reference: CSA/07/006).

5.0.9 Consent, Confidentiality and Anonymity

To ensure that the data protection of Combat Stress beneficiaries was not violated, I did not have access to Combat Stress beneficiaries' names or contact details prior to beneficiaries contacting myself. Combat Stress sent out the Participant Invite Letter and Participant Information Sheet to eligible beneficiaries on my behalf. Only beneficiaries who made contact directly with myself or who contacted Combat Stress (allowing their details to be passed on) were eligible to participate.

It was important to ensure the anonymity of Combat Stress beneficiaries taking part, in particular, to ensure that Combat Stress and specifically the clinical staff, did not know the identity of beneficiaries who went on to take part in the interview. This anonymity would allow participants to speak freely about their help-seeking experience with Combat Stress (or any other institution) without fear that this would impact on their treatment or any relationships with Combat Stress.

This anonymity was complicated by the need for Combat Stress to be able to send follow-up reminder letters to encourage recruitment, without mailing people who had already been in contact with myself. To achieve anonymity and the possibility of follow up, Combat Stress assigned an administrative employee, who had no clinical responsibilities, to manage the collating of information on eligible beneficiaries. They were also informed that all identities of participants should be kept strictly confidential to only themselves and myself. When beneficiaries made contact with me, I detailed to the administrative employee at Combat Stress, who these individuals were. Therefore, when the first and second batch of participants follow-up reminder letters were sent out, the administrative employee had the details of which individuals needed to be followed up. Alternatively, when an individual contacted Combat Stress, the administrative employee would pass on their details to me if requested by the participant. Combat Stress also informed me of the number of individuals who opted out of the study (without sharing personal details such as names). Finally, Combat Stress participants were informed that they could discuss the study with Combat Stress or others if they so wished, however the study information emphasised that anonymity would be kept for all participants unless they chose otherwise.

After telephone contact was made to arrange a telephone interview, participants were encouraged to ask any questions about the study and were informed that consent would be recorded at the beginning of their telephone interview. Individuals were informed that by taking part in the survey, they consented to KCMHR being able to use their data but that the data would be anonymised and would not be linked to any personal identifiers. Participants were informed that the interviews would be recorded, that the recordings would not be linked to any personal identifiers, and that after the recordings were transcribed, they would be destroyed. Participants were informed that they could ask for their interview recording to be destroyed, and that they could remove their data from the study up until one month after the interview, as after data were transcribed and coded, it would not be possible to link it to a specific individual. Furthermore, participants were free to ask questions at any time during the interview. Participants were also encouraged to identify a time and place where they could be interviewed in private when they were unlikely to be disturbed.

Participants were informed that all information would be kept strictly confidential. Data was stored securely, and was only accessible to the research team and was not shared with anyone outside the research team. Participants were informed that the only exception to their confidentiality was if they told me something that made me concerned about their safety or the safety of others.

5.0.10 Risk Protocol

Independent Medical Officer

This study provided an Independent Medical Officer to all participants should they have had any concerns or questions about the study. The Independent Medical Officer was available to give impartial advice. Their sole function was to ensure participants safety and well-being whilst participants took part in the study.

If participants reported suicidal ideation or experienced acute distress during the interview, there was a risk protocol I could enact. This process would offer a call back from the KCMHR on call medical officer who would discuss the problems raised by the participants. After this discussion, the medical officer would then get in contact with the participant's General Practitioner, medical officer or their welfare officer to highlight the distress experienced and enact appropriate support mechanisms if appropriate.

5.0.11 Financial Reimbursement

Participants who completed a telephone interview were reimbursed for their time. This was in the form of a £15 cheque.

5.0.12 Qualitative Software and Coding

Interview transcripts were coded through the software NVivo 10.

5.0.13 Transcripts

I transcribed two interviews. The remaining eight interviews were transcribed by a professional transcriber who had transcribed my previous qualitative interviews and who had worked with KCMHR on previous military studies. The transcriber was again employed to allow the efficient production of transcripts to enable analysis to proceed in a timely fashion. The use of a transcriber, had no impact on the analysis and interpretation of results because of the methods I employed to immerse myself in the qualitative data. I followed the same procedure as previously, for example when transcripts were received back from the transcriber, I checked them for accuracy by re-listening to the interview and correcting any text that had been transcribed incorrectly. Additionally the initial interviews I transcribed myself gave a good basis from which to re-listen to the subsequent interviews to check for accuracy and detail of transcription. Each interview was given equal attention to assess the interviews for participants' tone of voice, gaps in answers, coughs/laughs or other non-spoken details that would add evidence to the meaning and experience of the interview for both the participant and myself.

5.0.14 Reflexivity

For my interviews, I followed the same procedures as before. I wanted to be able to assess my role or influence in the interview, and to enable myself to have in-depth understanding of each interview to allow fair and balanced coding of interview data. This whole method of reflexivity also allowed a fair and balanced analysis of interviews when comparing the KCMHR group interviews to the Combat Stress interviews. Please see page 93 for a description of this process previously utilised in my first qualitative study.

5.0.15 Analysis

Thematic analysis was used to analyse the qualitative interviews (for in-depth description please refer to section 3.1 in Chapter 3).

The Combat Stress help-seeking group was coded independently from the previous coding framework that I had created for the KCMHR cohort non-help-seeking and help-seeking groups. I coded inductively, starting from afresh to ensure I did not let the previous coding frame affect or bias my interpretation of codes from the Combat Stress interviews. I wanted to ensure I treated these interviews independently from the previous interviews to allow for unbiased coding. Coding inductively and independently allowed for the possibility of new codes to be identified in the Combat Stress group.

The analysis for the Combat Stress group followed the six phases of thematic analysis detailed in Appendix 9. When the group had been analysed up to steps four and five, I began to create an overall 'thematic map/model' to collate the data from the Combat Stress interviews. It was only after analysis had been conducted on the Combat Stress interviews, that I then combined interview data to allow for comparison with the KCMHR non-help-seeking and help-seeking groups. Phase six then began during the write-up stage for this study using data from all of the interview groups in the KCMHR cohort and the Combat Stress qualitative study. The results section for the Combat Stress study is written in context and sometimes in comparison with the KCMHR cohort interview group. The following discussion (Chapter 9) then explicitly compares the data from the qualitative and quantitative studies and its ensuing implications.

5.1 - Qualitative Results Study 2 – Combat Stress

This section presents the qualitative results from the in-depth semi-structured interviews conducted with 10 beneficiaries recruited from the Armed Forces charity, Combat Stress. Please note all participants' names have been changed.

5.1.1 Study Sample Characteristics

To help understand the context of results, particularly in relation to participants' variety of help-seeking pathways and experiences, this section details some contextual background information on participants' military Service, symptoms individuals experienced, perceived causes of problems experienced and use of professional health services and treatment received.

All participants were ex-Service personnel, having left Service within approximately the last five years. All participants had served either in Afghanistan or Iraq. The majority of participants had served on multiple tours, and several had also served in Northern Ireland and Kosovo.

Three participants had been medically discharged from Service for mental and physical injuries related to their deployments and one individual had been administratively discharged. The remaining participants had left Service freely, in some cases due to traumatic experiences. Nine participants had a formal diagnosis of PTSD and one participant was diagnosed with anger/stress management problems. All participants were recent help-seekers with Combat Stress (within the last year), however half of the participants had previously also sought help in Service and eight individuals had sought help on the NHS. The majority of participants had received treatment from Combat Stress on their 6-week intensive PTSD treatment course. The majority of individuals had also received treatment from DMS and the NHS in the form of stress, anxiety or anger management, CBT, EMDR, NLP, counselling and medication. Six participants had attempted suicide or had suicidal intentions. Many individuals had waited several years in Service or after leaving before seeking help. Overall, individuals had experienced many different routes to seeking help with Combat Stress and experienced many different professional healthcare services from the point of their first help-seeking attempt. Finally, the majority of individuals were living with and managing their PTSD, with some highlighting their desire for further treatment and support (Please refer to Table 6).

Causes of problems experienced

Participants detailed what they believed their problems were related to. The vast majority associated their current mental health problem with difficult deployment experiences and problems transitioning to civilian life.

'I was a nurse in the British Army... I think it was mainly in relation to being constantly under mortar attack, being bombed, dealing with trauma casualties, people I knew, serious injuries, things like that. That's for a very... for a sustained period.' (Andrew – Pg.1, Line 43)

'...when I first came back from Afghanistan I was really struggling... I was really struggling to sort of get back into the swing of being back here, and not in an area where I'm likely to be shot or something.' (Aidan – Pg.2, Line 76)

Symptoms experienced

Participants were asked how they had realised they were experiencing a stress, emotional or alcohol problem. The majority of participants described experiencing heightened aggression over and above their normal aggression levels.

'So when you say something in the army you did it, but in the Civilian Street it's not quite set the way. And it was the different way of things and I got quite aggressive and ... And I found that I was lashing out so all the little things... I'd lash out more at my family and my wife and my daughter. And the little things they were doing I was blowing up like Mount Vesuvius and getting really aggressive.' (Will, Pg.1, Line 22-29)

'...little bits kept happening like I was getting anxious, I was losing my temper, I was getting aggressive, I was lashing out and a lot of these things kept on happening.' (Callum, Pg.1, Line 21)

Participants also detailed experiencing a variety of symptoms such as anxiety, nightmares, panic attacks, sleep problems, self-harm, hyper-vigilancy and excessive alcohol consumption. Many of these symptoms led individuals to realise that they might be experiencing a problem.

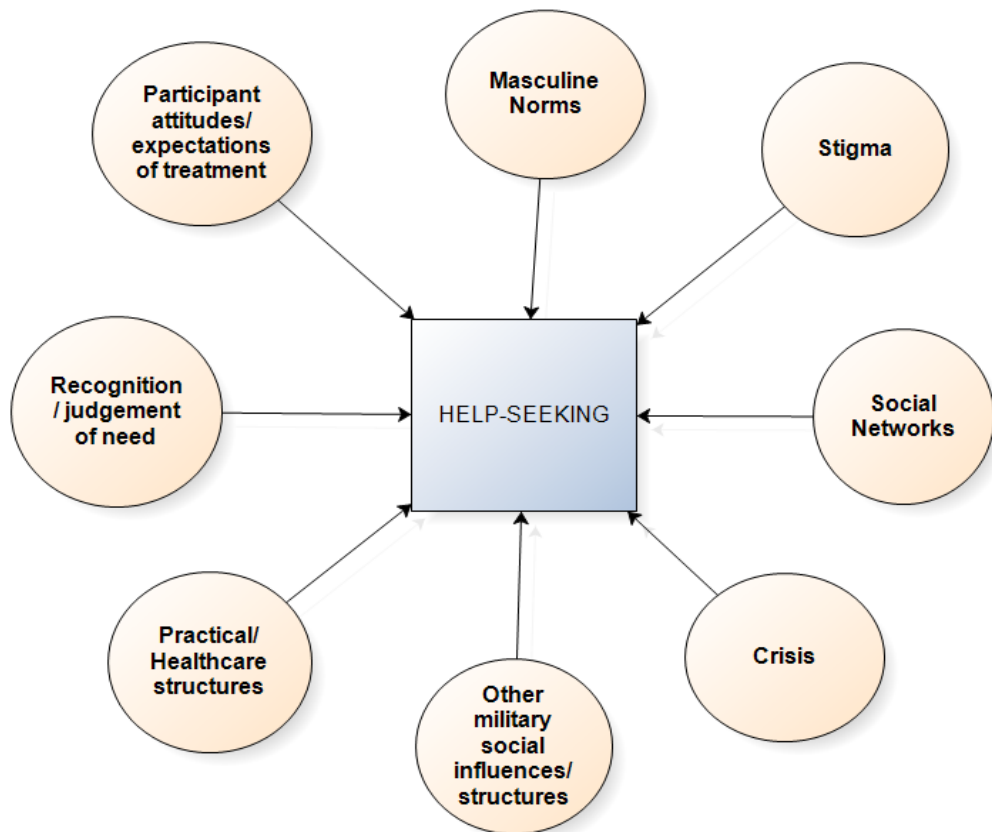
Table 6 – Qualitative Study: Two Sample Characteristics Overview

Participant	Combat Stress Diagnosis	Help-Seeking Sources	Suicide Intention/ Attempt (Yes/No)	Circumstances on leaving Service	Treatment Course at Combat Stress	Previous Treatment (before CS)
Chris	PTSD	- DMS - VRMHP - NHS - Combat Stress	Yes	Left Service of own accord	PTSD 6-Week Intensive Course	- No treatment in Service - CBT - Anger Management - EMDR - Medication
Andrew	PTSD	- DMS - NHS - NHS Veterans Service - Combat Stress	No	Left Service of own accord	PTSD 6-Week Intensive Course	- No treatment in Service - Medication
Matthew	PTSD	- SPVA - NHS - Combat Stress	No	Medical discharge	PTSD 6-Week Intensive Course	- Medication
David	PTSD	- NHS - DMS - Combat Stress	Yes	Medical discharge	None taken as yet	- No treatment in Service - Counselling
Callum	PTSD	- DMS - NHS - Combat Stress	Yes	Left Service of own accord	PTSD 6-Week Intensive Course	- No treatment in Service - EMDR
Greg	PTSD	- NHS - Combat Stress	Yes	Left Service of own accord	PTSD 6-Week Intensive Course	- No treatment in Service
Aidan	PTSD	- NHS - Combat Stress	Yes	Administrative discharge	PTSD 2-week block Courses	- CBT - Anxiety Management
Joshua	PTSD	- NHS - Combat Stress	No	Left Service of own accord	PTSD 6-Week Intensive Course	- NLP
Joe	PTSD	- DMS - NHS - Combat Stress	Yes	Medical Discharge	PTSD 6-Week Intensive Course	- Medication - CBT - EMDR
Will	Stress/anger management	- NHS - Combat Stress	No	Left Service of own accord	Awaiting treatment	- None

5.1.2 Help-Seeking Summary Model

When summarising themes up to their highest level (a supra-theme), barriers and facilitators of help-seeking fell into eight groups (Figure 16).

Figure 16 - Overview Combat Stress Supra-Themes



Six of these supra-themes were the same supra-themes identified in the KCMHR cohort interviews. These similar supra-themes identified were:

- Recognition/judgement of need
- Stigma
- Masculine Norms
- Attitudes/expectations of Treatment
- Social Networks
- Other military social influences/structures

The barrier and facilitator themes identified within these supra-themes however often subtly differed between the KCMHR cohort and Combat Stress interview groups (these differences are highlighted in the results section below, discussed in Chapter 6 and can be compared by viewing Appendix 14 that provides a diagram of an amalgamation of the KCMHR cohort and Combat Stress Help-Seeking Models together).

Two new supra-themes were also identified in the Combat Stress interviews. These new supra-themes were:

- Crisis
- Practical/Healthcare Structures

Figure 17 details an overview of the Combat Stress Help-Seeking Model detailing supra-themes and their associated barrier/facilitators themes and sub-themes. Under the newly identified supra-theme ‘Practical/Healthcare Structures’, sat a new barrier theme, ‘Practical/Healthcare barriers’. This barrier theme describes the practical barriers individuals faced through negotiating different healthcare systems.

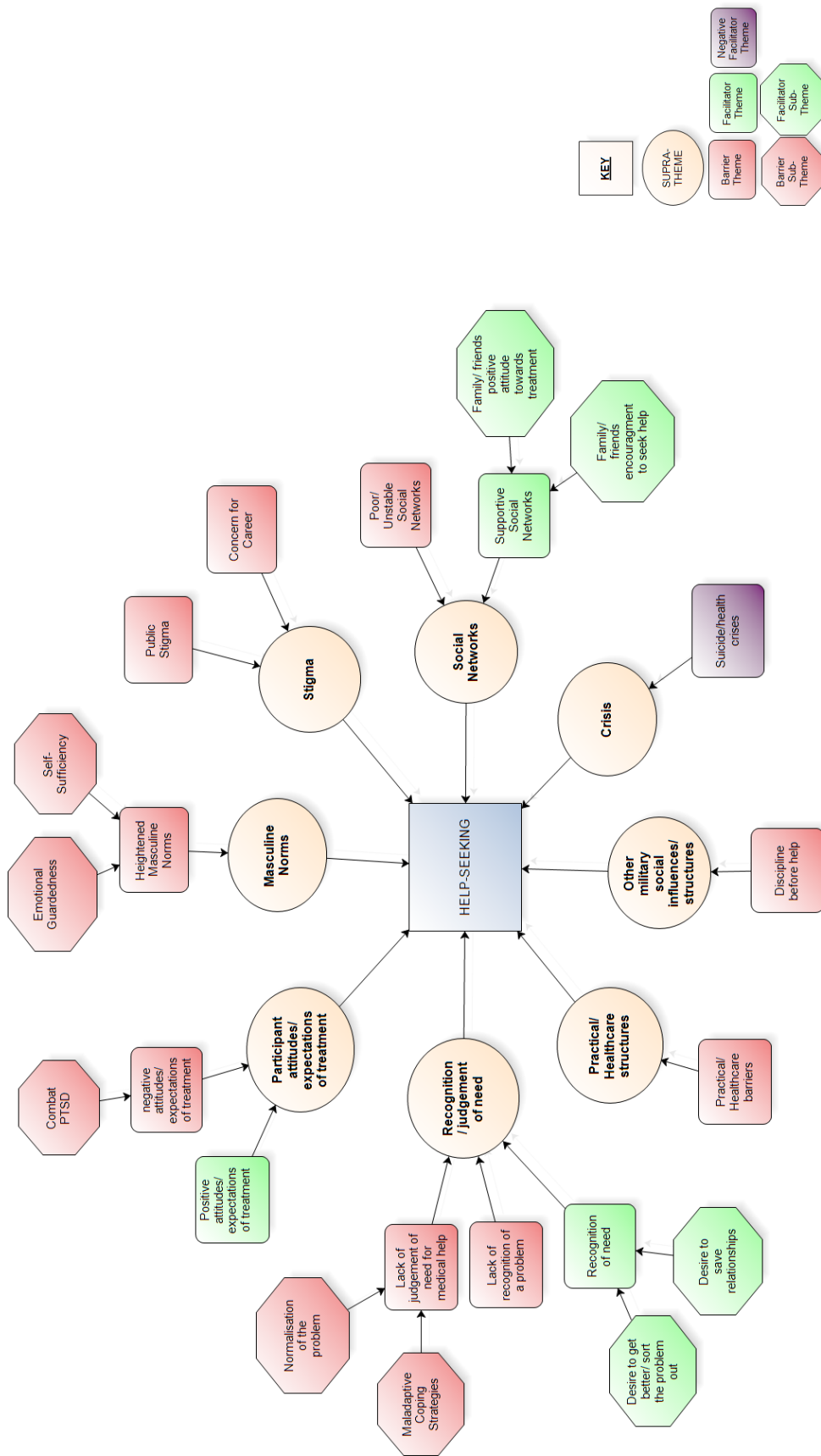
Under the new supra-theme ‘Crisis’ sat the new theme ‘suicide attempts/health crises’. This theme did not fit into the categories of a ‘barrier’ or ‘facilitator’ of help-seeking. I therefore termed the new theme a ‘negative facilitator’ of help-seeking. This theme describes the situation where an individual was propelled to seek help because of negative circumstances often surrounding crisis situations. A negative facilitator theme does not hold the same positive connotations of other facilitators of help-seeking such as social support from family and friends for example, but describes the circumstances where participants’ help-seeking was precipitated by negative crisis situations.

In summary, facilitators of help-seeking were more widely discussed and more prominent than discussions of facilitators of help-seeking in the previous KMCHR cohort help-seeking group. Barriers to help-seeking however were also prominently discussed by the Combat Stress help-seeking participants. Certain Combat Stress barrier themes had a mirror opposite facilitator theme of help-seeking, for example, the facilitator theme ‘Positive attitudes/expectations of treatment’ was mirrored by the barrier theme ‘Negative attitudes/expectations towards treatment’.

Please see Appendix 15 for a numerical overview of the themes detailed in this study. This table provides a quick reference to the definitions of the themes discussed. The table details

overall numbers of how many Combat Stress help-seekers referenced a theme or sub-theme and how many times a theme or sub-theme was accumulatively mentioned.

Figure 17 - Overview Combat Stress Help-Seeking Model



5.1.3 Supra-Theme – Crisis

This new supra-theme encapsulates the concept of help-seeking precipitated by circumstances of crisis. Participants described reaching crisis points where they were propelled or forced by the situation to seek help. This theme includes where participants felt they had reached a stage where they could not cope anymore, often where their health and daily functioning had deteriorated to unmanageable levels. This theme additionally describes where participants reached crisis points of intentions to commit suicide or actual suicide attempts that became the final deciding factors in seeking help. Help-seeking was sometimes enforced upon individuals from automatic referrals that were made by healthcare services after suicide attempts that resulted in hospitalisation. This theme embodies the notion that individuals had reached the end of their ability to cope, or one of their lowest points in living with their mental health problem, and seeking help was one of the few options left to them.

Negative Facilitator Theme – Suicide/health crises

Suicide or health crises are conceptualised as a negative facilitator theme. These negative circumstances in participants' lives compelled them or forced them to seek help, sometimes unwillingly and often as a last attempt to save their own lives. **8/10** Combat Stress participants described crisis situations that precipitated their help-seeking.

Callum described being desperate and overwhelmingly needing to seek help because of his experience of PTSD symptoms that he had lived with for several years. He described reaching a crisis point in self-harm and a suicide attempt:

'...it was coming to... close to the end to be honest because I was... I was getting that bad. I was probably... I was putting my fists through walls. I was more or less trying to knock myself unconscious because the images I was having in my head was traumatic images. And the only way I could try and get them out was to cause myself pain...' (Pg.2-3, Line 95-101)

'And then it was getting... it was getting worse and worse and worse so I had to... it was just that the case of just saying that I do need help.' (Pg.3, Line 105)

David describes *'meeting the breaking point'* (Pg.12, Line 563). **David** had been medically discharged from Service without on-going mental health support. He described reaching a crisis point after he had discussed the problems he was experiencing with his mother, who he felt had not been sympathetic to his situation. He remarked that he felt at the time, *'I think if my mum can't be bothered with me and help me out, then what's the point of being here?'* (Pg.8, Line 387). This situation culminated in his suicide attempt, which forced him to realise he couldn't cope on his own and needed help:

'That's enough. Enough's enough. You can't do it on your own. You've tried, you died and that's it!' (David, Pg.10, Line 466)

After leaving the Armed Forces, **Greg** described how he went out partying and taking drugs as a form of escapism, which caused his health to decline:

'I was losing myself more and more and more, and it got to the point where it's like the lid just came off my mind....' (Pg.4, Line 154)

I asked **Greg** what encouraged him to seek help:

'Well in my eyes it was either that or commit suicide' (Pg.8, Line 364).

Joe was medically discharged from Service because of his PTSD diagnosis. He explained how his life and health deteriorated after leaving Service, as he was taken off of his medication and was not transitioned to NHS health services:

'I wanted to live, but it was too hard dealing with the PTSD symptoms with the lack of sleep you know, the nightmares all the time, being on edge all the time, watching over my shoulder every two seconds...' (Pg.12, Line 560)

'I think I could see it in myself that I was on self-destruct mode I think. There was no other way out. There was... well there was two ways I either tried to keep going the way I was or I was going to kill myself. Because I couldn't cope...' (Pg.11, Line 527)

Joe went on to describe how he was propelled to seek help with his GP after an incident at a pub where he ended up in police custody after he tried to *'fight more or less a whole pub'* (Pg.2, Line 73). He was offered medication from his GP and received visits from the local mental health team. His help-seeking with Combat Stress was eventually precipitated by his family finding out about Combat Stress services after Joe was hospitalised following a suicide attempt.

Chris described many instances of help-seeking in Service and with private healthcare providers after leaving Service. He however attempted suicide and was shocked into seeking help by the situation where his child had been present during his suicide attempt:

'it is a bit of a culture shock because my daughter saw it and she burst into tears. And then I was like 'Yeah I do need help!' (Pg.10, Line 485)

Aidan explained how the new pressure in his life of having a child made him realise he had problems that he needed to seek help for. He explained how he realised if he didn't seek help, his problems might cause him to hurt himself:

'Well I've got to get help because otherwise I'm going to end up losing everything or ending up ending myself or something... (Pg.9, Line 445)

'I was having sleepless nights from my problems and now I was having sleepless nights because the little one wasn't sleeping, and whatever. And I... when he was born it really sort of hit me that I've got problems and I've got to sort it out otherwise I'm going to do ... something drastic.' (Pg.5, Line 233)

Overall within this supra-theme of crisis, individuals are forced to seek help when they meet a crisis point that tips them over the edge into help-seeking. These circumstances often include poor health and daily functioning, and suicide intentions or attempts. Frequently after suicide attempts individuals are referred by the health services into mental health treatment or support, or the individual and their family are impelled to seek help, finding out about Combat Stress. Whilst these circumstances result in help-seeking, the situation surrounding the individual is often a negative one, where they may be acutely ill, and ultimately help-seeking had not been encouraged by positive factors.

5.1.4 Supra-Theme – Practical/Healthcare Structures

This supra-theme describes practical or health structures that create certain experiences for individuals when they negotiate seeking professional help for mental health problems. These experiences create the healthcare pathway for the individual. These experiences affect individuals ease or difficulty in help-seeking and engagement with treatment. Practical structures refer to logistic experiences of help-seeking and receiving treatment such as individual's knowledge of healthcare services available, the individuals' ability to take time off work for treatment and the required transport needed to attend healthcare services. Healthcare structures refer to the way healthcare institutions are designed and how this affects individuals' help-seeking pathway. This might include ease or difficulty of referral processes, case management and waiting times. Sometimes the delineation of practical versus healthcare structures is not clear with some examples presenting characteristics of both. For example, the practical availability of healthcare services is both a logistic and healthcare structure that affects the ability of an individual to seek treatment.

Barrier Theme – Practical/Healthcare barriers

This barrier theme comprises instances where participants described practical or healthcare structures that were an impediment to help-seeking for their mental health problem and their

engagement with treatment. These barriers delayed or prevented attempts at help-seeking or created disincentives to engage fully with treatment. **10/10** Combat Stress help-seekers reference this barrier theme.

Participants referenced practical or healthcare barriers throughout their healthcare pathway whether seeking help in-Service with Defence Medical Services or after having left Service with the NHS or Combat Stress.

Different Diagnoses

One barrier recounted by over half of the participants was the different diagnoses that they received from many different healthcare institutions. These diagnoses were different from the final diagnoses individuals received. These diagnoses often meant individuals were treated with medication or given courses of treatment that did not seem to improve their health status. This outcome left individuals frustrated or disengaged with treatment and their own health. For example, **Chris** had received private health treatment from his employer before receiving his PTSD diagnosis on the NHS:

'I'd had therapy for anger management and stress management and stuff like that... and I had the CBT and I was just getting misdiagnosed and...that I was an alcoholic...' (Pg.12, Line 560)

Aidan described in Service how he sought help after returning from deployment but was told he had adjustment disorder that would improve with time. After **Aidan** left Service he sought help again and was put on blood pressure tablets because he presented with shaking hands. After returning to his GP several times, he was eventually referred to mental health services and diagnosed with PTSD. He remarked:

'...now looking back on it I don't think the diagnosis I was given by the psychologists while I was in the Army was technically the right sort of diagnosis. But obviously its hard to tell at the time, isn't it you know?' (Pg.2, Line 92).

Engagement with Multiple Healthcare Services

Participants also discussed the many different healthcare services they had engaged with. They felt like they had been passed to and from different people, which they found difficult and tiring. **Joe** had sought help when he was in Service and received medication, CBT and EMDR for his PTSD. He then had been medically discharged without transition to NHS healthcare services, but had concurrently sought help with the NHS, who referred him to Combat Stress, who referred him to the Veteran and Reserves Mental Health Programme. **Joe** eventually ended back up at Combat Stress to take part in their 6-week intensive

treatment. When I asked **Joe** what was important for me to understand about help-seeking for a mental health problem he remarked:

'I think the main one is the fact that going from one place to another place to another place is very disheartening and difficult. You know everyone's different, but I'd say the majority of soldiers when you get passed from pillar to post find it very difficult.' (Pg.19, Line 927-931)

Taking Initiative To Seek Help

In relation to the difficulty of diagnosis and being referred through many services, participants remarked how hard it was having to take the initiative in seeking help to receive treatment. **Greg** commented:

'you don't know about all these things... like these people that can help. You have to really... you have to want it to find it...' (Pg.13, Line 615)

'You don't know who's ... You know you just have to go to what the first place and then you sort of build up other networks, get other numbers and you go up to different places and they invite you to places and it just sort of goes from there. But it was a hard ladder to climb.' (Pg.13, Line 621)

High Turnover of Healthcare Professionals

Participants noted that a high turnover of mental health professionals was significantly detrimental to help-seeking. This meant participants had to recount trauma several times to different people, in addition to of describing their problems to the many different health services to which they were referred. **Aidan** explained how he had ceased his treatment with the NHS because his mental health practitioner was moving on:

'the psychologist that I was seeing she was leaving... I didn't want to have to go through a change and have to see another psychologist and then start from the beginning again.' (Pg.14, Line 699)

Joe who had encountered many different healthcare services explained:

'...what I'm getting at is I've got to speak to another person yet again and go through all my... all the details all over again which ain't nice, I don't like doing it. Its... it's... it's sickening really, it brings like a sick sort of feelings in my stomach everything I've got to think about it or go through it again. So you know I've gone through the Army, the NHS first of all who turned around and said "Oh there's nothing we can do", (umm) Combat Stress I've had to open myself up and do a six week intensive course there. I was passed onto the NHS again... you know there's four different people I've been passed onto and I'm... I'm going through the same thing again and... and I'm finding it to be very, very, very difficult to keep going through it.' (Pg.14-15, Line 701-713)

Combat Stress Healthcare Barriers

There were also specific barriers to seeking help and engaging with Combat Stress that participants recounted. One of the difficulties was related to the length of treatment that Combat Stress offers in its six week or two week block intensive PTSD treatment, and the nature of the treatment offered 'in-house' at Combat Stress treatment centres. Participants noted that it was extremely difficult to get time off work to receive treatment, which acted as a barrier to their help-seeking and engagement with treatment.

Callum explained how he had to wait longer to receive treatment because of the difficulties of getting time off work:

'I would have been on a course sooner but with work commitments they couldn't release me as soon as they wanted to. So I had to go through a big massive assessment in work... an appeal process to try and get the six weeks off because it was... That was... that was a major problem' (Pg.2, Line 75)

Aidan commented that he did not believe his employer was supportive of giving time off for the treatment:

'but then the foreman he's a bit... well he's not quite so supportive of it, you know. He's pleased that I've asked for help but then now it's come to the fact that I've got to go and have two week blocks for treatment as a first sort of part of my treatment, he's not quite so keen on it!' (Pg.9, Line 447)

David had still not engaged fully with Combat Stress or been on the intensive PTSD course that was suggested, because he could not fit the Combat Stress appointments around his work or allow the time off to receive treatment in-house:

'to be honest if anything I was scared because they were on about me going to one of their houses [a Combat Stress treatment centre]. And I had three dogs, I wanted to work because I have to pay my debts' (Pg.3, Line 135)

'they wanted me to go into the house and I said "No!" But then because I was working all the time I couldn't... my timings wouldn't... couldn't work around them'. (Pg.4, Line 183)

Half of the participants remarked that a barrier to seeking help was the long waiting times they had experienced to get on a treatment course at Combat Stress. Participants also described the difficulty of enduring the waiting times, when often they had sought help at a point where they needed help desperately. **Andrew** explained:

'I went into limbo because I was waiting for Combat Stress... And I had to wait sort of three months for a referral, and then I had to wait six weeks for the Welfare Officer to come out and then I had to get a call.' (Pg.5, Line 236-242)

'And then I think I did starting going into depression then and I was like becoming quite depressed and becoming very tired, very lethargic and my mood was very, very low. It was awful, worst time of my life, definitely.' (Pg.7, Line 327-330)

'That was a lifetime of being in the darkest hellhole I've ever been in, you know. And you know the only light in the tunnel for me was getting treatment, and then people saying it's probably going to take three or four months. That was just... insurmountable for me. I just couldn't take that. That was the hardest of the lot.' (Pg.14, Line 704-709)

In relation to waiting times experienced, there was a feeling from participants that Combat Stress was underfunded and needed more resources to deal with the numbers of individuals that were seeking help with them currently.

'The only thing I would say is I don't think their administration services are as good as they could be really. You know sometimes they don't answer the phone, and probably because they're so busy. You feel like you're constantly doing the chasing all the time' (**Andrew**, Pg.11, Line 534-537)

'Combat Stress is a charity and you know it's a small charity at that. So for them to deal with the sheer number of people that are suffering, I mean it is a hard task for them to do.' (**Aidan**, Pg.12, Line 563-566)

Participants also felt Combat Stress was under-publicised which meant many people needing help would not have heard of their services. **Matthew** commented:

'Because I'd never ever heard about Combat Stress until like Help for Heroes and the SPVA told me about it.' (Pg.13, Line 645-646)

'You're having conversations with the lads that were in the same time as me [receiving treatment at Combat Stress], you know, it was all... we all said the same thing you know there's not enough publicity on it. Help for Heroes has massive, massive publicity. Everyone knows about them. But everyone needs to know about the Combat Stress as well.' (Pg.14, Line 661-664)

Two of my participants experienced a major barrier to seeking help with Combat Stress and that was Combat Stress' requirement that they had to be sober and/off drugs before Combat Stress could engage with them in treatment. **Greg** explained how Combat Stress couldn't treat him before he had stopped abusing substances, however he was abusing substances to manage his PTSD symptoms. Additionally he could not find a drug rehabilitation service near his home on the NHS, so he therefore had to stop using drugs by himself, without support.

'I'm not going to lie, it took a while [to stop using drugs]. It took a long time because I'd go a week or two and as soon as one of the symptoms came I'd... because I knew that Ketamine gave me like that safe place, it was like the only thing I could do. Like I couldn't go anywhere, I couldn't go to Combat Stress, I couldn't you know... I was just stuck here' (Pg.16, Line 761-766)

In summary, there were many different barriers to seeking help, which revolved around practical healthcare barriers that delayed, or disincentivised help-seeking and engagement with treatment. These practical healthcare barriers were present across different healthcare institutions and were an important factor in making help-seeking more difficult for individuals who were often trying to seek help at difficult points in their lives.

5.1.5 Supra-Theme – Recognition/Judgement Of Need

The supra-theme 'Recognition/judgement of need' was evident in both the Combat Stress help-seeking group interviews and the KCMHR cohort interviews. This supra-theme encapsulates the notion, that whether an individual recognises their problem or not, is crucial in terms of help-seeking. Some Combat Stress beneficiaries in this study simply did not recognise they had a problem and therefore, help-seeking was never an option explored. Additionally, this theme encompasses whether an individual, on recognising they may have a problem, then recognises that the problem they are suffering from may need professional help or medical treatment. This theme highlights that simple recognition of a problem does not necessarily precipitate help-seeking. The key to help-seeking for participants was decided on whether they judged their problem to be one that needed professional help or not.

Barrier Theme – Lack of recognition of a problem

Within this theme, participants discussed why they had not sought help for their mental health problem. **4/10** Combat Stress participants explained they had not realised that they had a problem and therefore seeking help was not a decision they had thought about.

I asked **Will** whether there was anything that put him off seeking help:

'No, I guess I just thought that me as an individual that there was nothing wrong'
(Pg.5, Line 217-218).

Greg also echoed this sentiment:

'I wasn't aware at the beginning that I had a problem' (Pg.1, Line 18-19).

Even after Greg's family had pointed out to him he may need help, he described how his denial obfuscated his ability to recognise there was a problem, commenting that he thought at the time:

'I don't need help', 'I'm alright' (Pg.8, Line 400-401).

Joe equally describes this denial and fighting against his family who had said to him he might need help. He recalls saying:

'I ain't going anywhere! There's nothing wrong with me. The problem is is you lot keeping onto me [his family]. If you didn't keep onto me there wouldn't be a problem!' That sort of thing. I think it was all the way through it you... you just have fought against it you know? "I haven't got it" "I haven't got this" "There's nothing wrong with me". And everyone else could see it. (Pg.9, Line 451-456)

Barrier Theme – Lack of judgement of need for medical help

This theme describes how participants recognised they had a problem but then justified to themselves or others why they didn't need to seek professional help. Much of their explanation at the time was based on the judgement of their own need and the tactics employed, consciously or unconsciously, to cope with and manage their problem without seeking medical help. This theme does not describe or include individuals who deny they have a problem at all. The sub-themes that created this theme are: 'Normalisation of the problem' and 'Maladaptive coping strategies'. Overall **9/10** Combat Stress help-Seekers referenced this theme. The previous sub-themes apparent in the KCMHR cohort interview groups of 'Minimisation of the problem' and 'Deservedness to seek help' were not apparent in the Combat Stress help-seeking group.

Barrier Sub-theme – Normalisation of the problem

This sub-theme describes how individuals whilst accepting they have a problem, go on to normalise this problem, often describing how their life and behaviours are normal for an individual who has Served in the Armed Forces, or alternatively how their problems are normal everyday life stresses that everyone faces. Participants justified not seeking help for problems that they believed to be normal for them or normal for other people. Imbued in this theme was also the acceptance by individuals of the status quo, that this was just the way their life was which they accepted as a normal experience. **5/10** Combat Stress help-seekers referenced this theme.

Callum, Chris and **Joe** explained how they normalised their symptoms for many years before they sought help:

'...the Hyper-vigilancy had been going on for three years, and that was... I just put that down to the Army training and then... and then I was having the nightmares and I was just putting them down to just being in the Army. Flashbacks I was just putting them just down to being memories.' (Callum, Pg.6, Line 270-274)

'But to be honest I never thought it was a problem because I'd never heard anything about PTSD. I didn't know what it was. And I just assumed like this is just the way I am. This is my way of life. This is what I've adapted to. This is what I learnt in my six months tour of Iraq, and so I never thought I had a problem' (Chris, Pg.5, Line 249-254)

'... I'd go out, go out for a good piss-up, I'd be in the following day and the day after I'd go out for a piss-up again! But you know if I got into an argument with someone and there was a bit of fisty-cuffs, there was a bit of fisty-cuffs. You know it's... I think the normality of being in war and... and fighting is as normal when I come home' (Joe, Pg.10, Line 462-468)

Barrier Sub-theme – Maladaptive Coping Strategies

Participants described many maladaptive coping strategies that enabled them to manage or avoid, and therefore cope with their mental and physical health symptoms. These strategies allowed the participants to ignore or avoid psychological distress they were experiencing and in doing so, meant individuals believed they were coping with their problems and therefore did not need to seek help. The maladaptive coping strategies delayed Combat Stress participants from seeking help. The most commonly described maladaptive coping strategies included: heavy alcohol use or substance misuse and emotional avoidance tactics. **9/10** Combat Stress help-seekers referenced this theme.

Some participants described how they purposefully kept busy to avoid thinking about some of the problems they were experiencing. **Andrew**, for example, talked about how he left his demanding role in Service, for another demanding career which kept him busy and unable to have the time to think or reflect on some of the problems he was experiencing.

'And I think my coping strategy when I looked back at my career, so since the last six years, it was the whole change... things changed, things changed and it's something new. I couldn't feel and I think last year my body couldn't take it anymore. And I became physically exhausted and then when I could no longer utilise that coping strategy, I think that's when I went off the rails.' (Pg.2-3, Line 98-105)

Matthew and **Will** also commented how the nature of Service was a barrier to seeking help because it occupied their mind and time, so they did not have time to think about their problems or consider seeking help:

'I mean like if you're in an unit that's constantly busy like myself, I mean you don't have the time... you don't have the time to go and seek help or anything because you're... like the way operations come around now... like with Afghanistan and stuff like that it's you know constantly like training...' (**Matthew**, Pg.13, Line 617-623)

'Well when I was in and around the military environment and the military machine, then I didn't feel the necessity to seek any help. It was... well the pace of life was that fast, it was a case of that you didn't have time so...' (**Will**, Pg.8, Line 387-390)

Other participants used alcohol or drugs to cope with their symptoms:

'...my main way of coping and dealing with things was drinking' (**Joe**, Pg.2, Line 80-81)

'I had drink problems where I was drinking like pints of vodka in the night to try and sedate me because I was trying to knock myself out I think' (**Chris**, Pg.5, Line 244-247)

'when I was in the battalion along with my other friends we'd drink for days on end and I kind of more talking to ourselves, crying, telling stories about things, about friends we've lost.' (**Joshua**, Pg.13, Line 617-620)

'And as soon as I got back from Iraq the first time, after all the stuff that happened, I started getting into the drug scene...But now talking to specialists about it and looking back at it, I was sort of self-medicating.' (**Greg**, Pg.3, Line 100-115)

For many participants the coping strategies they employed enabled them to get on with their lives by pushing to the back of their mind the problems they were experiencing and avoiding thinking about their emotions. **Aidan** explained:

'I was just trying me best to sort of carry on as normal and not really think too much about it.' (Pg.3, Line 141-142) *'It is hard like to sort of having things going on while you're busy, but sometimes I think it's better when you're busy because it almost keeps your mind off it.'* (Pg.4, Line 162-164)

Within the barrier theme 'judgement of need', individuals can continue for many years employing unhealthy coping strategies that delay them from seeking help. Participants also reasoned with themselves that the problems they were experiencing were normal and therefore they did not consider them issues they would seek professional help for.

Facilitator Theme – Recognition of need

This theme describes how help-seeking participants were able to seek help when they recognised their own need, accepted that they had a problem, and accepted that the problem they were experiencing warranted seeking professional/medical help. This facilitator theme, mirrors the opposite theme, 'Lack of recognition/judgement of need'. Under this theme sit

the sub-themes, 'Desire to get better/sort the problem out' and 'Desire to save relationships'. The participants 'desire to get better' or a wish to 'sort the problem out' was sometimes precipitated by participants reaching a point that brought to the fore their own sense of responsibility towards their family and the severity of their problem in terms of their own daily functioning. In addition, many participants' spouses/partners had been affected by their problems and the participant wished to save their relationships in the hope of a better future together. Frequently, participants' recognition of need was precipitated by spouses, family or friends identifying to them that they believed there was a need to seek medical help. Within this theme, participants have moved on from their previous acceptance of the status quo and realised that their health can improve and their lives can be lived differently. Participants here understood that professional/medical treatment might help them to improve their situation. **9/10** Combat Stress help-seekers referenced this theme.

Facilitator Sub-theme – Desire to get better/sort the problem out

This theme encapsulates participants' rejection of the status quo and their desires to improve their health and their current living situations with a recognition that medical help-seeking could provide the support that they need. The impetus to change their situation acted as a catalyst to override other concerns or barriers to help-seeking. **9/10** Combat Stress help-seekers referenced this sub-theme.

Often participants desire to get better or to sort the problem out was precipitated by their feelings of care and responsibility towards their family and children. **Matthew** described how he decided to do the Combat Stress six week intensive course because he realised the effect his problems were having on his family:

'It's not just you that's suffering, it's her [his wife] and the children and stuff you know.' (Pg.6, Line 259-260).

Will also commented how he wanted to get better so he could get on better with his family and have a positive effect on them:

'...so I wanted to find a way that I could get help from them [Combat Stress] so I could better relate with my step-daughter and be able to converse with my wife without becoming agitated.' (Pg.3, Line 144-146)

David described how it was his responsibility to his pets that encouraged him to want to get better and seek help:

'Yeah, it's the fact that I had three dogs and I didn't know want no one else taking control of my dogs or my house and everything because... and I'd tried to take responsibility for my actions. Sort it out, sort of thing.' (Pg.8, Line 370-373)

Some participants remarked how they wouldn't have sought help for themselves, but because they were in a relationship they cared about, they wanted to get better for their partner.

Aidan commented:

'I might not have been so keen to sort of get help if it hadn't been for my wife' (Pg.7, Line 337-338).

Aidan also described how he accepted his need for help because of responsibility to his first child:

'It was that point that you know it was the realisation that there was more to it than I was willing to accept, but I've kind of got to accept it because it's not just me anymore I've got a little one to look after.' (Pg.5, Line 243-246)

Callum similarly remarked:

'My thing was always me, my wife and kids because I didn't do it [seek help] for myself' (Pg.7, Line 311-312).

Joshua saw getting better and seeking help as an extension of his development as a person after he left Service, where his future health was important:

'I think yeah it was just that basically my own self development in terms of myself' (Pg.6, Line 287-288) *'Like I say I've seen a lot of my kind of friends lose mental state, so I didn't want this happening. I wanted to kind of challenge it.'* (Pg.6, Line 294-296) *'You know what I mean my future's more important than my pride.'* (Pg.7, Line 307-308)

Lastly, **Joe** explained that he wanted to get better because he believed it was a way he could save his job and continue to work in the Armed Forces, he recalls a medical officer telling him his diagnosis:

“And unfortunately I think you've got PTSD, mate”. And I said “Right, ok. No dramas, how are we going to fix it? You know I need to get myself better. I need to get myself back in” [to his job].' (Pg.5, Line 241-243) *'I just wanted to get myself better and be back in work.'* (Pg.12, Line 588)

Facilitator Sub-theme – Desire to save relationships

This theme highlights the process of recognition of need through participants' relationships with spouses/partners, children and family. In this theme, participants come to the realisation that their behaviour has a detrimental and possibly terminal effect on the future of their relationship. Alternatively, participants' spouses/partners discussed with them the negative effect of their behaviour, which caused a process of self-realisation within the participant. Finally, ultimatums were issued by spouses/partners that if they didn't change or seek help, then they could not continue in the relationship. These situations caused participants to move from the status quo, to a place where they needed to sort out their problem in an attempt to save the future of relationships that were important to them. **6/10** Combat Stress help-seekers referenced this theme as facilitating their help-seeking.

Matthew described how he sought help because he didn't want his children growing up and continuing to experience his aggression. He describes how his children had seen him punch a kitchen cabinet door off its hinges:

'I slammed it into the wall and of course my kids were about you know and my missus like got to me so I didn't want my kids seeing that kind of stuff.' (Pg.4, 191-193) *'Yeah I didn't want them growing up around it and when they got older looking back and thinking "God my Dad was a... my Dad was an arsehole". You know?'* (Pg.6, Line 272-276)

Callum and **Will** describe a similar situation, where they sought help because they didn't want their children witnessing their problems and wanted to have a good relationship with them:

'...it was what I didn't want the kids seeing, kids to know me. I got a three year old and a one year old. Now they've seen me having a panic attack once and I didn't want them seeing me. And then if I did hit myself, I didn't want them thinking it was normal for them to hit themselves as well' (Callum, Pg.7, Line 314-318)

'what encouraged me to get the help was that I didn't want my now wife and her daughter, she's my step-daughter... growing up the same way I did... within an environment where there was always an argument with my parents or there was aggressiveness constantly in the house.' (Will, Pg.3, Line 139-143)

Chris had just met his partner and wanted a new start and a good future relationship:

'I then met my partner who I'm with now and I was hoping that I can get a new start in life. Like the right time get rid of all that stuff... and hopefully it [seeking help] would get rid of the PTSD' (Pg.9, Line 454-457)

For some participants, help-seeking was precipitated by ultimatums from their partners or families:

'It was more a case of that when my wife basically turned around to said to me that if I didn't change then she'd basically leave and I'm just like oh I can't be doing that to these people' (Will, Pg.2, Line 89-92)

'I'd say it's my little sister give me the opportunity because like me and her kids get on. We're like close because I was a Godfather to her kids. And she was... she come to the point where that's it. She goes "Sort yourself out, get yourself together or you ain't seeing my kids or your Godson". And that's why I had to do it. [seek help]' (David, Pg.9, Line 416-420)

Overall the supra-theme 'Recognition/judgment of need' highlighted the circumstances where individuals had to recognise they had a problem and recognise that this problem needed professional help. Participants also possessed a desire to get better, often precipitated by the need to save relationships that had suffered from the circumstances of their mental health illness. The theme highlights that individuals experienced barriers in recognising their need and this was a main factor in delaying or discentivising their help-seeking.

5.1.6 Supra-Theme – Social Networks

This supra-theme encapsulates how the nature and strength of participants' social networks and social support were important in terms of facilitating or creating barriers to help-seeking. This supra-theme was also identified in the KCMHR cohort interview group. Overall, Combat Stress help-seekers described military structures and transition to civilian life that created disjointed social networks, which had a detrimental effect on the strength of social support both in Service and after having left Service. However, all participants additionally discussed supportive social networks that were significant structures around them that were vital in enabling them to seek help and to continue seeking help when certain attempts were unsuccessful.

Barrier Theme – Poor/Unstable Social Networks

This barrier theme describes where the participant highlighted the fractured nature of social networks in Service and/or the disconnect with the military and friends after leaving Service. This structure worked against the facilitating nature of good social networks that may support an individual to seek healthcare for a mental health problem. This barrier theme includes incidents where participants indicated loneliness or social withdrawal/isolation. This barrier theme should be assessed under the context of military identity, the strength of bonds created in Service and the depth of problems experienced when these close social

networks are ruptured. This fracturing of supportive social networks works against an individual having trusted social networks within which they feel they can disclose the problems they are experiencing. It includes notions of social withdrawal where individuals specifically cut themselves off from previous friendship groups or from their families as a coping mechanism, which had negative cyclical effects on participants' social support. **8/10** Combat Stress help-seekers referenced this theme.

As highlighted in the previous qualitative study, Combat Stress participants also discussed the disjointed nature of Service, where social networks were frequently broken up as a result of returning from deployment or from promotions and relocations. They discussed the difficulties of leaving Service and therefore leaving many friends behind, whilst also having few friends in civilian life. **Chris** explains how as a Reservist, he had little social support after returning from deployment:

'Yeah, I mean so... our training days were like Tuesday night and... one weekend every month. And so... at this point there just weren't enough people... there weren't a lot of people around you. I mean like on my tour in a different regiment and when they come back they moved to Germany and I stayed in the UK and ... I had no one around me.' Pg.15, Line 714-720)

Joshua explained how his time in Service had made him feel very cut off from normal civilian life and from his family:

'...each time I'd less wanted to go home, not that like I didn't like my family anymore. But I was finding the communication not just with my family, but with civilians and just society in general. I could feel it cutting off...' (Pg.3, Line 108-112)

Participants also discussed how they purposefully isolated themselves from their family and friends when they were experiencing mental health problems:

David: *'... since I got medically discharged from the Army, its felt like I was left alone to deal with everything.'* (Pg.5 Line 237-239) *'I literally went to isolated mode. Just literally locked myself in the house'* (Pg.5, 250-251)

'I basically cast everyone aside, I didn't want to talk with anyone at all' (**Callum**, Pg.11, Line 504-505)

'well I used to live with my mum at the time, and my mum used to say 'Oh do you want a cuddle?' I'm like 'Leave me alone! I don't want no one near me!' I used to push a lot of people away.' (**Chris**, Pg.5-6, Line 254-257)

Greg described how when he had made the decision (after leaving Service) to address his drug use, he had to cut himself off from his friends that he used drugs with and that this left him isolated:

'...the wider friends are still doing the parties and still doing what they do, if you know what I mean? So I had to pull away from a lot so I've only... My close friends don't live around my area, they're sort of dotted around all over the place so they haven't seen the things I've been going through' (Pg.9, Line 450-454)

Facilitator Theme Supportive Social Networks

This facilitator theme includes when participants described family or friends support or encouragement to seek help or described family or friends positive attitude toward mental health treatment. This facilitator theme, mirrors its opposite barrier theme of 'unstable/poor social networks'. **10/10** Combat Stress help-seekers referenced this theme.

Facilitator Sub-theme – Family/friends encouragement to seek help

Help-seeking participants often described their spouses/partners or family's encouragement to seek help. This support and encouragement helped individuals to persist in their help-seeking, particularly when certain healthcare services or treatments had not been successful in improving their health. **8/10** Combat Stress help-seekers referenced this theme.

Participants cited many occasions where their partners or families had told them they needed to seek help and then supported them to do it:

'it was kind of my wife that you know kind of finally pushed me over the edge to seek the help. Because I thought I felt like a bit of a coward for needing the help to be honest... But she you know she talked me round and I realised that I wasn't. You know there was a lot of lads that need it.' (**Matthew**, Pg.2, Line 77-85)

Chris: *'over about two years my wife kept saying 'You need help!' 'You need help!' 'You need help!' (Pg.10, Line 460-461) 'I mean my wife was like... she was quite supportive saying that I'm going to take you here and take you there and that, and I'll come with you to all your appointments and if you don't feel like talking, I'll talk for you.'* (Pg.11, Line 531-534)

Greg: *'It was the outside, like friends and my mum especially, that saw it. And my mum said to be "Look you need to go to the doctors, you need to. There's something up with you and I don't know what it is"'* (Pg.1, Line 23-26) *'So she took me to the GP to see him'* (Pg.1, Line 28-29)

Aidan: *'Later on my partner, she's absolutely fantastic, and she was kind of one that said to me 'Well no it doesn't make any difference what anyone else thinks and you've got to do this because it's for you... You know my mum and dad got the details for Combat Stress and said to me that they thought that I needed to ask for help.'* (Pg.6, Line 287-296)

Andrew described receiving good support from his wife in encouragement to seek help and then further support from his work and colleagues, he remarked that the support he had received was vital to his help-seeking and his engagement with treatment at Combat Stress:

'I was very lucky and I was saying I think that one of the pillars of my success is that I've got a very supportive network. And I think that's essential if you're going through this kind of thing. A lot of the guys I was living... I was going through the course with [at Combat Stress], a lot of the lads there were like on their own. You know and when you're on your own you've got nobody have you?' (Pg.13, Line 639-644)

David also echoed these sentiments when I asked him what the most important thing was in encouraging him to seek help, he responded:

'I would say family. Family, friends. Hundred per cent supportive. If you don't get hundred per cent support you might say bye bye. You need to get hundred per cent support. And then you've got to help yourself at the same time.' (Pg.16, Line 800-803)

Facilitator Sub-theme – Family/friends positive attitude towards treatment

Some help-seeking participants described family or friends positive attitudes towards treatment, which had encouraged them to seek help and had encouraged them to continue with treatment after they had first sought help. All Combat Stress participants referenced this theme.

Aidan commented:

'on the whole everybody is like very pleased that I've actually turned around and asked for help' (Pg.8, Line 368-369) *'well everybody that knows about my problems have been very supportive and helpful as much as they can'* (Pg.9, Line 437-439).

I asked **Joe** what his wife and close friends thought about him seeking help, he responded:

'They're very supportive. Very, very supportive. Yeah. I couldn't fault any of them to be fair with you. If anything they were the one who was spurring me on to go. They were the one that wanted me to go, you know.' (Pg.16, Line 776-779)

Will described his family and friends support for Combat Stress and for the treatment they offer:

'well my family think its good that I'm getting help. My wife's glad I'm getting the help...' (Pg.6, Line 298-299) *'My Nan's a great supporter and she thinks it would do me good as well. And she's a great rallier for charity events for Combat Stress and*

raising money so she's sort of... following me quite closely with it. And my other... I've got a friend in Germany who's a trained counsellor and he's followed it [his help-seeking] quite closely.' (Pg.7 Line 307-310)

Some participants discussed how supportive their family or friends were of their current treatment, which had encouraged them to continue with their treatment and recovery. Family and friends having positive attitudes towards mental health treatment wasn't therefore always a facilitator causing help-seeking, but it did however enable successful help-seeking and engagement with treatment after help-seeking. For example **Callum** had not told many of his family that he was receiving treatment with Combat Stress. He described that he decided to tell his wider family about the treatment he was receiving and said how the positive response towards his treatment encouraged him whilst he was at Combat Stress and made him feel more understood by his family:

'... the support I got from me family was over... all of... certain parts of my family was quite overwhelming actually.' (Pg.11, Line 509-511) *'And because I was actually away in a unit... in a professional establishment for six weeks and only allowed to come home for two days. I think it made people realise "Well Jesus he is... he is sick, he is not... he is unwell and he has got problems so he... needs more therapy".'* (Pg.11, Line 527-533)

Hence the nature of individuals' social support through social networks formed important barriers to, or facilitators of help-seeking in creating the environment in which participants were isolated and unsupported, or alternatively connected with friends and family who could encourage and support an individual to seek the help they needed. Social networks equally played a role in supporting individuals to engage with treatment.

5.1.7 Supra-Theme – Stigma

This supra-theme encapsulates participants' references to the stigma of mental health problems as a barrier to help-seeking. It was also identified in the previous qualitative study. This supra-theme comprises the barrier themes of 'public stigma/anticipated stigma' and 'concern for career', where it includes participant's references to stigmatising beliefs concerning the effect of disclosing a mental health problem on their career. There was no concurrent facilitating theme that mirrored the barrier of stigma. Overall, these barriers were cited by **8/10** Combat Stress help-seekers. The barrier themes identified in the KCMHR cohort group interviews of 'self-stigma' and 'concern for medical records' were not identified.

Barrier Theme – Public/Anticipated Stigma

In this barrier theme, participants described a barrier to care as being the anticipated effect of public stigma and/or discrimination for seeking help for mental health problems from the general public, family, friends, and colleagues. This theme constitutes a desire by participants not to be labelled as ‘mad’, or ‘lying’ about having a problem, or be labelled as ‘weak’ or a ‘coward’ by others. A new aspect was described within this barrier theme compared with the previous qualitative study, in that participants described experiencing stigma in the form of social distancing. Hence whilst stigma acted as a barrier to initial help-seeking, individuals also felt stigmatised during help-seeking and receiving treatment. **8/10** Combat Stress help-seekers referenced this theme as a barrier to seeking help.

Participants were particularly concerned about what other people, their friends, family and colleagues would think or say about them if they sought help for a mental health problem. Additionally participants did not want to be seen or treated differently by others, which was a barrier to disclosing a problem or seeking help.

David described being put off seeking help as he did not want to be judged by others:

It was fifty/fifty I did [seek help], but I was scared. Just because I didn't want people to look at not their faces, but their noses down on me thinking I'd got PTSD and 'Oh he's going through a mental thing, he's gone mental' and all those stupid things coming out of their heads.' (Pg.2, Line 71-75)

'But I was just scared at first. I was just nervous. I didn't want anyone judging me because of PTSD' (Pg.6, 295-296)

Other participants similarly cited their concerns about anticipated stigma:

'So you know it was down to me that I didn't want to get help because you know I didn't want to be the person that 'Oh he's got to get help for some of his...' or 'He's turned into a nutter' and you know' (**Aidan**, Pg.15-16, Line 762-765)

'I was very, very worried about what other people were going to say and think and everything' (**Andrew**, Pg.14, Line 674-676)

'it's the whole stigma attached to having PTSD, I think that there's no... no one in the forces would really admit it' (**Callum**, Pg.9, Line 421-423)

Joshua described the stigmatisation he had seen his friend receive after he had sought help for a mental health problem and explained that this reality deterred other from seeking help:

'What I say is everyone around him [his friend] then kind of you know stopped hanging around him. The hierarchy, sergeant major, sergeant, corporal... they were all told not to speak to the person. And this was the mentality. It was kind of if you're going sick with mental health you know you're not part of the team....You've got low moral fibre.' (Pg.10, Line 469-477)

'You'd also be seen as like a disease in the platoon or in the company. You'd be a negative thing when everyone's training to go somewhere, you're not. So you'd be isolated.' (Pg.8, Line 386-389) *'So people who have got problems they see these people are isolated and go right, I don't want to be part of that.'* (Pg.8, Line 393-395)

Participants highlighted that they didn't want to be seen as weak or attention seeking:

'They [his colleagues] might just simply look at me and going "Oh you're putting it on" "You're attention-seeking"' (**David**, Pg.16, Line 791-792)

'You don't want to go sick while serving, it's a form a weakness or something like that' (**Matthew**, Pg.12, Line 559-560)

'if you had any other kind of medical condition you would just say oh I've just been ill. But when it's a mental health problem, you think well maybe it's a weakness, maybe it's a sign of weakness here that I've you know I've got this. Maybe it's because I couldn't cope and things like that' (**Andrew**, Pg.12, Line 572-577)

'And you know I didn't want to have that sort of stigma because you know I didn't know whether it really does happen, but even now I don't talk to any of the lads that I was serving with about my problems because I don't want anybody to sort of see me as a weak person or whatever.' (**Aidan**, Pg.3, Line 132-136)

Some participants discussed their experience of stigma when others had socially distanced themselves after finding out about their mental health problem:

'Some people don't know how to be around you, and they don't how to speak to you. And you know they're worried you're going just you know just flip out or well they just don't know what to say to you.' (**Andrew**, Pg.14, Line 665-668)

'Honestly. I think they [his work colleagues]... they keep their distance from you a bit as well, they give me a bit of a wide berth, they try... because they don't know what I'm going to do. They don't know what I'm thinking and they don't know what I'm going to do next.' (**Joe**, Pg.16, Line 791-794)

Lastly participants also remarked on stigma from the general public towards mental health problems. Andrew explained that this general stigma had made it harder for him to seek help:

'...because there is a real stigma with mental health in this country. I'm afraid there is, but it is. It's getting better, but there is a real stigma. There's a lack of

understanding, there's a lack of awareness, there's a fear of mental health. And you know because if I'd have broken my leg you just go and get it fixed wouldn't you? But when it's an injury people can't see they don't understand it' (Pg.10, Line 487-493)

Similarly, Callum remarked on the effect of the media in causing stigma and negative perceptions of mental health problems, which he believed would adversely affect others wanting to seek help:

'there was a case not long ago where a guy killed his children and he actually blamed PTSD for it and that was just a get out of jail free card really. Now that was negative publicity.' (Pg.14-15, Line 698-701)

Barrier Theme - Concern about Career

This barrier theme includes participants concerns about seeking help for a mental health problem and the negative impact they believe it would have on their careers. These beliefs were set in the background of anticipated stigma and anticipated discrimination that they believed might be a potential result of disclosure of their mental health problem to a medical professional or their employers. This theme was referenced by **6/10** Combat Stress help-seekers.

Callum explained that he thought the biggest barrier to seeking help was the potential effect it could have on someone's career in the military:

'I think the stigma to be honest, because while you're in the forces I think you don't really... you don't really want to say anything because if you're...if you admit you're having a psychological problem then people may think that you're going to get penalised for it, you're not going to get promoted. You're not... you're not going to get on the highest training. You're not going to be able to handle a weapon' (Pg.9, Line 411-417)

Joshua echoed this reasoning for why he didn't seek help in-Service:

'I knew I couldn't seek it [help]... it wasn't a possibility to seek help in the infantry. My whole job was to go out and do tours. Stuff like seeking help was meaning that I can't do tours' (Pg.12, Line 565-568)

Joe who had sought help in Service was eventually medically discharged because of his mental health problem. He described how having to leave Service 'broke' him as all he'd 'wanted to be was a soldier' (Pg.5, Line 248-249). He described the reality of the effect of a mental health problem on his career:

'I couldn't touch weapons so I couldn't do guard... I couldn't go on exercise. I couldn't go with the battalion wherever they went' (Pg.5, Line 230-232)

David's military career had also ended after seeking help. Whilst seeking help, he explained to one of his Commanders, *'The reason why I didn't come to you was because I don't want to lose my job in the army.'* (Pg.6, Line 277-278). David was however eventually medically discharged because of his PTSD.

Additionally concern for careers spanned into participants civilian work jobs. **Andrew** described concern for his career and the reality of the repercussions of seeking help on his career initially:

'so I suppose that was the only barrier was well if I push the button and say I've got a problem and I start this process rolling, how's that going to affect my career? And... there have been repercussions from that because when I went back to work initially I wasn't allowed to drive, I had to do another driving assessment to be allowed to drive with them' (Pg.10, Line 494-500)

In summary, the supra-theme of stigma and its associated themes emphasise the concerns individuals had about the effect of disclosing a mental health problem and the concurrent stigma or discrimination that they believed could be experienced as a result of this. Participants highlighted the desire to avoid stigmatising labels from family, friends or colleagues. Participants were concerned that disclosing a mental health problem would negatively affect their career and this therefore influenced their help-seeking decisions. The effect of a mental health problem on an individuals' career and associated concerns appear to be rooted in the reality of participants experiences, where seeking help negatively affected their careers.

5.1.8 Supra-Theme – Masculine Norms

This supra-theme covers the concept of masculine norms and how these affect help-seeking behaviours in both negative and positive ways. Masculine norms for the purposes of this supra-theme are defined as dominant western male gender roles that prescribe beliefs about masculine behaviours, which in turn affect an individual's approach to help-seeking (O'Neil, 2008, Wester et al., 2012). Within the supra-theme, participants described adherence to dominant male gender roles, behaviours and characteristics. Participants directly or indirectly linked adherence to these masculine norms with their help-seeking behaviours. In the previous qualitative study, masculine norms were found to be both a barrier and facilitator of help-seeking, however references to 'Inverted Masculine Norms' i.e. that it is brave to seek help, were not identified in the Combat Stress dataset. Hence heightened

masculine norms were only identified as a barrier to help-seeking within the Combat Stress group.

Barrier Theme – Heightened Masculine Norms

This theme describes how participants adhered to dominant masculine norms and directly or indirectly linked these beliefs to their lack of help-seeking for the problem they were experiencing. In this barrier theme, asking for help stood in contradiction to participants' beliefs in terms of what they understood was required of them to be a 'man'. Additionally, sub-themes within this theme encapsulate participants' descriptions of the facets of masculine norms such as emotional guardedness (dislike of discussing emotions) and self-sufficiency. **9/10** Combat Stress help-seekers referenced this theme.

Joshua did not want his family to think that he wasn't brave, and therefore did not seek help when he recognised he might need to, describing it as the '*male mentality*' (Pg.12, Line 578):

'So I got out and I was like right I could go seek help, but now I was like what plan? Where my sisters and brothers, the whole last year they've thought I'd been the bravest person you know. I've been this and that and you know the next thing they're going to say I'm weak or something, I'm not going to do it.' (**Joshua**, Pg.12, Line 586-591)

David and **Matthew** didn't want to seek help because they believed their colleagues in-Service would tell them to deal with it like a man or brush it off:

“Deal with it, man up, deal with it” and that's what it is in the Army, just get on with it.' (**David**, Pg.16, Line 792-794)

I think if you went to one of the seniors or an officer and said, “Look I need to go and talk to someone about this” They'll probably turn around and say “Shut up and get on with it” you know what I mean? (**Matthew**, Pg.13, Line 624-627)

Joe recounted how his mum had wanted him to seek help but his male mentality got in the way of him accepting that he might need help:

'But she'd be onto it for about a year. Well since... before I even left the Army I think... well when I was in the Army she was on about it and obviously me being a male and a soldier stuck up my own arse trying to be a big boy...' (Pg.9, Line 447-450)

Sub-Theme - Emotional Guardedness

This theme describes how participants' made reference to how they preferred to keep emotions or problems to themselves, how they disliked discussing or disclosing personal feelings or problems, and how they put up a guard or a front so others couldn't get too close to them. This theme is closely related to ideals of masculine norms, in that participants believe that men should be stoic and private with their emotions. Emotional guardedness acts as a barrier to help-seeking as it stops the process of disclosure, of talking about and discussing mental health problems, and in turn may be interrelated with delays in self-realisation and acceptance of a problem. **7/10** Combat Stress help-seekers referenced emotional guardedness.

Matthew discussed how he put on a front when he realised he might have a mental health problem and had a tendency to put up his guard about his emotions:

'... Just didn't want to cry and stuff you know. I suppose I was putting on a brave front probably you know.' (Pg.11, Line 533-534)

'My wife says it to me as well. She says like if we've been talking about things or something. She'll say to me "Oh there you go, you've put... you know you've put your armour back on, I can't get through to you anymore, I can't talk to you' (Pg.11, Line 540-543)

David also discussed hiding his emotions from his family:

'Sometimes it's... I can't cry in front of them... I've got to go away and literally cry because it is upsetting what I've put everyone through' (Pg.11, Line 530-532)

Joshua went on to describe how the nature of military Service affected soldiers' ability of empathy and expression leaving them at a deficit when trying to discuss emotions:

'So then lads get back from tours and they're trying hard to express themselves because they're not allowed to speak out openly and express themselves to start with.' (Pg.3, Line 149-151)

'you talk to your friends maybe sober about stuff which happened out on the tours. That's all the matter of fact as if you were talking about maybe EastEnders or something like that. So never carrying any kind of weight. So you've all been there, you've all done that and you know what I mean, no one kind of really cares that you're training to do it again in a couple of months' (Pg.13, Line 636-642)

Barrier Sub-Theme - Self Sufficiency

The theme self-sufficiency encapsulates participants' desire to cope with problems on their own, without the help of medical professionals or other people. Sometimes involved in the

idea of self-sufficiency was the notion that the participant did not want to burden people with their problems. The participants made a judgement on their need and concluded they were able to/or had to deal with the problem by themselves. Some of the reasons for traits of self-sufficiency are bound up in ideas of masculinity, that men should be able to deal with problems or fix things on their own. **5/10** Combat Stress help-seekers referenced this sub-theme.

Aidan explains that after he left Service, he wanted to cope with the problems he was experiencing without seeking help:

'... because I was still on sort of suffering with things and I was still determined that I wasn't going to have any problems and I was just going to sort of... I was going to get over it' (Pg.5, Line 224-227)

Will described feeling frustrated with people asking him to seek help because he felt he was dealing with it ok alone... *'I've coped with it, I've got on with it, why can't people just leave it be?'* (Pg.5, Line 218-219)

Other participants did not want to burden anyone else with their problems and believed they should be capable of coping alone.

David: *'basically I didn't want to bother them my family or anyone else'* (Pg.5, Line 249-250)

Callum: *'I've got the memories and I don't really want my problems going onto other people... so I don't... I don't go telling anyone it's this, this. I don't go telling my dad's because I don't want them having the image'* (Pg.12, Line 594-597)

Overall, heightened masculine norms and aspects of masculine norms such as emotional guardedness and self-sufficiency played a role in creating barriers to help-seeking.

5.1.9 Supra-Theme – Attitudes/expectations towards mental health treatment

This supra-theme encompasses participants' attitudes and expectations towards mental health treatment. These attitudes and expectations act as barriers or facilitators of help-seeking depending on whether the participant had positive or negative attitudes about mental health treatment. These attitudes or beliefs may be based in the reality of experience or may be perceptions held participants. These attitudes or expectations covered beliefs about professional health services and medication.

Barrier Theme – Negative attitudes/expectations towards mental health treatment

This barrier theme collates the incidences where participants noted their negative attitudes or expectations towards mental health treatment, directly or indirectly citing these beliefs as barriers to medical help-seeking. **9/10** Combat Stress help-seekers referenced this theme.

Participants cited their lack of confidence in different aspects of professional medical services as a barrier to help-seeking. Some participants discussed their views that the Armed Forces weren't interested in trying to treat mental health problems, which stopped many people from coming forward for help. **Joshua** remarked that in Service he was:

'...frustrated with the hierarchy why they're actually not helping these guys [men with mental health problems]' (Pg.9, Line 411-412), 'And them not pulling out their thumb and having a bit of moral courage and wanting to deal with these things. They'd rather cover it up...' (Pg.11, Line 534-536).

Greg and **Callum** similarly discussed their opinion that the Army didn't want to deal with mental health problems:

'I feel there should be people in the military that are trained in this sort of stuff to pick it up early. Not when it's too late... When you're out of the army you've got no military help, you're sort of fending for yourself. And, yeah, the army don't really want anything to do with it' (**Greg**, Pg.11, Line 521-525)

'I think the forces don't really ask you [about mental health problems] because they don't want to know the real answer.' (**Callum**, Pg.15, Line 712)

There were also negative views discussed by participants about the willingness or the ability of the NHS to treat individuals who had been in the military. These negative experiences individuals had on the NHS had discouraged them from using NHS services at the time and discouraged them currently.

Callum: *'... the NHS are very... because it's a military thing, they don't really want to touch it [his PTSD diagnosis]. So they ignore it. (Pg.10, Line 467-469) 'Well it was that no one wanted to take ownership of the situation or of the case. It was because it was... I think the.. they're intimidated or they don't know what to do with the PTSD on the military side. Now if I had PTSD because of a car crash or a serious assault or a physical assault whatever, it is a lot more common in the history sort of thing is more common in the real world. But because of my condition, as mine was to do with explosions and gunshots and tanks and people getting blown up and all that. That's not a normal thing in the real world so I think that was a bit intimidating towards the NHS. That's why they just passed me along the line really.'* (Pg.16, Line 776-786)

Some of these negative views revolved around the concept of 'Combat PTSD'. Participants described their PTSD arising from combat as being different to other forms of PTSD and therefore the NHS was not equipped to understand or to deal with their specific form of PTSD. Some of these views were compounded by NHS services referring individuals on to Combat Stress, or being unable to treat individuals within their services. Their negative experiences using NHS services and their views regarding 'Combat PTSD' currently dissuaded participants from using NHS services.

Joe: *'Yeah. And then civilian street you know there's only... no much... not much help there. People were trying to help, but they didn't have the (umm) the experience of veterans or ex... ex people who'd been out in combat roles. They'd dealt with people with PTSD, but not my specific PTSD. So they were very... well to be honest with you they didn't want to take it on. That's how I felt. Civilian... civilian street didn't want to take it on.'* (Pg.13, Line 616-622)

I ended up seeing a civilian lot again through the NHS... And he [the doctor] was very honest and he turned around and he said "You know with PTSD we can treat it and stuff like that, but with your one it's Combat PTSD. We don't know anyone who... who can help you out with that' (**Joe**, Pg.1, Line 45-50)

Aidan: *'well, you know Military PTSD I think is more, or from what I've told by various different psychologists and doctors and whatever, it's different to sort if you were to have a car accident and develop PTSD. It's a slightly different kettle of fish.'* (Pg.14, Line 676-678).

'And it seems to me a bit of a consensus with most of the lads if you asked them that you know the NHS and Combat Stress are two totally different kettles of fish. And the only real way to go for somebody who's like got service related mental health is with Combat Stress.' (**Aidan**, Pg.15, Line 713-717)

Andrew equally described how his Combat PTSD was different from other forms of PTSD. He had not had a good experience on the NHS and this confirmed to him that it needed to be treated separately by Combat Stress:

'You know and you get people with PTSD when they witness a nasty car crash, you know? I think that's a... not to disparage or kind of mitigate or reduce their experiences, but it's a different field to suffering PTSD from being in the theatre of war. And I think that's where Combat Stress holds unique expertise which to my mind is why I responded so well to it. Whereas the NHS haven't got a bloody clue about that, you know, and I found it very patronising and very insulting. And I found their lack of military just wound me up, you know... And to me that's I suppose the key... the key difference is that you need to be treated like its own discipline because it is its own discipline...' (Pg.16-17, Line 810-822)

Other participants had general negative attitudes or expectations of treatment that created barriers to help-seeking and receiving treatment. **Matthew** felt that his civilian doctor did not care for his treatment:

‘Well yeah I felt... I felt like I was between a rock and a hard place you know, and no one... everyone was just like “yeah, whatever” you know “we don't care, just do one”’ (Pg.12, Line 584-586) ‘They just wanted to fob you off with tablets, “Deal with it”, you know, whatever’ (Pg.12, Line 591-592)

Will was nervous about the treatment process and having to disclose his problems to his assessor and his wife:

‘I was a bit unsure about what sort of questions they might ask and some of the answers I had to give.’ (Pg.4, Line 177-179)

Some participants particularly disliked the connotations they perceived of being on medication and therefore either disengaged with doctors offering this option or did not adhere to taking their medication:

‘When I went in the GP... the GP said about me having some medication and I just didn't want to... I think it was only my... my... because of the stigma attached to the medication and the mental illness, I didn't really want to go down that road’ (Callum, Pg.14, Line 667-670)

‘I was on loads of medication. Sometimes I was taking it and sometimes I wasn't because it was just felt like oh I'm taking drugs’ (David, Pg.13, Line 631-633)

Overall, participants' lack of confidence in professional health services, both in Service and on the NHS, created barriers to seeking help and engaging with treatment from available health services. Some of these negative attitudes were born out of experience and currently stood as barriers to seeking help for participants.

Facilitator Theme – Positive attitudes/expectations towards mental health treatment

This facilitator theme captures where participants noted positive attitudes or expectations towards mental health treatment that enabled or facilitated their help-seeking and engagement with treatment. Many of these positive attitudes were created by their experience of help-seeking. This facilitator theme mirrors the opposite barrier theme ‘negative attitudes or expectations towards mental health treatment. **8/10** Combat Stress help-seekers referenced this theme.

Chris described his approach to help seeking and treatment. **Chris'** positive attitude towards trying different treatments enabled him to accept the treatment and help that was on offer:

'I'm quite open to it to be honest with you [help-seeking and treatment]. I'll try absolutely everything and which I have done, everything that's been available I've always gone for it.' (Pg.12, Line 576-578)

Combat Stress participants noted positive attitudes towards mental health treatment, however this was often as a result of their treatment in the NHS or at Combat Stress. There was little evidence these attitudes caused help-seeking, nonetheless participants positive experiences encouraged them to successfully engage in their treatment. These positive experiences and the continued support offered by Combat Stress, facilitated help-seeking in creating the knowledge of future support and confidence in accessing that support.

Participants praised the treatment and continued support they had received at Combat Stress, where they felt they could return for support:

Callum: *'...but the dealings I had with Combat Stress...literally the first phone call and I knew straightaway that it was... and it was professional.'* (Pg.4, Line 172-174)
'Now if I go back and then I you know I sort of say I'm really, really struggling with this, this, this. Then they'll put me back onto another two-week course. So just because I've been on the six weeks it doesn't mean it's the end, so to speak' (Pg.13-14, Line 646-650)

Aidan: *'You know I've got so much respect for them for doing it, and it makes our quality of life better they're there to support us when we need the support.'* (Pg.12, Line 570-572)

Will: *'For myself I know that I'm not alone now. You know that if I'm in desperate need and then I can pick up the phone and leave a message or I've got an emergency contact number'* (Pg.6, Line 284-286)

Joe explained there was continued community support from Combat Stress that he could access if he did become unwell again:

'The support is... the support in civilian street now where the community worker... that side of it is absolutely amazing and if anything... oh actually if anything goes wrong I think she would be able to get me called into see someone reasonably quick. So yeah the support on that side is brilliant.' (Pg.17, Line 855-860)

Matthew had been nervous about receiving treatment at Combat Stress and had only completed five assessment days at their treatment centre when he completed the interview with myself, however his positive experience meant he was happy to continue his future treatment:

'Oh I feel really good about it now to be honest [seeking help at Combat Stress]. You know since I've been there I feel really good about it. 'You know like all the nurses and they're so... so prepared about everything... you know all the staff even the

catering staff you know... you know not particularly the nurses. You can go and talk to anyone. ' (Pg.7, Line 333-343)

Overall, it was mainly participants positive attitudes and expectations of treatment born out of their experiences that acted as a facilitator of help-seeking in the future. Participants felt confident in Combat Stress and confident in the future support they could access should they need to.

5.1.10 Supra-Theme – Military Social Influences/Structures

This supra-theme comprises of social influences and barriers that were specific to the context of participants currently Serving in the Armed Forces. This supra-theme includes the barrier theme, 'discipline before help' which was also identified in the KCMHR interview group. The barrier 'Bullying' found in the KCMHR group was not apparent in the Combat Stress interviews.

Barrier Theme – Discipline before help

This barrier theme describes how the discipline system in the military was described as being quicker to react to incidences of aggression, violence or hazardous drinking than the welfare or medical system. It captures participants' description of incidences where Service personnel found themselves in fights or late to duty from drinking too much and that these situations were seen as issues of discipline, and not warning signs that the Service personnel in question may need mental health support or treatment. This theme represents structural and cultural barriers to help-seeking engendered by the discipline system in Service. **2/10** Combat Stress help-seekers referenced this theme.

Greg described how he believed his seniors could see he had a problem, but remarked how they treated him as a discipline issue, which did not create a positive environment for help-seeking:

'I was depressed and I had just a massive self-destruct mode and the army, for instance, like the people in charge were seeing it but they were just instead of like helping me, they were just telling me off and punishing me. And that made me reject it and it was just like that we were just bouncing off each other, if you know what I mean?' (Pg.11, Line 544-549)

Joshua described how Senior Commanders were focused primarily on their own careers and on keeping their soldiers fit and healthy to be able to deploy. He explains how this focus meant Senior Commanders did not want their soldiers unwell and instances of hazardous

drinking were immediately disciplined. **Joshua** explained that he believed it was easier for Commanders to discharge difficult soldiers rather than help them.

'...in the infantry as well, there's probably where the help is needed the most but... it's the most frowned upon. Basically if you're seen going to say the med centre we have there and you're asking about mental health. They basically, the way your bosses will see it and they'll tell you every morning, remind you not to be going to the med centre over anything like that. You know they've got a job and a career, you know you have the competition just like everywhere else.' (Pg.7, Line 335-342)

...they'd ignore the problem, think ok, 'old jonesey' So that's his second, third tour. He's been an excellent soldier and on the way he started having these bad drinking problems and wonder why he hasn't been coming back a day or two later. You know rather than looking at it that way they just go right discipline because you know like they would prefer the career. And for the managers as well, they want to try and stay professional. You know what I mean, nip these things in the bud. You don't want to have an open arm mentality to people with problems. They'd rather just get rid of them.' (Pg.8, Line 358-367)

In summary, the theme of 'discipline before help' seems to be an important factor in creating an atmosphere in Service where help-seeking is not encouraged and problems identified by Commanders are seen primarily as disciplinary issues, rather than welfare issues. Whilst this theme was only referenced a few times, it is a clear example of a barrier to seeking help, specific to the military experience. Interestingly it was also identified in the other KCMHR qualitative interviews adding evidence to the existence of this theme.

Overall, there were many barriers to help-seeking discussed by the Combat Stress group, but they also equally discussed many facilitators of help-seeking that were vital in terms of their initial help-seeking and help-seeking success. The most prominent barriers to help-seeking were practical/healthcare barriers, lack of judgement of need for professional help, public/anticipated stigma and heightened masculine norms. Facilitators of help-seeking and engagement with treatment were recognition of need and supportive social networks.

Chapter 6 – Qualitative Studies Summary

This chapter brings together the main findings from the qualitative studies conducted with the KCMHR cohort non-help-seeking and help-seeking groups, and with the Combat Stress help-seeking group. The in-depth semi-structured interviews gained insight into the barriers and facilitators of seeking help for mental health problems among military personnel. Interviews were conducted with 26 individuals overall. Ten non-help-seekers and six help-seekers were recruited from phase two of the KCMHR cohort study, a further 10 interviews were conducted with help-seekers who had sought help with Combat Stress, who are a leading voluntary organisation providing treatment and support for ex-Service personnel with mental health problems. Interviews were analysed using thematic analysis. Six supra-themes encapsulating barrier and facilitator themes were identified in both the KCMHR interview groups and the Combat Stress interview group, these were:

- Recognition/Judgement of Need
- Stigma
- Masculine Norms
- Attitudes/Expectations towards Mental Health Treatment
- Social Networks
- Other Military Social Influences/Structures

Two further supra-themes were identified in the Combat Stress interview group only, these were:

- Crisis
- Practical/Healthcare Structures

Figure 18 presents a diagrammatic model of these supra-themes. The additional themes added by the Combat Stress study are shaded in turquoise.

Figure 18 - Overview of Supra-Themes – King’s Cohort and Combat Stress Interview Groups

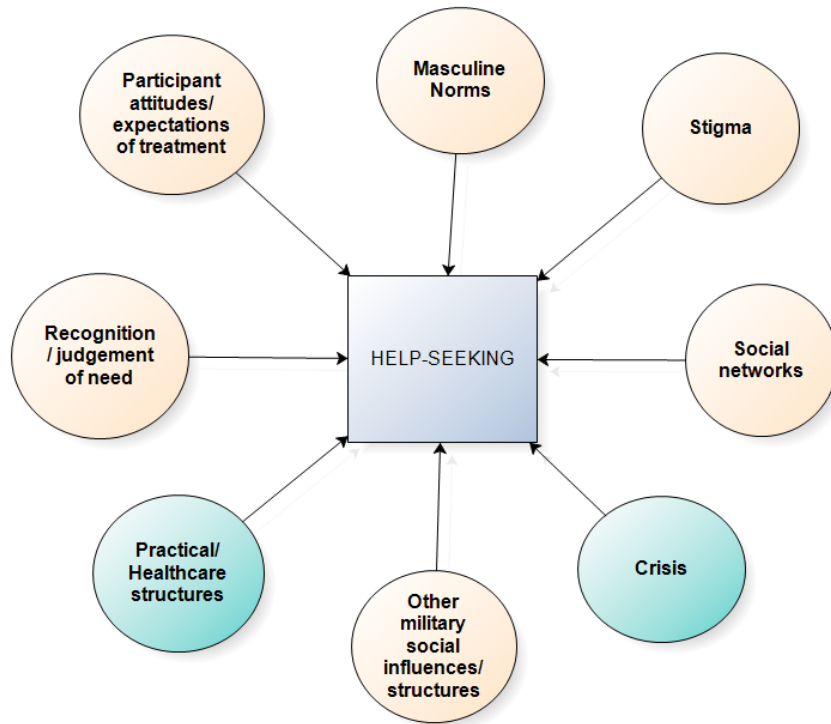
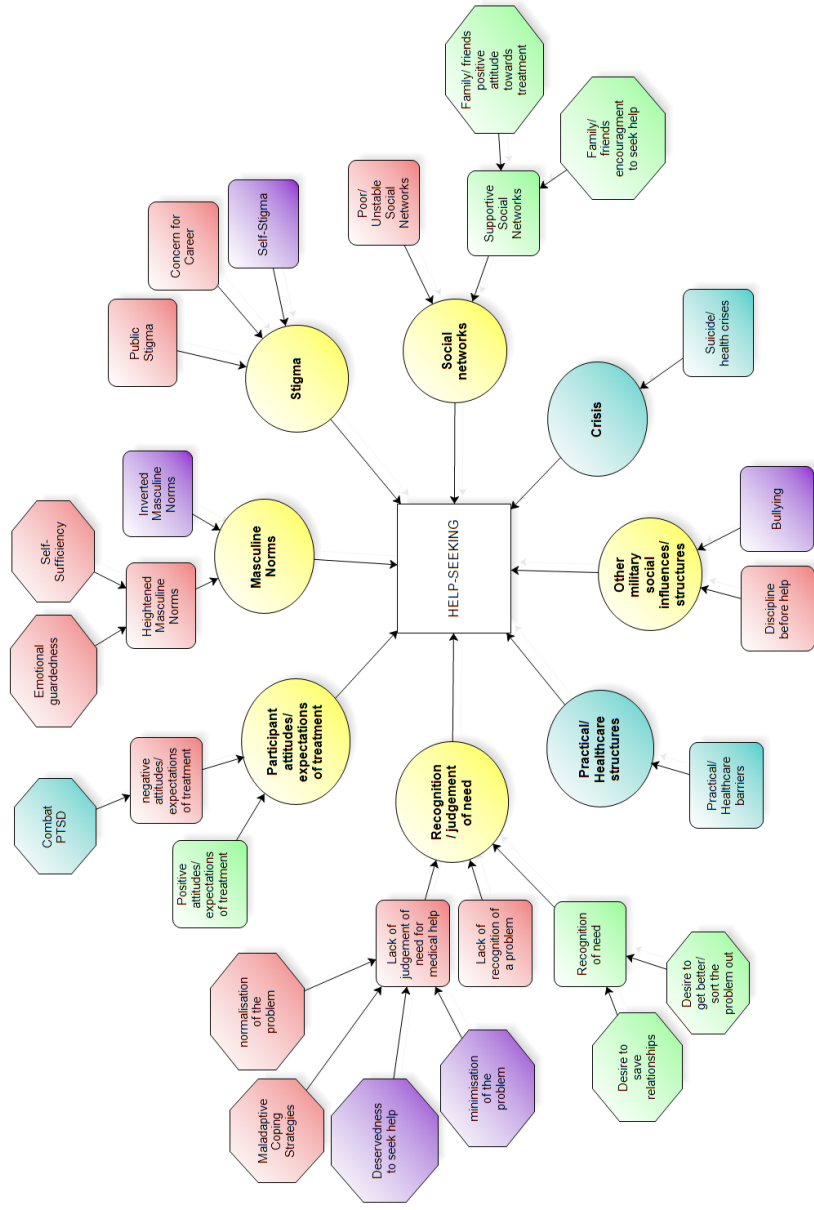


Figure 19 (below) presents a full diagram of the help-seeking model (including themes and sub-themes) combining all themes from the King’s cohort and Combat Stress interview groups. The model highlights which themes were similar and divergent between the King’s cohort and Combat Stress interview groups.

Figure 19 - Integrated Help-Seeking Model - King's Cohort and Combat Stress Interview Groups



Key
Yellow: Supra-themes found across King's and Combat Stress interview groups
Red: Barrier themes found across King's and Combat Stress interview groups
Green: Facilitator themes found across King's and Combat Stress interview groups
Turquoise: New supra-themes/themes/sub-themes found in the Combat Stress interview group
Purple: Themes/sub-themes only identified in the King's Cohort interview group

To aid numerical comparisons between groups, please refer to Table 7 for an overview of all interview groups' respective number of participant references to barrier and facilitator themes. (Associated aggregated supra-themes and divided sub-theme data are excluded for parsimony – to view a complete detailed table of all these, please see Appendix 16).

6.1 Prevalent Barrier Themes Across All Interview Groups

Underneath the supra-themes sit various barrier and facilitator themes. Certain barrier themes to help-seeking were common whether individuals had sought help or not, these included:

- **Lack of judgement of need for medical help**

25/26 participants referenced this theme. The majority of individuals at some point in their help-seeking pathway recognised they had a problem, yet they did not judge the need to seek professional help for this. Participants normalised or minimised their problems with some believing they did not deserve any potential help. Many participants used maladaptive coping strategies that dis-incentivised help-seeking and delayed recognition that they could benefit from professional support and treatment.

- **Public/anticipated stigma**

24/26 participants referenced this theme. The majority of individuals noted the anticipated stigma from others of disclosing a mental health problem. Participants wished to avoid being labelled as weak, mad, cowardly, or faking a problem. This stigma was persistent even after individuals had left Service and affected participants own stigmatising attitudes towards mental health problems. Combat Stress help-seekers additionally noted their experience of stigma where they felt colleagues had socially distanced themselves from them after the disclosure of their PTSD diagnosis.

- **Concern for career**

19/26 participants referenced this theme. A large proportion of participants were worried about the effect of disclosing a mental health problem on their career. For ex-Service personnel, many of these concerns were centered specifically on their time in the military. There were current ex-Service non-help-seekers who believed disclosing their problems to their civilian employer would also negatively affect their career. Some Combat Stress participants had experienced negative effects of seeking help for their mental health problem on their careers, in that a minority had experienced medical discharges from Service.

- **Heightened masculine norms**

25/26 participants noted this theme. Participants described adherence to particular masculine norms such as the desire to be seen as strong, self sufficient and competent. They described a dislike of talking about emotions and sharing problems with others. These norms often acted as barriers to seeking help for individuals. The act of seeking help went against their notions of what it was to be a man. Additionally individuals had a strong preference for self-management of problems without help from others.

- **Negative attitudes/expectations towards mental health treatment**

23/26 participants made reference to this theme. Participants discussed many different negative views or expectations they had towards mental health treatment. Some of these were general negative views, such as a lack of confidence that treatment or doctors could help them. Some of them were specific negative attitudes in relation to the trust individuals had in the MOD or ability of the NHS to treat military personnel. Some participants were concerned that mental health treatment would entail discussion of difficult emotions or entail pharmacological treatment. All of these negative attitudes dissuaded individuals from seeking help. Lastly some participants had bad experiences with healthcare services, which delayed their future help-seeking.

- **Poor/unstable social networks**

21/26 participants discussed this theme. A large proportion of individuals discussed the fragmented or poor social networks they had around them. The particular experience of military Service detracted from civilian friendships and had created intense friendship bonds in Service, which were continually disrupted through redeployments. When individuals left Service they noted their isolation from their previous military friends, whilst also having little support available to them in civilian life. The nature of these social networks detracted from the social support individuals had available to them. This therefore reduced the possible positive influences that social support could lend individuals in disclosure of problems and encouragement to seek help.

6.2 Prevalent Facilitator Themes Across All Interview Groups

There was only one common facilitator theme described across all interview groups, this was:

- **Supportive social networks**

24/26 participants discussed the presence of supportive social networks. For the majority of help-seekers an important facilitator of help-seeking was having family or friends encourage them to seek help. Often individuals sought help, not for themselves, but for the sake of their families. Combat Stress interviewees noted how good social support was key to them persisting in seeking help and engaging with their treatment. Interestingly non-help-seekers noted the potential support they believed they would receive if they were to seek help, however this had not precipitated their help-seeking.

6.3 Main Differences Between Non-Help-Seeking And Help-Seeking Group Interviewees

The KCMHR and Combat Stress help-seeking groups identified and referenced more facilitators of help-seeking than participants in the KCMHR non-help-seeking group. Two facilitator themes, ‘Recognition of need’ and ‘positive attitudes towards mental health treatment’, were not identified in the KCMHR non-help-seeking group. The facilitator themes referenced more often by help-seeking groups compared to the non-help-seeking group included:

- **Recognition of need**

13/16 help-seekers and **0/10** non-help-seekers referenced this theme. There was an increasing prevalence of this theme between help-seeking groups with **4/6** King’s cohort help-seekers and **9/10** Combat Stress help-seekers discussing this theme. Within this theme, participants’ recognition of their own health needs was pushed forward by their desire to ‘get better’ and to save relationships around them that had been negatively affected by their mental health problem.

- **Inverted masculine norms**

4/16 help-seekers compared to **1/10** non-help-seekers referenced this theme. Whilst there were few references to this theme, I identified it as being an important separating difference between the King’s cohort group help-seekers compared to non-help-seekers. Inverted masculine norms were not found in the Combat Stress help-seeking group. This facilitator theme describes how participants noted their masculine norms, however utilised language that aligned help-seeking with these norms, such as describing help-seeking as ‘brave’. The association of positive masculine attributes with help-seeking enabled some participants to seek help.

- **Positive attitudes/expectations towards mental health treatment**

11/16 help-seekers and **0/10** non-help-seekers described this theme. Again there was an increasing prevalence of this theme between help-seeking groups, with **3/6** King's cohort and **8/10** Combat Stress interview groups noting this facilitator of help-seeking. This theme describes participant's positive attitudes towards mental health care, where they believed treatment would be beneficial and therefore were encouraged to seek help. The Combat Stress help-seeking group noted their positive beliefs about mental health treatment, often as a result of treatment, rather than a view they held before they sought help. In contrast, the King's help-seekers noted this view before treatment. Hence positive attitudes towards mental health treatment enabled initial help-seeking *and* engagement with treatment.

6.4 Main Differences Between KCMHR And Combat Stress Interview Groups

Overall there were many similarities between the KCMHR non-help-seeking and help-seeking groups in terms of barriers identified and extent of help-seeking, compared to the Combat Stress help-seeking group. This was unexpected, as I had thought help-seeking groups would present similar results. There was an increasing prevalence of accumulative mentions of facilitators from the King's interview groups to the Combat Stress interview group. Taking into account interview group size, KCMHR non-help-seekers each made on average 2.8 references to facilitators overall, KCMHR help-seekers 9.8 and Combat Stress help-seekers 11.2 references.

Further differences were found between the KCMHR non-help-seeking and help-seeking groups compared to the Combat Stress help-seeking group. As mentioned previously, the supra-themes, '**Crisis**' and '**Practical/Healthcare Structures**', and their accompanying negative facilitator theme '*suicide/health crisis*' and the barrier theme, '*practical/healthcare barriers*', respectively, were only identified in the Combat Stress help-seeking group. There were additional subtle differences within supra-themes when comparing the Combat Stress help-seeking group to the KCMHR interview groups. These included (see Figure 19):

- The barrier theme *Self-Stigma* was not identified in the Combat Stress group.
- The facilitator theme, '*Inverted Masculine Norms*' was not identified in the Combat Stress group
- The barrier theme, '*Bullying*' was not identified in the Combat Stress group.

- The barrier sub-themes, '*Minimisation of the problem*' and '*Deservedness to seek help*', were not identified in the Combat Stress interview group.
- The barrier sub-theme, '*Combat PTSD*' was present in the Combat Stress interviews but not in the King's Cohort interviews.

The subtleties between and within themes are expanded upon in the main Discussion section (Chapter 9).

6.5 Different Stages Of Help-Seeking

The differences and gradation of themes found between the three interview groups highlight the possible different stages of help-seeking the interview groups represent, and the types of barriers encountered at different help-seeking stages. The KCMHR non-help-seeking group described few facilitators of help-seeking, despite the KCMHR help-seeking group describing increased references to facilitators, their overall depiction of their help-seeking was poor in terms of its quality and success, finally Combat Stress participants described more facilitators of help-seeking and were engaged in a treatment plan. Hence these differences might suggest the different stages of help-seeking between the three different interview groups:

- KCMHR non-help-seeking group - individuals at the beginning or pre-stages of the help-seeking process
- KCMHR help-seeking group - early stages of help-seeking and,
- Combat Stress help-seeking group - more engaged help-seekers.

Throughout the qualitative evidence, it was apparent that the quality and success of help-seeking was better in the Combat Stress group, but they also described a long help-seeking pathway. Comparatively, individuals in the KCMHR help-seeking group had often only consulted their GP, and the majority were not engaged in treatment. Hence the KCMHR help-seeking group described a more limited help-seeking pathway.

All groups described social or psychological barriers to help-seeking such as stigma or negative attitudes. However, only the more engaged, Combat Stress help-seeking group, discussed practical or healthcare barriers to help-seeking. This possibly highlights the importance of practical/healthcare barriers for individuals further on in the help-seeking process. This is further explored in the main Discussion section.

Overall there were particular barriers that were important to participants irrespective of help-seeking status. The most prominent of these themes, on the basis of participant references and overall accumulative references to a theme, was a *'lack of judgement of need for medical help'* and *'public/anticipated stigma'*. There was however only one facilitator of help-seeking that spanned interview groups which was, *'supportive social networks'*, however this facilitator did not encourage help-seeking in the KCMHR non-help-seeking group. The non-help-seeking group was distinguished from the help-seeking groups by its' lack of discussion of facilitators of help-seeking. Finally new themes emerged from the Combat Stress group and subtle thematic differences were apparent between the KCMHR and Combat Stress interview groups. For detailed numerical references across interview groups please see Appendix 16.

Table 7 - Barrier And Facilitator Themes - Summary Table Qualitative Studies

	Participant Reference to Barrier and Facilitator Themes			
	All Participants (n=26)	KCMHR Non-Help-Seekers (n=10)	KCMHR Help-Seekers (n=6)	Combat Stress Help-Seekers (n=10)
BARRIER THEMES				
Lack of recognition of need	12	4	4	4
Lack of judgement of need for medical help	25	10	6	9
Public/anticipated stigma	24	10	6	8
Self-stigma	14	9	5	0
Concern for career and medical records	19	9	4	6
Heightened masculine norms	25	10	6	9
Negative attitudes/expectations towards mental health treatment	23	8	6	9
Poor/unstable social networks	21	8	5	8
Discipline before help	5	1	2	2
Bullying	2	0	2	0
Practical/healthcare structures	10	0	0	10
NEGATIVE FACILITATOR THEME				
Crisis	8	0	0	8
FACILITATOR THEMES				
Recognition of need	13	0	4	9
Inverted masculine norms	5	1	4	0
Positive attitudes/expectations towards mental health treatment	11	0	3	8
Supportive social networks	24	8	6	10

Chapter 7 – Overview of Quantitative Study

Chapters 7-8 present my quantitative study method and results. This quantitative study assesses the health and help-seeking behaviours of military personnel (including, Service personnel, Reserves and ex-Service personnel) drawn from the KCMHR cohort study. The study aims to investigate associations of help-seeking, including public/anticipated stigma, self-stigma, attitudes towards mental health treatment, practical barriers and social support. Participants' knowledge of current healthcare services and willingness to use these services is also explored. This quantitative study aims to build upon my qualitative results and assess barriers and facilitators of help-seeking on a quantitative level.

7.1 - Quantitative Study Methods

7.1.1 Data Source

My quantitative study's sample is taken from a KCMHR clinical telephone interview study. The sample for this clinical interview study was recruited from phase 3 of the KCMHR cohort study (my first qualitative study was recruited from phase 2 of the KCMHR study). Individuals were recruited to the clinical telephone interview study, if they endorsed experiencing a stress, emotional or mental health problem in the last three years in the KCMHR cohort phase 3 questionnaire. I will describe phase 3 of the KCMHR cohort study, describe the clinical telephone interview study, and then describe the precise data utilised from both these sources.

7.1.2 Phase 3 KCMHR Cohort Study

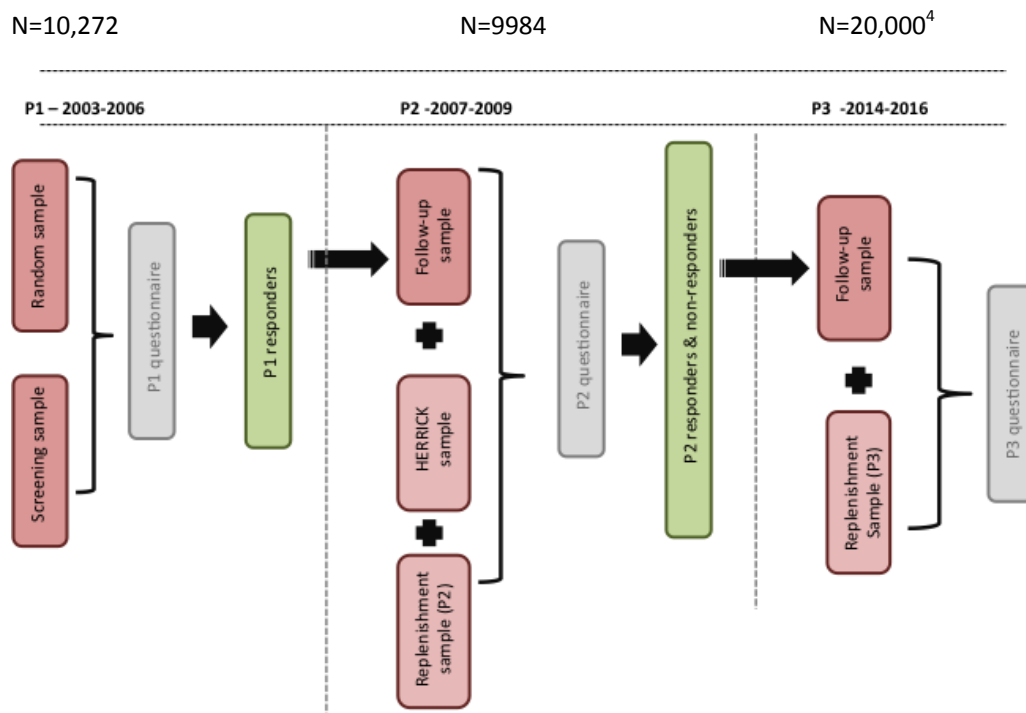
Study design and participants

The KCMHR cohort study aims to investigate whether the health of Serving & ex-Serving men & women has been affected by recent deployments and to examine more general issues relevant to the health & wellbeing of the UK Armed Forces. Data have been collected in 2003-2006 (phase 1) and 2007-2009 (phase 2). Currently, phase 3 of data collection is underway with an estimated timeframe of data collection spanning 2014-2016. The primary objective of phase 3 is to continue to describe the health of ex-Service, Regulars and Reserves, who participated in operations in Iraq (Operation TELIC) and Afghanistan (Operation HERRICK) with the aim of detecting any health effects which have developed since the start of the cohort study, and to describe the course and outcomes of the health effects uncovered in phases 1 and 2. Details of sampling methods, participants and questionnaire items of phase 1 and 2 can be found in Hotopf et al. (2006) and Fear et al. (2010).

At phase 3, all those in the KCMHR cohort study who responded at phase 1 or phase 2 are currently being resurveyed. A new replenishment sample is also being included of personnel who joined Service after the phase 2 replenishment was sampled in April 2007. This new replenishment sample will be representative of those who have joined the trained strength of the UK Armed forces since April 2007. Please see Figure 20 for a flow diagram depiction of the KCMHR cohort phases and samples.

All together over 20,000 potential participants are to be included in phase 3. In line with response rates from the previous phases (Phase 1 and 2 overall response rate 58.7% N=10,272 and 56.5%, N=9984 respectively) it is estimated there will be a final participating sample of approximately 10400 individuals.

Figure 20 - KCMHR's military cohort study: phases and samples



Data collection and materials

Those individuals taking part in phase 3, complete a self-administered quantitative questionnaire. An online version of the questionnaire was also developed and contains the same questions as the paper version. The questionnaires ask about individuals' military background, deployment history and experiences, mental and physical health, accidents and injuries, and relationships. Reservists are additionally asked about civilian employment, and

⁴ 'N' here is approximate and represents number estimated to be surveyed.

those who have left Service are asked about transition from Service and life since leaving the Armed Forces. The questionnaires take up to 45 minutes to complete. Please see Appendix 17 for a copy of the phase 3 questionnaire. As of September 2015, phase 3 had received back 5000 completed questionnaires out of an approximate 20,000 to be completed.

Ethics Approval Phase 1, 2 and 3

The KCMHR cohort study received full ethical approval, both from the MoD Research Ethics Committee (448/MODREC/13) and King's College Hospital Research Ethics Committee (NHS REC reference: 07/Q0703/36).

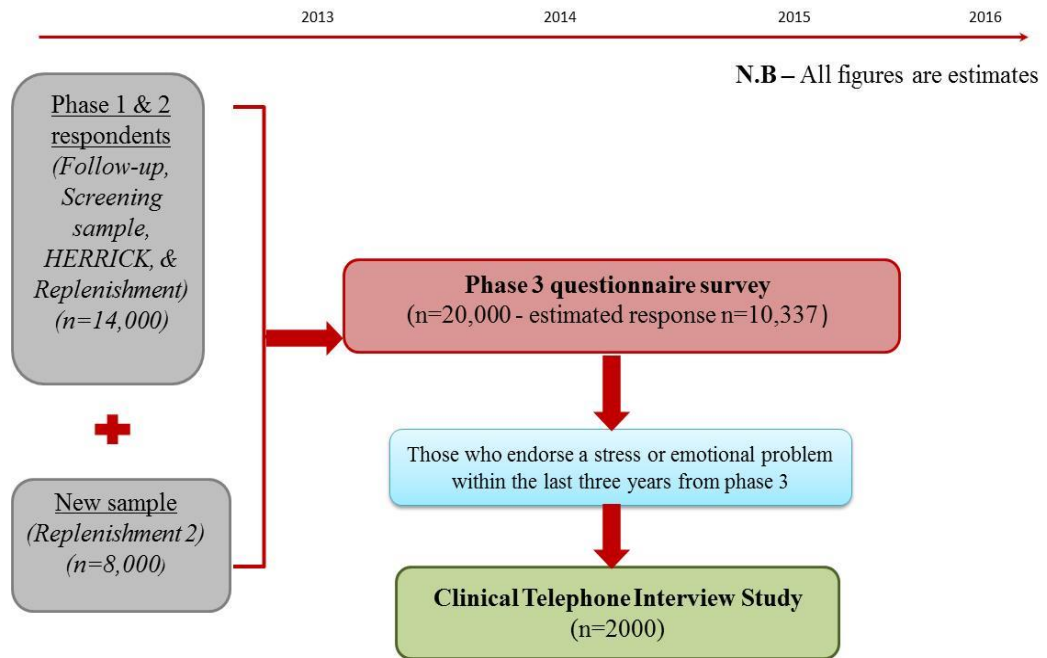
7.1.3 Clinical Telephone Interview

Study Design and Participants

My specific quantitative study sample comes from the clinical telephone interview study. The clinical telephone interview sample is currently being recruited from those who have completed the phase 3 questionnaire and who have consented to be contacted in the future. My quantitative study is therefore a pilot study of the clinical telephone interview study, taking the available data, as of July 2015, and running initial analyses (the full recruitment to the clinical interview study is not expected until mid-late 2016). The cut off for inclusion into my quantitative study was July 2015 to allow time for completion of analyses before the end date of this PhD. The clinical telephone interview is designed to explore health and help-seeking pathways of those that endorse a stress, emotional or mental health problem within the last three years, whilst also allowing comparisons between sub-groups of non-help-seekers and help-seekers.

As of July 2015, the research team carrying out the clinical telephone interview study had interviewed 575 individuals. The selection of individuals to take part in the clinical telephone interview study is on the basis of their response to the phase 3 questionnaire question: *'Have you had a stress, emotional or mental health problem in the last three years'*. Those that endorsed "yes" to this answer are currently being approached to take part in the clinical telephone interview study. Please see Figure 21 for a flow diagram of the clinical telephone interview sample.

Figure 21 - Phase 3 and Clinical Telephone Interview Sample Flowchart



The clinical study is expected to have consent to re-contact approximately 10,000 participants and it is estimated (from phase 2 response data (Hines et al., 2014a)) that 2000 of the 10,000 will endorse a stress, emotional or mental health problem and therefore be eligible to take part in the clinical telephone interview.

Data collection and materials

The study consists of a structured interview delivered over the telephone. The main components of the interview are:

- Mental health measures for depression, anxiety and PTSD
- Alcohol use and questions about the context of alcohol use
- Experience of a current stress, emotional, mental health or alcohol problem
- Suicidal thoughts and self-harm
- Awareness and willingness to use healthcare services
- Help-seeking status and sources of help-seeking
- Treatment received
- Barriers to care and stigma
- Social support

Please see Appendix 18 for a copy of the interviewers clinical telephone interview questionnaire and question response sheets.

Potential participants are invited to take part in the study by an invitation pack sent through the post. The invitation pack includes a letter providing introductory information about the study and a participant information sheet which includes information on participation, how to decline participation, consent forms with prepaid envelopes and laminated response cards detailing response options for some of the questions in the study.

The team carrying out this studying took verbal consent over the telephone as well as hard copy consent sent by participants from their study pack. The interview team made sure prior to the interview that that individual understood the requirements of the study and that the individual had the opportunity to ask further questions. Participants were free to withdraw at anytime and participation was voluntary. Interviews were recorded (with consent from the participant) and once the interview was completed, individuals received a reimbursement, as a thank you for their time of £25, as well as a Signposting booklet providing details of organisations that could offer help on a range of health and welfare issues.

The interview team had a risk protocol and a mental health clinician on call for this study. They would enact the risk protocol if they were concerned about a participant who was distressed or who disclosed information that could have serious implications for their health and wellbeing. If an interviewer were concerned about a participant, a risk form would be completed and call back from a mental health clinician would be offered to the participant. Lastly an independent medical officer was also assigned to the study that would provide independent advice and support to any study participants that wished to contact them.

Ethics

Full ethical approval was given to the clinical telephone interview study by the Ministry of Defence Research Ethics Committee (535/MODREC/14).

7.1.4 Current Study Specific Data

Study Sample

Whilst the clinical telephone interview study had collected data on 575 participants, my quantitative study consists of data from 453 *male* participants from the clinical interview study, who endorsed they had experienced a stress, emotional or mental health problem within the last three years in their phase 3 questionnaire. The inclusion of only male participants was to allow for comparisons to be made to my qualitative studies.

My quantitative study is therefore a preliminary study, using initial data from the clinical telephone interview study. As data are still being collected for the phase 3 questionnaire survey, it was not possible to apply survey weights to the data based on sample and response rates.

The majority of the clinical telephone interview did not ask for repeated data that was collected by the phase 3 questionnaire. For example the clinical telephone interview study did not re-ask questions on sex, age, education etc., the clinical telephone interview however did update information on life events. Hence some of my data for participants are taken from the phase 3 questionnaire (self-report) and some are taken from the clinical telephone interview (structured telephone interview). Please see Table 8 for a description of data/variables and their respective questionnaire study sources.

Table 8 - Quantitative Study Data Sources – Phase 3 and Clinical Telephone Interview

<u>Phase 3 Main Questionnaire Data Source</u> Variables	<u>Clinical Telephone Interview Data Source</u> Variables
Sex	SF-36 - Social Impairment
Age	GAD-7 – Generalised Anxiety Disorder-7
Education	PHQ-9 – Depression Module of PRIME-MD
Marital Status	PCL-5 – PTSD measure based on DSM-V criteria
Employment	Perceived Stigma and Barriers to Care for Psychological Problems- Stigma Subscale (PSBCPP-SS) with additional items from the Barriers to Access Care Evaluation (BACE)
Deployment	SSOSH – Short Form Self Stigma of Seeking Psychological Help
Last Deployment	Awareness and Willingness to use healthcare services
Military Rank	Recognition of current emotional, stress, mental health or alcohol problem
Serving Status	Help-Seeking Sources
Service Branch	Reasons for Seeking Help
Time Since Last Deployment	Multidimensional Scale of Perceived Social Support
AUDIT - Alcohol Use Disorders Identification Test	Life Events experienced since Phase 3 questionnaire*
Life Events*	

*Life Events data from phase 3 and life events data from the clinical telephone interview were combined into one variable, please see pg. 223 for a description.

7.1.5 Main Outcome Measures

1. Stigma and Barriers to Care

Stigma and barriers to care questions were assessed by measuring agreement with a series of hypothetical statements based on the Perceived Stigma and Barriers to Care for Psychological Problems - Stigma Subscale (PSBCPP-SS) as developed at the Walter Reed Army Institute of Research by Hoge et al. (2004) and additionally by Britt (2000) and Britt et al. (2008). The language of the PSBCPP-SS was altered for use in the UK with ex-Service populations (Iversen et al., 2011).

In addition to this scale, six items from the Barriers to Access Care Evaluation (BACE) (Clement et al., 2012), items 2, 8&26, 20, 21, 22, were adapted into five items, to use in tandem with the PSBCPP-SS (Please see Appendix 19 for a full copy of the BACE questionnaire).

All participants were asked: ‘...to rate each of the possible concerns that might affect your decision to receive mental health services’. Participants were presented with a five-level likert scale on a laminated response sheet (please see Appendix 18 response card BOX ‘K’), from, ‘1’ Strongly Agree, ‘2’ Agree, ‘3’ Neither agree nor disagree, ‘4’ Disagree and ‘5’ Strongly Disagree.

Detailed below, items 1-10 and 13-17 are based on the PSBCPP-SS and items 11-12 (BACE items 21, 8&26 combined) and 18-20 (BACE items 22, 2 and 20) are based on the BACE. Additional items were added from the BACE as influenced by my qualitative investigation within the KCMHR cohort. There were certain barriers to care that were described by participants in my qualitative interviews, but these factors were not captured by the PSBCPP-SS alone. I investigated the BACE questionnaire and found several items represented barriers to care described in my qualitative interviews. These were added to the clinical telephone interview schedule.

Participants were read the following statements (participants were not informed of the category of these statements but these categories are included for clarity for the reader):

I would not seek help for a mental health problem because:

Practical Barriers

1. I don't know where to get help
2. I don't have adequate transport

3. It is difficult to get an appointment
4. There would be difficulty getting time off work for treatment

Public/Anticipated Stigma Barriers

5. It would be too embarrassing
6. It would harm my career
7. Members of my unit or my colleagues might have less confidence in me
8. My unit leaders/bosses might treat me differently
9. My leaders/bosses would blame me for the problem
10. I would be seen as weak (by those who are important to me)
11. Not wanting a mental health problem to be on my medical records
12. Concern about what my friends and family might think

Attitudinal Barriers

13. Mental health care doesn't work
14. I don't trust mental health professionals
15. My visit would not remain confidential
16. I would think less of a team member/work colleague if I knew he/she was receiving mental health counselling
17. My leaders/bosses discourage the use of mental health services
18. I have had previous bad experiences with mental health professionals
19. Wanting to solve the problem on my own
20. Mental health treatment has harmful side effects

Specific Treatment of variable– stigma and barriers to care

The stigma and barrier to care items were categorised into different barrier types. This was informed by previous research (Britt et al., 2008, Kim et al., 2011, Clement et al., 2012).

Items 1-4 were grouped under '**Practical Barriers**' (Cronbach's α .71), items 5-12

'Public/anticipated Stigma Barriers' (Cronbach's α .89) and items 13-20 '**Attitudinal Barriers'** (Cronbach's α .69). Responses to each stigma or barrier to care question were grouped into two response categories of:

- '**Agree**' - combining 'strongly agree' and 'agree'.
- '**Disagree**' - combining 'disagree' and 'strongly disagree'.

Responses of 'neither agree nor disagree' were excluded from the analysis on all individual barrier statements, apart from the calculation of overall prevalence of barriers. The exclusion

of the category ‘neither agree nor disagree’ was conducted because the endorsement of this rating could not be categorised either way as an endorsement nor a disagreement with the statement. The category of ‘neither agree nor disagree’ ranged from, N=7 to N=137, for the 20 different barrier statements and had a median value of 60.5. The dropping of this category explains the differing ‘N’ recorded for each statement in Table 19.

In assessing the overall prevalence of practical, stigma and attitudinal barriers (Table 19), prevalence is measured by collating the number of individuals who endorsed at least one of the barrier items within that category. The overall percentage however does not drop the neutral category, ‘neither agree nor disagree’. Whilst I would have wished to drop those in the neutral category, the nature of collating multiple response items to create an overall prevalence by barrier types, meant it was possible that an individual could endorse one item in a barrier category, but also be neutral on another item in that same category. I however dropped individuals from the overall barrier prevalence calculation if they responded in the neutral category on all barrier items in that category. Overall there was only one individual who responded in the neutral category on all eight stigma barrier items, who was subsequently dropped from that specific analysis.

2. Help-Seeking Sources

The second main outcome measure was ‘type of help-seeking’ and ‘help-seeking sources’. To assess help-seeking sources, participants who endorsed a current or a resolved stress, emotional, or alcohol problem were asked to refer to a laminated response card (Appendix 18, response card BOX ‘M’). They were asked, *‘Have you spoken to or sought help from any of the following for your stress/emotional/alcohol problem’*. Participants could then choose from the options:

- A family member
- Friends/colleagues
- TRiM Practitioner
- Chain of Command
- GP/MO
- A hospital doctor
- A mental health specialist (e.g. Psychiatrist, Psychologist, Nurse Practitioner)
- Other non-medical professional (e.g. Medic, Padre, Social Worker, Welfare Officer, Counsellor)
- SSAFA/Combat Stress 24 Hour Help-line
- The Big White Wall

- Internet based therapy
- Service Charity (e.g. SSAFA, Royal British Legion, Help for Heroes)
- Combat Stress
- Veterans UK Helpline
- Veterans and Reserves Mental Health Programme
- NHS Veterans Service
- Other

Missing Data

Four individuals did not know or could not remember that they had endorsed experiencing a problem within the last three years on their phase 3 questionnaire. These individuals were therefore not asked subsequent questions on their help-seeking experiences or sources of help-seeking for their problem. Hence N=449 (out of 453) for prevalence estimates that assess help-seeking sources and the help-seeking outcome variable.

Specific Treatment of Variable – Help-seeking sources

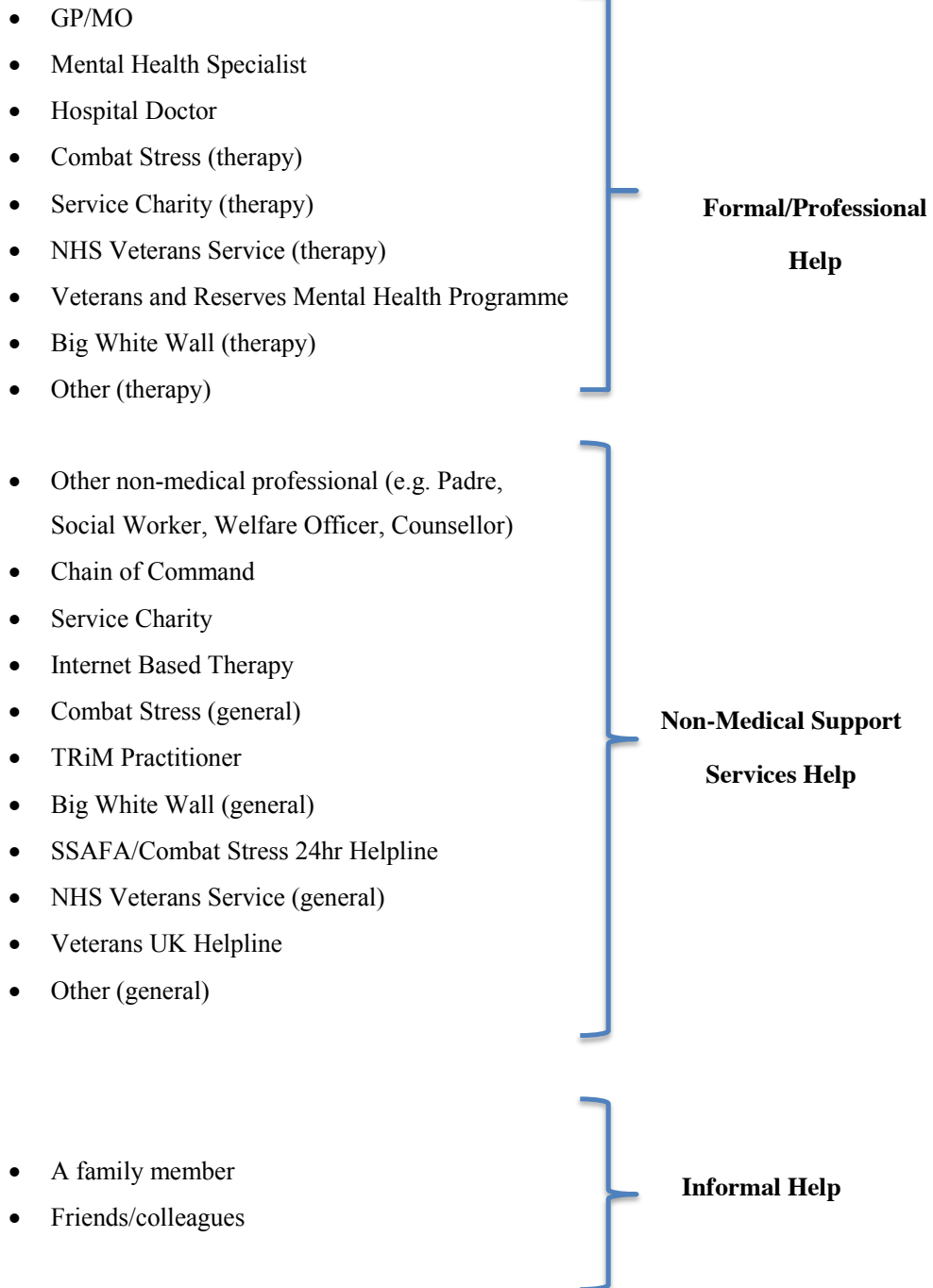
As individuals endorsed which options they had spoken to or sought help from, the research team also noted whether individuals specifically made mention of whether they had received therapy treatment from any of the services, as opposed to general support. For example individuals may have received therapy from the Big White Wall from online psychologists, however others may have only engaged with general support or self-help from Big White Wall. This difference was captured by the research team, who created new categories, explicitly stating whether help received was therapy based e.g. Big White Wall (therapy), as opposed to Big White Wall (general).

Table 14 assesses the prevalence of help-seeking by specific health/support service. I categorised the list of services participants could choose from into different types of help-seeking groups defined as:

- **Formal/Professional Help** – healthcare services offering professional/medical/therapeutic services provided by a qualified medical doctor, mental health specialist, clinician, therapist, psychologist or nurse practitioner.
- **Non-Medical Support Services Help** – services offering healthcare support, signposting services, or facilitation of self-help therapy without providing professional/medical/therapeutic services.
- **Informal Help** - individuals talking to/or seeking help from family and friends with no professional/medical input.

- **No Help Sought** – individuals who did not talk to or seek any form of help from any source, informal or formal.

The help-seeking source options were categorised as below:



The overall prevalence of help seeking source categories i.e. Formal/Professional, Non-Medical Support Services, Informal and No Help Sought (Table 14 in bold) was calculated

by assessing how many individuals had endorsed at least one of the options within that specific help-seeking category.

Tables 21 and 22 examine factors associated with help-seeking among the 449 participants who endorsed experiencing a current or resolved emotional, stress or alcohol problem in the last three years. The help-seeking outcome variable was created into a binary category with:

- **‘No Help’** - including those who had sought no help *and/or* those who had only spoken or sought help from family and friends.
- **‘Help-Seeking’** which combined those who had sought help from non-medical services *and/or* those who had sought help from Formal/Professional services.

Individuals in the ‘help-seeking’ group may have also sought help from family and friends, non-medical services and formal services, however individuals were considered help-seekers if they passed the threshold of seeking help from non-medical support services and/or formal/professional services. Conversely participants were considered non-help-seekers if they had only sought help from family and friends, or had sought no help at all. This decision was influenced by my qualitative interviews where many individuals had spoken to family and friends, however this ‘informal help-seeking’ in reality rendered them non-help-seekers at the time of interview as they had no intention to engage with formal services.

7.1.6 Explanatory Measures

1. Socio-Demographic Variables

Sex

All females were excluded from the analyses. All 453 participants were male.

Age

Age was split into six categories for Table 9 (sample characteristics) which ranged from 24-68. For regression analyses in Table 21, age was originally a continuous variable, which I rescaled by dividing by 10, and used as a categorical variable.

Education

Education describes the educational achievement/level of participants. This variable originally had six response categories and was combined into two categories:

- **Low Attainment** – No qualifications, O levels/GCSE’s/NVQs level 1-2 or equivalent or other professional qualifications.

- **High Attainment** - A levels/HNDs/NVQs level 3/Highers or equivalent or higher e.g. degree or postgraduate qualifications.

Marital Status

Marital Status originally had seven response categories and was combined into three response categories:

- **Married/Partner/Long-term relationship**
- **Single**
- **Divorced/Separated/Widowed**

Employment

This variable describes the current employment status of participants. The original variable from the phase 3 questionnaire was asked only to ex-Service and Reserve personnel and had nine response options to the question – ‘*Are you currently*’:

1. Working full or part time in a civilian job
2. Working as a civilian in the MoD or the UK Armed Forces
3. Now in the regular Armed Forces/FTRS
4. Working as a private security contractor
5. Self-employed
6. Not working but looking for employment
7. Not working due to ill health
8. Retired
9. Other

The variable was reduced into four categories and in Service personnel employment were added to the variable to make five categories with the options:

- **In Service** – included those who indicated they were Regulars and response 3 (above)
- **Employed (Civilian)** – included responses 1,2,4 and 5 (including Reserves)
- **Unemployed** – included responses 6 and 7
- **Retired** - included response 8
- **Other** – included response 9

Missing Data

Data were unavailable for five individuals employment status, hence N=448

2. Military Characteristic Variables

Deployment

The deployment variable describes whether an individual has deployed on operations or not. This variable was created from questions asked in the phase 3 questionnaire assessing deployment history. Participants were asked to endorse ‘Yes’ or ‘No’ as to whether they had deployed on a number of different operations. The responses to these questions were made into two response categories:

- **Any Deployment** - including TELIC (Iraq) HERRICK (Afghanistan) and other deployments such as Libya, Mali, Middle East, Horn of Africa, Syria and Iraq (post TELIC).
- **No Deployment.**

Last Deployment

The last deployment variable describes what deployment the participant last deployed upon. This variable uses date information from the phase 3 questionnaire that calculates which deployment would have been the participants’ last deployment. This variable had four response categories:

- **Not deployed**
- **TELIC**
- **HERRICK**
- **Other** (includes Libya, Mali, Middle East, Horn of Africa, Syria and Iraq - post TELIC)

For the regression analysis in Table 21 (factors associated with help-seeking) the category ‘Other’ was dropped due to small numbers.

Missing Data

There were missing data for four participants where their last deployment could not be determined.

Time Since Last Deployment

This variable describes the time, measured in years, since the participants last deployment. This variable was created from date information in the phase 3 questionnaire. The variable was calculated by using the most recent deployment operation month end date and calculating months passed up until the date of completion of the phase 3 questionnaire.

For example an individual whose last deployment was HERRICK 19, where they detailed their operation spanned from October 2013- June 2014; their time since deployment would be calculated from the 01/06/2014 up to the date of when they completed the phase 3 questionnaire. Where specific deployment end dates could not be identified, participants' last deployment information was taken, and an end date was estimated from when that deployment officially ended. For example, those whose last deployment was Libya did not have the option of specifying deployment dates, however the latest possible month of deployment was August 2011, hence 01/08/2011 was taken as their latest deployment date.

Missing Data

There were 12 individuals for whom I was unable to calculate a time since last deployment variable, as their most recent deployments were deployments that were currently on-going and did not have a fixed end date (for example Syria/Iraq - post TELIC). These 12 individuals were dropped from analyses when the using time since deployment variable leaving an N=441.

For descriptive statistics (Table 9) time since deployment was split into five groups:

- **No deployment**
- **<3 years since deployment**
- **3-5 years since deployment**
- **6-8 years since deployment**
- **>8 years since deployment**

For regression analyses (Table 21) the time since deployment variable was reduced into three groups:

- **No deployment**
- **<6 years since deployment**
- **≥6 years since deployment**

Military Rank

The military rank variable describes what rank participants held at time of the phase 3 interview or their rank when they had left the military.

Military rank was derived from the phase 3 questionnaire into:

- **Officer** – includes all Commissioned Officers across the Armed Forces Branches i.e. Royal Navy Midshipman rank and above, Army/Royal Marines 2nd Lieutenant rank and above and Royal Air Force Pilot Officer rank and above.
- **Other** – includes all Non-Commissioned Officers and lower ranks across the Armed Forces Branches i.e. Royal Navy/Army/Royal Marines Warrant Officer Class 1 rank and below, Royal Air Force Warrant Officer rank and below.

Serving Status

The serving status variable describes whether participants were current Service Personnel or had left Service. The original variable had four response options to the question '*Are you currently serving*':

1. Yes, I am a regular or in Full-Time Reserve Service (FTRS)
2. Yes, I am a recalled ex-regular
3. Yes, I am a volunteer Reserve (mobilised or not)
4. No, I have left the military

This variable was combined into two response categories:

- **Service Personnel** – includes all current Regulars and Reserves (responses 1, 2 and 3)
- **Ex-Service Personnel** – includes all those who had left Service, sometimes termed 'veterans' (response 4)

Reserves were combined with Service Personnel into one category because of small numbers of Reserves in the sample (N=29).

Missing Data

There were two participants that had missing data for this question, therefore N=451.

Service Branch

The service branch variable describes the specific service participants were employed within between the service branches. The original variable had four response categories of Royal Navy, Royal Marines, Army and Royal Air Force. The variable was reduced to three response categories to combine Royal Navy (N=59) and Royal Marines (N=8):

- **Naval Services** – includes the Royal Navy and Royal Marines
- **Army**
- **Royal Air Force**

3. Health Measure Variables

Social Impairment

Social impairment was measured by the health perception question from the SF36 (Ware Jr and Sherbourne, 1992). Participants were asked, *'In the past month, to what extent has your physical health or any emotional problems interfered with your normal social activities with family, friends, neighbours or groups?'* The measure provides five response categories from 'Not at all', 'Slightly', 'Moderately', 'Quite a bit', and 'Extremely'.

Specific Treatment of Variable – Social Impairment

The social impairment variable responses were combined into two response categories:

- **Limited/No Social Impairment** – this included the original response categories 'Not at all', 'Slightly' and 'Moderately'.
- **Social Impairment** – this included the original response categories 'Quite a bit' and 'Extremely'.

Generalised Anxiety Disorder

Generalised Anxiety Disorder was measured by the GAD-7 (Spitzer et al., 2006). This is a 7-item mental health measure that assesses generalised anxiety disorders. It asks participants about symptoms experienced over the last two weeks with four response categories and scores of, 'Not at all' (score 0), 'Several days' (score 1), 'More than half the days' (score 2), 'Nearly every day' (score 3). Please see Appendix 20 for an example of the GAD-7 questionnaire. Using a score cut off of 10 or more the measure has good sensitivity (89%) and specificity (82%). Cut off points of 5, 10, and 15 are interpreted as representing mild, moderate, and severe levels of anxiety on the GAD-7.

Specific Treatment of Variable – GAD-7

Participants were considered to be a probable mental health ‘case’ on the GAD-7 using a cut off of 10 or above. The variable was made into two response categories:

- **Positive Case** – GAD-7 score of 10 or above (moderate and severe anxiety).
- **Negative Case** – GAD-7 score below 10.

Depression

Depression was measured by the PHQ-9 which is the depression module of the PRIME-MD (Kroenke et al., 2001). The PHQ-9 is a 9-item measure that asks participants about symptoms experienced over the last two weeks with four response categories and scores of, ‘Not at all’ (score 0), ‘Several days’ (score 1), ‘More than half the days’ (score 2), ‘Nearly every day’ (score 3). Please see Appendix 21 for an example of the PHQ-9 questionnaire. A PHQ-9 score of 10 and above has a sensitivity of 88% and a specificity of 88% for major depression. PHQ-9 scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe, and severe depression.

Specific Treatment of Variable – PHQ-9

Participants were considered to be a probable mental health ‘case’ on the PHQ-9 using a cut off score of 10 or above. This cut off was chosen to mirror the moderate cut off choice also made for the GAD-7, to ensure consistency. The variable was made into two response categories:

- **Positive Case** – PHQ-9 score 10 and above (moderate and severe depression).
- **Negative Case** – PHQ-9 score below 10.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder was measured by the PCL-5. It is a 20-item measure of PTSD symptoms based on DSM-V criteria (Weathers et al., 2013). The measure asks participants how much they have been bothered by certain symptoms associated with stressful events in the past month, with the response categories and scores, ‘Not at all’ (score 0), ‘A little bit’ (score 1), ‘Moderately’ (score 2), ‘Quite a bit’ (score 3) and ‘Extremely’ (score 4). Please see Appendix 22 for an example of the PCL-5 questionnaire.

Specific Treatment of Variable – PCL-5

The originators of the PCL-5 from the National Centre for PTSD, US department of Veterans Affairs recommend a ‘case positive’ cut off point of a score of 38 and above⁵. Participants were hence considered a ‘case’ on the PCL-5 if they scored 38 or above. The variable was made into two response categories:

- **Positive Case** – PCL-5 score of 38 and above.
- **Negative Case** – PCL-5 score below 38.

Mental Health Caseness

This variable describes whether participants were currently considered to have probable mental health problem from meeting the threshold levels on the GAD-7 (score of 10 and above), the PHQ-9 (score of 10 and above) and the PCL-5 (score of 38 and above). This variable had two response categories:

- **Positive Case** – includes all those who met the threshold levels for a probable mental health problem on at least one of the GAD-7, PHQ-9 or PCL-5.
- **Negative Case** – includes all those who did not meet threshold levels for a probable mental health problem on any of the GAD-7, PHQ-9 or PCL-5.

Alcohol Use Disorders

Alcohol use was measured by the 10-item World Health Organization’s (WHO) Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001). The AUDIT was developed to screen for excessive drinking and in particular to help practitioners identify people who would benefit from reducing or ceasing drinking. The AUDIT is a 10-question measure that includes questions to screen for hazardous alcohol use, dependence symptoms and harmful alcohol use. Total scores of eight or more are recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence. The WHO suggests scores between eight and 15 are deemed appropriate for simple advice focused on the reduction of hazardous drinking. Scores between 16 and 19 suggest brief counselling and continued monitoring. AUDIT scores of 20 or are advised to warrant further diagnostic evaluation for alcohol dependence. The WHO also advise that AUDIT cut off scores may vary depending on the countrys’ drinking patterns. Please see Appendix 23 for an example of the AUDIT questionnaire and scoring.

⁵ <http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

Specific Treatment of Variable - AUDIT

AUDIT scores are presented in descriptive statistics, Table 9, in four categories of scoring aligned with the WHO diagnostic criteria:

- 0-7
- 8-15 (hazardous use)
- 16-19 (harmful use)
- 20+ (dependence)

In further regression analyses (Table 21) , participants were considered to be a ‘case’ if they had an AUDIT score of 16 and above. The variable was made into two response categories:

- **Positive Case** – AUDIT score of 16 and above.
- **Negative Case** – AUDIT score below 16.

The AUDIT cut off of 16 or above was chosen to avoid introducing false positive AUDIT cases into analyses. The Armed Forces drinking levels and patterns of consumption compared to the general population have been found to be at much higher levels, in part due to military culture and the use of alcohol in the Armed Forces as a tool for social bonding. Fear et al. (2007) found that 67% of men in the UK Armed Forces had an AUDIT score of 8+ (defined as hazardous drinking) compared to men in the general population of 38%. UK military studies since have used a 16+ cut off in their analyses using AUDIT measures to account for this increased base level of drinking in the Armed Forces (Fear et al., 2010).

Missing Data

Data was missing on the AUDIT variable for 16 individuals who only partially answered or did not answer the AUDIT questions, therefore N=437.

Stigma, Attitudinal and Practical Barriers to Care

A description of the Stigma and Barriers to Care measure can be found above (pg. 205). In the analysis where stigma, attitudinal and practical barriers to care are assessed as *explanatory* factors for help-seeking (Table 22) (*not* as outcome variables), responses to each stigma or barrier to care question were grouped into ‘**Agree**’ (combining ‘strongly agree’ and ‘agree’ ratings) and ‘**Disagree**’ (combining ‘disagree’ and ‘strongly disagree’). Responses of ‘neither agree nor disagree’ were excluded from the analysis.

For each stigma, attitudinal and practical barrier group and the associated statements, a count was made within barrier type, per individual, across items, as to how many times they endorsed different statements within that barrier category. ‘Agree’ was coded ‘1’ and ‘Disagree’ was coded ‘0’. As the stigma barrier group of items had eight items, individuals’ count of different items endorsed could range from 0-8. The attitudinal barrier item group had eight items with a count ranging from 0-8, and the practical barriers item group had four items with a count ranging from 0-4.

For the stigma barriers, this count was then taken and made into three tertiles. The lower and middle tertiles were made into the ‘**Lower Stigma**’ group and the highest tertile was made into the ‘**Higher Stigma**’ group. For the attitudinal barriers the count was taken and also made into three tertiles. The lower and middle tertiles were made into the ‘**Lower Attitudinal Barriers**’ group, and the upper tertile was made into the ‘**Higher Attitudinal Barriers**’ group. Lastly the practical barriers count was taken, and due to the distribution of the sample, was divided in half. The lower half was made into the ‘**Lower Practical Barriers**’ group and the upper half was made into the ‘**Higher Practical Barriers**’ group. (These group items can be found in Table 22)

Additionally, all stigma/barrier to care statements were regressed against help-seeking to assess for any associations on an individual stigma/barrier to care statement level and the relationship between endorsement of these statements and the effect on help-seeking.

Self-Stigma

Self-stigma was measured using a short-form version of the Self-Stigma of Seeking Psychological Help Scale (SSOSH) (Vogel et al., 2006). The SSOSH in its original form is a 10-item measure that assesses the extent of self-stigma and uniquely predicts attitudes toward and intent to seek psychological help. In the original measure participants are asked to rate the degree to which each item describes how they might react to the statements if they had a mental health problem. Individuals’ are offered a 5-point likert scale of, 1 ‘Strongly Disagree’, 2 ‘Disagree’, 3 ‘Agree & Disagree Equally’, 4 ‘Agree’, 5 ‘Strongly Agree’. Please see Appendix 24 for an example of the original SSOSH scale.

Specific Treatment of Variable - SSOSH

Self-stigma was specifically measured using five items from the SSOSH. Advice was taken from the SSOSH originators as to which items might best produce a short form self-stigma measure. Items 1, 3, 6, 8 and 10 were taken from the SSOSH (Cronbach’s α .89). These were considered robust and reliable items from the SSOSH that did not entail reverse scoring

(like the remaining SSOSH items). The language of the items was changed for UK understanding – replacing mentions of ‘therapist’ for ‘mental health professional’.

Participants were asked, *‘Some people do not seek help for problems because they are concerned that seeking help would affect the way they think about themselves. You may or may not react in this way. Please refer to the response options in BOX K to rate the degree to which each item describes how you might react in this situation.’* Participants were offered a 5-point likert scale from 1 ‘Strongly agree’ to 5 ‘Strongly disagree’.

For the purposes of analyses in Table 22 that assesses factors associated with help-seeking, item responses were first made into two response categories:

- **‘Agree’** – this included all responses ‘Strongly Agree’ and ‘Agree’ = coded ‘1’
- **‘Disagree’** – this included all responses ‘Disagree’ and ‘Strongly Disagree’ = coded ‘0’

All neutral responses where participants responded, ‘Agree and Disagree Equally’ were dropped from analyses. A self-stigma count was then made across all five items where individuals could have an overall score ranging from 0-5 (5 being the highest score of self-stigma). The self-stigma count across items was then made into tertiles. The lower and middle tertile was made into the **‘Lower Self-Stigma’** group and the upper tertile was made into the **‘Higher Self-Stigma’** group in analyses (Table 22).

Current recognition of a stress, emotional, mental health or alcohol problem

To assess individuals current recognition of a problem, participants were asked, *‘Do you think you currently have a stress, emotional or mental health problem?’* and, *‘Do you think that you currently have problems with alcohol?’* There were two responses categories of **‘Yes’** and **‘No’**.

Life Events

To examine potential stressful life events experienced by participants, a measure was adapted from Smid et al. (2013). The original measure assessed post-deployment stressors and exposure to stressful life events using a 10-item yes/no checklist specifically developed for their study. A total score is obtained by adding up life events endorsed over the 10 items.

Specific Treatment of Variable – Life Events

A life events measure was taken at the phase 3 questionnaire *and* at the clinical telephone interview stage. The phase 3 questionnaire asked participants to, *'Please indicate whether you have personally experienced the following events during the PAST 3 YEARS'*. There is an 11-item response checklist adapted for the phase 3 study population, with response items **'Yes'** or **'No'**. The item list was as follows:

- a) Divorce or broken relationship
- b) Accident
- c) Assault
- d) Severe physical illness
- e) Mental health problem
- f) Accident, assault or severe illness of someone close to you (e.e. spouse, own child, parent, brother, friend etc.)
- g) Death of someone close to you
- h) Burglary, robbery or other serious crime
- i) Financial problems
- j) Unexpectedly losing your job or being fired
- k) Arrested by police or charged with a criminal offence

A response of **'Yes'** was coded as '1' and a response of **'No'** coded as '0'. At the clinical interview stage, participants were asked the same life events measure, but were asked to endorse life events items that they had experienced *since* filling out the previous phase 3 questionnaire. Therefore, from these two counts of life events - a composite variable was constructed that counted life events experienced by participants in the last three years, since the time of the clinical interview. For descriptive statistics (Table 9), the count of life events was split into four groups (0, 1-2, 2-4, 5+ life events). For regression analyses (Table 21) the life events variable was reduced into three categories (0, 1-2, 3+ life events).

4. Other Explanatory Measures

Social Support

Social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988). The scale is a 12-item scale that measures participants subjectively assessed social support. The scale additionally has three subscales (of four items each) that assess different sources of support, including support from, 'Family', 'Friends' and 'Significant Others'. The scale uses a 7-point likert scale from, 1 'Very Strongly

Disagree’ to 7 ‘Very Strongly Agree’. Please see Appendix 25 for an example of the MSPSS measure.

Specific Variable Treatment

Using the MSPSS scale, the clinical telephone interview study used a reduced 3-point likert scale of from, 1 ‘Agree’, 2 ‘Neither agree nor disagree’ and 3 ‘Disagree’. Participants were asked how they felt about the 12 MSPSS statements.

For my regression analyses (Table 22) neutral answers of ‘neither agree nor disagree’ were dropped and response categories were reduced to:

- ‘Agree’.
- ‘Disagree’.

Higher scores indicated higher levels of perceived social support. A count was made across all social support items whereby individuals could have a score that ranged from 0-12 (12 being the highest social support score). Due to the distribution of scores, this count was then made into two halves. The lower half was made into the ‘**Lower Social Support**’ group and the upper half was made into the ‘**Higher Social Support**’ group in analyses (Table 22).

7.1.7 Other Measures

Awareness and Willingness to Use Healthcare Services

To measure participants’ awareness of and willingness to use different healthcare or support services, participants were asked: *‘There are a variety of places that you can go to get help if you have a stress emotional or alcohol problem. We would like to know if you are aware of various sources of support for these problems, and which ones you would be willing to use if you did have a problem.’* Participants were given a list of services on their response card (Please see Appendix 18, ‘BOX L’) and were asked, *‘Have you heard of/ do you know that ‘X’ is a source of support?’*, and given response categories of ‘**Yes**’ and ‘**No**’.

Participants were additionally asked to read through the list again and prompt which services they would be willing to use if they were to have a stress, emotional or alcohol problem, with response categories of ‘**Yes**’, ‘**No**’ and ‘**Don’t Know**’. The list included the following services:

- TRiM Practitioner
- Chain of Command

- GP/MO
- A hospital doctor/nurse
- A mental health specialist
- Other non-medical professional (e.g. Padre, Social Worker, Welfare Officer, Counsellor)
- SSAFA/Combat Stress 24 Hour Helpline
- The Big White Wall
- Service Charities (e.g. SSAFA, Royal British Legion, Help for Heroes)
- Combat Stress
- Veterans UK Helpline
- NHS Veterans Service
- Veterans and Reserves Mental Health Programme

Specific Treatment of Variable – Awareness and willingness to use healthcare services

In Table 12 and 13 – the prevalence of those willing to use services was based *only* on participants who had heard of the healthcare or support service.

Reasons for seeking help

To examine participants reasons for seeking help (Table 16), participants who had endorsed that they had sought formal/professional help (N=264) were asked, *'Looking at BOX N on your response card, What prompted you to go and seek help from your [formal health service source] for your stress/emotional and or alcohol problems'*. The list of response options individuals were given included:

- On the advice of a family member, friend or colleague
- On the advice of a TRiM practitioner
- On the advice of employer or Chain of Command
- I realised I had a problem
- I was concerned the problem was getting worse
- The problem had started to affect my work
- I was experiencing disciplinary problems as a result of the problem
- I realise I couldn't solve the problem myself like I had hoped
- I found a relevant service through word of mouth, an advert or online
- A change in life circumstances or a major life event
- Other

7.1.8 Overall Analysis

All statistical analyses were undertaken using the statistical software package STATA, version 11 (StataCorp LP, College Station, Texas). Data reported are descriptive statistics (percentages and sample sizes) assessing sample characteristics (Table 9), recognition of emotional/stress or alcohol problems by mental health status (Table 10 and 11), awareness and willingness to use healthcare/support services (Table 12 and 13), prevalence of help-seeking by specific health/support service (Table 14), prevalence of different reasons for seeking help (Table 16), prevalence of endorsement of barriers to seeking help overall and by mental health status (Table 19) and lastly prevalence of endorsement of stigma and barrier to care items in comparison with my meta-analysis results and other UK military studies (Table 20)

Table 19 assesses endorsement of stigma and barrier to care items as the *outcome variables* and mental health status as the *explanatory variable*. To compare endorsement of stigma and barriers to care amongst those with and without probable mental health diagnoses, unadjusted and adjusted odds ratios are presented with their 95% confidence intervals. Odds ratios were derived using logistic regression analysis and were adjusted by the confounding variables of rank, functional impairment and life events. These factors were deemed confounding variables as they were associated with the outcome i.e. endorsement of stigma and barrier to care statements (significant association with one statement or more) and the main explanatory variable - mental health status i.e. whether an individual was a probable mental health case in relation to mental health measures.

Table 21 and 22 investigate help-seeking status as the *outcome variable* (i.e. Non-help-seeking or Help-seeking) and several other factors such as socio-demographics, stigma and barriers to care and social support as *explanatory variables*. To compare factors associated with help-seeking amongst those who endorsed a stress, emotional or alcohol problem at the phase 3 interview stage - unadjusted and adjusted odds ratios are presented with their 95% confidence intervals. Odds ratios were derived using logistic regression analysis and were adjusted by the confounding variables of functional impairment, life events and current recognition of a stress/emotional/alcohol problem (at time of clinical telephone interview). These factors were deemed confounding variables as they were associated with the outcome of interest i.e. the help-seeking outcome (those who had sought help) – and the main explanatory variables of stigma and barriers to care (significant association with one stigma/barrier to care statement or more). There were several interactions I would have wished to explore in Table 22. For example it would be of interest to explore the help-seeking outcome and anticipated stigma/ barrier to care statements in relation to service

status i.e. whether someone was Serving or ex-Service, by Rank i.e. whether an individual was an officer or ‘other’ rank and by time since deployment. These different factors may have had different results in the different strata as these variables may have affected the response to the anticipated public stigma/barrier to care statements. For example there is previous evidence to suggest that anticipated public stigma is higher when an individual is deployed and reduces once an individual returns from deployment (Osório et al., 2013a). Hence time since deployment may be an important variable that affects the different responses to anticipated public stigma statements. Equally previous research also identified that ex-Service personnel experienced more practical barriers to seeking help compared to Service personnel (Iversen et al., 2011). Lastly officers have been identified as less inclined to seek help compared to ‘other’ ranks and therefore rank may affect answers to stigma barrier questions (Hines et al., 2014a). Due to overall sample sizes however, particularly in relation to individual anticipated public stigma and barrier to care statements, the stability and reliability of these interactions would have been questionable and therefore in this preliminary examination of this dataset these interactions were not explored.

7.1.9 Summary

Data collected from the clinical telephone interview proceeding out of the phase 3 study are used to address ‘Aim 4’ from my PhD thesis: *‘To examine quantitatively social support, military characteristics, attitudes towards mental health treatment, and stigma as associations of healthcare seeking.’* The sample and design of the quantitative study has been presented. The results of this study follow in section 7.2 of Chapter 7.

7.2 – Quantitative Results

This quantitative results section presents data on:

- Sample characteristics of participants from the clinical telephone interview study.
- Recognition of a current emotional, stress, mental health or alcohol problem at the time of the clinical interview, stratified by mental health status.
- Individuals' awareness of and willingness to use healthcare/support services overall and stratified by serving status.
- Prevalence of help-seeking by specific healthcare/support services.
- Overlap between different types of help-seeking (formal/professional, non-medical support services, and informal).
- Prevalence of participants' reasons for seeking help, overall and the overlap between these different reasons per participant.
- Prevalence of endorsement of public/anticipated stigma and barrier to care statements overall and stratified by mental health status.
- Association between public/anticipated stigma/barriers to care and mental health status.
- Demographic, social and military factors associated with help-seeking.
- Associations between help-seeking and stigma/barriers to care, social support and current recognition of a problem.

These analyses address 'Aim 4' of my thesis - To examine quantitatively social support, military characteristics, attitudes towards mental health treatment, and stigma as associations of healthcare seeking. There were five a priori alternative hypotheses:

Hypothesis 1: Mental health 'caseness' (i.e. if individuals have a probable mental health diagnosis) will be negatively associated with help-seeking

Hypothesis 2: Certain socio-demographic factors, for example, educational status and relationship status, will be associated with help-seeking. Specifically, lower educational status will be negatively associated with help-seeking. Being married, having a partner or being in a long-term relationship will be positively associated with help-seeking.

Hypothesis 3: Military characteristics, for example, rank and service branch, will be associated with help-seeking. Specifically higher rank and the Royal Air Force branch of Service will be positively associated with help-seeking.

Hypothesis 4: Increased barriers to care such as public/anticipated stigma, self-stigma, attitudinal or practical barriers will be negatively associated with help-seeking.

Hypothesis 5: Less social support will be negatively associated with help-seeking

These hypotheses and aims are explored in the following results section.

7.2.1 Sample Characteristics (Table 9)

All 453 participants were male with a mean age of 44 years ($SD \pm 9$ years). The vast majority of participants (84%, $n=380$) were married/with partners or were in long-term relationships. 56% ($n=253$) of the sample was in civilian employment. Most individuals (72%, $n=324$) had a high educational attainment of a standard of A-levels or higher. 61% ($n=274$) were ex-Service personnel and 39% ($n=177$) were in Service – 29 of these individuals included in the Service personnel group were Reserves. The majority of participants (63%, $n=285$) had Served in the Army, 22% ($n=101$) were Royal Air Force and 15% ($n=67$) were from the Naval Services. Non-Commissioned Officers or ‘other’ ranks made up 69% ($n=314$) of the sample, with the remainder (31%, $n=139$) being individuals who currently (or who were) Commissioned Officers. The greater part of the sample, 73%, ($n=332$) had been deployed, and overall 42% ($n=190$) of individuals had last deployed to Afghanistan. The mean time since individuals’ last deployment was 6.3 years ($SD \pm 3.8$ years).

When assessing participants’ health, 83% ($n=374$) of the sample reported that they had limited or no social impairment. The mean number of life events individuals had experienced was 2.6 events ($SD \pm 1.9$ events), with just under half of the sample experiencing two or more life events. Over half of participants (55%, $n=250$) endorsed that at the time of taking part in the clinical interview, they were currently experiencing a stress, emotional or mental health problem. Just under half of participants therefore (45%, $n=202$), recorded that the stress, emotional or mental health problems that they had experienced in the last three years (as reported in the phase 3 questionnaire to be eligible for the clinical telephone interview) had resolved itself or remitted; additionally, four individuals could not remember they had endorsed a stress, emotional or mental health problem at the phase 3 questionnaire stage. Only 9% ($n=41$) indicated they were currently experiencing (at the time of the clinical

telephone interview study) an alcohol problem (at phase 3, 16%, (n=72) indicated they had experienced an alcohol problem in the last 3 years). From the sample, 21% (n=95) met the diagnostic criteria for moderate to severe depression, 19% (n=84) for a moderate to severe anxiety disorder, 9% (n=43) had a probable diagnosis of PTSD, 58% (n=252) had an AUDIT score of 8+, and 19% (n=85) had an AUDIT score of 16+.

Table 9 - Characteristics of 453 Male Military Personnel in a Clinical Telephone Interview Sample

Characteristic	Total	N	%
Age	453		
≤34		83	18.32
35-39		68	15.01
40-44		87	19.21
45-49		105	23.18
50-54		61	13.47
≥55		49	10.82
Marital Status	453		
Married/Partner/Long-term relationship		380	83.89
Single		34	7.51
Divorced/Separated/Widowed		39	8.61
Employment	448		
In-Service		148	33.04
Employed (Civilian)		253	56.47
Unemployed		31	6.92
Retired		9	2.01
Other		7	1.56
Education	453		
Low Attainment (O-Levels/GCSE's or equivalent or less)		129	28.48
High Attainment (A-Levels/Degree/Postgrad)		324	71.52
Serving Status	451		
In Service ⁶		177	39.25
Ex-Service		274	60.75
Service Branch	453		
Naval Services		67	14.79
Army		285	62.91
Royal Air Force		101	22.30
Rank	453		
Officer		139	30.68
Other		314	69.32
Deployment	453		
Any Deployment		332	73.29
No Deployment		121	26.71
Last Deployment	449		
Not Deployed		121	26.95
Telic		125	27.84
Herrick		190	42.32
Other		13	2.90
Time Since Last Deployment	441		
No deployment		121	27.44
<3 years since deployment		82	18.59

⁶ Service personnel 'n' and % includes 29 Reserves

Characteristic	Total	N	%
3-5 years since deployment		73	16.55
6-8 years since deployment		73	16.55
>8 years since deployment		92	20.86
Impairment	453	374	82.56
Limited/No Social Impairment		79	17.44
Social Impairment			
Life Events	453		
0		63	13.91
1-2		174	38.41
2-4		137	30.24
5+		79	17.44
Self-Recognition of <i>current</i>⁷ problem emotional, stress, mental health problem	452		
Yes		250	55.31
No		202	44.69
Self-Recognition of <i>current</i> alcohol problem	453		
Yes		41	9.05
No		412	90.95
Met Criteria for mental health problem			
PHQ-9	453	95	20.97
GAD-7	453	84	18.54
PCL-5	453	43	9.49
AUDIT Scores	437		
0-7		185	42.33
8-15		167	38.22
16-19		44	10.07
20+		41	9.38

7.2.2 Self-Recognition of Problem by Mental Health Status (Table 10 and 11)

Overall there were 118 participants (26%) that fulfilled the criteria for being a ‘positive case’/mental health case as measured by the PHQ-9, GAD-7 and PCL-5. Of those individuals considered a mental health case, a large proportion (90%, n=106) recognised and reported that they were currently experiencing an emotional, stress or mental health problem. Hence there were 10% (n=12) of individuals who were considered a probable case, but did not recognise they were experiencing a problem. Over half of individuals who were not a probable mental health case (57%, n=190) did not report experiencing a current problem, but a large percentage (43%, n=144) who weren’t a negative mental health case, did endorse a

⁷ Recognition of current problem relates to participants recognition of a current emotional, stress, mental health or alcohol problem at the time of the clinical interview study (all participants endorsed they had experienced a stress, emotional or alcohol problem within the last 3 years in the phase 3 questionnaire to be invited to take part in the clinical study)

current stress, emotional or mental health problem⁸ (Table 10). There was a significant association between being a probable mental health case and self-recognition of a stress, emotional or mental health problem ($\chi^2 = 76.99$, $df=1$, $p=0.000$)

⁸ The 144 individuals who reported they were currently experiencing a stress, emotional or mental health problem but were a negative mental health case, had mean GAD-7 scores of '5' (threshold 10), mean PHQ-9 scores of '3' (threshold 10) and mean PCL-5 scores of '12' (threshold 38).

Table 10 – Self-Recognition of current emotional/stress/mental health problem by mental health status

		Mental Health Caseness (PHQ-9, GAD-7, PCL-5) (N=452)			
		Positive case (N=118)		Negative case (N=334)	
		n	%	n	%
Endorsed current emotional/stress/mental health problem (at time of clinical telephone interview study)	Y	106	89.83	144	43.11
	N	12	10.17	190	56.89

Overall there were 85 participants that were considered to have hazardous drinking, harmful to health and/or alcohol dependence as measured by the AUDIT, using a cut off of 16 and above (Table 11). Of these 85 individuals who were a positive case, only 35% (n=30) endorsed they were currently experiencing an alcohol problem, whilst a large proportion (65%, n=55) did not recognise they were experiencing a problem. There was a statistically significant association between AUDIT ‘caseness’ and self-recognition of a current alcohol problem (Fishers Exact Test $P=0.000$).

Table 11 – Self-Recognition of a current alcohol problem by mental health status

		Mental Health Caseness (AUDIT 16+) (N=437)			
		Positive case (N=85)		Negative case (N=352)	
		n	%	n	%
Endorsed current alcohol Problem (at time of clinical telephone interview study)	Y	30	35.29	8	2.27
	N	55	64.71	344	97.73

7.2.3 Awareness of and Willingness to use Healthcare/Support Services (Table 12 and 13)

Overall, nearly 100% (n=452) of participants had heard of, and were aware that their GP or Medical Officer was a source of support if they had a stress, emotional or alcohol problem. A large percentage (91%, n=411), were also willing to use their GP or Medical Officer for support for those problems (Table 12). High percentages, above 80%, had heard of mental health specialists, other non-medical professionals such as a padre or social worker, Service charities, hospital doctors/nurses, the Chain of Command and Combat Stress. Whilst participants’ awareness of these services was high, their willingness to use these services

was often lower; for example, 93% (n=423) of participants had heard of different Service charities, but of those aware of the charities, only 60% (n=254) were willing to use their services. The highest discordance of awareness and willingness was for the Chain of Command. 87% (n=395) were aware that the Chain of Command could be used for support, however of those that were aware of this, only 37% (n=146) were willing to use the support.

Services that participants were less aware of were TRiM Practitioners. 57% (n=255) of the sample were aware of TRiM practitioners, and of those who were aware, only 40% (n=102) were willing to use these practitioners. Below 30% of participants were aware of The NHS Veterans Service, The Veterans and Reserves Mental Health Programme and only 20% (n=91) of the sample had heard of the Big White Wall. Lastly under half (45%, n=41) of those that were aware of the Big White Wall, were willing to use it.

Table 12 - Awareness and Willingness to use Services

Type of health/support service	Awareness of Service (those who positively endorsed awareness)			Willingness to use Service (of those who were aware of the service, those who positively endorsed willingness to use service)		
	N	n	%	N	n	%
GP/MO	453	452	99.78	451	411	91.13
A mental health specialist	453	442	97.57	442	384	86.88
Other non-medical professional (Padre, Social Worker, Welfare Officer, Counsellor)	453	427	94.26	426	300	70.42
Service Charities (e.g. SSAFA, Royal British Legion, Help for Heroes)	453	423	93.38	423	254	60.05
A hospital doctor/nurse	453	403	88.96	403	298	73.95
Chain of Command	452	395	87.39	395	146	36.96
Combat Stress	453	374	82.56	374	246	65.78
SSAFA/Combat Stress 24 Hour Helpline	453	314	69.32	314	209	66.56
TRiM Practitioner	452	255	56.42	255	102	40.00
Veterans UK Helpline	453	254	56.07	254	154	60.63
NHS Veterans Service	453	126	27.81	126	80	63.49
Veterans and Reserves Mental Health Programme	453	118	26.05	118	74	62.71
The Big White Wall	453	91	20.09	91	41	45.05

The overall data describing the awareness and willingness of participants to use healthcare or support services was then stratified by serving status to assess whether awareness or willingness to use services was affected by whether an individual was currently Serving or had left Service (Table 13). Different healthcare services may be more well known to those

that they are relevant for; for example, The NHS Veterans Service is for ex-Service personnel and therefore may not be widely known by those in Service, conversely TRiM practitioners are targeted to those in Service and would not be applicable to provide support for those who had left Service.

Of note in Table 13, there was an association of awareness and serving status. This was demonstrated through the divergence of awareness of TRiM Practitioners between Serving (89%, n=157) and ex-Service personnel (35%, n=96) ($\chi^2=125.04$, df1, $P=0.000$). Whilst there was high awareness of Service charities overall, there was a difference of willingness to use Service charities, with a lower percentage of Serving personnel (52%, n=84) willing to use their services compared to ex-Service personnel (65%, n=169) ($\chi^2=3.84$, df1, $P=0.050$).

There were still low percentages of ex-Service personnel who were aware of veteran aimed services such as, The NHS Veterans Service (30%, n=83) and The Veterans and Reserves Mental Health Programme (25%, n=68). However, of those ex-Service personnel who are aware of these veteran services, there were slightly higher percentages of ex-Service individuals compared to Service personnel, willing to use the NHS Veterans Service (74%, n=62 v 43%, n=18, $\chi^2=8.12$, df1, $P=0.004$) and Veterans UK helpline (66%, n=104 v 53%, n=50, $\chi^2=2.41$, df1, $P=0.121$) (This difference in willingness however may reflect that these services were not applicable to Service personnel at that time).

Lastly a low percentage of participants were aware of the services that Big White Wall provides (who provides these services free to all Armed Forces and ex-Service personnel). Only 27% (n=47) of Service personnel and 16% (n=43) of ex-Service personnel aware of Big White Wall, and of these, only 40% (n=19) of Serving personnel and 51% (n=22) of ex-Service personnel were willing to use this service.

Table 13 - Awareness and Willingness to use Services Stratified by Serving Status

Type of health/support service	Awareness of Service - Service Personnel (those who positively endorsed awareness)			Willingness to use Service - Service Personnel (of those who were aware, those who positively endorsed willingness to use service)			Awareness of Service - Ex-Service Personnel (those who positively endorsed awareness)			Willingness to use Service - Ex-Service Personnel (of those who were aware, those who positively endorsed willingness to use service)		
	N	n	%	N	n	%	N	n	%	N	n	%
GP/MO	177	176	99.44	176	159	90.34	274	274	100.00	273	251	91.94
A mental health specialist	177	175	98.87	175	150	85.71	274	265	96.72	265	232	87.55
Other non-medical professional (Medic, Padre, Social Worker, Welfare Officer, Counsellor)	177	174	98.31	173	128	73.99	274	251	91.61	251	170	67.73
Service Charities (e.g. SSAFA, Royal British Legion, Help for Heroes)	177	162	91.53	162	84	51.85	274	259	94.53	259	169	65.25
A hospital doctor/nurse	177	158	89.27	158	116	73.42	274	243	88.69	243	182	74.90
Chain of Command	177	166	93.79	166	59	35.54	273	227	83.15	227	87	38.33
Combat Stress	177	153	86.44	153	101	66.01	274	219	79.93	219	145	66.21
SSAFA/Combat Stress 24 Hour Helpline	177	125	70.62	125	81	64.80	274	187	68.25	187	128	68.45
TRiM Practitioner	177	157	88.70	157	69	43.95	273	96	35.16	96	32	33.33
Veterans UK Helpline	177	94	53.11	94	50	53.19	274	158	57.66	158	104	65.82
NHS Veterans Service	177	42	23.73	42	18	42.86	274	83	30.29	83	62	74.40
Veterans and Reserves Mental Health Programme	177	49	27.68	49	32	65.31	274	68	24.82	68	42	61.76
The Big White Wall	177	47	26.55	47	19	40.43	274	43	15.69	43	22	51.16

7.2.4 Types of Help-Seeking by Specific Healthcare or Support Service (Table 14 and 15)

When participants were asked about their help-seeking for their current or resolved stress, emotional, mental health or alcohol problem (Table 14), just under 60% (n=264) of participants endorsed that they had spoken to or sought help from at least one formal/professional source. Within the grouping, 'Any Formal/Professional Help', the most utilised source of help was an individuals' GP or Medical Officer (51%, n=230), followed by a mental health specialist (37%, n=165). The remaining formal/professional services, such as Combat Stress, or services included in the 'other' category such as The NHS Veterans Service (therapy) had very low percentages (below 10%) of help-seeking through their services.

Overall just under 50% (n=213) of individuals endorsed they had spoken to or sought help from at least one non-medical support service. Within this category of help-seeking, most individuals had sought help from non-medical professionals such as a padre or social worker/welfare officer (25%, n=111), followed by those who had sought help with the Chain of Command (21%, n=95). The remaining non-medical support services such as Service charities, TRiM Practitioners, the SSAFA/Combat Stress 24hr helpline and services in the 'other' category had low percentages (below 11%) of individuals utilising these services as source of help.

A large proportion of participants had spoken to or sought help from informal sources i.e. family members, friends or colleagues (83%, n=371) with the majority of this group seeking help from a family member (73%, n=326). Finally there were 36 individuals (8%) who had not spoken to or sought help from anyone at all.

Table 15 describes the overlap between formal help-seeking other types of help-seeking. Of those that had sought any formal or professional help (n=264), 86% (n=228) had also sought informal help and 61% (n=161) had sought help from non-medical support services.

Table 14 - Prevalence of help-seeking by specific health/support service

	Prevalence of help seeking (N=449)	
Specific service individuals sought help with		
Any Formal/Professional Help	264	58.80
GP/MO	230	51.22
A mental health specialist	165	36.75
A hospital doctor	18	4.01
Combat Stress (therapy)	10	2.23
Service Charity (therapy)	10	2.23
Other ⁹	34	7.57
Any Non-Medical Support Services Help	213	47.44
Other non-medical professional (Medic, Padre, Social Worker, Welfare Officer, Counsellor)	111	24.72
Chain of Command	95	21.16
Service Charity (general)	26	5.79
Internet based therapy	18	4.01
Combat Stress (general)	11	2.45
TriM Practitioner	10	2.23
Big White Wall (general)	8	1.78
SSAFA/Combat Stress 24hr helpline	8	1.78
Other ¹⁰	48	10.69
Any Informal Help-seeking	371	82.63
A family member	326	72.61
Friends/colleagues	240	53.45
No help Sought	36	8.02

Table 15 - Overlap between Formal/Professional help-seeking and other types of help-seeking

	Formal Help-seeking	
	Yes (N=264)	
Type of Help Sought	n	%
Non-Medical Support Services	161	60.98
Informal	228	86.36
No Help	0	0.00

⁹ Other includes, 'NHS Veterans Service (therapy)', Veterans and Reserves Mental Health Programme, Big White Wall (therapy) and those that answered 'Other' (therapy).

¹⁰ Other includes NHS Veterans Service (general), Veterans UK Helpline and those that answered 'Other' (general).

7.2.5 Different Reasons for Seeking Formal/Professional Help (Table 16 and 17)

Participants who had sought formal/professional help were asked about the different reasons for their help-seeking (Table 16). The top five most endorsed reasons were, ‘I realised I had a problem’ (71%, n=188), ‘I was concerned the problem was getting worse’ (58%, n=153), ‘I realised I couldn’t solve the problem myself like I had hoped’ (50%, n=132), ‘On the advice of a family member, friend, colleague’ (44%, n=117) and ‘The problem had started to affect my work’ (41%, n=107). Less important reasons for seeking help were; advice from the Chain of Command or TRiM practitioners (13%, n=33), experiencing disciplinary problems (8%, n=20) or finding relevant services through word of mouth or adverts/online (3%, n=8). A large percentage of participants also gave ‘other’ as their reason for their help-seeking (65%, n=172). There were a myriad of ‘other’ reasons described by participants, however this category most commonly included help-seeking precipitated on the advice of GPs, Medical Officers, mental health nurse practitioner/CPN and Service charities who referred individuals for mental health help. Other reasons in this category also included individuals who had sought help because they were experiencing physical symptoms, or they had gone to see a doctor for a different reason and the problem came up, or individuals had attempted suicide, or they sought help because they were also experiencing other stressful life events, like births, illness or deaths.

Table 16 - Prevalence of different reasons for seeking help of those that used formal/professional services

Reason for Seeking Help	Prevalence (N=264)	
	n	%
I realised I had a problem	188	71.21
I was concerned the problem was getting worse	153	57.95
I realised I couldn’t solve the problem myself like I had hoped	132	50.00
On the advice of a family member, friend, colleague	117	44.32
The problem had started to affect my work	107	40.53
A change in life circumstances or a major event	72	27.27
On the advice of employer or Chain of Command/ TRiM practitioner	33	12.50
I was experiencing disciplinary problems as a result of the problem	20	7.58
I found a relevant service through word of mouth, an advert or online	8	3.03
Other	172	65.15

Table 17 assesses the overlap between different reasons for seeking help. Overall participants endorsed multiple reasons to explain their help-seeking with formal/professional services. There was much overlap between the top five reasons for seeking help. For example, of those that endorsed that they realised they had a problem (n=188), 70% (n=131) endorsed that they were concerned the problem was getting worse, 61% (n=114) that they

realised they couldn't solve the problem, 48% (n=90) that the problem had started to affect their work and 44% (n=83) also endorsed they sought help on the advice of a family member, friend or colleague. Additionally there was a large overlap between certain statements. For example of those individuals who endorsed that they were concerned their problem was getting worse (n=153), 65% (n=99) also endorsed that they realised they couldn't solve the problem like they had hoped and 56% (n=86) endorsed that they problem had started to affect their work.

Table 17 - Overlap Between Endorsements Of Reasons For Seeking Help

Reason for Seeking Help	Prevalence (N=264) %	1	2	3	4	5	6	7	8	9
	n									
1. I realised I had a problem	188	-	131 69.68	114 60.64	83 44.15	90 47.87	58 30.85	17 9.04	16 8.51	8 4.26
2. I was concerned the problem was getting worse	153	131 85.62	-	99 64.71	72 47.06	86 56.21	50 32.68	15 9.80	17 11.11	6 3.92
3. I realised I couldn't solve the problem myself like I had hoped	132	114 86.36	99 75.00	-	69 52.72	65 49.24	43 32.58	17 12.88	13 9.85	6 4.55
4. On the advice of a family member, friend, colleague	117	83 70.94	72 61.54	69 58.97	-	45 38.46	33 28.21	18 15.38	10 8.55	3 2.56
5. The problem had started to affect my work	107	90 84.11	86 80.37	65 60.74	45 42.06	-	30 28.04	17 15.89	18 16.82	4 3.74
6. A change in life circumstances or a major event	72	58 80.56	50 69.44	43 59.72	33 45.83	30 41.67	-	13 18.06	8 11.11	7 9.72
7. On the advice of employer or Chain of Command/TRIM practitioner	33	17 51.51	15 45.45	17 51.51	18 54.55	17 51.51	13 39.39	-	6 18.18	4 12.12
8. I was experiencing disciplinary problems as a result of the problem	20	16 80.00	17 85.00	13 65.00	10 50.00	18 90.00	8 40.00	6 30.00	-	3 15.00
9. I found a relevant service through word of mouth, an advert or online	8	8 100.00	6 75.00	6 75.00	3 37.50	4 50.00	7 87.50	4 50.00	3 37.50	-

N.B. - % relates to percentage overlap of different reasons for seeking help, taking the list on the left as the reference group. E.g. Reason 1 endorsed by 188 participants, 131 participants endorsed reason 1 *and* 2, hence percentage overlap of reason 2 with reason 1 = (131/188) 69.68%.

7.3 Anticipated Public Stigma, Barriers to Care and Mental Health Status (Table 19)

7.3.1 Endorsement of Anticipated Public Stigma and Barrier to Care Statements – all participants

Participants were given a list of concerns or thoughts that a person might have when they consider seeking help for a mental health problem. Overall, a majority of individuals endorsed at least one or more anticipated public stigma orientated barrier statements (66%, n=300), followed by attitudinal barrier statements (62%, n=280) and then practical barrier statements (25%, n=111). The eight different anticipated public stigma items were fairly consistently endorsed, however, of the eight attitudinal barrier items, only one item, *'I want to solve the problem on my own'*, was endorsed consistently, with the other attitudinal barrier items having low percentages of endorsement. Equally, all of the practical barrier statements had relatively low endorsement across the four items overall.

The top five most endorsed statements about anticipated public stigma or barriers to care that all participants indicated would affect their decision to seek help for a mental health problem were (percentages and barrier type in brackets):

1. *'Wanting to solve the problem on my own'* (62%, n=247, Attitudinal)
2. *'My unit leaders/bosses might treat me differently'* (52%, n=203, Stigma)
3. *'Not wanting a mental health problem to be on my medical records'* (47%, n=191 Stigma)
4. *'I would be seen as weak'* (43%, n=160, Stigma)
5. *'Members of my unit or my colleagues might have less confidence in me'* (41%, n=178, Stigma)

The five least endorsed statements were:

1. *'I don't have adequate transport'* (0.45%, n=2, Practical)
2. *'I don't know where to get help'* (5%, n=21, Practical)
3. *'My leaders/bosses discourage the use of mental health services'* (5%, n=20 Attitudinal)
4. *'I would think less of a team member/work colleague if I knew he/she was receiving mental health counselling'* (6%, n=25, Attitudinal)
5. *'I don't trust mental health professionals'* (6%, n=23, Attitudinal)

Hence overall, anticipated public stigma barriers are consistently important in effecting individuals' hypothetical decision to seek help for a mental health problem. Attitudinal and practical barriers are far less important with low endorsement of statements, except for the most endorsed statement overall, which was the attitudinal barrier, *'I want to solve the problem on my own'*. From the 9th most endorsed statement downwards, there were relatively low percentages of individuals endorsing the barrier statements.

7.3.2 Endorsement of Anticipated/Public Stigma and Barrier to Care Statements by Mental Health Status

From the literature, there is evidence to support the circumstance that those with mental health problems perceive greater levels of anticipated public stigma and barriers to care compared to those with sub-threshold symptoms (Hoge et al., 2004, Iversen et al., 2011, Kim et al., 2011, Pietrzak et al., 2011a, Ouimette et al., 2011, Warner et al., 2011, Osório et al., 2013b). When comparing the percentages of those who endorsed a anticipated public stigma or barrier to care statement between those *with* and *without* a probable mental health diagnosis (as measured by the PHQ-9, GAD-7 and PCL-5); the percentage of those that endorsed anticipated public stigma and barrier to care statements with a probable mental health diagnosis were consistently higher, compared to those without, across all items. For example, when taking the overall endorsement of practical, anticipated public stigma and attitudinal items (endorsement of at least one or more items); the endorsement of overall practical barriers for those with a probable diagnosis compared to those without was 36% (n=43) compared to 20% (n=68), overall stigma items 81% (n=96) v 61% (n=204) and overall attitudinal items 75% (n=88) v 57% (n=192).

Of the top five most endorsed anticipated public stigma and barrier to care statements for those with a probable mental health problem, all of the items were the same as those in the top five endorsed overall by all participants, however the order of ranking of endorsed items differed slightly. The top five most endorsed anticipated public stigma and barrier to care statements for those with a probable mental health problem compared to those without are found in Table 18.

Table 18 - Top Five Most Endorsed Anticipated Public Stigma/Barrier to Care Statements by Mental Health Status

Anticipated Public Stigma/Barrier to Care Statement	% agree among those with a diagnosis	% agree among those without a diagnosis	Barrier type
1. <i>'Wanting to solve the problem on my own'</i>	68% (n=73)	60% (n=174)	Attitudinal
2. <i>'My unit leaders/bosses might treat me differently'</i>	67% (n=69)	46% (n=134)	Public Stigma
3. <i>'I would be seen as weak'</i>	58% (n=60)	37% (n=100)	Public Stigma
4. <i>'Members of my unit or my colleagues might have less confidence in me'</i>	57% (n=58)	41% (n=120)	Public Stigma
5. <i>'Not wanting a mental health problem to be on my medical records'</i>	57% (n=63)	44% (n=128)	Public Stigma

7.3.3 Comparison of Anticipated Public Stigma Prevalence in those with a Probable Mental Health Problem With Meta-Analysis Pooled Estimate and UK Studies Stigma Prevalence Data (Table 20)

The top three most endorsed anticipated public stigma items in my quantitative study for those that had a probable mental health problem, match the top three concerns found in my meta-analysis results (which also presented public stigma data for those with a mental health problem) - reported in Chapter 2. The prevalence of endorsement of anticipated public stigma items from the PSBCPP-SS from my quantitative study compared to my meta-analysis results, sit consistently higher than the meta-analysis pooled prevalence estimates for each anticipated public stigma item. For example, in my quantitative study, the highest prevalence endorsed for an anticipated item was 67% (N=392) for, *'My unit leadership might treat me differently'*. Whilst this item was also the highest endorsed anticipated public stigma item from the meta-analysis, the pooled estimate was far lower at 44%.

As noted in the meta-analysis (pg. 64), individual UK military studies' anticipated public stigma prevalence for the different PSBCPP-SS items sat higher when compared to the pooled estimate meta-analysis and individual US military studies results. This finding is again replicated here. My quantitative findings of anticipated public stigma prevalence results are broadly in line with the prevalence estimates found in the UK studies of Iversen et

al. (2011), Osório et al. (2013b), Jones et al. (2013), that all sit higher than the pooled meta-analysis estimates and US studies results.

7.3.4 Association of Endorsement of Anticipated Public Stigma/Barrier to Care Statements and Mental Health Status

Table 19 presents data on anticipated and barrier to care statements as the *Outcome* variable on which mental health status is regressed as the *Explanatory* variable.

Overall Measures of Stigma/Barrier to Care Statements

In unadjusted analyses individuals who had a probable mental health diagnosis were more than twice as likely to endorse the overall measures of practical barriers (OR = 2.25, 95% CI: 1.42-3.57, $P < 0.005$), anticipated public stigma barriers (OR = 2.78, 95% CI: 1.67-4.64, $P < 0.005$) and attitudinal barriers (OR = 2.18, 95% CI: 1.37-3.49, $P < 0.005$). In adjusted analyses (adjusted for rank, impairment and life events), individuals who had a probable mental health problem were still more likely to endorse the overall measures of practical barriers (AOR = 1.76, 95% CI: 1.03-3.03, $P < 0.05$), anticipated public stigma barriers (AOR = 3.34, 95% CI: 1.84-6.07, $P < 0.005$) and attitudinal barriers (AOR = 2.51, 95% CI: 1.45-4.33, $P < 0.005$).

Unadjusted Analyses Individual Statements

Participants with a probable mental health diagnosis were statistically significantly more likely to endorse *all* of the different individual anticipated public stigma and barrier to care statements except for the items, '*I don't know where to get help*', '*I don't have adequate transport*', '*My visit wouldn't remain confidential*', '*I would think less of a team member/work colleague if I knew he/she were receiving mental health counselling*' and '*I want to solve the problem on my own*', which were not associated with having a probable mental health diagnosis.

Some individual items in unadjusted analyses had very large odds ratios, for example those who were case positive for a mental health problem were nearly six times more likely to endorse the statement, '*Mental health care doesn't work*' (OR=5.79, 95% CI: 2.51-13.30, $P < 0.005$) and over four times more likely to endorse the statement '*My leaders/bosses discourage the use of mental health services*' (OR=4.35, 95% CI: 1.74-10.86, $P < 0.005$). However caution must be taken when interpreting the association of some of these statements with mental health status, as some odds ratios have large confidence intervals and are unadjusted for confounders.

Adjusted Analyses Individual Statements

In adjusted analyses (adjusted for rank, impairment and life events), when assessing individual anticipated public stigma or barrier to care items (only performed on items where the outcome variable i.e. endorsement of anticipated public stigma/barrier to care items was N= 50 or above), all eight of the anticipated public stigma items remained significantly associated with having a probable mental health diagnosis. Participants who were case positive for a probable mental health diagnosis were nearly three times more likely than those without a probable diagnosis to endorse the anticipated public stigma statements, *'My unit leaders/bosses might treat me differently'* (AOR = 2.89, 95% CI: 1.64-5.08, $P<0.005$), *'I would be seen as weak'* (AOR = 2.82, 95% CI: 1.64-4.85, $P<0.005$), *'It would be too embarrassing'* (AOR = 2.73, 95% CI: 1.58-4.71, $P<0.005$) and *'My leaders/bosses would blame me for the problem'* (AOR = 2.59, 95% CI: 1.30-5.16, $P<0.01$).

Additionally in adjusted analyses there was significant association between endorsing the statement, *'I want to solve the problem on my own'* and those who were case positive on mental health measures (AOR = 1.82, 95% CI: 1.05-3.16, $P<0.05$). Finally after adjusting, the practical barrier statement, *'There would be difficulty getting time off work for treatment'* and its association with mental health status, was no longer significant. These analyses confirmed findings from previous literature, that individuals with a mental health problem are more likely than those without a diagnosis to perceive more anticipated public stigma and barriers to care, when thinking about seeking help for a mental health problem.

Table 19 - Prevalence of Endorsement of Barriers to seeking help overall and by Mental Health Status, and Association of Anticipated Public Stigma/Barrier to Care Statements as the Outcome Variable with Mental Health Status as the Explanatory Variable, Odds Ratio and 95% CI

Anticipated Public Stigma and Barriers to Care Statements ¹¹	Prevalence (positive endorsement of statement)												Mental health case positive (PHQ-9, GAD-7, PCL5)	
	Overall			% agree among those without diagnosis			% agree among those with diagnosis			Unadjusted	Adjusted ^{12,13}	Odds Ratio (95% CI)		
	n	N	%	n	N	%	n	N	%					
Practical Barriers•	111	453	24.50	68	335	20.30	43	118	36.44			1.76*	(1.03-3.03)	
I don't know where to get help	21	433	4.85	13	322	4.04	8	111	7.21			-	-	
I don't have adequate transport	2	446	0.45	0	331	0.00	2	115	1.74			-	-	
It is difficult to get an appointment	47	332	14.16	24	246	9.76	23	86	26.74			3.38***	(1.79-6.38)	
There would be difficulty getting time off work for treatment	69	427	16.16	42	322	13.04	27	105	25.71			2.31***	(1.34-3.98)	
Anticipated Public Stigma Barriers•	300	452	66.37	204	334	61.08	96	118	81.36			3.34***	(1.84-6.07)	
It would be too embarrassing	143	398	35.93	92	290	31.72	51	108	47.22			2.73***	(1.58-4.71)	
It would harm my career	157	383	40.99	102	280	36.43	55	103	53.40			2.36***	(1.37-4.06)	
Members of my unit or my colleagues might have less confidence in me	178	393	45.29	120	292	41.10	58	101	57.43			2.39***	(1.38-4.14)	
My unit leaders/bosses might treat me differently	203	392	51.79	134	289	46.37	69	103	66.99			2.89***	(1.64-5.08)	
My leaders/bosses would blame me for the problem	66	374	17.65	38	286	13.29	28	88	31.82			2.59**	(1.30-5.16)	

*p<.05, **p<.01, ***p<.005

•Percentage is in reference to overall N, including individuals who endorsed 'agreed', 'neither agree or disagree' and 'disagree'

¹¹ Stigma and Barrier to Care Statements are the Outcome variable on which Mental Health Status is regressed as the Explanatory variable.

¹² Adjusted for rank, impairment and life events

¹³ Variables are only adjusted if prevalence of endorsement of stigma/barrier to care statement is 50 or above (otherwise only univariate analyses are shown)

Anticipated Public Stigma and Barriers to Care Statements ¹¹	Prevalence (positive endorsement of statement)												Mental health case positive (PHQ-9, GAD-7, PCL5)	
	Overall			% agree among those without diagnosis			% agree among those with diagnosis			Unadjusted	Adjusted ²¹³	Odds Ratio (95% CI)		
	n	N	%	n	N	%	n	N	%					
I would be seen as weak	160	376	42.55	100	273	36.63	60	103	58.25	2.41***	(1.52-3.83)	2.82***	(1.64-4.85)	
Not wanting a mental health problem to be on my medical records	191	404	47.28	128	294	43.54	63	110	57.27	1.74*	(1.12- 2.71)	2.28***	(1.35-3.84)	
Concern about what my friends and family might think	135	411	32.85	89	303	29.37	46	108	42.59	1.78*	(1.13-2.81)	2.34***	(1.37-3.99)	
Attitudinal Barriers•	280	453	61.81	192	335	57.31	88	118	74.58	2.18***	(1.37-3.49)	2.51***	(1.45-4.33)	
Mental health care doesn't work	26	335	7.76	10	252	3.97	16	83	19.28	5.79***	(2.51-13.3)	-	-	
I don't trust mental health professionals	23	379	6.07	12	287	4.18	11	92	11.96	3.11**	(1.32-7.32)	-	-	
My visit would not remain confidential	40	400	10.00	26	299	8.70	14	101	13.86	1.69	(0.84-3.38)	-	-	
I would think less of a team member/ work colleague if I knew he/she was receiving mental health counselling	25	426	5.87	17	317	5.36	8	109	7.34	1.40	(0.59-3.34)	-	-	
My leaders/bosses discourage the use of mental health services	20	380	5.26	9	290	3.10	11	90	12.22	4.35***	(1.74-10.86)	-	-	
I have had previous bad experiences with mental health professionals	52	391	13.30	29	289	10.03	23	102	22.55	2.61***	(1.43-4.77)	1.90	(0.92-3.91)	
Wanting to solve the problem on my own	247	396	62.37	174	288	60.42	73	108	67.59	1.37	(0.86-2.18)	1.82*	(1.05-3.16)	
Mental health treatment has harmful side effects	34	316	10.76	18	245	7.35	16	71	22.54	3.67***	(1.76-7.65)	-	-	

•Percentage is in reference to overall N, including individuals who endorsed 'agreed', 'neither agree or disagree' and 'disagree' Those responding 'neither agree or disagree' are excluded from individual percentages pertaining to each stigma or barrier to care statement *p<.05, **p<.01, ***p<.005

Table 20 - Comparison of Endorsement Of Public Stigma Item Prevalence Using The PSBCPP-SS Across Quantitative Results, Meta-analysis And Individual UK Studies

PSBCPP-SS Stigma Statement	Quantitative Results Prevalence (N) (those with probable mental health diagnosis)	Meta-Analysis Pooled Estimate	UK Studies ¹⁴ Prevalence (N)				
			Gould et al. 2010	Langston et al. 2010	Iversen et al. 2011	Osorio et al. 2012	Jones et al. 2013
'My unit leadership might treat me differently'	67% (69/103)	44%	40% (245/613)	-	75% (244/325)	62% (426/688)	72% (182/253)
'I would be seen as weak'	58% (60/103)	43%	41% (251/613)	43% (175/406)	52% (169/325)	62% (429/688)	59% (149/254)
'Members of my unit might have less confidence in me'	57% (58/101)	41%	-	-	76% (247/325)	-	72% (184/254)
'It would be too embarrassing'	47% (51/108)	36%	-	61% (246/406)	45% (146/325)	54% (386/710)	40% (102/254)
'It would harm my career'	53% (55/103)	33%	25% (153/613)	39% (160/406)	52% (169/325)	55% (386/697)	61% (153/253)
'My leaders would blame me for the problem'	32% (28/88)	26%	-	-	25% (81/325)	-	30% (76/253)

¹⁴ All UK study data are included in the meta-analysis data

7.4 Demographic, Social and Military Factors Associated with Help-seeking and Service Utilisation (Table 21)

Three models of analyses were run to assess factors associated with formal/professional help-seeking, measured by service utilisation. These models include all individuals from the clinical telephone interview study (N=453) who endorsed at the KCMHR phase 3 cohort study questionnaire, that they had experienced a stress, emotional or mental health problem in the last three years. Hence all 453 participants are included regardless of their current self-recognition of a problem or current probable mental health status. My use of the term formal/professional help-seeking in this section includes those who sought help from formal/professional services *and* non-medical support services. In unadjusted analyses, service branch, impairment, life events and mental health caseness were significantly associated with formal/professional and non-medical support services help-seeking. In the unadjusted model, participants were more likely to use formal/professional or non-medical support services help within the last three years if:

- They were a member of the Royal Air Force (compared to the Army branch of Service) (OR = 1.91, 95% CI: 1.10-3.30, $P<0.05$),
- Reported social impairment due to their physical or emotional problems (OR = 2.20, 95% CI: 1.19-4.08, $P<0.05$),
- Were currently a probable, positive mental health case as measured by the PHQ-9, GAD-7 or PCL-5 in the clinical telephone interview study (OR=1.80, 95% CI: 1.10-2.96, $P<0.05$) or,
- Had experienced either 1-2 life events (OR=2.01, 95% CI: 1.11-3.65) or 3+ life events (OR=4.43, 95% CI: 2.41-8.14) with odds ratios positively increasing as the category increased (Test for Trend $P=0.000$).

Age, rank, education, serving status, marital status, last deployment, time since last deployment and AUDIT caseness were not associated with formal/professional help-seeking in the unadjusted models.

Adjusted Model 1

In the 1st adjusted model (adjusted for impairment, life events and current self-recognition of a stress, emotional, mental health or alcohol problem) a statistically significant association emerged between education level and formal/professional help-seeking. Low attainment in

education (GCSE's/ equivalents or below) was associated with 37% decreased odds of seeking help from formal/professional services (AOR = 0.63, 95% CI: 0.40-0.99, $P < 0.05$). After adjusting, only service branch and life events remained significantly positively associated with help-seeking. Individuals in the Royal Air Force (compared to the Army) were over twice as likely to seek formal/professional help, with an increase in odds ratio for the adjusted model (AOR = 2.29, 95% CI: 1.29-4.09, $P < 0.01$). Individuals who had experienced 1-2 life events were 1.9 times more likely to seek help from formal/professional services (AOR = 1.90, 95% CI: 1.04-3.46, $P < 0.05$) and individuals who had experienced three or more life events were 3.77 times more likely to seek formal/professional help (AOR = 3.77, 95% CI: 2.02-7.03, $P < 0.005$). Again, a positive trend was seen (Test for trend $P = 0.000$).

Overall in model 1 - age, rank, marital status, last deployment, time since last deployment, impairment, mental health caseness and AUDIT caseness were not associated with the help-seeking outcome.

Adjusted Model 2

The 2nd adjusted model was adjusted for the same factors as before (impairment, life events and current recognition of problem) *plus* mental health caseness i.e. whether an individual had a probable mental health diagnosis on the mental health measures. This adjustment was made in the second model to control for confounding and to assess the individual additional impact of individuals' mental health status on help-seeking outcome.

Education, service branch and life events (from model 1) remained associated with formal/professional help-seeking. Compared to the 1st model, controlling for mental health status had little effect on the model. Having lower education attainment was still associated with decreased odds of seeking formal/professional help or services (AOR = 0.62, 95% CI: 0.39-0.99, $P < 0.05$), being a member of the Royal Air Force was still associated with increased odds of seeking formal/professional help (AOR = 2.29, 95% CI: 1.28-4.08, $P < 0.01$) and experiencing 1-2 life events or 3+ life events compared with those who didn't experience any life events, was still associated with increased odds of seeking formal/professional help (AOR = 1.92, 95% CI: 1.05-3.50, $P < 0.05$) and (AOR = 3.76, 95% CI: 2.02-7.01, $P < 0.001$) respectively (Test for Trend $P = 0.000$).

Overall in model 2 - age, rank, marital status, last deployment, time since last deployment, impairment, mental health caseness and AUDIT caseness were again not associated with the help-seeking outcome.

Table 21 – Demographic, Social and Military Factors Associated with help-seeking among 449 UK military personnel who endorsed experiencing a stress/emotional/mental health or alcohol problem at KCMHR Cohort Phase Three Questionnaire Stage

Factor	No Help (N=133)		N	%	Formal/Professional and Non Medical Support Services Help-Seeking (N=316)					
	N	%			Unadjusted Model Odds Ratio (95% CI)	Adjusted 1 st Model ¹⁵ Odds Ratio (95% CI)	Adjusted 2 nd Model ¹⁶ Odds Ratio (95% CI)			
Age ¹⁷	43.49	±8.67	44.7	±9.24	1.01	(0.99-1.04)	1.01	(0.99-1.04)	1.01	(0.99-1.04)
Rank										
Other	95	71.43	216	68.35	1.00		1.00		1.00	
Officer	38	28.57	100	31.65	1.15	(0.74-1.81)	1.37	(0.86-2.18)	1.40	(0.87-2.24)
Education										
High attainment	88	66.17	233	73.73	1.00		1.00		1.00	
Low attainment	45	33.83	83	26.27	.70	(0.45-1.08)	.63*	(0.40-0.99)	.62*	(0.39-0.99)
Serving Status										
Service Personnel and Reserves	52	39.10	122	38.85	1.00		1.00		1.00	
Ex-Service	81	60.90	192	61.15	1.01	(0.67-1.53)	.86	(0.56-1.33)	.86	(0.55-1.32)
Service Branch										
Army	91	68.42	191	60.44	1.00		1.00		1.00	
Naval Services	22	16.54	45	14.24	.97	(0.55-1.72)	1.07	(0.59-1.94)	1.06	(0.58-1.93)
Royal Air Force	20	15.04	80	25.32	1.91*	(1.10-3.30)	2.29**	(1.29-4.09)	2.29**	(1.28-4.08)
Marital Status										
Married/Partner/Long-term	114	85.71	262	82.91	1.00		1.00		1.00	
Single	7	5.26	27	8.54	1.68	(0.71-3.97)	1.38	(0.57-3.34)	1.36	(0.56-3.32)
Divorced/Separated/Widowed	12	9.02	27	8.54	.98	(0.48-2.00)	.71	(0.33-1.51)	.71	(0.33-1.51)

*p<.05, **p<.01, ***p<.005

¹⁵ Adjusted for impairment, life events and current recognition of a problem

¹⁶ Adjusted for impairment, life events, current recognition and mental health caseness

¹⁷ Age was a continuous variable and was rescaled by dividing by 10 into a categorical variable

Factor	No Help (N=133)		Formal/Professional and Non Medical Support Services Help-Seeking (N=316)				
	N	%	N	%	Unadjusted Model	Adjusted 1 st Model ¹⁵	Adjusted 2 nd Model ¹⁶
					Odds Ratio (95% CI)	Odds Ratio (95% CI)	Odds Ratio (95%)
Last Deployment							
Not Deployed	34	25.95	87	28.81	1.00	1.00	1.00
Telic	39	29.77	86	28.48	.86 (0.50-1.49)	.86 (0.48-1.53)	.86 (0.48-1.53)
Herrick	58	44.27	129	42.72	.87 (0.53-1.44)	.86 (0.51-1.46)	.86 (0.51-1.46)
Time Since Last Deployment							
No Deployment	34	25.76	87	28.43	1.00	1.00	1.00
<6 years since deployment	53	40.15	100	32.68	.74 (0.44-1.24)	.77 (0.45-1.32)	.77 (0.45-1.32)
≥6years since deployment	45	34.09	119	38.89	1.03 (0.61-1.75)	.98 (0.56-1.70)	.97 (0.56-1.69)
Social Impairment							
No impairment	119	89.47	251	79.43	1.00	1.00	1.00
Impairment	14	10.53	65	20.57	2.20* (1.19-4.08)	1.54 (0.80-2.96)	1.45 (0.73-2.92)
Life Events							
Zero life events	31	23.31	29	9.18	1.00	1.00	1.00
1-2 life events	60	45.11	113	35.76	2.01* (1.11-3.65)	1.90* (1.04-3.46)	1.92* (1.05-3.50)
≥3 life events	42	31.58	174	55.06	4.43*** (2.41-8.14)	3.77*** (2.02-7.03)	3.76*** (2.02-7.01)
Mental Health Caseness (PHQ-9, GAD-7, PCL-5)							
Negative case	108	81.20	223	70.57	1.00	1.00	1.00
Positive case	25	18.80	93	29.43	1.80* (1.10-2.96)	1.15 (0.63-2.09)	1.15 (0.63-2.09)
AUDIT Caseness (16+)							
Negative case	102	79.07	247	81.25	1.00	1.00	1.00
Positive case	27	20.93	57	18.75	.87 (0.52-1.46)	.69 (0.40-1.19)	.69 (0.40-1.19)

*p<.05, **p<.01, ***p<.005

7.5 Stigma, Barriers to Care, Social Support and Recognition of a Problem as Factors Associated with Help-Seeking and Service Utilisation (Table 22)

Three models of analyses were run to assess the impact of public and self-stigma, barriers to care, social support and recognition of a problem, on the outcome of help-seeking from professional/formal and non-medical support services. These models again use all participants (N=453) who reported experiencing a stress, emotional or mental health problem at the KCMHR cohort phase 3 questionnaire who participated in the clinical telephone interview study.

In the unadjusted model, anticipated public stigma, attitudinal and self-stigma barriers were associated with formal/professional help-seeking, as was recognition of a current mental health problem. Specifically those who had higher anticipated public stigma overall (the top tertile group created from a count of endorsement of individual stigma items,) compared to the lower anticipated public stigma group (the lower and middle tertile groups), were 36% (or 1.5 times) less likely to seek formal/professional help (OR = 0.64, 95% CI: 0.41-0.99, $P<0.05$). There were three individual anticipated public stigma statements that were negatively associated with formal professional help-seeking. Those who endorsed that, *'it would be too embarrassing'* to seek help for a mental health problem were 38% (or 1.6 times) less likely to seek help from formal/professional services (OR = 0.62, 95% CI: 0.40-0.97, $P<0.05$). Those who endorsed their concern about, *'Not wanting a mental health problem to be on my records'*, when thinking about seeking help were 41% (or 1.7 times) less likely to seek formal/professional help. Lastly those who were concerned *'about what my friends or family might think'* if they sought help for a mental health problem were 45% (or 1.8 times) less likely to seek formal/professional help (OR = 0.55, 95% CI: 0.35-0.86, $P<0.01$).

Higher attitudinal barriers overall (the top tertile created from a count of endorsement of individual attitudinal barriers compared to middle and lower tertiles) was not associated with the help-seeking outcome. However three specific attitudinal individual statements were. Those who endorsed, *'My visit would not remain confidential'* and *'I would think less of a team member/work colleagues if I knew he/she was receiving mental health counselling'*, were 56% and 59% less likely to seek formal/professional services (OR = 0.44, 95% CI: 0.22-0.85), $P<0.05$ and (OR = 0.41, 95% CI: 0.18-0.93, $P<0.05$). Finally those who endorsed that they would not seek help because they wanted *'to solve the problem alone'* were 53% less likely to seek help from formal/professional services (OR = 0.47, 95% CI: 0.28-0.76, $P<0.001$).

Higher self-stigma barriers overall (the top tertile created from a count of endorsement of individuals self-stigma statements compared to middle and lower tertiles) was negatively associated with formal/professional help-seeking. Those in the higher self-stigma group were 54% or over two times less likely to seek formal/professional help, compared to those in the lower self-stigma group (OR = 0.46, 95% CI: 0.30-0.70, $P < 0.001$). There were three individual self-stigma statements that were negatively associated with formal/professional help-seeking. Participants who acknowledged that they would not seek help for a mental health problem because; *'It would make me feel inadequate if I went to a mental health professional for psychological help'*, *'If I went to a mental health professional, I would be less satisfied with myself'* and *'I would feel worse about myself if I could not solve my own problems'* were 58% (OR = 0.42, 95% CI: 0.27-0.66, $P < 0.001$), 51% (OR = 0.49, 95% CI: 0.31-0.79, $P < 0.001$) and 55% (OR = 0.45, 95% CI: 0.29-0.70, $P < 0.001$) respectively, less likely to seek formal or professional help.

Participants who had a current self-recognition (at the time of the clinical telephone interview) that they were experiencing an stress, emotional, mental health or alcohol problem were 1.8 times more likely to be utilising help from formal/professional services (OR = 1.79, 95% CI: 1.19-2.70, $P < 0.01$).

In unadjusted models, practical barriers overall, the practical barrier individual statements and levels of social support, were not associated with formal/professional help-seeking/service use.

Adjusted Model 1

In model 1 (adjusted for impairment, life events and current recognition of a problem), all of the previous associations, except two, remained significant with marginal changes to their respective odds ratios. The negative association between the attitudinal barrier statement, *'I would think less of colleagues if I knew he/she was receiving mental health counselling'*, was no longer associated with the formal/professional service use. Additionally, the positive association between professional/formal help seeking and current self-recognition of a problem was no longer significant. Measures of overall higher anticipated public stigma and self-stigma, and the individual anticipated public stigma, attitudinal and self-stigma statements (the same eight statements previous mentioned), all remained negatively associated with professional/formal help-seeking and service utilisation.

In model 1, a statistically significant association emerged between social support and help-seeking. Those who had lower social support (created from the lower half of a count of social support) were 41% (approximately 1.7 times) less likely to seek formal/professional help (AOR

= 0.59, 95% CI: 0.38-0.93, $P < 0.05$) than those who had higher social support (created from a count of the upper half of social support).

Adjusted Model 2

Model 2 was adjusted for impairment, life events, current recognition of a problem *and* mental health caseness. As previously described for Table 21 (assessing social/military demographics associated with help-seeking), mental health caseness was added into model 2 to assess the potential specific effect of controlling for having probable mental health diagnosis.

All associations described in model 1 remained significantly associated with formal/professional help-seeking, albeit some odd ratios were changed marginally.

Overall, individuals who had higher anticipated public stigma were 45% less likely to use formal/ professional help (AOR = 0.55, 95% CI: 0.35-0.88, $P < 0.05$). The same three individual anticipated public stigma statements, '*It would be too embarrassing*', '*Not wanting a mental health problem to be on my medical records*' and '*Concern about what my friends or family might think*', remained significantly negatively associated with formal/professional help-seeking. The statement with the largest odds ratio, negatively associated with the help-seeking outcome, was the concern about what friends and family might think if they were to seek help for a mental health problem. Individuals who agreed with this statement were 51% (or 2 times) less likely to utilise formal/professional services than those who did not endorse this statement (AOR = 0.49, 95% CI: 0.31-0.79, $P < 0.001$).

The two attitudinal statements, '*My visit would not remain confidential*' and '*Wanting to solve the problem alone*' continued to be significantly negatively associated with formal/professional help-seeking (AOR = 0.42, 95% CI: 0.21-0.86, $P < 0.05$) and (AOR = 0.47, 95% CI: 0.28-0.78, $P < 0.001$).

Individuals with higher self-stigma overall, were 58% less likely (or 2.4 times less likely) than those with lower self-stigma to utilise formal/professional services for help (AOR = 0.42, 95% CI: 0.27-0.66, $P < 0.001$). The three self-stigma statements '*It would make me feel inadequate if I went to a mental health professional for psychological help*', '*If I went to a mental health professional, I would be less satisfied with myself*' and '*I would feel worse about myself if I could not solve my own problems*', remained significantly negatively associated with the help-seeking outcome. The statement that presented the largest odds ratio was, '*It would make me feel inadequate if I went to a mental health professional for psychological help*'. Individuals who agreed with this statement were 62% less likely (or 2.6 times less likely) to use

formal/professional services compared to those who did not endorse the statement (AOR = 0.38, 95% CI: 0.23-0.62, $P < 0.001$).

Lower social support continued to be significantly negatively associated with using formal/professional help. Those with lower social support were 42% (or 1.7 times) less likely to use formal/professional services for help. (AOR = 0.58, 95% CI: 0.36-0.91, $P < 0.05$)

Variables in this model not associated with the help-seeking outcome were:

- The remaining anticipated public stigma statements:
 - o 'It would harm my career',
 - o 'Members of my unit might have less confidence in me',
 - o 'My unit leaders/bosses might treat me differently',
 - o 'My leaders/bosses would blame me for the problem' and,
 - o 'I would be seen as weak'

- The overall attitudinal barrier measure and remaining individual attitudinal statements:
 - o 'Mental health care doesn't work',
 - o 'I don't trust mental health professionals',
 - o 'I would think less of a colleague if I knew he/she was receiving mental health counselling',
 - o 'My leaders/bosses discourage the use of mental health services',
 - o 'I have had previous bad experiences with mental health professionals' and,
 - o 'Mental health treatment has harmful side effects'

- The overall practical barrier measure and all of the practical barrier statements

- The remaining self-stigma individual statements:
 - o 'Seeking psychological help would make me feel less intelligent',
 - o 'It would make me feel inferior to ask a mental health professional for help'

- Current self-recognition of a stress, emotional, mental health or alcohol problem.

7.6 Summary Final Adjusted Model 2

High anticipated public stigma, attitudinal barriers, self-stigma and low social support all negatively affected individuals' use of formal/professional and non-medical support services when controlling for mental health status, impairment, life events and recognition of a current problem.

Table 22 – Anticipated Stigma/Barriers to Care, Social Support and Recognition of a Problem as Factors Associated with help-seeking among 449 UK military personnel who endorsed experiencing a stress/emotional/mental health or alcohol problem

Factor	No Help (N=133)		Formal/Professional and Non Medical Support Services Help-Seeking (N=316)				
	N	%	N	%	Unadjusted Model	Adjusted 1 st Model ¹⁸	Adjusted 2 nd Model ¹⁹
					Odds Ratio (95% CI)	Odds Ratio (95% CI)	Odds Ratio (95% CI)
Anticipated Public Stigma Barriers							
Lower stigma	86	64.66	234	74.05	1.00	1.00	1.00
Higher stigma	47	35.34	82	25.95	.64* (0.41-0.99)	.57* (0.36-0.90)	.55* (0.35-0.88)
<i>It would be too embarrassing</i>							
Not endorsed	63	55.75	188	66.90	1.00	1.00	1.00
Endorsed	50	44.25	93	33.10	.62* (0.40-0.97)	.58* (0.36-0.93)	.54* (0.34-0.88)
<i>It would harm my career</i>							
Not Endorsed	60	53.10	164	61.42	1.00	1.00	1.00
Endorsed	53	46.90	103	38.58	.71 (0.46-1.11)	.68 (0.42-1.08)	.66 (0.40-1.04)
<i>Members of my unit or my colleagues might have less confidence in me</i>							
Not Endorsed	55	47.41	157	57.51	1.00	1.00	1.00
Endorsed	61	52.59	116	42.49	.67 (0.43-1.03)	.65 (0.41-1.02)	.64 (0.40-1.01)

*p<.05, **p<.01, ***p<.005

¹⁸ Adjusted for impairment, life events and current recognition of a problem

¹⁹ Adjusted for impairment, life events, current recognition and mental health caseness

Factor	No Help (N=133)		%		N	%	Formal/Professional and Non Medical Support Services Help-Seeking (N=316)		
	N	%	Unadjusted Model Odds Ratio (95% CI)	Adjusted 1 st Model ¹⁸ Odds Ratio (95% CI)			Adjusted 2 nd Model ¹⁹ Odds Ratio (95% CI)		
<i>My unit leaders/bosses might treat me differently</i> Not Endorsed	49	44.95	1.00	1.00	138	49.29	1.00	1.00	1.00
	60	55.05	.84 (0.54-1.31)	.79 (0.50-1.26)	142	50.71	.84 (0.54-1.31)	.79 (0.50-1.26)	.77 (0.48-1.22)
<i>My leaders/bosses would blame me for the problem</i> Not Endorsed	90	84.91	1.00	1.00	216	81.51	1.00	1.00	1.00
	16	15.09	1.28 (0.69-2.36)	1.02 (0.54-1.95)	49	18.49	1.28 (0.69-2.36)	1.02 (0.54-1.95)	1.01 (0.56-1.93)
<i>I would be seen as weak</i> Not Endorsed	58	53.21	1.00	1.00	154	58.56	1.00	1.00	1.00
	51	46.79	.80 (0.51-1.26)	.69 (0.43-1.11)	109	41.44	.80 (0.51-1.26)	.69 (0.43-1.11)	.67 (0.41-1.09)
<i>Not wanting a mental health problem to be on my medical records</i> Not Endorsed	51	43.22	1.00	1.00	159	56.38	1.00	1.00	1.00
	67	56.78	.59* (0.38-0.91)	.61* (0.39-0.96)	123	43.62	.59* (0.38-0.91)	.61* (0.39-0.96)	.59* (0.37-0.93)
<i>Concern about what my friends or family might think</i> Not Endorsed	68	57.14	1.00	1.00	204	70.83	1.00	1.00	1.00
	51	42.86	.55** (0.35-0.86)	.51*** (0.32-0.81)	84	29.17	.55** (0.35-0.86)	.51*** (0.32-0.81)	.49*** (0.31-0.79)

Factor	No Help (N=133)		Formal/Professional and Non Medical Support Services Help-Seeking (N=316)			
	N	%	N	%	Adjusted Odds Ratio (95% CI)	
					Unadjusted Model	Adjusted 1 st Model ¹⁸
Attitudinal Barriers						
Lower Attitudinal barriers	99	74.44	243	76.90	1.00	1.00
Higher Attitudinal barriers	34	25.56	73	23.10	.87 (0.55-1.40)	.75 (0.46-1.24)
<i>Mental health care doesn't work</i>						
Not Endorsed	81	96.43	224	90.69	1.00	1.00
Endorsed	3	3.57	23	9.31	2.77 (0.81-9.48)	2.71 (0.73-10.06)
<i>I don't trust mental health professionals</i>						
Not Endorsed	95	95.96	257	93.12	1.00	1.00
Endorsed	4	4.04	19	6.88	1.76 (0.58-5.29)	1.54 (0.49- 4.83)
<i>My visit would not remain confidential</i>						
Not Endorsed	94	83.93	263	92.28	1.00	1.00
Endorsed	18	16.07	22	7.72	.44* (0.22-0.85)	.42* (0.21-0.86)
<i>I would think less of a team member/ work colleagues if I knew he/she was receiving mental health counselling</i>						
Not Endorsed	110	90.16	288	95.68	1.00	1.00
Endorsed	12	9.84	13	4.32	.41* (0.18-0.93)	.44 (0.19-1.04)

Factor	No Help (N=133)				Formal/Professional and Non Medical Support Services Help-Seeking (N=316)			
	N		%		Unadjusted Model Odds Ratio (95% CI)	Adjusted 1 st Model ¹⁸ Odds Ratio (95% CI)	Adjusted 2 nd Model ¹⁹ Odds Ratio (95% CI)	
				%				
<i>My leaders/bosses discourage the use of mental health services</i>	107	96.40	249	93.96	1.00	1.00	1.00	
	4	3.60	16	6.04	1.72 (0.56- 5.26)	1.24 (0.39-3.90)	1.20 (0.38-3.80)	
<i>I have had previous bad experiences with mental health professionals</i>	99	90.83	237	84.95	1.00	1.00	1.00	
	10	9.17	42	15.05	1.75 (0.85- 3.63)	1.40 (0.65-3.03)	1.38 (0.64-2.98)	
<i>Wanting to solve problem alone</i>	29	25.66	119	42.50	1.00	1.00	1.00	
	84	74.34	161	57.50	.47*** (0.28-0.76)	.47*** (0.29-0.79)	.47*** (0.28-0.78)	
<i>Mental health treatment has harmful side effects</i>	69	92.00	211	88.28	1.00	1.00	1.00	
	6	8.00	28	11.72	1.53 (0.61- 3.84)	1.34 (0.52-3.46)	1.26 (0.48-3.32)	
Practical Barriers	105	78.95	223	73.73	1.00	1.00	1.00	
	28	21.05	83	26.27	1.34 (0.82-2.17)	1.07 (0.64-1.79)	1.06 (0.63-1.77)	
<i>I don't know where to get help</i>	121	93.80	288	95.68	1.00	1.00	1.00	
	8	6.20	13	4.32	.68 (0.28-1.69)	.70 (0.27-1.82)	.69 (0.26-1.79)	

Factor	No Help (N=133)				Formal/Professional and Non Medical Support Services Help-Seeking (N=316)			
	N		%		Unadjusted Model Odds Ratio (95% CI)	Adjusted 1 st Model ¹⁸ Odds Ratio (95% CI)	Adjusted 2 nd Model ¹⁹ Odds Ratio (95% CI)	
<i>I don't have adequate transport</i>	Not Endorsed	128	99.22	99.68	1.00	1.00	1.00	
	Endorsed	1	0.78	0.32	.41 (0.03-6.61)	.26 (0.02-4.85)	.24 (0.01-4.41)	
<i>It is difficult to get an appointment</i>	Not Endorsed	77	89.53	84.43	1.00	1.00	1.00	
	Endorsed	9	10.47	15.57	1.58 (0.73- 3.42)	1.13 (0.49-2.57)	1.10 (0.48-2.53)	
<i>There would be difficulty getting time off work for treatment</i>	Not Endorsed	104	85.95	82.78	1.00	1.00	1.00	
	Endorsed	17	14.05	17.22	1.27 (0.70- 2.30)	1.01 (0.54-1.89)	1.00 (0.53-1.87)	
Self-Stigma	Lower Self-Stigma	75	56.39	73.73	1.00	1.00	1.00	
	Higher Self-Stigma	58	43.61	26.27	.46*** (0.30- 0.70)	.43*** (0.28-0.68)	.42*** (0.27-0.66)	
<i>I would feel inadequate if I went to a mental health professional for psychological help</i>	Not Endorsed	58	52.73	72.73	1.00	1.00	1.00	
	Endorsed	52	47.27	27.27	.42*** (0.27-0.66)	.39*** (0.24-0.63)	.38*** (0.23-0.62)	
<i>Seeking psychological help would make me feel less intelligent</i>	Not Endorsed	108	94.74	92.98	1.00	1.00	1.00	
	Endorsed	6	5.26	7.02	1.36 (0.53- 3.46)	1.10 (0.42-2.88)	1.06 (0.40-2.80)	

Factor	No Help (N=133)				Formal/Professional and Non Medical Support Services Help-Seeking (N=316)			
	N		%		Unadjusted Model Odds Ratio (95% CI)	Adjusted 1 st Model ¹⁸ Odds Ratio (95% CI)	Adjusted 2 nd Model ¹⁹ Odds Ratio (95% CI)	
<i>It would make me feel inferior to ask a mental health professional for help</i> Not Endorsed	86	78.18	250	83.06	1.00	1.00	1.00	
	24	21.82	51	16.94	.73 (0.42-1.26)	.67 (0.38-1.18)	.60 (0.34-1.08)	
<i>If I went to a mental health professional, I would be less satisfied with myself</i> Not Endorsed	66	60.00	207	75.27	1.00	1.00	1.00	
	44	40.00	68	24.73	.49*** (0.31-0.79)	.48*** (0.29-0.78)	.46*** (0.28-0.76)	
<i>I would feel worse about myself if I could not solve my own problems</i> Not Endorsed	45	39.13	156	58.87	1.00	1.00	1.00	
	70	60.87	109	41.13	.45*** (0.29-0.70)	.41*** (0.26-0.66)	.40*** (0.25-0.64)	
Social Support Higher Social Support	78	58.65	202	63.92	1.00	1.00	1.00	
	55	41.35	114	36.08	0.80 (0.53-1.21)	0.59* (0.38-0.93)	0.58* (0.36-0.91)	
Current Recognition of emotional /stress/mental health or alcohol problem No	68	51.13	116	36.83	1.00	1.00	1.00	
	65	48.87	199	63.17	1.79** (1.19-2.70)	1.40 (0.91-2.17)	1.36 (0.86-2.15)	

*p<.05, **p<.01, ***p<.005

Chapter 8 – Quantitative Summary Main Findings

This chapter provides an overview of the main findings from the quantitative study (Section 7.2 in Chapter 7.)

8.1 Recognition of a problem

- **High self-recognition of stress/emotional/mental health problem cohering with mental health status** - Large majority of participants (89.8%) who were classified as having a probable mental health problem also recognised that they were currently (at the time of the clinical telephone interview) experiencing a stress, emotional or mental health problem.
- **Lower self-recognition of alcohol problem** – The majority of participants (64.7%), who scored 16+ on the AUDIT, did not recognise that they were currently experiencing (at the time of the clinical telephone interview study) an alcohol problem.

8.2 Awareness and Willingness to use Healthcare/Support Services

- **High awareness of and willingness to use GP/Medical Officer as source of support for stress, emotional, mental health problems** – 99.8% aware and 91.1% willing to use.
- **High awareness of and willingness to consult with mental health specialist** – 97.6% aware and 86.9% willing to use.
- **High awareness of and low willingness to use Chain of Command for support** – 87.4% aware, 37.0% were willing to use.
- **Low awareness and willingness to use Big White Wall** – 20.1% aware and only 45.1% of these willing to use.
- **In Service personnel less willing to use Service charities for support compared to ex-Service personnel** – 51.9% v 65.3% respectively.
- **Low awareness of ex-Service/veteran services by ex-Service personnel** - e.g. ex-Service personnel had low awareness of The NHS Veterans Service (30.3%) and The Veterans and Reserves Mental Health Programme (24.8%).

8.3 Type of Help-Seeking

- **Variety of and multiple sources of help-seeking sought by participants** – most common was informal help-seeking (82.6%), Formal/Professional (58.8%) and Non-Medical Support Services (47.4%).

- Most common informal help-seeking was with family members (72.6%).
- Most common formal/professional help-seeking was with GP/MO (51.2%).
- Most common non-medical support services help-seeking was with non-medical professionals (24.7%).

8.4 Reason For Seeking Formal/Professional Help

- **Most common reason for seeking help was:**
 - Self-recognition of a problem (71.2%).
 - Increasing impairment affecting functioning (58.0%).
 - Lack of ability to solve the problem alone (50.0%).

8.5 Demographic, Social and Military Factors Associated with Formal/Professional Help-Seeking/Service Use

- **Lower educational attainment was negatively associated with formal/professional help-seeking** (AOR=0.62, 95% CI: 0.39-0.99, $P<0.05$).
- **Being a member of the Royal Air Force (compared to the Army) was positively associated with formal/professional help-seeking** (AOR=2.29, 95% CI: 1.28-4.08, $P<0.01$).
- **Experiencing life events was positively associated with formal/professional help-seeking** (1-2 life events – AOR= 1.92, 95% CI: 1.05-3.50, $P<0.05$, 3+ life events – AOR=3.76, 95% CI: 2.02-7.01, $P<0.001$).

8.6 Endorsement of Anticipated Public Stigma and Barriers to Care

- **Top concern affecting participants' decision to seek help for a mental health problem:** Attitudinal Barrier – ‘Wanting to solve the problem on my own’ (endorsement of 60.4% without mental health diagnosis, 67.6% with mental health diagnosis).
- **Other top concerns for participants with a probable mental health diagnosis were anticipated public stigma orientated barriers:**
 - Being treated differently by leaders/bosses (67.0%).
 - Being seen as weak (58.3%).
 - Unit members or colleagues having less confidence in them (57.4%).

- **Participants with a probable mental health problem had (up to) three times increased odds of endorsing anticipated public stigma/barrier to care items compared to those without a probable diagnosis.**

8.7 Stigma/Barriers to Care, Social Support as Factors Associated with Help-Seeking/Service Utilisation

- Measures of **anticipated higher public stigma, higher self-stigma and lower social support** were **negatively associated** with formal/professional and non-medical support services help-seeking. (AOR = 0.55, 95% CI: 0.35-0.88, $P < 0.05$), (AOR = 0.42, 95% CI: 0.27-0.66, $P < 0.001$), (AOR = 0.58, 95% CI: 0.36-0.91, $P < 0.05$) respectively.
- **Top three endorsed anticipated public stigma concerns for those with a probable mental health diagnosis were not associated with help-seeking.**
- **Specific anticipated public stigma barriers negatively associated with formal/professional help-seeking:**
 - Too embarrassing to seek help (AOR=0.54, 95% CI: 0.34-0.88, $P < 0.05$).
 - Not wanting mental health problems on their medical records (AOR=0.59, 95% CI: 0.37-0.93, $P < 0.05$).
 - Concern about what friends and family might think (AOR= 0.49, 95% CI: 0.31-0.79, $P < 0.001$).
- **Specific attitudinal barriers negatively associated with formal/professional help-seeking:**
 - Participants who believed their visit would not remain confidential (AOR=0.42, 95% CI: 0.21-0.86, $P < 0.05$).
 - Wanting to solve their problem alone (AOR=0.47, 95% CI: 0.28-0.78, $P < 0.001$).
- **Specific self-stigma barriers negatively associated with formal/ professional help-seeking:**
 - Those who endorsed they would feel inadequate getting psychological help (AOR=0.42, 95% CI: 0.27-0.66, $P < 0.001$).
 - Those who endorsed they would be less satisfied with themselves if they saw a mental health professional (AOR=0.46, 95% CI: 0.28-0.76, $P < 0.001$).

- Those who endorsed they would feel worse about themselves if they could not solve their own problems (AOR=0.40, 95% CI: 0.25-0.64, $P<0.001$).

8.8 Hypotheses

There was a mixture of results in relation to the a priori, alternative hypotheses held at the beginning of the quantitative work.

- Hypothesis 1 was not upheld, mental health caseness was not associated with help-seeking.
- Hypothesis 2 was partly upheld, lower education attainment was negatively associated with help-seeking, however relationship status had no association with help-seeking.
- Hypothesis 3 was partly upheld, being a member of the Royal Air Force branch was positively associated with help-seeking, however rank was not associated with help-seeking.
- Hypothesis 4 was partly upheld, increased barriers of anticipated public stigma, self-stigma and attitudinal barriers were negatively associated with help-seeking, conversely practical barriers were not associated with help-seeking.
- Hypothesis 5 was upheld, lower social support was negatively associated with help-seeking.

Chapter 9 - Main Discussion – Qualitative And Quantitative Studies

This chapter brings together a summary discussion of the main findings from my systematic review, my two qualitative studies, and my quantitative study that have assessed barriers and facilitators of help-seeking for mental health problems in UK military samples. This chapter aims to integrate and discuss these findings in relation to available literature, including papers published after my literature review, and help-seeking theory.

From concurrent evidence in both my qualitative and quantitative studies, this PhD finds the most prominent barriers to seeking help for mental health problems in the UK military populations were: 1) **public and self-stigma** and 2) **attitudinal preferences for self-management of problems** and 3) **poor social support**. The most prominent facilitator of help-seeking was **supportive social networks**. These main findings are discussed first, with proceeding discussion focused upon other relevant results.

9.1 Stigma

The findings in this research build up a complex picture of the effect of stigma on help-seeking for a mental health problem. Stigma in its different guises, for military populations could be a decisive barrier along the entire help-seeking pathway that deters individuals from seeking help and engaging in treatment.

9.1.1 Public Stigma

Prevalence of Anticipated/Public Stigma Concerns

The presence and prevalence of stigma as a barrier to seeking help is consistently supported by military literature that finds anticipated public stigma to be a barrier most endorsed by military samples compared to other barriers to care, irrespective of whether personnel are full-time Regulars, Reserves or ex-Service personnel (Hoge et al., 2004, Britt, 2000, Britt et al., 2008, Iversen et al., 2011, Osório et al., 2013b). Both my qualitative studies and quantitative study confirm the high prevalence of anticipated public stigma concerns across all interview groups and service status. This aligns with research where stigma has generally ranked much higher among individuals in the military than in other population groups, as assessed by a systemic review investigating the impact of mental health-related stigma on help-seeking (Clement et al., 2014).

Interviewees in the qualitative studies did not want to be seen differently or treated differently by their colleagues, their friends and their family. There was also a distinct desire to avoid being labelled by others as ‘mad’, ‘bad’, ‘weak’ or ‘lying’. The findings from my

quantitative study support the qualitative findings of public/anticipated stigma as an important concern when seeking help. When assessing barriers that might affect an individual's decision to seek help for a mental health problem, utilising measures from the PSBCPP-SS and the BACE, all eight anticipated public stigma items came in the top 10 endorsed barriers. This was both when analysing participants' responses overall and when stratifying these responses by mental health status. Hence the impact of anticipated public stigma is important to those with and without a mental health problem.

Anticipated public stigma barriers were endorsed at statistically significant higher levels in those individuals with a mental health problem compared to those without. This also adds to the current evidence that those with a mental health problem are specifically the individuals who perceive or experience anticipated public stigma barriers more acutely than those without a diagnosis (Hoge et al., 2004, Iversen et al., 2011, Kim et al., 2011, Ouimette et al., 2011, Pietrzak et al., 2011a, Warner et al., 2011, Osório et al., 2013b).

Specific Anticipated Public Stigma Concerns

The most important public stigma concerns for those who had a probable mental health problem was concern that unit leaders/bosses might treat them differently, being seen as weak, and members of their unit or work colleagues having less confidence in them. When comparing prevalence rates with studies in my meta-analysis on comparable stigma items, the top three concerns in my quantitative study match the top three concerns from the meta-analysis. When comparing the prevalence of endorsed stigma items with recent UK studies, my quantitative study prevalence rates, sit consistently above the overall meta-analysis prevalence estimate. This finding is in line with other UK military studies whose stigma prevalence data also sit above the meta-analysis prevalence estimate (Iversen et al., 2011, Osório et al., 2013b, Jones et al., 2013). This adds further evidence that recent UK studies seem to show higher stigma prevalence rates compared to US studies. This is an area where further comparative work could be fruitful in explaining these differences between countries (Sharp et al., 2015).

The joint qualitative and quantitative findings highlight the importance participants placed on avoiding negative labels associated with seeking help for a mental health problem. This finding is supported by literature on label avoidance. Here anticipated public stigma impacts help-seeking when it leads to label avoidance (Corrigan et al., 2014). Individuals wished to avoid the perceived stigma and discrimination they believe they would receive for seeking help for a mental health problem and therefore chose not to interact with healthcare services. General population research has highlighted negative stereotypes held about individuals with

mental health problems - these include ideas of people with mental health illness being dangerous, unpredictable, and incompetent (Rüsch et al., 2005, Angermeyer and Dietrich, 2006). Some participants qualitatively echoed knowledge of these stereotypes and described their wish for others not to see them as dangerous, or to have less confidence in them. Several Combat Stress participants also explained that on disclosing their help-seeking to colleagues, they believed their colleagues then socially distanced themselves who now saw them as dangerous.

Participants sometimes described their own stigmatising attitudes towards others who had previously sought help for mental health problems. A recent study in a US active military sample found that it was specifically stigmatising perceptions of others who were seeking help for a mental health problem that negatively affected treatment seeking (Britt et al., 2015). Hence it is not just individuals' concerns about being labelled by others, but individuals' *own* stigmatising labelling of others, which negatively affects help-seeking decisions.

The particular issue of being seen as weak in quantitative results was also confirmed by my qualitative studies as being an important barrier. Being seen as weak or a coward was a particular worry highlighted by interviewees. The concept of seeking help for a mental illness seems to be highly equated with weakness in military samples. Experiencing a mental health problem and seeking help may go against masculine norms of self-sufficiency, competency and toughness encouraged by military service (Alfred et al., 2014). Additionally the idea of a 'lack of moral fibre' (LMF) or cowardice was a concept embedded in participants' ideas of help-seeking. The official concept of LMF was created in World War Two in the RAF to dissuade air crewmen from going sick. Individual's labelled with LMF were deliberately stigmatised, lost their flying badges and sent to neuropsychiatric centres (Jones and Wessely, 2005). It seems that some concept of LMF still remains within the current Armed Forces and it specifically acts as a help-seeking deterrent.

Association Of Anticipated Public Stigma And Healthcare Service Use

Previous literature was identified through my systematic review that found anticipated public stigma in military populations was not associated with help-seeking or intentions to use healthcare services, and a minority of studies found a positive association. This finding was at first counterintuitive if considering anticipated public stigma a barrier to seeking help, based on anticipated public stigma prevalence results. These studies had found that those who endorsed high anticipated public stigma were not deterred from seeking help.

Competing explanations were discussed in my review. These potential explanations included:

- **‘Disinclined actors’** – where individuals have high stigma but are forced to seek help because the severity of their mental health problem produces crises and situations that override that stigma barriers, *Or* facilitators of help-seeking such as supportive social networks override the high stigma barriers allowing someone to seek help, despite their high levels of stigma.
- **Stigma measurement problem** – that the PSBCPP-SS may not fully capture the experience of stigma for current military populations and therefore may not find an association.
- **Self-stigma or other variables are more important barriers** – public stigma may only be important in that it is a first step in the process of internalising self-stigma or indeed other barriers such as attitudes towards mental health care may be more important.
- **‘Modified Labelling Theory’** – a positive association may be reflective of the situation where thinking about seeking help or engaging with healthcare services *causes* high stigma (rather than stigma causing help-seeking).

I can now explore which of these competing explanations makes the most sense in light of my studies findings and recent literature. Of the military studies that have measured the association of anticipated public stigma and mental health care service utilisation, seven studies found no association between endorsed anticipated stigma and service use (Pietrzak et al., 2009, Kehle et al., 2010, Kim et al., 2011, Rosen et al., 2011, Hoerster et al., 2012, Jones et al., 2013, Harpaz-Rotem et al., 2014) two studies found a positive association (Rosen et al., 2011, Elnitsky et al., 2013) and only one (published after my systematic review) found a negative association (Blais et al., 2014a). My quantitative study, however, found a negative, statistically significant association of anticipated public stigma and help-seeking, as measured by use of healthcare/support services. Individuals who were high in their anticipated public stigma concerns were 45% less likely to use formal/professional/non-medical support services.

There are several reasons as to why my study may have found a negative association where other studies have not. The measurement of stigma includes two BACE items, which interestingly were both statistically significant associations with help-seeking when taking the statements individually. It may support the theory that the PSBCPP-SS statements alone have not properly captured the measurement of anticipated public stigma, and indeed why

other authors are moving towards the use of other stigma measures in recent studies (Blais and Renshaw, 2013, Blais et al., 2014a, Vogt et al., 2014a). It may also support the finding of a negative association between anticipated public stigma and help-seeking as found by Blais et al. (2014a) who used the Perceptions of Stigmatisation by Others for Seeking Help (PSOSH, (Vogel et al., 2009)) to measure stigma in a military study (and not the PSBCPP-SS). Lastly my measurement of the outcome variable included formal/professional help-seeking *and* non-medical support services; therefore I may have found this association because of my expanded definition and measurement of help-seeking. Lastly the cross-sectional nature of the quantitative study must be noted, here I can not assume the direction of causation, whilst some proceeding literature that I have discussed in my literature review would encourage me to think that higher anticipated public and self-stigma causes reduced help-seeking, it may also be true that not seeking help causes higher stigma, or that proceeding experiences in an individuals life (for example previous negative experiences with help-seeking and healthcare experiences) causes stigma which causes non-help-seeking. Hence these explanations must temper following conclusions.

The three most endorsed anticipated public stigma statements were not associated with help-seeking in my quantitative study (albeit all eight anticipated public stigma items were fairly consistently highly endorsed). Why do individuals endorse something as a major concern to their help-seeking, but it not be associated with their help-seeking behaviours? As previously discussed in my systematic review, there may be an intention-gap (Sheeran, 2002).

Individuals' intentions do not always match up to their behaviours. In my studies, we have examples of 'disinclined actors'; those who note their specific anticipated public stigma (for example in relation to the concern about being treated differently by their bosses if they sought help), but subsequently are not deterred from seeking help, despite this concern. It may be that particular aspects of anticipated public stigma act only as deterrents, delaying help-seeking, but may not be a non-negotiable barrier if certain facilitating factors are in place. However those anticipated public stigma statements that were negatively associated with help-seeking (embarrassment, concern for medical records and concern what friends and family might think), may be more salient barriers that truly prevent help-seeking in military populations in certain circumstances. Here however, we must be careful not to write off particular anticipated public stigma concerns as 'non-important' if they are not associated with help-seeking. There is evidence from my Combat Stress qualitative study and military literature that many military personnel seek help at crisis points when the severity of their condition compels help-seeking (Murphy et al., 2014) – hence certain anticipated public stigma barriers may delay help-seeking to a point where individuals are extremely unwell, who do eventually seek help, but it is not from a lack of anticipated public stigma barriers.

Individuals have had to weigh their need against their stigma concerns (similar to ‘need factors’ in the Anderson model of healthcare utilisation (Andersen, 1995)), until their need for treatment becomes too great and overrides the anticipated public stigma concerns. This explanation may account for the lack of association of certain anticipated public stigma statements and help-seeking.

Concern for Career and Medical Records

I specifically draw attention to the anticipated public stigma concern that individuals had regarding their career and medical records, as it was an issue prevalent in my qualitative, quantitative and meta-analysis studies. Whilst the anticipated public stigma item, *‘it would harm my career’*, was not associated with help-seeking, concerns about mental health problems being recorded on medical records were.

Participants discussed the anticipated public stigma or discrimination they believed they would receive in relation to their careers if they were to seek help for their mental health problem. They also highlighted the issue of a mental health illness being recorded on medical records, as they felt it could affect their future career prospects. My quantitative evidence in support of this found that only 36% of Service personnel were willing to use the Chain of Command for mental health support. This low percentage may reflect the concern individuals have about officially disclosing a mental health problem and the potential effect this may have on their careers.

I believe concerns about career and medical record confidentiality may be particular to the Armed Forces. When individuals are in Service, they are in the difficult position where their employer is also their healthcare provider. Members of the Armed Forces may face the situation where disclosure of a mental health problem, could result in their Medical Officer informing their Chain of Command of the problem. Medical Officers in Service have to disclose health problems that could affect the safe functioning of a unit, particularly in the context of availability of firearms and deployments. A mental health disclosure to the Chain of Command could affect the individuals’ deployability, ability to conduct duties with firearms, and ability to take part in courses that enable promotion. In this way, an individuals’ medical records in Service do not belong to them, but they belong to the MOD. This lack of personal ownership may produce a certain uneasy situation for Armed Forces personnel who perhaps do not view the document as a confidential item and therefore are keen to guard against any potential ‘negative marks’ that could be put on their records if they were to seek help.

This explanation is supported by the negative views found in the UK military towards individuals with mental health problems and their job rights. In Jones et al. (2013), 50% of their UK Service Personnel sample who were asked on their intended future behaviour toward people with mental health problems, were either neutral or did not agree with the statement that, *'in the future they would work with someone with a mental health problem'*. This also coheres with the view endorsed in the Forbes et al. (2013) study, where a UK military sample held more negative views compared to the general population about the job rights of those with mental illness. These views may not be solely relevant to the Armed Forces, but may be a factor relevant to safety critical industries such as the police or airline pilots where team safety relies on the health of individuals and mental ill health may be perceived to affect this functioning (Pinfold et al., 2003, Pasillas et al., 2006, Britt and McFadden, 2012). These negative views are representative of the concerns individuals have in relation to their careers when thinking about disclosing mental health problems.

Rowan et al. (2014) however highlight that it is difficult to discern between actual career impacts of seeking help in the military for a mental health problem, and the perception of impact. They argue that negative perceptions of career impacts, whether accurate or inaccurate, may deter Service personnel from seeking treatment. What therefore is the reality of the effect of seeking help on career prospects in the UK military? A UK study of soldiers who were referred to Deployed Field Mental Health Teams (FMHT) whilst deployed in Iraq 2003-2007 found that three-quarters of those referred to the FMHT were returned to their deployed unit and approximately three-quarters of those assessed by the FMHT remained in Service two years after referral (Jones et al., 2010). More recent research on UK Service Personnel referred to mental health teams whilst deployed in Afghanistan 2006-2010, assessed return to duty (RTD) in the operational area and longer-term occupational consequences following return from deployment (Jones, N. currently under review). The study again found that over three-quarters of those assessed, returned to their unit whilst on operation. In relation to longer-term occupational outcomes, a third experienced adverse occupational consequences in the four years after returning home. Hence the reality of the UK picture for the majority of individuals that seek help in Service is a fairly positive one in terms on occupational outcomes. However it also appears that a sizeable minority group of individuals will suffer adverse occupational outcomes in Service. Hence harmful repercussions for individuals' careers are not just a perception but a reality experienced by a significant minority.

US military research shows a similar picture to the UK in terms of occupational outcomes of seeking help for a mental health problem (Rowan, 1996, Rowan and Campise, 2006). Rowan

et al. (2014) found in a deployed US sample that individuals who self-referred for a mental health problem, rather than being compelled to seek help by their commanding officers, were significantly less likely to have contact made with their command or to experience negative career impacts. This study emphasised that negative career impact was minimal for those who sought help early on their own initiative, however those who had severe mental health problems did experience duty-limiting recommendations. Hence overall, the concern that seeking help for a mental health problem may negatively impact a career in the military is a valid concern, particularly for those that may have severe mental health problems. However there is also an argument to promote the positive reality of limited career impact for the majority of individuals that seek help.

9.1.2 Self-Stigma

Self-stigma with regards to help-seeking was particularly prevalent amongst my KCMHR interview groups. High self-stigma was also found to be negatively associated with help-seeking in my quantitative analysis.

Self-stigma as discussed in the literature review, has been evidenced to be a considerable barrier to seeking help in general populations (Vogel et al., 2006, Vogel et al., 2007b, Conner et al., 2010). The link between public stigma and willingness to seek counselling has been evidenced to be fully mediated by self-stigma and attitudes (Vogel et al., 2007a). A recent military population study also found that self-stigma fully mediated the association of anticipated stigma and help-seeking intentions in a National Guard sample (Blais and Renshaw, 2014). Hence there is evidence that public stigma contributes to the experience of self-stigma, which in turn affects help-seeking attitudes and willingness to seek help. It therefore coheres that my quantitative study found both public and self-stigma to be negatively associated with help-seeking, and my qualitative studies found public and self-stigma particularly intertwined.

My interviews particularly highlighted the four-stage process of self-stigma (Corrigan et al., 2006) which includes;

1. A person with a mental illness is aware of public stigma and negative stereotypes (e.g. that individuals with mental health problems are dangerous);
2. They endorse that stereotype (e.g. they agree that individuals with mental problems are dangerous);

3. They apply that stereotype to themselves (e.g. I have a mental health problem therefore I am dangerous) and,
4. This self-application has a negative effect on self-worth and efficacy (e.g. I am less of a person because I am mentally ill and dangerous and less able to achieve my goals)

Many interviewees described knowledge of public stigma, stigmatising beliefs and the self-stigma, that they felt weak or a lesser person for needing help. A systematic review on self-stigma and mental health problems upheld strong negative relationships between self-stigma, hope, self-esteem and empowerment (Livingston and Boyd, 2010). In this way, self-stigma creates the ‘why try’ effect, where individuals do not try to seek help, because they feel they are not able or worthy (Corrigan et al., 2009). This ‘why try’ effect is subtly demonstrated in Gary’s (KCMHR non-help-seeker) account where he describes how he would have felt like a ‘maggot’ seeking help because he did not feel worthy. This barrier may also tie in with the barrier, ‘deservedness to seek help’, found in my qualitative studies.

Additional quantitative and qualitative evidence supporting self-stigma as a barrier to seeking help is found in Blais and Renshaw (2013) and Murphy et al. (2014) who found in military samples, a negative relationship between self-stigma and help-seeking intentions. A systematic review of stigma and help-seeking by Clement et al. (2014) found self-stigma exhibited small and consistent negative association with help-seeking for mental health problems. Recent research has also indicated a negative relationship between self-stigma and the likelihood of treatment drop out in military samples (Britt et al., 2015). Self-stigma is as yet, a currently under-researched stigma concept in military literature and may be an important variable to assess in future analyses.

Of particular note are the Combat Stress interview group who made no references to self-stigma. I believe this result may be a function of characteristics of the Combat Stress group who had all received some form of treatment and assessment. Part of the Combat Stress treatment programme both in individual and group work, seeks to challenge the stigma of mental health problems through education. Additionally treatment programmes through its trauma focused therapy and occupational health work seeks to build individuals back up with new coping skills and tools to give individuals the confidence to manage their mental health problem. I believe the effect of treatment may be one reason why Combat Stress participants did not mention self-stigma. It does not necessarily mean that self-stigma was never an issue for them, but their experience of treatment and their developed place on a help-seeking pathway means self-stigma may have decreased, as they have received the benefits of that

treatment. This interpretation is supported by Murphy et al. (2014) who found that Service personnel were able to overcome their self-stigma and shame through their engagement with treatment and positive experiences of changes in their lives precipitated by the help-seeking. Equally a systematic review found treatments associated with improvements in self-stigma experienced by individuals included psycho-education and confidence/esteem building techniques to tackle self-stigma (Mittal et al., 2012).

Taken as a whole, we can see compelling evidence in both quantitative and qualitative studies that helps to explicate why stigma, both public and self-stigma, is such a matter of interest for those seeking help for a mental health problem in the Armed Forces. Of particular note are the concerns individuals have about what others might think of them (both personally and professionally) and concerns individuals have with regards to their careers. In terms of competing explanations discussed at the beginning of this section, my studies uphold a theory of ‘disinclined actors’, that those with high anticipated public stigma may be compelled to seek help by their need or through facilitating factors, however the findings may also begin to question the PSBCPP-SS measure and whether it measures stigma aptly. Lastly the studies provide evidence for the statistically significant negative association between anticipated public stigma and self-stigma with help-seeking outcomes.

9.2 Preference for Self-Management

Both my qualitative investigations and quantitative studies provide evidence that participants’ preference to manage their problems alone was a distinct barrier to seeking help. In my qualitative studies, participants indicated a desire for self-sufficiency where they wanted to fix, or cope with their problem alone, and therefore did not want to disclose their difficulties or ask for help. In my quantitative research the most endorsed reason (out of all reasons) that individuals were concerned about when seeking help for a mental health problem, was the fact they wanted to solve the problem alone. This preference of, ‘*Wanting to solve the problem alone*’, had a statistically significant negative relationship with help-seeking. Lastly half of my participants in the quantitative study who had sought help, said they reason they had sought help was because they had realised they couldn’t solve the problem on their own like they had hoped.

Military and general population literature upholds these qualitative and quantitative findings. Large percentages of individuals do not seek help because they wish to solve or manage their problems on their own (Iversen et al., 2005, Mojtabai et al., 2011, Britt et al., 2012, Momen et al., 2012, Jones et al., 2013). A recent longitudinal study by Adler et al. (2015) found that

self-management, or the preference for managing problems alone, was correlated with less treatment-seeking over time in a sample of US soldiers.

9.2.1 Self-Management - Masculine Norms and Self-Stigma

In addition to this literature, some of my qualitative and quantitative research gives insights into the reasons behind why individuals wanted to self-manage. The preference for self-management, i.e. the desire to solve problems alone, was particularly tied to participants' adherence to masculine norms, military culture, and the desire to avoid the self-stigma or 'knock' to their confidence/esteem of failing to solve a problem alone by seeking help.

Masculine norms here refer to conformity to western masculine norms, which encourage personal self-reliance, stoicism and strength (Alfred et al., 2014). Masculine norms were particularly prevalent within my qualitative studies across all interview groups. Some participants felt that as a man they should be able to fix their problem alone and to fail in doing so would be a weakness. This is supported by Jones et al. (2013) research where 45% of Service personnel endorsed that, '*Strong people can resolve psychological problems by themselves*', highlighting a connection Service personnel made between their self-sufficiency and their strength (or weakness) as a person.

Other interviewees described a macho bravado culture in Service of 'manning up' and getting on with things, where they felt they couldn't let other people see weakness and therefore opted to manage their problems alone. Equally the identity of being in the Armed Forces or being a soldier meant they believed they had to be emotionally as well as physically tough. The negative effect of this masculine culture on help-seeking outcomes is noted in much of the military literature (Iversen et al., 2005, Gibbs et al., 2011, Simmons and Yoder, 2013). Quantitative evidence also found heightened masculine norms existed in military samples (Kurpius and Lucart, 2000, Jakupcak et al., 2006) and secondly that adherence to these norms lowered psychological well-being (Alfred et al., 2014) and delayed treatment seeking for mental health problem (Addis and Mahalik, 2003, Yousaf et al., 2013).

My qualitative interviews presented evidence that some participants' preference for self-management, was tied up with their dislike of discussing emotions. Recent research supports the notion that a dislike of talking about emotions (which I term 'emotional guardedness') in military samples impedes help-seeking behaviours. Vermetten et al. (2014) collated semi-structured interviews with key military mental healthcare stakeholders across five defence forces (including the UK and US). One finding highlighted the difficulty Service personnel

had in talking about their problems and how this dissuaded individuals from seeking help. The study explained that many of the main treatments, such as cognitive behavioural therapy, relied heavily on verbal skills, which Service personnel were not comfortable with. Additionally a quantitative study conducted by Blais et al. (2014b) found that individuals in the National Guard presenting with more PTSD avoidance cluster symptoms were less likely to use mental health services because they wanted to avert scenarios where they would have to disclose their trauma and talk about their emotions.

The connection between masculine norms, self-stigma and self-management is relevant for help-seeking behaviours. In my quantitative study, those who endorsed, *'I would feel worse about myself if I could not solve my own problems'*, were 60% less likely to seek formal/professional help. From my qualitative studies, individuals wished to avoid the self-stigma that help-seeking would bring i.e. That if they sought help it would mean that they had not been resilient and that they were weak, as dictated by their adherence to masculine norms. This connection between masculine norms and self-stigma is supported in US general population research, where heightened masculine norms was found to increase self-stigma and concurrently decrease positive attitudes towards seeking help for mental health problems (Vogel et al., 2011).

The preference for self-management was replicated in both qualitative and quantitative studies and was intertwined with masculine norms, military culture and self-stigma. The prevalence of this preference is also supported by military literature. Self-management and masculine norms were therefore important contributors to help-seeking behaviour within the context of the military environment.

9.3 Poor Social Support/Supportive Social Networks

Evidence from both my quantitative and qualitative studies support the factor that poor or unstable social networks act as a barrier to seeking help. From my quantitative study, those who had lower social support from family, friends and significant others, were 42% less likely to seek formal/professional help. In relation to the quantitative study, I must however be careful not to over-interpret the direction of causation, as the nature of the quantitative cross-sectional study can not detail the direction of causation between lower social support and help-seeking. However taking into account the results from my qualitative studies that elaborate on mechanisms of causation, these poor social networks were also prevalent barriers, mentioned across all interview groups. In contrast to this, supportive social networks were highlighted as a key facilitator of help-seeking in my qualitative studies.

Participants cited family and friends encouragement to seek help and wanting to save relationships, as key motivations that precipitated help-seeking

Participants recurrently mentioned the fractured nature of their friendships and social support due to the nature of military Service and the loss of these social networks on leaving the Armed Forces. All of these factors together meant individuals who were experiencing mental health problems were without the social networks and support systems that could have allowed them to disclose their problems, and potentially be encouraged to seek help. The nature of Service life seems to have weakened civilian social networks by the fact Service life is often consuming with little time to build civilian social networks. Military life also created fractured and unstable military social support in the continual break up of units through redeployments and promotions. Social support was additionally weakened when individuals left Service, as they left their military identities and friendships behind.

For Service personnel it has been evidenced that strong social bonding is needed to alleviate traumatic impacts of combat, such as the loss of significant friends in conflicts (Elder Jr and Clipp, 1988). It was found in the UK military that the use of TRiM (trauma risk management – training for military personnel that seeks to identify and support individuals suffering with psychological distress – please see Greenberg et al. (2008)), working through the mechanism of positive social support - assisted psychological resilience, and decreased the prevalence of CMD and PTSD (Frappell-Cooke et al., 2010). Increased unit support and cohesion was found in US military samples to be associated with positive utilisation mental health services (Harpaz-Rotem and Rosenheck, 2011) and decreased unit support was found to be negatively associated with help-seeking (Pietrzak et al., 2009). Hence we can see how important social support is for individuals in Service, particularly after deployment and potential traumatic events, and how the nature of military life (in splitting units up for reposting requirements), often disrupts the supportive relationships that could encourage someone to seek help.

Additional evidence to support some of this interpretation is found in Hatch et al. (2013) who showed in a large study of UK Service and ex-Service personnel, that ex-Service personnel reported less social participation outside work and general disengagement with military social contacts, in comparison to Service personnel. They also found that ex-Service personnel were more likely to report CMD and PTSD symptoms compared to Service personnel and these symptoms were associated with participation in fewer social activities and maintaining a smaller social network.

The depiction of the military as demanding and consuming by participants is also supported by sociological literature that frames the military as a social institution that is 'total' and 'greedy'; making high demands on those that are part of it, and affecting the nature of many social relationships (Coser, 1974, Segal and Harris, 1993, Dandeker et al., 2003). Dandeker et al. (2003) highlight how on leaving Service, the loss of social embeddedness and group cohesion is hard to cope with, which negatively affects transition and re-integration into civilian life. Smith and True (2014) also discuss the concept of 'warring identities' that US veterans experience on leaving the Armed Forces. From their qualitative research they discuss how veterans experience an identity conflict on leaving Service, which creates mental stress in those who find it difficult to reconcile their soldier and their civilian identities. They describe that often as a coping strategy, veterans withdraw themselves socially to reassert a sense of control over their transition to civilian life, which limits their opportunities for social support.

Reserves may particularly feel the difficulties of 'warring identities' and loss of social relationships as they transition in and out of mobilisation. Research found that deployed Reserves compared to non-deployed Reserves had an increased likelihood of relationships problems and were more likely to report actual or serious consideration of separation from their partner (Harvey et al., 2012). Conversely in a UK study, Reserves who felt able to talk about personal problems (and therefore utilise social support) were less likely misuse alcohol (Du Preez et al., 2012). Evidence from this collection of research highlights the specific influence military Service has on the size and nature of social networks. It also underlines the impact of social isolation, and supports my qualitative evidence, that social support may be key for understanding the health outcomes of those in the Armed Forces, particularly in relation to their propensity to seek help.

Simply having a social network, however, does not necessarily mean this will have a positive impact on help-seeking. Military and general population literature agree that it is the size, quality and attitudes that are present in social networks that determine positive or negative effects on help-seeking and service use (Albert et al., 1998, Pfeiffer et al., 2012, Kogstad et al., 2013). For example in a qualitative study of veterans by Sayer et al. (2009), they found that negative social network experiences on return from deployment such as societal rejection, social network discouragement of help-seeking or withdrawal from social networks, acted as barriers to treatment. Using this evidence in conjunction with other evident themes in my qualitative sample (such as public/anticipated stigma, negative attitudes towards help seeking, and masculine norms), it could be possible that even those

who had large social networks, would have ultimately been put off help-seeking by the prevalent attitudes in their direct social network that discouraged help-seeking.

In my findings, poor social networks were reflected in the reduced size of the social network around individuals, particularly for those who had left Service. This in turn decreased the potential support individuals could receive from their peers in disclosing their mental health problems and receiving support. Informal support may potentially be important in an individuals' help-seeking pathway, as those in military samples most commonly use informal help (Iversen et al., 2010, Hines et al., 2014a). In my own sample, 86% of those seeking formal/professional help had also utilised informal help. This aligns with Brown et al. (2014) who find in a UK community sample that three quarters of those with a probable mental health problem, who sort formal help, were also utilising informal help. They emphasise the prevalence and potential influence, the role informal help plays for those with mental health problems and hence poor social networks inevitably work against good informal social support.

A relevant facilitator of help-seeking was participants' desires to save relationships around them that had been negatively affected by their mental health problem. It was frequently the overriding care participants had for their spouses and children that caused participants to recognise their need to seek help. Building on these factors, i.e. that individuals need an adequate size of social network, with facilitating attitudes towards help-seeking to encourage help-seeking; it is interesting that within my interviewees in my non-help-seeking group, simple awareness of the positive attitudes that their family or friends had towards help-seeking, was not a strong enough facilitator to cause help-seeking. Within this study it seems that it was *specific* encouragement (and not general positive attitudes) from family or friends, or sometimes 'orders' from spouses to seek help, that ultimately made individuals seek formal help. This coheres with my quantitative analysis that found 44% of participants sought formal/professional help on specific advice of family, friends or colleagues.

This interpretation of direct encouragement, positively impacting on help-seeking is supported by Warner et al. (2008) who found influential factors for US Service personnel in overcoming barriers to care was having, 'family and friends strongly encourage' soldiers to get help. Meis et al. (2010) found in a returning National Guard sample from Iraq, that as relationship adjustment improved with their spouse, the association of PTSD severity and the odds of the military personnel obtaining mental health services strengthened. They hence concluded that supportive intimate relationships facilitated mental health treatment utilisation for soldiers with PTSD symptoms. My findings are additionally supported by

Zinzow et al. (2013) in their qualitative research with active duty US Army personnel. They found a facilitator of mental health treatment seeking to be social support; specifically having 'family/spouse' or, 'peer/battle buddy' encouragement to seek help, as well as having a trusted person to talk to was crucial in terms of help-seeking. Lastly recent research in a sample of US veterans with PTSD, found that social encouragement from family, friends or other veterans to seek mental health care, increased the odds of treatment receipt, even after the analysis controlled for mental health beliefs (Spoont et al., 2014). Hence this provides evidence to add to my quantitative and qualitative findings that poor social support acts a barrier to help-seeking and to my qualitative finding that strong social support and encouragement to seek help from participants spouses and families, is an important factor in positive help seeking behaviour.

An exception to this interpretation can be found within the Combat Stress help-seekers group. They are a group that cite potential support, good attitudes and specific encouragement to seek help from their families, however the majority of Combat Stress participants only sought help at crisis points. Here the social support and encouragement from family to seek help in the years before crisis events did not seem to be a strong enough facilitator to engender help-seeking on its own. It may be that the Combat Stress participants present a group with acute diagnoses and many barriers that overpowered the facilitating factor of supportive social networks. It was evident however in the Combat Stress group that they described how vital their family support was in terms of persisting with help-seeking and in their engagement with treatment. Hence social support may be a relevant factor in successful engagement with treatment and increase the likelihood of seeking help, when individuals' mental health problems are severe (Thoits, 2011).

Overall I believe there is a specific impact that military Service enacts on the potential social support available to individuals throughout their experience of life in Service, and as civilians. Having important relationships that individuals' care about and having supportive family and friends encouragement to seek help, are vital in terms of help-seeking success.

9.4 Other Relevant Barriers to Care

9.4.1 Negative Attitudes/Expectations Towards Mental Health Treatment

My qualitative and quantitative studies bring mixed evidence as to the effect of negative attitudes or expectations towards mental health treatment as a barrier to seeking help. In line with previous UK studies (Iversen et al., 2011, Jones et al., 2013), my own quantitative analysis confirmed that negative attitudinal views do not rank high as concerns that participants worried about when seeking help. The only attitudinal barrier that ranked highly

was the view that individuals wanted to solve the problem alone (which has been previously discussed). Alternatively however, my qualitative findings may give a more nuanced picture of prevalent negative attitudes towards treatment and healthcare services that may be more relevant to current military populations. These attitudes revolve around general negative attitudes towards mental health treatment and NHS services, negative attitudes towards taking medication, and a lack of faith in the ability of the MOD and NHS to be able to treat PTSD. These negative attitudes served as important barriers that prevented or delayed help-seeking in all interview groups.

In my quantitative regression analyses, those who had higher attitudinal barriers overall were *not* less likely to use formal/professional services. There was however one PSBCPP-SS item that had a statistically significant association with help-seeking, which was, *'My visit would not remain confidential'*. As previously discussed in the anticipated public stigma/medical records section (pg. 270-276), Service personnel may not believe their visit would remain confidential and therefore the specific issue of confidentiality may be a prominent barrier to disclosing mental health problems in Service.

There is consistent evidence from US and Canadian military literature that holding negative attitudes towards mental health care is associated with decreased care seeking propensity and healthcare service utilisation, with many studies using the PSBCPP-SS items (Pietrzak et al., 2009, Brown et al., 2011, Kim et al., 2011, Sudom et al., 2012). Recent research in US military populations also supports this. Valenstein et al. (2014) found that negative beliefs about treatment were associated with reduced service use in National Guard soldiers. Garcia et al. (2014) finds that recent veterans from Afghanistan and Iraq compared to Vietnam and Gulf War veterans were more likely to endorse negative treatment attitudes as possible barriers to care. These differences in US and UK research may be a function of measurement, that is, that UK studies have not adequately measured attitudinal barrier concerns specific to treatment attitudes (like the Valenstein and Garcia research have), and/or the use of the PSBCPP-SS attitudinal items do not reflect attitudinal barriers that are currently relevant to UK populations. Overall I believe there is evidence from my qualitative studies, that attitudinal barriers preventing help-seeking have not been adequately specified to UK military concerns.

My qualitative findings give a more nuanced identification of different negative attitudes (compared to PSBCPP-SS items) that were important to all of my interviewees. In my qualitative studies, there were some general negative attitudes shared by all groups, which included: apprehension about the help-seeking process, a general lack of faith in the medical

profession, and serious concerns about pharmacological treatments. In military samples, it is the specific negative connotation of taking medication or ‘drugs’ that may be relevant as a barrier to care. Other UK and US research support my qualitative finding, highlighting concerns military populations have about medication (Sayer et al., 2009, Zinzow et al., 2013, Murphy et al., 2014). In a recent US study, 36% of veterans endorsed that, ‘*Medication for mental health problems have too many negative side effects*’, this belief was associated with a lower likelihood of service use for veterans who presented with depression (Vogt et al., 2014b).

Most studies measuring negative attitudes in military populations measure an item that relates to whether individuals trust medical professionals. Participants in my qualitative study highlight a general lack of faith in medical professionals, which I believe is subtly different to whether individuals trust them. This lack of faith in the UK may be related to dissatisfaction towards NHS services, as many of these references were directed towards GP’s and general NHS services. From the current empirical evidence it is unknown how prevalent these views are at a military population level, however from the most recent UK GP Survey 2015, high percentages of the UK general population were positive about their experiences in primary care and did not share these views of a lack of faith in the NHS service (GP Patient Survey – National Summary Report 2015²⁰).

Combat Stress participants differed in their focus of negative attitudes towards treatment. Combat Stress participants specifically highlighted that they believed that the MOD did not want to address mental health problems and that the NHS could not treat their form of PTSD, which they termed ‘Combat PTSD’. These negative attitudes were born out of a mixture of perception and experience that contributed to delays in seeking help. The evidence of these negative attitudes is particularly important considered in the context of mental health policy within the MOD and NHS over the last five years. The MOD has put in place many programs that focus on improving mental health understanding and provisions within Service, however participants still described their mistrust of the MOD that prevented their help-seeking. It is apparent from my quantitative study that whilst 94% of Service personnel knew their Chain of Command could offer mental health support, only 36% of these people were willing to use the Chain of Command for support. This may support this perception of a lack of faith in the MOD’s approach to mental health problems. There is however, no empirical evidence to support how widespread these views are at the military population level, and indeed these views could be specific to the Combat Stress group. The Combat

²⁰ <http://gp-survey-production.s3.amazonaws.com/archive/2015/July/July%202015%20National%20Summary%20Report.pdf>

Stress group may have in part lost trust in the MOD because of their circumstances where some of them had to leave Service because of their diagnosis.

There was a distinct negative attitude towards the ability of the NHS to treat military personnel in the Combat Stress group. Combat Stress participants described their PTSD as 'Combat PTSD' and delineated this type of PTSD as different from other types treated on the NHS. There was the belief that the NHS could not treat 'Combat PTSD', because the NHS did not have required experience of it. This viewpoint is potentially extremely damaging to the NHS and future UK military health policy if ex-Service personnel lack faith in the NHS' ability to treat them. This issue is discussed in detail in the implications and conclusions section, Chapter 11. Overall my quantitative study and other UK studies, may not have found high prevalence or association between attitudinal barriers and help-seeking, because the relevant attitudinal barriers may not have been measured, and these attitudinal barriers may be very specific to the UK experience of healthcare services.

9.4.2 Lack of Judgement of Need for Medical Help

There was much evidence primarily arising from my qualitative studies that identified participants' lack of judgement of their own need to seek professional help, as a barrier to help-seeking. Participants minimised, normalised and managed their problems through maladaptive coping strategies that delayed and prevented help-seeking. Participants also cited beliefs that they did not deserve treatment. Individuals may minimise or normalise their problems because of public and self-stigma, or preferences for self-management or adherence to masculine norms. Hence the lack of judgement of need for professional/medical care, may not be a direct barrier to help-seeking but may be a symptom of other barriers.

Minimisation or normalisation of mental health problems i.e. low perceived need, may be driven by a lack of mental health knowledge in the military. For example 53% of a sample of Regulars, Reserves, Serving and ex-Service personnel could not correctly identify symptoms of PTSD (Fear 2012 – personal correspondence), and therefore military personnel may not recognise and may concurrently 'write off' identifying symptoms. This is not too dissimilar from evidence found in general populations; for example an Australian general population sample found that two-thirds of public could not recognise specific disorders such as PTSD (Reavley and Jorm, 2011).

However simply improving mental health literacy has not been shown to have an impact of help-seeking. A systematic review that assessed mental health literacy interventions across six randomised control trials, found that whilst mental health literacy content (such as mental

health literacy education, help-seeking information, videos with patients describing mental health treatment, online CBT using cognitive restructuring) was effective in improving help-seeking attitudes in the majority of studies at post-intervention, it had no effect on help-seeking intentions or behavior (Gulliver et al., 2012). Therefore certain mental health literacy interventions aimed at the Armed Forces by the MOD may not be effective in precipitating positive help-seeking behaviours.

Many participants normalised their experience of a mental health problem or alcohol use and indicated that they believed their symptoms to be part and parcel of training and experiences that came with the profession of being in the Armed Forces. There is evidence that certain behaviours encouraged in training and deployment, such as channelled aggression, hyperarousal, vigilance, the ability to numb emotions in the face of trauma or death and functioning on limited sleep (Hoge, 2010), may cause individuals to recognise these behaviours as a normal result of Service, rather than an indication of a mental health problem. There is a long history of alcohol use in Service (Verrall, 2011) and high levels of alcohol related harm or dependence compared to the UK general population (Fear et al., 2007). Equally there are high levels of aggression and violence in UK and US Armed Forces (MacManus et al., 2015), and hence individuals may align these behaviours with the normal operating status and thereby normalise their mental health problems.

Whilst it is apparent that people are generally prone to underestimating their need to seek treatment (Andrade et al., 2014), military populations may have additional factors that play into their sense of need. Participants often cited a lack of deservedness to seek help by minimising their problems and relating the extent of their problems to other people they knew in the Armed Forces. They cited how others had a worse situation to theirs and therefore, they would have felt unworthy seeking help. The overt numbers, types of casualties and deaths broadcasted by media outlets on UK deployments to Iraq and Afghanistan over the last ten years may bolster this idea of a lack of deservedness. Whilst it is a triumph of medical science that individuals in the Armed Forces have survived injuries in the field, never survived by generations before (Brown et al., 2012), the media has also created vivid examples of those who have obvious, severe life-changing injuries and indeed has created objects of comparison by which others judge themselves (Kleykamp and Hipes, 2015). The media and charities have also grasped on to the image of the 'hero warrior' for injured Service personnel and created the 'hero-victim' dichotomy (McCartney, 2011, Hines et al., 2014b). This dichotomy has been utilised by the Armed Forces charity sector in order to raise funds and awareness, however it is possible that individuals compare themselves to individuals who have gone through extreme injuries and circumstances, and deem their

problems of minor significance, not worthy of treatment. This may be particularly exacerbated for ‘unseen’ mental health problems compared to physical injuries (Hines et al., 2014a).

Lastly the finding of maladaptive coping strategies as a barrier to help-seeking in the qualitative studies makes sense within the framework of ‘emotion focused coping’. When individuals are exposed to stressors, two types of coping can be employed. These types include, ‘problem focused coping’ (PFC) and ‘emotion focused coping’ (EMC) (Carver, 1997). PFC strategies involve practical constructive steps to actively address problems, such as seeking practical solutions or social support. EMC strategies attempt to reduce the emotional stress caused by the problem, for example avoidance, distancing or substance abuse. Research has found that PFC strategies are taken when an individual feels something constructive can be done for a problem, whilst EMC strategies are taken when an individual feels a problem must be endured (Carver et al., 1989). Many interviewees when discussing why they were not seeking help for a problem emphasised an acceptance that the problems they were experiencing were just a normal part of their lives and something to be coped with. It therefore makes sense that if individuals have an attitude that they must cope with a problem, they may be more likely to employ maladaptive coping strategies that obfuscate the source of distress. Hence emotional avoidance, heavy drinking and social avoidance all described by interviewees, display EMC tactics and therefore also highlight that a large proportion of participants at some point (consciously or sub-consciously) did not believe there was a solution to the problem they were experiencing.

Alternatively some literature highlights that PTSD produces certain behaviours as part of its’ symptomology that may act as barriers to help-seeking (Hoge, 2011). For example Sayer et al. (2009) qualitative study found that veterans were less likely to use mental health care because they wanted to avoid repeated disclosure of their trauma. Blais et al. (2014b) found that it was specifically higher avoidance severity out of different PTSD symptom clusters (e.g avoidance, re-experiencing, dysphoria, and hyperarousal clusters) that predicted lower treatment utilisation. My specific qualitative sample contains a higher proportion of individuals with a PTSD diagnosis and therefore it may also be possible that the finding of the use of maladaptive coping strategies may represent a PTSD diagnostic specific barrier to seeking help.

9.4.3 Logistic/Practical Barriers

Logistic or practical barriers in seeking help were not endorsed as prevalent issues in my quantitative research or associated with help-seeking. However, within my qualitative research, practical barriers were highlighted by all Combat Stress interviewees and yet not identified in KCMHR cohort interview groups. I posit these findings may be a function of the measurement of practical barriers and the relevance of practical barriers at different stages of the help-seeking pathway, with practical barriers being more pronounced for engaged help-seekers.

The practical barriers assessed in the quantitative analysis appraised whether individuals experienced the barriers of, not knowing where to seek help, not having adequate transport, not being able to get appointments, and not being able to get time off work for treatment. All of the potential practical barriers were not endorsed as important barriers and were ranked in the bottom half of concerns, both for those with a probable mental health diagnosis and those without. Equally practical barriers were not associated with help-seeking in regression analysis. These findings support much other UK military quantitative work that finds practical barriers, in terms of seeking help, are less important than stigma or attitudinal barriers in affecting help-seeking behaviour (Iversen et al., 2011, Jones et al., 2013, Osório et al., 2013a). US military research also confirms a far lower importance of practical barrier concerns compared to other social and psychological barriers (Hoge et al., 2004, Pietrzak et al., 2009, Gould et al., 2010, Kehle et al., 2010, Britt et al., 2011, Gorman et al., 2011, Kim et al., 2011, Ouimette et al., 2011, Warner et al., 2011, Hoerster et al., 2012, Sudom et al., 2012).

However, whilst individuals in the quantitative study did not endorse not knowing where to get help at any prevalent level, it is also apparent that they did not have knowledge of the main services the Government has implemented to support Armed Forces mental healthcare. My results identified that there were certain important healthcare or support services that individuals had very little awareness of, and in particular the service offered free to all Armed Forces, The Big White Wall. Equally there was low awareness of ex-Service specific healthcare services amongst both Service personnel and Ex-Service personnel, specifically, The NHS Veterans Service and The Veterans and Reserves Mental Health Programme. These findings are concerning considering all of these three services were implemented as policy responses to improve access and services available for Armed Forces mental healthcare (VRMHP since 2006 and The NHS Veterans Service and Big White Wall since 2011, after the Murrison Report). Hence participants effectively only knew a reduced choice of the potential services available to them, therefore the practical barrier item measuring

whether people have knowledge of where to get help, does not examine the quality of this knowledge. Limited knowledge of healthcare services may subsequently effect decisions to seek help if participants are unwilling to use the services they are aware of.

Therefore it is also relevant to highlight the healthcare or support services that individuals were aware of and yet did not want to use. In particular, there was high awareness of Service charities, however a relatively low willingness to use them for support, particularly from Service personnel. This may be because current Service personnel have a view that Service charities are only applicable to ex-Service or older veterans, or they may simply not know the plethora of services available to them through the Armed Forces charity system. For example a study found that recent UK ex-Service personnel did not consider themselves to be 'veterans' (a term used by Service charities) and associated the term with older WW2 veterans (Burdett et al., 2012). Hence these views may cause current Service and ex-Service personnel to discount support offered by Service charities if they feel it is not applicable to them.

When addressing my qualitative results, it became clear there was a huge list of practical or healthcare structural barriers that prevented or delayed my Combat Stress group from accessing and engaging in mental health treatment. These included practical barriers experienced on both in the NHS and whilst accessing support from Combat Stress. They included the problems of having to take initiative to seek help several times through the NHS, contending with different diagnoses, long waiting times and the difficulty in the length of treatment at Combat Stress in terms of taking time off work for treatment. They also believed that Combat Stress was underfunded and under-publicised as a treatment service for the Armed Forces.

I believe the Combat Stress group may have been the only group to highlight practical barriers to help-seeking because of their status as engaged help-seekers and because of the nature of their diagnosis with complicated and long help-seeking pathways. These individual's described experiencing many different healthcare services through different help-seeking attempts, prior to their crisis points. Due to the complicated nature of a PTSD diagnosis and the fact it is a relatively rare diagnosis on the NHS (approximately 3% of the UK general population (McManus et al., 2009)), it may be an illness that is difficult in its' presentation and diagnosis, particularly when individuals themselves are reluctant to disclose their problems. In this way the Combat Stress group know about practical barriers to help-seeking because they have been engaged in healthcare services. Individuals who are early help-seekers or non-help-seekers (like the KCMHR interview groups) will not have

experienced or be aware of practical barriers to seeking mental healthcare, because they are not at the point yet of real engagement with services. Hence my quantitative study and other military quantitative studies may not find practical barriers to be an issue because they have not stratified samples by levels of help-seeking engagement and often do not have samples available where non-help-seekers can be compared to help-seeking groups.

Some of these practical barriers within the NHS may be common to all individual's using mental healthcare services such as waiting times and high turnover of professionals (Iacobucci, 2014, Lousada et al., 2015). However, some of these practical barriers are specific to the way Combat Stress runs their PTSD treatment services and may be an area for NHS commissioning and Combat Stress itself, to focus on in developing their treatment services to be more integrated in peoples' lives and work commitments. The belief that Combat Stress participants held - that Combat Stress was under-publicised is supported by a UK study that examined the public's awareness of veterans charities and found very low percentages were aware of Combat Stress' existence (Gribble et al., 2014). However this view was not born out by my quantitative analysis that actually found fairly high levels of awareness of Combat Stress (above 80%) in both Service personnel and ex-Service personnel.

Overall whilst practical barriers were not prevalent and not associated with help-seeking, I believe there is a case to be made that practical barriers may be more relevant to engaged help-seekers and overall knowledge of military mental health services could still be improved.

9.5 Other Relevant Facilitators of Help-Seeking

A deficit in the military literature is that there is too much focus on barriers to help-seeking and not enough on facilitators; hence there are only a few studies that measure facilitators of help-seeking with which to compare my qualitative findings.

9.5.1 Inverted Masculine Norms

This facilitator theme in the qualitative study was not prevalent, but I have assessed it to be an important facilitator of help-seeking as its' presence delineated differences between my help-seeking and non-help-seeking interview groups.

KCMHR help-seekers made reference to help-seeking behaviour as being 'brave' or 'courageous'. The specific language used to describe help-seeking was in stark contrast to

KCMHR non-help-seekers who described help-seeking as ‘weak’ or ‘unmanly’. It is interesting that help-seekers who viewed help-seeking as supporting the masculine notions of strength and courage, were concurrently able to seek help. In this scenario, the action of seeking help did not go against adherence to masculine norms but supported it, and potentially enabled help-seeking behaviour. There is evidence in the specific language used by participants such as, ‘having the balls’ or having ‘backbone’ to seek help, which all reflected traits of strength and masculinity. It is however important to note that none of the Combat Stress help-seekers mentioned ‘inverted masculine norms’. The majority of Combat Stress interviewees sought help at crisis points, therefore it is likely that many facilitators of help-seeking were simply not present in the thinking of the majority of this group. Alternatively it is possible that this facilitator theme is not in reality a facilitator of help-seeking, and might not be represented at a population level.

From the available literature it is not clear whether inverted masculine norms would have an effect on help-seeking. In Jones et al. (2013), 80% of Service personnel with a probable mental health problem endorsed that they believed, *‘It takes courage or strength to get treatment for a psychological problem’*, however 40% of individuals who were symptomatic in this study had not sought help. Hence this belief did not seem to have affected positive help-seeking behaviours. Conversely, a US study of Service personnel, Zinzow et al. (2013), proposed that stigma reduction methods should include attempts to reframe the beliefs such as, “seeking help is a weakness”, by emphasising the alternative, that seeking help requires strength and courage. A Canadian, general population, qualitative study of males with depression assessed how masculine roles and identities mediated depression-related suicidal ideation. Oliffe et al. (2012) found that men who chose a pathway that rationalised help-seeking as a, ‘wise’, solution focused behaviour, believed seeking help would preserve their masculinity, and were able to counter their suicidal ideation by connecting with others and disclosing their problems. Here males upheld their masculinity by seeking help because they had fought the ‘good fight’ in trying to solve their problems and regain control over their lives.

Inverted masculine norms could signal a move to problem focused coping, as the act of help-seeking is a way to regain control (or to get better) and therefore reassert an individual’s masculinity in their ability to cope and solve problems. In believing the act of help-seeking to be one that adheres to masculine norms (in that it is a brave, strong action that will achieve a good result), adherence to masculine norms may perversely and positively encourage help-seeking. Murphy et al. (2014) qualitative study of positive pathways to help-seeking in UK Service personnel, comments that a facilitator of help-seeking was individuals believing that

they could regain an internal locus of control (Hiroto, 1974) over their illness, by seeking help. Hence the impact of masculine norms were not always negative on help-seeking. There is, however, extremely limited evidence that connects inverted masculine norms to help-seeking behaviour or service utilisation.

9.5.2 Positive Attitudes/Expectations Towards Mental Health Care

Positive attitudes towards mental health care were not particularly prevalent. Within the KCMHR help-seeking group, it highlighted a difference in the help-seeking group compared to the non-help-seeking group, where the presence of these positive attitudes encouraged help-seeking. In the Combat Stress help-seeking group, whilst positive attitudes towards mental healthcare were prevalent, these positive attitudes were often as a result of good help-seeking experiences with Combat Stress, and not a cause of their help-seeking.

Kehle et al. (2010) found that more positive attitudes regarding mental health treatment, as measured by the, ‘Attitudes Toward Seeking Professional Psychological Help Scale’ (Fischer and Farina, 1995), were associated with greater utilisation of psychotherapy. A recent longitudinal study assessing determinants of help-seeking in US soldiers found that positive attitudes, such as ‘believing mental health counselling can benefit those who need it’, was associated with an increased likelihood of treatment-seeking (Adler et al., 2015). A qualitative study found that positive treatment beliefs, such as believing mental health treatment would work and that seeking treatment was way to take care of yourself, all had positive effects on US Army personnel’s’ positive help-seeking behaviours (Zinzow et al., 2013). Simply having these positive attitudes however may only be one factor in help-seeking. In a UK study of Service personnel, Jones et al. (2013) found that over 80% of probable mental health cases believed that seeking mental health support was helpful for those who needed it, however 40% of individuals with probable mental health problems, were not seeking help in this sample.

Within my Combat Stress interviews, positive attitudes towards seeking help were described more often as a result of their good help-seeking experiences with Combat Stress rather than a precursor to help-seeking. Current military studies that have assessed adherence to treatment have not measured positive facilitators of engagement with help-seeking, such as positive attitudes towards care (Rosen et al., 2011, Hoerster et al., 2012, Harpaz-Rotem et al., 2014). A recent US study of soldiers found a main reason for drop out from PTSD treatment was negative attitudes about mental health treatment (Hoge et al., 2014). Hence it would be valuable to have studies that assess positive facilitators and not just the absence (or presence) of negatives attitudes to assess its impact on help-seeking.

9.6 Other Relevant Findings

9.6.1 Crisis

The factor of ‘crisis’ as identified in my Combat Stress qualitative study, I deemed (and termed) to be a ‘negative facilitator’. That is, crisis situations presented themselves in participants’ lives often as a result of their worsening mental health problem and caused or forced individuals to seek help. This factor was identified in the majority of the Combat Stress help-seekers and described the negative circumstances that precipitated help-seeking, frequently in the form of suicide attempts. Participants described being automatically engaged in the NHS healthcare system through their hospital admission and referrals, or by a stark recognition after their crisis episode that they had to seek help.

The factor of ‘crisis’ precipitating help-seeking is important to this study because crisis is a poor outcome, and a product of all the potential barriers identified, that prevented and delayed help-seeking. Here individuals have coped with their mental health problem, up until their breaking point and have not succeeded in their help-seeking.

This qualitative finding may be a factor related to the nature of the Combat Stress help-seeking group who are at the most challenging end of the help-seeking spectrum, in terms of their acute diagnoses and time taken to seek help. The majority of the Combat Stress participants had a PTSD diagnosis. Equally, help-seekers with Combat Stress take between 2-13 years to seek help after leaving Service (van Hoorn et al., 2013). From evidence in my qualitative studies, these participants have also experienced different pathways to help-seeking and many failed attempts to receive the appropriate treatment. This group may represent individuals who have multiple barriers to seeking help, also influenced by their PTSD diagnosis. Individuals with PTSD have been evidenced to have higher stigma than those with other diagnoses (Iversen et al., 2011) and also experience more avoidant behaviours (Blais et al., 2014b). Therefore these individuals may cope with their mental health problems for a long time before they seek help and only seek help when they absolutely have to.

I believe there is evidence for the factor of crisis in help-seeking outcomes from my quantitative study. In my quantitative study, 27% of individuals endorsed that they had sought help because of a change in life circumstances or major event. Equally the number of life events experienced (such as divorce, assault or ill health) was also positively associated (in a positive trend) with seeking formal/professional help in regression analyses. Here we

can see that as the number of major events builds up causing stress/crisis and impacting on an individuals' ability to function, individuals become more likely to seek help. This is supported by empirical work in military help-seeking that finds the severity of mental health problem is related to help-seeking intentions and mental health service use (Rosen et al., 2011, Harpaz-Rotem and Rosenheck, 2011, Hoerster et al., 2012, Sodom et al., 2012). Murphy et al. (2014) research also supports the finding that military individuals seek help when they reach a crisis point. In their study, individuals recognised their need to seek help after experiencing a crisis because they realised they could no longer cope with or ignore their mental health problem.

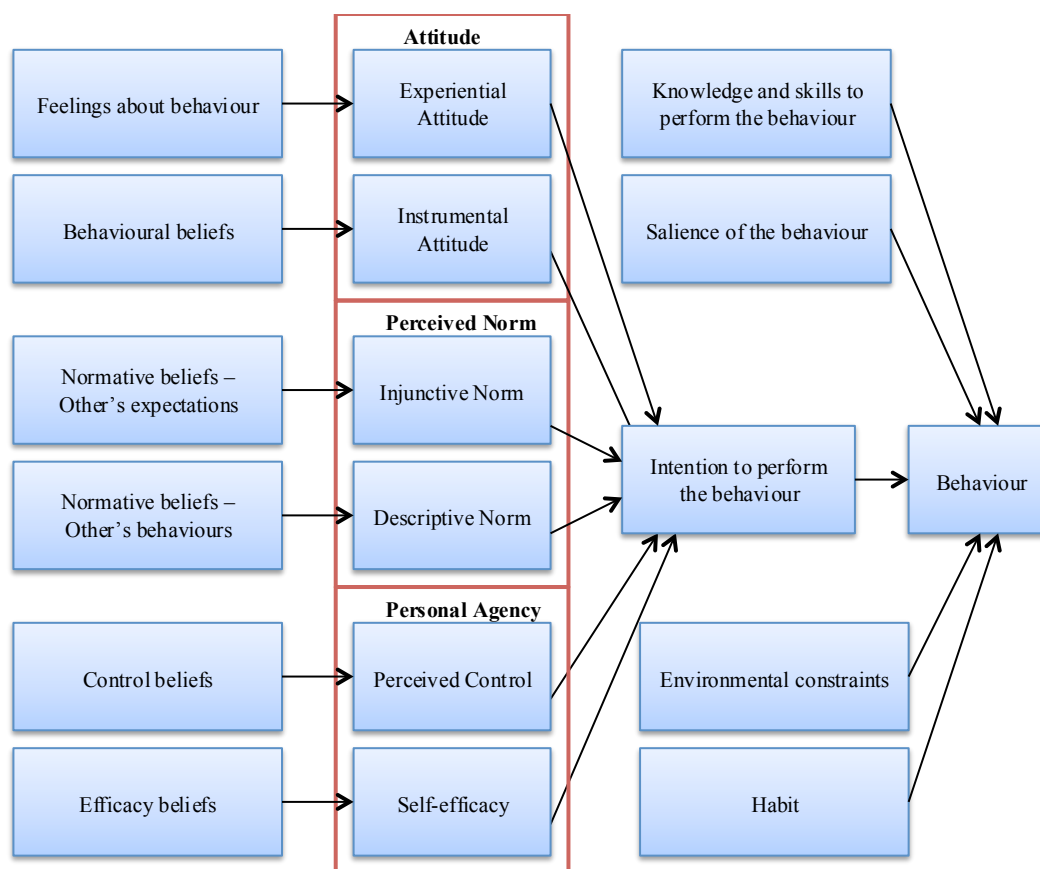
The factor of seeking help when reaching a crisis point is also evidenced across other populations and illnesses such as that of psychosis (Tanskanen et al., 2011) and cancer (Smith et al., 2005). However, of particular relevance and similarity to my study is the work by Biddle et al. (2004). They found young men between ages 16-24 were particularly unlikely to seek help for mental health problems unless they were severely distressed and in crisis. Men also had a higher threshold of severity at which they would seek help than women. In their further qualitative work, Biddle et al. (2007) reports how their participants continually renegotiated the boundaries of what they deemed 'normal' and 'real' problems when experiencing increasingly severe symptoms. The 'realness' of their distress only became apparent when a crisis occurred, during which help was often enforced on participants after hospital admissions. The normalisation of problems in this study, matches the normalisation of problems my participants described in my qualitative studies and may account for crisis episodes experienced.

Participants may ultimately reach crisis points because of the interaction and amalgamation of different barriers to care. It is interesting to note that in the cases of crises in the Combat Stress group, the facilitators of help-seeking often proceeded the point of crisis and were the result (and not the cause) of engagement with treatment (such as a desire to get better or positive attitudes towards care). Where social support was present, it was not a strong enough facilitator before the crisis point to enable engaged help-seeking. Hence within this group it may be that facilitators are few, and facilitators that are apparent, may be ineffective due to the extent of the barriers faced. These individuals are the main impact point that future policies and interventions may want to focus their efforts upon to encourage earlier help-seeking and avoid the huge social and economic costs of individuals reaching crisis points before seeking help.

9.6.2 Help-seeking process – models and pathways

It is useful to view my results in light of theory from the Integrated Behavioural Model (IBM) that includes constructs from the Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB). I also combine these ideas with concepts in the Transtheoretical Model (TM) (Prochaska et al., 2008) (For a description of these theories please see Chapter 1, pg.35). The IBM model emphasises that important determinants of behaviour are behavioural intentions (Montano and Kasprzyk, 2008). IBM proffers that a particular behaviour is most likely to occur if, 1) a person has a strong intention to perform it and the knowledge and skill to do so, 2) there is no serious environmental constraint preventing performance, 3) the behaviour is salient and, 4) the person has performed the behaviour previously. IBM similarly to TPB also assumes a causal chain that links attitudes, perceived norms and personal agency to behaviour through behavioural intentions (See Figure 22)

Figure 22 - Integrated Behavioural Model (Montano and Kasprzyk, 2008)



My quantitative measures, and many of my qualitative barrier and facilitator themes fit under the framework of attitudes, perceived norms and personal agency and help to explain the complex puzzle of the underlying effect and function of beliefs and its effect on intentions to perform (or not perform) a help-seeking behaviour.

The Transtheoretical Model (also referred to as the ‘Stages of Change’ Model), whilst not directly used to assess a help-seeking intentions model, I believe offers interesting insight into the different stages of readiness individuals experience in relation to changing health behaviour. Primarily the theory focuses on constructs and processes that move individuals closer to behaviour and changing health behaviour permanently, such as encouragement of healthy eating or increasing physical activity (Prochaska et al., 2008). It posits stages of:

- Pre-contemplation (no intention to take action),
- Contemplation (intention to take action in the future),
- Preparation (intention to take action presently and behavioural steps taken in forward direction),
- Action (changing of overt behaviour),
- Maintenance (changing of overt behaviour over time) and,
- Termination (no temptation to relapse and confidence in changes).

This model is useful if we also see help-seeking in the light of a health behaviour that has several different stages. From the quantitative and qualitative findings it was apparent that individuals found themselves in these different stages, for example; pre-contemplation (i.e. not recognising they had a problem and not seeking help) contemplation (assessing pros/cons, barriers/facilitators of seeking help), preparation (researching available help options, disclosing problems to family/friends), action (seeking professional help) maintenance (engagement in treatment) and termination (confidence to seek help in the future if needed). Combining this theory of stages of different health behaviours with the theories of TRA/TPB and IBM, we can begin to analyse a picture of why individuals can move on from certain stages, or indeed why individuals relapse into non-help-seeking. We can analyse what affect their attitudes, perceived norms and personal agency has on whether they are moved to help-seeking action and whether they can maintain that action with engagement in treatment.

My qualitative data is useful for assessing stages of help-seeking, whilst my quantitative data can explicate what variables might impact help-seeking at any point in the timeline. When

assessing the qualitative data it became clear that help-seeking was not a strict linear process. Individuals did not inevitably move from non-help-seeking to help-seeking. A help-seeking action did not necessarily indicate a successful health outcome in engagement with treatment. For example, the quality and success of help-seeking within the KCMHR help-seeking group was poor. It became apparent during interviews that the majority of individuals who identified themselves as help-seekers in the KCMHR help-seeking group, had not properly engaged with professional services, and were not engaged with a formal treatment plan. Additionally it was interesting to note that some current KCMHR non-help-seekers identified themselves as previous help-seekers, but currently were not seeking help for the problems they were experiencing. Combat Stress help-seekers described different episodes of help-seeking and non-help-seeking and described several routes explored in help-seeking that did not come to fruition, before they accessed Combat Stress. It became apparent that the status of help-seeking could not be assessed as a binary outcome, but as a continuous scale or spectrum where individuals moved forwards and backwards from non-help-seeking, to pre-help-seeking status to help-seeking. Many individuals described experiencing setbacks in their help-seeking and returned to a non-help-seeking status.

It therefore upholds the concept that we should look at help-seeking in stages.

Utilising my quantitative data we can assess that there are variables at the stages of non-help-seeking and help-seeking that affect intentions to seek help. For example the underlying beliefs found in **attitudes** – such as the preference for self-management, **perceived norms** – such as anticipated public stigma, and **personal agency** – such as the presence of self-stigma or social support – all affect intentions to perform a behaviour and from my qualitative studies we can conclude that not all of these influencing factors are constant. It therefore explains how an individual could take an action to seek help, however after experiencing obstacles (for example the help-seeking did not solve the problem, anticipated public stigma was encountered, supportive relationships changed due to life circumstances) or experiencing success (diagnosis and treatment was offered, encouragement from social support), either move backwards to non-help-seeking or move forwards with real engagement in their help-seeking.

9.6.3 Different types of barriers and facilitators at different help-seeking stages

When looking at my qualitative studies, it was evident that different barriers to seeking help were more prevalent at different points in the help-seeking pathway. If I posit using the TM that the KCMHR non-help-seekers were at the non-help-seeking/pre-stages of help-seeking, the KCMHR help-seekers were at an early stage of help-seeking, and the Combat Stress

help-seekers were more engaged help-seekers— it was evident that social and psychological barriers to seeking help, such as anticipated public stigma or attitudes towards mental health care, even though important across the interview groups, were slightly more prevalent at non-help-seeking, early help-seeking stages (i.e. KCMHR non-help-seeking and help-seeking groups). Equally, practical/or healthcare barriers were more prevalent at later help-seeking stages (i.e. the Combat Stress help-seeking group). In addition, anticipated public stigma, self-stigma and negative attitudes were important barriers for non-help-seekers at the beginning of their help-seeking pathway in my quantitative study. Recent UK Armed Forces research supports evidence of decreased public stigma concerns in those who have engaged with treatment and have remitted symptoms, compared to those with and without probable mental health diagnoses (Jones et al., 2015). UK military research also found anticipated public stigma was heightened during deployment compared to non-deployment (Osório et al., 2013a). Hence this research upholds the concept that anticipated public stigma is not always constant and may be related to help-seeking and treatment status.

Throughout my KCMHR interview groups (non-help-seekers and early help-seekers), practical barriers were mentioned once by one interviewee. In contrast all Combat Stress participants discussed practical or healthcare barriers. This finding makes intuitive sense in that social and psychological barriers are more prescient for someone deciding whether they should seek help, however once help has been sought, an individual will logically experience the healthcare system and potentially experience the practical or healthcare barriers that exist in that specific healthcare system.

When relating this idea to the IBM (Figure 22 and Figure 23) it may be that attitudes and perceived norms, which relate to social and psychological barriers, are important in early stages of help-seeking in affecting intentions to seek help. However that personal agency may relate more to practical barriers, in that it includes the concepts of perceived control and self-efficacy i.e. an individual's perception of the degree to which certain environmental factors make it easy/difficult to carry out help-seeking and an individual's degree of confidence in the ability to perform the behaviour in light of obstacles. An individual may only understand environmental factors (practical barriers) when they are further on in the help-seeking process experiencing the healthcare system. If real practical barriers are met, this may affect the individuals' self-efficacy or confidence that they know how to overcome these barriers. An individual could hence change their opinion of their control over the help-seeking process (affecting personal agency in the IBM) and move backwards to a non-help-seeking state (despite overcoming negative attitudinal or perceived norms). A UK review and a separate US review cite that practical barriers, such as long waits from referral to

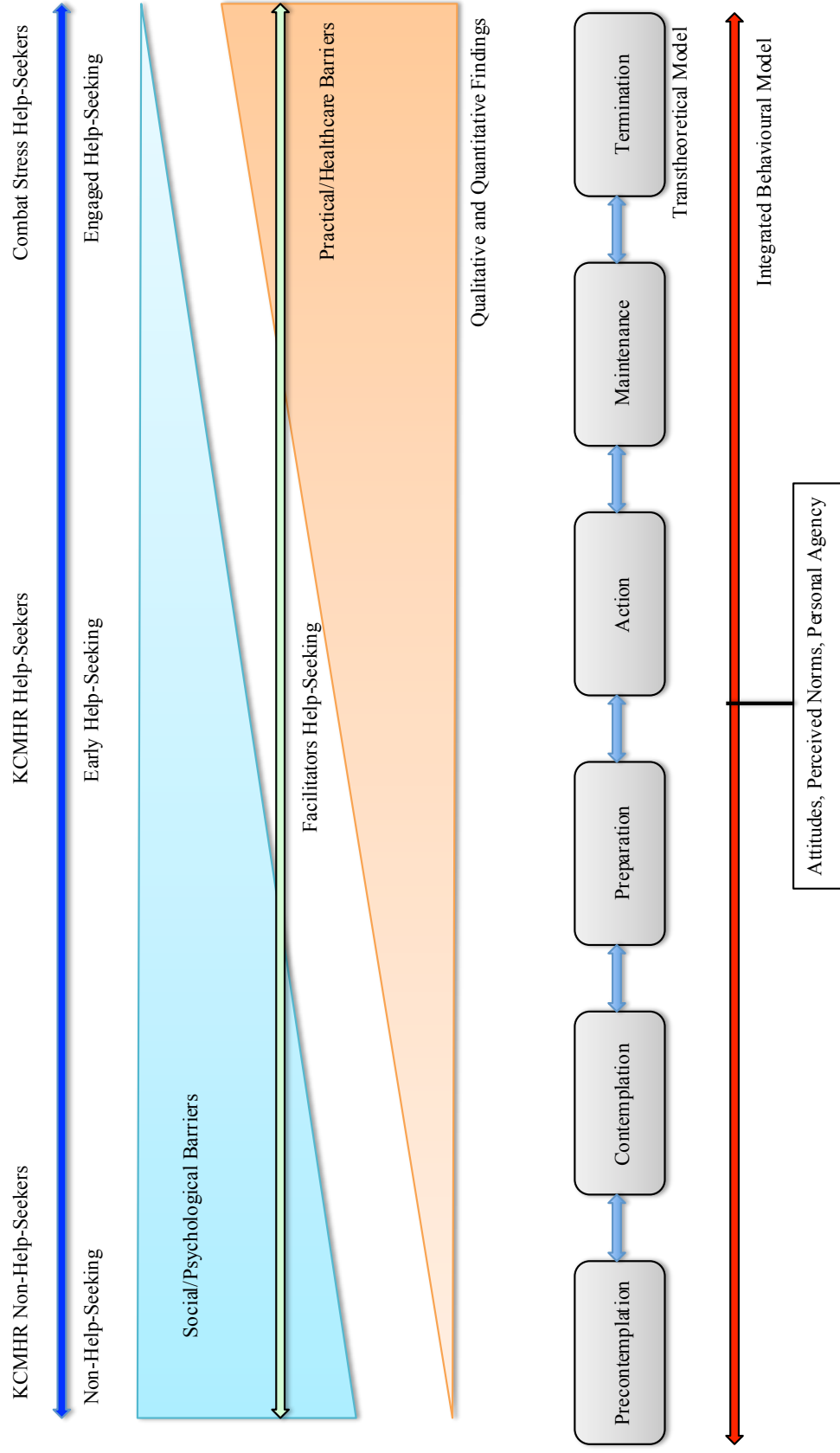
appointments, were relevant in causing patients to miss mental health appointments and subsequently drop out of treatment after initial help-seeking (Mitchell and Selmes, 2007, Barrett et al., 2008). This therefore emphasises the impact of practical barriers at a later stage of help-seeking.

It is hence a point of interest in this discussion that practical or healthcare barriers may be more important for individuals engaged in help-seeking. Assuming satisfactory availability of mental health services, interventions upon these practical/healthcare barriers will affect whether an individual maintains their help-seeking status, whether they are able to engage in treatment and whether they will have the confidence in the future to use a particular help-seeking route. Interventions upon social and psychological barriers, such as programs to reduce the stigma of mental health problems, may affect attitudinal and perceived norms, which could potentially have a positive impact on earlier stages of help-seeking. Figure 23 brings together these models and findings in diagrammatic form to facilitate an integrated approach to viewing these concepts and results.

9.7 Summary

Overall this PhD finds confirmatory evidence from the literature and both qualitative and quantitative studies that anticipated public stigma, self-stigma, the negative attitudinal preference for self-management, and poor social support, negatively affect help-seeking for mental health problems in military populations. This PhD also finds evidence that supportive social networks, act as key facilitating factors that encourage help-seeking. Other potential barriers and facilitators of help-seeking were also discussed. Finally, findings were discussed in the context of help-seeking theory, with a focus on the potential differential importance of certain barriers at different stages of help-seeking.

Figure 23 - Integrated Model of Help-Seeking



Chapter 10 - Strengths And Limitations

10.1 Studies Overall

Most military help-seeking literature focuses on barriers to care and often does not measure positive factors that might enable individuals to seek help. This PhD provides new evidence on what facilitators of help-seeking might be present in a help-seeking pathway. These include supportive social networks, inverted masculine norms and positive attitudes towards seeking mental health treatment. In turn this work can support new avenues of research that provide a focus on positive facilitators of help-seeking and ways of encouraging supportive environments around those who may need to seek help.

A strength of my PhD thesis is that my studies have been able to access non-help-seeking and help-seeking groups. Many help-seeking studies are only able to access treatment seeking groups. This omits information on the groups most in need of support or treatment, that is, those who do not seek help. Additionally, the ability to compare the characteristics both qualitatively and quantitatively of non-help-seekers and help-seekers has highlighted both similarities and differences between these groups. My research has prioritised and sampled those least likely to seek help and those who are most likely to experience barriers (for example, in qualitative studies, men aged 18-35 years and in quantitative studies those endorsing a stress, emotional or mental health problem). This is a positive characteristic of the research, as it focuses attention on difficult help-seeking pathways, providing ‘worst case scenarios’. By focusing research and proceeding interventions upon acute presentations, it will also help those in the military population who have less severe problems or barriers.

A main strength of my studies has been to gather qualitative information from three different groups of help-seeking pathways (non-help-seeking, help-seeking and help-seeking in the Service charity/voluntary sector). However, whilst my studies have gathered help-seeking data across groups of Service personnel, Reserves and ex-Service personnel, I believe the research is limited in addressing the specific help-seeking experiences of Reserves, which is unlike pure Regulars who become ex-Service personnel. For example Reserves have their healthcare provided by the DMS when mobilised and by the NHS when demobilised, this may have an effect on their help-seeking decisions, pathways and continuity of care. As my quantitative study was a preliminary study (based on a subset of a larger dataset), I was not able to examine the experiences of Reserves due to a small Reserve sample. My qualitative studies did include current Reserve and ex-Reserves, however, a separate qualitative study focused on Reserves, may be appropriate for future research. Reserves health is a significant area for future work, particularly in light of the Strategic Defence and Security Review 2010

and ‘Reserves 2020’²¹ that seeks to reduce Regular Armed Forces numbers and double Reserve numbers by 2020. Deployed Reserves compared to non-deployed Reserves are more likely to have relationship difficulties and an increased risk of PTSD (Harvey et al., 2012). As their numbers will be increasing, it is important their concurrent help-seeking behaviours are explored adequately.

My study did not address help-seeking for mental health problems in female military personnel. Whilst UK female military personnel have been evidence to be more likely to seek help than males (Iversen et al., 2010, Hines et al., 2014a), UK female personnel have also been found to have higher levels of alcohol misuse and psychological distress compared to male personnel (Rona et al., 2007, Mulligan et al., 2010) and CMD (Woodhead et al., 2012, Goodwin et al., 2015). Equally the qualities identified as being different in females in general populations that aid help-seeking, such as reduced attitudes of stoicism and preferences for self-management (Judd et al., 2008), may not be the same in military females, since these females exist within a culture where these specific negative attitudes are prevalent and may influence their help-seeking preferences. Hence specific attention should be paid to female help-seeking pathways in the military.

A potential limitation of this research is the differing boundaries set across the qualitative and quantitative studies to categorise mental health ‘caseness’, i.e. the threshold set to identify those who may have a probable or actual mental health problem. In the KCMHR qualitative study, short form mental health measures for depression (PHQ-2), anxiety (GAD-2), PTSD (PC-PTSD) and alcohol use (AUDIT-C) were used to identify those with a probable mental health problem and therefore those who might be likely to need mental health treatment. Hence on these short form measures alone, it is possible there were individuals in the interview group who would not have been a positive mental health case on longer measures, and may not have received a clinical diagnosis further on in their help-seeking pathway. These short form measures only give an indication of individuals who are likely candidates who should fill out the long form of the measure to assess a probable mental health problem. However as detailed in Appendix 6.1, the PHQ-2 using a score ≥ 3 has a sensitivity of 83% and a specificity of 92% for major depression (Kroenke et al., 2003), the GAD-2 had both high sensitivity and specificity for anxiety disorders (e.g. generalized anxiety disorder 86% sensitivity, 83% specificity) (Skapinakis, 2007), the PC-PTSD using a cut off of ≥ 3 yields a sensitivity of 78% and specificity of 87% (Bliese et al., 2008), and the AUDIT-C using a cut off ≥ 4 has a sensitivity of 86% of patients with heavy drinking and/or

²¹ To view the Government policy document, Reserves in the Future Force 2020 – please follow the link below: <https://www.gov.uk/government/consultations/future-reserves-2020-consultation>

active alcohol abuse or dependence with a specificity of 72% (Bush et al., 1998). Hence all of these measures are efficient at predicting those who would score as a case on longer measures and receive mental health diagnoses.

In the Combat Stress qualitative study, individuals' mental health 'caseness' was on the basis of a clinical diagnosis given to them by a mental healthcare professional/ psychologist/ psychiatrist. Lastly within my quantitative study, mental health caseness was determined by those who were case positive on the longer form mental health measures of, depression (PHQ-9), anxiety (GAD-7) and PTSD (PCL-5). Whilst these measures have been rigorously tested for their specificity and sensitivity as detailed in section 7.1 (3), Pg.217, again they indicate a probable diagnosis and not a clinical diagnosis. Hence it is again possible that individuals within the quantitative analysis that are in the positive mental health 'caseness' group, may not have gone on to receive a clinical diagnosis from a mental healthcare professional. With this in mind, it is useful to take these differences into account when comparing findings from the three studies. The KCMHR qualitative study and the quantitative study may overestimate the number of individuals that would have a mental health diagnosis and be in need of treatment. This in turn could affect their specific perceptions of barriers to care. Conversely, it is also important to note that individuals in all studies recognised that they were experiencing a mental health, stress/emotional or alcohol problem. Ultimately that recognition may be an important factor in creating groups of people who are alike in their perceptions, with which to be able to compare help-seeking experiences. Within the practical limits of many research studies that rely on self-report data, these mental health measures are the best tools the field has at present, baring clinical diagnoses, it is however pertinent to be mindful of how the differences of diagnosis across my studies could affect help-seeking data.

10.2 Mixed Methods Research

The use of mixed methods research strengthens the findings of this PhD, as I have been able to triangulate evidence from my qualitative, quantitative and meta-analyses. The first qualitative study was used to inform some of the measures utilised in the quantitative clinical interview study. Hence the questions asked of participants in the clinical interview study were as relevant as they could be, based on the qualitative investigation. Together, the use of qualitative and quantitative studies produced confirmatory analysis and creates confidence in results where findings support each other. Additionally, where findings do not support each other, mixed methods are adept in highlighting these divergences and allowing further discussion as to why certain differences may be present. Weaknesses include the fact that due to timing of the clinical interview study data collection, only my first qualitative study

findings were able to influence measures utilised in the clinical study. Hence possible interesting avenues that the Combat Stress interviews highlighted, could not be investigated quantitatively (such as specific negative attitudes or practical barriers, or analyses of time taken to seek help).

10.3 Systematic Review and Meta-Analysis

This is the first systematic review and meta-analysis of the military literature that I am aware of that produces an overview of stigma prevalence and investigates stigmas' relationship to mental health problems, its association with help-seeking intentions and service use.

Weaknesses of the review include the fact that not all data could be obtained from authors and therefore data that could have added to overall findings may have been missed.

Limitations in the literature meant that only a small number of studies assessed help-seeking by measuring service utilisation. This means there may be a deficit of evidence to be able to do a full assessment of the relationship of stigma with actual help-seeking, rather than propensity to seek help.

10.4 Qualitative Studies

10.4.1 Strengths

There are few qualitative studies produced within the military mental health help-seeking literature. These qualitative studies add evidence to the military literature overall, and present some of the first UK qualitative studies that investigate mental health and help-seeking in the UK Armed Forces. The semi-structured, participant led, in-depth interviews allowed for detailed exploration of issues that were relevant to participants and were not based on assumptions (as much as was possible) that I had made about their experiences of help-seeking. I believe this interview format allowed for a frank overview of the factors immediately relevant to military populations, and has been able to assess their help-seeking decisions in the current context of their lives and healthcare structures around them.

The use of in-depth interviews within a participatory framework is a strength. It has kept the research real with vivid examples. By working collaboratively with participants, it empowers them as the experts of their own experiences. This participant focus is therefore good in grounding research in practical policy implications and solutions, and creating the impetus for the research to have tangible impact.

The use of telephone interviews for the qualitative studies has also been a success. From additional data collected (not reported in this PhD), interviewees were asked about their

experience of being interviewed over the telephone. All reported that the telephone mode was practical and convenient; many said that the anonymity of the telephone reduced embarrassment whilst talking about sensitive subjects, so they were able to be more open. Lastly, where individuals acknowledged they preferred face to face interviews, they equally reported that the telephone mode was still a good way of conducting the interview and they were comfortable with the interaction. The type and depth of data gathered from my qualitative studies provides evidence that telephone interviews did not hamper the quality of data I was able to collect. Conversely there is evidence that the telephone mode has made the process more amenable for individuals who may have felt more embarrassed to disclose problems if I had been interviewing them face to face.

The use of qualitative interviews adds evidence of explanations and potential causes when considering help-seeking decisions that the quantitative study alone often could not access. For example, in quantitative studies, individuals are often classed as ‘help-seekers’ if at a minimum they have seen a doctor or their GP. My qualitative study with KCMHR help-seekers identified a poor quality of help-seeking. This qualitative information gives new perspective to the quantitative measurement of help-seeking and helps us to identify that not all help-seeking may be equal. In this way, I believe the qualitative studies have provided some interesting avenues for future quantitative work to explore.

Lastly the qualitative study interviewing Combat Stress help-seekers provides original evidence on the help-seeking pathways of this group who have not been studied before. It also provides insights into help-seeking occurring outside of mainstream NHS services, with individuals who have acute PTSD diagnoses and who have taken many years to seek help.

10.4.2 Limitations

A limitation of the qualitative studies is that data on help-seeking pathways, specifically for alcohol problems, was possibly not as distinct as it was for mental health problems. Only two interviewees in the KCMHR cohort interviews endorsed they were experiencing an alcohol problem. Whilst many other interviewees discussed their experiences with alcohol across all interview groups, these alcohol issues were intimately intertwined with their mental health problems and therefore it was difficult to assess differential help-seeking barriers concerning alcohol problems compared to mental health problems. The high comorbidity of alcohol problems with mental health problems, and specifically PTSD, in military samples (Brewin et al., 2012) makes eliciting data for alcohol problems alone, problematic. Help-seeking for alcohol problems is an area that future help-seeking studies could address to determine

whether there are differential barriers according to diagnosis type or whether issues of comorbidity share barriers relating to mental health problems.

A limitation of my KCMHR cohort help-seeking interview group, was that I was only able to recruit six participants. This was due to recruitment difficulty in finding eligible help-seekers. In an ideal world, I would have originally preferred 2-4 more participants to have taken part in these interviews. It was unexpected that it would be difficult to recruit help-seekers in the KCMHR study as I had assumed individuals who were not help-seeking might be less amenable to discuss help-seeking issues, however this was not the case. I believe the main issue of response and in particular of help-seekers, was primarily one of contact failure, rather than individuals actively choosing not to take part in the screening survey. The database I had to contact individuals only had 107/282 e-mail addresses available, and of these I received 63 bounce-backs from e-mails that were no longer in use. Therefore the primary vehicle I had left to contact individuals was through postal contact. I surmise that individuals who are asked to complete an online survey are less likely to do so, if they receive this request through the post, rather than have the e-mail drop into their email inbox, where they can more easily click on the link and complete a survey. Additionally there were also issues with contacting people through their postal addresses as I received 68 postal returns from individuals who were no longer at their address, the majority of these returns were from military addresses that were out-dated on our database. These issues of contact may have biased the sample to ex-Service personnel who had more permanent postal addresses compared to Service personnel. Indeed the two KCMHR studies recruited five Service personnel, compared to 10 ex-Service and one Reserve. This could possibly have affected the discussion of help-seeking barriers to more ex-Service issues, however it became prominent in most interviews that individuals discussed their help-seeking pathway across the spectrum of their military and ex-Service experience, therefore I do not feel this bias affected the help-seeking data untowardly.

The implications of not recruiting 10 help-seekers for the KCMHR group, may mean that I did not reach data saturation with this group and therefore there may have been additional themes uncovered from securing more interviews. At the time of analysis, I was however satisfied that data in the KCMHR help-seeking study did reach saturation point and ethically I did not believe it was appropriate to push for more interviews under the context that I believe saturation had been achieved. Lastly, the further help-seeking interviews with the Combat Stress group bolstered information available on help-seeking groups and therefore I was satisfied that the help-seeking data collected was robust and sufficient.

It is also useful to consider further biases in my qualitative studies as a result of recruitment. It is possible that individuals who want to take part in an interview are at a point where they are more pre-disposed to talk about their problems and may represent a different group to those who do not want to address their problems or discuss help-seeking issues. Therefore there may be a slight bias towards those who are more likely to seek help in the long run (even if they were a current non-help-seeker). This may in turn affect the barriers or facilitators of help-seeking that they discussed. Equally of those who did not participate in the interview, I was unable to assess whether they were different to the groups that did take part in the interviews. Lastly the Combat Stress help-seekers, may be different from other help-seekers in this study as the group as a majority are at the more acute end of the mental health diagnoses (the majority with a PTSD diagnosis) and have long help-seeking pathways. This may also affect the nature of the barriers they discussed and their help-seeking behaviours as the chronic nature of their mental health illness may affect their perception of barriers to care.

Broadly the qualitative studies have the limitations that are characteristic of all qualitative investigations. For example, the themes identified cannot be extrapolated as evidence of the validity of these themes to military population level, without using quantitative evidence in tandem. Equally, we are not able to positively confirm the themes that are relevant at a military population level stratified into different groups such as, Service personnel versus Reserves or ex-Service, or Army branch versus the Naval services. Lastly, there will always be some amount of interviewer influence over the nature of findings, for example, in setting the topic interview guide, taking part in the interview and in coding interview scripts. However, I believe I have been as transparent and reflective in my epistemology, methods and the practice of conducting my interviews.

10.5 Quantitative Study

10.5.1 Strengths

My quantitative study is one of the few military studies that measure the association of stigma and barriers to care with service utilisation. Many previous studies have only measured care seeking propensity or attitudes towards hypothetical help-seeking. Hence my study is able to connect attitudes and intentions to actual help-seeking action (or inaction) and therefore produce more robust results in terms of real help-seeking behaviour.

The quantitative study strength is found in the measures utilised. The use of the stigma and barriers to care measure, the PSBCPP-SS allowed the study to be able to compare its results to my previous meta-analysis. This allowed for comparisons with the pooled evidence (and

many other studies) and confirmation of much of the stigma prevalence evidence found in my systematic review. The addition of certain measures from the BACE, concerning barriers to seeking healthcare for mental health problems, has expanded the available evidence in the military literature on the barriers associated with help-seeking. The quantitative study is the first UK military study to measure self-stigma and provides compelling results with which to build further research in assessing the interaction of public/anticipated stigma and self-stigma, and its association with help-seeking.

10.5.2 Limitations

The quantitative study however has its limitations. It is a cross-sectional study and therefore can only assess help-seeking at this one point in time. Whilst I did not aim to assess help-seeking overtime in these studies, in relation to investigating help-seeking pathways and different or fluctuating barriers or facilitators experienced at different times, longitudinal studies might confer more benefits. Longitudinal studies would allow us to assess, for example, whether stigma is lower in those who have sought help because of treatment or whether it was low in the first place for these individuals. Additionally as the quantitative study is cross-sectional I can not be assured of the direction of causation. Whilst high anticipated public and self-stigma were associated with lower likelihood of help-seeking and so an assumption is made that higher public and self-stigma reduces help-seeking, it could also be possible that a lack of help-seeking causes increased stigma. Equally lower social support was associated with a lower likelihood of help-seeking – hence under cross-sectional analysis it is unclear whether lower social support causes reduced help-seeking or whether reduced help-seeking causes lower social support; in that individuals who are not help-seeking may have less encouragement and general support from professional sources to discuss their problem with others and have less coping tactics offered by professionals that may include reaching out to their social support networks. Hence with cross-sectional data, I can surmise the direction of causation from studies that have proceeded this work, but ultimately I must be tempered in my conclusions regarding the quantitative analysis.

In the clinical telephone interview, there is the problem of the reliability of data collected. Individuals may not have answered honestly due to social desirability of certain questions assessing stigma (Tourangeau and Yan, 2007) or if they did not believe the anonymity of the interview and wished to conceal the use of certain healthcare services. Equally, some participants may not have answered accurately, as in any self-report data collection, individuals may confuse what healthcare services they used or what services they are aware of. Whilst many measures were taken by interviewers in the telephone clinical interview study to address these types of issues (i.e. by ensuring anonymity and by using structured

prompt cards), it could mean that public or self-stigma and its association with help-seeking is underestimated, thereby underestimating the negative relationship between these variables.

The quantitative study could only investigate a set amount of measures. It did not investigate masculine norms, or the effect of this on help-seeking. This is an area where there is a gap in quantitative research that could usefully provide empirical evidence to build on much sociological and qualitative evidence already present in the literature. There is a need to explore the presence of these norms in military populations, their interaction with public and self-stigma and whether these norms affect help-seeking behaviours.

Overall I believe that despite certain limitations identified this PhD, it has been successful in producing original research, it has utilised empirical evidence and theory and set its findings and implications within social, political and policy contexts. I have been able to build upon literature in this field, and finally have proffered avenues for future research. These are discussed further in my implications and conclusions, Chapter 11.

Chapter 11 – Implications And Conclusions

11.1 Summary

Overall the aim of this research was to determine what the main barriers and facilitators of help-seeking were for individuals in the military with mental health problems. This research aimed to explicate the reasons why help-seeking is low in UK military populations (Iversen et al., 2011, Hines et al., 2014a). From this research it is apparent there are many, multifaceted, military influenced, barriers and facilitators of help-seeking that impact military personnel's decisions to seek help for a mental health problem. From my findings there are certain barriers and facilitators of help-seeking that could benefit from clinical and policy interventions, and certain findings that highlight the need for further research.

11.2 Conceptualisation of Help-Seeking and Help-Seeking Pathways

My qualitative research has implications for the way help-seeking research might conceptualise and measure help-seeking in future studies. In quantitative studies, the definition of a 'help-seeker' is restrictive, where individuals must identify whether they have sought help, with a list of services, within a timeframe, or whether they have not. This measurement of being a help-seeker, however, does not necessarily measure how successful help-seeking has been. For example, in many studies we do not know whether that individual engaged in services, were they referred? And are they currently receiving treatment? It is possible, much like the interviewees in my KCMHR help-seeking group, that many 'help-seekers' in these quantitative studies may be little different to non-help-seekers. Their help-seeking status (as quantitatively measured) may comprise of a single visit to the GP, where the specific mental health problem may not have been discussed.

This has implications for quantitative research as the level of help-seeking may be overestimated. I believe future quantitative studies would benefit from being able to identify non-help-seekers from informal help-seekers (using family and friends for support), and early help-seekers (those who have an initial engagement with formal/professional services but no further referral or treatment), from those who are engaged in help-seeking and receiving professional treatment. This therefore conceptualises help-seeking as a pathway, with non-help-seekers and help-seekers on a spectrum of help-seeking. Studies would then be able to pinpoint the specific barriers or facilitators of help-seeking that are relevant to different points in the help-seeking pathway. Equally this nuance is important because research should also be able to identify what moves someone from being an early help-seeker to being successfully engaged in treatment and what factors are associated with this.

There is more research needed on the role that informal help-seeking plays in help-seeking outcomes and its relationship with formal help-seeking (Brown et al., 2014) i.e. is informal help-seeking a facilitating step to formal help-seeking or does it delay formal help-seeking? Furthermore, do individuals fare better with engagement in treatment if they have also sought informal help? Overall this conceptualisation may have implications for clinicians and policy makers. Knowledge of these pathways may change expectations of help-seeking so that an individual seeking help with a GP/Medical Officer is only envisaged as a first step, that may require additional help-seeking steps, for that help-seeking behaviour to have a successful outcome.

I believe this research has highlighted, on a qualitative level, that there may be different barriers to help-seeking that are more prescient at different points in the help-seeking pathway. Social and psychological barriers (such as public and self-stigma and attitudes towards mental health treatment) appear relevant all along the help-seeking pathway, however some of these barriers may diminish once individuals are engaged in treatment. Practical barriers may be increasingly prominent to more engaged help-seekers who are negotiating healthcare services and experiencing the realities of the healthcare services available. Future research that assesses longitudinal help-seeking could help to explicate whether there are certain barriers or facilitators of help-seeking that are more important at different stages of a help-seeking pathway.

In terms of clinical and policy implications, simply assessing a single type of barrier to be the most crucial (for example public/anticipated stigma) and focusing interventions on that area, may concurrently neglect the types of barriers that individuals might face at different points in their pathway. Equally only addressing practical barriers, for example, by increasing the availability and access to services, may not address the social or psychological reasons, which determine the initial stages of help-seeking. This research provides preliminary evidence that a multi-pronged approach may be needed to address a mixture of barriers and facilitators to support all points of the help-seeking pathway.

11.3 Stigma

Anticipated public stigma and self-stigma have both been found to be prominent barriers to help-seeking in this study. Further research is recommended to analyse why the prevalence of anticipated public stigma might be higher in UK military populations compared with levels found in US military populations. Further research is required in military populations to understand the complex mechanisms of public/anticipated stigma and self-stigma in relation to help-seeking. Public/anticipated stigma perceptions may determine both the level

of self-stigma and directly impact help-seeking, therefore, tackling public/anticipated stigma should have a positive effect on help-seeking outcomes through both these pathways. At a military population level, there is a need to positively impact perceptions and stereotypes of people living with mental health conditions. A recent qualitative study of UK Army Medical and Unit Welfare Officer's perceptions of mental health stigma, found that there was desire to have more interaction with soldiers who had good experiences of seeking help, to combat stigmatising stereotypes (Keeling, 2015 under review). Focus groups with US Army personnel showed that personal testimonies of those who had successful treatment and sharing success stories was one of the most effective methods for decreasing stigma and encouraging help seeking (Clark-Hitt et al., 2012). For help-seekers there seems to be evidence that addressing self-stigma through psycho-education and self-confidence/esteem building work, will not only reduce their self-stigma but also increase their adherence to treatment (Mittal et al., 2012, Britt et al., 2015).

There is a need for the MOD to reappraise the methods they use to address stigma. Endorsement of concerns about anticipated public stigma are high, particularly in those with a probable mental health condition. The success of the MOD stigma campaign, 'Don't Bottle It Up'²², was not formally assessed and it is therefore difficult to say whether it had an impact on changing public stigma in the military. Additionally, ex-Service personnel have had no such campaign directed towards them. Whilst some ex-Service personnel may have benefited from the Time To Change²³ campaign targeted at the UK general population, there could be an argument that a specific campaign should be directed towards the UK ex-Service population. This is particularly pertinent as the military population in general are more likely to endorse stigma at higher levels than those in the general population (Clement et al., 2014). It may be advisable that the MOD and the DH Armed Forces Policy Team work with and learn from the successful anti-stigma campaign, 'Time to Change', in assessing what tactics have worked in the UK general population (Evans-Lacko et al., 2014). It is unclear currently what interventions in military populations might be successful in changing public stigma and negative attitudes, as previous randomised controlled trials aimed at targeting stigma and negative attitudes found no positive effects in changing these viewpoints (Greenberg et al., 2010, Mulligan et al., 2012).

Of note are the concerns individual's had about their careers and having a mental health problem recorded on their medical records. There is a need for the MOD to be transparent on

²² For an overview of the campaign please follow this link to the British Army Website <http://www.army.mod.uk/welfare-support/23386.aspx>

²³ For information on the campaign please see the Time to Change Website <http://www.time-to-change.org.uk>

the potential effect of seeking help for a mental health problem on someone's career. Whilst UK military research identified there was a significant minority of individuals who experienced the negative effects of seeking help for mental health problems on their career (Jones, 2015 under review), US military research also highlighted that those who sought help early, had far better employment outcomes (Rowan et al., 2014). As part of MOD anti-stigma messages it should be publicised that *not* seeking help, could be a far greater risk to an individual's career.

In terms of medical records and confidentiality, if the stigma of mental health problems can be addressed, the concurrent stigma of having a mental health problem on medical records should reduce. Ultimately however, the MOD will always be Service personnel's employer and healthcare provider. The Armed Forces is a safety critical industry and relies on knowledge that their units are fit for purpose and deployable. I think where work could more easily be done is to address attitudes the Armed Forces have towards their medical records once they leave Service and their rights in terms of employment if they have a mental health problem. There should be education promoted such that ex-Service personnel understand their medical records in civilian life belong to them and are confidential under the Data Protection Act (1998) and Human Rights Act (1998). Individuals should also be made aware of their civilian employment rights if they have a mental health problem under the Equality Act (2010), and equally directed to resources of support such as those found on the Time to Change or MIND²⁴ websites.

I believe my research has highlighted specific research methodological questions in terms of the use of different stigma measures and gaps in our current knowledge on stigma. There is a need to assess the use of the PSBCPP-SS (Hoge et al., 2004, Britt, 2000, Britt et al., 2008) and determine how it aligns with other anticipated public stigma measures used in military and general population research. This would help to clarify the utility of this measure for current military populations. Finally, few military studies have measured self-stigma; this is a distinct deficit in the literature. Future research should include self-stigma measures to address the spectrum of stigma relationships that may affect help-seeking.

11.4 Preference for Self-Management of Problems

The specific presence of the desire to self-manage or to solve problems alone was detrimental to help-seeking and has been replicated in several military and general

²⁴ Employment rights support for those with mental health problems <http://www.time-to-change.org.uk/your-organisation/support-workplace/where-do-i-stand-legally>

population studies as a barrier to help-seeking (Iversen et al., 2005, Mojtabai et al., 2011, Britt et al., 2012, Momen et al., 2012, Jones et al., 2013, Adler et al., 2015).

The preference for self-management or self-sufficiency in solving problems must be an attitude the MOD seeks to address - that whilst military training enables one to solve problems, the script of teamwork and support should be emphasised. For example, that just as a soldier can not conduct a mission alone, an individual should not have to cope alone, and deserves the support of their unit to be able to take steps to seek help. In this way there may be utility in teaching problem focused coping techniques as part of resilience training in Service, to reframe military personnel's response to stress and emotional problems.

There is evidence from this study (and other studies) that positive help-seeking behaviours are related to problem focused coping strategies (Carver et al., 1989, Oliffe et al., 2012). Problem focused coping strategies encourage behaviours that focus on practical solutions and utilising social support. Military personnel who saw help-seeking to be a positive practical step to address a problem, often overcame the social and psychological barriers they had. If this coping strategy could be linked with resilience training and self-care within the Armed Forces, it could help to change military personnel's attitudes towards self-management and encourage help-seeking behaviours.

Self-management of problems was intertwined with masculine norms in my qualitative study. As masculine norms are highly engrained in the culture of the UK military, from an intervention perspective, there may be value in utilising these masculine norms to positive effect to benefit help-seeking. This has been suggested by Zinzow et al. (2013) work in US military populations that recommended the need to reframe beliefs associating help-seeking with weakness, and associate them with courage. Hence when the MOD addresses the military population about mental health and help-seeking, there may be value in using language that promotes the 'bravery' or 'courage' or 'practicality' in seeking help as a constructive method to solve a problem. By default phrases could be avoided that denote negative connotations such as, 'it's not weak to seek help' or 'people won't think less of you'.

In terms of research implications, UK military research has not quantitatively measured the association of masculine norms and help-seeking, hence I believe this is an area that deserves exploration. In future quantitative work, it will be important to assess the specific mechanisms and relationships that masculine norms have with other factors involved in the help-seeking pathway, such as public and self-stigma, and attitudes towards mental health

care. This will help us to understand the causal mechanisms through which these norms operate, in order to discern what types of interventions are best placed to improve help-seeking outcomes.

11.5 Social Support

Poor social support was a distinct barrier affecting participants' propensity to seek help, whilst supportive social networks enabled a help-seeking environment. The operational requirements of Service and military life exact pressure upon supportive social relationships. Whilst it is difficult to see operational structures and demands changing of the Armed Forces, there must be a duty of care, acknowledged by the MOD, that there may be pressure points where individuals are more vulnerable. These might include times such as after deployment or after promotions, where individuals are without their usual networks of social support. Certain support structures already in place, such as TRiM practitioners²⁵, play a positive role in providing peer support and identifying possible mental health problems, however this training should also be given to Commanding Officers who are equally responsible for military personnel's welfare.

When individuals leave Service their social support may be limited. One attempt to engage personnel after leaving Service is the Veteran Information Service. This service sends out signposting information on support and welfare services to ex-Service personnel, 12 months after leaving Service. It is currently unknown whether this service will have an effect on help-seeking outcomes. It may be here, that Service charities focus their efforts on engaging with younger Service personnel. Whilst the Royal British Legion is known for its principles of comradeship and social opportunities offered to its members, the general profile of ex-Service population is an ageing one (over 64% are over 65 years old – Royal British Legion Household Survey 2014), and it apparent that many younger generations are not aware of the Royal British Legion (Gribble et al., 2014). Hence there may be a need for Service charities to assess how they can engage with young service personnel, so social opportunities are increased and knowledge of support services are therefore known by default in these younger communities.

There is equally a need to educate and to support military families (including ex-Service families). Families were key in encouraging individuals to seek help and providing continued support that enabled several help-seeking attempts when initial routes failed. If families have

²⁵ TRiM-trained personnel undergo specific training in the management of people after traumatic incidents. Those who are identified as being at risk after an event are invited to take part in an informal interview which establishes how they are coping. For an overview of TRiM's use in the UK Armed Forces please see: Greenberg et al. 2008.

better awareness of mental health problems and have knowledge of support services, military personnel will be more likely to make positive help-seeking steps. There is a program in the UK called Mental Health First Aid England²⁶. They have a small program that specifically provides training to UK Armed Forces families and individuals working with the Armed Forces to recognise the signs and symptoms of mental ill health and understand how to signpost Armed Forces individuals to appropriate support services. Whilst this specific training has not been assessed in terms of its impact on help-seeking outcomes, the overall programme has been evidenced to improve mental health literacy, improve attitudes towards mental health treatment and decrease stigma (Kitchener and Jorm, 2006, Hadlaczky et al., 2014). This program if implemented on a wider basis could have positive impacts on the attitudes and knowledge within social networks and enable more situations where military personnel are encouraged to seek help by their families.

11.6 Awareness of Healthcare Services

It is disappointing that Service personnel and ex-Service personnel are not aware of many healthcare or support services that are available to them (or would be available to them on leaving Service). The least well-known services were the Veterans UK Helpline, The NHS Veterans Service, The Veterans and Reserves Mental Health Programme and the Big White Wall. These services have the potential to provide signposting, support and treatment services for the military population. A large proportion of Service personnel and the majority of ex-Service personnel were not aware of these veteran services. It is a failing of Government policy to implement these services but not fully address publicising these services to the relevant populations. These services in turn may not have an accurate measure of need in their community. In future Government planning, there must be budget assigned to publicising and improving awareness of these services, so individuals have a chance to assess the options of support that may have available to them. It is however good news for Combat Stress that a large majority in the study were aware of them and two-thirds of those aware of them were willing to use their service.

11.7 Attitudes Towards Mental Health Care

Participants had a distinct lack of confidence in the MOD and the NHS. This was both in the MOD and NHS' attitudes towards mental health and their ability to treat mental health problems. These attitudes present challenges for the MOD and NHS to tackle. Individuals in Service must believe the MOD is serious about supporting those with mental health

²⁶ Mental Health First Aid England website: <http://mhfaengland.org>

problems and ex-Service personnel must believe the NHS can treat their mental health problems.

In terms of military personnel's confidence in the NHS, the policies pursued by the Government and Department of Health over the last five years, in relation to ex-Service personnel's health provision on the NHS, has promoted two different and opposing programmes of development. On one hand within the NHS, there is no desire to provide separate healthcare provision to ex-Service personnel. The NHS Constitution must provide fair and equal access to healthcare for all UK citizens. However provisions following the Murrison report (please see Appendix 2) have created ex-Service badged NHS services that provide access points into mental health care for ex-Service personnel. Whilst this does not go against the NHS constitution, as it recognises an inequality of access, the military and general population see an ex-Service specific service, and this could reduce confidence in general NHS services, as individuals may think that the treatment service is somehow different to normal NHS services.

Additionally within National Specialist Commissioning, Combat Stress was commissioned to provide a specialist PTSD treatment service for the NHS. This treatment service is the treatment that the majority of Combat Stress participants experienced. Combat Stress participants did not assess this service to be NHS associated and many believed that this was the only treatment service that could address the needs of a PTSD diagnosis for military individuals. It is possible these separate services focused on ex-Service personnel and military mental health create the idea of 'Combat PTSD'. Whilst the treatment provided at Combat Stress is more intensive than the NHS and provides a military context to treatment, it does however follow NICE approved guidelines and may be similar to treatment offered for PTSD elsewhere in the NHS. The view therefore, that PTSD caused by combat is different to other PTSD and needs specific treatment, may concurrently reduce confidence in NHS services. It may also discourage individuals from seeking help within the NHS for any mental health problem where there are not specific ex-Service badged services.

In terms of research implications, these specific negative attitudes found in my qualitative studies, should be investigated quantitatively to assess whether these views are prevalent and related to help-seeking outcomes. The UK specific healthcare provision for the Armed Forces is quite different from other international military healthcare systems that have separate healthcare systems for veterans (like the United States) or insurance systems (like the Australian Defence Forces). Ex-Service personnel and Reserves access the NHS after they have left Service or when demobilised. Therefore it makes sense that barriers to care

and those surrounding the healthcare system will be specific to the healthcare system in question. Hence, specific UK research should be conducted on attitudes towards the NHS comparing military populations to the UK general population to assess whether these attitudes are different, and whether they have the potential to act as additional barriers to care for military populations.

11.8 Final Conclusions

If we are able to alleviate certain barriers and encourage certain facilitators, we may be able to increase the number of people that recognise the point at which professional help is appropriate. This would encourage earlier help-seeking that could help to avert poor outcomes associated with seeking help at crisis points. Whilst I have not investigated engagement with treatment specifically, this research highlights the future importance of defining and measuring what successful help-seeking looks like to engender policy interventions that promote more meaningful help-seeking outcomes.

Overall I can concur with previous findings, that barriers and facilitators of help-seeking were influenced by the context of military life and culture (Iversen et al., 2005, Langston et al., 2007). Anticipated public stigma is prevalent in the UK military population and is a prominent barrier associated with help-seeking (Iversen et al., 2011, Jones et al., 2013). I can additionally build on these findings and suggest that self-stigma, the preference for self-management of problems, and poor social support are also barriers to seeking help. I can additionally conclude that supportive social networks are potentially an influential factor in positive help-seeking behaviours. Lastly this work has presented preliminary findings on the possible stages of help-seeking and barriers that may be relevant at different stages of a help-seeking pathway.

11.9 Clinical/Policy Recommendations

1. Multi-pronged approach is advisable to address a mixture of barriers and facilitators and support all aspects of the help-seeking pathway.
2. Implement new/revised anti-stigma programs that measure outcomes, based on successful anti-stigma campaigns to tackle negative stereotypes and public stigma in military populations.
3. Address the preference for self-management of problems in Service by education and use of inverted masculine norms.

4. Extension of mental health support in Service, including mental health education and practical signposting information offered to Commanding Officers and military families (including ex-Service families).
5. Extension of Service charities engagement with young military populations (Service and ex-Service) offering opportunities for social engagement and comradeship.
6. Budget allocated to publicising mental healthcare services for Service personnel, Reserves and ex-Service personnel.
7. DH and Combat Stress policy appraisal of the way ex-Service mental health services are integrated in the NHS and how this affects confidence in NHS services.

11.10 Research Recommendations

1. Quantitative development and use of more sensitive measures of help-seeking that can delineate non-help-seekers, informal help-seekers, early help-seekers and engaged help-seekers and investigate relationships between these types of help-seeking.
2. Longitudinal studies in military populations that assess barriers and facilitators of help-seeking.
3. Examination of the factors why there might be differential levels of anticipated public stigma in UK compared to US military populations.
4. Increased research in military populations on the relationship of public/anticipated stigma and self-stigma with help-seeking.
5. Assessment of alignment of the PSBCPP-SS scale with other anticipated public stigma scales.
6. Research that measures masculine norms in UK military and effect on help-seeking.
7. Investigation into specific UK military negative attitudes towards mental health treatment.
8. Examination of Reserves and female personnel specific help-seeking pathways.
9. Qualitative analysis of barriers and facilitators of help-seeking for alcohol problems.

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Appendices

Appendix 1

**Stigma as a Barrier to Seeking Health Care Among Military Personnel
With Mental Health Problems (Sharp et. al, 2015)**

Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problems

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Approximately 60% of military personnel who experience mental health problems do not seek help, yet many of them could benefit from professional treatment. Across military studies, one of the most frequently reported barriers to help-seeking for mental health problems is concerns about stigma. It is, however, less clear how stigma influences mental health service utilization. This review will synthesize existing research on stigma, focusing on those in the military with mental health problems. We conducted a systematic review and meta-analysis of studies between 2001 and 2014 to examine the prevalence of stigma for seeking help for a mental health problem and its association with help-seeking intentions/mental health service utilization. Twenty papers met the search criteria. Weighted prevalence estimates for the 2 most endorsed stigma concerns were 44.2% (95% confidence interval: 37.1, 51.4) for "My unit leadership might treat me differently" and 42.9% (95% confidence interval: 36.8, 49.0) for "I would be seen as weak." Nine studies found no association between anticipated stigma and help-seeking intentions/mental health service use and 4 studies found a positive association. One study found a negative association between self-stigma and intentions to seek help. Counterintuitively, those that endorsed high anticipated stigma still utilized mental health services or were interested in seeking help. We propose that these findings may be related to intention-behavior gaps or methodological issues in the measurement of stigma. Positive associations may be influenced by modified labeling theory. Additionally, other factors such as self-stigma and negative attitudes toward mental health care may be worth further attention in future investigation.

barriers to care; health care; help-seeking; mental health; military; service utilization; stigma; veterans

Abbreviations: AOR, adjusted odds ratio; CI, confidence interval; PSBCCP-SS, Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale; PTSD, post-traumatic stress disorder.

INTRODUCTION

The mental health needs of serving and veteran/former service personnel have been the focus of current research since the recent military deployments of troops to Iraq and Afghanistan (1–4). Numerous studies have shown that the prevalence of any mental health disorders, including post-traumatic stress disorder (PTSD) and alcohol disorders in United Kingdom, United States, and Canadian military personnel, is approximately 37%, 43%, and 15%, respectively (2, 5–9). Across all nations, a large proportion of military personnel who experience mental health problems do not seek help (1, 9–13). Typically 40%–60% of those who could benefit from professional treatment do not access help or

services (1, 14, 15). Of those that do access help in the United Kingdom, most help sought is from nonmedical/informal sources (13, 16). There are also concerns, especially in the United States, that up to 60%–70% of veterans with a mental health diagnosis do not receive adequate treatment (8 or more sessions) within a year of their diagnosis (17, 18). As a result of these findings, there has been much research examining barriers that impede help-seeking behavior and engagement with treatment, which has aimed to understand the substantial unmet need of mental health care in military populations.

Contemporary studies have identified many different barriers to help-seeking in military populations, including stigma (14, 19–21), practical/logistic barriers to care (14, 22), negative attitudes related to mental health treatment (23, 24), and

poor recognition of the need for treatment (21, 25). However, a large proportion of this research has primarily examined the impact of stigma on help-seeking behaviors and the role that it plays in decisions to seek help (10, 14, 18–21, 23, 24, 26–32).

Stigma is a complex and contested construct with many theoretical facets. Although there are competing definitions, we describe some of the most relevant and most often used terms below. Stigma is often conceptualized as a belief relating to an “attribute that is deeply discrediting,” that reduces the target, whether it be the self or other, “from a whole and usual person to a tainted, discounted one” (33, p. 265). Theoretically stigma can occur at individual, interpersonal (interactions among dyads or groups), and sociocultural levels (across societies or cultures) (34). Stigma that occurs at the sociocultural and interpersonal levels has often been termed *public stigma* or *enacted stigma*. The process of stigmatization follows when groups with power stereotype hold prejudice and discriminate against a group that has been labeled as separate or different (35–37). This stigmatization is related to shared cultural beliefs held by the general public or, in this case, the military organization about the attributes of those with mental illness that can lead to explicit acts of discrimination and hostility resulting in enacted stigma (38). At the individual level, a facet of stigma has been described as *felt normative stigma*, which is the individual’s belief about the prevalence of stigmatizing views among people in their community (38). Additionally, *anticipated stigma* has been termed the extent to which people believe they personally will be viewed or treated in a stigmatizing way if their mental health problem or related help-seeking becomes known (39, 40). *Internalized stigma* for an individual, not in a stigmatized group, results in prejudice toward the stigmatized or *stigma endorsement* (38, 41). However, *self-stigma* reflects a stigmatized individual’s internalization of actual or perceived negative societal beliefs toward those who have mental health problems. Self-stigmatization can lead to feelings of shame and inadequacy, which may affect an individual’s self-worth and confidence to seek help (42, 43). Stigma types at all of these levels interact with each other and can act as barriers to help-seeking (34, 44).

Military organizations may engender certain stigmatizing beliefs in relation to help-seeking for mental health problems that may also persist into civilian life (27, 45, 46). These beliefs may be related to military culture, rules, and conduct learned and experienced in service. For example, the value placed on the actions of the group to achieve military objectives above all else, the cultures of reliance upon each other, masculinity, self-sufficiency, and the stigmas of going sick or shirking work have been noted to affect help-seeking behaviors (11, 20, 47). The requirement for operational readiness through good health conflicts with the direct availability of mental health care provided by the military for service personnel. In this sense, personnel are faced with a choice between disclosure of health problems in order to access care and the potential negative effect upon their operational effectiveness and, thus, their careers. Hence, military objectives, health care, structures, and cultures may interact to create barriers to seeking help for mental health problems, and personnel may therefore elect not to disclose mental health problems (27, 48).

Across the literature when considering mental health help-seeking from formal/professional or medical sources, stigmatizing beliefs are reported at consistently greater levels than practical or logistical barriers to care, irrespective of whether personnel are full-time regular military, reserves, or veterans/former service members (1, 14, 19, 39, 49). Research has also consistently found that personnel reporting more mental health symptoms perceive greater levels of stigma and barriers to care than those with subthreshold symptoms (1, 14, 23, 49–52).

The aims of this review were to address the following:

- What types of stigma have been explored in military studies that examine medical/formal help-seeking behaviors for those with mental health problems?
- What is the prevalence of stigma measured in military populations of those experiencing mental health problems?
- What is the direction and strength of association between stigma and medical/formal help-seeking intentions and mental health service use among those with mental health problems?

This review is important as there is a need to systematically assess and collate the available evidence about stigma and its relationship with medical/formal help-seeking and mental health service use in military populations with mental health problems. We are not aware of any review that has previously brought this literature together. There is a need to review the methods, methodologies, and research designs used in the military studies in this research area to allow an assessment of the robustness and quality of results in this field of research.

This review focuses on those in military populations who have probable mental health problems as they are the group most in need of mental health care. Their help-seeking behaviors are important to understand in terms of their need to access mental health care and the associated evidence that they experience a higher stigma prevalence compared with healthy military populations (1, 14, 23, 49–52). Questions regarding (hypothetical) help-seeking will also be more salient for individuals with a mental health problem than for those without. This review focuses upon medical or formal help-seeking rather than support from family and friends or welfare officers/chaplains/charities with no associated medical/formal input. This is to assess access to medical/formal services for those who are unwell who could most benefit from that access. Additionally, this review focuses on recent military populations, primarily those who have been active during the Afghanistan and Iraq conflicts, from 2001 onward. By conflating international stigma data from these groups who may be negotiating present-day health-care systems, we believe that it may be possible to assess the most relevant contemporary military mental health-care barriers.

METHODS

Search strategy

The literature search was conducted in February 2014. Relevant studies published since 2001 in peer-reviewed journals were identified through electronic searches on MEDLINE, PsycINFO, Embase, Web of Science, and Scopus databases.

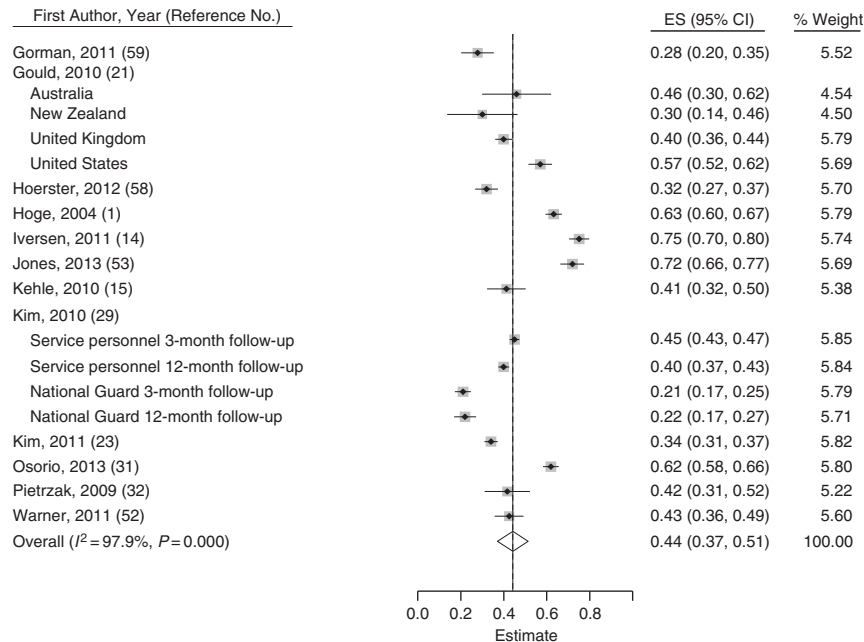


Figure 1. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), "My unit leadership might treat me differently," across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

Key search terms were combined with Boolean operators. These included the following:

1. "mental health" OR "mental illness" OR "mental disorder" OR "psychological distress" OR "common mental health disorders" OR "anxiety" OR "stress disorders" OR "acute stress" OR "posttraumatic stress disorder" OR "PTSD" OR "depression" OR "alcohol" OR "substance misuse" OR "substance abuse," combined with
2. "help-seeking" OR "help-seeking behaviour" OR "help-seeking attitudes" OR "help-seeking intentions" OR "barriers to healthcare" OR "healthcare seeking" OR "treatment seeking" OR "healthcare utilisation" OR "healthcare utilization" OR "service utilisation" OR "service utilization," combined with
3. "stigma" OR "self-stigma," combined with
4. "military personnel" OR "military" OR "service personnel" OR "armed forces" OR "armed services" OR "veterans" OR "ex-service personnel" OR "reserves" OR "national guard" OR "navy" OR "marines" OR "air force" OR "soldiers," using the AND operator.

Duplicate papers were removed, and the reference lists of all eligible studies were checked for additional studies. Disserta-

tion abstracts were reviewed to check whether the authors' work had been published in peer-reviewed journals. Authors were also asked to view the reference list and indicate any other possible missing studies.

After full-text articles were accessed to assess eligibility, authors of any studies that were deemed eligible but did not report the relevant data were followed up. Additional data were received from Iversen et al. (14), Jones et al. (53), Kehle et al. (15), Osório et al. (49), and Pietrzak et al. (32).

Inclusion criteria

1. Studies using quantitative methodologies.
2. All studies published in peer-reviewed journals.
3. Populations including international military populations (regular military, reserves (or international equivalents), National Guard, and veteran/former service personnel).
4. Recent military populations studied since 2001.
5. Studies that measured mental health; this included common mental health disorders (depression and anxiety disorders), PTSD, and alcohol problems (hazardous drinking, misuse, abuse, dependence).

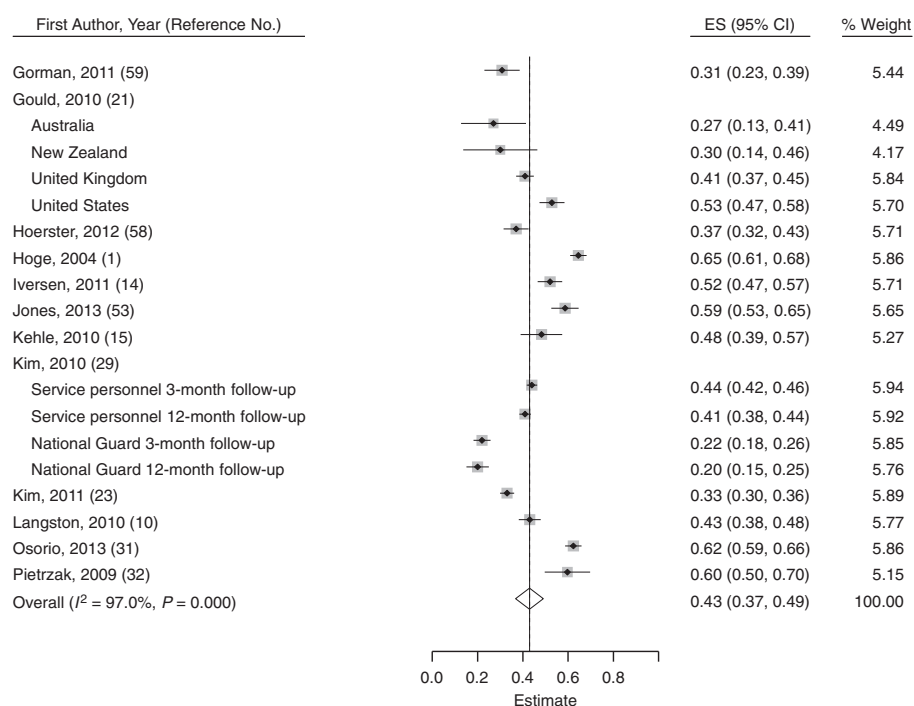


Figure 2. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBPCP-SS), "I would be seen as weak," across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

6. Studies that measured the association between stigma and medical/formal help-seeking for those in the military experiencing mental health problems. This included attitudes/intentions to seek medical/formal help and actual mental health service use. *Medical/formal help-seeking* was defined as medical/formal help-seeking for mental health problems resulting in service use (in-service and ex-service mental health services) such as primary care, secondary mental health services, psychotherapy, psychologist, psychiatrist, and counseling.
7. Studies that used stigma as measured on a scale or subscale utilizing established and/or validated measures of stigma.
2. Measured help-seeking intentions or service use but did not measure stigma.
3. Measured stigma and help-seeking intentions but did not stratify their sample by mental health status or control for mental health status in statistical models (unless data could be obtained from authors).
4. Where prevalence of stigma OR association of stigma and help-seeking intentions/service use was not reported and data could not be obtained from the authors.

Data extraction and analysis

Data extraction was conducted by one researcher (M. L. S.). Data from 20 papers were extracted, which included information on author, title and date of publication, overall sample size, sample size of those with mental health problems, country the study originated from, study design, sample selection criteria, and service status (i.e., regular military, reserves, National Guard, veteran/former service personnel), when data were gathered in relation to deployment, empirical

Exclusion criteria

Papers were excluded that

1. Addressed stigma as a help-seeking barrier in other populations such as the general population, nonmilitary occupational studies, military contractors, military spouses, prisoners, and homeless individuals.

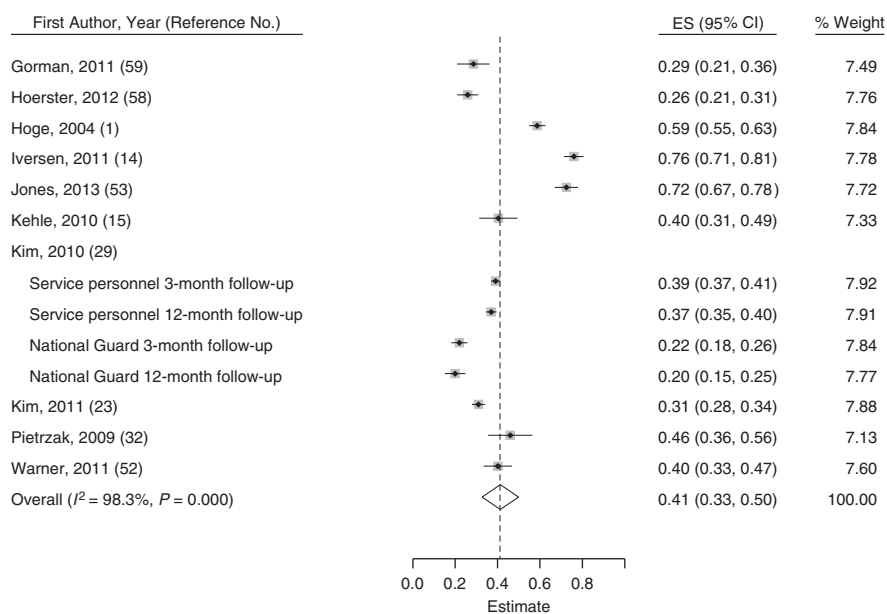


Figure 3. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), "Members of my unit might have less confidence in me," across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

measurement of stigma including associated stem questions and Likert scale treatment, internal reliability of stigma scale used (Cronbach's α scores), and key variables measured (Web Table 1 available at <http://aje.oxfordjournals.org/>).

Data were also extracted including information on the prevalence of stigma items of those with mental health problems (Web Table 2). The numerator (the number of individuals endorsing stigma items) and the denominator (the sample size or number of participants who had mental health problems and responded to the item) were entered into the review database. Studies did not, however, consistently report numerators, denominators, or prevalence; hence, these data were calculated from available data in the paper, or additional data were obtained from the authors.

Prevalence expressed as the percentage of endorsed stigma items, standard errors, and 95% confidence intervals were calculated for meta-analyses to produce weighted averages for the 6 most common stigma items measured in samples across the 20 studies. Stata statistical software, Release 11 (StataCorp LP, College Station, Texas), was used for the meta-analyses.

1. The metan command was used to produce forest plots (Figures 1–6), displaying the prevalence of endorsed stigma items, 95% confidence intervals, and weights for each sample, as well as the overall weighted average and 95% confidence interval.

2. Fixed-effects models were initially run for each stigma item; however, random-effects models were then fitted to account for high heterogeneity among study samples after assessment of I^2 , which is an estimate of the variability in results across studies that can be attributed to heterogeneity as opposed to chance (54). Heterogeneity measured through I^2 ranges from 0% to 100% and benchmarks high heterogeneity at greater than 50%.
3. Meta-analyses for each stigma item were stratified by the country (United States and United Kingdom) to assess sources of heterogeneity further.

Additional data were also extracted from papers on measures of association between stigma scores and help-seeking intentions/mental health service utilization including other key findings of note (Tables 1 and 2).

Quality analysis

The review assessed the quality of the eligible papers utilizing the following guideline question areas: method of sample recruitment/selection, response rates, clarity of aims, appropriateness of design to stated objectives, sample size justification, measurement validity and reliability, adequate description of statistical methods, adequate description of

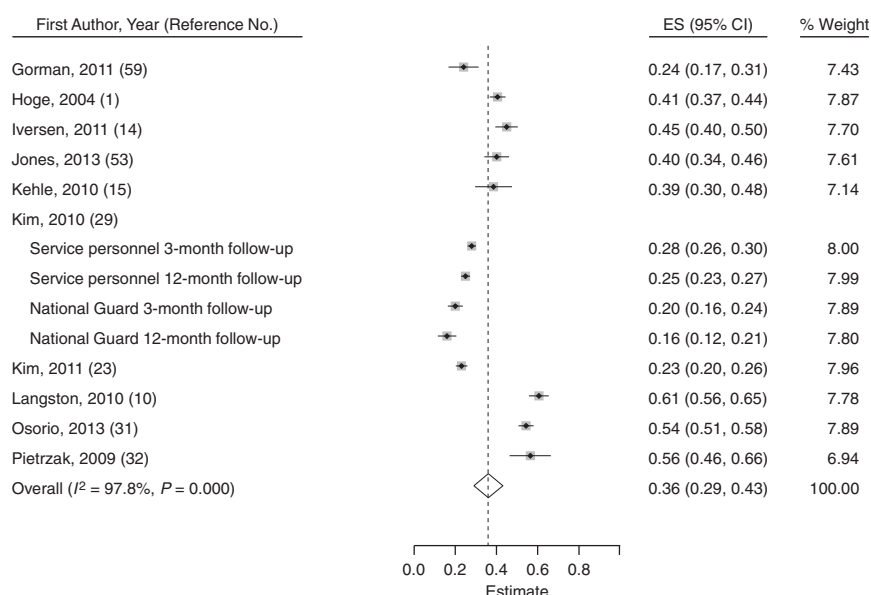


Figure 4. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), "It would be too embarrassing," across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

basic data, assessment of statistical significance, serendipitous findings, adequate discussion of main findings, selection basis, interpretation of null findings, reporting of all important results, generalization of results, comparison with results to previous literature, and implications of the study for policy and practice (55). Issues of quality are noted in the study characteristics (Web Table 1) and commented upon in the Discussion.

RESULTS

Study selection

Initial searches returned 191 abstracts that met the initial search criteria (Figure 7). Of these, 114 duplicates were removed, leaving 77 abstracts. Forty-three abstracts were excluded that did not meet the inclusion criteria.

Thirty-four articles remained after the inclusion criteria were applied. The 34 full-text articles were then accessed for eligibility, and 19 articles were removed.

Fifteen papers were eligible for inclusion. After reviewing the references of the 15 eligible papers and sharing the list with other authors (N. F., L. G.), we identified a further 9 papers. After review of the full-text articles of the additional papers, 6 extra papers were considered eligible for inclusion into the study, the other 3 additional studies were excluded,

and 1 further paper (56) was removed as it originated from the same data set as a newly included paper that had a larger study sample (15).

Overview of studies

Twenty papers met the review inclusion criteria. Eighteen of the 20 studies were cross-sectional, and 2 papers used a prospective design (57, 58). Out of the 20 eligible papers, those by Ouimette et al. (51) and Rosen et al. (18) utilized the same data set, but the former reports on stigma prevalence and the latter on the association of stigma with mental health service use. Similarly, Hoge et al. (1) and Brown et al. (22) used data sets that overlapped, but the former reports on stigma prevalence and the latter on the association of stigma and help-seeking intention.

The studies were carried out among the military populations of the United States ($n = 14$), United Kingdom ($n = 4$), and Canada ($n = 1$). One paper additionally assessed the militaries from the United Kingdom, the United States, Australia, and New Zealand in a comparative study. Five papers assessed samples in which all participants had probable mental health diagnoses, and 15 studies assessed broader samples including those with and without probable mental health problems. The largest study sample size of those with mental health problems was 2,520; the smallest was 30. In 1 paper, the

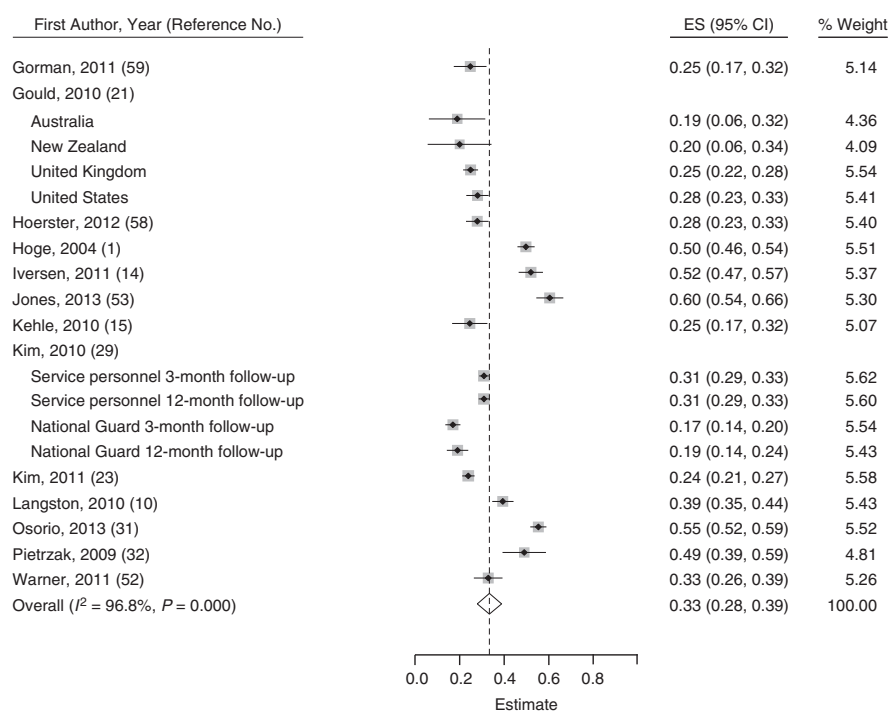


Figure 5. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), "It would harm my career," across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

sample size of those with mental health problems was not reported (4). Seven papers researched current service personnel/active-duty soldiers, 5 papers researched veteran/former service personnel, 3 papers reported on the National Guard, and 5 papers researched a mixture of service personnel, National Guard/reserves, and veteran/former service personnel. All papers contained research participants who were deployed to recent Iraq or Afghanistan conflicts, except 3 papers that also included as part of their sample those deployed to Timor Leste (New Zealand participants (21)) and veterans of the Vietnam era (18, 51).

Measurement of stigma

The majority of papers ($n = 18$) assessed anticipated stigma by using a core 6-item stigma subscale measuring anticipated stigma and its effect on decisions to seek treatment for psychological problems in military populations (Web Table 1). This was achieved through the use of the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), developed by Hoge et al.

(1), Britt et al. (19), and Britt (39). Of these 18 papers, 7 added additional items to the scale (15, 22–24, 53, 59), and 5 of these papers selected and measured fewer items than the core measure (10, 21, 49, 52, 58). Blais and Renshaw (4) added "Perceptions of Stigmatization by Others for Seeking Psychological Help" (60) and "Self-Stigma Associated with Seeking Psychological Help" (43) in addition to the core measure of PSBCPP-SS. Jones et al. (53) also added items from the "Reported and Intended Behaviour Scale" (61). Rosen et al. (18) and Ouimette et al. (51) measured a mixture of stigma facets including discomfort with help-seeking and concerns for social consequences (anticipated stigma) by using a stigma subscale developed from Mansfield et al. (62) and Vogt (46).

The measurement of help-seeking intention was either through the endorsement of different stigma items and their effect on decisions to seek treatment (i.e., "Rate each of the possible concerns that might affect your decision to seek treatment for a psychological problem (e.g., a stress or emotional problem such as depression or anxiety attacks) from a mental health professional (e.g., a psychologist or counselor)") or through questions assessing care-seeking propensity (e.g.,

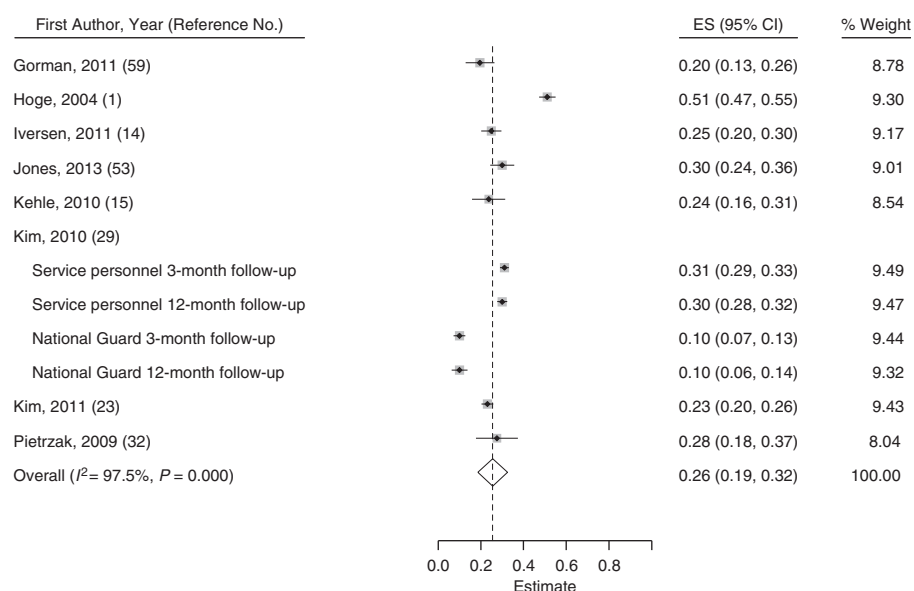


Figure 6. Forest plot displaying the prevalence for each study and an overall weighted prevalence for the stigma item from the Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale (PSBCPP-SS), “My leaders would blame me for the problem,” across studies from 2004 to 2014. Weights are from random-effects analysis. CI, confidence interval; ES, estimate.

“Are you currently interested in receiving help for a stress, emotional, alcohol, or family problem?”). Additional measurement of help-seeking intention was through self-report of mental health service utilization (e.g., respondents were asked to indicate whether they had received help for a stress, emotional, alcohol, or family-related problem from a treatment provider in the last “x” months) or alternatively by assessing medical records. Three studies assessed “adequate” service utilization or “completion of treatment” (by reporting the count of visits to mental health services with 8–12 visits representing adequate treatment) (18, 57, 58).

Prevalence of anticipated stigma and intentions to seek help

Fourteen studies reported anticipated stigma prevalence per endorsed stigma item. Ouimette et al. (51) used a different stigma measure assessing discomfort with help-seeking and concerns about social consequences and so cannot be directly compared with other studies’ prevalence findings; however, the study found that these stigma-related barriers were more salient than institutional factors (not fitting into Department of Veterans Affairs care, staff skill and sensitivity, logistic barriers, etc.). The 13 studies that were comparable by their use of items on the PSBCPP-SS had high levels of variability in the prevalence of endorsed stigma items. Across studies, over

the 6 stigma items, I^2 ranged from 96.8% to 98.3%. Studies were additionally stratified by country, grouping together studies from the United Kingdom and United States to investigate whether this accounted for heterogeneity. Stratification by country had little effect on the high heterogeneity. For example, the I^2 for studies from the United States and United Kingdom for the stigma item, “It would be too embarrassing,” remained at 94.2% and 91.6%, respectively. Hence, meta-analyses here are reported across all studies and stigma items.

When rank ordered by weighted prevalence (Table 3) and forest plots (Figures 1–6), the most frequently endorsed of the core 6 stigma items was being treated differently by leaders and the least frequently endorsed was being blamed for having a mental health problem.

Association of anticipated stigma with mental health service utilization

Seven studies found no association between endorsed anticipated stigma and mental health-care service utilization, initiation, or completion of treatment (Table 1). Two studies found positive associations between endorsed anticipated stigma and mental health-care service utilization; however, the effects seen were small. For example, there was a positive association found between anticipated stigma and utilization of mental health services by combat medics in general (male

Table 1. Association Between Stigma and Health Service Use From Studies Published in 2004–2014

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Association Between Stigma and Mental Health Service Use	Other Relevant Findings
Harpaz-Rotem, 2014 (57)	United States	Veterans	Prospective	137	No significant difference in anticipated stigma between those that did not receive mental health treatment (mean = 3.18, SD, 0.87) and those that did receive treatment (mean = 3.18, SD, 0.87) and those that did not receive treatment (mean = 2.94, SD, 1.04; $t = 1.224$; $P = 0.223$; $df = 134$).	Veterans in this study who endorsed greater stigma were not deterred from utilizing mental health services. Multivariate logistic regression revealed that greater unit-level stigma was associated with greater severity of PTSD symptoms (OR = 1.05, 95% CI: 1.02, 1.09; $P = 0.002$), but not with initiation of use of mental health services. Study investigates specific symptom clusters and effect on treatment-seeking. Post hoc analysis—PTSD re-experiencing symptoms associated with increased odds of initiating treatment (OR = 1.13, 95% CI: 1.05, 1.23; $P = 0.002$), numbing symptoms associated with increased odds of mental health treatment (OR = 1.12, 95% CI: 1.08, 1.16; $P = 0.001$). Likelihood of retention in treatment positively associated with greater severity of PTSD symptoms (OR = 1.09, 95% CI: 1.04, 1.15; $P < 0.001$).
Keñle, 2010 (15)	United States	National Guard	Cross-sectional	424 overall; 117 with mental health problems	Stigma did not significantly predict mental health service utilization when using either of positive stigma scales (AOR = 1.05, 95% CI: 0.92, 1.22; $P > 0.05$) or stigma as measured in a high/low median split (AOR = 1.24, 95% CI: 0.745, 2.065; $P > 0.05$) (model adjusted for mental health status).	Models unadjusted for mental health status found positive stigma to be associated with greater mental health service use (AOR = 1.40, 95% CI: 1.05, 1.85; $P = 0.02$). Severity of illness (need factor score) (AOR = 1.52, 95% CI: 1.18, 1.96; $P < 0.01$), and in-theater injuries (AOR = 1.98, 95% CI: 1.13, 3.47; $P < 0.05$) all positively associated with mental health service use.
Rosen, 2011 (18)	United States	Veterans	Cross-sectional	482	No association of stigma with retrospective reports of initiating therapy (AOR = 1.12, 95% CI: 0.82, 1.52; $P > 0.05$) or prospectively (after survey time 1) (AOR = 1.07, 95% CI: 0.73, 1.57; $P > 0.05$). Positive association of stigma and completing 8 or more PTSD psychotherapy visits (AOR = 1.51, 95% CI: 1.00, 2.28; $P < 0.05$). Positive association between reporting stigma and retrospective reports of use of Veteran Centre counselling services (AOR = 1.69, 95% CI: 1.24, 2.30; $P < 0.01$).	One in 3 veterans endorsed moderate/high stigma concerns as barriers to care; however, stigma was not retrospectively or prospectively associated with initiating psychotherapy. Those that reported higher levels of stigma concerns were more likely to complete treatment and have used Veteran Centre counselling. Retrospective initiation (prior to survey) and prospective use of PTSD psychotherapy services were positively associated with severity of mental health problem/injury (AOR = 1.21, 95% CI: 1.01, 1.46; $P < 0.01$), and AOR = 1.73, 95% CI: 1.21, 2.47; $P < 0.01$). Retrospective initiation (prior to survey) of PTSD psychotherapy was positively associated with an individual's being diagnosed in a veteran association mental health-care setting rather than a medical setting (AOR = 2.68, 95% CI: 1.65, 4.35; $P < 0.01$). Prospective initiation of PTSD psychotherapy was associated with being part of a male Iraq/Afghan group (reference, male Vietnam era group) (AOR = 2.95, 95% CI: 1.37, 6.36; $P < 0.01$). Patients with greater impairment or desire for help did not receive more sessions of psychotherapy. Hence, the amount of care used was not determined by need or desire for help.
Pietrzak, 2009 (32)	United States	Veterans	Cross-sectional	272 overall; 102 with mental health problems	Stigma was not associated with counseling visits (AOR = 0.92, 95% CI: 0.53, 1.58; $P = 0.76$). Stigma was not associated with medication use (AOR = 1.11, 95% CI: 0.64, 2.27; $P = 0.78$).	Group who screened positive for a mental health problem scored higher on the stigma scale compared with those who did not (mean = 2.69, SD, 0.87 vs. mean = 2.31, SD, 0.9; $F = 7.7$; $df = 1$ and 247 ; $P < 0.001$; Cohen's $d = 0.54$) and were more likely to endorse nearly all of the stigma items (ORs = 2.10–4.15). PTSD was positively associated with counseling and medication visits (AOR = 10.69, 95% CI: 2.97, 36.39; $P < 0.05$). Negative beliefs about mental health care were negatively associated with counseling and medication visits (AOR = 0.55, 95% CI: 0.36, 0.85; $P < 0.05$), and AOR = 0.69, 95% CI: 0.38, 0.85; $P < 0.05$).

Table continues

Table 1. Continued

First Author, Year (Reference No.)	Study Location	Population/Type	Study Type	Study Size	Association Between Stigma and Mental Health Service Use	Other Relevant Findings
Kiun, 2011 (23)	United States	In-service personnel (regular military)	Cross-sectional	2,693 overall; 881 with mental health problems	Stigma not associated with treatment utilization for mental health care. Association of anticipated stigma with any type of care/treatment (AOR = 1.03, 95% CI: 0.84, 1.41; P = 0.502). Mental health professional—military (AOR = 1.16, 95% CI: 0.87, 1.54; P = 0.308). Mental health professional—civilian (AOR = 0.93, 95% CI: 0.58, 1.49; P = 0.772).	Top 3 concerns about barriers to care for those with and without mental health problems were all stigma related; however, this did not predict service use. Negative attitudes toward treatment predicted decreased treatment utilization from: Any type of care/treatment (AOR = 0.63, 95% CI: 0.45, 0.87; P = 0.005). Mental health professional—military (AOR = 0.58, 95% CI: 0.41, 0.84; P = 0.004) (nonsignificant result for mental health professional—civilian (AOR = 0.70, 95% CI: 0.39, 1.24; P = 0.219)).
Hoerster, 2012 (58)	United States	Veterans	Prospective	305	Stigma was not associated with receipt of adequate mental health treatment (9 or more mental health visits) (odds ratios not reported). Receipt of treatment as a continuous variable was not associated with stigma (odds ratios not reported).	Stigma barriers were most commonly endorsed (111 veterans, 37% endorsed at least 1 stigma-related barrier). Those with greater symptom severity and females were more likely to receive adequate treatment after adjustment for either PTSD symptom severity or depression symptom severity and sex, military branch, endorsement of stigma-related barriers, and service status (AOR = 1.03, 95% CI: 1.01, 1.05; P = 0.003) and being female (AOR = 4.82, 95% CI: 1.37, 16.99; P = 0.014) were associated with receiving adequate treatment. Depression symptom severity (AOR = 1.06, 95% CI: 1.01, 1.11; P = 0.01) and being female (AOR = 3.98, 95% CI: 1.17, 13.49; P = 0.027) were associated with receiving adequate treatment.
Jones, 2013 (53)	United Kingdom	Regular military/reserves	Cross-sectional	484 overall; 262 with mental health problems	Stigma was not associated with utilization of mental health services for those with mental health problems after adjustment for rank, age, service length, sex, relationship status, and deployment in the last year (AOR = 2.27, 95% CI: 0.57, 3.82; P > 0.05).	Those with common mental health disorders or PTSD symptoms had increased odds of endorsing stigma (AOR = 3.07, 95% CI: 1.95, 4.84; P < 0.05) but not among those drinking alcohol at potentially harmful levels (AOR = 1.08, 95% CI: 0.68, 1.70; P > 0.05). A statistically significant trend was observed for increasing levels of stigma reported from the lowest levels among non-help-seekers to the highest levels among help-seekers, through moderate levels among negative screening help-seekers and positive screening help-seekers, to the highest levels among positive screening non-help-seekers (χ^2 test for trend = 25.23, P ≤ 0.0001). Over 90% of those that screened positive for a mental health problem endorsed that "Mental health support can be useful for those who need it". Eighty percent of those that screened positive for a mental health problem endorsed that "It takes courage or strength to seek help from professionals". Those who endorsed that other people with mental health problems were also more likely to report higher levels of stigma (AOR = 2.66, 95% CI: 1.47, 4.82; P < 0.05).
Erlitsky, 2013 (63)	United States	Regular military (Army, Air Force, Navy, Marine Corps, Coast Guard, combat medics)	Cross-sectional	799 overall; 54 with mental health problems	Positive association of anticipated stigma and mental health service utilization by combat medics (AOR = 1.61, 95% CI: not reported, P = 0.01). Positive association of anticipated stigma and mental health service utilization by males (AOR = 1.58, 95% CI: 1.09, 2.30).	A nonsignificant association was observed between stigma and mental health service utilization by female combat medics (AOR = 1.46, 95% CI: 0.78, 2.76).

Abbreviations: AOR, adjusted odds ratio; CI, confidence interval; OR, odds ratio; PTSD, post-traumatic stress disorder; SD, standard deviation.

Table 2. Association Between Stigma and Care-Seeking Propensity From Studies Published in 2004–2014

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Association Between Stigma and Care-Seeking Propensity	Other Relevant Findings
Sudom, 2012 (24)	Canada	Regular military/reserves	Cross-sectional	2,437 overall; 196 with mental health problems	Stigma was not associated with care-seeking propensity (interest in receiving help) (AOR = 1.1, 95% CI: 0.8, 1.3; $P = 0.588$).	The top 3 barriers to care were all stigma related (includes those without a mental health problem); however, stigma was not associated with care-seeking propensity after adjustment for mental health status. Those with a mental health problem (and increased severity of mental health problem) were more likely to be interested in care currently, less severe mental health problem (AOR = 3.7, 95% CI: 2.3, 14.2; $P = 0.000$), more severe mental health problem (AOR = 10.0, 95% CI: 5.3, 18.7; $P = 0.000$). Those with past mental health service use were more likely to be interested in care currently (AOR = 3.4, 95% CI: 1.9, 6.0; $P = 0.000$). Structural barriers were associated with greater interest in care (AOR = 1.5, 95% CI: 1.1, 1.8; $P = 0.002$). Negative attitudes toward mental health care were associated with less interest in care (AOR = 0.6, 95% CI: 0.5, 0.8; $P = 0.000$).
Brown, 2011 (22)	United States	In-service personnel (regular military)	Cross-sectional	577	Positive association of anticipated stigma with care-seeking propensity (interest in receiving help) (AOR = 2.28, 95% CI: 1.46, 3.59; $P < 0.05$).	Recognition of current problem was positively associated with interest in receiving help (AOR = 6.68, 95% CI: 3.66, 12.24; $P < 0.05$). Past-year care from health-care provider was positively associated with interest in receiving help (AOR = 1.78, 95% CI: 1.11, 2.86; $P < 0.05$). Negative attitudes to mental health care were associated with lower likelihood of interest in receiving help (AOR = 0.58, 95% CI: 0.38, 0.89; $P < 0.05$).
Jones, 2013 (53)	United Kingdom	Regular military/reserves	Cross-sectional	484 overall; 262 with mental health problems	Positive association of stigma with care-seeking propensity (interest in receiving help) (AOR = 3.19, 95% CI: 1.80, 5.65; $P < 0.05$).	Refer to Table 1 for other relevant findings.

Table continues

Table 2. Continued

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Association Between Stigma and Care-Seeking Propensity	Other Relevant Findings
Blais, 2013 (4)	United States	National Guard/reserves	Cross-sectional	165 overall; those with mental health problems, not reported.	<p>Nonsignificant correlations of anticipated stigma (measured through PSBCPP-SS and PSOSH) and help-seeking from mental health professional or physician/advanced practice registered nurse.</p> <p>PSBCPP-SS anticipated stigma correlation with help-seeking intention from a mental health professional ($r = -0.05$, $P > 0.05$).</p> <p>PSBCPP-SS anticipated stigma correlation with help-seeking intention from physician/advanced practice registered nurse ($r = 0.01$, $P > 0.05$).</p> <p>PSOSH anticipated stigma from unit leader, unit members, and family/friends and correlation with help-seeking from mental health professional ($r = -0.13$, $P > 0.05$; $r = -0.01$, $P > 0.05$; $r = 0.03$, $P > 0.05$, respectively).</p> <p>Self-stigma negatively correlated with help-seeking intentions from a mental health professional or physician/advanced practice registered nurse ($r = -0.41$, $P < 0.001$; $r = -0.24$, $P < 0.01$, respectively).</p> <p>Structural equation modeling was conducted to test the overarching model of help-seeking. Paths were specified from a latent variable of anticipated stigma created from the PSOSH variables with the additional variables of self-stigma, marital status, PTSD severity, history of previous mental health care, and perceived likelihood of redeployment to help-seeking from a mental health professional or physician/advanced practice registered nurse.</p> <p>Paths from self-stigma to help-seeking intentions from both a mental health professional and physician were significantly negative (standardized coefficient = -0.34, $P < 0.001$; standardized coefficient = -0.20, $P < 0.01$, respectively).</p> <p>The path from the latent variable of anticipated stigma was nonsignificant (standardized coefficient = -0.01, $P > 0.05$).</p>	<p>Self-stigma was negatively related to help-seeking intentions; however, anticipated stigma was not related to help-seeking intention (only bivariate correlations).</p> <p>Anticipated stigma from unit leaders was significantly higher than anticipated enacted stigma from unit members/friends ($t_{(147)} = 3.66$, $P = 0.001$) and family/anticipated enacted stigma from unit members was significantly higher than anticipated enacted stigma from family/friends ($t_{(149)} = 6.92$, $P = 0.001$).</p> <p>Those married (mean = 3.51, SD = 1.88) reported a greater intention to seek mental health care from a mental health professional ($F_{(1, 162)} = 7.40$, $P = 0.01$) than those unmarried (mean = 2.72, SD = 1.74).</p> <p>Those married (mean = 3.04, SD = 1.73) reported a greater intention to seek help from a physician/advanced practice nurse ($F_{(1, 162)} = 10.90$, $P = 0.001$) than those unmarried (mean = 2.18, SD = 1.51).</p> <p>Those reporting a history of mental health care (mean = 4.35, SD = 1.76) reported a greater intention to seek help from a mental health professional ($F_{(1, 154)} = 15.74$, $P = 0.001$) than those without a history of mental health care (mean = 2.92, SD = 1.81).</p>

Abbreviations: AOR, adjusted odds ratio; CI, confidence interval; PSBCPP-SS, Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale; PSOSH, Perceived Stigma of Seeking Help Scale; PTSD, post-traumatic stress disorder; SD, standard deviation.

and female) and male combat medics (adjusted odds ratio (AOR) = 1.61, 95% confidence interval (CI): not reported, $P = 0.01$, and AOR = 1.58, 95% CI: 1.09, 2.30, respectively) (63). In the paper by Rosen et al. (18), a positive association was found between stigma and completing 8 or more PTSD psychotherapy visits (AOR = 1.51, 95% CI: 1.00, 2.28, $P < 0.05$), and a positive association was also found between reporting stigma and retrospective reports of use of veteran center counseling services (AOR = 1.69, 95% CI: 1.24, 2.30, $P < 0.01$).

Association of anticipated stigma and self-stigma with mental health care-seeking propensity (interest in receiving help)

The findings with regard to this outcome were varied (Table 2). Two studies found no association between anticipated stigma and care-seeking propensity (i.e., stigma was not associated with interest in receiving help for mental health problems) (4, 24). Two studies found a positive association of anticipated stigma and care-seeking propensity—that is, those who endorsed stigma items were 2–3 times more likely to be interested in receiving help: Brown et al. (22) (AOR = 2.29, 95% CI: 1.46, 3.59, $P < 0.05$) and Jones et al. (53) (AOR = 3.19, 95% CI: 1.80, 5.65, $P < 0.05$). Finally, 1 study found a negative association between self-stigma and intentions to seek help: Blais and Renshaw (4), using structural equation modeling, reported that paths from self-stigma to individuals' help-seeking intentions from both a mental health professional and a medical doctor were significantly negative (standardized coefficient = -0.34 , $P < 0.001$, and standardized coefficient = -0.20 , $P < 0.01$, respectively).

DISCUSSION

Overall, after a systematic review of this literature, several key findings are apparent. There are a substantial number of studies on stigma and barriers to care with few studies examining how stigma is associated with actual mental health service utilization. A quarter to just over two-fifths of those in the military with mental health problems, across countries and across service/veterans/former service, endorse anticipated stigma as factors that might affect their decision to seek help for mental health problems. Despite the fairly high and consistent prevalence of anticipated stigma, the majority of studies found no association between anticipated stigma and mental health service use or intentions to seek help, and the minority of studies found a positive association. Hence, those that endorsed high anticipated stigma still utilized mental health services or were still interested in seeking help. These findings do not cohere with the majority of evidence in civilian literature, that is, that stigma negatively affects help-seeking from medical/formal sources for those with mental health problems (41). There could be several competing explanations for these findings; however, we discuss the results on stigma prevalence first.

Stigma prevalence

The prevalence of anticipated stigma concerns among those in the military with mental health problems is consis-

tently highest in relation to concerns about unit leadership treating them differently, being seen as weak, and unit members having less confidence in them if they seek help for a mental health problem. These results highlight the importance of individuals' perceptions, be they correct or not, and the influence of prevailing military culture that may dissuade them from seeking help or disclosing mental health problems (27, 52). Individuals in the military can be medically downgraded and taken off weapon handling, particularly if they are put on medication for mental health problems. This can act as a barrier to help-seeking and may be reflected in the anticipated stigma concerns associated with leadership and unit members. However, these stigma concerns may also be a result of safety critical industries similar to those of the fire service, police, or airline pilots, where team safety may rely on the high performance and health of other team members and where mental ill health may be perceived to affect this functioning (64–66). Additionally, the stigma concern that individuals may be seen as weak for seeking help may be an extremely ingrained stigmatizing belief associated with the masculine culture of militaries. Studies have noted this masculine culture in military populations and its negative effects on help-seeking behaviors for mental health problems (11, 14, 45, 47). These concerns persist even after individuals have left service. We propose that cultures, beliefs, and behaviors learned in service may be pervasive into civilian life and continue to affect stigmatizing beliefs (46).

When assessing studies that sat consistently above or below the overall weighted prevalences across the majority of stigma items, we can infer from high heterogeneity that different studies' sample structures and contexts may be factors that interact to affect prevalence outcomes. Prevalence in studies could be affected by service status. Active service personnel have been shown to endorse higher levels of anticipated stigma compared with National Guard or veteran/former service personnel samples (14, 29). Additionally, the National Guard samples of Gorman et al. (59) and Kehle et al. (15) (to a lesser extent) in this review sat consistently below the weighted average across stigma items. This difference in stigma may reflect differences in health-care provision and community cultures while in service between active service personnel and National Guard/reserves. National Guard or reserves may endorse fewer stigmas as they can access local mental health care when demobilized without the same visibility or anticipated stigma from their military community compared with those in active service. The type of mental health problem measured in the sample group could also affect high prevalence. Those with probable PTSD have been shown to endorse stigma items at higher levels than those with depression (14). Hence, studies that utilize more expansive measures for their group "screening positive" for mental health problems may lower their overall prevalence results. Stigma has also been evidenced to be a moving entity that changes over time, with service personnel reporting higher anticipated stigma while deployed compared with postdeployment; hence, studies may differ in stigma prevalence, related to when surveys were taken in relation to deployment (31). Prevalence could also be influenced by country. The majority of United Kingdom studies show consistently higher endorsed anticipated stigma than the majority of US

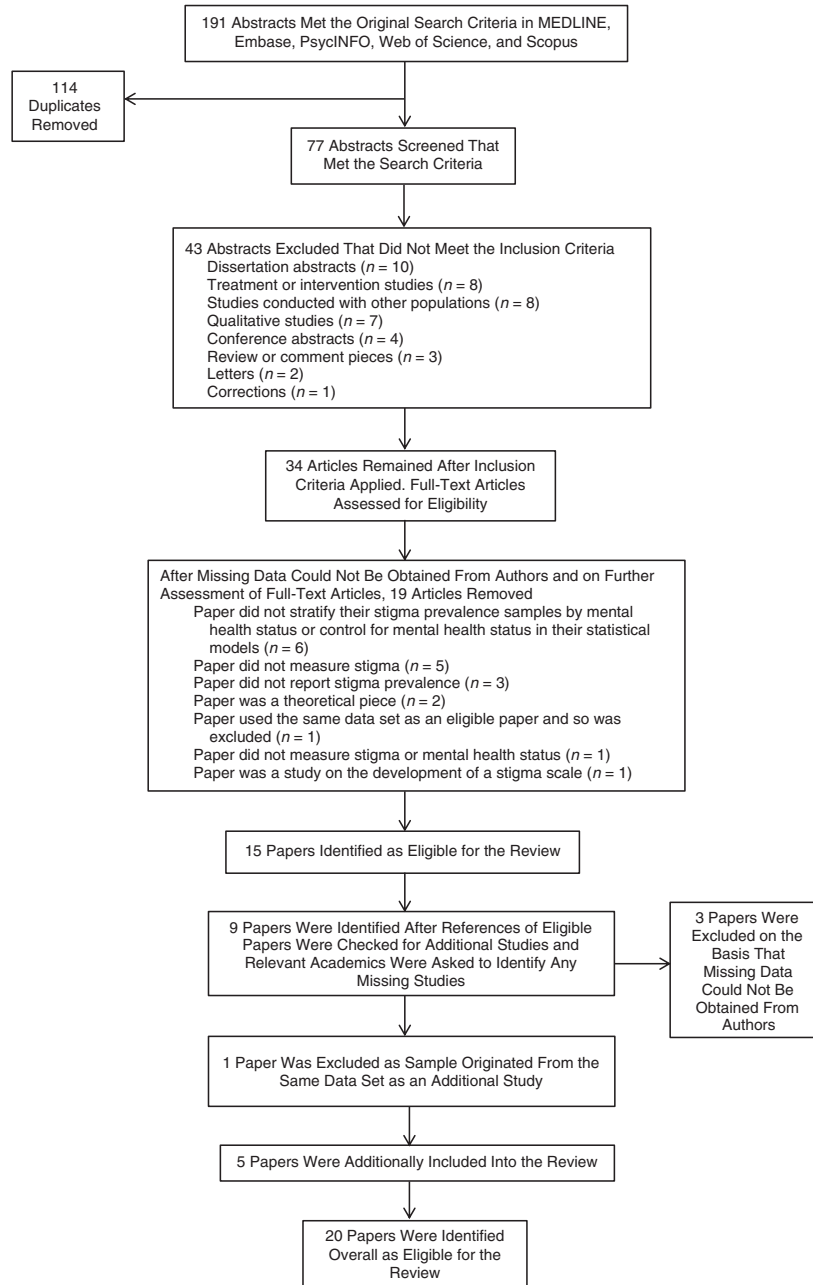


Figure 7. Study selection flow chart.

Table 3. Item Weighted Prevalence From Studies Published in 2004–2014 Using the PSBCPP-SS

Stigma Item	Prevalence, %	95% Confidence Interval
My unit leadership might treat me differently.	44.2	37.1, 51.4
I would be seen as weak.	42.9	36.8, 49.0
Members of my unit might have less confidence in me.	41.3	32.6, 50.0
It would be too embarrassing.	36.1	29.0, 43.2
It would harm my career.	33.4	27.9, 38.9
My leaders would blame me for the problem.	25.5	18.6, 32.5

Abbreviation: PSBCPP-SS, Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale.

samples. Further comparative work on stigma in the militaries from the United Kingdom and the United States may be worth investigation to explain these differences.

Finally, there is a lack of studies that measure the association of stigma with actual mental health-care service utilization. The majority of papers measure only the effect of stigma on help-seeking intentions, that is, whether a barrier to care “might” affect seeking mental health care, with an assumption that intention would lead to an action. However, we cannot say from these prevalence values whether potential barriers to help-seeking do transpose into help-seeking inaction (or action), and therefore the outcome of interest may not be adequately measured. Additionally, the use of self-report for measuring service utilization may not be a robust way to measure this outcome, as individuals with high levels of stigma may not disclose mental health service use (53).

Association of stigma and help-seeking intentions/service use

The findings that anticipated stigma in the majority of studies was not associated with help-seeking intentions or mental health service use and that in the minority of studies it was positively associated seem a nonintuitive outcome if considering stigma a barrier to help-seeking. Despite individuals in these studies endorsing anticipated stigma, it did not deter their intentions to seek help or affect their actual mental health service use. Several explanations could account for these findings.

It may be that there is an “intention gap” between the intention/nonintention to seek help and the subsequent action or inaction. When looking at intention-behavior relations, we found that Sheeran’s empirical review (67) reports that it is the “inclined abstainers” that make up the large majority of the intention gap, that is, those that want to act but choose not to, rather than the “disinclined actors,” that is, those that do not want to perform an act but subsequently do so. However, in the case of individuals in these studies, they would be defined as “disinclined actors,” that is, individuals who note their anticipated stigma, but some of whom subsequently seek help. Other factors may uphold a theory of “disinclined

actors” such as the repeated findings that the severity of mental health problems is positively related to help-seeking intentions and mental health service use (18, 24, 57, 58). Hence, it may be that individuals endorse anticipated stigma; however, the severity of their mental health problem, which may lead to crisis points in their lives or functional impairment, overrides the barrier to care of anticipated stigma, causing them to seek help as their mental health problem can no longer be ignored or coped with successfully (16, 68). Jones et al. (53) also uphold the notion that concealment of a mental health problem in service may be difficult because of close health supervision, and therefore individuals may be compelled to seek help by the chain of command when behavioral or psychological disturbances are present.

In addition to this, it may be that facilitators of help-seeking are more powerful than barriers to care (69, 70). Warner et al. (48) found one of the most influential factors in a US military sample for overcoming barriers to seeking care was having family and friends strongly encourage soldiers to get help. This is also supported by the “Theory of Reasoned Action/Planned Behavior,” that intentions to perform an action are shaped by the perceived social pressure to perform/not perform a behavior (71, 72). Indeed, some studies in this review found a positive association between greater unit support and utilization of mental health services (57) and found that decreased unit support predicted increased stigma and barriers to care (32). These findings have also been supported in research that found US commissioned and noncommissioned officers’ positive leadership behaviors were predictive of individuals’ positive decisions to seek mental health treatment (25). Hence, social support could explain how individuals who are disinclined to seek help subsequently seek help, and it could be an important variable to include in future analyses.

Additionally, it should be noted that stigma may simply not be associated with help-seeking intentions or service use if individuals have not recognized or linked their symptoms with the need for medical help. Fikretoglu et al. (73) showed that 80% of those who might have benefited from mental health treatment failed to recognize their own treatment needs and did not seek help. Equally, those with alcohol problems were the least likely in military studies to recognize their own treatment needs (9, 16, 53). Hence, the impact of stigma on mental health service utilization may not be truly measured if individuals do not perceive they have a problem that might require accessing mental health care.

Alternatively, a positive relationship between stigma and help-seeking intentions/service use could be related to “modified labeling theory,” that is, that having an interest in receiving mental health care makes respondents more aware of stigma from others (74). Hence, the process of thinking about or receiving help makes individuals think more acutely about or experience the repercussions of seeking help; thus, service use or interest in care causes higher stigma rather than stigma causing service use.

Finally, 3 studies found that negative attitudes toward care were negatively associated with help-seeking intentions/mental health service use (22, 24, 32). This finding is also supported by other research that found the most commonly endorsed barriers to care for non-help-seeking service personnel with

PTSD were negative attitudes toward treatment (75). It may be that negative attitudes toward mental health care are more important barriers to help-seeking in the military than anticipated stigma and may need future focus in terms of interventions and policy decisions. However, it is not clear at present which intervention strategies will be successful in changing negative attitudes in the military. Previous randomized controlled trials aimed at targeting stigma and negative attitudes toward mental health care in the United Kingdom military found no effect in changing these attitudes (76, 77).

Stigma—types, measurement, and methodology

In these military studies, anticipated stigma was the most commonly assessed, with the majority of studies utilizing the same stigma scale (PSBCPP-SS). Intuitively, this form of stigma may be salient for military populations. Previous research has shown that disclosing a psychological problem in the military is perceived as more stigmatizing than having a physical medical problem (39) and that military personnel may choose not to disclose a mental health problem to avoid being labeled as different from so-called “normal” soldiers, as dictated by norms and cultures within their militaries (45, 78).

However, there have been recent methodological questions explored in the literature as to whether the PSBCPP-SS scale measures anticipated stigma effectively, with some authors utilizing alternative scales such as the “Perceived Stigma of Seeking Help” (4, 79) or “Endorsed and Anticipated Stigma Inventory” tool for military populations (80). Hence, the lack of association found between stigma and help-seeking intentions or service use may be a function of the PSBCPP-SS tool. Recent studies such as that by Blais et al. (79) (subsequently published after the systematic review) have found a negative association between anticipated stigma and intentions to seek help using the Perceived Stigma of Seeking Help tool. Some studies used the PSBCPP-SS tool on veteran/former service study samples with stigma items referencing “units members” and “unit leadership.” These points of reference may not be valid for individuals who have left service, which could have affected responses to these studies. Additional research assessing the comparative validity and utility of stigma scales in military populations would benefit the evidence available in this field.

In the studies included in this review, it is unclear why anticipated stigma was the main construct explored. Only 1 paper measured self-stigma and found a negative effect upon help-seeking (4). Self-stigma appears to be a discreet psychological construct that is unlike public stigma or anticipated stigma (81). For instance, individuals may endorse public stigma, but they may not then internalize this stigma. Self-stigma has been shown to be a considerable deterrent to receiving mental health care in general populations (43); it has also been linked to negative attitudes toward mental health services and to less intentions to seek different forms of mental health treatment (44, 82). Additionally, those who endorse greater self-stigma are less likely to return for further mental health treatment after an initial visit (83). However, from this review, it is largely unknown whether self-stigma has an impact on mental health service use or help-seeking

intentions in the military, and it could potentially be an important facet of stigma that may act as a barrier to help-seeking that needs future exploration.

Finally, there are some methodological quality issues that may have affected studies’ outcomes. Three papers that found no association of stigma and mental health service utilization drew their samples from treatment-seeking or help-seeking samples, that is, individuals who were able to be sampled because of an initial engagement with Veteran Affairs services or health screening events (18, 57, 58). These samples of help-seeking individuals may not be generalizable to the key population of interest, that is, military populations that do not seek help for mental health problems. Those who have taken the step to attend a health-screening event may be more likely in the future to use mental health services and at the same time endorse high anticipated stigma because of their interaction with mental health services. Hence, current (and future) military cohort studies are best placed to address recruitment of large enough samples of those experiencing mental health problems, who are non-help-seekers and help-seekers, selected on a random basis for ensuring robust results.

There is inconsistency in the use of language used to describe stigma. For example, some papers use the language “self-stigma” or “internal stigma” (10) when referring to items assessed using measures of anticipated stigma. Hence, there is a need within military studies for more clarity in stigma descriptions, definitions, and conceptual frameworks used to explain different forms of stigma (26, 84). The current study suggests that modified versions of the scales used to assess stigma are widely utilized. This may impact upon the validity and reliability of the scales, though many studies do report *as* for the modified scales.

Strengths and weaknesses

This is the first systematic review and meta-analysis of the military literature that we are aware of that generates an overview of stigma prevalence, its relationship to mental health problems, and its association with help-seeking intention and service use. Weaknesses of this review include the fact that not all data could be obtained from authors and, therefore, data that could have contributed to findings may have been missed.

Implications and conclusions

This study’s key findings have shown that, while anticipated stigma prevalence is high in military populations with mental health problems, the majority of studies found that anticipated stigma was not associated with help-seeking intentions or mental health service utilization, and the minority of studies found a positive association of this relationship.

We propose that these findings may be related to an intention-behavior gap where individuals who are disinclined to seek help are compelled when reaching a crisis point or enabled to seek help by positive facilitators of help-seeking, such as supportive family/friends/unit, to overcome stigma. More research on the role of social networks and their interaction with stigma in the help-seeking process would be valuable. From the information gathered in these studies, we cannot tell how long someone has been “disinclined” before

he/she acts to seek help. Delays in treatment may create additional negative impacts on individuals' long-term health outcomes, relationships, or families. Further research could usefully address delays in treatment-seeking associated with stigma. Policies, therefore, could be aimed to encourage early help-seeking and sustained engagement with mental health services to avoid the high social and economic costs of individuals seeking help at crisis points.

It is evident that certain stigma concerns have remained prevalent to various degrees across studies, time periods, countries, for those in service, and for those who have left the military. It is also an issue for concern that individuals may experience stigma as a result of their help-seeking, as research indicates that the stigma of mental illness can often be more damaging than the mental illness itself (85). Questions must be asked regarding antistigma campaigns for military populations, whether they are able to have a large enough effect on stigma concerns, and additionally whether veteran/former service populations can be reached effectively in the promotion of antistigma messages. There may be a need to learn from successful antistigma campaigns aimed at general populations to then adapt these methods to the context of military populations.

We also suggest that the lack of association between stigma and help-seeking may be a result of methodology. This review highlights the different language, terms, and scales used in stigma research. While these terms, scales, and models of stigma are contested, it may be difficult for the field to progress in a cohesive fashion. It is suggested that future theoretical work is needed to inform methodological approaches and stigma scales, which would bear much utility in addressing these issues.

Finally, there may also be the need for research to focus on other potential barriers to help-seeking in military populations, such as self-stigma, negative attitudes toward mental health treatment, or individuals' own recognition of need for mental health care, to help further understand the low proportion of help-seekers for mental health problems in the military.

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Table 1 – Association between stigma and health service use – Studies 2004-2014

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Results: association between stigma with mental health service-use	Other relevant findings
Harpaz-Rotem, 2014 (57)	US	Veterans	Prospective	137	No significant difference in anticipated stigma between those that did not receive mental health treatment (M=3.18 SD=0.87) and those that did receive mental health treatment (M=2.94 SD=1.04) (t=1.224, p=0.223, df=134)	<p>Veterans in this study who endorsed greater stigma were not deterred from utilising mental health services.</p> <p>Multivariate logistic regression revealed that only greater unit support (odds ratio [OR], 1.06; p=0.006; 95% CI, 1.02-1.10) and severity of PTSD symptoms (OR, 1.05; p=0.002; 95% CI, 1.02-1.09) were associated with initiation of use of mental health services</p> <p>Study investigates specific symptom clusters and effect on treatment seeking. Post hoc analysis - PTSD re-experiencing symptoms associated with increased odds of initiating treatment (OR, 1.13; p =0.02; 95% CI, 1.05-1.23), numbing symptoms associated with increased odds of retention in treatment (12 or more mental health visits) (OR, 1.15; p=0.001; 95% CI, 1.06-1.24).</p> <p>Likelihood of retention in treatment positively associated with greater severity of PTSD symptoms (OR, 1.09; p>0.001; 95% CI, 1.04-1.15)</p>
Kehle, 2010 (15)	US	National Guard	Cross-sectional	424 overall; 117 with mental health problems	Stigma did not significantly predict mental health service utilisation when using number of positive stigma items as the predictor (AOR 1.017, p>0.05, 95% CI, 0.921-1.122) or stigma as measured in a high/low median split (AOR 1.24, p>0.05, 95% CI, 0.745-2.065) (model adjusted for mental health status)	<p>Models unadjusted for mental health status found positive attitudes towards mental health treatment (AOR 1.40, p<0.05, 95% CI, 1.10-1.79), receiving therapy in theatre (AOR 2.21, p<0.05, 95% CI, 1.12-4.33), severity of illness (need factor score) (AOR 1.52, p<0.01, 95% CI, 1.18-1.96) and in-theater injuries (AOR 1.98, p<0.05, 95% CI, 1.13-3.47) all positively associated with mental health service use.</p>
Rosen, 2011 (18)	US	Veterans	Cross-sectional	482	<p>No association of stigma with retrospective reports of initiating therapy: (AOR 1.12, p>0.05, 95% CI 0.82-1.52) or prospectively (after survey time 1) (AOR 1.07, p>0.05, 95% CI, 0.73-1.57)</p> <p>Positive association of stigma and completing 8 or more PTSD psychotherapy visits (AOR 1.51, p<0.05, 95% CI, 1.00-2.28)</p> <p>Positive association between reporting stigma and retrospective reports of use of Veteran Centre counselling services (AOR</p>	<p>1 in 3 veterans endorsed moderate/high stigma concerns as barriers to care, however stigma not retrospectively or prospectively associated with initiating psychotherapy.</p> <p>Those that reported higher levels of stigma concerns were more likely to complete treatment and have used Veteran Centre counselling.</p> <p>Retrospective initiation (prior to survey) and prospective use of PTSD psychotherapy services was positively associated with severity of MH problem/impairment (AOR 1.44, p<0.01, 95% CI, 1.01-1.89) & (AOR 1.73, p<0.01, 95% CI 1.21-2.47)</p> <p>Retrospective initiation (prior to survey) of PTSD psychotherapy was positively associated with an individual being diagnosed in a Veteran</p>

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Results: association between stigma with mental health service-use	Other relevant findings
Pietrzak, 2009 (32)	US	Veterans	Cross-sectional	272 overall; 102 with mental health problems	1.69, p<0.01 CI, 1.24 -2.30)	<p>Association mental healthcare setting rather than a medical setting (AOR 2.68, p<0.01, 95% CI, 1.65-4.35)</p> <p>Prospective initiation of PTSD psychotherapy associated with being Male Iraqi/Afghan group (reference male Vietnam era group) (AOR 2.95, p<0.01, 95% CI, 1.37-6.36)</p> <p>Patients with greater impairment or desire for help did not receive more sessions of psychotherapy. Hence amount of care used was not determined by need or desire for help.</p>
Kim, 2011 (23)	US	In-Service Personnel (Regulars)	Cross-sectional	2623 overall; 881 with mental health problems	<p>Stigma was not associated with counseling visits - (AOR=0.92, p=0.76, 95%CI, 0.53-1.59)</p> <p>Stigma was not associated with medication use - (AOR=1.11, p=0.78, 95% CI, 0.54-2.27)</p>	<p>Group who screened positive for a mental health problem scored higher on stigma scale compared to those without a diagnosis (2.89 SD (1.0) versus 2.31 SD (0.9), F=17.71, df=1 and 247, p<0.001, Cohen's d=.54) and were more likely to endorse nearly all of the stigma items (ORs 2.10-4.15).</p> <p>PTSD positively associated with counselling and medication visits (AOR 10.69, p<0.05, 95% CI, 2.97-38.39).</p> <p>Negative beliefs about mental health care were negatively associated with counselling and medication visits. (AOR 0.83, p<0.05, 95% CI, 0.72-0.95) & (AOR 0.69, p<0.05, 95% CI, 0.56-0.85)</p>
Hoerster, 2012 (58)	US	Veterans	Prospective	305	<p>Stigma was not associated with receipt of adequate MH treatment (9 or more MH visits) - ORs not reported.</p> <p>Receipt of treatment as a continuous variable was not associated with stigma -</p>	<p>Top three concerns about barriers to care for those with and without mental health problems were all stigma related – however this did not predict service use.</p> <p>Negative attitudes towards treatment predicted decreased treatment utilisation from:</p> <p>Any type of care/treatment – (AOR 0.63, p=0.005, 95% CI, 0.45-0.87)</p> <p>Mental Health Professional – Military – (AOR 0.58, p=0.004, 95% CI, 0.41-0.84) (non-significant result for Mental Health Professional Civilian (AOR 0.70, p=0.219, 95% CI, 0.39-1.24)</p> <p>Stigma barriers were most commonly endorsed (111 veterans, 37% endorsed at least one stigma related barrier)</p> <p>Those with greater symptom severity and females were more likely to receive adequate treatment after adjustment for either: PTSD symptom severity or Depression symptom severity and - sex, military branch, endorsement of</p>

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Results: association between stigma with mental health service-use	Other relevant findings
Jones, 2013 (53)	UK	Regular/ Reserves	Cross-sectional	484 overall; 262 with mental health problems	<p>ORs not reported</p> <p>Stigma was not associated with utilisation of mental health services for those with mental health problems after adjustment for rank, age, service length, sex, relationship status and deployment in the last year (AOR 2.27, p>0.05, 95% CI 0.57-3.82)</p>	<p>stigma related barriers and endorsement of trust-related barriers.</p> <p>PTSD symptom severity (AOR 1.03, p=0.003, 95% CI, 1.01-1.05), and being female (AOR 4.82, p=0.014, 95% CI, 1.37-16.99) associated with receiving adequate treatment</p> <p>Depression symptom severity (AOR 1.06, p=0.01, 95% CI, 1.01-1.11), and being female AOR 3.98, p=0.027, 95% CI, 1.17-13.49) associated with receiving adequate treatment.</p> <p>Those with common mental health disorders or PTSD symptoms had increased odds of endorsing stigma (AOR 3.07, p<0.05, 95% CI, 1.95-4.84) but not amongst those drinking alcohol at potentially harmful levels (AOR 1.08, p>0.05, 95% CI 0.68-1.70)</p> <p>Statistically significant trend for increasing levels of stigma reported from the lowest levels amongst non-help-seekers who screened negative for mental health problems, through moderate levels among negative screening help-seekers and positive screening help-seekers to the highest levels amongst positive screening non-help-seekers (χ^2 test for trend= 25.23, p<0.0001)</p> <p>Over 90% of those that screened positive for a mental health problem endorsed that 'Mental health support can be useful for those who need it'</p> <p>80% of those that screened positive for a mental health problem endorsed that 'It takes courage or strength to get treatment for a psychological problem'</p> <p>Those that expressed potentially discriminatory views about other people with mental health problems also more likely to report higher levels of stigma (AOR 2.66, p<0.05, 95% CI 1.47-4.82)</p>
Elimitsky, 2013 (63)	US	Regulars (Army Combat Medics)	Cross-sectional	799 overall; 54 with mental health problems	<p>Positive association of anticipated stigma and utilisation of mental health services by Combat Medics (AOR 1.61, p=0.01, 95% CI not reported)</p> <p>Positive association of anticipated stigma and MH service utilisation by males (AOR 1.58, 95% CI 1.09-2.30)</p>	<p>Non-significant association between stigma and MH service use by female combat medics (AOR 1.46, 95% CI, 0.78-2.76)</p>

Abbreviations
AOR – Adjusted Odds Ratio
CI – Confidence Interval
M - Mean
MH – Mental Health
OR – Odds Ratio
PTSD – Post traumatic Stress Disorder
SD – Standard Deviation
UK – United Kingdom
US – United States of America

Table 2 – Association between stigma and care seeking propensity – Studies 2004 - 2014

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Results: association between stigma and care seeking propensity	Other relevant findings
Sudom, 2012 (24)	Canada	Regular/Reserves	Cross-sectional	2437 overall; 196 with mental health problems	Stigma was not associated with care seeking propensity (interest in receiving help) (AOR 1.1, p=0.588, 95% CI, 0.8-1.3)	<p>Top three barriers to care were all stigma related (includes those without a mental health problem) however stigma was not associated with care seeking propensity after adjustment for mental health status.</p> <p>Those with a mental health problem (and increased severity of mental health problem) were more likely to be interested in care currently. Less severe mental health problem (AOR 5.7, p=0.000, 95% CI, 2.3-14.2), more severe mental health problem (AOR 10.0, p=0.000, 95% CI, 5.3-18.7)</p> <p>Those with past mental health service use were more likely to be interested in care currently (AOR 3.4, p=0.000, 95% CI, 1.9-6.0)</p> <p>Structural barriers associated with greater interest in care (AOR 1.5, p=0.002, 95% CI, 1.1-1.8)</p> <p>Negative attitudes towards mental health care was associated with less interest in care (AOR 0.6, p=0.000, 95% CI, 0.5-0.8)</p>
Brown, 2011 (22)	US	In-Service personnel (Regulars)	Cross-sectional	577	Positive association of anticipated stigma with care seeking propensity (interest in receiving help) (AOR 2.29, p<0.05, 95% CI, 1.46-3.59)	<p>Recognition of current problem was positively associated with interest in receiving help (AOR 6.69, p<0.05, 95% CI, 3.66-12.24)</p> <p>Past year care from healthcare provider was positively associated with interest in receiving help (AOR 1.78, p<0.05, 95% CI, 1.11-2.86)</p> <p>Negative attitudes to mental health care associated with lower likelihood of interest in receiving help (AOR 0.58, p<0.05, 95% CI 0.38-0.89)</p>
Jones, 2013 (53)	UK	Regular/Reserves	Cross-sectional	484 overall; 262 with mental health problems	Positive association of stigma with care seeking propensity (interest in receiving help) (AOR 3.19, p<0.05, 95% CI 1.80-5.65)	See table 1 for other relevant findings
Blais and Renshaw, 2013 (4)	US	National Guard/Reserves	Cross-sectional	165 overall; those with mental health problems, N not reported.	Non-significant correlations of anticipated Stigma (measured through PSBCPP-SS and PSOSH) and help-seeking from mental health professional or medical doctor/advanced practice registered nurse.	<p>Self-stigma negatively related to help-seeking intentions however anticipated stigma not related to help-seeking intention (only bivariate correlations).</p> <p>Anticipated stigma from unit leaders was significantly higher than</p>

First Author, Year (Reference No.)	Study Location	Population Type	Study Type	Study Size	Results: association between stigma and care seeking propensity	Other relevant findings
					<p>PSBCPP-SS anticipated stigma correlation with help-seeking intention from a mental health professional ($r=-0.05$, $p>0.05$)</p> <p>PSBCPP-SS anticipated stigma correlation with help-seeking intention from medical doctor/advanced practice registered nurse ($r=0.01$, $p>0.05$)</p> <p>PSOSH - anticipated stigma from unit, leader, unit members, family/friends and correlation with help-seeking from mental health professional ($r=-0.13$, $p>0.05$), ($r=-0.01$, $p>0.05$), (0.03, $p>0.05$)</p> <p>Self-Stigma negatively correlated with help-seeking intentions from a mental health professional or medical doctor/advanced practice registered nurse ($r=-0.41$, $p<0.001$) ($r=-0.24$, $p<0.01$)</p> <p>Structural Equation Modelling was conducted to test overarching model of help-seeking. Paths were specified from a latent variable of anticipated stigma created from the PSOSH variables with additional variables of self-stigma, marital status, PTSD severity, history of previous mental health care and perceived likelihood of redeployment to help-seeking from a mental health professional or medical doctor/advanced practice registered nurse.</p> <p>Paths from self-stigma to help-seeking intentions from both mental health professional and medical doctor were significantly negative. (standardised coefficient = -0.34, $p<0.001$) & (-0.20, $p<0.01$)</p> <p>Path from the latent variable of anticipated stigma was non-significant (standardised coefficient = -0.01, $p>0.05$)</p>	<p>anticipated enacted stigma from unit members, $t(147) = 3.66$, $p = 0.001$, and family/friends, $t(146) = 9.88$, $p = 0.001$, and anticipated enacted stigma from unit members was significantly higher than anticipated enacted stigma from family/friends, $t(149) = 6.92$, $p = 0.001$.</p> <p>Those married ($M = 3.51$, $SD = 1.88$) reported a greater intention to seek mental health care from a mental health professional, $F(1, 162) = 7.40$, $p = 0.01$, than those unmarried ($M = 2.72$, $SD = 1.74$).</p> <p>Those married ($M = 3.04$, $SD = 1.73$) reported a greater intention to seek help from a medical doctor/advanced practice nurse, $F(1, 162) = 10.90$, $p = 0.001$, than those unmarried ($M = 2.18$, $SD = 1.51$).</p> <p>Those reporting a history of mental health care ($M = 4.35$, $SD = 1.76$) reported a greater intention to seek help from a mental health professional, $F(1, 154) = 15.74$, $p = 0.001$, than those without history of mental health care ($M = 2.92$, $SD = 1.81$).</p>

Abbreviations

AOR – Adjusted Odds Ratio

CI – Confidence Interval

M – Mean

PSBCPP-SS – Perceived Stigma and Barriers to Care for Psychological Problems – Stigma Subscale

PSOSH – Perceived Stigma of Seeking Help Scale

PTSD – Post traumatic Stress Disorder

SD – Standard Deviation

UK – United Kingdom

US – United States of America

Web Table 1 - Study Characteristics 2004-2014

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma stem question ¹ and Likert scale ²	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Qualify assessment
Blais, 2013 (1)	Cross-sectional	Overall sample N=165 (N of those with MH problems not reported)	US	National Guard/ Reserve	Those who had deployed to Iraq/Afghanistan	PSBCPP-SS PSOSH SSOSH	The General Help-Seeking Questionnaire (GHSQ; Wilson et al. 2005) Participants asked to rate how likely they would be to seek help from mental health professionals or medical doctors/nurses if they were experiencing psychological distress.	10 months post deployment on average	PSBCPP-SS = 0.90 PSOSH = 0.94 SSOSH = 0.84	<ul style="list-style-type: none"> MH Status – PCL-M Past Treatment Demographics 	<ul style="list-style-type: none"> Cross-sectional study therefore causal inferences of directionality of associations can not be made. Non-representative National Guard sample Does not measure health service utilisation
Brown, 2011 (2)	Cross-sectional	Those with MH problems N=577 (full sample)	US	In-Service Personnel (Regulars)	Active duty, those who screened positive for a mental health problem	PSBCPP-SS plus one item – 'My leaders discourage the use of mental health services' Stem question - 'Rate each of the following concerns that might affect your decision to receive mental health counselling or services if you ever had a problem'	Care Seeking Propensity – participants asked: 'Are you currently interested in receiving help for a stress, emotional, alcohol or family problem?' Scored as a dichotomous outcome.	3 months post-deployment	0.90	<ul style="list-style-type: none"> Recognition of current problem Past service use Barriers to care (access barriers, negative perceptions of MH care) Unit efficacy Deployment satisfaction and leadership quality Demographics 	<ul style="list-style-type: none"> Cross-sectional design Self-report survey No objective measure of mental health service utilisation
Elitsky, 2013 (3)	Cross-sectional	Overall sample N=799 Those with MH problem	US	In-Service Personnel (Regulars)	Combat Medics stationed in Europe or Fort Hood, Texas during Iraq/Afghanistan conflicts	PSBCPP-SS	Participants were asked if they had receipt of MH counselling services in past year with an associated list of	3-6 months post deployment	0.84	<ul style="list-style-type: none"> MH Status – PCL-M, PHQ-9 Perceived Threat Scale Combat Experiences 	<ul style="list-style-type: none"> Cross-sectional design May not be representative of larger combat medic group or wider

¹ Stem question will only be noted where it differs from the original stigma scale

² Likert Scale will only be noted where it differs from the original stigma scale

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
		N=54					providers which to select from.			Scale • Barriers to Care • Demographics	military population • Small MH group sample • Self-report of health service use
Goman, 2011 (4)	Cross-sectional	Overall sample N=332 Those with MH problem N=133	US	National Guard	-	PSBCPP-SS – plus one item 'I don't want it on my military records' Stem question - respondents ask to 'rate each of the possible concerns that might affect your decision to receive mental health counselling or services'	Participants asked whether they had received mental health services during the prior 12 months for a problem related to stress, emotional issues, alcohol or family with an associated list of providers	1 ½ to 3 months post deployment	Not reported	• MH status - BDI-II & Suicidal ideation, PCL-M, AUDIT	• Sample limited to National Guard members from Midwest attending a workshop-attendance could have influenced responses, no information on those that did not attend. • Cross-sectional design • Self report health service use
Gould, 2010 (5)	Cross-sectional	US – Overall sample N=2241, Those with MH problems N=514 UK - N=4713, N=613 AUS - N=163, N= 37 NZ – N=97, N=50	US, UK, Australia, New Zealand	In-Service Personnel (Regulars)	-	PSBCPP-SS – 3 Items only • It would harm my career • My unit leadership might treat me differently • I would be seen as weak	Help-seeking intentions/barriers to care measured through PSBCPP-SS i.e. participants asked to rate concerns that may have an effect on decisions to seek treatment	US – week after deployment (re-deployment i.e. returning home from deployment) UK – during third location decompression (re-deployment) AUS- during last week of deployment NZ – at Force Extraction Process (re-deployment)	Not reported	MH Status – US= PHO-9, PCL UK= PC-PTSD AUS= Kessler 10 NZ=Kessler 10	• Cross-sectional studies • Comparison of many different studies – different demographics, deployments, analysis of stigma complicated by multiple definitions differences in caseness measures and questionnaires administered different times of deployment cycle. • No measures of MH service use • AUS and NZ

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Harpaz-Rotem, 2014 (6)	Prospective	Overall sample N=137	US	Veterans	Iraq/Afghanistans veterans who were referred to MH screening, screened positive for PTSD/depression and had not received treatment 1 year before their initial assessment.	PSBSCP-SS	MH service use was defined as number of outpatient MH visits recorded in VA electronic records during year after initial contact. Additionally identified a subgroup who attended 12 or more MH visits during the observed period.	Not reported (Post-deployment and veteran status)	0.89	<ul style="list-style-type: none"> Mental Health status PHQ-9 and PCL-M. CAGE Screen Pittsburgh Sleep Quality Inventory Combat Experiences Scale Post-deployment support scale Fear of loss of vigilance questionnaire Abbreviated version of the beliefs about psychotropic medications and beliefs about psychotherapy scales Connor Davidson resilience scale Satisfaction with life scale Demographics 	<ul style="list-style-type: none"> Treatment seeking sample (findings may not generalise to non-help-seekers) Relatively small sample size PSBSCP-SS used on veteran sample – items may not make sense for veterans
Hoerster, 2012 (7)	Prospective	N=305	US	Veterans	Iraq/Afghanistans veterans assessed at intake to VA post-deployment health clinic who endorsed symptoms of depression/PTSD / alcohol misuse	PSBSCP-SS – 4 items <ul style="list-style-type: none"> 'It would harm my career'. 'Members of my unit might have less confidence in me'. 	Receipt of outpatient MH care documented with admin data from VISN 20 Data Warehouse one year after intake at VA post-deployment health clinic.	Not reported (post deployment and veteran status)	0.886	<ul style="list-style-type: none"> MH Status – PHQ-9, PCL-M, PHQ-9 alcohol abuse subscale Barriers to care (access and trust) Demographics 	<ul style="list-style-type: none"> Treatment seeking sample PSBSCP-SS used on veteran sample – items may not make sense for veterans

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
						<ul style="list-style-type: none"> 'My unit leadership might treat me differently', 'I would be seen as weak' 	variable created - veterans who had 9 visits were considered to have received adequate treatment.				
Hoge, 2004 (8)	Cross-sectional	Overall sample N= 6201 Those with MH problems N=731	US	In-Service Personnel (Regulars)	Iraq/Afghanistan Service Personnel (4 US combat infantry units)	PSBCPI-SS	Participants asked about experience of current distress and whether they were interested in receiving help for these problems (not used in stigma analyses) Use of professional MH services in the past month or past year (not used in stigma analyses) Help-seeking intentions/barriers to care also measured through PSCPP-SS	Before deployment N=2530 or 3-4 months after deployment N=3671	Not reported	<ul style="list-style-type: none"> MH Status – PHQ-9, PCL Current distress Combat Experiences 	<ul style="list-style-type: none"> Cross-sectional design Combat units may not generalise to wider military population
Iversen, 2011 (9)	Cross-sectional	Overall sample N=821 Those with MH problems N=325	UK	In-Service Personnel (Regulars and Reserves), Ex-Service personnel	Representative sample of UK Armed Forces weighted to those experiencing mental ill health	PSBCPI-SS (item language adapted to suit in-service and ex-service personnel types)	Health service use based on Client Services Receipt Inventory (not used in stigma analyses) Receipt of treatment (not used in stigma analyses) Help-seeking intentions/barriers to care measured	Not reported	Not reported	<ul style="list-style-type: none"> MH status – PHQ-9, PC-PTSD Deployment experience since 2003 Perceived needs Demographics 	<ul style="list-style-type: none"> Cross-sectional design Potential bias is self-report of MH symptoms No measure of MH service utilisation

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Jones, 2013 (10)	Cross-sectional	Overall sample N=484 Those with MH problems N=262	UK	In-Service Personnel (Regulars and Reserves)	stratified 50/50 regular/reserve and 50/50 deployed on TELIC /deployed elsewhere	PSBCPP-SS-4-point Likert Scale plus two items 'People with mental illness should not be given any responsibility' and 'I would think less of a colleague if I knew they were receiving mental health treatment'	Personnel were asked if they were currently accessing support for a stressful, emotional or family problem, or currently interested in receiving support from a list of nine potential help sources	NA/not reported – non-deployed sample	Not reported	<ul style="list-style-type: none"> Barriers to care (practical) Demographics 	<ul style="list-style-type: none"> Cross-sectional design Self report of MH utilisation, no objective measure to confirm MH use.

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale'	Empirical measurement of help-seeking	When stigma/MH data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Kehle, 2010 (11)	Cross-sectional	Overall sample N=424 Those with MH problems N=117	US	National Guard	Soldiers recruited from a large longitudinal project	<p>resolve psychological problems by themselves'</p> <ul style="list-style-type: none"> 'Psychological problems tend to work themselves out without help' <p>Reported and intended Behaviour Scale (RIBS) items 5-8 (Stigma behaviour scale)</p> <p>PSBCPF-SS plus 3 items</p> <ul style="list-style-type: none"> 'I would think less of a member of my team if s/he went to a psychiatrist or other mental health professional' 'I would think less of a member of my team if s/he and their spouse went to a marriage counselor' 'I would avoid going to see a psychiatrist or other mental health professional because of how it would 	<p>Self-reported use of VA and non-VA psychotherapy and psycho-pharmacotherapy since return from deployment</p> <p>Single items were used to assess in-theater psychotherapy use with yes/no dichotomous answers: 'Did you receive one-on-one counseling for combat stress from any mental health professional during your recent deployment?', and in-theater medication use "During your most recent deployment to Iraq, how often</p>	3-6 months post-deployment	0.92	<ul style="list-style-type: none"> MH Status BDI-II, PCL-M Perceived mental health need Deployment Resilience Inventory Combat Experiences Scale Attitudes towards seeking professional psychological help Barriers to Care (organisational/practical, negative attitudes towards care General Health Post-deployment Social Support Scale Post-deployment stressors scale 	<ul style="list-style-type: none"> Cross-sectional design Relatively small sample of MH group Self-report of mental health utilisation

First Author, Year (Reference No.)	Study Design	Overall N/ (N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Kim, 2010 (12)	Cross-sectional	Overall sample N=10,386 Those with MH problems N=4,353	US	In-Service Personnel (Regulars), National Guard	Deployment to Iraq, Brigade Combat teams	affect my relationship with my unit/ team members	did you use prescribed medications for your mood, nerves, mental health, or sleep? Service utilisation – respondents asked whether they had received mental health services for a stress, emotional, alcohol or family problem form either a mental health professional at a military or civilian facility or a general medical doctor at a military or civilian facility. (not used in stigma analyses)	3 months post deployment or 12 months post deployment	0.95	<ul style="list-style-type: none"> Satisfaction with in-theater mental health service Demographics MH Status PHQ-9, PCL, Aggression Current distress. Barriers to care (organisational/ practical barriers) Demographics 	<ul style="list-style-type: none"> Cross-sectional design Combat unit may not be generalisable to wider military population Expansive definition of 'positive screen' for MH group
Kim, 2011 (13)	Cross-sectional	Overall sample N=2623 Those with MH problems N=881	US	In-Service Personnel (Regulars)	Deployed to Afghanistan/ Iraq at least once since 2001	PSBCPP-SS – plus one item, 'It might affect my security clearance'	Service utilisation – Respondents were asked to indicate whether they had received help for a stress, emotional, alcohol or family problem from a treatment provider Help-seeking intentions/ barriers to care	6 months post-deployment	0.93	<ul style="list-style-type: none"> PHQ-9, GAD-7, PCL. Aggression Current distress Barriers to care (negative attitudes towards MH care and organisational/ practical) Demographics 	<ul style="list-style-type: none"> Cross-sectional design Self report of MH utilisation Participants only asked about MH utilisation in past 3 months – longer period of time to assess MH use Expansive definition of

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Langston, 2010 (14)	Cross-sectional	Overall sample N=1559 Those with MH problems N= 406	UK	In-Service Personnel – Royal Navy	Royal Navy	Adapted from PSBCPP-SS – I would be perceived as weak by the Chain of Command <ul style="list-style-type: none"> It would adversely affect my promotion prospects I would be less likely to be given role/tasks of responsibility I would be embarrassed asking for help My peers would find out and treat me badly or tease me 	Help-seeking intentions/barriers to care measured through PSBCPP-SS	Not reported	Not reported	<ul style="list-style-type: none"> MH status – GHQ-12, PCL-C Demographics 	<ul style="list-style-type: none"> positive screen for MH group Cross-sectional design Royal Navy sample may not be generalisable to wider military population. Non-random sample Adaptation of PSBCPP-SS not tested for internal reliability
Oorio, 2013 (15)	Cross-sectional	Overall sample N=23,101 Those with MH Problems N=875	UK	In-Service Personnel (Regulars and Reserves)	Collation of 9 different UK Armed Forces datasets	PSBCPP-SS – 4 items <ul style="list-style-type: none"> My commanders would treat me differently I would be seen as weak It would harm my career It would be too embarrassing Stem question - 'I would not seek help for a mental health problem.... my	Help-seeking intentions/barriers to care measured through PSBCPP-SS i.e. participants asked to rate concerns that may have an effect on decisions to seek treatment	Two groups – those surveyed whilst deployed and those surveyed on re-deployed i.e. on return home from deployment	Not reported (barriers to care and stigma subscale 0.92)	<ul style="list-style-type: none"> MH status - PCL-C, PC-PTSD Barriers to care (organisation/practical and negative attitudes) Demographics 	<ul style="list-style-type: none"> Cross-sectional design No MH utilisation measure

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale ³	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Onimete, 2011 (16)	Cross-sectional	N=490	US	Veterans	Vietnam, Iraq and Afghanistan veterans Aged 18-69, recently diagnosed with PTSD within last 6 months (patients excluded if they had any VA outpatient or inpatient PTSD treatment in 2 years before that visit)	Developed from 25 item measure based on items from the barriers to help seeking scale (Mansfield et al 2005 and Vogt 2011) Participants indicated the degree to which each potential barrier hindered their use of healthcare. 4 point Likert scale '1' not at all, '2' slightly, '3' moderately, '4' very much. Discomfort HelpSeeking [DHS] • My problems aren't a big deal they will go away in time. • I don't want to overreact to problems that aren't serious. • I don't like to.	Help-Seeking intentions/barriers to care measured through stigma related barriers and to which degree stigma barriers hindered their use of healthcare.	Not reported (post deployment and veteran status)	DHS= 0.84 CSC= 0.72	<ul style="list-style-type: none"> MH Status – CES-D, IES-R Barriers to care (institutional, logistical, not fitting in) Demographics 	<ul style="list-style-type: none"> Cross-sectional design Treatment seeking sample Stigma scales in need of further psychometric testing No MH utilisation measure

³ First 9 items – instructions read, 'The following are some reasons people might have for NOT seeking help with personal problems. Please read each reason and decide how important it would be in keeping you from seeking help.'

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale ⁴	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
						<p>get emotional about things</p> <ul style="list-style-type: none"> I don't like other people telling me what to do. I don't like to talk about feelings. I would think less of myself for needing help. Privacy is important to me, and I don't want other people to know about my problems. <p>Concerns about Social Consequences (CSC)</p> <ul style="list-style-type: none"> I don't want to look stupid for not knowing how to figure these problems out My problems are embarrassing I'm concerned that other people might find out information in my VA records I only want to be seen individually, not in a therapy group 					

⁴ Last two items instructions read, 'The following are some reasons people might have for NOT seeking help for personal problems from the VA or Vet Center. Please read each reason and decide how important it would be in keeping you from seeking help.'

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Pietrzak, 2009 (17)	Cross-sectional	Overall sample N=272 Those with MH problems N=102	US	Veterans	Drawn from first two waves of Connecticut Iraq/Afghanistan veterans needs assessment survey – those who served between Jan 2003 – March 2007	PSBQPI-SS	Service use – measured by visits in last 6 months to MH professional for counselling or medication.	Not reported (post deployment and veteran status)	0.91	<ul style="list-style-type: none"> MH Status – PCL-M, PHQ-9, CAGE. Post-deployment Social Support Scale Comorbidities Davidson Resilience Scale Beliefs about Psychotropic Medication and Psychotherapy Measure Demographics 	<ul style="list-style-type: none"> Cross-sectional design Low response rate hence possible response bias Limited generalisability -need larger more diverse OIF-OIF veteran sample
Rosen, 2011 (18)	Cross-sectional	N=482	US	Veterans	Recently received diagnoses of PTSD during VA outpatient visit within last 6 months. Vietnam, Iraq/Afghanistan veterans	Stigma subscale – six items Developed from 25 item measure based on items from the barriers to help seeking scale (Mansfield et al. 2005 and Vogt, 2011)	Service utilisation – Measure use of psychotherapy and counselling from VA PTSD psychotherapy visits determined by National Care Database before survey time 1 (retrospective) and after survey time 1 (prospective)	Not reported (post deployment and veteran status)	0.81	<ul style="list-style-type: none"> MH status - IES-R Severity of PTSD Desire for help Help-seeking attitudes Demographics 	<ul style="list-style-type: none"> Cross-sectional design Treatment seeking sample Stigma scale items in need of further psychometric testing

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Stidom, 2012 (19)	Cross-sectional	Overall sample N=2437 Those with MH problem N=196	Canada	In-Service Personnel (Regulars and Reserves)	All Canadian forces personnel deployed on two consecutive 7 month rotations of a combat and peace support operation in Afghanistan 2009-2010	<p>Empirical measurement of stigma, stem question, and Likert scale</p> <ul style="list-style-type: none"> I don't want to look stupid for not knowing how to figure these problems out I'm concerned that other people might find out information on my VA records 	Care Seeking – Propensity – participants asked whether they were currently interested in receiving help for a stress, emotional, alcohol or family problem.	During deployment	Not reported	<ul style="list-style-type: none"> MH Status – PCL-C, PHQ-9 Location of deployment Barriers to care (stigma, structural barriers, negative attitudes towards care) Demographics 	<ul style="list-style-type: none"> Cross-sectional design No measure of MH service utilisation

First Author, Year (Reference No.)	Study Design	Overall N/(N those with MH problems)	Country	Engagement type	Sample selection criteria	Empirical measurement of stigma, stem question, and Likert scale*	Empirical measurement of help-seeking	When stigma/MH service use data gathered in relation to deployment	Cronbach's Alpha Score of Stigma Scale used	Other key variables	Quality assessment
Warner, 2011 (20)	Cross-sectional	Overall sample N= 1712 Those with MH problems N=207	US	In-Service Personnel (Regulars)	US Army Soldiers from one infantry brigade combat team undergoing routine Post-Deployment Health Assessment in 2008	this deployment* PSBCPP-SS – 3 <ul style="list-style-type: none"> My unit leadership would have less confidence in me Members of my unit would view me differently It would harm my career Stem question – respondents asked to 'Rate each of the possible concerns that might affect their decision to receive mental health services'.	Participants were asked about the presence of thoughts that they were 'Interested in receiving help for a stress, emotional, alcohol or family problem' (not used in stigma analyses) Willingness to receive care – participants asked to rate on a 5-point Likert scale 'if screening results indicated we believe I have an on-going behavioural health issue, I will seek treatment' (not used in stigma analyses) Help-Seeking intentions/barriers to care measured through PSBCPP-SS and stigma barriers hindered their use of healthcare.	30 days before return from Iraq deployment	Not reported	<ul style="list-style-type: none"> MH status - PHQ-2, PC-PTSD, suicidal ideation, PCL-M, PHQ-9 Interpersonal relationships questions 	<ul style="list-style-type: none"> Cross-sectional design Combat units may not be generalisable to wider military population No measure of MH utilisation

Abbreviations

- AUDIT - Alcohol Use Disorders Identification Test
- AUS – Australia
- BDI-II - Beck Depression Inventory-II
- CAGE Screen - Alcohol abuse screen

- CES-D - The Centre for Epidemiological Studies Depression Scale
- CSC – Concerns about social consequences (of seeking help) measure
- DHS – Discomfort with help-seeking measure
- GAD-7 - Generalised Anxiety Disorders-7
- GHQ-12 - General Health Questionnaire-12
- IES-R - The Impact of Events Scale-Revised
- Kessler 10 - non-specific measure for psychological distress
- MH – Mental Health
- NCO – Non-commissioned officer
- NZ – New Zealand
- PCL-C - PTSD Checklist – Civilian
- PCL-M - PTSD Checklist – Military version
- PC-PTSD - Primary Care PTSD Screen
- PHQ/PHQ-9 / PHQ-2 - Patient Health Questionnaire (depression screen)
- PSBCCPP-SS - Perceived Stigma and Barriers to Care for Psychological Problems – Stigma Subscale (PSBCCPP-SS – Hoge et al. 2004, Britt et al. 2008). Six items, five point Likert scale from strongly agree to strongly disagree. Stem question follows; “Using the scale provided, rate each of the possible concerns that might affect your decision to seek treatment for a psychological problem (e.g., a stress or emotional problem such as depression or anxiety attacks) from a mental health professional (e.g., a psychologist or counsellor).” Six items include; ‘It would harm my career’, ‘Members in my unit might have less confidence in me’, ‘My unit leadership might treat me differently’, ‘My leaders would blame me for the problem’, ‘I would be seen as weak’)
- PSOSH - Perceptions of Stigmatisation by Others for Seeking Help (PSOSH - Vogel, Wade and Ascheman, 2009) - Participants rate their agreement with each statement about how others might perceive them if they were to seek psychological help from 1=not at all to 5= a great deal. Different targets in this study addressed were; anticipated enacted stigma from unit leader, unit members, family/friends.
- PTSD – Post Traumatic Stress Disorder
- RIBS – Reported and Intended Behaviour Scale (RIBS Evans-Lacko et al. 2011) – Stigma behaviour scale that measures intended discriminatory behaviour towards people with mental health problems. Participants indicate strength of agreement with 8 statements on a Likert Scale. Example items include: I would live with, work with, live nearby and continue a relationship with someone with a mental health problems.
- SSOSH - Self Stigma of Seeking Help (SSOSH Vogel, Wade & Hakke, 2006) 10 items that assesses self stigma for seeking help for a mental health problem. Participants rate their agreement with each statement using a 5 point Likert scale of 1=strongly disagree to 5=strongly agree.
- UK – United Kingdom
- US – United States of America
- VA – Department of Veterans Affairs
- VISN - Veterans Integrated Service Networks

Web Table 1 References

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Web Table 2 - Stigma Prevalence (using PSBCPP-SS items) of those with probable/actual mental health problems studies 2004-2014

Anticipated Stigma Problem and Barriers to Care for Psychological Problems Stigma Sub-Scale (PSBCPP-SS)	Hoge et al. 2004 (N=731)	Gould et al. 2010* (US N=314, UK N=613, AUS N= 37, NZ N=30)	Kim et al. 2010 #	Depression, anxiety and PTSD		Gorman et al. 2011^ (N=133)	Vensen et al. 2011^ (N=225)	Kim et al. 2011^ (N=881)	Werner et al. 2011^ (N=207)	Hoerster et al. 2012 (N=305)	Osorio et al. 2012^ (N=675)	Langston et al. 2010^ (N=466)	Pietrak et al. 2009^ (N=102)	Jones et al. 2013^ (N=262)	Kelle et al. 2010^ (N=117)	
				US	UK											AUS
Mental health problems included in prevalence data	Depression, anxiety and PTSD	US=Depression, anxiety and PTSD UK=PTSD AUS=Psychological distress NZ= Psychological distress^	Depression, anxiety, PTSD aggression^, current distress^	3 months Post-dep Service Personnel (N=2,023 National Guard N=497)	12 months Post-dep Service Personnel (N=1,566 National Guard N=267)	Depression & Suicidal ideation, PTSD and hazardous drinking	Depression, anxiety, alcohol abuse and PTSD	Depression, anxiety, aggression current distress (see 'H'), alcohol abuse (see 'W')	Depression and PTSD	Depression and PTSD	Depression and PTSD	PTSD	Non specific psychiatric morbidity and PTSD	Depression, PTSD and alcohol abuse	CMD, PTSD, alcohol abuse	Depression, PTSD
Respondents asked to Rate each of the possible concerns that might affect your decision to receive mental health counselling or services if you even had a problem																
<i>It would be too embarrassing</i>	41% (240/641)		28% (52/186)	20% (92/460)	25% (35/142)	16% (41/256)	45% (146/325)	23% (203/881)			54% (386/710)	61% (246/406)	56% (53/94)	40% (102/254)	39% (44/114)	
<i>It would harm my career</i>	50% (319/640)	28% (88/314)	31% (58/187)	17% (80/470)	31% (43/140)	19% (49/257)	52% (169/325)	24% (211/881)	33% (68/207)	28% (84/300)	55% (386/697)	39% (160/406)	49% (50/102)	61% (153/253)	25% (28/114)	
<i>Members of my unit might have less confidence in me</i>	59% (377/642)		39% (73/187)	22% (101/459)	37% (52/141)	20% (38/133)	76% (247/325)	31% (273/881)	40% (83/207)	26% (79/305)			46% (40/87)	72% (184/254)	40% (46/114)	
<i>My unit leadership might treat me differently</i>	63% (405/637)	57% (179/314)	45% (83/185)	21% (96/457)	40% (57/142)	27% (37/133)	75% (244/325)	34% (300/881)	43% (88/207)	32% (95/297)	62% (426/688)		42% (50/84)	77% (182/253)	41% (47/114)	
<i>My leaders would blame me for the problem</i>	51% (328/642)		31% (57/185)	10% (46/460)	30% (42/142)	10% (26/133)	25% (81/325)	23% (203/881)					28% (22/80)	30% (76/253)	24% (27/114)	
<i>I would be seen as weak</i>	65% (413/640)	53% (166/314)	44% (81/184)	22% (103/468)	41% (58/142)	20% (41/133)	52% (169/325)	33% (291/881)		37% (110/297)	62% (429/688)	43% (175/406)	60% (55/92)	59% (149/254)	48% (55/114)	

* 'N' is reported from number of those who participated in studies with probable of actual mental health problems – where N is not provided stratified by mental health problems, calculations have been made from available data.

* Studies that coded participants' responses of 'strongly agree' and 'agree' into a positive response but were unclear of their treatment of the neutral category in the Likert scale.

- # Unclear how Likert scales were treated in relation to positive and negative responses and treatment of neutral categories.
- • Studies that coded participants' responses of 'strongly agree' and 'agree' into a positive response, 'strongly disagree' and 'disagree' into a negative response and excluded the middle category 'neither agree or disagree'.
- ^ Studies that coded participants' responses of 'strongly disagree', 'disagree' and 'neutral' into a negative response
- ♣ Studies that only had a four-point Likert scale and coded participants' responses of 'strongly agree' and 'agree' into a positive response and 'strongly disagree' and 'disagree' into a negative response.

^j Additional data was requested from the author to inform stigma prevalence including all mental health diagnoses into one group (original paper has this information stratified by type of mental health problem)

ⁱⁱ Additional data was requested from the author to inform stigma prevalence by mental health status

^{iv} Prevalence data calculated from available data reported in the paper.

^{iv} Additional data was requested from author to inform stigma prevalence

^v Additional data was requested from the author to inform stigma prevalence

^{vi} Additional data was requested from the author to inform stigma prevalence

^{vii} Kessler, R. C., et al., *Short screening scales to monitor population prevalences and trends in non-specific psychological distress*. Psychological medicine, 2002. **32**(6): p. 959-976.

^{viii} Both Australian and New Zealand samples used measure psychological distress; Kessler, R. C., et al., *Short screening scales to monitor population prevalences and trends in non-specific psychological distress*. Psychological medicine, 2002. **32**(6): p. 959-976.

^{ix} Respondents were asked whether they had experienced a stress, emotional, alcohol or family problem in the last month. Those who indicated a moderate or severe problem were considered to be at risk of mental health problems.

^x Item is phrased 'I would be embarrassed asking for help'

^{xi} Item is phrased 'It would adversely affect my promotion prospects'

^{xii} Item is phrased 'My unit leadership would have less confidence in me'

^{xiii} Item is phrased 'My unit bosses might treat me differently'

^{xiv} Item is phrased 'Members of my unit would view me differently'

^{xv} Item is phrased 'My commanders would treat me differently'

^{xvi} Item is phrased 'My bosses would blame me for the problem'

^{xvii} Item is phrased 'I would be seen as weak by those who are important to me'

^{xviii} Item is phrased 'I would be perceived as weak by the Chain of Command'

Appendix 2

UK Military Health Policy

Service personnel and mobilised Reserves receive their healthcare provision from Defence Medical Services whilst in Service. Ex-Service personnel and demobilised Reserves receive their healthcare service provision from the National Health Service.

Armed Forces Covenant

The Armed Forces Covenant was enshrined into law in 2011 by the Armed Forces Act. The Covenant provides context for the Government's mental health policy towards the UK Armed Forces. The Armed Forces Covenant sets out the relationship between the nation, the Government and the Armed Forces. It recognises that the whole nation has a moral obligation to members of the Armed Forces and their families, and it establishes how they should expect to be treated. The two principles of the Covenant include:

- The Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services.
- Special consideration is appropriate in some cases, especially for those who have given the most, such as the injured and the bereaved.

The Covenant exists to redress the disadvantages that the Armed Forces community may face in comparison to other citizens, and to recognise sacrifices made. The Armed Forces Covenant is supported by the Community Covenant and the Corporate Covenant. The Community Covenant encourages local communities to support the Armed Forces community in their area and promote public understanding and awareness. The Corporate Covenant is a public pledge from businesses and other organisations who wish to demonstrate their support for the Armed Forces community. For more information please see: <https://www.gov.uk/government/policies/armed-forces-covenant>

Military Mental Health Policy and Healthcare Services

Government military mental health policy has focused on increasing access to mental health services for military populations, increasing points of intervention and decreasing the stigma of mental health problems in the Armed Forces. Associated policies and services are listed below.

- Creation of Reserves Mental Health Programme in 2006 in response to research that found increased risk of mental health problems in deployed Reserves compared to non-deployed Reserves (Hotopf, 2006). Now renamed **The Veterans and Reserves Mental Health Programme** (VRMHP). It provides medical assessments for ex-Service personnel and Reserves who have concerns about their mental health related to Service. For more information please see <https://www.gov.uk/guidance/support-for-war-veterans>

- Government commissioned ‘**Murrison**’ report into military mental health – ‘**Fighting Fit**’¹ – recommended key policies to improve provision of mental health services which included:
 - **Mental health assessments** made formal requirement of discharge process from Service.
 - **Veteran Information Service** – Ex-Service personnel are contacted 12 months after leaving Service with signposting information on health and welfare services.
 - **Ex-Service badged NHS mental health services also termed ‘The NHS Veterans Service’** – examples of these services include the South West Veterans Mental Health Service² and Military Veterans Service Great Manchester and Lancashire³.
 - **Creation of 24-hour veteran mental health helpline** – run in partnership by Combat Stress and Rethink Mental Illness⁴.
 - **Free access to Big White Wall** – for all Service personnel, Reserves, ex-Service personnel and their families. Online mental health self-help and guided support service⁵.

- NHS National Specialist Commissioning - **Commissioning of a specialist PTSD treatment service** delivered by Combat Stress that has the capacity to treat 224 ex-Service personnel per year for PTSD⁶.

Additionally, the MOD has made efforts to decrease barriers to care by focusing on awareness and education through:

¹ For access to the original Murrison report, please follow this link:
<https://www.gov.uk/government/publications/fighting-fit-a-mental-health-plan-for-servicemen-and-veterans--2>

² <http://www.swveterans.org.uk>

³ <https://www.penninecare.nhs.uk/your-services/military-veterans-service/>

⁴ <https://www.gov.uk/government/news/veterans-mental-health-helpline-launched>

⁵ www.bigwhitewall.com

⁶ <http://www.combatstress.org.uk/veterans/treatment-centres/ptsd-intensive-treatment-programme>

- **Mental health pre-deployment briefings.**
- **Trauma Risk Management Training (TRiM)**⁷ (Greenberg, 2008).
- **Third location decompression**⁸.
- **Anti-stigma campaigns** - 'Don't Bottle it up'⁹.

For more information on mental health support for Armed Forces please see:

<https://www.gov.uk/guidance/mental-health-support-for-the-uk-armed-forces#fighting-fit-a-mental-health-plan-for-servicemen-and-veterans>

⁷ TRiM-trained personnel undergo specific training in the management of people after traumatic incidents. Those who are identified as being at risk after an event are invited to take part in an informal interview which establishes how they are coping. For an overview of TriM's use in the UK Armed Forces please see: <http://www.kcl.ac.uk/kcmhr/publications/assetfiles/screening/Greenberg2008-trim.pdf>

⁸ The aim of Decompression is to provide a friendly environment that allows Service personnel time to start 'winding down' after their operational tour and prior to rejoining friends and family in the UK. Decompression currently takes place in Cyprus.

⁹ Information on the MOD anti-stigma campaign, 'Don't Bottle it Up' <http://www.army.mod.uk/welfare-support/23386.aspx>

Appendix 3

Social influences and barriers to healthcare seeking for mental health problems among UK military – Qualitative Study 1

CODEBOOK EXAMPLES

Participant negative attitude/expectation of mental health treatment (parent sub-code)	
Code description	Negative attitudes or expectations towards mental health treatment
Where to use the code	Large subsuming sub-code - Collates child codes where participant expresses any negative attitudes or expectations towards mental health treatment whether these are based in reality or assumptions/perceptions
Where not to use the code	Not to be used for general coding of negatives attitudes, codes must sit under a specific child code to then be collated under this sub-code.

Concern seeking help for nothing (child sub-code of participant negative attitude/expectation of mental health treatment)	
Code description	Describes non-help-seekers and help-seekers negative expectations of mental health treatment with regards to their concern that they don't want to visit the doctor for no reason.
Where to use the code	Use where participant expresses the desire not to seek help because they don't want to seek help if nothing is wrong with them. Relate to potential embarrassment they may have in being vulnerable disclosing a problem to then be told they are fine – hence in their mind making an issue out of nothing. May have links with self-stigma, self-esteem, concerns about being weak.
Where not to use the code	-

Concern for treatment outcome (child sub-code of participant negative attitude/expectation of mental health treatment)	
Code description	Describes non-help-seekers and help-seekers negative attitudes/expectations that treatment may not result in a successful outcome.
Where to use the code	Use where participant expresses concerns related to the potential unsuccessful outcome of treatment. Participant may indicate their worries that if treatment does not work they would feel

	completely stuck.
Where not to use the code	Not to be used where participant describes concerns about treatment process or type of treatment.

Doesn't think Dr could help
(child sub-code of participant negative attitude/expectation of mental health treatment)

Code description	Describes non-help-seekers and help-seekers negative attitudes/expectations about the ability of the medical profession to offer them help.
Where to use the code	Use where the participant cites the reason for not seeking help being their belief that the dr (GP/MO) wouldn't be able to offer support/help or treatment for their problem, or the attitude that they just can't see what the dr could offer them. The reasons for this belief may be varied; their problem isn't 'medical', they have tried dr's help/treatment before and it didn't work, their problem isn't big enough, their problem is normal. Related to mental health knowledge of treatment and services.
Where not to use the code	-

Doesn't want to be medicalised
(child sub-code of participant negative attitude/expectation of mental health treatment)

Code description	Describes non-help-seekers and help-seekers negative attitudes that seeking treatment/help turns their problem and/or them into a medical case, which they wish to avoid.
Where to use the code	Use where participant expresses the desire for their problem not to be medicalised.
Where not to use the code	-

Doesn't want to take medication
(child sub-code of participant negative attitude/expectation of mental health treatment)

Code description	Describes non-help-seekers and help-seekers negative attitudes/expectations towards pharmacological treatment
Where to use the code	Use where participant expresses a reason for not seeking help being their concern that they would be offered pharmacological treatment and they do not want to take medication for their problem. Often imbued idea that they would have little choice over their treatment. Also related to stigma.
Where not to use the	Not to be used where individual does not want to participate in

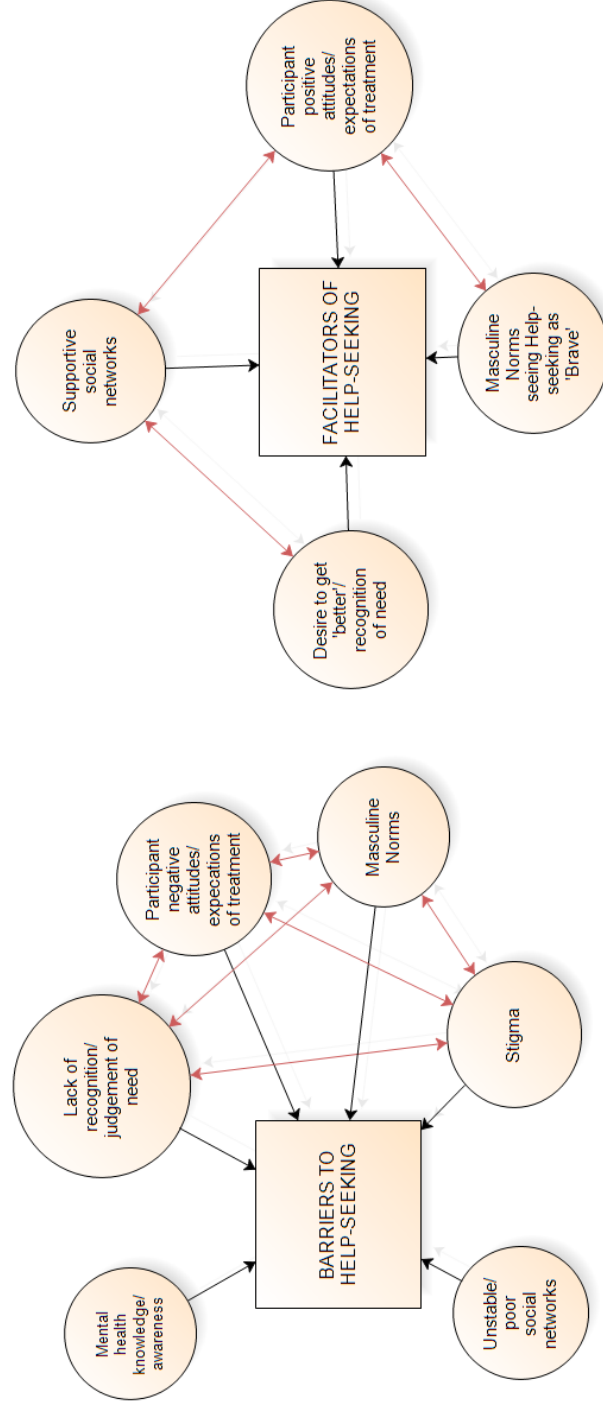
code	other forms of treatment (e.g. counselling, CBT, anger management etc.)
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Dr as a stranger (child sub-code of participant negative attitude/expectation of mental health treatment)	
Code description	Describes non-help-seekers and help-seekers negative perceptions of dr's as unknown strangers
Where to use the code	Use where participant expresses concern that they do not know their dr and therefore would not want to disclose problems to a stranger. Related to emotional guardedness, non disclosure, mental health knowledge.
Where not to use the code	-

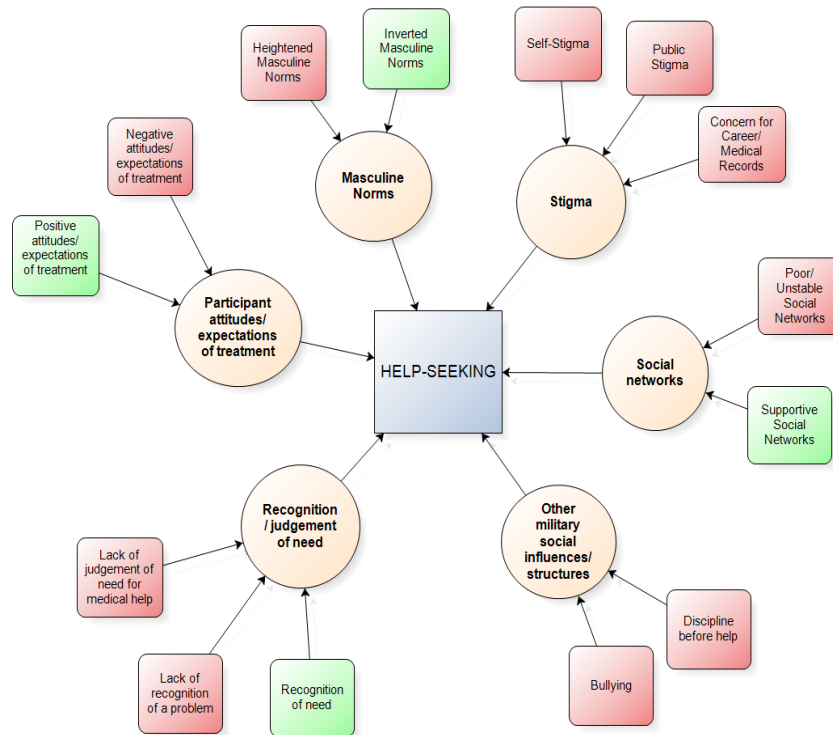
Appendix 4

Example of Thematic Model Progression From Qualitative Study One

- Diagram at phase 4 of thematic analysis showing separated barriers and facilitators of help-seeking (this model omits sub-themes for parsimony for the reader, red arrows detail potential connections between themes)



- **Diagram after phase 5 and 6** of thematic analysis –Barrier (in red) and facilitator themes (in green) that mirror each other have been matched up and subsumed under supra-themes (in yellow). (This model omits sub-themes for parsimony for the reader and omits red arrows detailing potential connections between themes)



Appendix 5

Qualitative Study One - King's Cohort Interviewee Group – Participant Invitation Letter and Participant Information Sheet



Principal Investigators:

Dr Nicola Fear
Dr Laura Goodwin
Professor Christopher Dandeker
Marie-Louise Sharp

Invitation to take part in a research study on the social influences and barriers to seeking healthcare for mental health problems among UK military personnel

Dear

We are contacting you from the King's Centre for Military Health Research (KCMHR), King's College London, to invite you to take part in a research study. The study aims to find out more about social influences and barriers to seeking healthcare for mental health problems among UK military personnel. This includes the experiences of current Service personnel (Regulars and Reserves) and Ex-Service personnel.

We would like to thank you for previously taking part in the KCMHR well-being surveys of Serving and ex-Serving members of the UK Armed Forces and agreeing that you could be contacted again by the research team.

The study will initially involve participation in a survey, this can be completed securely online or through a hard paper copy on request. The survey will take no more than 5-10 minutes to complete. Individuals will then be asked to take part in a telephone interview with our researcher which will take approximately one hour, and we will give you £15 as a thank you.

Participation in the study is confidential and voluntary. However, we need your help if we are to more fully understand the barriers facing military personnel when seeking healthcare for mental health problems. Please read the attached/enclosed Participant Information Sheet which provides more information about the study.

If you are interested in taking part please follow the website link <https://www.surveymonkey.com/s/healthcarestudy> to our secure online survey. **To access the survey please enter your unique identification number XXXX**

If you would like to receive the survey by hard copy to then return to KCMHR by prepaid envelope, please contact the office number below.

If you have any further questions or would like to opt out of the study you can (i) email us at marie-louise.sharp@kcl.ac.uk detailing your wish to opt out, or with your preferred contact telephone numbers and we will call you, or (ii) you can call us directly on 020 7848 5269.

If we have not heard from you within a couple of weeks we will try to contact you by calling you.

Thanking you for considering taking part.

Yours sincerely

M-L Sharp



Research into the social influences and barriers to seeking healthcare for mental health problems among UK military personnel

PARTICIPANT INFORMATION SHEET

Introduction

You are invited to take part in this research project because you have previously taken part in the King's Centre for Military Health Research, Health and Well-being surveys of Serving and ex-Serving members of the UK Armed Forces. It is important that you understand why the current research is being done and what your participation will involve, so that you can make an informed decision as to whether you wish to take part. Please read the following information and discuss it with others if you wish.

What is the King's Centre for Military Health Research (KCMHR)?

KCMHR is an academic research team at King's College London. We have been conducting independent research into issues relevant to current and former members of the UK Armed Forces since 1996.

Who is funding the study?

The study is being funded by the Economic Social Research Council and the Royal British Legion as part of a PhD Project at KCMHR.

What is the purpose of the study?

The study aims to investigate the social influences and barriers to seeking healthcare for mental health problems among UK military personnel. This includes the experiences of current Service personnel (Regulars and Reserves) and Ex-Service personnel. The information you give will help us to identify any barriers that military personnel face when seeking help for stress, emotional or alcohol problems related to their deployments or broader military experiences. The information you provide will create new evidence that will inform understanding and practical decisions about the provision of mental healthcare services both within the UK Armed Forces and the National Health Service.

How has KCMHR been able to contact you?

You have previously taken part in the King's Centre for Military Health Research, Health and Well-being surveys of Serving and ex-Serving members of the UK Armed Forces and have agreed that the research team could contact you in the future.

Do you have to take part in the study?

Your invitation to take part in the study is completely confidential. You are under no obligation to take part and are free to withdraw at any time without giving a reason.

If you decide to take part, what will you be asked to do?

You will be asked to take part in our survey. This will take no more than 5-10 minutes to complete. You can complete this survey through our secure online site or you can request to receive a hard copy of the survey by post to return to KCMHR through a prepaid envelope.

Each individual that decides to take part has been given a unique identification number. You can find your specific identification number on this information sheet, or by contacting the research office. By taking part in the survey you allow us to use your information in our research, however all information will be anonymised without any personal identifiers.

Some of those who take part in the online survey will be contacted to take part in a telephone interview with our researcher at a time convenient for you. This will take approximately one hour, and as a thank you for your time we will give you £15.

What will you be asked about in the survey?

The online survey will ask brief questions about your well-being and mental health and any use of healthcare services.

What will you be asked about in the telephone interview if you are contacted to take part?

We will ask about your physical and mental health and well-being, with a particular focus on your mental health and any stress, emotional or alcohol problems related to your deployment(s) or broader experiences in the military. We will ask you about your experiences in help-seeking, any use of healthcare services, your views on mental health and expectations about mental health treatment. We will also ask you about any medication you use and your social networks. Your consent and interview will be recorded to help ensure researchers do not miss any of the information you give.

Will everyone who completes the online survey be contact to take part in the telephone interview?

Not everyone who completes the online survey will be contacted for a further telephone interview, we do however appreciate the time individuals give to participating in the survey. Everyone who completes the online survey will receive a Signposting Booklet which contains the contact details of organisations that can offer relevant help.

What about confidentiality?

All information will be kept strictly confidential. It will be stored securely, and will only be accessible to the research team. We will not share your personal information with anyone outside of the research team. The only exception is if you tell us something which makes us concerned about your safety or the safety of others, which we are legally obliged to do. However, we would discuss this with you before telling anyone else.

For how long will your information be stored?

The information collected about you will be stored for 20 years, in line with guidance from the Medical Research Council. After this time, the information will be securely destroyed.

What are the benefits of taking part?

Many people who have been interviewed have said that they valued the opportunity to talk about their experiences. By taking part you will be helping us to better understand the difficulties individuals face in seeking-help and accessing mental healthcare services. Additionally this information can potentially support the development of healthcare services and improve the experiences of military personnel in the future.

What are the possible disadvantages of taking part?

It is unlikely that taking part in the study will be harmful to you. However, if you are not comfortable answering any of the questions, you will be able to stop the survey or the telephone interview at any time. If you become distressed during the telephone interview a mental health professional will call you if you wish, to talk to you about your mental health and to offer help and advice. We also have a Signposting Booklet, which contains the contact details of organisations that can offer relevant help.

What if you are concerned before or during the study and want independent advice?

The study will provide an Independent Medical Officer should any you have any general concerns or distress about the study. The Independent Medical Officer will be available to

give impartial advice. His sole function is to ensure your safety and well-being whilst you take part in the study. His contact details are;

*Col Peter McAllister L/RAMC, Consultant Advisor in Psychiatry (Army)
DCMH Catterick, Duchess of Kent Barracks, Catterick Garrison, DL9 4DF
Tel: 01748873058
Email: CONSULTANTPSYCHIATRIST@JMS.MOD.UK*

What will happen to the results of the research?

The overall findings will be published in academic journals, written up as part of a KCMHR PhD, and presented to interested organisations in the military health and welfare field. We will send you a Newsletter summarising our findings. Results will be reported in a way that individuals cannot be identified ensuring anonymity and confidentiality.

How will you get the £15?

Once you have completed the telephone interview, we will send you a cheque for £15.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by the National Research Ethics Service. A research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers.

What to do next?

If you are happy with the information above and **wish to take part** please follow the website address <https://www.surveymonkey.com/s/healthcarestudy> to our secure online survey. To access the secure online survey you will need your unique identification number detailed on your invite letter.

If you would like to receive the survey hard copy by post to return to KCMHR through a prepaid envelope, please get in touch with the office through the contacts below.

If you would like **more information** or if you would **like to opt out** from participation in the study, please contact the research team on 020 7848 5269 or send us an email at marie-louise.sharp@kcl.ac.uk either detailing your wish to opt out or giving your contact telephone numbers and our researcher will call you to answer any questions you may have.

If we don't hear from you within a couple of weeks, we will try to contact you to check you have received the study information pack and to see if you have any queries about the study.

Thank you for taking the time to read this information.

Kings Centre Military Health Research
Institute of Psychiatry
King's College London
Weston Education Centre,
10 Cutcombe Road
London
SE5 9RJ

Tel: 0207 848 5269

Appendix 6

Qualitative Study One – Online Screening Survey Tool



UK Military Healthcare Study

Study Information - Welcome

Thank you for your interest in the research being undertaken by the King's Centre for Military Health Research (KCMHR).

You are invited to take part in this research project because you have previously taken part in KCMHR research and agreed to be contacted again. If it would be helpful for you [please click on this link](#) to have a look at the Participant Information Sheet we previously sent you. Your participation in the study is confidential and voluntary.

The current study aims to find out more about why military personnel do or don't seek help for mental health. This includes the experiences of current Service personnel (Regulars and Reserves) and ex-Service personnel.

The study involves participation in a survey, this can be completed securely online here by clicking 'Next' or through hard paper copy on request from the KCMHR office (please see contacts below). The survey should take no more than 5-10 minutes to complete. The survey will ask brief questions about your well-being, mental health and any use of healthcare services.

Some of those who take part in the survey will be contacted at a later stage to take part in a telephone interview with our researcher at a time convenient for you. This will take approximately one hour and as a thank you for your time we will give you £15.

For more information on the study or to request a hard copy of the survey, please contact the research office - 0207 848 5269 or marie-louise.sharp@kcl.ac.uk

To continue please click on 'next'.

PREVIEW & TEST



UK Military Healthcare Study

Study Consent

- * 1. Please enter your 4 digit unique identification number which can be found on your Participant Invite Letter**

(If you can not find this please contact the KCMHR Office on 0207 848 5269)

- * 2. Please could you confirm your date of birth:**

Date of Birth DD MM YYYY
 / /

- * 3.**

I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

I confirm that I have read and understood the Participant Information Sheet for this study and have had the opportunity to ask questions.

If no, [please click here](#) for another chance to read the information sheet we previously sent you.

Yes

No



UK Military Healthcare Study

General Health

*** 4. In general, how would you rate your health?**

Excellent Very Good Good Fair Poor

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UK Military Healthcare Study

Use of Healthcare Services

*** 5. Within the last year have you experienced a stress or emotional problem?**

- Yes
- No

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UK Military Healthcare Study

*** 6. Regarding this stress/emotional problem, did you go to see:
(please tick all that apply)**

- GP/Medical Officer
- A Specialist (e.g. hospital doctor, psychiatrist, nurse, counsellor)
- Non-Medical Professional (e.g. Padre, Social Worker, Welfare Officer)
- No Help Sought

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UK Military Healthcare Study

*** 7. Do you think this problem is a consequence of: (please tick all that apply)**

- Deployment
- General Military Service
- Non-Military Related Circumstances
- Don't Know

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UK Military Healthcare Study

*** 8. Within the last year have you experienced an alcohol problem?**

Yes

No

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UK Military Healthcare Study

*** 9. Regarding this alcohol problem, did you go to see:
(please tick all that apply)**

- GP/Medical Officer
- A Specialist (e.g. hospital doctor, psychiatrist, nurse, counsellor)
- Non-Medical Professional (e.g. padre, social worker, welfare officer)
- No Help Sought

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*** 10. Do you think this problem is a consequence of: (please tick all that apply)**

- Deployment
- General Military Service
- Non-Military Related Circumstances
- Don't Know

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Current Health

*** 11. Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being unable to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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*** 12. The next few questions are about bad experiences that might have happened to you at any time in your life. 'Bad experiences' are things seeing bad things in a combat situation, seeing someone killed or seriously injured, a serious car accident, having a loved one die by murder or suicide, or any other experiences that either put you or someone close to you at risk of serious harm or death.**

Has anything like this ever happened to you at any time in your life?

Yes

No

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*** 13. With regards to that bad experience, in the past month have you:**

	Yes	No
Had nightmares about it or thought about it when you did not want to?	<input type="radio"/>	<input type="radio"/>
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	<input type="radio"/>	<input type="radio"/>
Were constantly on guard, watchful, or easily startled?	<input type="radio"/>	<input type="radio"/>
Felt numb or detached from others, activities, or your surroundings?	<input type="radio"/>	<input type="radio"/>

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*** 14. How often do you have a drink containing alcohol?**

- Never Monthly or less 2-4 times a month 2-3 times a week
 4 or more times a week

*** 15. How many drinks containing alcohol do you have on a typical day when you are drinking?**

- 0 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

*** 16. How often do you have six or more drinks on one occasion?**

- Never Less than monthly Monthly Weekly Daily or almost daily

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Completion and Thank you

Thank you for taking part in the survey.

All individuals who have completed the survey will be sent a Signposting Booklet which contains the contact details of organisations that can offer relevant help and services. To see an online version, [please follow this link](#).

If you would like any more information on the study, please get in touch with the KCMHR research team on 0207 848 5269 or e-mail marie-louise.sharp@kcl.ac.uk

- * 17. As detailed in the Participant Information Sheet, some individuals will be contacted in the next month to take part in a telephone interview with our researcher, which will take approximately one hour, and we will give you £15 as a thank you.**

Would you be happy for us to contact you?

- Yes
- No

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*** 18. Please could you supply us with the best telephone number to contact you on:**

Phone Number:

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Done

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Appendix 7

Qualitative Study One – Signposting Booklet



Social Influences and barriers to seeking healthcare for mental health problems in the UK military

General Information on services for Serving and ex-Service personnel



University of London

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1. National Mental Health Services and Advice

For those of you **still serving** the first port of call should be your **Medical Officer; the Chain of Command; the Padre**. For **veterans** the first port of call is your **GP**. For **Reservists** the first port of call is the **TA Chain of Command** or your **GP**.

Big White Wall

An anonymous peer support network that encourages you to be open about what is on your mind, to learn more about yourself and what is troubling you. It is available 24/7 and is free for serving personnel, veterans and their families. You can talk anonymously through your troubles with the whole community, a selected group or individual. Trained mental health professionals can help small groups of members to resolve problems like stress, anxiety and depression.

Tel: 020 7060 1677

Email: theteam@bigwhitewall.com

Website: www.bigwhitewall.com

Combat Stress 24 Hour Helpline

Providing confidential help and advice on any mental health issues to the military community and their families

Tel: 0800 138 1619

Text: 07537 404 719 (standard charges may apply for texts)

Email: combat.stress@rethink.org

Combat Stress

The Ex-Services Mental Welfare Society. Contact head office for details of your local office. Open Monday - Friday, 9am - 5pm.

Tel: 01372 841600

Email: contactus@combatstress.org.uk

Website: www.combatstress.org.uk

Forcesline

As part of Soldiers, Sailors, Airmen and Families Association (SSFA) this support line offers totally confidential, non judgemental, guidance on all personal/welfare issues including sexual harassment, discrimination, bullying, racism, drugs, depression, alcohol, debt, relationship counselling and suicide to the Army community from anywhere in the world. It is completely independent of the military chain of command. Open 7 days a week from 10.30am -10.30pm (UK time)

From UK and Bosnia/Kosovo: 0800 731 4880

From Cyprus: 800 91065

From Germany: 0800 1827 395

Fawkland Islands: #6111

Rest of the World*: 0044 1980 630854 (*staff will phone you back)

Absent without Leave (AWOL) Line: 01380 738137

Website: www.ssafa.org.uk/how-we-help/forcesline

The Veterans and Reserves Mental Health Programme (VRMHP) (formerly the Medical Assessment Programme)

Provides mental health assessments for veterans and Reservists who have concerns about their mental health as a result of service.

The Medical Assessment Programme has moved from St Thomas' Hospital, London to Chilwell, Nottingham. The service is now co-located with Reservist Mental Health Programme and renamed the VRMHP.

The VRMHP is available to veterans who have deployed since 1982 and are experiencing mental health challenges as a result of military service. The service will remain the same; a full mental health assessment by a consultant psychiatrist with accompanying guidance on care and treatment for the veteran's local clinical team. Referrals to the VRMHP will preferably be made by the individual's GP however self-referrals will now be accepted for this service.

Reservists

The Reserves Mental Health Programme, run in partnership with the NHS, is open to all current or former members of the UK Volunteer and Regular Reserves who have been demobilised since 1 January 2003, following operational deployment overseas as a Reservist and who believe that their deployment may have affected their mental health.

Freephone helpline: 0800 032 6258

Email: aphsedcmhchl-vmhp@mod.uk

Website: <https://www.gov.uk/support-for-war-veterans#the-veterans-and-reserves-mental-health-programme>

and

<http://www.army.mod.uk/welfare-support/23247.aspx>

MIND

Mind infoline offers a range of advice on mental health issues and also offers legal advice. The website also has links to a wide range of booklets and leaflets. Open Monday – Friday, 9.15am – 5.15pm.

Tel: 0845 766 0163

Website: www.mind.org.uk

NHS Direct

Call or email health professionals for advice about mental and physical health.

Tel: 0845 4647 (24hr)

Website: www.nhsdirect.nhs.uk

Samaritans

Someone to talk to 24 hours a day, they also offer face to face appointments in local branches.

Tel: 08457 90 90 90

Email: jo@samaritans.org

Website: www.samaritans.org

The Veterans Agency

Offers advice or puts you in contact with appropriate organisations. Open Monday - Thursday, 8.15am - 5.15pm, Fridays, 8.15am - 4.30pm.

Tel: 0800 169 2277 (Free to ring from most mobiles)

Overseas: +44 1253 866043

Textphone: 0800 169 3458

Email: help@veteransagency.mod.uk

Website: www.veterans-uk.info

Royal British Legion

Provides financial, social and emotional support to all those who have served and are currently serving in the Armed Forces, as well as their families. Open Monday – Friday, 10am – 4pm.

Tel: 08457 725725

Website: www.britishlegion.org.uk

2. Regional/local Mental Health Service and Advice

List of regional/local services is not exhaustive – Please contact Combat Stress 24 hour helpline for more information on local services if you can not find an appropriate service listed below.

Tel: 0800 138 1619

Text: 07537 404 719 (standard charges may apply for texts)

Email: combat.stress@rethink.org

Veterans First Point

Aims to provide a one-stop shop for veterans and their families living in Lothian, working with organisations that might be able to help a veteran or their family to resolve whatever issue they may have.

Tel: 0131 220 9920

Website: www.veteransfirstpoint.org.uk

All Wales Veterans Health and Wellbeing Service

All Wales service for veterans who need psychological support, treatment and advice. The service also provides help to access employment, benefits and housing advice. Open to any veteran living in Wales who has served at least one day with the British Military as either a regular service member or as a Reservist who has a service related psychological injury. Self-Referral or referral by GP.

Tel: 029 2074 2062 (Mon-Fri 8-3.30) Secretary Sharon Bowles

Email: Sharon.bowles@wales.nhs.uk

Email: neil.kitchiner@wales.nhs.uk

Website: <http://www.veteranswales.co.uk>

NHS Humber Veterans Outreach Service

Mental health triage and assessment for military veterans registered with GPs across Yorkshire and the Humber.

Tel: 01482 617594

E-mail: veteransoutreachservice@humber.nhs.uk

Website: <http://www.humber.nhs.uk/services/veterans-outreach-service>

Lancashire Care NHS Foundation Trust Veterans Mental Health Website

Website dedicated to increase NHS staff awareness of Veteran mental health problems and needs and to provide ease of access to resources relevant to veterans and their families.

Website: <http://lcfveterans.wordpress.com>

NHS Tees, Esk and Wear Valleys NHS Foundation Trust Veteran Services

Services include Community Veterans Mental Health Service, Veterans Wellbeing Group, Veterans' Wellbeing Assessment and Liaison Service and Veterans Mental Health Awareness Training

Tel: 01388 646800

Email: veterans.veterans@nhs.net

Website: <http://www.tevv.nhs.uk/Our-services/Trustwide-services/Veteran-services/>

NHS Pennine Military Veterans' Service

Service to improve the mental health and emotional wellbeing of ex-service personnel and their families. Service covers the whole North West, working closely with local services. Self referral or referral through GP.

Tel: 0161 253 6638

E-mail: mviapt.enquiries.nw@nhs.net

Website: <http://www.penninecare.nhs.uk/Pages.asp?catID=9>

West Midlands Regional Veterans Mental Health Network

Network of eight Mental Health Trusts has been established across the West Midlands region to support the identification and engagement of veterans into services

Website: <http://www.southstaffsandshropshealthcareft.nhs.uk/Services/Veterans-Mental-Health-Service/Default/West-Midlands-Regional-Veteran-s-Service.aspx>

South Staffordshire & Shropshire Veterans' Mental Health Services

Tel: 0800 500 3113 Phone (If ringing from a mobile phone 01785 258041)

E-mail: veterans.support@sssft.nhs.uk

Website: <http://www.southstaffsandshropshealthcareft.nhs.uk/Services/Veterans-Mental-Health-Service/Default/Staffordshire---Shropshire.aspx>

South West Veterans Mental Health Partnership Service

Provides help to military veterans across the whole of the South West of England. Referrals from veterans themselves, their families or carers, from any health or social care professional or recognised charity.

Tel: 0300 555 0112

E-mail: referral@swveterans.org.uk

Website: <http://www.swveterans.org.uk>

NHS London Veterans' Community Mental Health Service

Mental Health Service for veterans in London, self-referral or referral by charity or GP

Telephone: 020 7530 3666

Email: veterans@candi.nhs.uk

Website: <http://www.candi.nhs.uk/veterans/>

3. General Advice and Support

Citizens Advice Bureau

The national centre can give you the number of your local office

Tel: 020 7833 2181

Web: www.adviceguide.org.uk

Debt Advice Line

Leave a message to request an information pack or factsheet. Open Monday-Friday, 9am-9pm (24-hour voicemail)

Freephone: 0808 808 4000

Web: www.nationaldebtline.co.uk

Hive

Tri-Service information network offering range of advice to all members of the service community.

Central Office: 01722 436498/9

Email: hivegb@hqland.army.mod.uk

Homefront Forces

Support for partners, parents and children of those in the Forces.

Web: www.homefrontforces.com/

RAF Community Website

For RAF personnel and their families. Information on a wide range of topics, including family separation, housing and support groups.

Web: www.rafcom.co.uk/

Rear Party

Online community for families and friends of military personnel.

Web: www.rearparty.co.uk/

Forum: www.rearparty.co.uk/Forums.html

Royal British Legion

Open Monday - Friday, 10am - 4pm

Tel: 08457 725725

Website: www.britishlegion.org.uk

Royal Navy Community Website

For RN personnel and their families. Information on a wide range of topics, including family wellbeing, community support and support services as well as a help desk for advice.

Website: www.royalnavy.mod.uk/Community/Members-area

The Site

Information and advice on many topics including relationships, health and wellbeing, homes, money, work, study and travel.

Website: www.thesite.org

The Veterans Agency

Offers advice or puts you in touch with appropriate organisations. Free helpline for veterans and their families. Open Monday - Thursday, 8.15am to 5.15pm, and Friday, 8.15am to 4.30pm.

Freephone: 0800 169 2277

Textphone: 0800 169 34 58

Email: veterans.help@spva.gsi.gov.uk

Website: www.veterans-uk.info

Regimental Admin Officer

Can offer advice for those still serving.

4. Alcohol and Drugs

Addaction

Information website about coping with alcohol and drug dependency.

Website: www.addaction.org.uk

Alcoholics Anonymous

A fellowship of men and women who share their experience, strength and hope with each other to help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking.

Tel: 08457 697555

Website: www.alcoholics-anonymous.org.uk

Al-Anon

Provides support to anyone whose life is, or has been, affected by someone else's drinking as they believe alcoholism affects the whole family, not just the drinker. Open 10am - 10pm, 365 days a year

Confidential Helpline Tel: 020 7403 0888

From Northern Ireland: 028 9068 2368 (Helpline Monday - Friday, 10.00am - 1.00pm, Monday - Sunday inclusive, 6.00pm - 11.00pm)

From Republic of Ireland*: 01 873 2699 (Helpline Monday - Friday, 10.30am - 2.30pm)

From Scotland: 0141 339 8884 (Helpline 10am - 10pm, 365 days a year)

Email: enquiries@al-anonuk.org.uk

Website: www.al-anonuk.org.uk/

Drinkline

Offers free, confidential information and advice on alcohol. Open Monday - Friday, 9am - 11pm

Tel: 0800 917 8282 (England and Wales only)

Website: www.nhs.uk/livewell/alcohol

National Drugs Helpline - FRANK

FRANK is a confidential service to speak to a professionally trained advisor about drugs.

Tel: 0800 77 66 00 (24hrs/365 days a year)

Website: www.talktofrank.com

Turning Point

National health and social care provider to help people find a new direction in life and help tackle substance misuse, mental health issues or employment difficulties

Tel: 020 7481 7600

Email: info@turning-point.co.uk

Website: www.turning-point.co.uk

5. Jobs and Employment

Employment Service Direct (Job Centre)

Open Monday - Friday, 8am - 6pm and Saturdays, 9am - 1pm.

Tel: 0845 6060 234

Textphone: 0845 6055 255

Website: www.gov.uk/browse/working/finding-job

NACRO

Aims to help those with a criminal record get back into work. Open Monday - Friday, 9am - 5pm.

Tel: 0800 0181 259

Email: Helpline@nacro.org.uk

Website: www.nacro.org.uk

SaBRE

Offers advice to reservists about their employment rights and responsibilities. Open Monday - Friday, 9am-5pm.

Tel: 0800 389 5459

Website: www.sabre.mod.uk

6. Grants for Courses/Education

Adult Learning Grant

Financial assistance to help adults back into education. Learner support helpline is open 7am to 8pm.

Information on advanced learning loans:

Website: www.direct.gov.uk/en/EducationAndLearning/AdultLearning/FinancialHelpForAdultLearners/index.htm

For further source of financial help with childcare contact the learner support helpline:

Tel: 0800 121 8989

Army Education Centre

Available to those still serving.

Royal British Legion

The British Legion has grants and scholarships available for ex-service personnel and their dependants, spouses of ex-service personnel and their dependants. Open 10am-4pm Monday-Friday.

Tel: 08457 725725

Welfare Tel: 020 3207 2182 or 2183 or 2186

Email: WSWelfare@britishlegion.org.uk

Website: www.britishlegion.org.uk

Army Benevolent Fund

Offers a range of financial grants for care in the home, holidays, bursaries, annuities and practical support to serving and ex-service personnel and their families.

Tel: 020 7591 2060

Website: www.soldierscharity.org

Princes Trust

For help with setting up your own business or with money for courses, for those aged 18-25.

Tel: 0800 842842

Website: www.princes-trust.org.uk

RAF Benevolent Fund

For former RAF personnel or their families. Offers a wide range of practical, financial and emotional support.

Tel: 0800 169 2942

Website: www.rafbf.org.uk

For those still serving, contact should be made through Chief Clerk or Flight Commander.

Royal Navy Benevolent Trust

Offers a range of help, including grants and advice, for serving and ex-serving members of the Royal Navy and Royal Marines and their families, including those who are separated or divorced and now living with a new partner.

Tel: 02392 690112 or 660296 or 725841

Email: rnbt@rnbt.org.uk

Website: www.rnbt.org.uk/

Service family members can also get basic skills training at their local Armed Forces education facility. Ask at your local facility for details.

7. Help Claiming Benefits

Benefits Agency

Open Monday-Friday, 9am-5pm.

Tel: 020 7712 2171

SSAFA

SSAFA (Soldiers, Sailors, Airmen and Families Association) Open Monday-Friday, 9.15am-5pm.

Tel: 020 7403 8783

Website: www.ssafa.org.uk

Royal British Legion

Open Monday-Friday, 10am-4pm

The British Legion also has funding available for families of ex-service personnel in need.

Tel: 08457 725725

Website: www.britishlegion.org.uk

8. Housing

Government Housing information

Website: www.communities.gov.uk/housing

Haig Homes

Lets rental property to ex-Service personnel. Open Monday - Friday, 9am - 5pm.

Tel: 020 7685 5777

Website: www.haighomes.org.uk/

Email: haig@haighomes.org.uk

JSHAO

Provides civilian housing information, advice and, where possible, placement to service persons and their dependants and to ex-service personnel still occupying service accommodation. Open Monday - Friday, 8.30am - 4.30pm.

Tel: 01722 436575.

Email: lf-jshao-mailbox@mod.uk

Website: www.mod.uk/DefenceInternet/DefenceFor/ServiceCommunity/Housing

One More Move

Online resource to help military families get through each move. Open Monday - Friday, 9am - 5pm.

Tel: 01603 271827

Website: www.onemoremove.co.uk

SPACES

Assistance for single ex-Service personnel in finding housing. Open Monday - Friday, 9am - 5pm.

Tel: 01748 833797 or 872940 or 830191

Email: spaces@echg.org.uk

Website: www.spaces.org.uk

SSAFA: Housing Advice

Soldiers, Sailors, Airmen and Families Association: Open Monday-Friday, 9.15am- 5pm.

Tel: 01722 436400

Website: www.ssafa.org.uk

Stoll Foundation

Provides temporary and permanent housing for ex-service personnel. Open Monday - Friday, 9am - 5pm.

Tel: 020 7385 2110

Email: fundraising@stoll.org.uk

Website: www.oswaldstoll.org.uk

Veteran's Aid

Provides help for veterans who are homeless or are likely to become homeless. This includes help with hostel accommodation, financial assistance, meal vouchers and clothing, advice and advocacy.

Freephone: 0800 0126867

Email: info@veterans-aid.net

Website: www.veterans-aid.net/

9. Relationship Guidance and Family Support

Army Families Federation

Helps still serving military families sort out a range of problems. Open Mon-Fri, 9am-5pm.

Tel: 01980 615525

Website: www.aff.org.uk

Army Welfare Service

Offers professional and confidential welfare support for servicemen and women and their families.

By post to: The Army Welfare Information Service,
HQ Landforces, Louisburg Block, Erskine Barracks,
Wilton, Salisbury, SP2 0AG

Tel: 01722 436569

Email: AWS-Welfareinformationservice@mod.uk

Website: www.army.mod.uk/welfare-support

Cruse

Cruse supports people through bereavement.

Daytime helpline: 0844 477 9400

Email: helpline@cruse.org.uk

Website: www.cruse.org.uk

Naval Families Federation

A range of information for Royal Naval and Royal Marines families.

Tel: 02392 654374

Website: www.nff.org.uk

RAF Families Federation

Information and support for RAF families. Open Monday - Friday, 10am - 3pm.

Tel: 01780 781650

Website: www.raf-ff.org.uk

Relate

Offers phone counselling, internet counselling and/or appointments for face to face counselling. Open Monday - Friday, 9am - 5pm.

Tel: 0845 130 4016

Website: www.relate.org.uk

Relate for Parents

Free support, ideas, guidance and information.

Tel: 0300 100 1234

Email: relateforparents@relate.org.uk

Website: www.relateforparents.org.uk

Working Families

Helping children, working parents and carers and their employers find a better balance between responsibilities at home and work.

Freephone helpline (low income families): 0800 013 0313

Tel: 020 7253 7243

Email: advice@workingfamilies.org.uk

Website: www.workingfamilies.org.uk

10. Information on Equality and Rights

Equality and Human Rights Commission

Specially trained staff provide information and guidance on discrimination and human rights issues. Open Monday - Friday, 8am - 6pm.

In England:

Tel: 0845 604 6610

Textphone: 0845 604 6620

In Wales:

Tel: 0845 604 8810

Textphone: 0845 604 8820

In Scotland

Tel: 0845 604 5510

Textphone: 0845 604 5520

Website: www.equalityhumanrights.com

Appendix 8

HELP-SEEKING TOPIC GUIDE

1. From the online survey you ticked that you are currently experiencing (within the last year) a (stress/emotional) and/or an (alcohol problem);
 - Can you tell me a bit more about this?
 - *(If needed)* You indicated the problem was related to (deployment) (general military Service) (non-military related circumstances) – can you tell me more about this?
2. From the online survey I see that you've been to see a GP/Specialist (Medical professional) about your problem;
 - Could you describe to me when you realised that you wanted to see a health/medical professional about your problem?
3. Can you tell me how you went about getting help?
 - Was there anything that encouraged you or made it easier to seek help?
 - Was there anything that put you off or made it harder to seek help?
 - How do you feel about getting professional help?
 - What do people close to you think about you getting professional help? i.e. your partner, family, friends?
 - What do people less close to you think about you getting professional help? i.e. other friends, colleagues?
4. What treatment/support did you receive?
 - Are you happy with the treatment you received?
5. Thinking over everything we have discussed in relation to help-seeking, is there anything we haven't talked about that you think is important for me to know or understand?
6. How have you found the experience of talking about these issues over the telephone?
 - Is there anything you found particularly good about using the telephone?
 - Is there anything that was more difficult about a telephone interview?

Notes on potential question themes/concepts:

- Question 1: Background/Current Health Status
- Question 2: Self-Perceived Need for Care, Process of recognition for a problem
- Question 3: Process of Help-Seeking (Barriers and Enablers) - Social Influences - Role of family/friends/employers, Attitudes/Expectations of Mental Health Treatment, Public Stigma/Self Stigma, Practical Issues.
- Question 4: Service Utilisation, Engagement with Treatment, Satisfaction with Outcomes.
- Question 5: Unaddressed issues/unanticipated insights led by participant.
- Question 6: Assessment of Participants' Experience of the Telephone Mode.

NON-HELP-SEEKING TOPIC GUIDE

1. From the online survey you ticked that you are currently experiencing (within the last year) a (stress/emotional) and/or an (alcohol problem);
 - Can you tell me a bit more about this?
 - *(If needed)* You indicated the problem was related to (deployment) (general military Service) (non-military related circumstances) – can you tell me more about this?
 - Could you describe to me when you realised you may have a problem?
2. From the online survey I see that you haven't seen a GP/specialist (Medical Professional) about your problem;
 - Can you tell me a little bit about why you haven't been to see a medical professional?
 - Is there anything that has put you off seeking help?
 - Is there anything that has got in the way or made it hard to seek help?
 - Is there anything that would encourage you or make it easier to seek help?
 - How would you feel about getting professional help?
 - How do you think people close to you would feel about you getting professional help? i.e. your partner, family, friends
 - How do you think people less close to you would feel about you getting professional help? i.e. other friends, colleagues.
3. Thinking over everything we have discussed in relation to help-seeking, is there anything we haven't talked about that you think is important for me to know or understand?
4. How have you found the experience of talking about these issues over the telephone?
 - Is there anything you found particularly good about using the telephone?
 - Is there anything that was more difficult about a telephone interview?

Notes on potential question themes/concepts:

- Question 1: Background/Current Health Status, Process of Recognition for a Problem
- Question 2: Process of Non-Help-Seeking (Barriers and Enablers) - Self-Perceived Need for Care, Social Influences - Role of family/friends/employers, Attitudes/Expectations of Mental Health Treatment, Public Stigma/Self Stigma, Practical Issues.
- Question 3: Unaddressed issues/unanticipated insights led by participant.
- Question 4: Assessment of Participants' Experience of the Telephone Mode.

Appendix 9

Phases of Thematic Analysis (Braun and Clarke 2006)

Phase	Description of the process
1	Familiarisation with data: Transcription of interviews, reading and rereading the data, noting down initial ideas.
2	Generation of initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes: Checking themes work in relation to the coded extracts and the entire data set, generation of a thematic map/model of the analysis.
5	Defining and naming themes: On-going analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6	Production of the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, production of a scholarly report of the analysis.

Appendix 10

Numerical Overview of Theme Prevalence – King’s Cohort Qualitative Study

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
Supra-Theme Recognition/judgement of need	Encapsulates the theme that recognition of a problem and judgement of need for professional help are key in influencing help-seeking behaviours				
Barrier Theme Lack of recognition of need	Participant did not recognise that they had a problem they needed to seek help professional/formal help for.	4 ¹	4	15 ²	6
Barrier Theme Lack of judgement of need for medical help	Participant endorses experiencing a problem but then also states the reasons why they do not need to seek medical help;	10	6	234	50
Sub-Theme					
• Minimisation of problem	- Problem is not a big problem	7	4	24	10
• Normalisation of problem					

¹ Bold numbers indicate aggregation of sub-themes and smaller codes into overall numbers. The table presents the number of participants to reference a theme and overall number of times themes were referenced by all participants.

² Please note aggregated numbers from overall references made to a theme will not add up from the sub-themes detailed, due to inclusion of data from smaller codes not included in the overview table.

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
<ul style="list-style-type: none"> • Deservedness to seek help • Maladaptive Coping Strategies 	<ul style="list-style-type: none"> - Problem is normal problem that others also experience - In comparison to others, (usually military others) the participant does not feel their problem is severe enough to warrant seeking help, as others are worse off and deserve the help more. - Participant has developed maladaptive coping strategies that has enabled them manage their problem and therefore they deem themselves to not need formal/medical help. 	9	2	54	3
		6	3	17	8
		8	6	78	22
Facilitator Theme					
Recognition of need	Participant acknowledges they have a problem and makes a judgement that they need to seek formal/medical help	0	4	0	24
Sub-Theme					
• Desire to get better/sort the problem out	Participants reject the status quo of living with their problem and emphasise a desire to improve their current health by seeking formal/professional help to help solve their problem.	0	4	0	16

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
<ul style="list-style-type: none"> Desire to save relationships 	Participants acknowledge a need to seek help to save or improve their current relationships that have been negatively affected by their problem.	0	2	0	8
<u>Supra-Theme Stigma</u>	Participants describe stigma as a barrier to seeking help for their problem	10	6	133	63
<u>Theme</u>					
Public Stigma	Participant describes barrier to care as being the anticipated effect of public stigma for seeking help for a mental health problem from family/ friends/ colleagues/doctors. Desire from participants not to be labeled as ‘Mad’, ‘Bad’ in relation to domestic violence problems, ‘Lying’ about having a problem, or be labeled as ‘Weak’ or a ‘coward’ or by others. Also includes where participant voices stigmatising views about mental health problems.	10	6	70	41
Self-Stigma	Participant voices personal beliefs about themselves that accepts and attributes the characteristics of negative mental health stereotypes to themselves. I.e. that having a mental health problem makes them a weak person. Also includes where a participant describes a lack of self-efficacy and self-worth because of their problem.	9	5	21	14

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
Concern for career and medical records	Participant describes not seeking help because of the concern they have for their career also influenced by the lack of confidentiality in Service of their medical records which they also cite to persist into the civilian world	9	4	42	8
Supra-Theme <u>Masculine Norms</u>					
Barrier Theme <u>Heightened Masculine Norms</u>	Participant expresses views against help-seeking influenced by their adherence to masculine norms, influenced and heightened by their experience of military culture. Often describe their beliefs that men should be strong, unemotional and independent and not show weakness.	10	6	99	64
Sub-Themes <u>Emotional guardedness</u>	Describes how participants disliked talking about feelings or emotions and therefore did not disclose the issues they were experiencing to others.	9	4	29	21
<u>Self-sufficiency</u>	Encapsulates a participants' desire to cope with and solve problems on their own.	10	5	39	20

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
<u>Facilitator Theme</u> Inverted Masculine Norms seeing help-seeking as ‘brave’	Participants endorsed similar masculine norms, however these beliefs were used to positive effect in help-seeking. I.e. instead of help-seeking being ‘weak’, it was a ‘brave’ act and therefore one that cohered with dominant masculine norms espoused.	1	4	2	5
<u>Supra-Theme</u> Attitudes/expectations towards mental health treatment	Attitudes and expectations towards mental health treatment acted as barriers or facilitators of help-seeking, depending on whether participants had negative or positive attitudes.				
<u>Barrier Theme</u> Negative attitudes/expectations towards mental health treatment	Participant described negative attitudes, expectations or beliefs about mental health treatment.	8	6	58	42
<u>Facilitator Theme</u> Positive attitudes/expectations towards mental health treatment	Participant described positive attitudes, expectations or beliefs about mental health treatment that encouraged help-seeking	0	3	0	9
<u>Supra-Theme</u> <u>Social Networks</u>	Encapsulates how the nature and strength of participants’ social networks were key in terms of facilitating or creating barriers to help-seeking through the strength (or weakness) of social support.				

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
<u>Barrier Theme</u> Poor/Unstable Social Networks	Participants highlighted the fractured nature of social networks in Service and disconnect with the military after leaving service. It also includes where participants indicated loneliness or social withdrawal. The poor social support had a negative effect on help-seeking.	8	5	54	23
<u>Facilitator Theme</u> Supportive Social Networks	Where participants' highlighted examples of good or supportive social networks that aided help-seeking.	8	6	26	21
<u>Sub-Themes</u> Family/friends encouragement to seek help	Participants' descriptions of family/friends encouragement to seek professional/medical help.	4	5	8	16
Family/friends positive attitude towards mental health treatment	Participants' descriptions of family/friends positive attitudes towards seeking mental health treatment.	8	3	18	5
<u>Supra-Theme</u> <u>Other military social influences/structures</u>	Social influences or barriers to help-seeking that were specific to the context of military Service.				
<u>Barrier Theme</u> Discipline before Help	Describes how the discipline system in Service was quicker to react to incidents of aggression, violence or hazardous drinking than the welfare or medical system was. In affect these issues are deemed as discipline issues	1	2	6	2

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number of Participants To Reference A Theme (at least once)</u>		<u>Number of (accumulative) References Across Themes Overall</u>	
		<u>Non-help-seekers (n=10)</u>	<u>Help-seekers (n=6)</u>	<u>Non-help-seekers</u>	<u>Help-Seekers</u>
	rather than warning signs an individual might need professional help for a mental health problem.				
<u>Barrier Theme</u> Bullying	Those in Service described not wanting to disclose a mental health problem that originated from bullying experienced in-Service for fear of reprisal.	0	2	0	22

Appendix 11

**Qualitative Study Two – Combat Stress – Participant Invitation Letter
and Participant Information Sheet**



Principal Investigators:

Professor Nicola Fear
Dr Laura Goodwin
Professor Christopher Dandeker
Marie-Louise Sharp

<http://www.kcl.ac.uk/kcmhr/research/phd/helpseeking.aspx>

Invitation to take part in a research study on the social influences and barriers to seeking healthcare for mental health problems among UK military personnel

We are contacting you from the King's Centre for Military Health Research (KCMHR), King's College London, to invite you to take part in a research study. The study aims to find out more about social influences and barriers to seeking healthcare for mental health problems among UK military personnel. This includes the experiences of current Service personnel (Regulars and Reserves) and Ex-Service personnel.

Combat Stress have agreed to support this study and have kindly sent out this Participant Invite Letter and Participant Information Sheet on our behalf.

The study will involve participation in a telephone interview with our researcher, which will take approximately 45 minutes to one hour, and we will give you £15 as a thank you.

Participation in the study is confidential and voluntary. Combat Stress will not be aware as to who participates in the study. We need your help if we are to more fully understand the barriers facing military personnel when seeking healthcare for mental health problems.

If you are **interested to take part**, please note your interest by (i) emailing us at marie-louise.sharp@kcl.ac.uk, or with your preferred contact telephone numbers and we will call you, or (ii) you can call us directly on 020 7848 5269.

Please also read the Participant Information Sheet, which gives detailed information on the study and what participation would involve.

If you **do not** wish to participate please contact KCMHR on the details above or Combat Stress on georgina.hodgman@combatstress.org.uk 01372 587018.

If you have any further questions about the study please contact the KCMHR team on the details above. If we have not heard from you within a couple of weeks and you have not opted out of the study, Combat Stress will try to contact you by calling you.

Thank you for your consideration to take part.

Yours sincerely

Marie-Louise Sharp



Research into the social influences and barriers to seeking healthcare for mental health problems among UK military personnel

PARTICIPANT INFORMATION SHEET

Introduction

You are invited to take part in this research project because you are a beneficiary of Combat Stress. It is important that you understand why the current research is being done and what your participation will involve, so that you can make an informed decision as to whether you wish to take part. Please read the following information and discuss it with others if you wish.

What is the King's Centre for Military Health Research (KCMHR)?

KCMHR is an academic research team at King's College London. We have been conducting independent research into issues relevant to current and former members of the UK Armed Forces since 1996.

Who is funding the study?

The study is being funded by the Economic Social Research Council and the Royal British Legion as part of a PhD Project at KCMHR.

What is the purpose of the study?

The study aims to investigate the social influences and barriers to seeking healthcare for mental health problems among UK military personnel. This includes the experiences of current Service personnel (Regulars and Reserves) and Ex-Service personnel. The information you give will help us to identify any barriers that military personnel face when seeking help for stress, emotional or alcohol problems related to their deployments or broader military experiences. The information you provide will create new evidence that will inform understanding and practical decisions about the provision of mental healthcare services both within the UK Armed Forces and the National Health Service.

How has KCMHR been able to contact you?

Combat Stress has agreed to support the study and has sent out a Participant Invite Letter and Participant Information Sheet on our behalf.

Do you have to take part in the study?

Your invitation to take part in the study is confidential. Combat Stress will not know who of their beneficiaries is taking part in the study. You can however choose to let anyone know of your participation if you wish. As Combat Stress will follow up participants who have not responded to the initial invite, one Combat Stress employee will be given information as to who has responded, so individuals are not chased up unnecessarily, but they will not know who has gone on to complete an interview. The information of those who have responded will be kept in strictest confidence and will not be shared with anyone else in Combat Stress. You are under no obligation to take part and are free to withdraw at any time without giving a reason.

If you decide to take part, what will you be asked to do?

Those who indicate their interest to participate will be contacted to take part in a telephone interview with our researcher at a time convenient for you. This will take approximately 45 minutes to one hour, and as a thank you for your time we will give you £15.

What will you be asked about in the telephone interview if you are contacted to take part?

We will ask about your physical and mental health and well-being, with a particular focus on your mental health and any stress, emotional or alcohol problems related to your deployment(s) or broader experiences in the military. We will ask you about your experiences in help-seeking, any use of healthcare services, your views on mental health and expectations about mental health treatment. We will also ask you about any medication you use and your social networks.

Your consent and interview will be recorded to help ensure researchers do not miss any of the information you give. Individuals can ask for their interview recording to be destroyed and removed from the study up until one month after the telephone interview, as after data is transcribed and coded, it may be difficult to link it to a specific individual.

Will everyone who indicates an interest be contacted to take part in the telephone interview?

Not everyone who indicates their interest to take part will be contact for an interview if study recruitment numbers have been exceeded. We do however appreciate the interest shown. Everyone who completes a telephone interview will receive a Signposting Booklet, which contains the contact details of organisations that can offer relevant help and support.

What about confidentiality?

All information will be kept strictly confidential. It will be stored securely, and will only be accessible to the research team. We will not share your personal information with anyone outside of the research team. The only exception is if you tell us something which makes us concerned about your safety or the safety of others, which we are legally obliged to do. However, we would discuss this with you before telling anyone else.

For how long will your information be stored?

The information collected about you will be stored for 20 years, in line with guidance from the Medical Research Council. After this time, the information will be securely destroyed.

What are the benefits of taking part?

Many people who have been interviewed have said that they valued the opportunity to talk about their experiences. By taking part you will be helping us to better understand the difficulties individuals face in seeking-help and accessing mental healthcare services. Additionally this information can potentially support the development of healthcare services and improve the experiences of military personnel in the future.

What are the possible disadvantages of taking part?

It is unlikely that taking part in the study will be harmful to you. However, if you are not comfortable answering any of the questions, you will be able to stop the telephone interview at any time. If you become distressed during the telephone interview a mental health professional will call you if you wish, to talk to you about your mental health and to offer help and advice. We will also contact your welfare officer for you if you wish. We also have a Signposting Booklet, which contains the contact details of organisations that can offer relevant help.

What if you are concerned before or during the study and want independent advice?

The study will provide an Independent Medical Officer should you have any general concerns or distress about the study. The Independent Medical Officer will be available to give impartial advice. His sole function is to ensure your safety and well-being whilst you take part in the study. His contact details are;

*Professor Neil Greenberg
Academic Centre for Defence Mental Health
Psychological Medicine
GKT School of Medicine & Institute of Psychiatry
Weston Education Centre
Cutcombe Road, London SE5 9RJ
0207 848 5351
neil.greenberg@kcl.ac.uk*

What will happen to the results of the research?

The overall findings will be published in academic journals, written up as part of a KCMHR PhD, and presented to interested organisations in the military health and welfare field. We will send you a Newsletter summarising our findings. Results will be reported in a way that individuals cannot be identified ensuring anonymity and confidentiality.

How will you get the £15?

Once you have completed the telephone interview, we will send you a cheque for £15.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by the Combat Stress Research Ethics Committee and the National Research Ethics Service. A research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and well-being of participants and researchers.

What to do next?

If you are happy with the information above and **wish to take part** please contact the research team on 020 7848 5269 or send us an email at marie-louise.sharp@kcl.ac.uk, alternatively you can give us your contact telephone numbers and our research will call you to confirm your interest and to answer any questions you may have.

If we don't hear from you within a couple of weeks, Combat Stress will try to contact you to check you have received the study information pack and to see if you have any queries about the study.

Thank you for taking the time to read this information.

Kings Centre Military Health Research
Institute of Psychiatry
King's College London
Weston Education Centre,
10 Cutcombe Road
London
SE5 9RJ
Tel: 0207 848 5269

Appendix 12

Qualitative Study Two – Combat Stress – Signposting Document



Social Influences and barriers to seeking healthcare for mental health problems in the UK military

General Information on services for Serving and ex-Service personnel



University of London

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1. National Mental Health Services and Advice

For those of you **still serving** the first port of call should be your **Medical Officer; the Chain of Command; the Padre**. For **veterans** the first port of call is your **GP**. For **Reservists** the first port of call is the **TA Chain of Command** or your **GP**.

Big White Wall

An anonymous peer support network that encourages you to be open about what is on your mind, to learn more about yourself and what is troubling you. It is available 24/7 and is free for serving personnel, veterans and their families. You can talk anonymously through your troubles with the whole community, a selected group or individual. Trained mental health professionals can help small groups of members to resolve problems like stress, anxiety and depression.

Tel: 020 7060 1677

Email: theteam@bigwhitewall.com

Website: www.bigwhitewall.com

Combat Stress 24 Hour Helpline

Providing confidential help and advice on any mental health issues to the military community and their families

Tel: 0800 138 1619

Text: 07537 404 719 (standard charges may apply for texts)

Email: combat.stress@rethink.org

Combat Stress

The Ex-Services Mental Welfare Society. Contact head office for details of your local office. Open Monday - Friday, 9am - 5pm.

Tel: 01372 841600

Email: contactus@combatstress.org.uk

Website: www.combatstress.org.uk

Forcesline

As part of Soldiers, Sailors, Airmen and Families Association (SSFA) this support line offers totally confidential, non judgemental, guidance on all personal/welfare issues including sexual harassment, discrimination, bullying, racism, drugs, depression, alcohol, debt, relationship counselling and suicide to the Army community from anywhere in the world. It is completely independent of the military chain of command. Open 7 days a week from 10.30am -10.30pm (UK time)

From UK and Bosnia/Kosovo: 0800 731 4880

From Cyprus: 800 91065

From Germany: 0800 1827 395

Fawkland Islands: #6111

Rest of the World*: 0044 1980 630854 (*staff will phone you back)

Absent without Leave (AWOL) Line: 01380 738137

Website: <http://www.ssafa.org.uk/how-we-help/forcesline>

The Veterans and Reserves Mental Health Programme (VRMHP) (formerly the Medical Assessment Programme)

Provides mental health assessments for veterans and Reservists who have concerns about their mental health as a result of service.

The Medical Assessment Programme has moved from St Thomas' Hospital, London to Chilwell, Nottingham. The service is now co-located with Reservist Mental Health Programme and renamed the VRMHP.

The VRMHP is available to veterans who have deployed since 1982 and are experiencing mental health challenges as a result of military service. The service will remain the same; a full mental health assessment by a consultant psychiatrist with accompanying guidance on care and treatment for the veteran's local clinical team. Referrals to the VRMHP will preferably be made by the individual's GP however self-referrals will now be accepted for this service.

Reservists

The Reserves Mental Health Programme, run in partnership with the NHS, is open to all current or former members of the UK Volunteer and Regular Reserves who have been demobilised since 1 January 2003, following operational deployment overseas as a Reservist and who believe that their deployment may have affected their mental health.

Freephone helpline: 0800 032 6258

Email: aphsedcmhchl-vmhp@mod.uk

Website: <https://www.gov.uk/support-for-war-veterans#the-veterans-and-reserves-mental-health-programme>

and

<http://www.army.mod.uk/welfare-support/23247.aspx>

MIND

Mind infoline offers a range of advice on mental health issues and also offers legal advice. The website also has links to a wide range of booklets and leaflets. Open Monday – Friday, 9.15am – 5.15pm.

Tel: 0845 766 0163

Website: www.mind.org.uk

NHS Direct

Call or email health professionals for advice about mental and physical health.

Tel: 0845 4647 (24hr)

Website: www.nhsdirect.nhs.uk

Samaritans

Someone to talk to 24 hours a day, they also offer face to face appointments in local branches.

Tel: 08457 90 90 90

Email: jo@samaritans.org

Website: www.samaritans.org

The Veterans Agency

Offers advice or puts you in contact with appropriate organisations. Open Monday - Thursday, 8.15am - 5.15pm, Fridays, 8.15am - 4.30pm.

Tel: 0800 169 2277 (Free to ring from most mobiles)

Overseas: +44 1253 866043

Textphone: 0800 169 3458

Email: help@veteransagency.mod.uk

Website: www.veterans-uk.info

Royal British Legion

Provides financial, social and emotional support to all those who have served and are currently serving in the Armed Forces, as well as their families. Open Monday – Friday, 10am – 4pm.

Tel: 08457 725725

Website: www.britishlegion.org.uk

2. Regional/local Mental Health Service and Advice

List of regional/local services is not exhaustive – Please contact Combat Stress 24 hour helpline (below) for more information on local services if you can not find an appropriate service listed below.

Tel: 0800 138 1619

Text: 07537 404 719 (standard charges may apply for texts)

Email: combat.stress@rethink.org

Veterans First Point

Aims to provide a one-stop shop for veterans and their families living in Lothian, working with organisations that might be able to help a veteran or their family to resolve whatever issue they may have.

Tel: 0131 220 9920

Website: www.veteransfirstpoint.org.uk

All Wales Veterans Health and Wellbeing Service

All Wales service for veterans who need psychological support, treatment and advice. The service also provides help to access employment, benefits and housing advice. Open to any veteran living in Wales who has served at least one day with the British Military as either a regular service member or as a Reservist who has a service related psychological injury. Self-Referral or referral by GP.

Tel: 029 2074 2062 (Mon-Fri 8-3.30) Secretary Sharon Bowles

Email: Sharon.bowles@wales.nhs.uk

Email: neil.kitchiner@wales.nhs.uk

Website: <http://www.veteranswales.co.uk>

NHS Humber Veterans Outreach Service

Mental health triage and assessment for military veterans registered with GPs across Yorkshire and the Humber.

Tel: 01482 617594

E-mail: veteransoutreachservice@humber.nhs.uk

Website: <http://www.humber.nhs.uk/services/veterans-outreach-service>

Lancashire Care NHS Foundation Trust Veterans Mental Health Website

Website dedicated to increase NHS staff awareness of Veteran mental health problems and needs and to provide ease of access to resources relevant to veterans and their families.

Website: <http://lftveterans.wordpress.com>

NHS Tees, Esk and Wear Valleys NHS Foundation Trust Veteran Services

Services include Community Veterans Mental Health Service, Veterans Wellbeing Group, Veterans' Wellbeing Assessment and Liaison Service and Veterans Mental Health Awareness Training

Tel: 01388 646800

Email: veterans.veterans@nhs.net

Website: <http://www.tewv.nhs.uk/Our-services/Trustwide-services/Veteran-services/>

NHS Pennine Military Veterans' Service

Service to improve the mental health and emotional wellbeing of ex-service personnel and their families. Service covers the whole North West, working closely with local services. Self referral or referral through GP.

Tel: 0161 253 6638

E-mail: mviapt.enquiries.nw@nhs.net

Website: <http://www.penninecare.nhs.uk/Pages.asp?catID=9>

West Midlands Regional Veterans Mental Health Network

Network of eight Mental Health Trusts has been established across the West Midlands region to support the identification and engagement of veterans into services

Website: <http://www.southstaffsandshropshealthcareft.nhs.uk/Services/Veterans-Mental-Health-Service/Default/West-Midlands-Regional-Veteran-s-Service.aspx>

South Staffordshire & Shropshire Veterans' Mental Health Services

Tel: 0800 500 3113 Phone (If ringing from a mobile phone 01785 258041)

E-mail: veterans.support@sssft.nhs.uk

Website: <http://www.southstaffsandshropshealthcareft.nhs.uk/Services/Veterans-Mental-Health-Service/Default/Staffordshire---Shropshire.aspx>

South West Veterans Mental Health Partnership Service

Provides help to military veterans across the whole of the South West of England. Referrals from veterans themselves, their families or carers, from any health or social care professional or recognised charity.

Tel: 0300 555 0112

E-mail: referral@swveterans.org.uk

Website: <http://www.swveterans.org.uk>

NHS London Veterans' Community Mental Health Service

Mental Health Service for veterans in London, self-referral or referral by charity or GP

Telephone: 020 7530 3666

Email: veterans@candi.nhs.uk

Website: <http://www.candi.nhs.uk/veterans/>

3. General Advice and Support

Citizens Advice Bureau

The national centre can give you the number of your local office

Tel: 020 7833 2181

Web: www.adviceguide.org.uk

Debt Advice Line

Leave a message to request an information pack or factsheet. Open Monday-Friday, 9am-9pm (24-hour voicemail)

Freephone: 0808 808 4000

Web: www.nationaldebtline.co.uk

Hive

Tri-Service information network offering range of advice to all members of the service community.

Central Office: 01722 436498/9

Email: hivegb@hqland.army.mod.uk

Homefront Forces

Support for partners, parents and children of those in the Forces.

Web: www.homefrontforces.org

RAF Community Website

For RAF personnel and their families. Information on a wide range of topics, including family separation, housing and support groups.

Web: www.rafcom.co.uk/

Rear Party

Online community for families and friends of military personnel.

Web: www.rearparty.co.uk/

Forum: www.rearparty.co.uk/Forums.html

Royal British Legion

Open Monday - Friday, 10am - 4pm

Tel: 08457 725725

Website: www.britishlegion.org.uk

Royal Navy Community Website

For RN personnel and their families. Information on a wide range of topics, including family wellbeing, community support and support services as well as a help desk for advice.

Website: www.royalnavy.mod.uk/Community/Members-area

The Site

Information and advice on many topics including relationships, health and wellbeing, homes, money, work, study and travel.

Website: www.thesite.org

The Veterans Agency

Offers advice or puts you in touch with appropriate organisations. Free helpline for veterans and their families. Open Monday - Thursday, 8.15am to 5.15pm, and Friday, 8.15am to 4.30pm.

Freephone: 0800 169 2277

Textphone: 0800 169 34 58

Email: veterans.help@spva.gsi.gov.uk

Website: www.veterans-uk.info

Regimental Admin Officer

Can offer advice for those still serving.

4. Alcohol and Drugs

Addaction

Information website about coping with alcohol and drug dependency.

Website: www.addaction.org.uk

Alcoholics Anonymous

A fellowship of men and women who share their experience, strength and hope with each other to help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking.

Tel: 08457 697555

Website: www.alcoholics-anonymous.org.uk

Al-Anon

Provides support to anyone whose life is, or has been, affected by someone else's drinking as they believe alcoholism affects the whole family, not just the drinker. Open 10am - 10pm, 365 days a year

Confidential Helpline Tel: 020 7403 0888

From Northern Ireland: 028 9068 2368 (Helpline Monday - Friday, 10.00am - 1.00pm, Monday - Sunday inclusive, 6.00pm - 11.00pm)

From Republic of Ireland*: 01 873 2699 (Helpline Monday - Friday, 10.30am - 2.30pm)

From Scotland: 0141 339 8884 (Helpline 10am - 10pm, 365 days a year)

Email: enquiries@al-anonuk.org.uk

Website: www.al-anonuk.org.uk/

Drinkline

Offers free, confidential information and advice on alcohol. Open Monday - Friday, 9am - 11pm

Tel: 0800 917 8282 (England and Wales only)

Website: <http://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx>

National Drugs Helpline - FRANK

FRANK is a confidential service to speak to a professionally trained advisor about drugs.

Tel: 0800 77 66 00 (24hrs/365 days a year)

Website: www.talktofrank.com

Turning Point

National health and social care provider to help people find a new direction in life and help tackle substance misuse, mental health issues or employment difficulties

Tel: 020 7481 7600

Email: info@turning-point.co.uk

Website: www.turning-point.co.uk

5. Jobs and Employment

Employment Service Direct (Job Centre)

Open Monday - Friday, 8am - 6pm and Saturdays, 9am - 1pm.

Tel: 0845 6060 234

Textphone: 0845 6055 255

Website: www.gov.uk/browse/working/finding-job

NACRO

Aims to help those with a criminal record get back into work. Open Monday - Friday, 9am - 5pm.

Tel: 0800 0181 259

Email: Helpline@nacro.org.uk

Website: www.nacro.org.uk

SaBRE

Offers advice to reservists about their employment rights and responsibilities. Open Monday - Friday, 9am-5pm.

Tel: 0800 389 5459

Website: www.sabre.mod.uk

6. Grants for Courses/Education

Adult Learning Grant

Financial assistance to help adults back into education. Learner support helpline is open 7am to 8pm.

Information on advanced learning loans:

Website: www.direct.gov.uk/en/EducationAndLearning/AdultLearning/FinancialHelpForAdultLearners/index.htm

For further source of financial help with childcare contact the learner support helpline:

Tel: 0800 121 8989

Army Education Centre

Available to those still serving.

Royal British Legion

The British Legion has grants and scholarships available for ex-service personnel and their dependants, spouses of ex-service personnel and their dependants. Open 10am-4pm Monday-Friday.

Tel: 08457 725725

Welfare Tel: 020 3207 2182 or 2183 or 2186

Email: WSWelfare@britishlegion.org.uk

Website: www.britishlegion.org.uk

Army Benevolent Fund

Offers a range of financial grants for care in the home, holidays, bursaries, annuities and practical support to serving and ex-service personnel and their families.

Tel: 020 7591 2060

Website: www.soldierscharity.org

Princes Trust

For help with setting up your own business or with money for courses, for those aged 18-25.

Tel: 0800 842842

Website: www.princes-trust.org.uk

RAF Benevolent Fund

For former RAF personnel or their families. Offers a wide range of practical, financial and emotional support.

Tel: 0800 169 2942

Website: www.rafbf.org.uk

For those still serving, contact should be made through Chief Clerk or Flight Commander.

Royal Navy Benevolent Trust

Offers a range of help, including grants and advice, for serving and ex-serving members of the Royal Navy and Royal Marines and their families, including those who are separated or divorced and now living with a new partner.

Tel: 02392 690112 or 660296 or 725841

Email: rnbt@rnbt.org.uk

Website: www.rnbt.org.uk/

Service family members can also get basic skills training at their local Armed Forces education facility. Ask at your local facility for details.

7. Help Claiming Benefits

Benefits Agency

Open Monday-Friday, 9am-5pm.

Tel: 020 7712 2171

SSAFA

SSAFA (Soldiers, Sailors, Airmen and Families Association) Open Monday-Friday, 9.15am-5pm.

Tel: 020 7403 8783

Website: www.ssafa.org.uk

Royal British Legion

Open Monday-Friday, 10am-4pm

The British Legion also has funding available for families of ex-service personnel in need.

Tel: 08457 725725

Website: www.britishlegion.org.uk

8. Housing

Government Housing information

Website: www.communities.gov.uk/housing

Haig Homes

Lets rental property to ex-Service personnel. Open Monday - Friday, 9am - 5pm.
Tel: 020 7685 5777

Website: www.haighomes.org.uk/

Email: haig@haighomes.org.uk

JSHAO

Provides civilian housing information, advice and, where possible, placement to service persons and their dependants and to ex-service personnel still occupying service accommodation. Open Monday - Friday, 8.30am - 4.30pm.

Tel: 01722 436575.

Email: AWS-JSHAO-Mailbox.co.uk

Website: <https://www.gov.uk/housing-for-service-personnel-and-families>

SPACES

Assistance for single ex-Service personnel in finding housing. Open Monday - Friday, 9am - 5pm.

Tel: 01748 833797 or 872940 or 830191

Email: spaces@echg.org.uk

Website: www.spaces.org.uk

SSAFA: Housing Advice

Soldiers, Sailors, Airmen and Families Association: Open Monday-Friday, 9.15am- 5pm.

Tel: 01722 436400

Website: www.ssafa.org.uk

Stoll Foundation

Provides temporary and permanent housing for ex-service personnel. Open Monday - Friday, 9am - 5pm.

Tel: 020 7385 2110

Email: fundraising@stoll.org.uk

Website: www.oswaldstoll.org.uk

Veteran's Aid

Provides help for veterans who are homeless or are likely to become homeless. This includes help with hostel accommodation, financial assistance, meal vouchers and clothing, advice and advocacy.

Freephone: 0800 0126867

Email: info@veterans-aid.net

Website: www.veterans-aid.net/

9. Relationship Guidance and Family Support

Army Families Federation

Helps still serving military families sort out a range of problems. Open Mon-Fri, 9am-5pm.

Tel: 01980 615525

Website: www.aff.org.uk

Army Welfare Service

Offers professional and confidential welfare support for servicemen and women and their families.

By post to: The Army Welfare Information Service,
HQ Landforces, Louisburg Block, Erskine Barracks,
Wilton, Salisbury, SP2 0AG

Tel: 01722 436569

Email: AWS-Welfareinformationservice@mod.uk

Website: www.army.mod.uk/welfare-support

Cruse

Cruse supports people through bereavement.

Daytime helpline: 0844 477 9400

Email: helpline@cruse.org.uk

Website: www.cruse.org.uk

Naval Families Federation

A range of information for Royal Naval and Royal Marines families.

Tel: 02392 654374

Website: www.nff.org.uk

RAF Families Federation

Information and support for RAF families. Open Monday - Friday, 10am - 3pm.

Tel: 01780 781650

Website: www.raf-ff.org.uk

Relate

Offers phone counselling, internet counselling and/or appointments for face to face counselling. Open Monday - Friday, 9am - 5pm.

Tel: 0845 130 4016

Website: www.relate.org.uk

Relate for Parents

Free support, ideas, guidance and information.

Tel: 0300 100 1234

Email: relateforparents@relate.org.uk

Website: www.relateforparents.org.uk

Working Families

Helping children, working parents and carers and their employers find a better balance between responsibilities at home and work.

Freephone helpline (low income families): 0800 013 0313

Tel: 020 7253 7243

Email: advice@workingfamilies.org.uk

Website: www.workingfamilies.org.uk

10. Information on Equality and Rights

Equality and Human Rights Commission

Specially trained staff provide information and guidance on discrimination and human rights issues. Open Monday - Friday, 8am - 6pm.

In England:

Tel: 0845 604 6610

Textphone: 0845 604 6620

In Wales:

Tel: 0845 604 8810

Textphone: 0845 604 8820

In Scotland

Tel: 0845 604 5510

Textphone: 0845 604 5520

Website: www.equalityhumanrights.com

Appendix 13

COMBAT STRESS HELP-SEEKING INTERVIEW TOPIC GUIDE

1. So you are a help-seeker with Combat Stress, I see that you must have been experiencing (within the last year) a mental health problem to seek help with them;
 - Can you tell me a bit more about this?
 - (*If needed*) Please could you tell me what you think the problem was related to for example; (deployment) (general military Service) (non-military related circumstances)
2. As a beneficiary of Combat Stress you have sought help through their treatment services;
 - Could you describe to me when you realised that you wanted to seek help in the first instance?
3. Can you tell me how you went about getting help?
 - Was there anything that encouraged you or made it easier to seek help?
 - Was there anything that put you off or made it harder to seek help?
 - How do you feel about getting professional help?
 - What do people close to you think about you getting professional help? i.e. your partner, family, friends?
 - What do people less close to you think about you getting professional help? i.e. other friends, colleagues?
4. What treatment/support did you receive?
 - Are you happy with the treatment you received?
5. (ONLY IF NOT DISCUSSED ELSEWHERE) Have you previously tried seeking any medical help in-Service or with an NHS GP/medical professional?
 - Can you tell me a little bit more about this experience?
 - (if no) Can you tell me why you didn't seek any medical help through these means?
6. Thinking over everything we have discussed in relation to help-seeking, is there anything we haven't talked about that you think is important for me to know or understand?
7. How have you found the experience of talking about these issues over the telephone?
 - Is there anything you found particularly good about using the telephone?
 - Is there anything that was more difficult about a telephone interview?

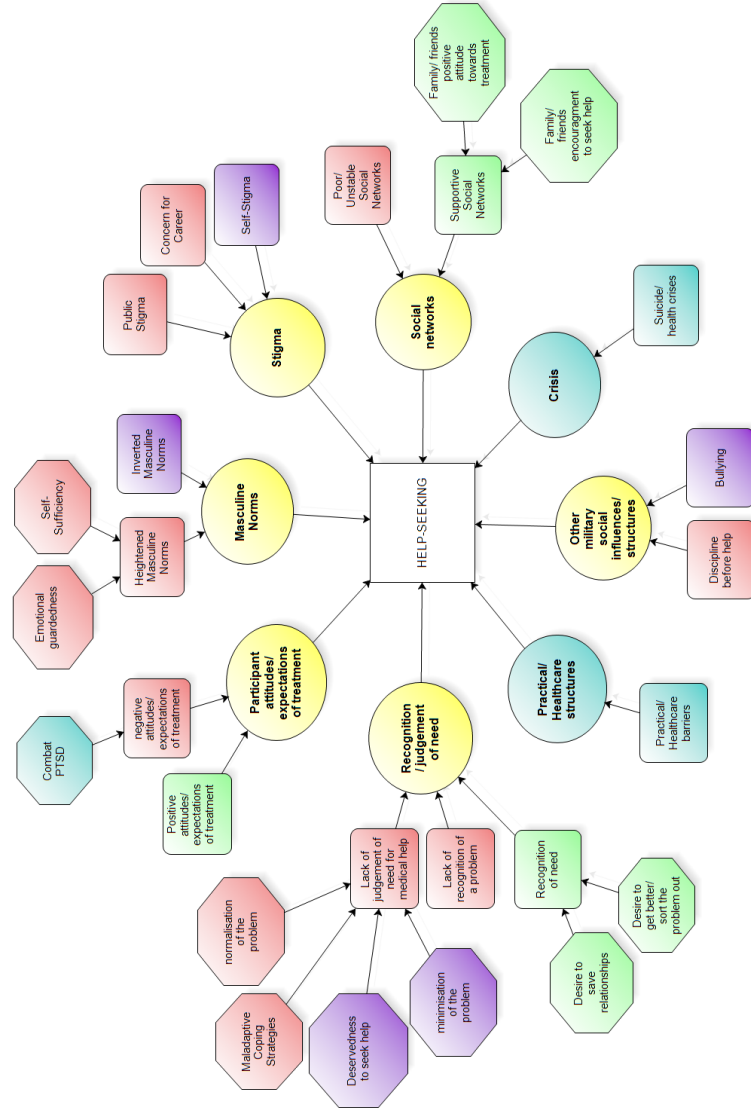
Notes on potential question themes/concepts:

- Question 1: Background/Current Health Status
- Question 2: Self-Perceived Need for Care, Process of recognition for a problem, previous help-seeking experiences
- Question 3: Process of Help-Seeking (Barriers and Enablers) - Social Influences - Role of family/friends/employers, Attitudes/Expectations of Mental Health Treatment, Public Stigma/Self Stigma, Practical Issues.
- Question 4: Service Utilisation, Engagement with Treatment, Satisfaction with Outcomes.
- Question 5: Previous mainstream help-seeking experiences, facilitators/barriers to care regarding main stream services

Question 6: Unaddressed issues/unanticipated insights led by participant.

Question 7: Assessment of Participants' Experience of the Telephone Mode.

Appendix 14 – KCMHR Cohort and Combat Stress Help-Seeking Summary Models



Key

- Yellow:** Supra-themes found across King's and Combat Stress interview groups
- Red:** Barrier themes found across King's and Combat Stress interview groups
- Green:** Facilitator themes found across King's and Combat Stress interview groups
- Turquoise:** New Supra-themes/themes/sub-themes found in the Combat Stress interview group
- Purple:** Themes/sub-themes only identified in the King's Cohort interview group

Appendix 15

Numerical Overview of Theme Prevalence - Combat Stress Qualitative Study

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Non-help-seekers (n=10)</u> (no. of participants to reference a theme)	<u>Non-help-seekers</u> (no. of accumulative references made to a theme overall)
Supra-theme Crisis	Encapsulates the situation where participants seek help because of crisis points reached in their lives where they feel compelled or forced to seek help as one of their last options.		
Negative Facilitator Theme Suicide/health crises	Describes participants' negative circumstances that compel them seek help. These crises most commonly involve suicide attempts and health crises.	8¹	41²
Supra-theme Practical/healthcare structures	Describes practical or health structures/institutions that create certain experiences/healthcare pathways for individuals when they negotiate seeking professional help for mental health problems		
Barrier Theme Practical/healthcare structures	Refers to practical or healthcare barriers experienced by individuals that delay or disincentivises help-seeking and engagement with treatment	10	99
Supra-theme Recognition/judgment of need	Encapsulates the theme that recognition of a problem and judgment of need for professional help are key in influencing a participants' help-seeking behaviours.		
Barrier Theme Lack of recognition of need	Participant did not recognise that they had a problem they needed to seek help professional/formal help for.	4	12
Barrier Theme Lack of judgement of need for medical help	Participant endorses experiencing a problem but then also states the reasons why they do not need to seek medical help;	9	64
Sub-Theme • Normalisation of problem	- Problem is a normal problem for	5	13

¹ Bold numbers indicate aggregation of sub-themes and smaller codes into overall numbers. The table presents the number of participants to reference a theme and overall number of times themes were referenced by all participants.

² Please note aggregated numbers from overall references made to a theme will not add up from the sub-themes detailed. This is due to inclusion of data from smaller codes not included in the overview table.

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Non-help-seekers (n=10)</u> (no. of participants to reference a theme)	<u>Non-help-seekers</u> (no. of accumulative references made to a theme overall)
<ul style="list-style-type: none"> Maladaptive coping strategies 	<p>them that others also experience</p> <ul style="list-style-type: none"> Participant has developed maladaptive coping strategies that has enabled them manage their problem and therefore they deem themselves to not need formal/medical help. 	9	45
Facilitator Theme			
Recognition of need	Participant acknowledges they have a problem and makes a judgement that they need to seek formal/medical help	9	40
<u>Sub-Theme</u>			
<ul style="list-style-type: none"> Desire to get better/sort the problem out 	Participants reject the status quo of living with their problem and emphasise a desire to improve their current health by seeking formal/professional help to help solve their problem.	9	24
<ul style="list-style-type: none"> Desire to save relationships 	Participants acknowledge a need to seek help to save or improve their current relationships that have been negatively affected by their problem.	6	16
<u>Supra-Theme</u>			
<u>Social Networks</u>	Encapsulates how the nature and strength of participants' social networks and social support were key in terms of facilitating or creating barriers to help-seeking.		
Barrier Theme			
Poor/Unstable Social Networks	Participants highlighted poor social support and the fractured nature of social networks in Service and disconnect with the military after leaving service. It also includes where participants indicated loneliness or social withdrawal.	8	28
Facilitator Theme			
Supportive Social Networks	Where participants' highlighted examples of good or supportive social networks that aided help-seeking.	10	52
<u>Sub-Themes</u>			
Family/friends encouragement to seek help	Participants' descriptions of family/friends encouragement to seek professional/medical help.	8	23

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Non-help-seekers (n=10)</u> (no. of participants to reference a theme)	<u>Non-help-seekers</u> (no. of accumulative references made to a theme overall)
Family/friends positive attitude towards mental health treatment	Participants' descriptions of family/friends positive attitudes towards seeking mental health treatment.	10	17
<u>Supra-Theme</u> Stigma	Participants describe stigma as a barrier to seeking help for their problem	8	75
<u>Barrier Theme</u> Public Stigma	Participant describes barrier to care as being the anticipated effect of public stigma for seeking help for a mental health problem from family/friends/colleagues. Desire from participants not to be labelled as 'Mad', 'Weak' or a 'coward' or by others. Participants also recount instances of social distancing experienced from others.	8	62
Concern for career	Participant describes not seeking help because of the concern they have for their career.	6	12
<u>Supra-Theme</u> <u>Masculine Norms</u>			
<u>Barrier Theme</u> Heightened Masculine Norms	Participant expresses views against help-seeking influenced by their adherence to masculine norms, influenced and heightened by their experience of military culture, in which they believe men should be strong, unemotional and independent and not show weakness.	9	34
<u>Sub-Themes</u> • Emotional guardedness	Describes how participants disliked talking about feelings or emotions and therefore did not disclose the issues they were experiencing to others.	7	20
• Self-sufficiency	Encapsulates a participants' desire to cope with and solve problems on their own.	5	15

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Non-help-seekers (n=10)</u> (no. of participants to reference a theme)	<u>Non-help-seekers</u> (no. of accumulative references made to a theme overall)
<u>Supra-Theme</u> Attitudes/expectations towards mental health treatment	Attitudes and expectations towards mental health treatment acted as barriers or facilitators of help-seeking, depending on whether participants had negative or positive attitudes.		
<u>Barrier Theme</u> Negative attitudes/expectations towards mental health treatment	Participant described negative attitudes, expectations or beliefs about mental health treatment.	9	43
<u>Facilitator Theme</u> Positive attitudes/expectations towards mental health treatment	Participant described positive attitudes, expectations or beliefs about mental health treatment.	8	20
<u>Supra-Theme</u> Military Social Influences/Structures	Social influences or barriers to help-seeking that were specific to the context of military Service.		
<u>Barrier Theme</u> Discipline before help	Describes how the discipline system in Service was quicker to react to incidents of aggression, violence or hazardous drinking than the welfare or medical system was. In affect these issues are deemed as discipline issues rather than warning signs an individual might need professional help for a mental health problem and do not create a positive environment to seek help.	2	3

Appendix 16

Overview of Theme Prevalence KCMHR & CS Qualitative Studies

Theme –Level	Codebook note form definition	Number Of Participants To Reference A Theme (at least once)			Number of (accumulative) References Across Themes Overall		
		KCMHR Non-help-seekers (n=10)	KCMHR Help-seekers (n=6)	Combat Stress help-seekers (n=10)	KCMHR Non-help-seekers	KCMHR Help-seekers	Combat Stress help-seekers
Supra-theme Recognition/judgement of need	Encapsulates the theme that recognition of a problem and judgment of need for professional help are key in influencing a participants' help-seeking behaviours.						
Barrier Theme Lack of recognition of need	Participant did not recognise that they had a problem they needed to seek help professional/formal help for.	4 ¹	4	4	15 ²	6	12
Barrier Theme Lack of judgment of need for medical help	Participant endorses experiencing a problem but then also states the reasons why they do not need to seek medical help;	10	6	9	234	50	64
Sub-Theme • Minimisation of problem	- Problem is not a big problem	7	4	-	24	10	-

¹ Bold numbers indicate aggregation of sub-themes and smaller codes into overall numbers. The table presents the number of participants to reference a theme and overall number of times themes were referenced by all participants.

² Please note aggregated numbers from overall references made to a theme will not add up from the sub-themes detailed, this due to inclusion of data from smaller codes not included in the overview table.

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
		<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
<ul style="list-style-type: none"> • Normalisation of problem • Deservedness to seek help • Maladaptive Coping Strategies 	<ul style="list-style-type: none"> - Problem is normal problem that others also experience - In comparison to others, (usually military others) the participant does not feel their problem is severe enough to warrant seeking help, as others are worse off and deserve the help more. - Participant has developed maladaptive coping strategies that has enabled them manage their problem and therefore they deem themselves to not need formal/medical help. 	9	2	5	54	3	13
		6	3	-	17	8	-
		8	6	9	78	22	45
Facilitator Theme							
Recognition of need	Participant acknowledges they have a problem and makes a judgement that they need to seek formal/medical help	0	4	9	0	24	40
<u>Sub-Theme</u>	Participants reject the status quo of living with their problem and emphasise a desire to improve their current health by seeking formal/professional help to help solve their problem.	0	4	9	0	16	24
<ul style="list-style-type: none"> • Desire to get better/sort the problem out 							

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
		<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
<ul style="list-style-type: none"> Desire to save relationships 	Participants acknowledge a need to seek help to save or improve their current relationships that have been negatively affected by their problem.	0	2	6	0	8	16
<u>Supra-Theme</u> Stigma	Participants describe stigma as a barrier to seeking help for their problem	10	6	8	133	63	75
<u>Theme</u> Public Stigma	Participant describes barrier to care as being the anticipated effect of public stigma for seeking help for a mental health problem from family/friends/colleagues/doctors. Desire from participants not to be labeled as 'Mad', 'Bad' in relation to domestic violence problems, 'Lying' about having a problem, or be labeled as 'Weak' or a 'coward' or by others. Also includes where participant voices stigmatising views about mental health problems.	10	6	8	70	41	62
Self-Stigma	Participants voices personal beliefs about themselves that accepts and attributes the characteristics of negative mental health stereotypes to themselves. i.e. that having a mental health problem makes them a weak person. Also includes where a participant describes a lack of self-efficacy and self-worth because of their problem.	9	5	-	21	14	-

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
		<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
Concern for career and medical records	Participant describes not seeking help because of the concern they have for their career also influenced by the lack of confidentiality in Service of their medical records which they also cite to persist into the civilian world	9	4	6	42	8	12
Supra-Theme							
Masculine Norms							
Barrier Theme							
Heightened Masculine Norms	Participant expresses views against help-seeking influenced by their adherence to masculine norms, influenced and heightened by their experience of military culture, in which they believe men should be strong, unemotional and independent, not show weakness.	10	6	9	99	64	34
Sub-Themes							
Emotional guardedness	Describes how participants disliked talking about feelings or emotions and therefore did not disclose the issues they were experiencing to others.	9	4	7	29	21	20
Self-sufficiency	Encapsulates a participants' desire to cope with and solve problems on their own.	10	5	5	39	20	15

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
		<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
<u>Facilitator Theme</u> Inverted Masculine Norms seeing help-seeking as 'brave'	Participants endorsed similar masculine norms however these beliefs were used to positive effect in help-seeking. I.e. instead of help-seeking being 'weak', it was described as a 'brave' act and therefore one that cohered with dominant masculine norms espoused.	1	4	-	2	5	-
<u>Supra-Theme</u> Attitudes/expectations towards mental health treatment	Attitudes and expectations towards mental health treatment acted as barriers or facilitators of help-seeking, depending on whether participants had negative or positive attitudes.						
<u>Barrier Theme</u> Negative attitudes/expectations towards mental health treatment	Participant described negative attitudes, expectations or beliefs about mental health treatment.	8	6	9	58	42	43
<u>Facilitator Theme</u> Positive attitudes/expectations towards mental health treatment	Participant described positive attitudes, expectations or beliefs about mental health treatment.	0	3	8	0	9	20

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
		<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
<u>Supra-Theme Social Networks</u>	Encapsulates how the nature and strength of participants' social networks were key in terms of facilitating or creating barriers to help-seeking through the strength or weakness of social support.						
<u>Barrier Theme</u> Poor/Unstable Social Networks	Participants highlighted the fractured nature of social networks in Service and disconnect with the military after leaving service. It also includes where participants indicated loneliness or social withdrawal. The lack of social support negatively affected help-seeking.	8	5	8	54	23	28
<u>Facilitator Theme</u> Supportive Social Networks	Where participants' highlighted examples of good or supportive social networks that aided help-seeking.	8	6	10	26	21	52
<u>Sub-Themes</u> Family/friends encouragement to seek help	Participants' descriptions of family/friends encouragement to seek professional/medical help.	4	5	8	8	16	23
Family/friends positive attitude towards mental health treatment	Participants' descriptions of family/friends positive attitudes towards seeking mental health treatment.	8	3	10	18	5	17
<u>Supra-Theme</u> Other military social influences/structures	Social influences or barriers to help-seeking that were specific to the context of military Service.						

		<u>Number Of Participants To Reference A Theme (at least once)</u>			<u>Number of (accumulative) References Across Themes Overall</u>		
<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>KCMHR Non-help-seekers (n=10)</u>	<u>KCMHR Help-seekers (n=6)</u>	<u>Combat Stress help-seekers (n=10)</u>	<u>KCMHR Non-help-seekers</u>	<u>KCMHR Help-seekers</u>	<u>Combat Stress help-seekers</u>
Barrier Theme Discipline before Help	Describes how the discipline system in Service was quicker to react to incidents of aggression, violence or hazardous drinking than the welfare or medical system was. In affect these issues are deemed as discipline issues rather than warning signs an individual might need professional help for a mental health problem.	1	2	2	6	2	3
Barrier Theme Bullying	Those in Service described not wanting to disclose a mental health problem that originated from bullying experienced in Service for fear of reprisal.	0	2	-	0	22	-

Themes apparent only in Combat Stress Qualitative study - Overview Theme Prevalence

<u>Theme –Level</u>	<u>Codebook note form definition</u>	<u>Non-help-seekers (n=10) (no. of participants to reference a theme)</u>	<u>Non-help-seekers (no. of references made to a theme overall)</u>
<u>Supra-theme</u> Crisis	Encapsulates the situation where participants seek help because of crisis points reached in their lives where they feel compelled or forced to seek help as one of their last options.		
<u>Negative Facilitator Theme</u> Suicide/health crises	Describes participants' negative circumstances that compel them seek help. These crises most commonly involve suicide attempts and health crises	8³	41⁴
<u>Supra-theme</u> Practical/healthcare structures	Describes practical or health structures/institutions that create certain experiences/healthcare pathways for individuals when they negotiate seeking professional help for mental health problems		
<u>Barrier Theme</u> Practical/healthcare structures	Refers to practical or healthcare barriers experienced by individuals that delays or disincentivises help-seeking and engagement with treatment .	10	99

³ Bold numbers indicate aggregation of sub-themes and smaller codes into overall numbers. The table presents the number of participants to reference a theme and overall number of times themes were referenced by all participants.

⁴ Please note aggregated numbers from overall references made to a theme will not add up from the sub-themes detailed. This is due to inclusion of data from smaller codes not included in the overview table.

Appendix 17

KCMHR Phase Three Cohort Study Questionnaire

VERSION 3.2

FOLLOW UP
KING'S
College
LONDON



Health & well-being survey of serving & ex-serving members of the UK Armed Forces: Phase 3

- ▶ You are already part of the largest ever study of the health and well-being of the UK Armed Forces. Thank you! Your contribution has already made a difference - we would now like to hear from you again.
- ▶ Participation in this study is voluntary. However, your response is vital if we are to understand the pros and cons of military life.
- ▶ We are an independent academic research team based at King's College London. The MoD supports the study.
- ▶ The information you provide is 100% confidential.

▶ **NOT ALL SECTIONS WILL APPLY TO YOU**

MORE THAN 20 PEOPLE WHO COMPLETE A QUESTIONNAIRE WILL WIN UP TO £500

STUDY INFORMATION

We are contacting you because you are already part of our research study of serving and ex-serving UK Armed Forces personnel. Thank you for taking part in an earlier phase of the study - we are now inviting you to participate in the third phase of the research.

It may have been a while since you completed a questionnaire, so let us remind you about the study. We are conducting the largest ever long-term study of the health and well-being of UK Armed Forces personnel. The study includes all Services, regulars and reserves, as well as those who have now left the military. It has been running since 2003 and about 20,000 people are now part of the study. The study aims to (1) monitor the health of those who have served on operations such as those in Iraq and Afghanistan and (2) investigate military life in general to find out about experiences as people progress through their military careers and after they leave the Armed Forces.

How do I take part in the study?

- ▶ Complete and return this questionnaire to us in the envelope provided.
- OR
- ▶ If you prefer, you can complete the questionnaire online at www.kcl.ac.uk/kcmhr and click on 'Health and Well-being Study Questionnaire'. Your login details can be found in the letter enclosed with this questionnaire.

As a thank you, we are offering those who complete a questionnaire the opportunity to take part in a prize draw. There are over twenty chances of winning between £25 and £500 (prizes: 1x £500, 2x £250, 5x £100, 5x £50 & 10x £25).

It is really important for us to receive a completed questionnaire from you regardless of whether you:

- are serving as a regular or reservist, or have now left the Armed Forces
- have deployed or not
- have any health problems or are well

You are under no obligation to take part in this study and are free to withdraw at any time. However, your participation is vital if we are to understand the pluses and minuses of military life and the health effects, if any, of deployment.

We are an independent research group from King's College London. The research is supported, and funded, by MoD. However, all the information you give us is 100% confidential and is stored anonymously. Neither the MoD, nor anyone else outside the research team will ever have access to your personal records. If you want to check us out, please contact the Service and Veterans Welfare on 020 7218 2418. There is widespread support for this study. The Principal Personnel Officers (Second Sea Lord, Adjutant General, Air Member for Personnel) and the Surgeon General, as well as SSAFA and the Royal British Legion, fully support this study.

More information on the study can be found in the enclosed Participant Information leaflet and also on our website www.kcl.ac.uk/kcmhr

Here are our contact details in case you want to get in touch with us:

King's Centre for Military Health Research (KCMHR),

King's College London, Weston Education Centre,

Cutcombe Road, LONDON, SE5 9RJ

Tel: +44 (0)20 7848 5351

Email: kcmhr@kcl.ac.uk

Twitter: @kcmhr

SECTION 1 – Background Information

1.1 What is your date of birth? (day/month/year) / /

1.2 How old were you when you first entered basic training/Apprentice College/Junior leaders/initial officer training or equivalent?
..... years of age

1.3 What is the highest level of education you have completed to date?

- Left school with no qualifications.....1 Degree/NVQs level 4-5.....4
 O levels/GCSEs/NVQs level 1-2 or equivalent.....2 Postgraduate qualifications.....5
 A levels/HNDs/NVQs level 3/1/Highers or equivalent.....3 Other professional qualifications.....6

1.4 To the nearest year, how long have you served (or did you serve) as a regular/FTRS?

(If you completed both FTRS and regular service, give combined length of service.)

..... years Have never served as a regular/FTRS.....1

1.5 To the nearest year, how long have you served (or did you serve) as a volunteer reservist?

..... years Have never served as a volunteer reservist.....

1.6 Are you currently serving?

- Yes, I am a regular or in Full-Time Reserve Service (FTRS).....1
 Yes, I am a recalled ex-regular.....2
 Yes, I am a volunteer reserve (mobilised or not).....3
 No, I have left the military.....4

1.7 What is your current rank or equivalent (or what was your rank when you left the military)?

Royal Navy	Army & Royal Marines	RAF
AB..... <input type="checkbox"/> 1	Prv/Mine..... <input type="checkbox"/> 1	AC/LAC/SAC/JT..... <input type="checkbox"/> 1
LR..... <input type="checkbox"/> 2	LtCpl to Cpl..... <input type="checkbox"/> 2	Cpl..... <input type="checkbox"/> 2
PO to WO1..... <input type="checkbox"/> 3	Sgt to WO1..... <input type="checkbox"/> 3	Sgt to WO..... <input type="checkbox"/> 3
Mid to Lt Cdr..... <input type="checkbox"/> 4	2nd Lt to Maj..... <input type="checkbox"/> 4	Plt Off to Sqd Ldr..... <input type="checkbox"/> 4
Cdr & above..... <input type="checkbox"/> 5	Lt Col & above..... <input type="checkbox"/> 5	Wg Cdr & above..... <input type="checkbox"/> 5
Other (please specify)..... <input type="checkbox"/> 6	Other (please specify)..... <input type="checkbox"/> 6	Other (please specify)..... <input type="checkbox"/> 6

1.8 What is your MAIN role/trade within your parent unit (or what was it when you left the military)?

Combat	<input type="checkbox"/> 1	Military Police	<input type="checkbox"/> 11
Medical	<input type="checkbox"/> 2	Flight Operations	<input type="checkbox"/> 12
EOD (bomb disposal)/C-IED-TF	<input type="checkbox"/> 3	Administrative	<input type="checkbox"/> 13
Logistics/supply	<input type="checkbox"/> 4	Driver	<input type="checkbox"/> 14
Aircrew	<input type="checkbox"/> 5	Warfare Branch	<input type="checkbox"/> 15
Engineering	<input type="checkbox"/> 6	Force Protection	<input type="checkbox"/> 16
Catering/chef	<input type="checkbox"/> 7	Other (Please specify)	<input type="checkbox"/> 17
Intelligence	<input type="checkbox"/> 8
Communications	<input type="checkbox"/> 9
Welfare	<input type="checkbox"/> 10

1.9 If you are a SERVING REGULAR, please complete this question for your day-to-day work in the Armed Forces.

If you are a RESERVIST or HAVE LEFT SERVICE, please answer this question for your day-to-day work in your civilian job. (If you are not currently working, please leave blank and go to Section 2)

To what extent do you agree or disagree with the following statements about your normal day to day work?
 Please tick one box for each statement.

	Strongly agree ¹	Agree ²	Disagree ³	Strongly disagree ⁴
a) I have to work very hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I have an excessive amount of work to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I have a lot of say about what happens on the job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I have a high level of skill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I have the freedom to decide how I do my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I have the chance to be creative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 2 – For current and ex-volunteer reservists

2.1 What is (or what was your last) civilian job title?

2.2 Are you currently:

Working full- or part-time in a civilian job	<input type="checkbox"/> ¹
Working as a civilian in MoD or the UK Armed Forces	<input type="checkbox"/> ²
Now in the regular Armed Forces/FTRS	<input type="checkbox"/> ³
Working as a private security contractor	<input type="checkbox"/> ⁴
Self-employed	<input type="checkbox"/> ⁵
Not working but looking for employment	<input type="checkbox"/> ⁶
Not working due to ill health	<input type="checkbox"/> ⁷
Retired	<input type="checkbox"/> ⁸
Other (please specify)	<input type="checkbox"/> ⁹

2.3 Has your current (or last) civilian employer ever requested or put pressure on you to leave the Reserve Forces?

Yes ¹ No ²

2.4 Were you in civilian employment at the time of your call-up for your LAST deployment as a reservist?

Yes	<input type="checkbox"/> ¹	(If YES, go to 2.5)
No	<input type="checkbox"/> ²	(If NO or not applicable, go to 2.7)
No, in regular service, FTRS or equivalent	<input type="checkbox"/> ³	
Not applicable, haven't deployed	<input type="checkbox"/> ⁴	

2.5 If you answered YES to question 2.4, did you return to the same job you held before your mobilisation?

Yes	<input type="checkbox"/> ¹	(If YES, go to 2.6)
No, resigned at time of call-up/mobilisation	<input type="checkbox"/> ²	
No, contract of employment ended just before/during deployment	<input type="checkbox"/> ³	
No, employer kept job open for me but I chose not to return	<input type="checkbox"/> ⁴	(If NO, go to 2.7)
No, employer did not keep job open for me	<input type="checkbox"/> ⁵	
No, other reason (please specify)	<input type="checkbox"/> ⁶	

2.6 If you returned to the same job, were any of the following a problem?

	Yes ¹	No ²	Not applicable ³
a) Loss of seniority, promotion opportunity, or responsibility in civilian job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Loss of income during call-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lack of support or resentment from co-workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lack of support from employer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.7 For the foreseeable future, do you intend to stay in the Reserve Forces?

Yes ¹ No ² Already left ³

2.8 If you do not intend to stay or have already left, what has influenced your decision to leave?

(Please tick ALL that apply)

a) Family commitments/welfare	<input type="checkbox"/>
b) Civilian career or business commitments	<input type="checkbox"/>
c) Want/wanted to join the regular Armed Forces	<input type="checkbox"/>
d) Health/fitness concerns	<input type="checkbox"/>
e) Age	<input type="checkbox"/>
f) Dissatisfaction with the Armed Forces	<input type="checkbox"/>
g) Do not/did not want to deploy	<input type="checkbox"/>
h) Other (please specify)	<input type="checkbox"/>

SECTION 3 – For those who have left regular Service

3.1 When did you leave the regular Armed Forces? (month/year) / /

3.2 How did you leave?

- End of service term or run out date ¹
- Premature voluntary release ²
- Medical discharge ³
- Administrative discharge ⁴
- Temperamental unsuitability ⁵
- Disciplinary discharge ⁶
- Voluntary redundancy ⁷
- Compulsory redundancy ⁸
- Other (please specify) ⁹
.....

3.3 Which of the following describes your reason for leaving? (please tick ALL that apply)

- a) Completed elective term of service
- b) Better employment prospects in civilian life
- c) Impact of Service life on family
- d) Work not exciting or challenging enough
- e) Dissatisfaction with pay
- f) Lack of promotion prospects
- g) Difficult to plan life outside of work
- h) Because of my experiences on deployment
- i) Pressure from family
- j) Too many deployments
- k) Didn't want to be away from home
- l) My service was terminated
- m) Health problems
- n) Pregnancy
- o) Accomplished everything I wanted
- p) Other (please specify)
.....

3.4 Have you been in trouble with the police/law since you left (NOT speeding/parking offences)?

- Yes
- No

3.5 How well would you say you are managing FINANCIALLY these days? Would you say you are:

- Living comfortably ¹
- Doing alright ²
- Just about getting by ³
- Finding it quite difficult ⁴
- Finding it very difficult ⁵

3.6 What is your longest period of job-seeking since leaving the Armed Forces? months

3.7 Are you currently:

- Working full- or part-time in a civilian job ¹
- Working as a civilian in MoD or the UK Armed Forces ²
- Working as a private security contractor ³
- Self-employed ⁴
- Not working, but looking for employment ⁵
- Not working due to ill health ⁶
- Retired ⁷
- Other (please specify) ⁸
.....

3.8 What is (or what was your last) civilian job title?

SECTION 4 – Your LAST deployment on Op HERRICK (Afghanistan)

4.1 Have you deployed on any Op HERRICK (Afghanistan)? Yes No (If NO, go to Section 5)

4.2 If YES, on which of these HERRICK operations have you deployed?

(Please tick all that apply - approximate dates have been included to help you)

- Op HERRICK 1 (Oct 2004-Apr 2005)
- Op HERRICK 2 (Apr 2005-Oct 2005)
- Op HERRICK 3 (Oct 2005-Apr 2006)
- Op HERRICK 4 (Apr 2006-Oct 2006)
- Op HERRICK 5 (Oct 2006-Apr 2007)
- Op HERRICK 6 (Apr 2007-Oct 2007)
- Op HERRICK 7 (Oct 2007-Apr 2008)
- Op HERRICK 8 (Apr 2008-Oct 2008)
- Op HERRICK 9 (Oct 2008-Apr 2009)
- Op HERRICK 10 (Apr 2009-Oct 2009)
- Op HERRICK 11 (Oct 2009-Apr 2010)
- Op HERRICK 12 (Apr 2010-Oct 2010)
- Op HERRICK 13 (Oct 2010-Apr 2011)
- Op HERRICK 14 (Apr 2011-Oct 2011)
- Op HERRICK 15 (Oct 2011-Apr 2012)
- Op HERRICK 16 (Apr 2012-Oct 2012)
- Op HERRICK 17 (Oct 2012-Apr 2013)
- Op HERRICK 18 (Apr 2013-Oct 2013)
- Op HERRICK 19 (Oct 2013-Jun 2014)
- Op HERRICK 20 (June 2014 and later)

We would now like to ask you about your LAST deployment on HERRICK – the last one you ticked above. Please answer all questions in this section about your LAST HERRICK deployment ONLY.

4.3 When did you enter theatre for your LAST HERRICK deployment? (day/month/year)

(If you don't know the exact date, please give month and year) / /

4.4 What was your MAIN duty during your LAST HERRICK deployment?

- Combat
- Medical mainly role 1 unit/RAP in a forward area
- Medical mainly in role 2/3 facility/Fd Hosp
- EOD (bomb disposal)/C-IED-TF
- Logistics/supply
- Aircrew
- Engineering
- Catering/chef
- Intelligence
- Communications
- OMLT/Partnering/Advisory ANA or ANP
- Welfare
- Military Police
- Flight Operations
- CIMIC/Reconstruction teams
- Administrative
- Driver
- Warfare Branch
- Force Protection
- Other (Please specify)

4.5 How often during your LAST HERRICK deployment did you believe you were in serious danger of being injured or killed?

Never Once or twice Sometimes Many times

4.6 During your LAST HERRICK deployment, for how long in total were you outside your base in a hostile area?

Not at all Up to one week One week to one month More than a month

4.7 During your LAST HERRICK deployment, how often did you:

	Never ¹	Once ²	2-4 times ³	5-9 times ⁴	10+ ⁵
a) Clear/search buildings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Give aid to wounded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) See personnel seriously wounded or killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Come under small arms/RPG fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Come under mortar/artillery fire/rocket attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Experience a landmine strike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Experience hostility from Afghan civilians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Discharge your weapon in direct combat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Find yourself in close proximity to an IED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Handle dead bodies/body parts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Had a mate shot/hit who was near you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Encounter sniper fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Experience a threatening situation and was unable to respond due to rules of engagement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Clear/search caves or bunkers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.8 For how long did you deploy? months weeks

4.9 When did you exit from theatre for your LAST HERRICK deployment? (day/month/year)

(If you don't know the exact date, please give month and year) / /

4.10 Did you deploy on your LAST HERRICK as a regular or a reservist?

Deployed as a regular

Deployed as a reservist

4.11 To what extent do you agree or disagree with the following statements about returning from your LAST HERRICK deployment? (Please tick ONE for each statement)

In the weeks after I came home.....	Agree ¹	Disagree ²	Not applicable ³
a) I had NO major problems on return from deployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I was well supported by the military	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I found it difficult to adjust to being back home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) People didn't understand what I had been through	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I did not want to talk about my experiences with my family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I found it difficult to resume my normal social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I had serious financial problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I argued more with my spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I have been let down by people who I thought would stand by me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I was involved in physical fights outside my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I was physically violent towards my spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I was physically violent towards another family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I had other major problems on return from deployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.12 Overall, did you think that the UK public was supportive of the mission in Afghanistan during your LAST HERRICK deployment?

Yes No

4.13 Since coming home, has anyone had a go at you or given you a hard time because you went to Afghanistan?

Yes No

SECTION 5 – Your LAST deployment on Op TELIC (Iraq)

5.1 Did you deploy on any Op TELIC (Iraq)? Yes No (If NO, go to Section 6 at the bottom of page 12)

5.2 If YES, on which of these TELIC operations have you deployed?

(Please tick all that apply - approximate dates have been included to help you)

Op TELIC 1 (Up to Apr 2003)	<input type="checkbox"/>	Op TELIC 10 (Jun 2007-Oct 2007)	<input type="checkbox"/>
Op TELIC 2 (May 2003-Oct 2003)	<input type="checkbox"/>	Op TELIC 11 (Nov 2007-Apr 2008)	<input type="checkbox"/>
Op TELIC 3 (Nov 2003-Apr 2004)	<input type="checkbox"/>	Op TELIC 12 (May 2008-Oct 2008)	<input type="checkbox"/>
Op TELIC 4 (May 2004-Oct 2004)	<input type="checkbox"/>	Op TELIC 13 (Nov 2008-Apr 2009)	<input type="checkbox"/>
Op TELIC 5 (Nov 2004-Apr 2005)	<input type="checkbox"/>	Op TELIC 14 (May 2009-Oct 2009)	<input type="checkbox"/>
Op TELIC 6 (May 2005-Oct 2005)	<input type="checkbox"/>	Op TELIC 15 (Nov 2009-Apr 2010)	<input type="checkbox"/>
Op TELIC 7 (Nov 2005-Apr 2006)	<input type="checkbox"/>	Op TELIC 16 (May 2010-Oct 2010)	<input type="checkbox"/>
Op TELIC 8 (May 2006-Nov 2006)	<input type="checkbox"/>	Op TELIC 17 (Nov 2010-May 2011)	<input type="checkbox"/>
Op TELIC 9 (Nov 2006-May 2007)	<input type="checkbox"/>	Iraq post-TELIC	<input type="checkbox"/>

We would now like to ask you about your LAST deployment on TELIC - the last one you ticked above. Please answer all questions in this section about your LAST TELIC deployment ONLY.

5.3 When did you enter theatre for your LAST TELIC deployment? (day/month/year)
(If you don't know the exact date, please give month and year) / /

5.4 What was your MAIN duty during your LAST TELIC deployment?

Combat	<input type="checkbox"/>	Welfare	<input type="checkbox"/>
Medical mainly role 1 unit/RAP in a forward area	<input type="checkbox"/>	Military Police	<input type="checkbox"/>
Medical mainly in role 2/3 facility/Fd Hosp	<input type="checkbox"/>	Flight Operations	<input type="checkbox"/>
EOD (bomb disposal)/C-IED-TF	<input type="checkbox"/>	CIMIC/ Reconstruction teams	<input type="checkbox"/>
Logistics/supply	<input type="checkbox"/>	Administrative	<input type="checkbox"/>
Aircrew	<input type="checkbox"/>	Driver	<input type="checkbox"/>
Engineering	<input type="checkbox"/>	Warfare Branch	<input type="checkbox"/>
Catering/chef	<input type="checkbox"/>	Force Protection	<input type="checkbox"/>
Intelligence	<input type="checkbox"/>	Other (Please specify)	<input type="checkbox"/>
Communications	<input type="checkbox"/>	<input type="checkbox"/>
OMLT/Partnering/Advisory ANA or ANP	<input type="checkbox"/>	<input type="checkbox"/>

5.5 How often during your LAST TELIC deployment did you believe you were in serious danger of being injured or killed?

Never Once or twice Sometimes Many times 4

5.6 During your LAST TELIC deployment, for how long in total were you outside your base in a hostile area?

Not at all 1 Up to one week 2 One week to one month 3 More than a month 4

5.7 During your LAST TELIC deployment, how often did you:

	Never ¹	Once ²	2-4 times ³	5-9 times ⁴	10+ ⁵
a) Clear/search buildings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Give aid to wounded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) See personnel seriously wounded or killed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Come under small arms/RPG fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Come under mortar/artillery fire/rocket attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Experience a handmine strike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Experience hostility from Iraqi civilians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Discharge your weapon in direct combat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Find yourself in close proximity to an IED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Handle dead bodies/body parts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Had a mate shot/hit who was near you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Encounter sniper fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Experience a threatening situation and was unable to respond due to rules of engagement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.8 For how long did you deploy? months weeks

5.9 When did you exit from theatre for your LAST TELIC deployment? (day/month/year)

(If you don't know the exact date, please give month and year) / /

5.10 Did you deploy on your LAST TELIC as a regular or a reservist?

Deployed as a regular 1
 Deployed as a reservist 2

5.11 To what extent do you agree or disagree with the following statements about returning from your LAST TELIC deployment? (Please tick ONE for each statement)

In the weeks after I came home....	Agree ¹	Disagree ²	Not applicable ³
a) I had NO major problems on return from deployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I was well supported by the military	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I found it difficult to adjust to being back home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) People didn't understand what I had been through	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I did not want to talk about my experiences with my family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I found it difficult to resume my normal social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I had serious financial problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I argued more with my spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I have been let down by people who I thought would stand by me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I was involved in physical fights outside my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I was physically violent towards my spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I was physically violent towards another family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I had other major problems on return from deployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6 – Other deployment information

6.1 In the past THREE YEARS, please estimate the total number of months you have been away on deployment.

..... months

6.2 SINCE THE BEGINNING OF 2008, have you been deployed on any of the following major operations?

Libya (Op ELLAMY)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mali (Op NEWCOMBE)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Middle East (Op KIPION)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Operations in or around the Horn of Africa	Yes <input type="checkbox"/>	No <input type="checkbox"/>

6.3 Since 2012, have you deployed on operations in the Syria/Iraq region?

Yes 1 No 2

SECTION 7 – Your health

• • BEFORE YOU CONTINUE, COULD YOU PLEASE CHECK YOU HAVE COMPLETED SECTION 6 ON PAGE 12 • •

71 Have you had any of the following problems in the last 3 years?

a) Physical ill-health	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Stress/emotional/mental health problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) Alcohol problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) Relationship/family problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>

72 If you ticked YES to ANY option in question 71 above, we would like to know if you went for help for each of these problems, and if so, where you went for help. (Tick all that apply)

	I went to:			
	GP/MO	Hospital doctor	Mental health specialist (e.g. psychiatrist, psychologist, counsellor)	Telephone help-lines or online therapy Other
Physical ill-health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress/emotional/mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship/family problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73 In general, how would you rate your health?

Excellent Very good Good Fair Poor

74 In the PAST MONTH, to what extent has your physical health or any emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick ONE box)

Not at all Slightly Moderately Quite a bit Extremely

75 In the PAST MONTH, have you had any of the following problems with your work or other regular daily activities as a result of your physical health or emotional problems? (Please tick ONE box on each line)

	Yes ¹	No ²
a) Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b) Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c) Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d) Had difficulty performing the work or other activities (e.g. it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

76 As accurately as you can, indicate the degree to which the following statements describe your feelings and behaviours. Rate the degree to which each statement applies to you.

	Not at all ¹	A little ²	Moderately ³	Quite a bit ⁴	Very much ⁵
a) I often find myself getting angry at people or situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) When I do get angry, I get really mad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) When I get angry, I stay angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) When I get angry at someone, I want to hit or clobber the person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) My anger interferes with my ability to get my work done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) My anger prevents me from getting along with people as well as I would like to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) My anger has a bad effect on my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

77 During the PAST MONTH, how often did you:

(Please tick ONE box on each line)

	Never ¹	Once ²	Twice ³	3-4 times ⁴	5+ ⁵
a) Get angry at someone and yell or shout at them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Get angry with someone and kick or smash something, slam the door, punch the wall etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Get into a fight with someone not in your family and hit the person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Get angry and hit your spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Get angry and hit another member of your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Threaten someone with physical violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

78 During the PAST MONTH, how much have you been bothered by any of the following problems

	Not bothered at all ¹	Bothered a little ²	Bothered a lot ³
a) Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Pain in your arms or legs or other joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Menstrual cramps or other problems with your periods (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Constipation, loose bowels, or diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Nausea, wind or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Irritability/outbursts of anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Double/blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Loss of concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Hearing problems/deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

79 Here are some general questions about your health.

Please answer ALL the questions on the page by CIRCILING the answer which you think most closely applies to you.

Within the LAST FEW WEEKS have you:

	0	1	2	3
a) been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
b) lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
c) felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
d) felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
e) felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
f) felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
g) been able to enjoy your normal day to day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
h) been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
i) been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
j) been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
k) been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
l) been feeling reasonably happy, all things considered?	More so than usual	About the same as usual	Less so than usual	Much less than usual

7.0 Here is a list of problems and complaints that people sometimes have in relation to stressful experiences. How much have you been bothered by these problems in the PAST MONTH?

Please read each one carefully, then tick the answer which you think most applies to you.

	Not at all ¹	A little bit ²	Moderately ³	Quite a bit ⁴	Extremely
a) Repeated, disturbing memories, thoughts, or images of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Repeated, disturbing dreams of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suddenly acting or feeling as if a stressful experience were happening again (as if you were re-living it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Feeling very upset when something reminded you of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Avoiding thinking about or talking about a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Avoiding activities or situations because they reminded you of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Trouble remembering important parts of a stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Loss of interest in activities that you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Feeling distant or cut-off from other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Feeling emotionally numb or being unable to have loving feelings to those who are close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Feeling as if your future will somehow be cut short?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Having trouble falling or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

question continued overleaf.....

7.0 continued... How much have you been bothered by these problems in the PAST MONTH?

Not at all¹ A little bit² Moderately³ Quite a bit⁴ Extremely

n) Feeling irritable or having angry outbursts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Having difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Being super alert, watchful or on-guard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Feeling jumpy or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Having strong negative beliefs about yourself, other people or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Blaming yourself or someone else for a stressful experience or what happened after it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Having strong negative feelings such as fear, horror, anger, guilt or shame?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Taking too many risks or doing things that could cause you harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.1 If you experienced ANY of the problems in 7.0 above (on pages 17 & 18), how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	<input type="checkbox"/> ¹
Somewhat difficult	<input type="checkbox"/> ²
Very difficult	<input type="checkbox"/> ³
Extremely difficult	<input type="checkbox"/> ⁴

SECTION 8 – Lifestyle and relationships

8.1 Have you smoked more than 100 cigarettes (5 packets of 20) in your lifetime? Yes No

8.2 Do you currently smoke? Yes No (If NO, go to 8.4)

8.3 If YES, how many cigarettes, cigars or rollups do you smoke a day? per day

8.4 How often do you have a drink containing alcohol?

- Never ¹ 2 times a week ⁴
 Monthly or less ² 3 times a week ⁵
 2-4 times a month ³ 4 times or more a week ⁶

8.5 How many UNITS of alcohol do you have on a typical day when you are drinking?

- 1 or 2 ¹ 10 to 14 ⁵
 3 or 4 ² 15 to 19 ⁶
 5 or 6 ³ 20 to 29 ⁷
 7 to 9 ⁴ 30 or more ⁸

A pint of standard beer / lager = 2 units. A single measure of spirit / standard glass of wine (175ml) = 2 units.
 A pint / can of strong beer / lager = 3 units. A bottle of alcohol (e.g. Smirnoff Ice) = 1.5 units.

8.6 How often do you have six or more units on one occasion?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.7 How often during the PAST YEAR have you found that you were not able to stop drinking once you had started?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.8 How often during the PAST YEAR have you failed to do what was normally expected of you because of drinking?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.9 How often during the PAST YEAR have you needed a first drink in the morning to get yourself going after a drinking session?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.10 How often during the PAST YEAR have you had a feeling of guilt or remorse after drinking?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.11 How often during the PAST YEAR have you been unable to remember what happened the night before because you had been drinking?

- Never ¹ Weekly ⁴
 Less than monthly ² Daily/almost daily ⁵
 Monthly ³

8.12 Have you or has someone else been injured as a result of your drinking?

- No ¹
 Yes, but not in the past year ²
 Yes, during the past year ³

8.13 Has a relative / friend / health worker been concerned about your drinking / suggested you cut down?

- No ¹
 Yes, but not in the past year ²
 Yes, during the past year ³

8.14 How often do you use your seatbelt when you drive or ride in a car/vehicle?

Always Nearly Always Sometimes Seldom Never

8.15 Do you drive? Yes No (If NO, go to 8.18)

8.16 When you are driving in a built up area, how close to the speed limit do you usually drive?

Within 5 miles per hour
 6-10 miles per hour above the limit
 More than 10 miles per hour above the limit

8.17 When you are driving on a motorway, how close to the speed limit do you usually drive?

Within 10 miles per hour
 11-20 miles per hour above the limit
 More than 20 miles per hour above the limit

The next few questions are about relationships

8.18 Are you:

Married Separated
 Living with partner Divorced
 In a long term relationship Widowed
 Single & not in a long term relationship

8.19 How satisfied are you with your marriage/relationship?

Extremely satisfied Dissatisfied
 Satisfied Extremely dissatisfied
 Neither satisfied or dissatisfied Not applicable

8.20 Do you have children under the age of 18 years?

Yes No

SECTION 9 – Events and injuries

9.1 In THE LAST 3 YEARS, have you experienced any of the following events?

a) A fall Yes No
 b) Vehicle accident or crash (any vehicle including aircraft) Yes No
 c) Blast or explosion (IED, RPG, land mine, grenade etc) Yes No
 d) Fragment or bullet wound above your shoulders Yes No
 e) Other event that caused injury (e.g. sports injury to the head) Yes No
 Please describe

(If NO to ALL of these, go to 9.5 on the next page)

9.2 Did any of the events in 9.1 result in any of the following?

(Please tick all that apply)

a) Being dazed, confused or 'seeing stars'
 b) Not remembering the injury
 c) Losing consciousness (knocked out)
 d) Concussion (e.g. headache, dizziness)
 e) Head injury
 f) Other physical injury
 g) None of these

9.3 Did any of the symptoms you ticked in question 9.2 happen:

a) During a HERRICK deployment Yes No
 b) During another military operation/training exercise Yes No
 c) When off-duty Yes No
 d) After leaving the military Yes No

9.4 If you were knocked out, for how long (approx)?

Less than 1 minute 1-10 minutes 11-29 minutes 30 minutes or more

9.5 Have you ever purposely harmed yourself (e.g. overdose)?

Yes No

9.6 Please indicate whether you have personally experienced the following events during the PAST 3 YEARS.

- a) Divorce or broken relationship Yes No
- b) Accident Yes No
- c) Assault Yes No
- d) Severe physical illness Yes No
- e) Mental health problem Yes No
- f) Accident, assault or severe illness of someone close to you
(e.g. spouse, own child, parent, brother, friend etc) Yes No
- g) Aggression or violence from a current or ex partner or spouse Yes No
- h) Death of someone close to you Yes No
- i) Burglary, robbery or other serious crime Yes No
- j) Financial problems Yes No
- k) Unexpectedly losing your job or being fired Yes No
- l) Arrested by the police or charged with a criminal offence Yes No

SECTION 10 – Final section

PLEASE ONLY ANSWER THIS SECTION IF YOU HAVE DEPLOYED TO IRAQ OR AFGHANISTAN SINCE 2002

10.1 Some people report that their views and attitudes change for the better as a result of deployments. Below is a list of areas where you may have experienced change. Please read each statement and tell us whether you have experienced a change for the better as a result of ALL your deployments to Iraq and Afghanistan since 2002.

No change for the better A small change for the better A medium change for the better A big change for the better

As a result of my deployment(s) to Iraq or Afghanistan since 2002:

- a) The things I see as being really important in my life have changed
- b) I appreciate the value of my own life more
- c) I developed new interests
- d) I developed a greater feeling of self-reliance
- e) I developed a better understanding of spiritual matters
- f) I can see more clearly that I can count on people in times of trouble
- g) I set up a new direction for my life
- h) I feel closer to other people
- i) I am more willing to express my emotions
- j) I am more confident that I can handle difficulties
- k) I am able to do better things with my life
- l) I am better able to accept the way things work out
- m) I can better appreciate each day
- n) New opportunities are available which wouldn't have been otherwise
- o) I am more understanding of others
- p) I put more effort into my relationships
- q) I am more likely to try to change things that need changing
- r) I have a stronger religious faith
- s) I discovered that I am stronger than I thought I was
- t) I learned to appreciate other people
- u) I am more able to accept that I need other people

10.2 If you feel there is anything we have not asked you about but which you feel is important, please describe it here

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please make sure you have completed the contact and prize draw details at the beginning of this questionnaire.
Please make sure you have completed all the sections relevant to you.
EVERYONE SHOULD HAVE COMPLETED SECTIONS 1, 6, 7, 8 and 9

PLEASE RETURN IN THE PRE-PAID ENVELOPE PROVIDED

Appendix 18

Clinical Telephone Interview Study and Response Cards

HELP-SEEKING, HEALTH CARE EXPERIENCES AND BARRIERS TO CARE IN SERVING AND EX-SERVING MEMBERS OF THE UK ARMED FORCES: AN INTERVIEW STUDY

Interview Schedule (Version 1.5)

[Instructions to Interviewers in red] *Information/instructions to be read to participants in black italics*
Other information in green

[Response cards will be sent to participants for questions marked*]

Set up

- Ensure you have the risk protocol on hand
- Ensure the equipment is working
- Ensure that colleagues are informed that you are doing an interview and will not disturb you
- Ensure to have the response card by hand with indications what is marked as formal medical support Box M (for Section 11)
- Ensure you have the list of key stress, emotional or alcohol problems on hand for question 11.8
- Ensure you have the list of commonly described medication for stress, emotional or alcohol problems on hand for question 11.10
- Ensure you have the list of key psychological services / talking therapies / counselling on hand for question 11.11

Information needed

- Ensure you have info about the date they completed the other questionnaire
- If they endorsed having an alcohol problem on the questionnaire
- Their previous and current serving status (regular/ reservist/veteran)
- Ensure you know some details from the participant to build rapport

Introduction

- 1) Informing
 - Introducing:
 - *Hello, do I speak with ? Hello, this isspeaking from the King's Centre for Military Health Research. You can call me How would you like to be addressed during this conversation? Have you been expecting my call? Okay, good.*
 - Thanking:
 - *Thank you for taking part in this project. That is great that you want to talk to me. Do you already have any questions about the interview before we get started?*
 - Time and privacy:
 - *Is this time still convenient for you? Or do I need to give you a call back at a later time if that is more convenient?*
 - *The interview will take about 60 minutes, is that okay? It might take less as not all the sections of the interview might be relevant to you.*
 - *Further the interview will be recorded with a Dictaphone to ensure we capture all what you say correctly. I hope that is fine with you?*
 - *As discussed when arranging the interview, this interview is private; are you in a private and quiet room? Nobody who is going to disturb you? Fine, that's great.*

OR

- *As discussed when arranging the interview, you would like to have someone sitting in with the interview. Is this still the case and the person is present? Okay, great. That's fine with us. [if they would like to have someone sitting in but that person is not present, ask whether we need to reschedule or they are happy to proceed]*
 - **Content:**
 - *Have you read the invitation/information package you have received? Do you have any questions about that?*
 - **Medication:**
 - *We will ask you some questions about your use of medication, if any. We are only interested in the medication you may take for a stress, emotional, alcohol or mental health problem you may have. So if you take medicines for these problems, it would be great if you have your medicine boxes by hand?*
 - **Response cards:**
 - *We have sent you some laminated response cards. Do you have those with you? These contain the different response options for some of the questions. I will refer to these at different points during the interview by asking you to refer to ' box A', for example. Please let me know if you need some extra time to find the right box. [When asking the participant to find relevant boxes during the interview, pause and check they have found the relevant box]*
 - **Consent:**
 - *Take and record consent at the start of the interview [see outline database]*
 - *Ensure your equipment is on and recording properly*
 - *Ensure that you are adding a beep (press telephone button 3 times) after taking consent, so we will be able to easily identify from what time point to erase the rest of the interview if needed (only in cases where the paper consent form has not been returned)*
 - *Before doing the beeps, suggest that it will indicate that the interview is about to begin and that the 3 beeps do not mean anything. Just a signal that the actual interview has started*
 - **Set-up:**
 - *The interview will consist of 12 different sections. We will ask you some questions about your general health, use of alcohol, mental health problems, help seeking and some questions about social support you may have received.*
 - *Some of these questions may be a bit sensitive. So please feel free to say you don't want to answer that particular question or say pass to move on. We are not here to judge you and there are no right or wrong answers. We are interested in your experiences and opinions.*
 - *Just to let you know that we had access to some of the information you provided on the other questionnaire, in case you might wonder why we know some things about you.*
- **2) Building rapport**
 - *If serving: From the postal questionnaire you filled in ... months ago I know that you are in the Naval Services / RAF / Army, is that correct? How long have you been with them? Is it correct that you are a regular, full-time reserve, volunteer reserve, recalled ex-regular?*
 - OR**
 - *If left: From the postal questionnaire you filled in ... months ago I know that you have left Service, is that correct? How long ago have you left? What is your current job at the moment?*

- Can you tell me a little bit more about your job?
- 3) Acquiring necessary information whilst building rapport
[Please ensure that you obtain an answer on this question as we want to add this in the database]
 - Are you currently serving?
 - 1) Yes I am a regular or Full-Time Reserve Service (FTRS)
 - 2) Yes I am a volunteer reserve (mobilised or not)
 - 3) Yes I am a recalled ex-regular
 - 4) No I have left the military

Ok, let's talk a bit more about some of the health care services you may use.

1. General Health

1.1	Are you registered with a GP? [read out response options]	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.2	And have you visited your GP or medical officer for any reason in the <u>past year</u> ? [ensure time frame] [MO only for those who are currently serving]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Thank you. I am now going to ask some questions about your general health</i>		
*1.3	<p><i>The possible responses for the next question can be found in box A on your response card. Have you found BOX A? Please choose one of these options when answering the next question.</i></p> <p>In general, how would you rate your health NOW?</p>	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

2. Longstanding Illness

2.1	Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, <u>at least 12 months</u> ? Would you say [read out response options and ensure time frame] [if yes, check what health problem / disability they refer to]	<input type="checkbox"/> Yes, limited a lot <input type="checkbox"/> Yes, limited a little <input type="checkbox"/> No
-----	--	--

3. Impairment

3.1	<p><i>Thank you. Please choose one of the answers in BOX B of the response card for this question.</i></p> <p>In the <u>past month</u>, to what extent has your physical health or any emotional problems interfered with your normal social activities with family, friends, neighbours or groups?</p>	<input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
-----	---	---

			<input type="checkbox"/> Extremely
3.2		In the past month, have you had any of the following problems with your work or other regular daily activities as a result of your physical health or emotional problems? <i>[read out response options and ensure time frame]</i>	
	a)	Cut down on the <u>amount of time</u> you spent on work or other activities? <i>[be careful if participant is not in a job, emphasize other activities]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b)	Accomplished <u>less</u> than you would like?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c)	Were limited in the <u>kind</u> of work or other activities	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d)	Had <u>difficulty</u> performing the work or other activities (for example it took extra effort)	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. GAD7

*4.1		<i>Thank you. Now for these questions please choose one of the options in BOX C.</i> <i>[ensure the time frame]</i> Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems:	
	a)	Feeling nervous, anxious or on edge	<input type="checkbox"/> 0= Not at all <input type="checkbox"/> 1= Several days <input type="checkbox"/> 2= More than half the days <input type="checkbox"/> 3= Nearly every day
	b)	Not being able to stop or control worrying	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	c)	Worrying too much about different things	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	d)	Trouble relaxing	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	e)	Being so restless that it is hard to sit still	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	f)	Becoming easily annoyed or irritable	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	g)	Feeling afraid as if something awful might happen	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

5. PHQ9

*5.1		[Researcher to continue onto these questions automatically]	
	a)	Having little interest or pleasure in doing things	<input type="checkbox"/> 0= Not at all <input type="checkbox"/> 1= Several days <input type="checkbox"/> 2= More than half the days <input type="checkbox"/> 3= Nearly every day
	b)	Feeling down depressed or hopeless	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
If NOT AT ALL for a AND b, then go to section 6			
	c)	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	d)	Feeling tired or having little energy	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	e)	Poor appetite or overeating	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	f)	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	g)	Trouble concentrating on things such as reading the newspaper or watching TV	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	h)	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	i)	Thoughts that you would be better off dead or thoughts of hurting yourself in some way [introduce with; this question may come a bit out of the blue but..] If answered anything other than zero on 5.1i ask the participant to elaborate on this. If seriously concerned, initiate the risk protocol directly, if not, continue. If you are still concerned at a later stage of the interview or after finishing the complete interview, initiate the risk protocol.	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

6. PCL – 5

Thank you. I am now going to read out a list of problems and complaints that people sometimes have in response to stressful life experiences. For each could you please choose an answer from BOX D on your response card? Have you found it?

OK, please listen to each problem carefully, and give me the response which best indicates how much you have been bothered by that problem in the past month.

[ensure the time frame]

*6.1		In the <u>past month</u> , how much were you bothered by:	
	a)	Repeated, disturbing, and unwanted memories of a stressful experience?	<input type="checkbox"/> 0= Not at all <input type="checkbox"/> 1= A little bit <input type="checkbox"/> 2= Moderately <input type="checkbox"/> 3= Quite a bit <input type="checkbox"/> 4 = Extremely
	b)	Repeated, disturbing dreams of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	c)	Suddenly feeling or acting as if a stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	d)	Feeling very upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	e)	Having strong physical reactions when something reminded you of stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	f)	Avoiding memories, thoughts, or feelings related to a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	g)	Avoiding external reminders of a stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	h)	Trouble remembering important parts of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	i)	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	j)	Blaming yourself or someone else strongly for a stressful experience or what happened after it?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

	k)	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	l)	Loss of interest in activities that you used to enjoy?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	m)	Feeling distant or cut off from other people?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	n)	Having trouble experiencing positive feelings (for example, being unable to have loving feelings for people close to you, or feeling emotionally numb)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	o)	Feeling irritable or angry or acting aggressively?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	p)	Taking too many risks or doing things that cause you harm?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	q)	Being "superalert" or watchful or on guard?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	r)	Feeling jumpy or easily startled?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	s)	Having difficulty concentrating?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	t)	Trouble falling or staying asleep?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	u)	Have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person? (Prompt: What about feeling as if you were in a dream, even though you were not awake? Feeling as if something about you wasn't real? Feeling as if time was moving more slowly)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	v)	Have there been times when things going on around you seemed unreal or very strange and unfamiliar? (Prompt: Do things going around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

7. Alcohol

Thank you. The next few questions I am going to ask you are about your drinking habits and use of alcohol. We understand these questions may be sensitive, but please answer the questions as honest and accurate as possible.

AUDIT-C		
*7.1	<p>For this question, please choose a response from BOX E on your response card. Ok? Can you tell me.....</p> <p>How often do you have a drink containing alcohol? <i>[If 'never' and deployed recently, ask whether it was due to their deployment; if so, ask them to reflect back to their drinking habits before going on tour].</i></p> <p><i>[Subsequently ask the participant what he/she normal drinks and ensure calculations are made accordingly for the next question]</i></p>	<input type="checkbox"/> 0= Never [Skip to Section 8] <input type="checkbox"/> 1= Monthly or less <input type="checkbox"/> 2= Two- four times a month <input type="checkbox"/> 3= Two times a week <input type="checkbox"/> 4= Three times a week <input type="checkbox"/> 5= Four or more times a week
*7.2	<p>Thank you. Please refer to BOX F and BOX F1 for this question.</p> <p>How many UNITS containing alcohol do you have on a typical day when you are drinking?</p> <p>A pint of beer/lager = 2 units; A pint of strong beer/lager = 3 units; A single measure of spirits = 2 units; A standard glass of wine = 2 units; A bottle of alcopop = 1.5 units</p>	<input type="checkbox"/> 0= 1 or 2 <input type="checkbox"/> 1= 3 or 4 <input type="checkbox"/> 2= 5 or 6 <input type="checkbox"/> 3= 7 to 9 <input type="checkbox"/> 4= 10 to 14 <input type="checkbox"/> 5= 15 to 19 <input type="checkbox"/> 6= 20 to 29 <input type="checkbox"/> 7= 30 or more
*7.3	<p>Thank you, and now choosing a response from BOX G, could you tell me...</p> <p>How often do you have six or more UNITS on one occasion? <i>[ensure the participant uses the correct UNITS]</i></p>	<input type="checkbox"/> 0= Never <input type="checkbox"/> 1= Less than monthly <input type="checkbox"/> 2= Monthly <input type="checkbox"/> 3= Weekly <input type="checkbox"/> 4= Daily or almost daily
*7.4	Looking at the list in BOX H of your response card can you tell me in which of these situations you usually drink?	
*7.5	And again looking at BOX H In which of these situations do you think you typically drink the most in a single session?	
*7.6	And now looking at the list in BOX I of your response card which of these options describe who you might drink with?	
*7.7	And again using BOX I and thinking about when you drink the most in a single session, who do you usually drink the most with, in a single session?	
*7.8	<p>Within the last 12 months, have you been to A&E or required emergency health care as a result of your drinking or a drink related injury or health problem? <i>[read out response options]</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

MOTIVATIONS FOR DRINKING - QUESTIONS FROM HILTON QUESTIONNAIRE

I am going to read out some reasons why people drink alcohol, and would like you to decide how often your own drinking is motivated by each reason. Please think about your most recent drinking habits. Listen carefully but do not think too much about its exact meaning. The responses for these questions can be found in BOX J on your response card. Have you found BOX J? I will read out each reason and then please choose the answer which you think best describes your own drinking.

*7.9) Do you drink:

a) to help you cope with distressing or disturbing thoughts and feelings	<input type="checkbox"/> 1= Never <input type="checkbox"/> 2= Some of the time <input type="checkbox"/> 3= Half of the time <input type="checkbox"/> 4= Most of the time <input type="checkbox"/> 5= Always
b) because of loneliness	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
c) to escape from your troubles	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
d) to forget the past	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
e) to put you at ease with other people	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

DRINKING MOTIVES QUESTIONNAIRE (DMQ-R)

f) Because your friends put pressure on you to drink	<input type="checkbox"/> 1= Never <input type="checkbox"/> 2= Some of the time <input type="checkbox"/> 3= Half of the time <input type="checkbox"/> 4= Most of the time <input type="checkbox"/> 5= Always
g) Because it helps you when you feel depressed or nervous	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
h) To be sociable	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
i) To cheer you up when you are in a bad mood	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
j) To get drunk	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
k) To fit in with a group	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
l) So you won't feel left out	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

8. Suicidal thoughts, attempts and self-harm from Revised CIS-R

Ok, thank you. In the next section I will be asking some more sensitive questions/these questions may come out of the blue. They deal with suicidal thoughts, attempts and self-harm. Is that okay? Please let me know if you feel uncomfortable at any point.

After finishing all the questions in this section and if the participant answered 'yes' and within the last year or in the last week on any, ask them to elaborate on this (e.g. can you tell me a little more about this?). If seriously concerned, initiate the risk protocol directly, if not, continue. If you are still concerned at a later stage of the interview or after finishing the complete interview, initiate the risk protocol. Always inform a senior member of the team about your concerns.

8.1	Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way? [read out responses]	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.2	If yes, was this: [read out responses]	<input type="checkbox"/> In the last week <input type="checkbox"/> In the last year <input type="checkbox"/> More than a year ago
8.3	Have you ever thought of taking your life, even though you would not actually do it? [read out responses]	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.4	If yes, was this: [read out responses]	<input type="checkbox"/> In the last week <input type="checkbox"/> In the last year <input type="checkbox"/> More than a year ago
8.5	Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself? [read out responses]	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.6	If yes, was this: [read out responses]	<input type="checkbox"/> In the last week <input type="checkbox"/> In the last year <input type="checkbox"/> More than a year ago

9. Stigma, barriers to care, and awareness of/ willingness to use services

Thank you. OK, let's move onto the next section. For this section, please refer to the response options given in BOX K on the response sheet.

I will now read out a list of concerns [or thoughts] that a person might have when they consider seeking help for a mental health problem. Using the response options in BOX K, I would like you to rate each of the possible concerns that might affect **YOUR** decision to receive mental health services. The list is relatively detailed and lengthy. Sorry for that, but please bear with us.

[Prompt participants by offering the decision between strongly agree and agree. For example, so would you strongly agree or agree with this statement?]

[Bear in mind that these questions are hypothetical]

***Stigma and barriers to care**

*9		I would not seek help for a mental health problem because:	
	1.	I don't know where to get help	<input type="checkbox"/> 1= Strongly Agree <input type="checkbox"/> 2= Agree <input type="checkbox"/> 3= Neither agree nor disagree <input type="checkbox"/> 4= Disagree <input type="checkbox"/> 5 = Strongly Disagree
	2.	I don't have adequate transport	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	3.	It is difficult to get an appointment	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	4.	There would be difficulty getting time off work for treatment	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	5.	It would be too embarrassing	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	6.	It would harm my career	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	7.	Members of my unit or my colleagues might have less confidence in me	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	8.	My unit leaders/bosses might treat me differently	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	9.	My leaders/bosses would blame me for the problem	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	10.	I would be seen as weak (by those who are important to me)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	11.	Not wanting a mental health problem to be on my medical records	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	12.	Concern about what my friends or family might think	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	13.	Mental health care doesn't work	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	14.	I don't trust mental health professionals	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	15.	My visit would not remain confidential	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	16.	I would think less of a team member/ work colleague if I knew he/she was receiving mental health counseling	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	17.	My leaders/bosses discourage the use of mental health services	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	18.	I have had previous bad experiences with mental health professionals	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	19.	Wanting to solve the problem on my own	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	20.	Mental health treatment has harmful side effects	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

***Self Stigma**

Some people do not seek help for problems because they are concerned that seeking help would affect the way they think about themselves. You may or may not react in this way. Please refer to the response options in BOX K to rate the degree to which each item describes how you might react in this situation.

21.	I would feel inadequate if I went to a mental health professional for psychological help	<input type="checkbox"/> 1= Strongly agree <input type="checkbox"/> 2= Agree <input type="checkbox"/> 3= Agree and disagree equally <input type="checkbox"/> 4= Disagree <input type="checkbox"/> 5 = Strongly disagree
22.	Seeking psychological help would make me feel less intelligent	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
23.	It would make me feel inferior to ask a mental health professional for help	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
24.	If I went to a mental health professional, I would be less satisfied with myself	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
25.	I would feel worse about myself if I could not solve my own problems	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

*** Awareness and willingness to use services**

There are a variety of places that you can go to get help if you have a stress, emotional or alcohol problem. We would like to know if you are aware of various sources of support for these problems, and which ones you would be willing to use if you did have a problem. First I will ask which sources of help you have heard of, followed by whether you would be willing to use them IF you were to have a stress, emotional or alcohol problem. Please find the list in BOX L.

26.a	Have you heard of/ Do you know that XXXX is a source of support.....? <i>[ask the participant to read through the list and prompt which ones they have heard off]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
27.b	Would you be willing to use? <i>[ask the participant to read through the list and prompt which ones they would be willing to use]</i> <i>[this question is hypothetical]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

10. Recognition of mental health problems

Thank you. Ok, we will move onto the next section now and in this section we will ask you about mental health problems you may have experienced yourself.

10.1	Do you think you <u>currently</u> have a stress, emotional or mental health problem? [If YES, go to 10.3] [If NO, go to 10.2]	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.2	On your questionnaire [completed around approx DATE], you mentioned that you had had a stress or emotional problem in the last 3 years. Has that now been sorted out/resolved? [IF DOESN'T REMEMBER OR UNSURE SKIP TO 10.8]	<input type="checkbox"/> Yes, resolved <input type="checkbox"/> No, on-going <input type="checkbox"/> Doesn't remember / unsure about stress or emotional problem
10.3	What do you think you have (had) /what is (was) it?	[open ended]
10.4	What do you think caused the stress or emotional problem?	[open ended]

10.5	When did this stress or emotional problem start? [If BEFORE JOINING THE ARMED FORCES, go to 10.6] [If DURING MILITARY SERVICE, SKIP to 10.7] [If AFTER LEAVING THE ARMED FORCES, SKIP to 10.8]	<input type="checkbox"/> Before joining the Armed Forces <input type="checkbox"/> During military service <input type="checkbox"/> After leaving the Armed Forces
10.6	So did you have this problem also during your military service? [If YES, go to 10.7] [If NO, go to 10.8]	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.7	Have you sought help for this stress or emotional problem whilst currently serving / you were serving?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10.8	Do you think that you currently have problems with alcohol? [IF NO and endorsed alcohol problems on questionnaire go to 10.9] [IF YES go to Section 11]	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.9	On the questionnaire [completed approx], you mentioned that you had had a problem with alcohol in the last 3 years. Has that now been sorted out/resolved?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't remember / unsure

[if CURRENT or RESOLVED stress/emotional AND/OR alcohol problems go to section 11]
[if NO CURRENT problem (either stress/emotional OR alcohol) and NEVER had a problem SKIP to section 12]

11.a Help-seeking

FOR **CURRENT OR RESOLVED** SOCIAL/ EMOTIONAL PROBLEMS **AND/OR** ALCOHOL PROBLEMS.

11.1	<p><i>Looking at BOX M on your response card</i> Have you spoken to or sought help from any of the following for [your stress or emotional problem] OR [alcohol problem] OR [stress, emotional and alcohol problems]?</p> <p>[Ensure to prompt the participant to say which one they have spoken to if yes; and if several problems discuss them separately]</p> <p>[Prompt on 'other things' they may have spoken to or sought help from]</p>	
If YES to ONE in 11.1:		
11.2	Did you find it helpful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES to MORE THAN ONE in 11.1:		
11.3	Which ones did you find helpful?	
11.4	Which did you find <u>most</u> helpful?	
If YES to ANY FORMAL MEDICAL HEALTH CARE SERVICE in 11.1		
11.5(i)	Where did you <u>first</u> go for help?	
IF A FORMAL MEDICAL HEALTH SERVICE NOT GIVEN IN 11.5(i)		
11.5(ii)	Where did you go next?	
[repeat until first formal medical healthcare service is mentioned]		

Treatment experiences

[Ask next set of questions separately for each formal health care service given in 11.5]

Ensure that you have information about what we identify as formal medical, non-formal medical and informal. Ask for clarification/more information if needed.

*11.6	Looking at BOX N on your response card What prompted you to go and seek help from your [first formal health service source] for your [stress/emotional problem] OR [alcohol problems] OR [stress, emotional and alcohol problems]?	
11.7	If you saw, were you given a diagnosis? [ONLY IF e.g. GP/MO/hospital doctor/ other mental health specialist/ Big White Wall (therapy)/ service charity (therapy) NHS Veterans Service or combat stress (therapy)]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't remember / unsure <input type="checkbox"/> NA
IF YES on 11.7:		
11.8	What did they tell you the diagnosis was?	[Open ended question but interviewer to have a list available]
11.9	And so when you went to see your [formal health medical service source] what did they do for you? Did they do any of the following:	
	a) Provide you with medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Provide you with a psychological or talking therapy or counselling	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Refer you to another health service (military mental health service, NHS, Combat Stress)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Advise you to seek help from another non-health organisation or charity (e.g. Relate, AA....)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e) Provide you with self-help materials	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f) Provide you with some general advice	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g) Gave you reassurance or explained that your difficulties were normal	<input type="checkbox"/> Yes <input type="checkbox"/> No

[If YES to A, B OR C in 11.9 ask remaining questions in section 11 otherwise repeat 11.9 for all formal medical healthcare services given in 11.1/11.5. If no further formal health services SKIP to section 12]

11.10. [If YES to 11.9a (medication)]	
<p><i>You told us that you were prescribed medication by the [insert name of service].</i> [Ensure you only record the medication provided by the formal medical health service sourced and thus for their emotional, stress or alcohol related problem]</p> <p>a) What was the name of the medication?</p>	[Open ended]
b) What was it prescribed for?	[Open ended]
c) Are you still taking it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Are you taking it/did you take it as prescribed by the [service]?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
e) And how long have you been taking it/did you take it for? [read response options]	<input type="checkbox"/> Up to a month <input type="checkbox"/> 1-6 months <input type="checkbox"/> >6 months
<p>If not currently taking it:</p> <p>f) When you stopped taking the medication, did you do so on the advice of the doctor?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Did you think the medication was helpful?	<input type="checkbox"/> Yes <input type="checkbox"/> No

11.11 If YES to 11.9b (taking therapy)	
<p><i>So you told us that you were given a psychological or talking therapy by the [insert name of service].</i></p> <p>a) Is this ongoing, or have you finished this therapy?</p>	<input type="checkbox"/> Ongoing <input type="checkbox"/> Finished
<p>b) [if ongoing] How many sessions have you had or how many times have you seen the therapist?</p> <p>c) [if ongoing] How many further sessions/appointments are planned?</p> <p>d) [if finished] How many sessions did you have, or how many times did you see the therapist?</p>	[Open ended]
<p>e) On average, how long did/does each session last? [read response options]</p>	<input type="checkbox"/> < 30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> Over 1 hour
<p>f) During each session is/was a specific problem discussed?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>g) Are/Were you given any homework as part of the treatment?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If treatment finished:</p> <p>h) Do you think that you completed the treatment, i.e. all of the sessions suggested by the therapist? [if YES continue to i, if NO continue to j]</p>	<input type="checkbox"/> Yes and I have been discharged <input type="checkbox"/> No
<p>i) Did you think the treatment was helpful?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>[if NO to h]</p> <p>j) Was that because you didn't think it was helping?</p> <p>k) Was this because it made you feel worse?</p> <p>l) Was this because you did not need it anymore?</p> <p>m) Was there another reason why you did not complete the treatment?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>[if YES to m]</p> <p>n) What was/were the other reason(s) why you did not complete the treatment?</p>	[Open ended]

11.12 Only If YES to 11.9c and the referral was to another FORMAL MEDICAL service)	
So you told us that you were referred to another health care service by the <i>[insert name of service]</i> .	
a) So which service were you referred on to?	
Repeat question 11.9 to 11.13	

11.13 If participant endorsed other FORMAL MEDICAL health care sources in question 11.1/11.5]	
i. You told us you went to <i>[list health care service(s) endorsed in q 11.1]</i> . If one: [Repeat question 11.9 to 11.13 as appropriate]	
OR	
If more than one: Where did you go first? _____	
[Repeat question 11.9 to 11.13 as appropriate for each]	
IF APPLICABLE (ie there are services (FORMAL MEDICAL) endorsed in 11.1 that we are yet to find out information about)	
ii. Where did you go next? _____	
[Repeat question 11.9 TO 11.13 as appropriate]	
[and so on for each service endorsed in 11.1]	

12. Life Events

Thank you. Can you please tell me whether you have personally experienced the following events since you have filled in the previous questionnaire? Based on our records you filled in the questionnaire at ..., so about ... months ago. Please answer yes or no to each of the questions.

[ensure you have the approximate date when they filled in the other questionnaire]

[ensure you check the time frame]

a)	Divorce or broken relationship	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
c)	Assault	<input type="checkbox"/> Yes <input type="checkbox"/> No
d)	Severe physical illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
e)	Mental health problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
f)	Accident, assault or severe illness of someone close to you (e.g. spouse, own child, parent, brother, friend etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
g)	Aggression or violence from a current or ex-partner or spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
h)	Death of someone close to you	<input type="checkbox"/> Yes <input type="checkbox"/> No
i)	Burglary, robbery or other serious crime	<input type="checkbox"/> Yes <input type="checkbox"/> No
j)	Financial problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
k)	Unexpectedly losing your job or being fired	<input type="checkbox"/> Yes <input type="checkbox"/> No
l)	Arrested by the police or charged with a criminal offence	<input type="checkbox"/> Yes <input type="checkbox"/> No

13. *Social Support

Thank you. And finally we just have a few last questions.

We are interested in how you feel about the following statements. For each of the next 12 statements, I will read the statement and then ask if you agree, disagree or neither agree nor disagree with the statement. You can find these responses in BOX O of your response card. It might feel a bit repetitive, sorry, but this is the last part of the questionnaire.

Listen to each statement carefully, and then indicate how you feel about each statement.

1.	There is someone close to me who is around when I am in need [someone close to me may refer to a significant other, brother, mate, buddy, partner etc..]	<input type="checkbox"/> 1= Agree <input type="checkbox"/> 2= Disagree <input type="checkbox"/> 3= Neither agree nor disagree
2.	There is someone close to me with whom I can share my joys and sorrows (or ups and downs)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
3.	My family really tries to help me	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4.	I get the emotional help and support I need from my family	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5.	I have someone close to me who is a real source of comfort to me	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6.	My friends really try to help me	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
7.	I can count on my friends when things go wrong	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8.	I can talk about my problems with my family	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
9.	I have friends with whom I can share my joys and sorrows	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
10.	There is someone close to me in my life who cares about my feelings	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
11.	My family is willing to help me make decisions	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
12.	I can talk about my problems with my friends	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

[For some participants these questions might be sensitive and confronting. Please be aware of this and try to be emphatic. Further, some small talk after this might be helpful before finalising the interview.]

1) Cooling down, thank for participation

- **Thanking:** Thank you so much for your participation.
- **Felt about interview:** What did you think about all the questions? How was that for you?
- **Any thoughts, thinks to chat about:** Is there anything else you want to share or want to chat about?

2) Cheque

- I want to thank you for your participation
 - We will send a thank you cheque as soon as possible. Let me check your address details?
 - And can I take your full name to ensure this is correct?
 - It can take about 4-8 weeks before you get the cheque.
 - Do you have any remaining questions?

Thank you.

PLEASE KEEP THIS SAFE FOR USE DURING YOUR INTERVIEW

Response card

A	Excellent	Very Good	Good	Fair	Poor
----------	------------------	------------------	-------------	-------------	-------------

B	Not at all	Slightly	Moderately	Quite a bit	Extremely
----------	-------------------	-----------------	-------------------	--------------------	------------------

C	Not at all	Several days	More than half the days	Nearly everyday
----------	-------------------	---------------------	--------------------------------	------------------------

D	Not at all	A little bit	Moderately	Quite a bit	Extremely
----------	-------------------	---------------------	-------------------	--------------------	------------------

E	Never	Monthly or less	2 to 4 times a month	2 times a week	3 times a week	4 or more times a week
----------	--------------	------------------------	-----------------------------	-----------------------	-----------------------	-------------------------------

F	1 or 2	3 or 4	5 or 6	7 to 9	10 to 14	15 to 19	20 to 29	30 or more
F1	A pint of standard beer/lager = 2 units A pint of strong beer/lager = 3 units	A single measure of spirits = 2 units A standard glass of wine = 2						

		units A bottle of alcopop (e.g. Smirnoff Ice) = 1.5 units						
--	--	--	--	--	--	--	--	--

G	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
----------	--------------	------------------------------	----------------	---------------	--------------------------------------

H*	At home At civilian friends' homes In the mess/ military clubs / on base At military friends' homes In civilian pubs, bars and/or clubs Other (please specify)
-----------	---

**Identify all that apply*

I*	Military friends and/or colleagues Other family members Civilian friends and/or colleagues On your own Spouse/Partner Other (please specify)
-----------	---

**Identify all that apply*

J	Never	Some of the time	Half of the time	Most of the time	Always
----------	--------------	-----------------------------	-----------------------------	-----------------------------	---------------

K	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
----------	-----------------------	--------------	----------------------------------	-----------------	--------------------------

L	TRiM Practitioner
	Chain of command
	GP/MO
	A hospital doctor/nurse
	A mental health specialist (<i>e.g. psychiatrist, psychologist, nurse practitioner</i>)
	Other non-medical professional (<i>e.g. Medic, Padre, Social Worker, Welfare Officer, Counsellor</i>)
	SSAFA/Combat Stress 24 Hour Helpline
	The Big White Wall
	Service charities (<i>e.g. SSAFA, Royal British Legion, Help for Heroes</i>)
	Combat Stress
	Veterans UK Helpline
	NHS Veterans Service
	Veterans and Reserves Mental Health Programme

M	A family member
	Friends/colleagues
	TRiM Practitioner
	Chain of Command
	GP/MO
	A hospital doctor
	A mental health specialist (<i>e.g. Psychiatrist, Psychologist, Nurse Practitioner</i>)
	Other non-medical professional (<i>e.g. Medic, Padre, Social Worker, Welfare Officer, Counsellor</i>)
	SSAFA/Combat Stress 24 Hour Help-line
	The Big White Wall
	Internet based therapy
	Service charity (<i>e.g. SSAFA, Royal British Legion, Help for Heroes</i>)
	Combat Stress
	Veterans UK Helpline
	Veterans and Reserves Mental Health Programme
	NHS Veterans Service
	Other (please specify)

N	On the advice of a family member, friend or colleague
	On the advice of a TRiM practitioner
	On the advice of employer or Chain of Command
	I realised I had a problem
	I was concerned the problem was getting worse
	The problem had started to affect my work
	I was experiencing disciplinary problems as a result of the problem

	I realise I couldn't solve the problem myself like I had hoped
	I found a relevant service through word of mouth, an advert or online
	A change in life circumstances or a major life event
	Other (please specify)

* Identify all that apply

0	Agree	Disagree	Neither agree or disagree
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Appendix 19

Barriers to Access to Care Evaluation (BACE v3)¹

Below you can see a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care we mean care from such staff as a GP (family doctor), community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem?

Please circle one number on each row to indicate the answer that best suits you.

For 'not applicable' e.g. if it is a question about children and you do not have children, please cross the Not applicable box.

	Issue	This has stopped, delayed or discouraged me NOT AT ALL	This has stopped, delayed or discouraged me A LITTLE	This has stopped, delayed or discouraged me QUITE A LOT	This has stopped, delayed or discouraged me A LOT
1.	Being unsure where to go to get professional care	0	1	2	3
2.	Wanting to solve the problem on my own	0	1	2	3
3.	Concern that I might be seen as weak for having a mental health problem	0	1	2	3
4.	Fear of being put in hospital against my will	0	1	2	3
5.	Concern that it might harm my chances when applying for jobs Not applicable <input type="checkbox"/>	0	1	2	3
6.	Problems with transport or travelling to appointments	0	1	2	3
7.	Thinking the problem would get better by itself	0	1	2	3
8.	Concern about what my family might think, say, do or feel	0	1	2	3
9.	Feeling embarrassed or ashamed	0	1	2	3
10.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)	0	1	2	3
11.	Not being able to afford the financial costs involved	0	1	2	3
12.	Concern that I might be seen as	0	1	2	3

	'crazy'				
13.	Thinking that professional care probably would not help	0	1	2	3
14.	Concern that I might be seen as a bad parent Not applicable <input type="checkbox"/>	0	1	2	3
15.	Professionals from my own ethnic or cultural group not being available	0	1	2	3
16.	Being too unwell to ask for help	0	1	2	3
17.	Concern that people I know might find out	0	1	2	3
18.	Dislike of talking about my feelings, emotions or thoughts	0	1	2	3
19.	Concern that people might not take me seriously if they found out I was having professional care	0	1	2	3
20.	Concerns about the treatments available (e.g. medication side effects)	0	1	2	3
21.	Not wanting a mental health problem to be on my medical records	0	1	2	3
22.	Having had previous bad experiences with professional care for mental health	0	1	2	3
23.	Preferring to get help from family or friends	0	1	2	3
24.	Concern that my children may be taken into care or that I may lose access or custody without my agreement Not applicable <input type="checkbox"/>	0	1	2	3
25.	Thinking I did not have a problem	0	1	2	3
26.	Concern about what my friends might think, say or do	0	1	2	3
27.	Difficulty taking time off work Not applicable <input type="checkbox"/>	0	1	2	3
28.	Concern about what people at work might think, say or do Not applicable <input type="checkbox"/>	0	1	2	3
29.	Having problems with childcare while I receive professional care Not applicable <input type="checkbox"/>	0	1	2	3
30.	Having no one who could help me get professional care	0	1	2	3

1. Barriers to Care Evaluation (BACE) Scale (v3) Institute of Psychiatry, King's College London © 2011. For permission to use and a copy of the manual, please contact Dr Sarah Clement sarah.clement@kcl.ac.uk or Professor Graham Thornicroft, graham.thornicroft@kcl.ac.uk.

Appendix 20

GAD-7 (Spitzer, 2006)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Appendix 21

PHQ-9 (Kroenke, 2001)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Appendix 22

PCL-5 (Weathers, 2013)

In the past month, how much were you bothered by:

a)	Repeated, disturbing, and unwanted memories of a stressful experience?	<input type="checkbox"/> 0= Not at all <input type="checkbox"/> 1= A little bit <input type="checkbox"/> 2= Moderately <input type="checkbox"/> 3= Quite a bit <input type="checkbox"/> 4 = Extremely
b)	Repeated, disturbing dreams of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
c)	Suddenly feeling or acting as if a stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
d)	Feeling very upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
e)	Having strong physical reactions when something reminded you of stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
f)	Avoiding memories, thoughts, or feelings related to a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
g)	Avoiding external reminders of a stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
h)	Trouble remembering important parts of a stressful experience?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
i)	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
j)	Blaming yourself or someone else strongly for a stressful experience or what happened after it?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
k)	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
l)	Loss of interest in activities that you used to enjoy?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
m)	Feeling distant or cut off from other people?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
n)	Having trouble experiencing positive feelings (for example, being unable to have loving feelings for people close to you, or feeling emotionally numb)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

o)	Feeling irritable or angry or acting aggressively?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
p)	Taking too many risks or doing things that cause you harm?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
q)	Being “superalert” or watchful or on guard?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
r)	Feeling jumpy or easily startled?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
s)	Having difficulty concentrating?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
t)	Trouble falling or staying asleep?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
u)	<p>Have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person?</p> <p>(Prompt: What about feeling as if you were in a dream, even though you were not awake? Feeling as if something about you wasn't real? Feeling as if time was moving more slowly)?</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
v)	<p>Have there been times when things going on around you seemed unreal or very strange and unfamiliar?</p> <p>(Prompt: Do things going around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

Appendix 23

AUDIT Questionnaire (Babor, 2001)

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Appendix 24

Self-Stigma of Seeking Help (SSOSH) (Vogel, 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix 25

Multidimensional Scale of Perceived Social Support

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
 Circle the "2" if you **Strongly Disagree**
 Circle the "3" if you **Mildly Disagree**
 Circle the "4" if you are **Neutral**
 Circle the "5" if you **Mildly Agree**
 Circle the "6" if you **Strongly Agree**
 Circle the "7" if you **Very Strongly Agree**

	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7