Barriers and facilitators in the pathway to care of military veterans

Carlene Huck

D.Clin.Psy. thesis (volume 1), 2014

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name:

Date:

Overview

This thesis focused on psychological help-seeking and the barriers and facilitators to mental health care in a military population. It is presented in three parts.

Part one is a literature review examining the role of stigma in relation to military personnel seeking help for psychological problems. The review highlighted that, despite concerns about perceived stigma from others being highly endorsed as a barrier to care in military personnel, public stigma concerns do not appear to predict actual help-seeking and care utilisation. The review suggested considerations for future research including refining the conceptualisation and measurement of stigma within this population as well as encouraging consideration of other potentially important factors, such as attitudes and beliefs about mental health and mental health treatment.

Part two is an empirical paper. This qualitative study aimed to understand the perspectives of UK ex-servicemen, and the barriers and facilitators, in relation to their pathway to care for mental health problems. The results indicated that there are specific barriers and facilitators that are more relevant at different stages in the veterans' pathway. A number of recommendations for future research as well as a set of clinical implications are proposed and discussed.

Part three is a critical appraisal of the research. It reflected on the practical, methodological, and conceptual issues encountered during the process of setting up and conducting research with an ex-military population. It covered areas relating to the literature in the field, factors influencing recruitment, and the process of conducting and analysing the interviews. Potential considerations for future research are highlighted.

Table of Contents

Overview..... 3

Table of Contents..... 4

List of Tables and Figures..... 5

Acknowledgements..... 6

Part 1: Literature Review……..... 7

Abstract……..... 8

Introduction……..... 9

Method……..... 16

Results……..... 20

Discussion……..... 37

References……..... 46

Part 2: Empirical Paper..... 54

Abstract..... 55

Introduction..... 56

Method..... 64

Results..... 75

Discussion..... 91

References..... 104

Part 3: Critical Appraisal..... 113

References..... 127

Appendices..... 130

Appendix 1. Glossary of Military Terms..... 131

Appendix 2. Participant Information Sheets and Consent Forms..... 134

Appendix 3. Semi-Structured Interview Schedule..... 140

Appendix 4. Notification of Ethics Approval..... 143

Appendix 5. Transcript and Coding Examples..... 158

List of Tables

Part 1. Literature Review

Table 1. *Proposed manifestations of stigma in the military*..... 12

Table 2. *Search terms*..... 17

Table 3. *Characteristics of the included studies*..... 22

Part 2. Empirical Paper

Table 1. *Participant information*..... 69

Table 2. *Veterans' pathway to care*..... 76

Table 3. *Barriers and facilitators to recognition and acknowledgement of a mental health problem*..... 80

Table 4. *Barriers and facilitators to initial help-seeking*..... 85

Table 5. *Barriers and facilitators to treatment use*.....88

Table 6. *Future considerations to support veterans seeking help*.....90

List of Figures

Part 1. Literature Review

Figure 1. *The impact of stigma on help-seeking*..... 11

Figure 2. *Flowchart of search strategy and results*.....19

Part 2. Empirical Paper

Figure 1. *Treatment initiation in veterans with PTSD*..... 59

Figure 2. *Referral process for the services*..... 66

Figure 3. *Participant recruitment procedure*..... 68

Acknowledgements

This research would not have been possible without the considerable support and input from a number of people.

I would firstly like to thank my supervisors Chris Barker and Ken Carswell for the large amount of time they have contributed in all stages and aspects of this thesis. They have provided advice, considerable expertise, and both practical and emotional support. I would like to thank Mark Hinton for his help in getting the research off the ground in one of the research sites and for his feedback and knowledge in relation to the empirical paper. Thanks also to Zahra Merali for helping with transcription of the interviews and reviewing some of the data analysis.

There are a number of people within the individual services who have acted as primary contacts and who have provided invaluable practical support in relation to the recruitment of participants and the organisation of this. In relation to this, I would specifically like to thank Trish Sullivan for her amazing administration and organisational help. I would also like to thank Tess Browne, Charlotte Johnson, and Lucy-Spencer Harper for their support in recruitment, and their provision of information and feedback in relation to the results of the empirical paper.

Lastly, I would like to thank Jude for proof reading and for being a constant source of support and encouragement.

Part 1: Literature Review

The role of stigma on psychological help-seeking in the military population

Abstract

Aims: Stigma has been proposed as one of the main factors influencing people's acknowledgement of, and their help-seeking for, psychological problems. This review aimed to understand the role of stigma in relation to help-seeking and service utilisation for psychological problems in regular[1] and veteran military personnel.

Method: A systematic search of PsycINFO, Embase, CINAHL, Medline, and PILOTS databases was conducted to identify studies that considered the role of stigma in relation to help-seeking in military personnel. It included studies with members of any of the Armed Forces (Army, Air Force, Navy), including reserve personnel and ex-servicemen.

Results: Twenty-one studies were considered in this review. Studies were predominantly survey-based, relied on self-report, and focused on populations of serving personnel in the United States of America (USA). Stigma was generally measured using a narrowly focused and unvalidated measure. There was little consideration of the role of self-stigma and how stigma in general influenced help-seeking in veteran populations.

Conclusions: Stigmatising beliefs, specifically concerns about anticipated public stigma, are the most frequently assessed and endorsed barriers to care in military personnel and are often rated as a greater concern than practical barriers to care. Despite this finding, public stigma was generally not associated with care-seeking propensity or help-seeking intentions. Not one study in this review showed help-seeking to be predicted by concerns about public stigma. Attitudinal factors such as beliefs about mental health, service providers, and mental health treatment were more predictive of help-seeking. Self-stigma was rarely considered in studies. Where it was, it was shown to predict less positive attitudes towards seeking treatment and to be negatively correlated with help-seeking intentions.

[1]For definitions of all military related terms please refer to Appendix 1.

Introduction

People who experience mental health problems often have to deal with both the psychosocial factors associated with having the difficulties, as well as the stigma of having a mental health label (Corrigan & Watson, 2002). Stigma is linked to a perceived weakness or inadequacy in relation to having, or seeking help for, a mental health problem (Vogt, 2011). In addition, it is associated with prejudice and discrimination (both from others and towards oneself), which can further exacerbate the difficulties that the person is already experiencing (Corrigan & Penn, 1999).

Military personnel are a population that is particularly vulnerable to developing mental health problems due to their exposure to traumatic events (Hoge et al., 2004). Deployment to combat zones can have a large psychological and physical impact on individuals returning to family and civilian life. The main psychological difficulties for veterans of combat include: Post Traumatic Stress Disorder (PTSD), depression, suicide, substance misuse, impulsivity and aggressive behaviour, and relationship problems (Resnik et al., 2012).

In keeping with studies of help-seeking within the general population (e.g. Cooper, Corrigan, & Watson, 2003; Oliver, Pearson, Coe, & Gunnel, 2005), studies with the military population have shown that a large proportion of military personnel who experience mental health problems do not seek professional help (Hoge et al., 2004; Iversen et al., 2010). Additionally, many do not attend follow-up appointments or continue with treatment following an initial referral for mental health assessment (Milliken, Auchterlonie, & Hoge, 2007).

The decision to seek help and utilise treatment is a complex process. Many individual, social, cultural, and system factors influence if and when help is sought, as

well as the type of help that is pursued (Hoge, et al., 2004; Rogler & Cortes, 1993). In a qualitative study with veterans, Stecker, Fortney, Hamilton, and Ajzen (2013), identified that concerns about treatment, emotional readiness, stigma, and logistical issues were the main reasons for not seeking-help. Stigma has been proposed as one of the main influential factors in relation to individuals' acknowledgement and help-seeking for mental health problems (Green-Shortridge, Britt, & Andrew 2007).

Stigma and help-seeking in the military

Stigma is described as a staged process involving the cognitive, emotional, and behavioural elements of negative stereotyping, prejudice, and ultimately discrimination (Corrigan, 2004). It can result in reduced access to social, economic and healthcare opportunities (Deacon, 2006). Linking with the Theory of Planned Behaviour (Ajzen & Fishbein, 1980), stigma is proposed to influence a person's attitude towards treatment, which in turn influences their willingness to seek help (Vogel & Wester, 2003).

Two conceptually similar models have been proposed relating to how stigma impacts on help-seeking in the military (Ben-Zeev, Corrigan, Britt, & Langford, 2012; Green-Shortridge et al., 2007). These models build on the understanding of stigma in the general population based on the work of Corrigan and Penn (1999) and Corrigan (2004).

The models distinguish between public stigma and self-stigma. Public stigma refers to the views held by the public in relation to mental illness and the prejudice and discrimination that may occur as a result. For example, 'people with mental illness are not capable and should not be given responsibility.' Self-stigma is defined as the internalisation of public stigma and negative stereotypes (e.g. I am weak for having a mental health problem). It can be associated with shame, threat to one's self-regard, low

self-esteem, and poorer quality of life (Corrigan & Watson, 2002). Self-stigma has been shown to be a stronger deterrent from seeking mental health treatment than public stigma (Kim, Britt, Klocko, Riviere, & Adler, 2011; Stecker et al., 2007).

Individuals' attempts to avoid the different elements of stigma are hypothesised to be associated with reduced likelihood of help-seeking. Fear of prejudice and discrimination, and potential self-stigma and low self-esteem, are likely to reduce motivation to seek help, impact on treatment adherence (Fung, Tsang, & Corrigan, 2008), and interfere with an individual's goals (e.g. pursuing employment and social activities), that are an important part of the rehabilitation process (Wahl, 1999).

Ben-Zeev et al. (2012) included the role of 'label avoidance' in their understanding of stigma in relation to the underutilisation of mental healthcare by military personnel. This is process by which people do not acknowledge symptoms or participate in services in order to avoid stigma and associated negative consequences of having a diagnosis or label (Ben-Zeev et al., 2012). The way that sigma may develop and be maintained is displayed in Figure 1. and Table 1.

Figure 1.

The impact of stigma on help-seeking (Developed from Corrigan 2004, and based on Shirvastava, Johnston, & Bureau, 2012)

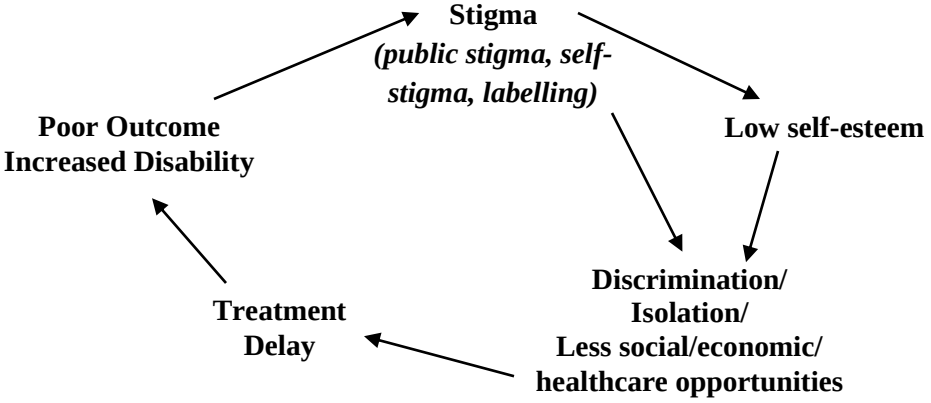


Table 1.

Proposed manifestations of stigma in the military (Ben-Zeev et al., 2012)

	Stigma type		
Stage	***Public stigma***	***Self-stigma***	***Label avoidance***
Stereotypes *(beliefs)* ↓	*"He is weak"* *"He is unreliable"* *"He is dangerous"*	*"I am weak/ unreliable"* *"I am a burden to my fellow soldiers"*	*"Diagnosis of PTSD means I am crazy"*
Prejudice *(Cognitive and emotional response)* ↓	*Disdain* *Distrust* *Fear*	*Poor self-esteem* *Poor self-efficacy*	*"Seeking treatment will mark me, I will be humiliated."*
Discrimination *(behavioural response)*	*Social isolation* *Ridicule* *Suspended promotion* *Exclusion from duties*	*Poor effort* *Soldier does not pursue advancement*	*Soldier denies any symptoms* *Soldier avoids going to clinic/hospital*

Stigma and stigmatisation are complex psychosocial phenomena. The literature has often considered stigma about mental illness as being synonymous with stigma in relation to help-seeking and has not necessarily separated these factors out. This may be because help-seeking is merely viewed as behaviour linked with mental ill health (Tucker, 2013). Individuals' reluctance to seek help due to fear, and wanting to avoid the consequences, of being viewed as mentally unwell can be referred to as anticipated public stigma (Corrigan, 1999). Anticipated public stigma in relation to help-seeking is the main area that has been considered in the literature and measures used with military personnel. However, studies have not generally assessed whether anticipated public stigma around help-seeking is different to that around receiving a mental health diagnosis or label. Recent studies in the general population argue that there are two

different types of self-stigma, namely self-stigma specifically related to mental illness and self-stigma in relation to help-seeking. It has been found that these two types of stigma independently predict intentions to seek-help (Tucker, 2013). Self-stigma has not been routinely considered in research with military personnel. Where it is has, it has largely focussed on self-stigma in relation to help-seeking.

The military has a set of specific cultural and organisational demands and practices and it is proposed that this results in greater stigma within this population (Greene-Shortridge, Britt, & Andrew, 2007). There is a high value placed on individual characteristics such as emotional strength, physical strength, resilience, and self-sufficiency (Vogt, 2011). In addition, military personnel are expected to be able to perform and function at a high and consistent standard (Nash, Silva, & Litz, 2009). Threats to these factors could be viewed, by the individual and their colleagues, as a weakness and therefore likely to impact on their ability to perform in their role. There is the risk of stigma being present in any situation where weakness is perceived. For example, having a mental health problem as well as seeking help for it (Tanielian & Jaycox, 2008).

Stigma in relation to mental health is prevalent in the military (Wright, et al., 2009); however, evidence of the impact of stigma on help-seeking within this population has been mixed (Sudom, Zamorski, & Garber, 2012). Many personnel have expressed concern about being treated differently (Gould et al., 2010), and their career prospects being compromised (Hoge et al., 2004) if they sought help for a problem. Personnel in higher ranks have been shown to express concern about others' perception of their ability to lead, and those in lower ranks were concerned about not receiving promotions and not being deployed (Stecker et al., 2007). Forty-five percent of military personnel

reported believing that admitting a mental health problem would result in people having less confidence in them (Britt, 2000). They have described concern that the public is stigmatising towards veterans with PTSD, and likely to view them as "crazy, dangerous or violent". They also express a belief that the public would blame them or see them as responsible for their problems due to them choosing to be in the military (Mittal et al., 2012). Veterans have reported fears of being labelled as a result of seeking help and receiving care for a mental health problem, and concerns about the potential consequences of this in relation to their career (Stecker et al., 2007). However, this process is complex and influenced by many social, environmental, and leadership factors. Higher levels of social support, more positive views of unit leadership, and greater unit solidarity and togetherness are associated with lower reported stigma in relation to seeking help for mental health problems (Britt, Greene, Castro, & Hoge, 2006; Pietrsak, Johnson, Goldstein, Malley, & Southwick, 2009; Wright et al., 2009).

Due to the potential detrimental role that stigma can play in relation to military personnel seeking help for mental heal problems, interventions are needed to reduce these barriers and promote treatment seeking and utilisation where it is necessary (Zinzow et al., 2012). One such intervention is the Trauma Risk Management Programme (TRiM). This is a peer-delivered psychological support programme that was introduced by the military to modify attitudes about PTSD, provide psycho-education, and support and refer personnel in need or at risk (Jones, Roberts, & Greenberg 2003). Evidence of its effectiveness is mixed and studies have encountered a number of methodological issues. Gould, Greenberg, and Hetherton (2007) showed that personnel trained in TRiM demonstrated improved attitudes about PTSD and stress, and were more likely to seek help. However, a longer term randomised study did not find a change in

psychological health or stigma scores regardless of training in TRiM. They do however highlight that it might be beneficial for personnel who have encountered more traumatic or combat exposure (Greenberg et al., 2010).

Aims

The current review aims to develop an understanding of the role of stigma in relation to help-seeking for psychological problems in the military and after leaving service. It will also consider the effectiveness of anti-stigma interventions used with this population. There is a previous literature review examining the role of stigma, beliefs, and attitudes in relation to military personnel and the impact of this on help-seeking (Vogt, 2011). There is also a previous, more current, review of interventions to reduce stigma in the military (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). The findings of this are incorporated into the discussion of this current review.

Vogt (2011) reviewed 15 articles on military personnel's beliefs about service use, published before September 2009. They concluded that concerns about stigmatisation were pervasive in the military including amongst veterans, National Guard (reserve personnel), and active duty personnel. Beliefs about public stigma and personal beliefs about mental illness were likely to act as significant barriers to care and help-seeking. The review highlighted that the majority of studies focused on public stigma and there was less focus on self-stigma and personal beliefs. Only one of the 15 studies looked at the predictive value of stigma in relation to service utilisation. Vogt (2011) highlighted that this would be an area for further research and understanding.

The current review aimed to build on the Vogt (2011) review by examining the literature published since that review and identifying new findings or continued gaps in the understanding of the role of stigma in relation to help-seeking in the military.

It addresses the following questions:

1. What is the role of stigma in relation to help-seeking for psychological problems in military personnel?
    a. Is this different for veterans and serving personnel?
    b. What is the impact of stigma on actual service utilisation?
2. What are the factors associated with stigma and help-seeking?
3. Is there a difference between the role and impact of self-stigma and public stigma?

Method

Inclusion and exclusion criteria

Studies included met the following criteria:

1. The population included adult military personnel including reserve and veteran personnel.
2. The studies focused on mental health rather than physical health problems. If studies considered both types of problems they were included.
3. The studies had at least one measure of stigma and attitudes or beliefs towards help-seeking.
4. The studies utilised a quantitative methodology including correlation and/or regression research design.
5. The studies were published in a peer-reviewed journal and written in English.

6. The studies were published between October 2009 and September 2013. A previous review (Vogt, 2011), had included studies up until the end of September 2009.

Exclusion criteria:

1. Studies exploring the emotional reactions of professional groups working with people in the military or the relatives of people in the military.
2. Review articles or articles presenting theoretical models.
3. Research with non-western military populations

Search strategy

Search terms are depicted below (see Table 2). Terms were exploded to incorporate as many potentially relevant studies as possible. The search specified that all two or three-word terms appeared adjacently. Parameters were set to search for articles that contained at least one search term from each of the three domains. The same keyword searches of the same terms were used across all databases.

Table 2.

Search terms

Population	***Stigma/beliefs***	***Help-seeking***
*Veteran**	*Stigma*	*Help seek**
Military personnel	*Belief**	*Health care seek**
Territorial army	*Attitude**	*Treatment seek**
National guard	*Barriers adj3 care*	*Health care utilization/utilisation*
	Barriers adj3 help	*Treatment utilization/utilisation*

*exploded terms

The studies included in the review were identified through searches on a number of online databases. Systematic searches were conducted separately on the PsycINFO,

Embase, CINAHL, Medline, and PILOTS (Published International Literature on Traumatic Stress) databases.

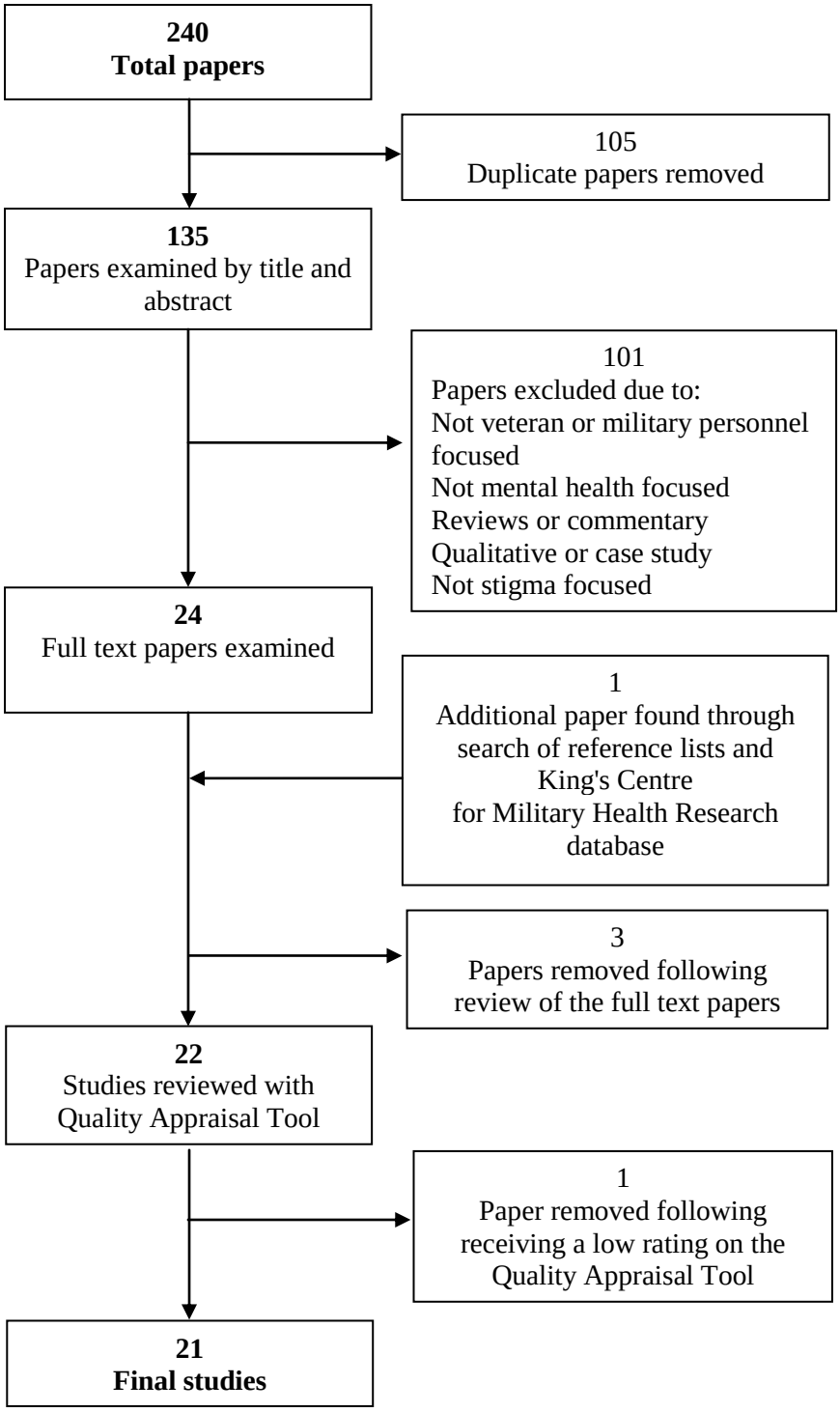
After the initial search, duplicate search results were removed. The titles and abstracts of all the remaining studies were then examined. Full texts were sourced and analysed where the abstracts did not provide sufficient detail. Studies not meeting the inclusion criteria were removed. Finally, the reference lists of relevant empirical research papers were also searched and a review of the King's Centre for Military Health Research database of published literature was conducted in order to locate additional studies. The search strategy and results are displayed in Figure 2.

Critical appraisal of the studies

Following the identification of the 22 papers, the researcher examined each study using a critical appraisal tool (Kmet, Lee, & Cook, 2004), in order to assess the research quality and allow for comparison across the studies. This tool was chosen due to its utility in comparing diverse study designs. Papers were rated across a maximum of 14 criteria. Examples of these criteria include: 'study design evident and appropriate' and 'analytic method described/justified and adequate.' Each criterion was rated as either 0 (not present), 1 (partial), 2 (present). The total score was divided by the total score possible to give a rating of between 0 and 1. Scores of over 0.75 were taken to represent a good level of quality and trustworthiness. The tool does not recommend a specific cut-off point; therefore, this figure was agreed as reasonable by the researchers. This procedure was repeated by an independent researcher. Any discrepancies in ratings were discussed and a final rating agreed. As a result of a very low score of 0.27 on this appraisal tool, one study was removed from the review leaving a final 21 studies.

Figure 2.

Flowchart of search strategy and results



Results

The results of this review are presented by firstly outlining the various characteristics of the studies that were included. Following this, each of the three questions raised in relation to the aims of this review are answered in turn. Twenty-one studies were included in this review. Their main characteristics and main findings are summarised in Table 3.

Characteristics of the studies

Population

The studies predominantly focused on USA-based military populations (15 studies). One was with the Canadian military and the remaining five were UK based. A total of 47,610 participants had taken part in the studies. Eleven studies were conducted with regular/active duty serving personnel. Five studies were conducted with the National Guard or reserve personnel in the US (total participants = 33,619). One study was done with both regular and National Guard personnel (total participants = 10,386). Only four studies included veterans. Two of these studies were conducted in the US Veterans Affairs (VA) organisation (total participants = 795). One study in the US included both ex-servicemen and currently serving personnel (total participants = 126), and one study in the UK included regular and reserve personnel and veterans (total participants = 821). Of the studies with active personnel, four were conducted during deployment, ten were conducted either immediately post-deployment or within the first year post-deployment to Iraq and Afghanistan, and the remainder were conducted at various time points.

Design

Fifteen studies were cross-sectional, three were longitudinal, two were cohort studies, and one utilised mixed methods.

Measures of stigma

All but four of the studies used a version of the Perceived Stigma and Barriers to Care Scale (PSBCS) based on Britt (2000), and Hoge (2004). This measure is not validated and includes measures of practical barriers to help-seeking as well as stigma. Different studies used different versions of this measure, often adapted to meet the needs of the population they were looking at. This measure only considers anticipated public or social stigma in relation to seeking help. Only four studies considered self-stigma. Two of the studies identified using the Self-stigma of Seeking Help scale (Vogel, Wade, & Haake, 2006). Other measures of stigma used in the studies included The Perceptions of Stigmatisation by Others for Seeking Help (Vogel et al., 2009), and the Barriers to Help-seeking Scale (Mansfield, Addis, & Courtenay, 2005).

Quality

All studies included in this review scored above 0.75 on the quality appraisal tool indicating a strong selection of good quality studies. Generally, the strengths of the studies included the sample sizes employed and the fact that the study questions, design, and outcomes were clearly described. Studies tended to score more poorly in relation to limited attempts to control for confounding variables and measures not being clearly defined and able to measure the outcomes robustly. These issues are described in more detail in relation to individual studies below.

Table 3.

Characteristics of included studies

Paper	N	Population	Design	Time points	Measures	Summary of findings
Arbisi et al. (2013)	40	National Guard soldiers with a mental health diagnosis (USA)	Longitudinal	- 1 month prior to deployment - 3.4 months post deployment - 8.5 months after this	- 7 item stigma subscale from Britt (2000) - ATSPPHS - MMPI-2 subset (cynicism) - PCL-M, BDI-II - Mental health service utilisation	- Negative attitudes toward mental health care, but not stigma, predicted failure to seek mental health care (OR 3.32). - Greater reported cynicism independently predicted lower mental health service utilisation (OR 0.24).
Blais & Renshaw (2013)	165	National Guard/Reserve combat veterans of the Afghanistan conflict (USA)	Cross-Sectional	Post-deployment from Iraq and Afghanistan	- PSBCS (6 item public/social stigma subscale) - PSOSH - SSOSH - PCL-M, GHSQ	- Self-stigma was negatively correlated with help-seeking intentions (r= -.41, p<.001) - Anticipated enacted public stigma was unrelated to help-seeking intentions. - Participants expected greater enacted stigma from their unit leader, then from their colleagues/unit members, and lastly from family/friends. - PTSD symptom severity was not associated with self-stigma, anticipated enacted stigma, or help-seeking intentions.
Britt et al. (2011)	428	National Guard/Reserve personnel (USA)	Cross-sectional	Varied	- PSBCS (6 item public stigma subscale) - Treatment seeking - Views of psychological problems - Attitudes toward treatment seeking (1 item) - Subjective norms	- Perceived stigma was associated with more negative attitudes towards treatment; however, it was not predictive of treatment seeking. - Positive attitudes towards treatment (OR 1.34) and beliefs about psychological problems not being handled by oneself (OR 0.67) were unique predictors of treatment seeking. Perceived control and subjective norms did not predict treatment seeking.
Britt et al. 2012)	1455	Active duty/Regular soldiers from a combat team (USA)	Cross-sectional	2, 3, and 4 months following return from Afghanistan	- 12 item PSBCS (7 item public/social stigma subscale) - Leadership scale	- Reports of stigma were consistent across time periods. - Higher ratings of negative non-commissioned officer behaviours and lower ratings of positive non-commissioned officer behaviours were correlated with higher reports of stigma (across all time points).

Paper	N	Population	Design	Time points	Measures	Summary of findings
Brown et al. (2011)	577	Combat veterans Screened positive for PTSD, depression, or GAD (USA)	Cross-sectional	3 months after deployment to Iraq	- 17 item PSBCS (7 item public/social stigma subscale) - Stigmatising attitude towards others (2 items) - Recognition of a current problem (1 item) - Interest in seeking in help (1 item) - Receipt of care in the past year	- Greater perceived unit stigma was related to increased likelihood of interest in receiving help (OR 2.29). - Negative attitudes about mental health were related to lower interest in seeking help (OR 0.58). - Negative attitudes about mental health were related to lower interest in seeking help (OR 0.58). - Higher-ranking personnel were less likely to be interested in receiving help (OR 0.21).
Fear et al. (2012)	611	Serving military personnel in Iraq (UK)	Cross-sectional	Data collected during deployment in Iraq	- 11 item PSBCS (6 item public/ social stigma subscale) - GHQ, Combat Exposure, PCL-C, Military and deployment factors	- Participants answering the anonymous questionnaire were more likely to report 3 out of the 11 stigmatising beliefs: 'leaders discourage the use of mental health services' (OR 2.23),' it would be too embarrassing' (OR 1.55), and 'I would be seen as weak' (OR 1.78) compared to those answering the non-anonymous questionnaires. They were more likely to report probable PTSD (OR 2.74) and PTSD caseness (OR 3.18).
Gorman et al. (2011)	332	National Guard members and 212 significant others participating in re-integration workshops (USA)	Cross-sectional	2-3 months post deployment	- 17 item PSBCS (7 item public/social stigma subscale) - PCL-M, BDI-II - Stressful Life event Scale - AUDIT	- Stigma and concerns about service utilisation appearing on military records ranked high as barriers. This linked with concerns about the influence of mental health issues on career advancement that were rated highly. - Perceived barriers to care for National Guard soldiers were lower than those reported by regular/active duty personnel (Hoge et al., 2004).
Held & Owens (2013)	126	Active and retired military service members (USA)	Cross-Sectional	Various	- SSRPH - SSOSH - ATSPPHS	- Greater public stigma was significantly associated with greater self-stigma ($\beta = .536$, $SE = .068$, $p < .001$), and attitudes toward seeking mental health treatment. - Self-stigma significantly predicted less positive attitudes toward seeking mental health treatment ($\beta = –.721$, $SE = .062$, $p < .001$). - Self-stigma fully mediates the relationship between public stigma and attitudes toward seeking mental health treatment.

Paper	N	Population	Design	Time points	Measures	Summary of findings
Hoerster et al. (2012)	305	Iraq and Afghanistan veterans with PTSD, depression, or alcohol problems (USA)	Longitudinal	At intake to a post-deployment health clinic. Attendance at a clinic in the following year	- 10 item PSBCS (4 item public/social stigma subscale) - PCL-M, PHQ-9 - Outpatient mental health care use - Treatment use	- Stigma-related barriers were highly endorsed. - However, the barriers measured did not interfere with receipt of adequate treatment. - Severity of PTSD (OR 1.03) and depression (OR 1.06) predicted greater mental health care utilisation.
Iversen, et al. (2011)	821	Regular military, reservists, and veterans (UK)	Cohort	In service at the time of the 2003 Iraq War	- 16 item expanded PSBCS (6 item public/social stigma subscale) - PHQ-9, PC-PTSD	- Regular personnel predominantly rated stigmatising beliefs as barriers to help-seeking. - Compared to regular personnel, reservist and veteran personnel reported more practical barriers. - The most significant barriers identified were anticipated stigma and lack of trust/confidence in mental health services.
Kehle, et al. (2010)	424	National Guard soldiers (USA)	Longitudinal	- Pre-deployment and - 2-3 months after return from deployment in Iraq	- 13 Stigma items PSBCS - 3 items assessing stigmatising attitudes towards others - ATSPHH - DRRI - Psychological Help Scale - PCL, BDI-II	- Concerns about stigma were rated by the participants; however, there was no relationship between stigma and self-reported treatment-seeking behaviour. - Positive attitudes towards care were associated with increased treatment seeking (OR 1.39).
Kim et al. (2011)	3,380	Active duty/regular soldiers (USA)	Cross-sectional	6 months post deployment to either Afghanistan or Iraq	- 17 item Barriers to care measure: (PSBCS; 4 items from Britt (2009), and 2 items taken from Mackenzie et al.): 7 item public/social stigma factor - Service utilisation (1 item) - PHQ-9, GAD-7, PCL	- Stigma and organisational barriers did not predict utilisation of any type of care/treatment. - Negative attitudes toward treatment were related with less utilisation. Those endorsing negative attitudes were 40% less likely to use any type of mental health care. - The use mental health services/professionals was significantly positively associated with reported organisational barriers

Paper	N	Population	Design	Time points	Measures	Summary of findings
Kim et al. (2010)	10386	Active duty/regular personnel and National Guard soldiers with mental health problems (USA)	Cross-sectional	3 and 12 months after return from deployment in Iraq	- 11 item PSBCS (6 item public/social stigma scale) - Self-reported service utilisation - PHQ-9, PCL - Aggressive behaviours	- Active duty soldiers reported significantly stronger feelings of stigma compared with National Guard soldiers at both time points. Three months-$t(2352)=8.25$, $p<.001$; 12 months-$t(1696)=5.65$, $p<.001$. - National Guard soldiers were significantly more likely than active duty soldiers to have used mental health care in the past month and 12 months post-deployment. - There was no difference in reported stigma and barriers to care across the two time points.
Langston, et al. (2010)	1599	Serving Naval personnel (UK)	Mixed Methods	Part of baseline data collection for the (TRiM) intervention	- Stigma measure not clearly defined - 5 internally stigmatising belief statements - External stigma - GHQ, PCL-C	- There was a low prevalence of externally stigmatising beliefs about mental health difficulties in royal naval personnel. - Internally stigmatising beliefs about how personnel might be treated and perceived themselves if distressed were common. - Internal stigma was reported two to three times more by distressed personnel than those who were not distressed.
Momen et al. (2012)	553	Marines (USA)	Cross-sectional	Various	- 18 item measure of barriers to care - 16 item measure of perceptions of combat stress reactions - Treatment utilisation	- Help-seeking was not significantly related to common barriers. - Personnel with and without combat experience did not differ significantly in their perceptions of barriers to care. - Those with a college degree were more likely to be embarrassed about mental health problems, worry about their units losing confidence in them, and leadership treating them differently.
Osório et al. (2013)	23101	Armed Forces personnel from all three branches (UK)	Cross-Sectional multiple surveys with different groups across time periods between 2008 and 2011	During deployment in Afghanistan or Iraq or Post-deployment (24-36 hours post leaving operational theatre and another group at 6 month follow-up)	- 4 public/social stigma items - PCL-C, PC-PTSD	- Reported stigma was greater than other reported barriers to care. - The most common stigmatising beliefs endorsed were concern about being treated differently by commanders and concern about being seen as weak. - There was a significant downward trend in reporting of stigma by deployed personnel between 2009 and 2011. This was not evident in the post-deployment surveys.

Paper	N	Population	Design	Time points	Measures	Summary of findings
Osório et al. (2012)	23101	Members from all of the three military services (UK)	Cross-Sectional multiple surveys with different groups across time periods between 2008 and 2011	During deployment in Afghanistan or Iraq or Post-deployment (24-36 hours post leaving operational theatre and another group at 6 month follow-up)	- 7 items from the PSBCS common to all surveys: 4 public/social stigma items - PCL-C, PC-PTSD	- Military personnel reported significantly higher levels of stigmatising beliefs and barriers to mental health care during deployment than at the post-deployment survey point. - Post-deployed personnel were more concerned about confidentiality. - Regular Forces reported significantly higher levels of stigma than Reserve Forces personnel. - Combat personnel reported higher levels of stigma and barriers to care than support personnel. - Officer ranks more likely to report stigma than junior ranks. - Probable PTSD was the strongest predictor of reporting stigma and barriers to care.
Ouimette et al. (2011)	490	Vietnam and Iraq/Afghanistan veterans diagnosed with PTSD (USA)	Cross-sectional	Veterans Affairs outpatients, newly diagnosed with PTSD (previous 6 months)	- BHSS - Additional barrier items based on (Vogt, 2011) - 12 stigma items: discomfort with help-seeking and concerns about social consequences (public and self – but not differentiated) - IES-R - Centre for Epidemiological Studies Depression Scale (CES)	- The most common reported barriers to mental health care were stigma-related. - Institutional barriers (logistical/practical barriers) were less prominent. - Greater severity of PTSD avoidance symptoms was associated with increased stigma related barriers to care. - The severity of re-experiencing symptoms was associated with fewer stigma-related concerns. - Being married was associated with increased discomfort with seeking help and higher perceived negative social consequences.
Rae Olmsted et al. (2011)	1453	Soldiers in treatment for mental health and substance abuse problems and soldiers who were not in treatment (USA)	Cross-sectional	Serving soldiers in treatment or attending a post-deployment health reassessment	- 16 items to assess perceived barriers substance abuse and mental health treatment separately (based on PSBCS): 11 items perceived stigma (public)	- Participants receiving any treatment had significantly higher perceptions of stigma than those not in treatment. - Those seeking treatment continued to perceive stigma surrounding their help-seeking.

Paper	N	Population	Design	Time points	Measures	Summary of findings
Rosen, et al. (2011)	482	Veterans with PTSD (USA)	Cohort	Diagnosed with PTSD within the preceding 6 months (Veterans of all conflicts including and since Vietnam)	- BHSS - Additional items based on a literature review of reasons for not seeking help (Vogt, 2011): - 6 item social stigma subscale - Number of psychotherapy sessions - IES-R - Medical Outcome Scale - Military Version	- Stigma, concerns about fitting in, and satisfaction with care were not retrospectively or prospectively associated with initiating treatment (psychotherapy). - Veterans expressed stigma concerns; however, those who did were no less likely to use care.
Sudom, et. al. (2012)	2437	Regular serving service personnel (Canada)	Cross-sectional	During deployment in Afghanistan	- 19 Items from Mental Health Assessment Team approach (MHAT) to assess perceived barriers and (public) stigma to seeking mental health care (included items based on Britt, 2000; Hoge et al., 2004, Britt et al., 2008; and Wright et al., 2009) - PCL-C, PHQ-9 - Care-seeking propensity (1 item) - Use of mental health services (1 item)	- No relationship was found between stigma and care-seeking propensity in any of the models - Practical/structural barriers were associated with greater care-seeking propensity. - Stigma was not predictive of interest in care. - Negative attitudes were associated with less interest in care. - Past care was positively associated with current interest in care. - Current disorder was associated with both stigma and structural barriers.

AUDIT - Alcohol Use Disorders Identification Test; ATSPPHS – Attitudes Toward Seeking Professional Psychological Help Scale (Fischer &Farina, 1995); BDI-II – Beck Depression Inventory; BHSS - Barriers to Help-seeking Scale (Mansfield, Addis, & Courtenay, 2005); DRRI – Deployment Risk and Resilience Inventory; GHSQ – The General Help-Seeking Questionnaire; IES-R – Impact of Events Scale; PCL-C – PTSD Checklist-Civilian Version; PCL-M – PTSD Checklist-Military Version; PC-PTSD – Primary Care PTSD Scale; PHQ- 9 - Patient Health Questionnaire; PSBCS – The Perceived Stigma and Barriers to Care Scale (Britt, 2000; Hoge, 2004); PSOSH – The Perceptions of Stigmatisation by Others for Seeking Help (Vogel, Wade, & Ascheman, 2009); SSOSH – Self-stigma of Seeking Help (Vogel, Wade, Haake, 2006); SSRPH - Stigma Scale for Receiving Psychological Help.

The role of stigma and beliefs in relation to help-seeking for psychological problems in the military

The studies in this review considered the role of stigma in relation to help-seeking in different ways. These are outlined below and then examined in turn:

- Seven studies reviewed the prevalence of certain types of stigmatising beliefs in relation to help-seeking within the Armed Forces and two studies looked at how this changed with time or at certain time points.
- Four studies considered the relationship of stigma with attitudes towards mental health and/or help-seeking intentions.
- Seven studies assessed how stigma impacted on treatment utilisation. Three studies considered this prospectively and three looked at these factors retrospectively. One study looked at the ongoing use of psychotherapy.

The prevalence of types of stigmatising beliefs in the Armed Forces

Gorman, Blow, Ames, and Reed (2011), Iversen et al. (2011), Kim et al. (2010), Langston et al. (2010), Momen, and Strychacz, Virre (2011), Osorio, Jones, Fertout, and Greenberg. (2013), and Sudom et al. (2012) all considered how frequently certain stigmatising beliefs were endorsed by different Armed Forces members. The most frequently endorsed anticipated public stigma barriers included:

- concerns about being treated differently (endorsed by between 30% - 71% of participants in Gorman et al., 2011; Iversen et al., 2011; Kim et al., 2010; Momen et al., 2011; Sudom et al., 2012)
- fear of people losing trust/confidence in them (73% and 49% of participants in Iversen et al., 2011 and Momen et al., 2011 respectively)
- being seen as weak (41% - 44% of participants in Gorman et al., 2011; Iversen et al., 2011; and Kim et al., 2010)

- concerns about health care utilisation appearing on military records/lack of confidentiality (37% and 59% of participants in Gorman et al., 2011 and Momen et al., 2011)
- fear of harm to their career (46% of participants in Momen et al., 2011).

Osorio et al. (2013) considered the ratings of stigma by serving personnel over a three-year period between 2008 and 2011 during both deployment and post-deployment phases. In keeping with the studies above, the most commonly endorsed beliefs were that participants were concerned that they would be treated differently by commanders and trusted less by their peers if they sought help. Of note is the finding that these beliefs were rated higher during deployment compared to post-deployment. Ratings of stigma reduced over the three-year period of the study.

Langston et al. (2011) conceptualised self-stigmatising beliefs differently and used a different measure to the other studies. They differentiated between internally stigmatising beliefs or beliefs about potential impact on oneself such as "I would be less likely to be given roles/tasks" and externalising stigmatising beliefs or beliefs about mental health problems in others such as "people who experience mental health problems are weak." The most common internally stigmatising belief was "I would be perceived as weak by the chain of command."

Iversen et al. (2011) was the only study to compare stigma ratings across serving, reserve, and veteran personnel. They found that regular-serving personnel were more likely to endorse stigma related barriers to care; whereas, both reservists and veterans were more likely to report practical barriers such as not knowing where to get help.

The relationship of stigma to help-seeking intentions/propensity

Blais and Renshaw (2013), Brown, Creel, Engel, Herrell, and Hoge (2011), Sudom et al. (2012), and Held and Owens (2013) considered the relationship between stigma and participants' ratings of help-seeking intentions/propensity.

Blais and Rensaw (2013) and Sudom et al. (2012), using a retrospective design, found that public/enacted stigma was not significantly related with help-seeking intentions and did not predict interest in receiving care respectively. Sudom et al. (2012) found that negative attitudes towards care, rather than concerns about public stigma, were associated with less help-seeking propensity. It should be noted that these studies were done with two very different populations and used very different measures to assess help-seeking intentions. Sudom et al. (2012) considered these factors with serving Canadian personnel whilst they were on deployment; however, help-seeking was only measured with a single yes/no item. Blais and Renshaw used a more comprehensive measure of help-seeking intentions, namely the GHSQ, with US National Guard combat veterans. The fact that the research was done with different populations is important and makes it difficult to compare across studies as both deployment and being a regular member rather than National Guard personnel are both factors that have been found to be associated with higher reported stigma and less likelihood of seeking-help.

In contrast to these studies, Brown et al. (2011) found that perceived stigma from participants' units was related to an increased interest in receiving help in a sample of combat veterans who screened positive for PTSD and other mental health problems. Recognition of a problem and level of need are both factors that have been found to be associated with increased help-seeking (Brown et al., 2011; Iversen et al., 2011) and thus may explain some of these results. Brown et al. (2011) also

considered participants' stigmatising views of others with mental health problems and found a trend towards these being related with reduced interest in seeking help.

Blais and Renshaw (2013) and Held and Owens (2013) considered ratings of self-stigma in relation to attitudes towards help. Self-stigma was shown to predict less positive attitudes towards seeking treatment and to be significantly negatively correlated with care-seeking intentions. Held and Owens (2013) assessed these variables in a self-selected sample of both active and ex-military service personnel; however, they did not differentiate between these populations in the analysis.

Treatment utilisation

Prospective help-seeking

The three longitudinal studies in this review (Arbisi et al., 2013; Hoerester et al., 2012; and Kehle et al., 2010), all considered whether participants' pre-deployment/immediate post-deployment ratings of public stigma were predictive of help-seeking (for those with psychological problems) in the months to a year after returning from active duty. All three found that although stigma items were endorsed highly there was no relationship between stigma and actual treatment seeking. Instead, severity of mental health problem, previous use of treatment, and higher levels of combat emerged as predictors of increased likelihood of treatment use. Negative attitudes (e.g. cynicism), were found to independently, over and above stigma, predict lower service utilisation (Arbisi et al., 2013). Only Hoerester et al. (2012) looked at independent records of health service utilisation; whereas the other studies relied on self-report data thus introducing a potential bias. Hoerester et al. (2012) looked at these factors in veterans attending VA clinics whereas the other two studies considered National Guard Soldiers.

A cohort study by Rosen et al. (2011) was the only study to look at ongoing use of psychotherapy. They found that veterans with PTSD were more likely to complete eight or more sessions of psychotherapy if they endorsed greater stigma concerns. However, in keeping with the studies above, they found no relationship between stigma concerns and retrospective or prospective commencement of psychotherapy or counselling.

Retrospective/current help-seeking

The cross-sectional studies of Britt et al. (2011), Kim et al., (2011), and Momen et al. (2012), measured or included a question to assess whether participants had recently sought help for mental health difficulties. All the studies showed that public stigma was not predictive of treatment utilisation. Again, other factors such as negative attitudes towards treatment (e.g. mistrust of health professionals and treatment being seen last resort), and beliefs about psychological problems (e.g. psychological problems tend to work themselves out) were uniquely predictive of decreased likelihood of treatment seeking (Britt et al, 2011; Kim et al., 2001). It should be noted that the three studies relied on a single item, self-report measure to assess treatment utilisation. Broadening this variable out to specify types of help or including actual health care records would increase the validity of these findings.

Britt et al. (2011) found that perceived stigma was related to overall negative attitudes towards seeking help but not to reported utilisation. Many of the studies highlighted above found that attitudinal factors were predictive of care-seeking propensity, help-seeking, and treatment use. Thus, stigma may moderate the impact of attitudinal factors on help-seeking.

In summary, the studies showed that despite anticipated public stigma barriers being reported highly by service personnel, these do not appear to have a

significant impact on self-reported help-seeking propensity and treatment utilisation. Instead, attitudinal factors (towards treatment and about providers), and beliefs about psychological problems appear to have more predictive power in relation to help-seeking. Only three studies specifically differentiated between public and self-stigma and considered the unique role of self-stigma. Results suggest that self-stigma may have a unique role to play in relation to help-seeking and this is discussed in more detail below. The studies generally relied on single item self-report measures of help-seeking and poorly defined or validated measures of stigma. In addition, it is difficult to compare across studies due to the use of different populations of service personnel and the indication that these populations report varied experience of stigma and beliefs about care.

Factors associated with stigma and help-seeking

The different factors found to impact on reporting of stigma and help-seeking across all the studies are considered in turn below.

Level of need

Six studies considered the level of need (symptom level and level of distress) and its relationship to reported stigma.

Four studies found that the level of need was associated with greater perceived public stigma and barriers to care (Kim et al., 2011; Iversen et al., 2011; Ouimette et al., 2011; Osorio et al., 2012). Osorio et al. (2012) found that probable PTSD was the strongest predictor of reporting stigma and barriers to care.

Two studies considered self-stigma and its relationship to level of need. Langston et al. (2010) found significantly higher self-stigmatising beliefs in people with high levels of distress related to mental health compared to those with none.

Conversely, in another study, PTSD symptom severity was not related to reports of self-stigma, public stigma, or help-seeking intentions (Blais & Renshaw 2013).

Mental health specific factors

Only one study considered the role of mental health specific factors. Greater severity of PTSD re-experiencing symptoms was associated with fewer stigma-related concerns, whereas greater severity of PTSD avoidance symptoms was related to greater reports of stigma (Ouimette et al., 2011).

Deployment and time

One study compared perceptions of stigma at different points in deployment. Personnel reported significantly greater levels of stigmatising beliefs and barriers to care during deployment compared to post-deployment (Osorio et al., 2012). Reporting of stigma during deployment was related to PTSD caseness, and having experienced one or two combat exposures. Male members, of officer rank and serving in a combat arm, were more likely to report stigma/PTSD post-deployment. Sudom et al. (2012) found that care seeking during deployment was not associated with any of the stigma or practical barrier factors that they measured.

Two studies that considered the perception of stigma across time periods on return from deployment. Kim et al. (2010) and Britt et al. (2012), found no difference in reporting of stigma and barriers to care in the months after personnel following return from active duty.

Anonymity

Fear et al. (2012) demonstrated that if military personnel were confident that their information was anonymous, they were more likely to report stigma concerns.

Education

Marines with a college degree were more likely to be embarrassed about mental health problems, worry about their units losing confidence in them and leadership treating them differently (Momen et al., 2012).

Combat experience

Two studies considered this factor and the evidence was varied. Marines with and without combat experience did not differ significantly in their perceptions of barriers to care (Momen et al., 2012). However, reporting of stigma during deployment was related to having experienced one or two combat exposures (Osorio et al., 2012).

Leadership

Five studies reported on elements of leadership and rank that could impact on stigma. Non-commissioned officer (NCO) behaviours predicted both stigma and practical barriers (Britt et al., 2012). Higher ratings of negative NCOs' behaviours (e.g. 'NCOs show favouritism') and lower ratings of positive NCOs' behaviours (e.g. 'NCOs treat all unit members fairly') were associated with higher reports of stigma. Officer behaviour did predict stigma. Anticipated stigma from unit leaders was rated as significantly higher than anticipated stigma from unit members and family/friends (Blais & Renshaw, 2013).

Brown et al. (2011) found that those of higher ranks were significantly less interested in receiving help than those in lower ranks. Langston et al. (2012) found that lower ranks were more likely to report stigma. In contrast, Osorio et al. (2012) found that those in officer ranks were more likely to report stigma compared to junior ranks.

Regular versus reserve/National Guard

Three studies considered the difference in reports of stigma between regular and reserve personnel. In a study in the US, active duty soldiers were found to be more likely to report stigma and less likely to have used mental health care post deployment compared to National Guard soldiers (Kim et al., 2010). In the UK, regular forces reported significantly higher stigma concerns than reserve personnel (Iversen et al., 2011; Osorio et al., 2012).

Treatment use

In a survey of serving soldiers, Rae Olmsted et al. (2011), found that participants receiving treatment for mental health problems rated public stigma more highly than those not in any treatment. They highlight that although stigma may be a barrier to treatment, the fact that it remains during treatment may impact on treatment use and potential dropout.

It can be seen that there are a wide range of factors that have the potential to impact on public stigma and help-seeking within the military population. Few studies consider the role of self-stigma and the experience of veterans.

Difference in the role of public stigma and self-stigma

Only three studies considered the role of self-stigma and compared this with public/fear of enacted stigma. Blais and Renshaw (2013) found that self-stigma was negatively correlated with help-seeking intentions and Held and Owens (2012) found that greater self-stigma predicted significantly less positive attitudes toward seeking mental health treatment. Self-stigma was shown to fully mediate the relationship between public stigma and attitudes toward seeking mental health treatment.

As highlighted above, Langston et al. (2010) conceptualised self-stigma differently to the other studies. Despite their measure not being clearly defined they

found that participants rated internally stigmatising beliefs significantly higher than externally stigmatising beliefs.

Discussion

This review aimed to build on the work of Vogt (2011), and to further explore the role and impact of stigma on help-seeking and treatment utilisation within the military population. In keeping with Vogt (2011), the papers included in the current review continue to demonstrate that stigma is a complex concept, and one that is not consistently defined or measured within the research. Whilst the literature shows that concerns about anticipated public stigma in relation to seeking help for mental health problems are present in different forms within military personnel, contrary to expectations, these concerns do not appear to be associated with help-seeking intentions or to impact on and predict help-seeking and treatment utilisation. Emphasising the narrow conceptualisation of stigma in the military is the fact that self-stigma is rarely considered in the literature. The experiences of ex-servicemen are infrequently considered and in addition, it is difficult to compare findings across the studies due to the large heterogeneity of military populations.

Stigma and help-seeking

Stigmatising beliefs, specifically anticipated public stigma in relation to seeking help for mental health problems, are the most frequently assessed and endorsed barrier to care in military populations and are often reported to be a greater concern than practical barriers to care (Gould et al., 2010; Iversen et al., 2011; Langston et al., 2010; Hoerster et al., 2012; Sudom et al., 2012).

Although it would be expected that beliefs around stigma would result in a decreased likelihood of seeking help, this has not been reflected in the research. Despite the high frequency of endorsement of barriers relating to public stigma, not

one study in this review showed help-seeking to be predicted by stigma. Further to this, stigma was not associated with care-seeking propensity (e.g. Sudom et al., 2012), or help-seeking intentions (Blais & Renshaw, 2013).

In some cases, completely contrary to what would be expected, stigma was related with a greater interest in receiving care (Brown et al., 2012), and stigma beliefs were more prevalent in those seeking treatment (Rae Olmsted et al. 2011). This may indicate that stigma issues become more salient once someone actually seeks help (Vogt, 2011). That is, the role of stigma might be more important when actually receiving treatment. Only one study (Rosen et al., 2011), considered perseverance in treatment and looked at the likelihood of veterans completing eight or more sessions of psychotherapy with stigma. They found a positive relationship between these two factors. They suggest that therapy may result in increased acknowledgement and reduced denial of a problem and this in turn results in increased perceptions of potential stigma.

Previous research has suggested that self-stigma is a strong deterrent to seeking help (Stecker et al., 2007) and models of stigma have emphasised the importance of its role in the help-seeking process. However, the studies in this review rarely considered self-stigma as an independent factor. Self-stigma and public stigma can be separated (Momen et al., 2012), but do interact with each other to influence help-seeking behaviour (Wright et al., 2009). Service members may be likely to internalise the negative view of seeking mental health treatment, and express concerns about losing their support network (Held & Owens, 2012). People with mental health problems can be kept at a distance by others (Britt, 2000), further influencing perceptions of stigma. Although self-stigma was not considered regularly in the literature, the studies that included it indicate that increased self-stigma in

relation to help-seeking is associated with lower help-seeking propensity. Future research should begin to consider the role of self-stigma in relation to help-seeking especially given its proposed influence on low self-esteem, and attitudes, beliefs and behaviours in relation to seeking-help from services.

The role of other factors on stigma and help-seeking

The range of potential other variables that are associated with help-seeking and/or impact on the role of stigma were highlighted in this review.

Level of need

In keeping with earlier studies (e.g. Hoge et al., 2004), this review showed that a level of need (as evidenced by symptom level and level of distress) was shown to be associated with greater perceived stigma and barriers to care. People with psychological problems may be up to three times as likely to report stigmatising beliefs than those without (Hoge et al., 2004; Gould et al., 2010). They may also be more at risk of stigma due to a greater perception of personal responsibility compared to those with physical problems (Rae Olmsed et al., 2011), which may further reduce the likelihood of seeking help (Green-Shortridge et al., 2007).

The role of attitudes towards care

This review highlighted that negative attitudes towards treatment (e.g. care being ineffective, cynicism, views of mental health), represent a distinct and additional barrier to care, and these attitudes were often predictive of care-seeking intentions and actual treatment utilisation over and above stigma factors (Britt et al., 2011; Brown et al., 2011; Kim et al., 2011; Sudom et al., 2012). Britt et al. (2011) found that perceived stigma was related to overall negative attitudes towards seeking help. Thus, stigma may moderate the impact of attitudinal factors on help-seeking. Vogt (2011) only identified one study that had specifically considered these factors.

Whilst recent studies are beginning to explore this area, more work is required to understand the impact of different types of beliefs on help-seeking and the potential interactions and/or relationships with factors such as stigma.

Other attitudinal barriers (e.g. belief in self-management) have also been shown to influence treatment seeking in both civilian (Schomerus & Angermeyer, 2008), and military populations (Stecker et al., 2007; Vogt, 2011). Other factors such as personal preference for particular types of help may influence veterans seeking help and engagement in treatment (Sayer et al., 2010). It could therefore be argued that interventions targeting negative attitudes and beliefs about treatments may have a greater impact than interventions focusing on challenging stigma (Hinshaw & Stier, 2008). Future research is necessary to better understand the role of attitudinal factors.

It can be difficult to separate out stigma towards help-seeking and stigma towards mental health and the different influences these might have in relation to service utilisation. However, a greater understanding of various attitudinal factors (e.g. towards mental health/mental health diagnosis) might go some way to understanding this distinction and broadening the understanding, conceptualisation, and measurement of stigma with this population.

Differences across military populations

In the heterogeneous nature of the military population, a range of other factors including deployment, role, leadership, and combat exposure have all been shown to influence the levels of stigma reported (Britt et al., 2012; Kim et al., 2010; Osorio et al., 2012; Momen et al, 2012).

The populations considered by the studies in this review were generally serving personnel or personnel recently returned from deployment. It could be argued that during deployment particular unit factors and military cultural factors are

more prevalent and would fit with the finding that deployed personnel report greater stigma (Osorio et al., 2013). Deployed personnel are in settings with unique demands and are therefore likely to experience different barriers. For example: the need to not show weakness for the sake of their unit (Sudom et al., 2012); internal and external pressures to not 'let the side down' or 'break ranks' (Osorio et al., 2013); and the lack of privacy making problems more visible to others. The fear of stigmatisation may promote isolation as individuals try to solve problems on their own and this may result in further or increased fears of stigmatisation and isolation. This would suggest that future studies should focus on considering the unique elements of the other variables such as deployment and rank and to examine how these might influence reports of stigma and the likelihood of help-seeking.

The studies have not generally considered veterans who have left the service or been out of the military for extended periods. This population could be argued to have a different set of potential barriers; for example, the influence of difficult re-integration into civilian life may have its own set of stigma barriers. A number of studies were also with National Guard/Reserve component. Again, this is a different population that may experience a unique range of barriers. Iversen et al. (2011) showed that reservist and veteran personnel were more likely to endorse practical barriers whereas regular personnel most commonly identified stigmatising beliefs as barriers. Regular personnel have also been found to report significantly higher levels of stigma than reserve forces (Kim et al., 2010; Osorio et al., 2012). These are areas that would benefit from future consideration and research.

Limitations of studies and methodologies

The measurement of stigma relies on self-report. Because of the implicit and unconscious nature of one's beliefs around stigma, these may not always be

accurately reported. The bias evident in this method of data collection is further emphasised by the fact that the large majority of studies in this area within the military rely on the Perceived Stigma and Barriers to Care Scale (Britt, 2000; Hoge, 2004), or a modified version of this scale to meet the needs of their study. This scale is unvalidated and only measures anticipated stigma in relation to seeking help (e.g. "People in my unit might have less confidence in me"). Although the items provide good face validity and links with early qualitative studies, it is likely to only represent a narrow interpretation of the construct of stigma. Thus, it can be difficult to draw conclusions from the findings of many of the studies. It is also not clear how relevant this questionnaire and the items are to an ex-servicemen population as they appear to be more geared towards those who are currently serving.

Only a small number of the studies in this review differentiate between self-stigma and public stigma. When self-stigma has been included in the research, it has been shown to have unique relational and mediating effect (e.g. Blais & Renshaw, 2013). Future research in relation to stigma in the military should focus on the development of a measure that allows for the measurement of stigma in the broader sense whilst still differentiating between the different factors that make it up.

The research in this area is generally cross-sectional making it difficult to draw conclusions. However, the recent longitudinal studies have been important in highlighting the lack of predictive relationship between stigma and help-seeking. The studies that did look at treatment utilisation often did not clearly differentiate the specific type of treatment or explore retention in treatment. This construct was often measured with a single yes/no item, thus losing much of the complexity in treatment use. Apart from two studies, measures of treatment use or help-seeking were based on self-report resulting in a certain amount of bias. Future studies should, where

possible, link reports of stigma and beliefs with actual service use as demonstrated by outpatient and inpatient records.

Stigma interventions

Zinzow et al. (2012) conducted a review of interventions and treatment adaptations specifically aimed at reducing barriers to care within military personnel. The interventions they reviewed include: early screening, identification and preventative interventions; brief interventions; technology-based interventions, enlisting fellow unit members, integrating clinicians into the military, and telecare. They found some support for the efficacy of adaptations to treatments such as the use of virtual reality and telephone based interventions. This would indicate positive moves towards overcoming barriers including stigma, engagement, and access to care. The use of peer support was also suggested to be a positive facilitator to the receipt of treatment; however, further evaluation is necessary.

Zinzow et al. (2012) highlight that there is limited research in this area relating to interventions to reduce barriers to help-seeking. They suggest further research around the early interventions to address stigma, negative attitudes towards mental health treatment, and increasing knowledge and recognition of symptoms. The review highlights that early interventions are likely to be delivered whilst personnel are active and on deployment in order to reduce some of the logistical barriers to help-seeking at later points. Given that stigma has been found to be highest during deployment (Osorio et al., 2012), this may face some logistical difficulties. Early intervention may be supported by early screening to identify at risk individuals (Zinzow et al., 2012). Given that leadership behaviours have been shown to impact on the level of stigma (Britt et al., 2012), it is essential to consider how

these interventions are delivered and by whom to ensure that stigmatising beliefs are not reinforced.

The UK military has recently introduced a number of psycho-educational interventions to reduce mental health-related stigma in the form of TRiM. There are currently limited reviews on the effectiveness of this; however, initial findings are mixed. Given the findings of this review, it may be that further interventions focussed on attitudinal factors and self-stigma/self-esteem may be of greater value.

Conclusions

Stigmatising beliefs, specifically concerns about anticipated public stigma in relation to help-seeking, are the most frequently assessed and endorsed barriers to care and are often rated as a greater concern than practical barriers to care. Despite this finding, not one study in this review showed help-seeking and treatment utilisation to be predicted by anticipated public stigma. Further to this, stigma was not negatively associated with care-seeking propensity or help-seeking intentions. Self-stigma was rarely considered in studies. Where it was, it was shown to predict less positive attitudes towards seeking treatment and to be significantly negatively correlated with care-seeking intentions. This is an area that would benefit from consideration in future research.

The measurement of public stigma in this population has primarily relied on a brief, unvalidated measure that may not be suitable for capturing the complexity of the construct of stigma or to meet the needs of a heterogeneous military population. This is especially relevant given the wide variety of factors such as rank, deployment characteristics, and reserve or regular status that has been shown to impact on stigma reporting. In addition, very few studies have considered the role of stigma in relation to help-seeking in ex-servicemen who have re-integrated back into civilian life and

who may experience different sets of barriers to care. Future research would be well placed in developing measures in this area.

Attitudinal factors such as beliefs about mental health and mental health treatment appear to be more predictive of help-seeking. Given that stigma, as it is currently measured and conceptualised, does not appear to negatively influence service utilisation and that the interventions that are in place have not been shown to make significant differences, it may be that resources and focus of interventions are directed more towards changing these attitudinal factors.

References

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social Behaviour*. Englewood Cliffs, NJ: Prentice-Hall.

Arbisi, P. A., Rusch, L., Polusny, M. A., Thuras, P., & Erbes, C. R. (2013). Does cynicism play a role in failure to obtain needed care? Mental health service utilization among returning U.S. National Guard soldiers. *Psychological Assessment, 25*(3), 991-996.

Ben-Zeev, D., Corrigan, P. W., Britt, T. W., & Langford, L. (2012). Stigma of mental illness and service use in the military. *Journal of Mental Health*, *21*(3), 264-273.

Blais, R. K., & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress, 26*(1), 77-85.

Britt, T. W. (2000). The stigma of psychological problems in a work environment: evidence from the screening of service members returning from Bosnia. *Journal of Applied Social Psychology*, *30*(8), 1599-1618.

Britt, T. W., Bennett, E. A., Crabtree, M., Haugh, C., Oliver, K., McFadden, A., & Pury, C. L. S. (2011). The theory of planned behavior and reserve component veteran treatment seeking. *Military Psychology*, *23*(1), 82-96.

Britt, T. W., Greene, T. M., Castro, C. A., & Hoge, C.W. (2006). The stigma of psychological problems in the military. In D. R. McCreary, & M. M. Thompson (Eds.), *American Psychological Association/US National Institute for Occupational Safety and Health Work, Stress, and Health conference.* Miami, FL, USA.

Britt, T. W., Wright, K. M., & Moore, D. (2012). Leadership as a predictor of stigma and practical barriers toward receiving mental health treatment: A multilevel approach. *Psychological Services, 9*, 26-37.

Brown, M. C., Creel, A. H., Engel, C. C., Herrell, R. K., & Hoge, C. W. (2011). Factors associated with interest in receiving help for mental health problems in combat veterans returning from deployment to Iraq. *Journal of Nervous and Mental Disease, 199*(10), 797-801.

Cooper, A. E., Corrigan, P. W., & Watson, A. C. (2003). Mental illness stigma and care seeking. *The Journal of Nervous and Mental Disease*, *191*(5), 339-341.

Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist*, *59*(7), 614-625.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*(9), 765-776.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, *9*(1), 35-53.

Deacon, H. (2006). Towards a Sustainable Theory of Health-Related Stigma: Lessons from the HIV/AIDS Literature. *Journal of Community & Applied Social Psychology*, *16*, 418-425.

Fear, N. T., Seddon, R., Jones, N., Greenberg, N., & Wessely, S. (2012). Does anonymity increase the reporting of mental health symptoms? *BMC Public Health, 12*, 797.

Fung, K. M., Tsang, H. W., & Corrigan, P. W. (2008). Self-stigma of people with schizophrenia as predictor of their adherence to psychosocial treatment. *Psychiatric Rehabilitation Journal*, *32*(2), 95-104.

Gorman, L. A., Blow, A. J., Ames, B. D., & Reed, P. L. (2011). National Guard families after combat: Mental health, use of mental health services, and perceived treatment barriers. *Psychiatric Services, 62*(1), 28-34.

Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., ... & Greenberg, N. (2010). Do stigma and other perceived barriers to mental health care differ across Armed Forces? *Journal of the Royal Society of Medicine, 103*(4), 148-156.

Gould, M., Greenberg, N., & Hetherton, J. (2007). Stigma and the military: evaluation of a PTSD psychoeducational program. *Journal of Traumatic Stress, 20*(4), 505-515.

Greenberg, N., Langston, V., Everitt, B., Iversen, A., Fear, N. T., Jones, N., & Wessely, S. (2010). A cluster randomised controlled trial to determine the efficacy of Trauma Risk Management (Trim) in a military population. *Journal of Traumatic Stress, 23*(4), 430-436.

Greene-Shortridge, T. M., Britt, T. W., & Andrew, C. (2007). The stigma of mental health problems in the military. *Military Medicine*, 172:157-161

Held, P., & Owens, G. P. (2013). Stigmas and attitudes toward seeking mental health treatment in a sample of veterans and active duty service members. *Traumatology, 19*(2), 136-143.

Hinshaw, S. P., & Stier, A. (2008). Stigma as related to mental disorders. *Annual Review of Clinical Psychology, 4*, 367-393.

Hoerster, K. D., Malte, C. A., Imel, Z. E., Ahmad, Z. S., Hunt, S. C., & Jakupcak, M. (2012). Association of perceived barriers with prospective use of VA mental health care among Iraq and Afghanistan veterans. *Psychiatric Services (Washington, D.C.), 63*(4), 380-382.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2008). Combat duty in Iraq and Afghanistan, mental health problems and barriers to care. *United States Army Medical Department Journal*, 7-17.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D. M., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*(1), 13-22.

Iversen, A., Van Staden, L., Hacker Hughes, J., Browne, T., Greenberg, N., Hotopf, M., Rona, R., Wessely, S., Thornicroft, G., & Fear, N. (2010).Help-seeking and receipt of treatment among UK service personnel. *The British Journal of Psychiatry*, *197,* 149-155.

Iversen, A. C., van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., . . . Fear, N. T. (2011). The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC Health Services Research, 11*, 31.

Kehle, S. M., Polusny, M. A., Murdoch, M., Erbes, C. R., Arbisi, P. A., Thuras, P., & Meis, L. A. (2010). Early mental health treatment-seeking among U.S. National Guard soldiers deployed to Iraq. *Journal of Traumatic Stress*, *23*(1), 33-40.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 617-627.

Kim, P. Y., Britt, T. W., Klocko, R. P., Riviere, L. A., & Adler, A. B. (2011). Stigma, negative attitudes about treatment, and utilization of mental health care among soldiers. *Military Psychology*, *23*, 65-81.

Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., Hoge, C. W., P.Y, K., . . . C.W, H. (2010). Stigma, barriers to care, and use of mental health services among active duty and national guard soldiers after combat. *Psychiatric Services, 61*(6), 582-588.

Kmet, L. M., Lee, R. C., & Cook, L. S. (2004) Standard Quality Assessment Criteria for Evaluating Primary Research Papers From a Variety of Fields. *Edmonton: Alberta Heritage Foundation for Medical Research*.

Langston, V., Greenberg, N., Fear, N., Iversen, A., French, C., & Wessely, S. (2010). Stigma and mental health in the Royal Navy: a mixed methods paper. *Journal of Mental Health, 19*(1), 8-16.

Mansfield, A. K., Addis, M. E., & Courtenay, W. (2005). Measurement of Men's Help-seeking: Development and Evaluation of the Barriers to Help-seeking Scale. *Psychology of Men & Masculinity*, *6*(2), 95-108.

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*, *298*(18), 2141-2148.

Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma Associated With PTSD. *Psychiatric Rehabilitation Journal, 36*(2), 86-92.

Momen, N., Strychacz, C. P., & Virre, E. (2012). Perceived stigma and barriers to mental health care in Marines attending the Combat Operational Stress Control program. *Military Medicine, 177*(10), 1143-1148.

Nash, W. P., Silva, C., & Litz, B. T. (2009). The historic origins of military and veteran mental health stigma: and the stress injury model as a means to reduce it. *Psychiatric Annals*, *39*(8), 789-794.

Oliver, M. I., Pearson, N., Coe, N., & Gunnell, D. (2005). Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. *The British Journal of Psychiatry*, *186*(4), 297-301.

Osório, C., Jones, N., Fertout, M., & Greenberg, N. (2012). Perceptions of stigma and barriers to care among UK military personnel deployed to Afghanistan and Iraq. *Anxiety, Stress and Coping*, *26*(5), 539-557.

Osório, C., Jones, N., Fertout, M., & Greenberg, N. (2013). Changes in stigma and barriers to care over time in U.K. Armed Forces deployed to Afghanistan and Iraq between 2008 and 2011. *Military Medicine*, *178*(8), 846-853.

Ouimette, P. C., Vogt, D. S., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R. E., . . . Rosen, C. S. (2011). Perceived barriers to care among veterans health administration patients with posttraumatic stress disorder. *Psychological Services*, *8*(3), 212-223.

Pietrzak, R., Johnson, D., Goldstein, M., Malley, J., & Southwick, S. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric Services*, *60*(8), 1118-1122.

Rae Olmsted, K. L., Brown, J. M., Vandermaas-Peeler, J. R., Tueller, S. J., Johnson, R. E., & Gibbs, D. A. (2011). Mental health and substance abuse treatment stigma among soldiers. *Military Psychology*, *23*(1), 52-64.

Resnik, L., Bradford, D. W., Glynn, S. M., Jette, A. M., Johnson Hernandez, C., & Wills, S. (2012). Issues in defining and measuring Veteran community reintegration: Proceedings of the working group on community reintegration, VA Rehabilitation Outcomes Conference, Miami, Florida. *Journal of Rehabilitation Research and Development*, *49*(1), 87-100.

Rogler, L. H., & Cortes, D. E. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry, 150*, 554-561.

Rosen, C. S., Greenbaum, M. A., Fitt, J. E., Laffaye, C., Norris, V. A., & Kimerling, R. E. (2011). Stigma, help-seeking attitudes, and use of psychotherapy in veterans with diagnoses of posttraumatic stress disorder. *Journal of Nervous and Mental Disease, 199*(11), 879-885.

Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiologia e Psichiatria Sociale, 17*(01), 31-37.

Shrivastava, A., Johnston, M., & Bureau, Y. (2012). Stigma of mental illness-1: Clinical reflections. *Mens Sana Monographs, 10*(1), 70.

Stecker, T., Fortney, J., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatric Services, 58*(10), 1358-1361.

Stecker, T., Shiner, B., Watts, B. V., Jones, M., & Conner, K. R. (2013). Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD. *Psychiatric Services, 64*(3), 280-283.

Sudom, K., Zamorski, M., & Garber, B. (2012). Stigma and barriers to mental health care in deployed Canadian forces personnel. *Military Psychology, 24*(4), 414-431.

Tucker, J. R., Hammer, J. H., Vogel, D. L., Bitman, R. L., Wade, N. G., & Maier, E. J. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology, 60*(4), 520.

Tanielian, T. L., & Jaycox, L. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery* (Vol. 1). Rand Corporation.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53(3),* 325-337.

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology*, *50*(3), 351-361.

Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatric Services*, *62*(2), 135-142.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, *25*(3), 467-478.

Wang, J. L. (2006). Perceived barriers to mental health service use among individuals with mental disorders in the Canadian general population. *Medical Care*, *44*, 192-195.

Warner, C. H., Appenzeller, G. N., Mullen, K., Warner, C. M., & Grieger, T. A. (2008). Soldier attitudes toward mental health screening and seeking care upon return from combat. *Military Medicine*, *173*(6), 563-569.

Wright, K. M., Cabrera, O. A., Bliese, P. D., Adler, A. B., Hoge, C. W., & Castro, C. A. (2009). Stigma and barriers to care in soldiers postcombat. *Psychological Services*, *6*(2), 108.

Zinzow, H. M., Britt, T. W., McFadden, A. C., Burnette, C. M., & Gillispie, S. (2012). Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review*, *32*(8), 741-753.

Part Two: Empirical Paper

Barriers and facilitators in the pathway to care of military veterans

Abstract

Aims: The use of formal healthcare systems is a complex process. It is well documented that only a minority of people with mental health problems seek help in relation to these difficulties. This study aimed to better understand the reported barriers and facilitators and the experiences of UK ex-servicemen in relation to their pathway to care for mental health problems.

Method: Sixteen help-seeking veterans[1] were recruited from two specialist veterans' services. They took part in semi-structured interviews exploring their experiences of help-seeking. Data from the interviews were analysed qualitatively using a combination of thematic and narrative analysis approaches.

Results: Participants described a journey, often spanning many years, to acknowledging and seeking help for their problems. There were three stages in the pathway to care; namely, acknowledgement and recognition, initial help-seeking, and treatment. The results showed a number of specific barriers and facilitators that are more relevant at these different stages in the veterans' pathway to care. Some of these were in keeping with previous research, such as the role of perceived stigma and practical barriers (e.g. time constraints). However, there were additional themes that have not been considered previously. These included fear of the meaning of symptoms and the importance of service providers having military knowledge.

Conclusions: This study provided an in-depth insight into the set of barriers and facilitators that are significant for UK ex-servicemen. The findings suggest that there are a number of factors that impact on help-seeking and that these should be included more broadly in research and measures evaluating barriers and facilitators to care. A number of clinical implications that may be more relevant at different points in veterans' pathways to care are also discussed.

[1]For definitions of all military related terms please refer to Appendix 1.

Introduction

Only a minority of people who experience mental health problems seek formal help for these difficulties (Andrews, Issakidis, & Carter, 2001; Wang et al., 2005). The use of healthcare systems is a complex and dynamic process: individual, social, cultural, and system factors all influence if and when help is sought, as well as the type of help that is pursued (Rogler & Cortes, 1993). Prompt diagnosis and treatment can reduce the impact of the difficulties on the individual, their family, and on society. Improving the understanding of the barriers and facilitators to help-seeking and the pathways to mental health care can aid the development of interventions to promote early detection, encourage timely help-seeking, and extend service responsiveness.

In keeping with studies within the general population, studies with the military population have shown that a large proportion of military personnel who experience mental health problems do not seek help for these problems (Hoge et al., 2004; Iversen et al., 2010; Kehle et al., 2010). Military personnel are at higher risk and vulnerable to the development of mental health problems, including Posttraumatic Stress Disorder (PTSD), due to their repeated exposure to traumatic events (Hoge et al., 2004; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). This is especially the case for personnel who have been deployed in combat roles (Fear et al., 2010). In addition, there is a growing literature highlighting the increased risk of psycho-social difficulties for those transitioning out of the forces and back into civilian life (Sayer et al., 2010). This can compound the challenges faced for those with mental health difficulties. Mental health difficulties can result in negative occupational, health, relationship and legal consequences for individuals, their families, and the wider society (Galovski & Lyons, 2004; Solomon, 2001), and it is

known that sufferers often do not seek appropriate help for many years (Sayer et al., 2009; Wang et al., 2005), which has the potential to increase the risk of co-morbid difficulties and problems in social and occupational functioning. Difficulties such as divorce, substance misuse, difficulties in social functioning and alienation from civilian life have been found to be more prevalent in veterans with PTSD compared to those without (Brewin, Garnett, & Andrews, 2011; Sayer et al., 2010).

Veterans in the United Kingdom (UK)

Twenty-three thousand military personnel left the UK Armed Forces between 2013 and 2014 (Ministry of Defence, 2014), and there are an estimated 5 million veterans living in the UK currently (Samele, 2013). Whilst the majority will re-integrate into civilian life without difficulty and will experience good physical and mental health (Fear et al., 2010), there is a significant minority that will experience social and psychological difficulties (Iversen et al., 2011).

There are no detailed statistics on the prevalence of mental health problems within the general veteran population; however, in a sample of UK ex-servicemen at risk of psychological and social problems, 43.8% were found to have a psychiatric diagnosis (Iversen et al., 2005). The most common diagnoses were depression, anxiety, PTSD, and alcohol problems. Co-morbid diagnoses were common with PTSD. Of those with any diagnosis, only half had sought help for their problems (Iversen et al., 2005). For those seeking help, PTSD was the most common presentation (MacManus & Wessely, 2013).

It was previously estimated that it was an average of 13 years after leaving the military before veterans in the UK sought help (Combat Stress, 2014). More recent information suggests that the time to seeking help is decreasing for veterans of

the Afghanistan conflict (down to an estimated 18 months) and that there is an increase in the number of veterans seeking help (Combat Stress, 2014).

After leaving the military, the responsibility for veterans' healthcare in the UK falls to the National Health Service (NHS). It may be that ex-servicemen have less accurate knowledge about the accessibility and effectiveness of the services available within the NHS. The recent operations in Iraq and Afghanistan and the increased focus on the wellbeing of service personnel have resulted in new government initiatives to support veterans to engage with and remain in treatment. This has included the Ministry of Defence (MoD), NHS trusts, and the main charitable veteran mental health service provider (Combat Stress) working closely together to deliver specialist community mental health services for Armed Forces veterans (MacManus & Wessely, 2013).

Help-seeking and pathways to care in the military

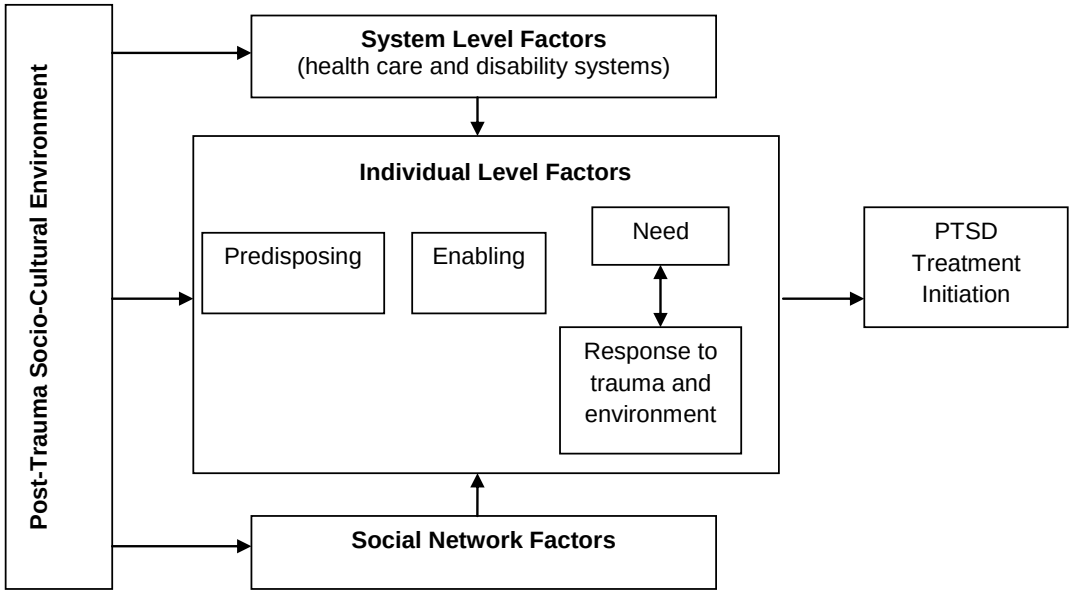
Pathways to care refers to the series of contacts and attempts to access services that individuals or their significant others go through in order to get their clinical needs met (Rogler & Cortes, 1993). A number of different social network, environmental, individual, and health system factors have been proposed to influence help-seeking initiation (Sayer et al., 2009). A literature review (Vogt, 2011) identified that the barriers to care in the US military fell into three main domains: individual background characteristics, institutional factors, and stigma-related beliefs about mental health and treatment.

The Anderson Behavioural Model (Anderson, 1995) is often used to understand service use. It proposes that an individual's use of treatment is determined by the level of need (perceived and actual), factors enabling their access to care and receptiveness to services (such as gender and beliefs). Sayer et al. (2009)

built on the Anderson Behavioural Model in their qualitative study of the factors influencing treatment initiation in US combat veterans with PTSD. They added social network factors, response to trauma, and the post-trauma environment specific to veterans to the model (see Figure 1).

Figure 1.

Treatment initiation in veterans with PTSD (Sayer et al., 2009)



Individual level factors

Predisposing

In serving military personnel, being young and male (Gould et al., 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), being a reservist rather than a member of the regular forces, and being of lower rank (Pietrzak et al., 2009), have all been found to be associated with reduced help-seeking and reporting more barriers to care.

Military training promotes many of the values that are synonymous with masculinity; for example, self-reliance, control, and emotional and physical strength (Vogt, 2011). Masculinity has been shown to be related to lower willingness and

more negative attitudes towards help-seeking (Berger, Levant, McMillan, Kelleher, &Sellers, 2005; Smith, Tran, & Thompson, 2008). Elements of military culture and training instilled during service are likely to exercise an ongoing influence on the motivations and attitudes of ex-servicemen (Langston, Gould, & Greenberg, 2007).

Stigma

Research with UK and US service personnel has highlighted that perceived stigma from others (public stigma), and a lack of confidence and trust in mental health providers are the most frequently endorsed barriers to seeking help (Hoge et al., 2004; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Langston et al., 2007; Ouimette et al., 2011; Pietrzak et al., 2009). However, studies have generally been with serving personnel and only used a narrow, unvalidated measure of barriers to care and have not included factors such as self-stigma, beliefs about mental illness and psychological treatment which have also been shown to be important factors in the help-seeking process (Arbisi, Rusch, Polusny, Thuras, Erbes, 2013; Blais & Renshaw, 2013; Kim Britt, Klocko, Riviere, & Adler, 2011).

Public stigma fears that have been measured in studies of military personnel include concern about being seen as weak by others, help-seeking perceived to be harmful to progress in their military career, and a fear of being treated differently by their unit and their commanders (Iverson et al., 2011; Kim et al., 2010; Langston et al., 2010). Self-stigma is the internalisation of public stigma (e.g. internalising the view that one is weak for seeking help). Self-stigma has been shown an important factor influencing help-seeking (Vogel, Wade, & Hackler, 2007) in studies of undergraduate students. Additionally, self-stigma has been found to mediate the role of other factors, such as masculinity, on attitudes towards help-seeking in a large sample of men from a variety of ethnic backgrounds (Vogel, Heimerdinger-Edwards,

Hammer, & Hubbard, 2011). Self-stigma has not been considered consistently in studies of help-seeking in ex-military personnel.

Beliefs about treatment

A set of potential barriers that have not been considered in detail in previous research on veterans include beliefs about mental illness and treatment (Zinzow et al., 2013). A number of potential treatment influencing beliefs in serving personnel have been proposed. These include believing that one can deal with problems by oneself and the belief that the problem is not severe enough to necessitate treatment (Britt et al., 2011; Kim et al., 2011). Other beliefs such as treatment will not work, medication will have many unwanted, intolerable side effects and professionals are untrustworthy may also influence motivation to seek and engage in treatment (Kim et al., 2011; Sayer et al., 2009).

Enabling factors

The logistical factors that can either impede or enhance access to care such as lack of transportation, difficulty finding the time to attend appointments, and financial concerns have also been found to influence serving military and ex-military personnel seeking help (Hoge et al., 2004; Kim, et al., 2011; Ouimette, 2011; Sayer et al., 2009). It has been suggested that military personnel are less knowledgeable about what help is available, where to source help, and as having more negative perceptions about the availability, accessibility, and effectiveness of services (Hoge et al., 2004; Sayer et al., 2009). In one study in the UK, veterans were found to experience similar barriers to care to serving personnel but to also experience additional logistical barriers including “not knowing where to seek help” (Iversen et al., 2011). Exploration of these factors in the research appears to have again relied on rating scales using a forced choice methodology with a limited number of endorsable

items. This highlights that further exploration of these constructs and other potentially influential factors within the veteran population is needed.

Need for treatment

Goldberg and Huxley's (1992) pathways to care model identifies a number of sequential steps and 'filters' that individuals must pass through in order to enter services and access the appropriate level of care. The first stage in this model is the recognition and appraisal of a level of need by the individual or others. Many military personnel who would meet the criteria for a mental health diagnosis fail to recognise that they have a disorder (Iversen et al., 2010). This is consistent with research showing that greater impairment due to PTSD, and PTSD symptom severity have also been found to be associated with help-seeking, treatment initiation and use (Kim et al., 2011; Rosen et al., 2011).

Response to trauma and the social-cultural environment following trauma

Personnel with mental health problems have been found to be more likely to report stigma and barriers to care than those without (Gould et al., 2010; Hoge et al., 2004), and less likely to seek help if they view themselves as responsible for their problems (Greene-Shortridge, Britt, & Castro, 2007). Veterans with PTSD have been shown to report significantly more barriers to care than those with other disorders and those without diagnosable disorders (Hoge et al., 2004). If PTSD symptoms lead to interpersonal difficulties, disconnection and withdrawal from their social network, it could follow that these individuals may report more barriers to treatment, feel less connected or have poorer experience within healthcare settings, or take longer to seek care (Ouimette et al., 2011).

Social network, system level, and socio-cultural environmental factors

Sayer et al. (2009) found that an individual's social network is an important influential factor and led to help-seeking regardless of the individual holding stigmatising beliefs. Studies within the general population have shown that regardless of what services are available, people are more likely to seek help for mental health problems from social networks rather than professionals (Boldero & Fallon, 1995). Where these networks encourage professional help, this has been found to be a facilitator to care (Vogel et al. 2007). Like other populations, Iversen et al. (2010) found that military personnel were more likely to show a preference to consulting non-medical support from peers, friends and chaplains.

Sayer et al., (2009) found that facilitators such as significant others aiding recognition and practically and emotionally motivating and facilitating them to access help led to help-seeking despite individuals holding negative beliefs towards treatment. This would suggest that these factors play an important role in treatment initiation among veterans with PTSD.

From the above review, it can be seen that there is a complex and multi-faceted relationship between individual, social, and environmental/system factors that influence military veterans' initiation of help-seeking and engagement in treatment. The majority of the research into barriers to care within the Armed Forces has been with serving personnel and mainly involving the use of limited item questionnaire measures that have been developed from research focusing on barriers to care in military personnel in the US.

Study aims

The present study used qualitative interviews to understand the subjective experience and the reported barriers and facilitators of UK ex-servicemen on their

pathway to seeking formal help. It aimed to increase understanding of constructs such as confidence in service providers and self-stigma that have been highlighted in other studies. A further aim was to understand what service models veterans think are beneficial, and to understand what, if any, the current NHS changes in the support for veterans have made.

The study therefore focuses on the following questions:

1. What are the personal, social, and logistical barriers and facilitators to help-seeking for a population of UK male military veterans?
2. What can be done to improve veterans' help-seeking and pathways to care?

Method

Setting and context

The research was conducted within two specialist veterans' services, both funded by the NHS. One is a specialist community veterans' service within a NHS trauma clinic. It provides a service to veterans living within a large urban area offering a comprehensive mental health assessment, treatment, and signposting and referral service for veterans. Where appropriate they provide specialist treatment for PTSD, and other trauma-related difficulties such as excessive substance use or challenges with emotion regulation. For the purposes of this study, this service will be referred to as the NHS Veterans' Service (NVS). The other is a UK charity providing specialist residential and community assessment and treatment for veterans who are suffering from a range of mental health difficulties. The charity has a number of centres based across the UK. These centres provide a service for veterans in a large catchment area. Participants were recruited from a centre servicing the Midlands and the North of the UK. This service will be referred to as the Charity Veterans' Service (CVS).

There is often cross-over between the services, in particular CVS services in the South East of England and the NVS. For example, a CVS welfare officer might refer a veteran to the NVS following initial assessment, and the NVS may refer people to the local branch of the CVS if appropriate. The welfare officers in the CVS are ex-military, and they are generally the first point of contact for clients. Both services have an open access policy, allowing multiple routes of referral including self-referral. The potential routes of referral and treatment are displayed in Figure 2.

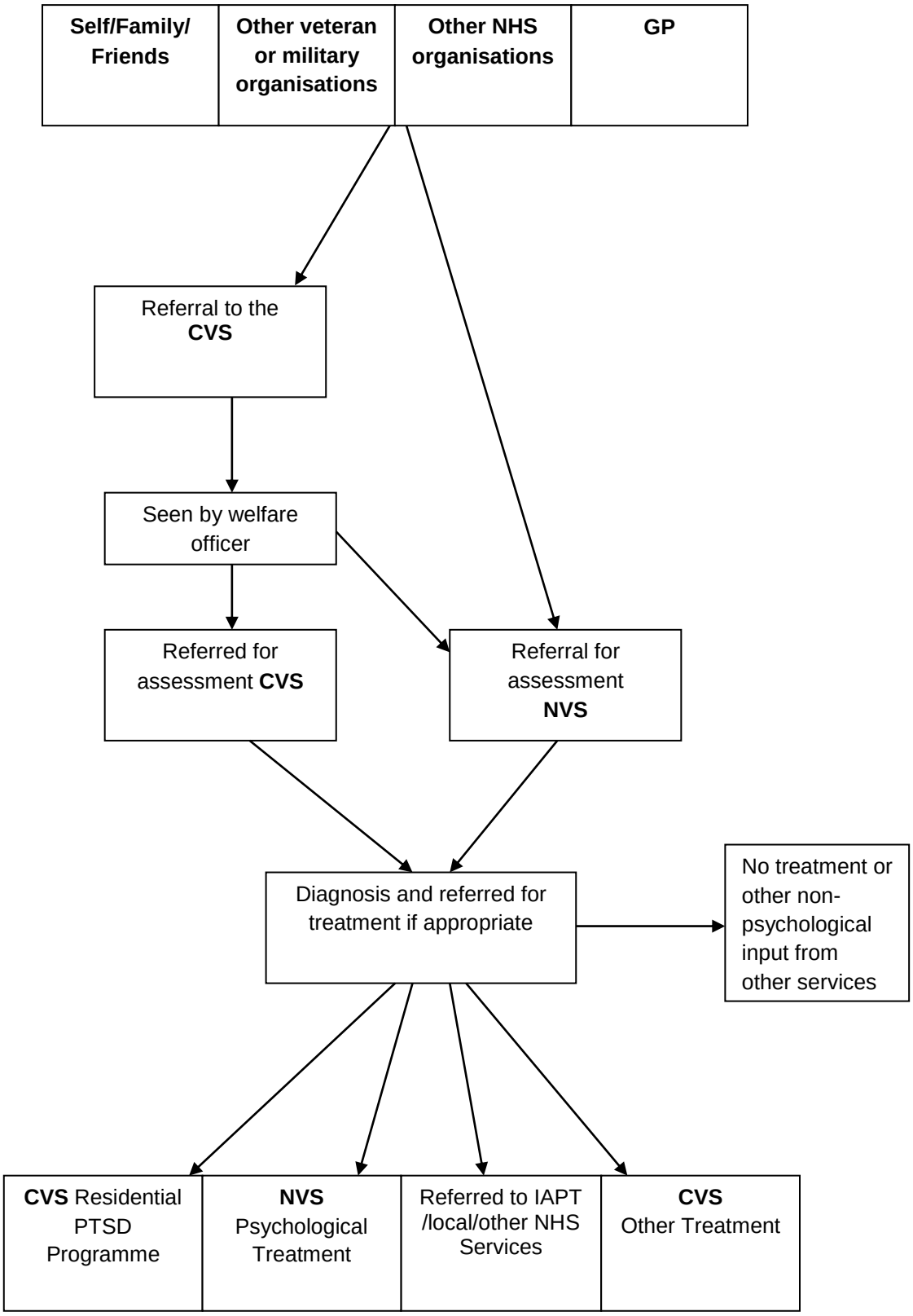
Procedure

Design

The original methodology for this study was a mixed-methods approach. The quantitative part of the study involved the use of questionnaire measures and correlation and multiple regression analysis to explore the relationship between help-seeking and other variables hypothesised to influence help-seeking and service utilisation. These included masculinity, self-stigma, perceived stigma from others, social support, and practical barriers. This part of the study would have required a minimum of 70 completed questionnaires in order to achieve sufficient power to produce meaningful results. Due to significant and unexpected recruitment difficulties, considerably fewer questionnaires were returned than anticipated. Therefore, only the qualitative part of the research is reported in this paper.

Figure 2.

Referral process for the services



Recruitment

Veterans referred to the NVS and those in the CVS PTSD residential programme between October 2013 and February 2014 were informed of the research aims (via a flyer, Appendix 2.1), and provided with an information sheet explaining the procedure (Appendix 2.2), by their assessing or treating clinician. Veterans who expressed an interest in participating provided their contact details (either by post, online, or telephone depending on their preference), and were then contacted by the researcher. Potential participants were given full information about the study and an opportunity to ask any questions before those wishing to proceed provided formal signed consent (Appendix 2.3).

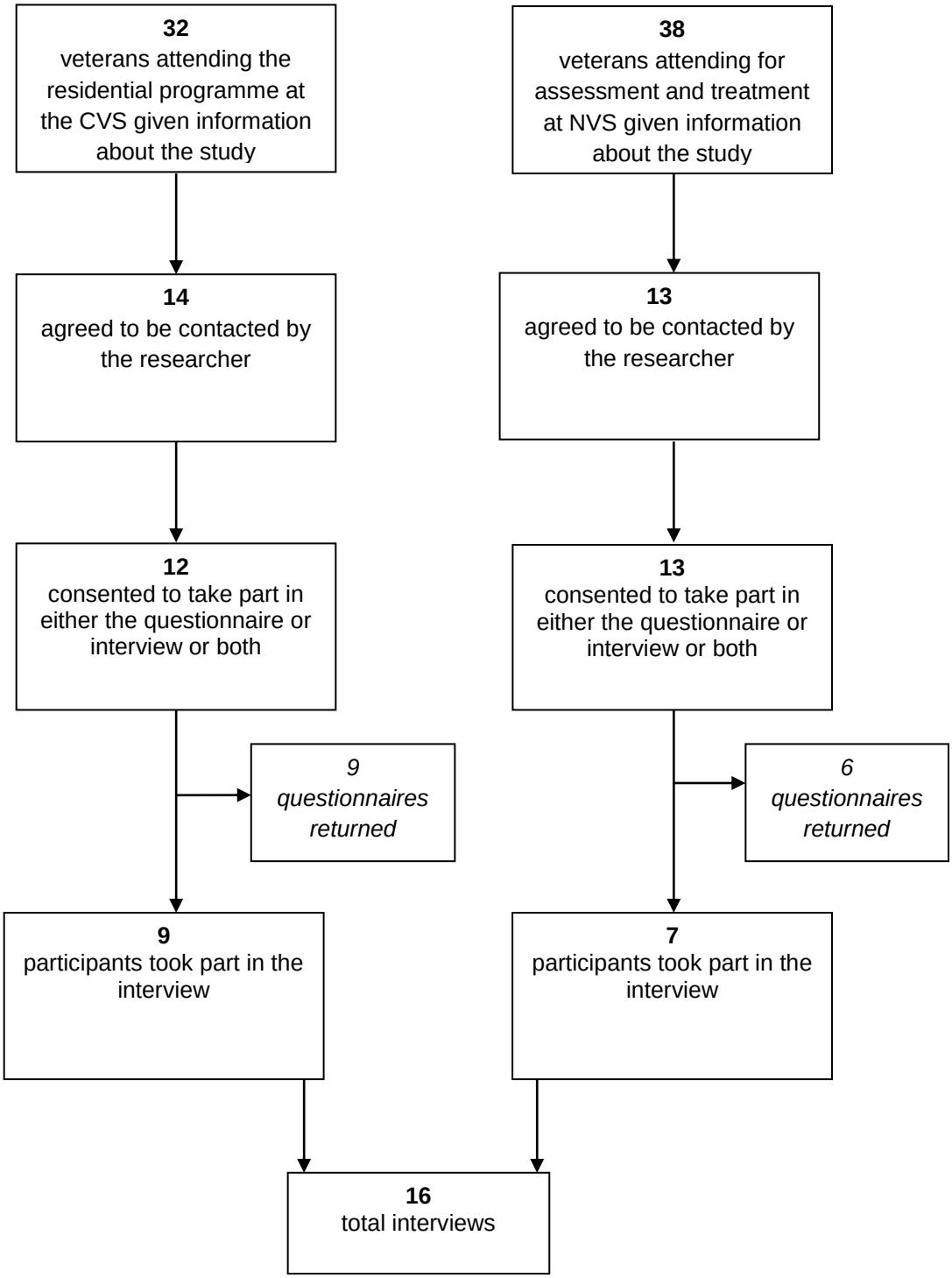
As part of the process of gaining consent, participants from both the NVS and the CVS were also asked to indicate if they would be willing to take part in an audio-recorded interview with the researcher. Participants were made aware that their participation was voluntary and that any decision to withdraw would not influence the service that they received. Separate consent for the interview, as opposed to the questionnaire study, was also obtained (Appendix 2.4). Interviews were conducted at the participants' respective services. Those veterans who took part in the interview received a £10 store voucher in recognition and thanks for their participation.

Following the interview, participants were also asked if they would be willing to provide feedback, on the researchers' understanding of the themes raised in their interviews. Those that agreed were sent a copy of the results as compiled by the researcher and asked to provide any feedback they felt relevant. Six veterans were sent a copy of the results, and two provided feedback on the domains and themes that had been identified.

A flowchart depicting the recruitment process is detailed in Figure 3.

Figure 3.

Participant recruitment procedure



Participants

Sixteen male veterans consented to taking part in the semi-structured interview. The demographic information on the participants is displayed in Table 1.

Table 1.

Participant information

Number	Age Range	Marital Status	Employment	Diagnosis
1	40-49	Married/Cohabiting	Full time	Anxiety, Alcohol dependence
2	20-29	Single	Full time	PTSD and Depression
3	30-39	Separated	Full time	PTSD and Depression
4	30-39	Married/Cohabiting	Unfit to work	PTSD and Other disorders
5	40-49	Single	Part time	PTSD and Depression
6	30-39	Married/Cohabiting	Unemployed	Depression
7	40-49	Divorced	Full time	PTSD and Other disorders
8	30-39	Married/Cohabiting	Unemployed	PTSD
9	60-69	Married/Cohabiting	Retired	PTSD
10	30-37	Married/Cohabiting	Unfit to work	PTSD
11	20-29	Married/Cohabiting	Unemployed	PTSD
12	50-59	Married/Cohabiting	Unemployed	PTSD
13	30-39	Married/Cohabiting	Unemployed	PTSD and Depression
14	20-29	Married/Cohabiting	Unemployed	PTSD
15	40-49	Divorced	Unemployed	PTSD and Depression
16	30-39	Married/Cohabiting	Full time	PTSD and Other disorders

The majority of participants had a diagnosis of PTSD (*N*=14). Eight had a co-morbid diagnosis alongside PTSD. Fourteen had been regular members of UK military forces and two had been in the Territorial Army/Reserve forces. Fourteen described themselves as White British and two as White Other. The interviewees were all of non-commissioned ranks including Private (*N*=9); Lance Corporal (*N*=1); Corporal (*N*=2); Sergeant (*N*=1); Staff Sergeant (*N*=2); and Warrant Officer Class 2 (*N*=1). Participants' length of service ranged from two to 31 years (*M*=12.25, *SD*=7.89). They had been deployed on between one and six tours of duty (*M*=2.68, *SD*=1.74), and had been out of the military for between one and 29 years (*M*=8.44, *SD*=8.22).

Semi-structured interview

The researcher designed the semi-structured interview schedule (Appendix 3) in consultation with the research supervisors and other professionals working with veterans in the respective services. The aim of the interview was to elicit veterans' experiences of their mental health difficulties and help-seeking.

It covered the following areas:

- A description of the development of their mental health problem and a description of their pathway to being assessed and/or treated at the service.
- What they noticed and what factors contributed to their decision to seek help.
- The help-seeking attempts when they first noticed something might be wrong and their perception of the barriers and facilitators to seeking help (explored for both professional and non-professional help-seeking).
- Experience of accessing help and perceptions of the services available.
- Their perception of support available from the military, their family, from the NHS and others.
- What recommendations they could make to improve their experience of seeking help.

To begin, participants were asked to describe their experiences of help-seeking. Following this, follow-up questions and prompts examining specific areas of interest highlighted above were asked.

Interviews were audio-recorded and transcribed verbatim using Express Scribe software (NCH Software, 2012). The researcher transcribed twelve interviews and a research assistant transcribed the other four interviews. Interviews lasted an average of 52 minutes (*SD* = 12.55).

Ethics

Ethical approval was obtained from National Research Ethics Service (NRES), Committee North West Liverpool East (Appendix 4.1), on the 5th June 2013, and from the Combat Stress Ethics Committee on the 22nd October 2013 (Appendix 4.2). A substantial amendment was made to the NRES application prior to any recruitment based on some addition information required by the Combat Stress Ethics Committee. Approval was granted for this on the 23rd October 2014 (Appendix 4.3). A second substantial amendment (Appendix 4.4) to include recruitment for the semi-structured interviews from a second site was agreed on the 20th January 2014.

Researchers' perspective

Good practice in qualitative research suggests that it is necessary for researchers to disclose their own values, orientation, and preconceptions and expectations for a study (Stiles, 1993). This increases transparency and can increase the validity of the findings. The researcher was a clinical psychology graduate student in her early thirties and from a non-UK background. From her experiences growing up in a country where mental health still holds a lot of stigma, she had developed an interest in how people conceptualise and understand mental health difficulties and how these inform choices made in relation to help-seeking. She had previously worked in adult psychology services with people with PTSD and other mental health problems but had not worked in specialist services for veterans. She had a special interest in engaging young people to access services.

The researcher utilised regular supervision and reflection throughout the research process. The researcher had an affinity for systemic and social constructionist models of working and understanding difficulties. The aim of this

research was to provide one potential way of understanding participants' narratives that seemed valid and meaningful, rather than to look for one 'truth.' Reflecting on issues arising allowed the researcher to hold an awareness of her own biases and leanings in order to understand how these may influence the analytical process particularly in the context of development of themes arising from the data.

The research supervisors were two male clinical psychologists working in the specialist veterans' services and a male Professor of Clinical Psychology at University College London.

Analysis

The data was initially analysed using thematic analysis, with the aid of Dedoose qualitative data analysis software (Dedoose, 2013). This software helps organise the data and offers a mechanism for considering and reviewing the themes. Thematic analysis is a method for identifying, analysing, reporting, and interpreting patterns within data (Braun & Clarke, 2006). An advantage of this approach is its flexibility and adaptability to many theoretical frameworks (Pistrang & Barker, 2012). Due to the emergence of strong narratives in each of the interviews, a narrative approach was also used to augment the main thematic analysis and to do justice to the storied nature of participants' accounts.

Thematic analysis

Thematic analysis involved a number of steps (Braun & Clarke, 2006). Although the steps were followed in a linear fashion, stages were revisited and reviewed as more information and feedback from the research team was received on the emerging themes.

The first step involved familiarisation with the data. This involved reading and re-reading the transcripts. General notes about the factors relevant to the

interviews and the research questions were made. A number of the transcripts were also read by the researcher's supervisors and feedback was given in order to reduce potential bias in the analysis. They also provided input on interview style.

The transcripts were uploaded anonymously into the Dedoose software. The second stage involved working systematically through the data and selecting the elements of text that represented some form of meaning. These excerpts were tagged within the software with a code. Each code highlighted the perceived underlying meaning (Appendix 5). A broad, inclusive approach was used at this stage.

In the third stage of analysis the initial set of codes were reviewed and collated and sorted into potential broader level 'themes'. These themes represented a set of recurrent codes representing a similar idea. The themes were examined and reviewed for their internal consistency and distinctness from one another by repeatedly checking the raw data. Themes were collated and collapsed into a single theme or split where indicated.

Following this, an online and hand-written review of the themes, linking different ideas and helping to better understand the relationships between themes, was explored. This was augmented by the narrative analysis (see below). This led to organising the data into a higher-level structure that included overarching descriptive domains at the broadest most inclusive level that subsequently divided into themes and subthemes.

The researcher took the lead in the analysis; however emerging domains and themes were discussed and reviewed in consultation with supervisors and the research assistant. No further interviews were conducted after the initial 16 due to data saturation being reached and no new themes being present within the data.

Narrative analysis

Narrative analysis of qualitative data can help "follow participants down their trails" (Riessman, 2008). Narrative analysis can provide a way of understanding the 'big picture' of participants' experience. It aims to preserve the personal stories of individuals and of the series of events they describe in a way that could not be done justice by just looking at the individual components (Riessman, 2008). It was deemed an appropriate method in this instance as it provides a format for organising data from a range of participants, reporting multiple themes, with joint experience, in a way that represented the chronology of events clearly.

After each transcript was analysed thematically, a summary narrative was composed using the themes. A basic structure of the storied pathway to care for veterans was developed from this summary narrative. This provided a basic outline for organising how the results were described. The pathway to care involved progression through a number of steps or stages. Within each of these stages there were the domains of specific barriers and facilitators to care in that stage. In addition to the barriers and facilitators, there were a number of other themes that were either particular to the stage or crossed the stages. The individual narratives for each of the themes, outside of the specific barriers and facilitators, at each stage were aggregated into a composite narrative in order to provide a coherent and rich description. The composite narratives were comprised of actual quotations from participants. These were condensed in some instances in order to give a sense of cohesion and flow to the composite narrative. This method has been used in other help-seeking research to augment the thematic analysis (c.f. Collins & Barker, 2009).

Credibility checks

In accordance with guidelines on qualitative research (e.g. Yardley, 2008), a number of credibility checks were conducted. During data collection, members of the research team independently read four of the transcripts. These were discussed and ideas were used to inform the initial coding. The initial codes were shared with the team and discussions were held about the initial framework and themes they produced. Updates on the emerging domains and themes were checked with the supervising team and with a research assistant who was familiar with the data. Where discrepancies or queries were present, consideration of the coded excerpts within the relevant theme were reviewed and changes made as appropriate.

A draft of the final results, including both the narrative and thematic analysis, was shared with six of the participants and with two clinicians working in the respective services. The participants had requested to be emailed for their feedback. Two of the participants responded. They highlighted that they thought the results were a good reflection of their experience or that of other veterans they knew. One participant wanted to emphasise the fact that his decision to seek help had not been voluntary. This element of help-seeking is included in the discussion. The clinicians described the results as linking with the anecdotal reports they had from veterans.

Results

Results are presented chronologically, according to participants' stages in their pathways to care. Three main stages were identified: Stage 1: recognition and acknowledgement of a mental health problem, Stage 2: initial help-seeking, and Stage 3: pathway through treatment. Within each stage the narrative material is presented first in the form of composite narratives, and then the barriers and facilitators are organised thematically (see Table 2). The section ends with an outline

of the changes veterans would like to see in the pathway to care. The format in which the results are displayed is represented in Table 2.

Table 2.

Veterans' pathway to care

Stage	Themes
1. Recognition and acknowledgement of a mental health problem	1.1 *Emergence and impact of symptoms*[a]
	1.2 *Coping*
	1.3 Barriers and facilitators to acknowledgement and recognition
2. Initial help-seeking	2.1 *Experience of support and follow up from the military*
	2.2. *Experience of GPs*
	2.3 Barriers and facilitators to initial help-seeking
3. Pathway through treatment	3.1 *Experience of generic services*
	3.2 *Specialist veteran services*
	3.3 Barriers and facilitators to pathway through treatment

[a]*Themes displayed in italics are represented by composite narratives in the results*

Stage 1: Recognition and acknowledgement of a mental health problem

Participants described a journey, often over many years, to recognition and acknowledgement of their problem. The data are presented in terms of the emergence and impact of symptoms, the participants' coping mechanisms, and then the barriers and facilitators relevant to this stage.

1.1 Emergence and impact of symptoms

All participants acknowledged that prior to seeking help, either they or others had noticed a set of symptoms or problems. Generally, it was others who had noticed the problems first. Ten identified that, retrospectively, they were able to identify that

their problems or symptoms had emerged during service, and four indicated that they had emerged after leaving the military. Two indicated that their problems had started as the result of difficult experiences during childhood; for example, the experience of abuse, but that these had been exacerbated by their experiences during service. The main symptoms participants described were: feeling different from normal, mood swings, being on edge, anger, flashbacks and nightmares, trouble sleeping, self-harm or suicidal thoughts, engagement in risky behaviour, and a decrease in socialising.

Composite narrative:

> I was hypervigilant, everything was a threat [P8]. My mood was fluctuating with depression like symptoms or anxiety [P15]. I'd get panic attacks [P6]. I'd have nightmares, flashbacks [P13]. I couldn't sleep [P2] because I'd get night sweats and terrors [P10]. I used to lock myself away. I was sitting around and wasn't taking care of myself, I just wasn't interested in anything around me [P8]. I resorted to hurting myself [P2]. I had stopped interacting with people, stopped eating [P5], I started sleeping around and indulging in inappropriate behaviour patterns [P5]. I was making stupid decisions, getting into debt [12]. The drinking was a big problem [P3]; I was drinking too much, starting fights all the time, and not concentrating in work [P10]. I sort of went on edge, tight to myself [P2], I'd just snap. Anything could trigger me off [P4]. I became very angry, aggressive [P16]. I started taking out all my frustrations on my wife and my family [P10]. I just didn't feel right [P7]. I thought there was something wrong, that I'd changed. You just feel like you've lost your soul, that's what it feels like [P15].

The main impact of symptoms was on family and friendship relationships. Participants described partners often being the recipients of their frustrations and a number of break-ups and failed relationships.

Composite narrative:

> I've got two failed marriages, and another long term relationship I failed. [P8] I was a very, very hard person to live with. I wasn't a nice man [P4]. I was pushing loved ones away. [P13] My wife...she's suffered a lot. It's hard for her. [P6] I've abused her emotionally, calling her names, blaming her...It affected our relationship really bad, to the point that we almost broke up and I'd been kicked out the house. [P2] I started taking out all my frustrations on my wife and family; over-aggressive, blaming them for everything. Whenever they'd do something wrong, I'd fly off the handle. And we almost got divorced for it. [P10] She said she didn't love me and all that. [P9] My wife moved out with our kids and then I knew it was serious. [P3] I'd split up from family life and was living in my car. [P11] I've lost all my friends, lost all my family. [P12]

1.2 Coping

All the participants discussed different ways of coping. Three sub-themes emerged. These were: '*having to fight and be strong*,' '*hiding the problem,*' and '*alcohol use*.' Some of these had emerged as a result of military training, military culture, or as a result of their upbringing. These ways of coping appeared to influence their pathway to care in a number of ways. For example, having to be strong and fight may result in someone not considering other help is available or necessary, or alternatively it might assist someone to persevere to get the help that they need regardless of the feedback that they get from services or others. Many veterans spoke of trying to hide or bury their problems, which often prolonged the time that it took for them to seek help. Drinking was deemed a normal part of military life and appeared to be something veterans took with them into civilian life. Alcohol use appeared to serve many purposes. In some respects it provided a way of escaping from the symptoms, but it was also seen as being a preferable problem to a mental health diagnosis.

Composite narrative:

> I was taught not to think about such things in my upbringing. [P9] You're bred to be immune from pain or to think 'I haven't got this problem'. [P4] In the army...it was just a case of 'get on with it, it's normal, you're just doing your job'...so I just thought that I'd grin and bear it. [P16] I didn't tell anybody. [P7] I was keeping a cap on it, an emotional cap, [P15] that's probably why it's gone on as long as it has. [P6] I had to be strong for the lads. How much confidence would they have if you are a quivering wreck? [P14] I said I'll deal with this and be big and strong and tough. [P8] I was self-medicating, alcohol, recreational drugs. All to get that high, to feel good. [P15] I was drinking a lot more just to sleep and stuff [P3]...to block things out. [P13] Because I was falling part, one of my go to personalities is 'Military me.' Military me can hold it together under times of great duress." [P5] I've always looked after myself. I've always dealt with things myself, in my own way. [P2] I knew I could cope. 'Yeah, I can crack on with this' [P14] No one's ever sat down and said to me, this is what you're suffering with and we think you fit in that box. I've worked it out myself. [P12] That particular fighting spirit was a disadvantage to me then. But now I'm finding it an advantage. [P5] It was me who went and got the help. Nobody else did it for me. [P11]

1.3 Barriers and facilitators to recognition and acknowledgement

Veterans reported a range of barriers and facilitators to recognition and acknowledgement of the problem (Table 3). These included factors relating to the minimisation or noticing of symptoms, social support, and knowledge. There was broad consistency between the participants in the acknowledgement of these factors.

Participants described a mixture of normalising, minimising and denial of their symptoms and emotions. Symptoms were viewed as a normal part of military life, ignored, or put down to other factors; for example, tiredness. These barriers were exacerbated by a lack of knowledge or not having heard of PTSD, and a belief that mental health problems and PTSD were not relevant to them. Veterans discussed perceptions of others being more likely to struggle with problems; for example, civilians, or veterans of the World Wars who had lost whole battalions, or younger less experienced veterans. They described a belief that mental health problems did not fit with their military training and background (i.e. that they were trained to be strong and resilient and thus should not be affected by such things).

Despite the negative impact of symptoms on relationships, all the participants highlighted the importance and role of others in noticing their symptoms. However, participants also highlighted that they did not initially respond or listen to them, and it was only when many people started to comment or that their difficulties had got particularly bad that they started to pay attention. Ten of the participants described how they experienced a downward spiral of problems and difficulties and how one thing often led to, and exacerbated, other problems. Often this culminated in a critical incident that acted as a prompt to acknowledging the problem and seeking help. These incidents included: attempted suicide, aggression or trouble with the law, and the potential loss of a relationship/having something to live for.

Table 3.

Barriers and facilitators to recognition and acknowledgement of a mental health problem

Domain and themes	Prevalence[a]	Illustrative quotations
Barriers to recognition and acknowledgement		
Minimising/normalising/ blocking out symptoms	General	"You don't really realise that there is a problem at the start because it's just memories and stuff." [P3] "I just thought that I was a veteran that was suffering from service and I thought that was normal." [P15] "I just put it to the back of my mind." [P9] "I just ignored them, because, I'm in the army...you fight wars, you come back, you're lucky."
Lack of knowledge and/or belief that PTSD/mental health problems were not relevant to the individual	General	"I can honestly say that I didn't know what PTSD was until my mum and dad told me." [P2] "Just thinking to myself that no one in the army goes through this sort of thing. We're trained to be strong and just to get on with it." [P13] "I always look at the old soldiers from World War Two who lost whole battalions and every friend around them. I used to think...how can I have something, I haven't seen the quantity that they saw?" [P14]
Facilitators to recognition and acknowledgement		
Recognition and feedback from others	Typical	"When it was one person saying it, I didn't really pay much attention, but in the space of a week, an employer, a friend, and a flatmate had all felt the need to take me aside and say 'I think you're really struggling'." [P5] "My wife she saw a change in me because I wasn't the same person that I was when she met me." [P16]
Downward spiral and noticing of symptoms	Typical	"It is not until other things come in…say alcohol or substance abuse, gambling, so forth you know, until it starts to affect your everyday life…that's when you start to take notice, and more that other people start to notice." [P3]. "It was a spiral down, just stuck into a loop of low motivation which just keeps going down. I just got to a point." [P6]
Critical incident	General	"I knew there was a problem when I attempted to hang myself." [P3] "Everyone gets to their own point and mine was when I met my wife." [P10] "I eventually got to a point about 12 months ago where I began to feel that my temper was getting the better of me and that it was time to get some help." [P15]

[a]General: theme applies to all but one or two of the participants (14-16). Typical: theme applies to more than half of the participants (8-13). Variant: theme applies to up to half of the participants (3-7). Rare: theme applies to one or two participants (1-2).

Stage 2: Initial help-seeking

Following recognition and acknowledgement of the problem, most participants described not knowing where to get help from or not having information about services. Half the participants described using the internet to get information on their symptoms and where they might be able to get help. Four participants initially sought help whilst they were still serving in the military. The other 12 participants sought help post-service. Six initially went to their General Practitioners (GP) or some other NHS service and the other six approached charitable veterans' services or other military related services for help and information (e.g. The British Legion, Combat Stress, Service and Personnel and Veterans Agency).

2.1 Experience of support and follow up from the military

Many of the veterans described a level of dissatisfaction with the support and follow up that they received from the military, both whilst they were serving and on discharge. Support for potential mental health problems following deployment was described as non-existent or a token effort as there was a lack of follow up and mental health issues were not taken seriously. Where support was provided, it was reported to not be particularly helpful.

Composite narrative:

> In the military there's a real token effort and gesture. [P3] I had only arrived in the UK for about 24 to 48 hours (from active duty). Stuff like that doesn't come to the fore then. [P3] If you do say that you are affected mentally...then you have to stay for a whole range of tests and stuff like that. And we all just wanted to get out of there, get home, have a beer, and relax. [P1] It was all that trauma, and not any guidance, not any help, not any debriefing, not any counselling, not any asking 'are you ok?' even. [P12] I went to the army doctor. He said 'two Anadin and man up.' [P9] I tried to get help...but they said 'you're fine, normal, I don't think I need to see you anymore.' [P13] There was no mention of PTSD during service or discharge. [P15] The main thing they were looking at was tying up the paperwork and saying 'Yes, he's fit for work.' It was never taking seriously...it was brushed under the carpet. [P10] The mental health teams and psychiatrist in the army were as much use as an ashtray on a motorbike. No sort of diagnosis, no sort of practical things to do, nothing. [P7] The treatment I got from the army was shocking...they were more

> focussed on thinking it was just the alcohol. [P14] The military has one of the highest divorce rates, so there's lots of help for that, but not for mental health. [P11] There's no follow up. It's dangerous that they just put you out and that's it. You're on your own and you're walking around and you're wondering why these things are getting to you. They don't understand and you don't understand. [P14] I didn't have any contact with anyone. No one phoned me up to ask me how I was...no face to face contact...It was basically, you've given us 14 years, now get on with it and leave. [P16]

2.2 Experience of GPs

GPs are often the first point of contact that veterans have with formal services. The participants who accessed their GP initially described them as facilitating their journey to help in a number of ways. These included providing a provisional diagnosis, usually depression, prescribing antidepressants, and referring them on to other services such as counselling, Improving Access to Psychological Therapies (IAPT), or adult mental health teams. Only one person reported that their GP had referred them immediately to a specialist veterans' service. Many of the participants spoke positively about their experience of GPs, especially where they had knowledge of PTSD or the military; however, there were some participants who indicated that they did not believe that their GP had done enough or had enough knowledge about their condition.

Composite narrative of more positive experience of GPs:

> The first thing that I did was go to the doctors. [P10] I spoke about my problems with the army. [P4] She's ex-army, very sympathetic, very knowledgeable about PTSD. She diagnosed me straight away, but obviously you have to wait for your formal diagnosis. [P15] The doctor said it's nothing to be ashamed of, [P2] and made me an appointment with the veterans' service and said to just wait for a letter from them. [P13]

Composite narrative of less positive experience of GPs:

> I initially went to the doctors but that wasn't very helpful. [P6] The GP just said about depression. [P10] He gave me antidepressants and sleeping tablets. [P13] He said 'yes, sounds like you've got it. Here you go, I'll put it on your notes, PTSD'. He put it on my notes, after a 5 minute conversation. I don't understand how he can do that. [P1] I wasn't given any information about it. I just thought it was a low mood and the tablets would give me a better feeling about myself. [P8] I also think my GP sent me to [name of hospital], but I don't remember this...they diagnosed me with PTSD. The only help I

> had after that was that my GP suggested that I go for four/five counselling sessions in a clinic. [P12]

Five participants spoke about how they viewed being prescribed medication, such as antidepressants, as belittling or diminishing. Their views are combined in a narrative below:

> I've never gone to a doctor and said look I need help...I felt quite little being told I had to take tablets. [P2] I didn't want to become addicted to things like Prozac...I was one of those people who never took a tablet for a headache anyway. [P12] The idea of spending the next 20 years on medication horrifies me. [P5]

2.3 Barriers and facilitators to initial help-seeking

Participants described a number of barriers and facilitators that influenced their initial help-seeking. The barriers included perceptions of stigma, fear, and a lack of knowledge of where to get help from. The facilitators that were important primarily appeared to be related to advice and support from others. The full list of themes relevant to this stage are displayed in Table 4.

Participants raised stigma related concerns about being judged by others and seen as weak, a coward, and someone who should not be in the military. They expressed anxiety about being viewed as malingering and lazy, or as odd, weird, and unstable. Perceived stigma also included worries about getting a label and being ostracised and it impacting on one's career. Self-stigma was a distinct separate barrier and included feelings of shame, vulnerability and embarrassment and viewing self as weak, worthless, and a failure for seeking help. Fear of losing control, of the meaning of symptoms, and of the unknown were barriers to participants seeking help following acknowledgment that there might be a problem. In addition, especially for those who first noticed their problems whilst serving in the military, perceived stigma from others acted as a barrier to pursuing help.

Participants spoke about not knowing where to get help for their difficulties and how this was exacerbated by their experience of isolation and being alone. Isolation was sometimes a reflection of the symptoms that someone was experiencing but it was also the result of difficulty integrating back into civilian life or not knowing anyone else with similar difficulties. Isolation further impacted on the participants' view of themselves, which acted as a further barrier to help-seeking.

With regards to facilitators, participants often learned about the potential nature of their problems and where to try and get help through word of mouth and information from other ex-servicemen and veterans who had received help from particular services. Significant others practically and emotionally supported initial help-seeking by being encouraging and understanding, and either making the initial telephone call or the referral for the person, or taking the person to the initial appointment. Many of the veterans expressed a great amount of gratitude towards their significant others for remaining faithful and continuing to support them through their pathway of care. For a few of the participants, initial assessment was a requirement of other support they were receiving or a stipulation made by their significant other in order to keep their relationship. Some veterans reported having got to a point where they felt that they and nothing to lose in terms of seeking help, and where it could potentially do more good than harm.

Table 4.

Barriers and facilitators to initial help-seeking

Domain and themes	Prevalence[a]	Illustrative quotations
Barriers to initial help-seeking		
Perceived stigma from others	General	"You are going to be painted with the same brush...weak." [P7] "People victimising me every day...saying "Here comes a sicky, thinks he is ill. There's nothing wrong with him. He's bluffing it." [P13] "You wouldn't say you have PTSD because it would affect your career." [P16]
Self-stigma	General	"This was my career. And all of a sudden I was left back out, alone with no job, I lost my dignity, I lost my pride, I lost my sense of self-worth." [P12] "I thought I was a failure. Like everything I had done up to that point was insignificant." [P8] "It demeaned me in the sense that I wasn't a proper man." [P4]
Fear of the meaning of symptoms, of the unknown, of losing control	Typical	"The fear factor. I was afraid of what PTSD might mean." [P4] "Are they going to cart me off somewhere and give me electroshock therapy and things like that...I was apprehensive, it was something new, something different, and something that I didn't know anything about." [P8] "The fear of going insane...Having no more control." [P14]
Not knowing where to get help	Typical	"I wish I'd known about this place earlier. Because I would probably have come here earlier. Which would have made it, I wouldn't say easier for me, but it would have taken, say, ten years less to get to the point I'm at now." [P8]
Isolation	General	"You think you're the only person in the world. You don't hear of anyone else having it. You don't see it advertised...so you think you're on your own." [P2] "It's difficult, because I've never known anyone who's been through the process or anything like that." [P11] "At one point I stayed in the house for nine months, never left the door." [P8]
Facilitators to initial help-seeking		
Information from other veterans or service personnel	Typical	"A couple of lads I'd known that had come back from Afghan, this one guy came back and got treatment straight away. EMDR stuff. And it was him who said to me "I think you may have PTSD, get it checked out." [P10]
Others encouraging and practically supporting help-seeking	Typical	"My wife took me after one of the suicide attempts." [P13] "It was actually my wife who phoned." [P14] "My wife pushed it...she came with me the first time." [P6]
Help-seeking as a requirement/necessary	Variant	"I went into an ex-servicemen's homeless accommodation and one of the deals with that was that we saw somebody" [P7] "I didn't go off my own back, I was shoe-horned into it, I was placating the missus." [P1]
Nothing to lose	Variant	"I thought, in for a penny, in for a pound, let's go for it." [P7] "It was something to do." [P9] "So now, I've got to the point where I don't care who knows or not, I just want it fixed." [P10]

[a]General: theme applies to all but one or two of the participants (14-16). Typical: theme applies to more than half of the participants (8-13). Variant: theme applies to up to half of the participants (3-7). Rare: theme applies to one or two participants (1-2).

Stage 3: Pathway through treatment

Following initial help-seeking, receiving and remaining in treatment was not always straightforward. Many veterans described it taking numerous attempts to get the help that they felt they needed. They had often initially been referred to non-veteran specialist services, including generic counselling and IAPT within the NHS prior to being referred to specialist veterans' services.

3.1 Experience of generic services

Three participants accessed IAPT and described difficulties accessing and getting the service they needed and then when they did get the service, it not being sufficient.

Composite narrative:

> So I went through the NHS through the doctors. This is where it all went wrong. I referred myself, [I was] referred by my GP. I didn't get any phonecalls. I had to ring them myself. [P15] They said that takes ages, you're on the list, but that takes ages. I said I was told that it would be quicker because I was a veteran. They said, 'Oh, we weren't told you were a veteran'. [P10] The sessions were really repetitive. All we seemed to go on about one incident over and over and over again...I didn't connect really with what I was doing. So I didn't really feel that it helped so much. [P10]

Nine participants accessed non-specialist services and described the treatment not addressing the issue or connecting with the person or the problem.

Composite narrative:

> She didn't say anything, just sat down and looked at me, and that's not the right thing to do with me, but she didn't even attempt to know me first, she just sat there and looked at me...I just ended up getting confused. It actually just ruined my weekends. [P6] I went four times to a counsellor. And all they wanted to do was know about my childhood. I said there's nothing wrong with my childhood [P8] She had it in her head that she was not going to look at it as PTSD...she was trying to put a square shape into a round hole. It won't fit. [P12] I tried counselling but it didn't do me any good. I tried healing. I tried Raiki. I tried everything over the ten years. [P15]

3.2 Specialist veteran services

All participants spoke about the importance of services needing to be specialised in the needs of veterans and in understanding military culture; although many highlighted that prior to accessing the specialist veteran services, they had never heard about them. They generally reported positive experiences of the services.

Composite narrative:

> Within two days, I'd had a home visit. Talking to them two in my own home was a breath of fresh air. They knew what an IED (Improvised Explosive Device) was, they knew what a tour was [P16]. They understood the terminology. [P16] The people who work there are either serving veterans or ex-veterans and may have suffered with it themselves. So they know exactly what to do. [P2] You just feel they will understand because there are other people there with the same sort of stuff and similar issues. [P12]

When asked about their preference for specialist veteran services in either the NHS or within the third sector, three participants indicated they would prefer the NHS, seven indicated the third sector, and four stated that they had no preference. Examples of responses indicating that the specialist nature of the service was most important are outlined below:

> Either or, as long as they are specialised in the treatment that we need. [P11] I would feel more comfortable with the military focused. It gave me confidence knowing that this was the veterans' trauma clinic and they only deal with veterans. [P12]

3.3 Barriers and facilitators to pathway through treatment

Participants reported several relevant barriers and facilitators to the pathway through treatment (Table 5). There was broad consistency in reports across participants.

Table 5.

Barriers and facilitators to pathway through treatment

Domain and themes	Prevalence[a]	Illustrative quotations
Barriers to engagement treatment		
Care providers or civilians not understanding/not connecting	General	"Talking to someone...I was thinking to myself 'He doesn't understand.' 'What's he going to help me with?'" [P13] "So I just thought, 'You're not getting me, I don't trust you.' there was a trust issue." [P12]
Care not joined up or followed up.	Typical	"It's a year since I first sought help and I'm still being assessed. I'm not getting anywhere." [P3] "I don't know if someone from the NHS had been in touch or what? I don't even know how I got referred here." [P11]
Treatment being difficult/opening up a can of worms	Typical	"It was easy until two years ago and it was like a cat put amongst the pigeons. Opened a can of worms." [P9] "Every time I used to come here I was frightened to come and get therapy because it would take me a week to get over the therapy." [P4]
Practical Barriers	Typical	"It was so spread out, we only had a certain amount of sessions because of work commitments and stuff." [P10] "My wife is in full time education. I had the kids as well. So I had to work out a way where she could have a few hours off each day to do the school stuff." [P11]
Facilitators to engagement in treatment		
Respect and trust for professionals who have military knowledge/experience and experience of working with veterans	Typical	"You're more likely to get someone who has treated a veteran before. So then you can connect more and the other person can understand it more." [P11] "The trust was there instantly because I knew he was ex-military. So I said a lot more to him than I'd ever said to my girlfriend." [P8]
Knowing you are not alone and being with and trust of others who have experienced the same	Typical	"The biggest thing I've got from this place is identification and to realise that I'm not on my own." [P14] "I got to speak to a few of the lads who were going through the programmes. They said it was really helpful and that I wasn't the only one." [P13]
Caring, unobtrusive, validating, and respectful approach by professional	Typical	"For a colonel (welfare officer) to sit with you three hours, it impressed me that he would do that for someone who was a private in the army. He gave me time, and I respect him for that...it showed me that he cared." [P12] "It was the understanding, it was the caring, professionalism." [P15]

[a]General: theme applies to all but one or two of the participants (14-16). Typical: theme applies to more than half of the participants (8-13). Variant: theme applies to up to half of the participants (3-7). Rare: theme applies to one or two participants (1-2).

Barriers to treatment included care not being joined up, a lack of communication, treatment as difficult to access due to location, work and family constraints, and financial implications. Participants also described treatment as difficult and the fact that it opened up a "can of worms" as being a barrier to them continuing to pursue help. One of the biggest barriers to treatment was participants being suspicious of civilian care providers and thinking and experiencing them as not understanding and not connecting with them.

Participants who described positive experiences of treatment highlighted that being able to develop a relationship with the provider and the provider being caring, unobtrusive, and giving them time and hope as important factors. Where the care provider had military knowledge and experience, this was a further facilitator as they were viewed as being more understanding, knowledgeable, and deserving of respect. Participants described an instant bond and trust with other military personnel. They said that being around other veterans or people experiencing similar difficulties helped them feel less isolated and safer.

What needs to be different?

In addition to the three identified stages in the participants' pathways to care, there were a number of themes regarding what veterans believed could be different or things that would have helped them seek help sooner (Table 6).

A number of veterans emphasised a wish for others not to have to experience similar difficulties in getting help and turning to the unhelpful ways of coping which they had. Veterans spoke passionately about believing that the military should be more involved in their care and follow up. There were suggestions that the MoD should be contributing financially to the services providing specialist treatment for veterans.

Table 6.

Future considerations to support veterans seeking help

Themes	Prevalence[a]	Illustrative quotations
Role of military in increasing personnel's' knowledge of mental health	General	"From training level...the army could implement some mental health awareness lessons." [P11] "You get taught basic first aid. Why not get taught the basics of PTSD? Give us the knowledge." [P14] "If I'd known about it earlier, then I would have done it earlier." [P8]
Role of military in recognising, supporting, and following up those with problems	Typical	"They need to notice the symptoms... Injured soldiers get regular check-ups. There should be some kind of check-up system for the mental health side of things too...You would recognize the people with the problems from the start...and there'd be a paper trail." [P3]. "The lads should be given something on discharge that...(provides) more awareness of the military mental health charities." [P15] "We should be monitored...Every time we see our GP it should come up on the computer. 'How are you mentally, how are things at home, how are you copying with life?'" [P15]
Advertising and raising awareness about specialist services available	Typical	"A lot of information needs to be available to the GPs...more awareness...closer communication between organisations." [P7] "You hear about Help for Heroes and people recognise that because of the physical injuries. There's not enough media coverage for this (specialist mental health services)." [P8] "I think if it was publicised. Putting adverts on the TV highlighting the symptoms and where to get help." [P16]
Support for families	Variant	"Families need to be involved in what we go through (treatment)." [P7] "If the wives or partners of people with PTSD were contacted...to let their side of the story out...because it doesn't just affect people like me. It affects your wife, kids, extended family, everyone around you." [P12]

[a]General: theme applies to all but one or two of the participants (14-16). Typical: theme applies to more than half of the participants (8-13). Variant: theme applies to up to half of the participants (3-7). Rare: theme applies to one or two participants (1-2).

The things that veterans deemed important when considering future service provision included: increasing awareness and advertising about mental health in veterans and services available, aiding early recognition, increasing the role of the military in supporting those with problems, and support for families. The participants believed that the military should get involved in relation to mental health from early on in their training. There were thoughts that stigma, for one, would be reduced if mental health awareness was made part of basic training alongside basic first aid, for

example. Regular follow up and monitoring was deemed important. Again mental health being viewed as or responded to in a way equivalent to physical health was alluded to. Many of the veterans spoke about how increasing the media representation of mental health difficulties would be helpful. Advertising about services was seen as particularly important, especially for GPs. Given the critical role that significant others appear to play in supporting recognition and seeking help for difficulties, it seemed to fit that the families being involved and supported through the process would be an important factor for services to consider.

Discussion

Many of the same barriers and facilitators to help-seeking that have been identified in previous studies with military personnel were found to be important factors in this study, specifically lack of recognition, perceived public stigma, and lack of trust in providers (Hoge et al., 2004; Iversen et al., 2011; Zinzow et al., 2013). However, veterans also highlighted a number of other important factors in their help-seeking pathway that have not been highlighted by previous research: principally fear of the meaning and consequences of symptoms; care not being joined up; and the importance of service providers having military knowledge.

Some barriers and facilitators are better understood as being more relevant at different points in the veterans' journey to care. Whilst acknowledging that veterans' pathways to care are not always straightforward and do not always follow a set path, this is an important finding as it suggests that different interventions may have more impact at different points.

Recognition of the problem

That the majority of participants spoke about things having to reach a crisis point or for there to be a severe incident before they thought that they might need to

seek help is important and fits with previous literature with serving personnel (Zinzow et al., 2013), and with studies showing that greater impairment, distress and symptoms predicts the initiation and use of healthcare (Rosen et al., 2011). This may partly represent a carry-over of factors such as resilience and self-sufficiency that are promoted in the military training and culture. A number of the participants described attempting to cope with things on their own and continuing to be strong and fight through their symptoms. This links with a finding that one of the regularly reported beliefs impacting on the decision to use mental health services by military personnel was a desire to solve problems on one's own (Momen, Strychacz, &Virre, 2012). It is interesting that although this can be a barrier to recognition and initial help-seeking, this same fighting spirit served some personnel well when they had to persevere with trying to get appropriate treatment. It is possible that reframing from seeking help as a show of strength may go some way to reducing some of the stigma associated with receiving help. In addition, it will be important for therapists to be aware of these military cultural factors and to tailor therapy accordingly; for example, as a fight against the symptoms or in line with beliefs around strength and honour.

A lack of recognition is commonly identified as a barrier to help (Iversen et al., 2010). It is likely that the time to initial help-seeking is a function of the length of time to recognition. Therefore, focusing on interventions to increase recognition will be best placed to reduce time to seek help. Brown, Creel, Engel, Herrel, and Hoge (2011) found that in a group of military personnel who met the criteria for mental health problems, those who recognised that they had a problem were seven and half times more likely to be interested in receiving help compared to those who did not. In the present study, the factors contributing to a lack of recognition included a lack of knowledge about mental health, and normalising or minimising of symptoms.

Participants spoke of a belief that their symptoms were a normal reaction to combat. Whilst normalisation can be helpful in reducing stigma, increasing veterans' knowledge of the potential impact of combat on mental health is important. This would also increase their perception of mental health problems potentially being relevant and possible to them, and thus increase the chance of them noticing symptoms. Whilst there are current initiatives to try and address this in serving personnel the military; for example, TRiM, some initial results suggest it is not fully effective in its aims (Greenberg et al., 2010). The participants in the current study spoke about their experience of these initiatives as not being taken seriously and being more of a "token effort". It may be that interventions directed specifically at those leaving the forces and including their significant others or family as part of their reintegration would be more beneficial.

One of the biggest facilitators to recognition was the role of others in identifying the problem. This is similar to the findings of Sayer et al. (2009). Therefore, increasing the awareness and understanding of the significant others of veterans may aid earlier recognition. There is evidence that veterans are less engaged with military social contacts and in social activities compared to serving personnel (Hatch et al., 2013). Isolation was identified by veterans in this study as being a barrier to initial help-seeking. Thus aiding veterans to maintain some links with their military family or helping them find ways to link in with veteran organisations that are relevant to them may act as a protective factor. Military culture promotes shared responsibility between personnel for relying on each other for physical and psychological support (Langston et al., 2007). This is known as the buddy system. It is known that military personnel are more likely to speak to peers than to formal support providers (Greenberg et al., 2003). Many veterans spoke of finding out about

services and the nature of their problems through other veterans and also spoke of the benefits of being around other veterans with similar difficulties. Encouraging the 'buddy system', post military service, especially with those who may have already sought help and found it useful, will be an important consideration.

It was evident that the role of others is important throughout the whole pathway to help. Mental health is known to impact on the sufferer's significant others (Taft, Vogt, Marshall, Panuzio, & Niles, 2007), and it follows that they would therefore be motivated to emotionally and practically support the individual's help-seeking. Family members and significant others were found to support initial help-seeking through providing advice, encouragement and practical support, and they were also important in supporting ongoing treatment through remaining faithful and supportive to the veterans. A number of the veterans highlighted their views that it would be important to include significant others more in their treatment or to provide them with a space to get support for themselves.

Initial help-seeking

Exploration of the different factors influencing initial help-seeking showed that both public stigma and self-stigma were important barriers to help-seeking. Importantly, results from this study would suggest that the current definition and understanding of public stigma in military populations could be expanded beyond the current practice of considering fear of being seen as weak or people losing confidence in them. This is because in addition to concerns about being seen as weak, veterans in this study described concerns about being seen as unstable, a failure and as malingering. This is similar to the findings in a qualitative study with US veterans (Mittal et al., 2013). It is known that veterans experience additional practical barriers to care (Iversen et al., 2011), and this study suggests that veterans

may experience additional stigma concerns; although, further research and comparisons with UK serving personnel is required.

In keeping with previous studies, participants described concerns that mental health problems would impact on their career (Hoge et al., 2004; Iversen et al., 2011). Importantly, the veterans who described attempting to seek help in the military, described experiences of being side-lined and looked over for promotion. Thus some of the perceived stigma may represent actual experiences of veterans. Some of these concerns may also carry over into civilian employment.

Another important finding in the barriers to initial help-seeking was in relation to the theme of "Fear of meaning of symptoms". Veterans spoke of concern and fear about what their symptoms might mean about themselves, about losing control, as well as the potential consequences. In many cases, this fear represented a lack of knowledge and understanding of the symptoms of PTSD in particular, and the potential routes for treatment. These barriers were exacerbated by the majority of veterans describing not knowing where to get help for their problems. As indicated by the participants, it will be important for there to be more information available about mental health symptoms and for the services and treatment available to be better advertised and promoted. Initiatives in civilian communities to increase mental health literacy in relation to depression and knowledge about the treatments available have been found to be effective in increasing recognition, positive beliefs about treatments, and openness about problems (Jorm, Christensen, & Griffiths, 2005).

Encouragement and support by significant others and knowing other people who had sought help and who recommended a particular service was very important to initial help-seeking, according to the veterans in this study. This is in keeping with work regarding the development of stigma reducing interventions in the general

population, which suggests that encouraging contact with others who have had mental health problems is one of the most successful ways of reducing stigma (Corrigan & Penn, 1999). A minority of participants spoke about having to seek help to either save a relationship or because it was a condition of a service they were in. Although these veterans had not wilfully sought help, it is important to acknowledge that this was a potential route into services. Advice from others who can recommend a treatment based on their experience of seeking help has been found to increase the likelihood of a person seeking treatment (Tijhuis, Peters, & Foets, 1990). This may be an important consideration when considering how to advertise and raise awareness of services and who this is best done by. Veterans spoke of an immediate trust and respect for the knowledge and information provided by other ex-servicemen.

Treatment

The fact that a separate set of barriers arose in relation to treatment is not surprising and fits with previous research where only a few veterans with a diagnosis of PTSD received eight or more therapy sessions (Rosen et al., 2011). One of the barriers emerging was that treatment can be difficult and can 'open a can of worms' and this is in keeping with information from studies with civilian populations which show that fears about treatment and fear of discussing painful emotions are a barrier to care (Vogel, Wester, & Larson, 2007). There is little information and research in relation to veterans' beliefs about treatment and its efficacy. This, and a lack of knowledge about treatment, was found to be a factor in a qualitative study with serving personnel (Zinzow et al., 2013). The health belief model (Janz, Marshall, & Becker, 1984) suggests that people will seek help and persevere with treatment if they view themselves as vulnerable to the problem, are cued to act, and believe that the treatment they receive will be effective and outweigh the negatives or barriers to

action. This would suggest that psycho-educational interventions should not only focus on aiding the recognition and understanding of mental health difficulties but also on increasing veterans' positive expectations about treatment. This information may again be best delivered by veterans who have been through treatment and found it helpful. Additionally, where treatment or assessment can be delivered by ex-service personnel or practitioners with military knowledge, this is likely to act as a further facilitator and increase engagement. Respect and trust for a provider's military knowledge and experience was an important factor highlighted by the veterans in this study.

Veterans who had sought help in non-specialist services described the important barriers of not feeling they were understood by, and not being able to connect with, civilian providers and this fits with previous anecdotal evidence (Busuttil, 2010). Concerns raised were specifically in relation to civilians not being familiar with military terminology and culture. This is likely to be exacerbated by a veteran's experience of care not being joined up. A number of veterans spoke about not being clear about the treatment pathway or going from one service to another and still being assessed. In the UK there are a number of different third sector services for veterans with different therapeutic approaches. There are also differences in the models of service deliveries in the specialist veteran services in the NHS and how they link with the CVS (MacManus & Wessley, 2013). This can be confusing for veterans and can further emphasise the barrier to care of services and care not being joined up.

Substance misuse

In keeping with other studies with military personnel, many veterans spoke about coping with their symptoms through substance misuse, usually alcohol misuse

(Mittal et al., 2013). Alcohol use served as a way of 'keeping a lid' on the problem and was seen as preferable to having a mental health problem. It often masked underlying PTSD symptoms and was often then seen as the problem instead. Alcohol misuse impacts on recognition, can contribute to the downward spiral of problems that veterans describe, and it can also impact on treatment as most services will require the individual to get their alcohol use under control before working on the trauma. It is well known that there is a culture of alcohol use in the military and that there are higher rates of misuse in UK serving and ex-service personnel compared to the general population (Fear et al., 2010). Understanding the specific barriers to care for alcohol problems in veterans will be important to increasing help-seeking in this area. Raising healthcare providers' awareness of the functions of alcohol misuse in this population will also be helpful in aiding earlier recognition of other problems.

Experience of the military

Unexpectedly, participants spoke strongly about their negative perception of the treatment they received from the military. They described the programmes in place during service as being inappropriately timed (too soon after return from deployment), and not taken seriously or not adequate. This is in line with research which suggests that the current programmes to prevent post-deployment mental health problems in military personnel, such as TRiM, and BATTLEMIND (to manage post-deployment stress), do not appear to reduce symptoms of traumatic stress or affect mental health status (Greenberg et al., 2010; Mulligan et al., 2012).

The veterans in this study emphasised the importance of there being on-going mental health screening in order to address delays in recognition, and for this to be in line with the physical monitoring they receive. Mental health problem rates have

been shown to be highest approximately four months post-deployment (Milliken et al., 2007), indicating that the timing of any intervention and screening is important. There was some indication from the reserve personnel in this study that they perceived a need for a different care pathway. Reserve personnel have been found to be at higher risk for mental health problems compared to regular personnel (Fear et al., 2010; Iversen et al., 2009), and to experience greater levels of perceived stigma and barriers to care (Kim et al., 2011). They also have different experiences of serving within the military (in terms of their obligations and preparedness), and returning home from operational combat when they return to their original civilian lives and employment (Iverson et al., 2009). This is an area that would benefit from further exploration.

Limitations

The use of a convenience sample consisting of a group of participants that were currently seeking help for their difficulties means that it may be difficult to generalise some of the findings from this study. It would be of specific interest to explore the experiences of veterans who are not seeking help, although, the recruitment of these veterans would be difficult. The use of two very different services meant that the participants came from a range of geographical areas (both urban and rural), and were at various stages in their pathway to care. Whilst this provided a range and depth of information, it is possible that veterans experience different barriers and facilitators to care depending on their location and the services available in that area. However, despite these limitations, there was a high degree of consistency in the findings with most themes being described by the majority of participants.

Female veterans were not recruited for this study due to the low number of female veterans seen in the services and the initial plan to conduct a quantitative study alongside the qualitative one. It is likely that females may experience unique barriers to care and have different experiences in relation to help-seeking. This is an area that will benefit from further exploration.

Given that the participants recruited from the CVS were in the process of participating in a six-week residential programme, it is possible there were similarities between participants in terms of the shared experiences and conversations they were having as part of being on the programme. This may have restricted the range of views expressed.

The fact that the interviews took place during the participants' assessment and treatment within the services may have impacted on how the interviewees reported their experiences. That is, they might have been pulled to respond in a specific or socially desirable way based on the context.

The participants were asked to retrospectively recall a number of complex emotions, interactions and processes, some of which had occurred many years previously. It is likely that their recall of these will have been influenced by specific memories or dominant narratives within the veterans' culture.

Although the majority of veterans had PTSD, there were a two who had other diagnoses. Previous studies have found disorder specific barriers (Ouimette et al., 2011). It may be that the different experiences of the participants who did not have PTSD may have been lost in amongst the discussion and commonality between the experiences of veterans with PTSD.

The range of veterans recruited in this study, in terms of their age, length of service, etc., is likely to be somewhat reflective of the wider veteran population.

However, recent changes in services within the UK and the practice of the military may mean that veterans who have left service more recently may have different experiences.

Clinical implications

Whilst steps have been made towards providing specialist services for veterans, it is likely that there are still a number of things that could be put in place to further support veterans in seeking appropriate help sooner.

The frequent description by veterans of not knowing about PTSD specifically and that they could be susceptible to it, would suggest that the Armed Forces needs to continue to promote understanding of the potential impact of combat on mental health. Where possible, including personnel who have experienced mental health difficulties but who have received treatment and found this helpful should be included in this training and information provision. This will increase normalisation of the risk of developing mental health difficulties and work towards decreasing stigma. It may also increase the likelihood of earlier recognition. In addition, mental health should be monitored and dealt with in an equivalent way to physical health as far as possible. The timing of input and monitoring following return from deployment should also be considered.

Veterans should be followed up and monitored regularly post their military service. This should include regular monitoring of their mental health. Specialist services need to be marketed more widely, including to GPs specifically. There are some steps already in place to facilitate this. For example, The Royal College of General Practitioners, The Royal British Legion and Combat Stress have developed guidance and a leaflet to support GPs to identify and address the healthcare needs of veterans more effectively (“Meeting the healthcare needs of veterans”, 2011).

Service personnel need to be made explicitly aware of the specialist services available to them on discharge from the military. Their families and significant others should be made aware of the symptoms to look out for and the services available.

Where appropriate, veterans should be referred to these specialist services and the use of generic psychology services within the NHS should be avoided. Given that it can take a lot of effort for a veteran to seek help, it is important that they are seen quickly and a clear, shared and joined-up plan is put in place. This would require strong links across services. It would be preferable that assessment and treatment can take place within the same service to avoid any unnecessary treatment delay and repetition across services. Given the unique language, norms, and motivations within the military, it will be important for psychologists and other service providers working with this population to increase their cultural competence and knowledge about the needs of the military population and to adapt their therapeutic style accordingly (Reger, Etherage, Reger, & Gahm, 2008). Services for veterans should employ staff with specific experience or knowledge about military culture and the factors influencing veterans. If possible, employing some staff who have served themselves would be important.

Being seen in groups is also likely to increase veterans' retention in treatment due to their perception of sharing an experience with people they can trust and who they respect. Many veterans spoke of the importance of knowing they were not the only one as being a facilitator to treatment. Families or important people in the veterans' lives should be included in the treatment process or given the opportunity to receive their own support where appropriate and requested by the veterans.

Conclusions

This study provided an in-depth insight into the set of barriers and facilitators that are important for UK ex-servicemen. The findings suggest that current focus of quantitative studies and measurement of barriers to care in military personnel are not sufficient for considering the needs UK veterans.

Importantly, there are specific barriers and facilitators that are more relevant at different stages in the veterans' pathway and journey to care. Thus, it will be important for interventions to target these different barriers at different points. Other factors such as self-stigma, fear, and the role of reliance should be explored further in order to tailor interventions appropriately.

There are a range of important facilitators to care, specifically the role of others in encouraging and emotionally and practically supporting veterans to seeking help. It is important that these facilitators are promoted in interventions in order to reduce treatment delay. The recent data suggesting that more veterans are seeking help sooner is encouraging. The current interventions in place need to be built on and refined in order to support this further.

References

Anderson R. (1995). Revisiting the Behavioural Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behaviour. 6*(10), 1-10.

Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilisation. *British Journal of Psychiatry, 179,* 417-425.

Arbisi, P. A., Rusch, L., Polusny, M. A., Thuras, P., & Erbes, C. R. (2013). Does cynicism play a role in failure to obtain needed care? Mental health service utilization among returning U.S. National Guard soldiers. *Psychological Assessment, 25*(3), 991-996.

Blais, R. K., & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress, 26*(1), 77-85.

Berger, J. M., Levant, R., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of Gender Role Conflict, Traditional Masculinity Ideology, Alexithymia, and Age on Men's Attitudes Toward Psychological Help-seeking. *Psychology of Men & Masculinity*, 6, 73-78.

Boldero, J. & Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom? *Journal of Adolescence, 18,* 193-209.

Brewin, C., Garnett, R., & Andrews, B. (2011).Trauma, identity and mental health in UK military veterans. *Psychological Medicine, 41*(8), 1733-1740.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), pp. 77-101.

Britt, T. W., Bennett, E. A., Crabtree, M., Haugh, C., Oliver, K., McFadden, A., & Pury, C. L. S. (2011).The theory of planned behaviour and reserve component veteran treatment seeking. *Military Psychology, 23*(1), 82-96.

Brown, M. C., Creel, A. H., Engel, C. C., Herrell, R. K., & Hoge, C. W. (2011). Factors associated with interest in receiving help for mental health problems in combat veterans returning from deployment to Iraq. *Journal of Nervous and Mental Disease, 199*(10), 797-801.

Busuttil, W. (2010). Combat-related stress. *Promoting men's mental health. Oxford: Ratcliffe*, 125-41.

Collins, P, Barker, C, (2009). Psychological help-seeking in homeless adolescents. *International Journal of Social Psychiatry*, 55(4), 372-384.

Combat Stress (2014). 57% Increase in Afghanistan Veterans seeking mental health support. Retrieved May 23rd 2014 from: http://www.combatstress.org.uk/news/2014/05/57-increase-in-afghan-veterans-seeking-mental-health-support/

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*(9), 765.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*(3), 124-130.

Dedoose Version 4.5, web application for managing, analyzing, and presenting qualitative and mixed method research data (2013). Los Angeles, CA: SocioCultural Research Consultants, LLC.

Fear, N. T., Jones, M., Murphy, D., Hull, L., Iversen, A. C., Coker, B., ...& Wessely, S. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces? A cohort study. *The Lancet*, *375*(9728), 1783-1797.

Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behaviour, 9,* 477-501.

Goldberg, D & Huxley, P. (1992) *Common mental disorders. A bio-social model*. London: Tavistock.

Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., . . . N, G. (2010). Do stigma and other perceived barriers to mental health care differ across Armed Forces? *Journal of the Royal Society of Medicine, 103*(4), 148-156.

Greenberg, N., Langston, V., Everitt, B., Iversen, A., Fear, N. T., Jones, N., & Wessely, S. (2010). A cluster randomised controlled trial to determine the efficacy of Trauma Risk Management (Trim) in a military population. *Journal of Traumatic Stress, 23*(4), 430-436.

Greenberg, N., Thomas, S. L., Iversen, A., Unwin, C., Hull, I., Wessely, S. (2003). Do military peacekeepers want to talk about their experiences: perceived psychological support of UK military peacekeepers on return from deployment. *Journal of Mental Health, 12,* 565-573.

Greene-Shortridge, T.M., Britt, T.W., & Castro, C.A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*(2), 157-161.

Hatch, S. L., Harvey, S. B., Dandeker, C., Burdett, H., Greenberg, N., Fear, N. T., & Wessely, S. (2013). Life in and after the Armed Forces: social networks and mental health in the UK military. *Sociology of Health & Illness, 35*(7), 1045-1064.

Hoge, C. W., Castro C. A., Messer S. C., McGurk, D. Cotting, D. I. & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351,* 13-22.

Iversen, A., Dyson, C., Smith, N., Greenberg, N., Walwyn, R., Unwin, C., ...& Wessely, S. (2005). 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. *The British Journal of Psychiatry*, *186*(6), 480-486.

Iversen, A., Van Staden, L., Hacker Hughes, J., Browne, T., Greenberg, N., Hotopf, M., Rona, R., Wessely, S., Thornicroft, G., & Fear, N. (2010). Help-seeking and receipt of treatment among UK service personnel. *The British Journal of Psychiatry*, *197,* 149-155.

Iversen, A. C., Van Staden, L., Hughes, J. H., Greenberg, N., Hotopf, M., Rona, R. J., ...& Fear, N. T. (2011). The stigma of mental health problems and other barriers to care in the UK Armed Forces.*BMC Health Services Research*, *11*, 31.

Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education & Behaviour*, *11*(1), 1-47.

Jones, N., Roberts, P., & Greenberg, N. (2003). Peer-group risk assessment: a post-traumatic management strategy for hierarchical organizations. *Occupational Medicine, 53*(7), 469-475.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zealand Journal of Psychiatry*, *39*(4), 248-254.

Kehle, S. M., Polusny, M. A., Murdoch, M., Erbes, C. R., Arbisi, P. A., Thuras, P., & Meis, L. A. (2010). Early mental health treatment-seeking among US National Guard soldiers deployed to Iraq. *Journal of Traumatic Stress*, *23*(1), 33-40.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*(12), 1048-1059.

Kim, P., Thomas, J., Wilk, J., Castro, C., &Hoge, C. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services*, *61*(6), 582-588.

Kim, P. Y., Britt, T. W., Klocko, R. P., Riviere, L. A., & Adler, A. B. (2011). Stigma, negative attitudes about treatment, and utilization of mental health care among soldiers. *Military Psychology, 23*, 65-81.

Langston, V., Gould, M., & Greenberg, N. (2007). Culture: what is its effect on stress in the military? *Military Medicine, 172*(9), 931-935

MacManus, D., & Wessely, S. (2013). Veteran mental health services in the UK: Are we headed in the right direction? *Journal of Mental Health*, *22*(4), 301-305.

Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma Associated With PTSD. *Psychiatric Rehabilitation Journal*, *36*(2), 86-92.

Meeting the Healthcare Needs of Veterans (2011). Retrieved on 21st June 2014 from: http://www.rcgp.org.uk/policy/rcgp-policy-areas/veterans-healthcare-needs.aspx

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*, *298*(18), 2141-2148.

Ministry of Defence (2014).UK Armed Forces annual personnel report. Retrieved on 30th May 2014 from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/312539/uk_af_annual_personnel_report_2014.pdf

Momen, N., Strychacz, C. P., & Virre, E. (2012). Perceived stigma and barriers to mental health care in Marines attending the Combat Operational Stress Control program. *Military Medicine, 177*(10), 1143-1148.

Mulligan, K., Fear, N. T., Jones, N., Alvarez, H., Hull, L., Naumann, U., ...& Greenberg, N. (2012). Postdeployment Battlemind training for the UK Armed Forces: a cluster randomized controlled trial. *Journal of Consulting and Clinical Psychology, 80*(3), 331-341.

Ouimette, P. C., Vogt, D. S., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R. E., ...& Rosen, C. S. (2011). Perceived barriers to care among veterans health administration patients with posttraumatic stress disorder. *Psychological Services, 8*(3), 212-223.

Pietrzak, R., Johnson, D., Goldstein, M., Malley, J., & Southwick, S. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric Services, 60*(8), 1118-1122.

Pistrang, N., & Barker, C. (2012). Varieties of qualitative research: A pragmatic approach to selecting methods. In Cooper H (Ed.), *APA handbook of research methods in psychology: Vol. 2 research designs (pp. 5-18).* American Psychological Association.

Reger, M. A., Etherage, J. R., Reger, G. M., & Gahm, G. A. (2008). Civilian psychologists in an Army culture: The ethical challenge of cultural competence. *Military Psychology*, *20*(1), 21-35.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Rogler, L. H., & Cortes, D. E. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry, 150,* 554-561.

Rosen, C. S., Greenbaum, M. A., Fitt, J. E., Laffaye, C., Norris, V. A., & Kimerling, R. E. (2011). Stigma, help-seeking attitudes, and use of psychotherapy in veterans with diagnoses of posttraumatic stress disorder. *Journal of Nervous and Mental Disease, 199*(11), 879-885.

Samele, C (2013). The mental health of serving and ex-Service personnel. A review of the evidence and perspectives of key stakeholders. The Mental Health Foundation. Retrieved on 30th May 2014 from: http://www.mentalhealth.org.uk/content/assets/PDF/publications/the-mental-health-of-serving-and-ex-service-personnel.pdf?view=Standard

Sayer, N., Griedemann-Sanchez, G., Spoont, M., Murdock, M., Parker, L., Chiros, C., & Rosenheck, R. (2009).A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry, 72*(3), 238-253.

Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services, 61*(6), 589-597.

Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behaviour help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity, 9*, 179-192.

Solomon, Z. (2001). The Impact of posttraumatic stress disorder in military situation. *Journal of Clinical Psychiatry*, *62*(17), 11-5.

Stiles, W. B. (1993).Quality control in qualitative research. *Clinical Psychology Review*, *13*(6), 593-618.

Taft, C. T., Vogt, D. S., Marshall, A. D., Panuzio, J. & Niles, B. D. (2007). Aggression among combat veterans: Relationships with combat exposure, symptoms of posttraumatic stress disorder, dysphoria, and anxiety. *Journal of Traumatic Stress, 20,* 135-145.

Tijhuis, M. A. R., Peters, L., & Foets, M. (1990). An orientation toward help-seeking for emotional problems. *Social Science & Medicine, 31*(9), 989-995.

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys Don't Cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counselling Psychology,* 58(3), 368–382.

Vogel, D. L., Wade, N., & Hackler, S. (2007). Perceived public stigma and the willingness to seek counselling: The mediating role of self-stigma and attitudes toward counselling. *Journal of Counselling Psychology, 54,* 40-50.

Vogel, D. L., Wester, S. R., & Larson, L. M. (2007). Avoidance of counseling: Psychological factors that inhibit seeking help. *Journal of Counseling & Development, 85*(4), 410-422.

Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatric Services, 62*(2), 135-142.

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 603-613.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 629-640.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. *Qualitative Psychology: A Practical Guide to Research Methods*, *2*, 235-251.

Zinzow, H. M., Britt, T. W., Pury, C. L., Raymond, M. A., McFadden, A. C., & Burnette, C. M. (2013).Barriers and facilitators of mental health treatment seeking among active-duty army personnel. *Military Psychology*, *25*(5), 514-535.

Part Three: Critical Appraisal

Introduction

This critical appraisal will consider my reflections on some of the practical, methodological, and conceptual issues encountered during the process of conducting research with an ex-military population. Firstly I will consider my own experience of setting up a research project in this area. I will then look at factors relating to recruitment and the process of conducting and analysing the interviews. Throughout the review I will highlight potential considerations that future research in this area might benefit from.

Setting up research with veterans

Working to understand the specific experiences and needs of military veterans was an area that fit with both my desire to conduct clinically-based research, as well as it being an area where there is a lot of current media attention, and government and third sector initiatives. Throughout the process of carrying out this research, from the initial development of a topic, to conducting the interviews and analysing the data, I have had to continually reflect on and consider my own preconceptions and biases. I was aware that my strongest motivation in developing a research idea was finding a topic that would be clinically meaningful with relevant implications for practice. This led to me working with a vulnerable clinical population and is also likely to have framed some of my focus and thinking.

Growing up in Zimbabwe within a culture that can view mental health difficulties in quite a negative way and which does not readily accept the need for mental health treatment, I have always had an interest in what influences the perception of need for and use of services. I held preconceived ideas that perceived public stigma and lack of education and information would be the two defining factors in preventing help-seeking. I had to be careful to 'bracket' these in the

process of conducting the research so as to try and reduce this bias (Creswell & Miller, 2000). Whilst working with a clinical population provides a level of practice-based evidence, it does involve having to overcome a number of practical issues, such as recruitment problems, and these are discussed in more detail below.

Terminology

Despite having some personal interest in the military through having friends and family who serve or who have served in the Armed Forces, I did not have a lot of prior knowledge of the military. Thus, when I was reviewing the literature I initially found some of the terminology confusing. This is something I reflected on following completion of the research and when thinking about some of the themes that arose. I specifically thought about how the veterans described a 'them and us' situation between themselves and civilians and described a particular barrier to treatment in relation to civilians not understanding them. To me, this emphasised the need to make research papers clearer and more accessible to a range of people in order to reduce the gap in knowledge and understanding. Interestingly, this difficulty with some of the terminology was less of a problem in the interviews themselves and I reflect on the possible reasons for this in the interview section below.

An example of the different terminology used is in relation to that of the term 'veteran' which is often used interchangeably to refer to veterans of operational combat as well to ex-service personnel in general. After completing the research, I came across information suggesting that the term 'veteran' is not always adopted by all ex-service personnel, and many younger personnel would not identify with this label, instead seeing it as being more relevant to veterans of the World Wars (Howarth, 2011). This has potentially important implications for both this research,

especially in terms of recruitment, as well as service delivery and how services are made visible and accessible for all.

Limitations of the literature

The literature highlighted a wide variety of potential barriers and facilitators to care and a number of different factors influencing the development of problems; however, there was often a level of contradiction and a number of limitations across the studies. An example is that some studies indicate that serving personnel and veterans are at increased risk of mental health problems/difficulties whereas others found that there was no difference between the rates of mental health problems in serving personnel and in the general population. However, these studies do not always differentiate between personnel who have been in operational combat roles and their amount of combat exposure and those who have not; the role of pre-existing psychological problems; and many only employ screening measures to assess mental health. It is known that those who face greater levels of combat exposure are likely to experience greater levels of mental health problems (Rona et al., 2009). Military personnel are a heterogeneous group and pathways to help-seeking are complex. In addition, the number of potentially confounding factors is large. This is likely to be reflected in the confusion and disparity within the literature.

Previous research into the barriers and facilitators to care in veterans has primarily relied on information from studies with serving personnel in the United States (US). Studies in the United Kingdom (UK) had often used the same measures or built on the findings from the US with an expectation that the populations would be similar. Apart from the cultural and operational differences between US and UK veterans, US veterans are able to access the Veterans Affairs/Administration (VA) for access to integrated healthcare and benefit systems. Their experiences and needs

are considerably different to that of UK veterans. This emphasised the need to do more exploratory and in-depth research in relation to the UK-specific veteran population who have to rely on civilian services.

Study design difficulties

Initially a mixed methods approach was planned. Previous quantitative research had only looked at a limited range of factors using brief measures. Including a broader range of factors and using the qualitative part of the study to triangulate information would have provided a holistic view of the subject area. Whilst the recruitment problems were disappointing and meant that the quantitative part of the study had to be abandoned, they did provide the opportunity to focus on the qualitative arm of study. Qualitative approaches allow the in-depth exploration of an area and can provide new information and understanding (Pope, Ziebland & Mays, 2000), which seemed particularly important when considering the experiences and needs of UK veterans.

Involving two very different services in the research provided a range of information thereby enhancing the credibility of the study; however, it did mean that there were different factors that each service deemed relevant to cover in the research. Thus in developing the focus of the study it was important to balance the methodological rigor with the needs of the services in order to make the research both conceptually and clinically meaningful and useful.

Recruitment within this population

The extent of the difficulties in recruiting, especially for the quantitative arm of this study, was not fully anticipated. Many veterans expressed an interest to their assessing clinician in taking part in the study; however, they were then difficult to contact and follow up. For many who did consent to taking part, a large number did

not return the questionnaires. In addition, it was often difficult to schedule times for those participants who wanted to take part in the interview. A number of appointments were missed or had to be rearranged.

In the feedback from one of the participants on taking part in the study, he highlighted some of the potential reasons he thought that veterans had been less likely to complete the questionnaire or to participate in general. These included veterans being distracted and disorganised, being angry at the military, being lazy, being suspicious about the study, and the idea of taking part in the study being too upsetting. From my experience of conducting this research, I was most aware of participants finding it difficult to schedule time for the interviews and the different levels of importance or relevance that various participants placed on taking part.

Questionnaire design and recruitment

The questionnaire was quite long and there was no monetary incentive to complete it. Both these factors have been found to reduce response rates (Cook, Heath, & Thompson, 2000; Porter, 2004). Although the Ministry of Defence is working towards increasing the basic skills of service personnel, approximately two fifths of recruits are reported to have the reading age equivalent to an 11-year-old (Sellgren, 2013). It is possible that potential participants were put off completing the questionnaire by both the length and the level of literacy that was required. Whilst every effort was made to make all the information accessible in this study, this is an area that would benefit from more consideration in future studies.

Participants were approached either during their initial assessment or during the early part of their treatment regarding taking part in the study. It is possible that the timing of the invitation to the research might have influenced the willingness of some potential participants to take part. In the interviews, many veterans described

experiencing considerable anxiety prior to their first assessment, and they also often only attended after things in their lives had reached a crisis point. Thus it is likely that many of the veterans were in a state of considerable distress at their initial assessment. They are likely to have found the amount of information they were given overwhelming and it may be that taking part in the research was low on their list of priorities. Additionally, clinicians often have a lot of things they have to cover in the assessment and the invitation to take part may have not been given the full attention or priority it could have benefitted from. It may have been better to approach potential participants further along in the process. However, many veterans do not attend follow-up appointments, and even fewer attend for the full course of treatment (Seal et al., 2010).

Reasons for non-participation

The barriers that the veterans highlighted as impacting on their help-seeking and staying in treatment are likely to be similar to the barriers to participation in the study, for example, a lack of trust and suspiciousness in relation to civilian service providers. Some veterans in this study expressed anger at, and disillusionment with, the service received from military and from other civilian-based mental health services. It is possible that carryover effects from these experiences may have also influenced participation. Other research has shown that stigma (Corrigan, Watson, Warpinski, & Gracia, 2004), loss of confidentiality (Hewison & Haines, 2006), concerns about costs (Unger et al., 2013), and mistrust (Shavers-Hornaday, Lynch, Burmeister, & Torner), are often reasons for non-participation.

The subject matter of a research project and its salience and relevance to potential participants are also likely to influence their involvement (Cook et al., 2000). The pathway to care for veterans is complex and that participants were

approached at different points in their pathway to care and had different levels of recognition of their problem and need for help. Therefore, they were likely to have different perceptions of how relevant and meaningful the research was to them. Bayley et al. (2014) found that the most important factors related to a low response rate in studies were a lack of interest in the study and failure to answer follow up.

Social exchange theory suggests that research participants are more likely to take part when they trust "that the expected rewards of responding will outweigh the anticipated costs" (Dillman, 2007, p. 27). It was notable that during the interviews, a number of veterans spoke passionately about wanting to help others not to have a similar experience to them as a motivation for doing the research. This was particularly the case for the veterans recruited from the residential programme. These veterans were likely to have had more time to reflect on their experience of seeking help. For those who declined to participate, it may have been that the potential benefits of taking part were less evident, that they were experiencing severe mental health difficulties, or that their experience of mental health services had not been good and made them not want to have any further contact. One veteran taking part in the interviews highlighted the fact that the nature of the study meant that taking part in the interviews at the London National Health Service community service was limited to only those that had the spare time and cash to attend, who could attend during working hours, and who did not live too far away. This reflects some of the practical barriers also discussed in the interviews.

There was an erroneous expectation by the research team that because veterans are used to completing forms, and have to complete them as part of the standard initial assessment, that they would be happy to do this in relation to this study. Whilst it is true that serving personnel are expected to complete forms

regularly in the course of their service, this is part of their employment and determined by the military. It is important to consider willingness of participants. During military service, they may feel that it is something they have to do, and an inconvenience. A couple of participants mentioned just going through the motions when completing questionnaires whilst serving, and that they were unlikely to answer them truthfully, fearing the consequences. During the research, it came to the team's attention that we could not use one of the research sites at Charity Veterans Service because the veterans there were being asked to take part in numerous research studies. Research study overload in this population is an important consideration, especially within the specialist services they are accessing.

Interview process

The interviews relied on a convenience sample. This may have introduced a level of bias to the study as those veterans who chose to and who were able to take part may have shared similar characteristics and views (Bayley et al., 2014).

The veterans who took part in the interviews generally appeared to be very engaged in the process and this was evidenced by the richness of data gathered in the interviews. However, the fleeting nature of their engagement was confirmed by the fact that despite being very positive about the nature of the study and expressing an interest in continuing to contribute to the study, only a minority responded to attempts to follow them up for feedback on the themes arising.

Power differentials

Throughout the interview process, I was acutely aware of power differentials that may exist, especially given that the interviews were taking place in the services where the veterans were receiving treatment. Interview sites can provide a place to enact and exacerbate power relationships (Elwood & Martin, 2000). Veterans were

recruited from two services; however, the majority had come through the same route of entry via the CVS welfare officer. All the veterans spoke very positively about the welfare officer, specifically his military background and that he had come to their house at a time convenient for them. It is possible that negotiating a place of meeting with potential participants may give them more power in the interaction and increase participation and engagement. The participants in the residential programme had committed to a six-week residential treatment programme. This commitment might mean that they had more time to reflect on their experiences. Further analysis of any differences between the participants in different services may further facilitate understanding of issues of power between the researcher and the participants.

The military culture revolves around levels of hierarchy and power and I did consider that elements of the interview situation might enact some of these. Despite attempts to reduce power imbalances in the interview situation, it cannot be ignored that all interactions and communications have some level of inherent power dynamic and the fact that in interviews, the interviewer introduces topics and directs the questions (Kvale, 1996). Interestingly, and in contrast to the expected direction of the power differential, I occasionally experienced some of the veterans as believing they had attributes or experiences that meant they were superior to civilians, which probably also links with the 'them and us' dynamic mentioned previously. For example, some of the veterans spoke about Post Traumatic Stress Disorder being something that only civilians who were not strong enough to cope would get. This made me wonder if this element of superiority linked with one of the barrier themes in the data concerning mental health problems not being seen as relevant to the individual. That is, the veterans viewed themselves as too highly trained and too physically and mentally strong, and thus above being affected by these problems.

Servicemen feeling contempt towards, and viewing themselves as superior to, civilians has been shown in other studies (Brewin, Garnett, & Andrews, 2011). Whilst I can see how this view of themselves is very protective whilst serving, I wondered too if this was an element that made interacting and reintegrating with civilian life difficult. This is an area that would benefit from further exploration.

Factors related to the interview

I was aware of potential difficulties engaging this population group and was also aware that I did not want to reinforce any of their potentially negative experiences of help-seeking. Given that participants were all male and ex-military, I also considered my role as both a woman and a civilian and how this might impact the rapport I was able to build. I noticed that I employed a more open stance to going through the interview schedule and allowed the participants to lead the telling of their story of help-seeking. I was able to follow up leads and prompt certain lines of enquiry more easily this way. I found that keeping brief notes whilst interviewing ensured that I was able to ask all the questions relevant to the areas covered by the interview. I think that adopting a more open and flexible approach to the interview aided engagement, as I was really able to listen to and understand the veterans stories. However, in doing so I became aware of the pull to be more therapeutic-based compared to research-based and focused on information gathering, which I tried to monitor through regular reflection during the interviews and when listening back to them afterwards. From reading the literature, I increased my awareness of a number of current issues (e.g. the Trauma Risk Management programme and decompression following operations), as well as the terminology relevant to military personnel. I think this aided rapport building within the interview situation.

Many of the veterans spoke passionately about their ideas about how things could be different. Future research may want to consider how to involve veterans more in the research process in conceptualisation, analysis, and authorship (Gordon, 1998). This is likely to expand the current understanding in this area. Reflecting on the methodology, I think it may have been helpful to include veterans in consultation around the interview schedule. This may have increased the depth of information gained. At the time it was thought that consulting with clinicians working with veterans would provide a good level of information in relation to the important areas to be considered; in hindsight, including veterans would have been the best practice.

Analysis

Good thematic analysis of data goes beyond just following procedures and involves becoming fully involved with the data (Corbin & Strauss, 2000). Having conducted all the interviews and completed the majority of the transcription, I believe I had a strong understanding and familiarity with the data which increased my sensitivity and allowed me to pick up on significant issues (Corbin & Strauss, 2000). As highlighted above, it was important for me to be reflective and to consider the role of my own prior knowledge, views, and experiences in interpreting the data. However, I am aware that we cannot fully account for all these factors and therefore it was important to consult with others and to have a wide variety of informants from different sites, including both the participants and the service providers, to comment on the themes gathered from the data. This provided a form of triangulation to increase the credibility of the data (Shenton, 2003).

Thematic analysis allowed a flexible approach that is compatible with other methods (Braun & Clarke, 2006), and this suited the needs of this research study well. The use of a web-based programme (Dedoose, 2013), to support the analysis of

the data provided a clear, convenient and user-friendly way to code data, compare themes and assess for internal consistency by constant comparison (Corbin & Strauss, 2000). It allowed easy and ready access to information that could be manipulated and presented in a range of different ways. However, the risks of relying on this method were made clear by the fact that during the analysis and write up of the data, Dedoose's server crashed and all saved data was lost.

The choice of using a narrative approach to augment the thematic analysis grew out of there being a large amount of data that was generally in the form of a story of the veterans' pathways to care. Narrative approaches have been used and found to provide coherence and organisation of information (Riessman, 1993), and consider how the story told relates to the events it explains (Hollway & Jefferson, 2000). Thus, a narrative approach fitted with the needs and nature of the data. There are a large number of different approaches and ways of organising data that come under the banner of narrative analysis (Riessman, 1998). This initially proved quite difficult in relation to narrowing it down and choosing a particular method that fitted with the needs of this study. The choice of method developed from the experience of one of the supervisors using a similar approach in relation to a help-seeking study with adolescents (Collins & Barker, 2009). This approach provided a method of structuring and organising the data in a way that closely matched the stories told by the participants. In addition, further narrative analysis within the themes and across the participants helped bring the stories to life. I believe that this increased the face validity of the findings. However, the diversity and disparity across different methods reinforced the difficulties inherent in conducting robust qualitative analysis.

Conclusions

Conducting research in this area has not been without its difficulties and methodological concerns. The recruitment problems particularly emphasise some of the day to day reality of trying to engage veterans in services. Additionally, the use of a qualitative approach, whilst valuable, does restrict the ability to generalise some of the findings. However, in spite of this, I believe this study has provided an important insight into the experiences and needs of a vulnerable population. I hope that future research can build on this work and that services will consider some of the recommendations made in relation to engaging and treating veterans in the UK.

I think consideration needs to be given to how to reduce the gap in understanding between veterans and civilian service providers and researchers in this area. I believe that this will require two different sets of focus. The first is that civilian service providers need to be more informed about the needs of veterans and the important terminology that they might use. Researchers in this area have a level of responsibility in relation to making studies accessible and clear to all, including those outside of the field. The second is that involving veterans beyond just being participants and including them in the conceptualisation and undertaking of research might broaden the understanding and focus of studies as well as better inform the type of interventions required, and also help recruitment.

References

Bayley, P. J., Kong, J. Y., Helmer, D. A., Schneiderman, A., Roselli, L. A. ...& Chapman, J. C. (2014). Challenges to be overcome using population-based sampling methods to recruit veterans for a study of post-traumatic stress disorder and traumatic brain injury. *BMC Medical Research Methodology*, *14,* 48.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Brewin, C. R., Garnett, R., & Andrews, B. (2011).Trauma, identity and mental health in UK military veterans. *Psychological Medicine*, *41*(8), 1733-1740.

Collins, P., & Barker, C. (2009). Psychological helpseeking in homeless adolescents. *International Journal of Social Psychiatry*, 55, *4*,372-384.

Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in Web- or Internet-based surveys. *Educational and Psychological Measurement, 60,* 821-836.

Corrigan, P. W., Watson, A. C., Warpinski, A. C., & Gracia, G. (2004). Stigmatising attitudes about mental illness and allocation of resources to mental health services. *Community Mental Health Journal, 40(*4), 297-307.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-130.

Dedoose Version 4.5, web application for managing, analyzing, and presenting qualitative and mixed method research data (2013). Los Angeles, CA: SocioCultural Research Consultants, LLC.

Dillman, D. A. (2007). *Mail and Internet Surveys: The tailored design method. 2007 update with new Internet, visual, and mixed mode guide (2nd ed.).* New York: John Wiley & Sons.

Elwood, S. A., & Martin, D. G. (2000). "Placing" interviews: location and scales of power in qualitative research. *The Professional Geographer, 52(*4), 649-657.

Gordon N. (1998) Critical reflection on the dynamics and processes of qualitative research interviews. *Nurse Researcher,* 5, 72-81.

Hewison, J., & Haines, A. (2006). Overcoming barriers to recruitment in health research. *British Medical Journal, 333(*7562), 300-302.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. Sage.

Howarth, G. (2011). *Draft veterans' ('ex-military') health needs assessment for Kent and Medway.* Retrieved on 20th June 2013 from: file:///C:/Users/Carly/Downloads/Veterans%20Health%20Needs%20Assessment%20Draft%207.0.pdf

Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing.* Sage

Porter, S. R. (2004). Raising response rates: What works? *New Directions for Institutional Research, 121*, 5-21.

Pope, C., Ziebland, S., & Mays, N. (2000) Analysing qualitative data. British Medical Journal, 320, 114-116.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Rona, R. J., Hooper, R., Jones, M., Iversen, A. C., Hull, L., Murphy, D., ...& Wessely, S. (2009). The contribution of prior psychological symptoms and

combat exposure to post Iraq deployment mental health in the UK military. *Journal of Traumatic Stress*, *22*(1), 11-19.

Shavers-Hornaday, V. L., Lynch, C. F., Burmeister, L. F., & Torner, J. C. (1997). Why are African Americans under-represented in medical research studies? Impediments to participation. *Ethnicity & Health*, *2*(1-2), 31-45.

Sellgren, K. (2013). Almost 40% of army recruits have reading age of 11, MPs warn. Retrieved on 30th May 2014 from: www.bbc.co.uk/news/education-23346693.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63-75.

Unger, J. M., Hershaman, D. L., Albain, K. S., Moinpout, C. M., Petersen, J. A., Burg, K., Crowley, J. J. (2013). Patient income level and cancer clinical trial participation. *Journal of Clinical Oncology, 31(*5), 536-542.

Appendices

Appendix 1. Glossary of Military Terms.....131

Appendix 2. Participant Information Sheets and Consent Forms.....134

Appendix 2.1 Recruitment Flyer.....135

Appendix 2.2 Participant Information Sheet.....136

Appendix 2.3 Consent Form – Questionnaire.....138

Appendix 2.4 Consent Form – Interview.....139

Appendix 3. Semi-Structured Interview Schedule.....140

Appendix 4. Notification of Ethics Approval.....143

Appendix 4.1 NRES Committee North West Liverpool East approval.....144

Appendix 4.2 Combat Stress Ethics Committee approval.....151

Appendix 4.3 Substantial Amendment One.....152

Appendix 4.4. Substantial Amendment Two.....155

Appendix 5. Transcript and Coding Examples.....158

Appendix 1.

Glossary of Military Terms

Glossary of Military Terms

Active duty personnel: refer to regular personnel.

Combat support: are units which primarily provide logistical support by providing supply, maintenance, transportation, health services, and other services required by the soldiers of combat units to continue their missions in combat.

Deployment: Any activity that relates to duty in the Armed Forces that involves an operation, location, command, or duty that is different from the person's normal duty assignment Deployment generally relates to going on an operational tour to an area of combat (e.g. being deployed for service in Iraq or Afghanistan).

Military personnel: This is a blanket term to refer to members of all three branches of the Armed Services (Army, Navy, Air Force).

National Guard: This is the reserve and state organised units of the US Army and Air Force. It is composed of citizens who voluntarily enlist and who undergo standard military training. They are trained to work with regular forces and are available for service in national and local emergencies. The majority of National Guard personnel hold a civilian job while serving part-time as a National Guard member.

Officers and Non-Commissioned Officers: an officer is a member of an armed force or uniformed service who holds a position of authority.

Commissioned Officers are graduates of military academies or officer training schools. They derive authority from her Majesty the Queen. Commissioned officers are typically the only persons in an armed forces environment able to act as the commanding officer of a military unit. Officer ranks include Colonels, Majors, and Captains.

Non-commissioned officers (NCOs) usually obtain their position of authority by promotion through the enlisted ranks. The NCO is the one who handles the troops on a daily basis. The officers give the idea of what must be done and the NCO puts that into practice. Non-commissioned officer ranks include corporals, sergeants, and staff sergeants.

Regular personnel: Their full time employment is in a branch of the Armed Forces. They are involved in full-time duty in the active military service.

Unit: is a homogeneous military organization (either combat, combat-support or non-combat in capability) that includes service personnel predominantly from a single arm of service, or a branch of service. Its administrative and command functions are self-contained.

Veteran: for the purpose of this paper, the term veteran refers to ex-servicemen regardless of the length and nature of their service within the UK Armed Services (Army, Royal Air Force, and the Royal Navy). Where the term relates to veterans of combat (who may still be serving), this will be specifically highlighted.

Veterans Affairs/Veterans Administration: is a US government-run military benefit system for veterans and their dependents. It provides an integrated health care system including hospitals, clinics, community living centres, housing, readjustment counselling centres, and other facilities.

Appendix 2.

Participant Information Sheets and Consent Forms

Appendix 2.1

INVITATION TO TAKE PART IN A STUDY LOOKING AT THE BARRIERS AND FACILITATORS TO CARE OF MILITARY VETERANS

Would you like to take part in a study of help-seeking for military veterans? We hope that the information from this study will help develop services to support other ex-servicemen, who may be in a similar situation, to get the right sort of help as soon as possible.

What does it involve?

- Filling out a set of questionnaires

- And if you would like to, taking part in a face-to face interview with a researcher about your journey to seeking help.

What happens next?

The person you meet for your appointment will give you an information sheet about the study and ask if you are happy to be contacted by the researcher with regards to taking part.

If you are happy to take part, please let them know if you would prefer to be contacted via telephone, post, or email.

Many thanks in advance for considering taking part

If you would like any further information, please contact:
Carly Huck, Trainee Clinical Psychologist.
Email: [redacted]
Telephone: [redacted]

Appendix 2.2

PARTICIPANT INFORMATION SHEET

Barriers and facilitators in the pathway to care of military veterans
(Student Research Project)

We would like to invite you to take part in this study. Before you decide you want to take part, it is important for you to understand what the study involves and why we are doing it. The information below will help you to make your decision. Please ask us if there is anything unclear or if you would like more information.

What is the purpose of the study?
This study is being carried out by researchers at UCL in collaboration with the [service names]. We would like to find out about the things that make it easier or more difficult for military veterans to seek help for mental health problems. We hope that this study will help us to better meet the mental health needs of veterans and to help inform services that provide support to veterans.

Why have I been invited to take part?
You have been invited to participate in the study as this is the first time you have been seen at Combat Stress. We are inviting all veterans referred to the service to take part.

Do I have to take part?
Participation in any part of the study is completely voluntary. You are free to withdraw at any point in the process, without giving a reason. Your decision will not affect the standard of care you receive with Combat Stress.

What will happen to me if I choose to take part?
The clinician you meet with as part of your assessment will ask if you are willing to be contacted by the researcher to gain your consent to take part. If you opt in, you will be asked whether you would prefer to be contacted by telephone, post, or online, and will be asked to provide contact details in relation to this. We will then ask for your consent to take part in the study and explain any further questions you have.

There are two parts to the study. You can choose to take part in one, both, or neither.

Part 1
You will be asked to complete a set of questionnaires anonymously. The questionnaires will ask about your views in relation to seeking help for mental health problems, and some of the things that might have supported or acted as barriers in this process. This should take about half an hour to forty minutes of your time. We will also ask for your consent for us to have access to your files held by [service name]. This will allow us to use information you provide as part of your assessment at [service name] and reduce the number of questions we need to ask in the survey.

Part 2
You will also be asked if you are willing to take part in a face-to-face interview with the researcher, Carly Huck (Trainee Clinical Psychologist), at [service name] at a later date. We will ask for your separate consent in relation to this and will send a letter to the clinical team at [service name] to let them know that you are taking part. The interview will be audio recorded; however, all identifiable information will be removed to ensure your confidentiality. The interview will take about an hour and will involve you being asked questions in relation to your experience of seeking help for your difficulties.

What will happen to the information I provide?
Information from the questionnaires will be analysed to identify the factors that influence veterans seeking help for mental health problems and difficulties. Information from the interviews will be transcribed to help us analyse the data. The analysis will be carried out by the research team to identify the main ideas expressed by everyone that participated. All participant identities will be confidential and all data anonymised. This research is part of an academic qualification and results will be written up as part of a doctoral thesis which may also be published in a peer-reviewed scientific-journal and other places. All participant identities will be confidential and all data anonymised.

What are the risks and benefits of taking part?
Thinking about your experience of getting help can possibly be upsetting. It may be that some difficult memories are evoked. If so, you will be able to take a break or stop all together. You also do not have to answer any questions that you might find difficult. If you withdraw, information collected up until that point may still be used.

It may also be helpful to take part. Many people find that reflecting on their experience can be beneficial. Your participation may help improve future services for veterans. Participants taking part in the interview will receive a £10 store or travel voucher as thanks.

Will my taking part in this study be kept confidential?
All data will be collected and stored in accordance with the Data Protection Act 1998. Your answers to the questionnaires will be confidential. Questionnaires will be identifiable by number only.

Audio recordings from the interviews will be stored on a password-protected computer and will be securely destroyed once transcripts have been made. Audio recordings will be kept for no longer than 2 weeks. Names and other personally identifiable information will be removed from transcripts to ensure anonymity. We may include direct quotations from interviews in the published report but will not include names of participants and we will make sure that any quotations we use cannot be linked to individuals. We will store the anonymous interview transcripts in a secure location for up to twenty years.

What if there is a problem?
If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. If you would like to speak to an independent person about this, please contact Camden and Islington NHS Foundation Trust Advice and Complaints Service (was **PALS**) on **020 3317 3117.**

In the unlikely event that you are harmed by taking part in this study, compensation may be available. If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. Any potential claims should be made in writing to Dr Chris Barker who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Contacts
If you have any further questions about this study please contact Carly Huck, Trainee Clinical Psychologist, University College London. Email: c.huck@nhs.net, Tel: **07855429719**

Thank you for considering taking part in this study

Appendix 2.3

CONSENT FORM – QUESTIONNAIRE

Barriers and facilitators in the pathway to care of military veterans

(Student research project)

Name of Researchers: Chris Barker (Chief Investigator), Carly Huck(Researcher), and Ken Carswell (Co-Investigator)

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 06.01.2014, v3.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my current or future medical care or legal rights being affected. I understand that any information provided up to the point of withdrawal may be kept in the study. ☐

3. I give permission for the researchers to have access to my assessment records held by [service name]. I understand that they will use this anonymously for research purposes ☐

4. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from UCL, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

If you are happy to be contacted at a later point to see if you would like to take part in a follow-up face-to face interview with a researcher, please tick here. ☐

If you would like a copy of the final results from the study, please write your email or postal address below:

Appendix 2.4

CONSENT FORM – INTERVIEW

Barriers and facilitators in the pathway to care of military veterans

(Student research project)

Name of Researchers: Chris Barker (Chief Investigator), Carly Huck (Researcher), and Ken Carswell (Co-Investigator)

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 06.01.2014 (v3.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the interview at any time without giving any reason. I understand that this will not affect my current or future medical care or legal rights being affected. I understand that any information provided up to the point of withdrawal may be kept in the study. ☐

3. I understand that the information I provide will be audio taped, recorded and saved on a computer. It will be anonymised, transcribed, and then the original recording will be erased. All information will be used for the purpose of this research only. ☐

4. I understand that there is a possibility of direct quotes from my interview being included in the final report. I understand that these quotes will be made completely anonymous. ☐

5. I agree to the clinical team at [sevice name] being informed of my participation in the study. ☐

6. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from UCL, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

7. I agree to take part in the interview in relation to the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Appendix 3.

Semi-Structured Interview Schedule

Qualitative Semi-Structured Interview

We are interested in understanding some of the reasons veterans may seek-help for emotional difficulties, or problems controlling their emotions. We are also interested in finding out who they seek this help from, and what factors either help or discourage people from seeking help. We would be grateful if you could participate in an interview in relation to your own personal experience of seeking help. There are no right or wrong answers, so please just answer the questions openly and with as much information as you feel able to give.

1. **Could you tell me a bit about what has been going on for you that led you to coming to this service?**

2. **Explore development of problem/s**
   Prompts – When did they start, what factors contributed to the difficulty occurring, relationship to tours and military experience?

3. **What did you notice happen/change first?**
   - **What first prompted you to think that something might be wrong?**

   Prompts – What feedback did you get from others around you,
   What did you think was going on/how did you explain it?

4. **Help-seeking**
   - **What/if anything did you do when you first thought something might be wrong?**

   Prompts - What type of information or help did you try to access and where from?

   - **What prompted you to seek help or speak to someone else?**

   Prompts - Why did you choose this person/type of help?
   What were your thoughts about seeking this type of help/speaking to this person? What did you think about yourself for seeking help? What did you think others might think of you for seeking help?

   - **Was there anything that stopped you or held you back from seeking help/speaking to someone else? If so, what was it?**

   Prompt – issues related to stigma, ideas of strength and coping etc

   - **What things helped/led to you actually seeking help/speaking to someone else?**

   - **How long did it take between noticing something was wrong and first seeking help?**

5. **Professional help-seeking prompts (if the above is not formal help)**
   - **What was the first type of professional help you sought?**

   Prompts - Did anyone else encourage/discourage you to do so? What was their view? What were your thoughts about seeing a professional (positive and negative)?

   - **What was your experience of seeking help from civilian services (if appropriate)?**

   Prompts - How did you find this help?

- **Did anything hold you back/stop you from actually seeking professional help before you did?**

Prompts - What did you think about yourself for seeking professional help? What do you think others might think of you for seeking professional help? What were some of the difficulties accessing this help?

- **What was the outcome of this?**

6. <u>Experience of seeking-help</u>

What was your experience of first seeking help?

Prompt – investigate helpfulness of responses, explore differences from military experience if civilian helping services

N.B. If not covered in the questions above – check the participant's experience of seeing their GP and whether they were referred to IAPT and their experience of this.

7. <u>Perception of support</u>

- **When your problem started developing, how did you view the support available for you?**

Prompts – What support was available to you? Support from military, support from family and friends, other service personnel, Perception of NHS and civilian support

8. Thinking back over your experience of seeking help, what would you have changed to have made your experience of seeking help improved?

a. What would you change about the military and access to help
b. What about accessing civilian services?
c. How might you have been encouraged to seek help sooner?

9. If given the choice, would you have a preference for getting help from specialist veteran clinics within the NHS or within in the Third Sector?

- If indicate a preference, explore why so.

10. Any other comments about the process of seeking help?

Appendix 4.

Notification of Ethics Approval

Appendix 4.1

National Research Ethics Service
NRES Committee North West - Liverpool East
HRA NRES Centre Manchester Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ
Telephone: 0161 625 7832
Facsimile: 0161 625 7299

05 June 2013

Professor Chris Barker
Professor of Clinical Psychology
University College London
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street, London
WC1E 6BT

Dear Professor Barker

Study title:	**Barriers and facilitators in the pathway to care of military veterans**
REC	**13/NW/0436**
IRAS	**124560**

The Proportionate Review Sub-committee of the NRES Committee North West - Liverpool East reviewed the above application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Helen Penistone, nrescommittee.northwest-liverpooleast@nhs.net.

Ethical opinion
On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. The following points relate to the Participant Information Sheet:

- It should state that 'your participation **may** help improve…', not **will** help
- There should be an independent contact for any complaints provided rather than asking the reader to contact the researcher. There should be a named contact and telephone number.
- It should be explicit that the research is being undertaken as part of an academic qualification. This should be stated in the third person, please change this in the information sheet for questionnaires and interviews.

- It should be clear that a letter will be sent to the patient's clinical team as per the consent form.
- It should be clearly stated how long it would be before recordings of the interviews would be securely destroyed.
- Within the Participant Information Sheet it states that should 'you withdraw, information collected up until that point may still be used' however on the consent form it says it 'will still be used.' Please correct accordingly.

Also, on the flyer please correct the spelling of the word facilitator. Within section A53 it states that participants will be asked on the consent form if they want a copy of the results from the study. This needs adding to the consent form.

Ethical review of research sites
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion
The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Advertisement	Flyer - 1.0	17 April 2013
Evidence of insurance or indemnity	UCL	
GP/Consultant Information Sheets	1.0 -	21 May 2013
Interview Schedules/Topic Guides	1.0 -	17 April 2013
Investigator CV	Professor Chris	
Investigator CV	Miss Carlene Huck	
Investigator CV	Dr Ken	
Participant Consent Form: Questionnaire - LVS	1.1	17 April 2013
Participant Consent Form: Interview - LVS	1.1	17 April 2013
Participant Consent Form: Questionnaire -	2.1	17 April 2013
Participant Information Sheet: LVS	1.1	17 April 2013
Participant Information Sheet: Combat Stress	2.1	17 April 2013
Protocol	1.2	17 April 2013
Questionnaire: The General Help-seeking	Validated	
Questionnaire: Inventory of Attitudes Towards	Validated	
Questionnaire: Medical Outcomes Study: Social	Validated	
Questionnaire: Self-Stigma of Seeking Help	Validated	
Questionnaire: Male Norms Role Inventory	Validated	
Questionnaire: Demographic Information	1	17 April 2013
Questionnaire: Barriers to Care Questionnaire	1	17 April 2013
Questionnaire: Barriers to Help-seeking Scale -	1	17 April 2013
Questionnaire: Barriers to Help-seeking Scale -		
REC application	3.5	23 May 2013
Referees or other scientific critique report		18 October
Summary/Synopsis	1.0 - Flow	07 March 2013

Membership of the Proportionate Review Sub-Committee
The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website. information is available at National Research Ethics Service website > After Review

13/NW/0436 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members'training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

On behalf of
Mrs Glenys J Hunt
Chair

Email: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: List of names and professions of members who took part in the review

"After ethical review – guidance for researchers"
A Research Ethics Committee established by the Health Research Authority

Copy to: Miss Carlene Huck
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street, London
WC1E 6BT

Dr Ken Carswell the Traumatic Stress Centre
73 Charlotte Street
London
W1T 4PL

Dr Clara Kalu R&D 1st Floor
Maple House
Rosenheim Wing, Ground Floor
25 Grafton Way, London
WC1E 6DB

Mrs Angela Williams
Camden & Islington NHS Foundation Trust
3rd Floor, West Wing St Pancras Hospital
125-133 Camden High Street
London
NW1 7JR

Dave Wilson
R&D Department
University College London
25 Grafton Way, London
WC1E 6DB

NRES Committee North West - Liverpool East
Attendance at PRS Sub-Committee of the REC meeting

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mrs Glenys J Hunt	Lay member	Yes	
Mr Chris Irving	Biomedical Scientist	Yes	
Miss Kimberley Saint	Trainee Clinical Scientist	Yes	

Health Research Authority

National Research Ethics Service
NRES Committee North West - Liverpool East
HRA NRES Centre
Manchester Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

06 August 2013

Miss Carlene Huck
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street London WC1E 6BT

Dear Miss Huck

Study title:	**Barriers and facilitators in the pathway to care of military veterans**
REC reference:	**13/NW/0436**
IRAS project ID:	**124560**

Thank you for your email of 05 August 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 05 June 2013

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering email from Carlene Huck		05 August 2013
Participant Information Sheet: Combat Stress	2.2	12 June 2013
Participant Information Sheet: LVS	1.2	12 June 2013
Participant Consent Form: Questionnaire - LVS	1.2	12 June 2013
Participant Consent Form: Interview	1.2	12 June 2013
Participant Consent Form: Questionnaire -	2.2	12 June 2013
Advertisement	Flyer	

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of insurance or indemnity	UCL	

GP/Consultant Information Sheets Letter to clinical team about participation	1.0 -	21 May 2013
Interview Schedules/Topic Guides Qualitative Questionnaire	1.0 -	17 April 2013
Investigator CV: Professor Chris Barker		
Investigator CV: Miss Carlene Huck		
Investigator CV: Dr Ken Carswell		
Protocol	1.2	17 April 2013
Questionnaire: The General Help-seeking	Validated	
Questionnaire: Inventory of Attitudes Towards Help-	Validated	
Questionnaire: Medical Outcomes Study: Social Support	Validated	
Questionnaire: Self-Stigma of Seeking Help	Validated	
Questionnaire: Male Norms Role Inventory	Validated	
Questionnaire: Demographic Information	1	17 April 2013
Questionnaire: Barriers to Care Questionnaire	1	17 April 2013
Questionnaire: Barriers to Help-seeking Scale –	1	17 April 2013
Questionnaire: Barriers to Help-seeking Scale –		
REC application	3.5	23 May 2013
Referees or other scientific critique report		18 October 2012
Summary/Synopsis	1.0 - Flow Chart	07 March 2013
Participant Information Sheet: Combat Stress	2.2	12 June 2013
Participant Information Sheet: LVS	1.2	12 June 2013
Participant Consent Form: Questionnaire - LVS	1.2	12 June 2013
Participant Consent Form: Interview	1.2	12 June 2013
Participant Consent Form: Questionnaire - Combat	2.2	12 June 2013
Advertisement	Flyer	

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0436 **Please quote this number on all correspondence**

Yours sincerely

Miss Helen Penistone
Committee Co-ordinator

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Appendix 4.2

Reply to: Tyrwhitt House
Oaklawn Road
Leatherhead
Surrey KT22 0BX
Tel: (01372) 587107
Fax: (01372) 587081
Email: walter.busuttil@combatstress.org.uk

Dictated 22nd October 2013

Ms Carlene Huck
Trainee Clinical Psychologist
Research Department of Clinical, Educational & Health Psychology
University College London
Gower Street
London WC1E 6BT

Dear Ms Huck,

Re: Research Proposal Barriers and Facilitators in the pathway to care of military veterans study

I am delighted to inform you that your research proposal has been approved by the Combat Research & Ethics Committee.

Your point of contact will be Dr Mark Hinton Consultant Clinical Psychologist and Head of Psychology and Psychological Therapy.

I wish you well, in your research, and the very best of luck.

Yours sincerely,

[redacted]

Dr Walter Busuttil MB ChB MPhil MRCGP FRCPsych
Consultant Psychiatrist
Medical Director

c.c. Dr Mark Hinton

Appendix 4.3

Health Research Authority
National Research Ethics Service
NRES Committee North West - Liverpool East
HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ
Tel: 0161 625 7832
Fax: 0161 625 7299

23 October 2013

Miss Carlene Huck
Research Department of
Clinical, Educational and
Health Psychology
University College London
Gower Street, London
WC1E 6BT

Dear Miss Huck

Study title:	**Barriers and facilitators in the pathway to care of military veterans**
REC reference:	**13/NW/0436**
Amendment number:	**Substantial Amendment 1**
Amendment date:	**08 October 2013**
IRAS project ID:	**124560**

The above amendment was reviewed at the meeting of the Sub-Committee held on 17 October 2013.

Ethical opinion
Approval was sought to add questions to the demographic questionnaire and qualitative interview.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents
The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMPs): Substantial Amendment		08 October 2013
Questionnaire: Demographic Information	2.1	26 September 2013

Interview Schedules/Topic Guides	1.2	01 September 2013

Membership of the Committee
The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

13/NW/0436: Please quote this number on all correspondence

Yours sincerely

[redacted]

On behalf of
Professor Neil Pender
Vice-ChairNRES Committee North West - Liverpool East

Enclosures: List of names and professions of members who took part in the review

Copy to:
Professor Chris Barker
Professor of Clinical Psychology
University College London
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street, London
WC1E 6BT

Mrs Angela Williams
Camden & Islington NHS Foundation Trust
3rd Floor, West Wing St Pancras Hospital
125-133 Camden High Street
London
NW1 7JR

Attendance at Sub-Committee of the REC meeting on 17 October 2013

Name	*Profession*	*Capacity*
Professor Neil Pender	Professor of Orthodontics	Expert
Dr Peter Walton	Lay Member	Lay

Also in attendance:

Name	*Position (or reason for attending)*
Miss Helen Penistone	REC Manager

Appendix 4.4

Health Research Authority
National Research Ethics Service
NRES Committee North West - Liverpool East
HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ
Tel: 0161 625 7832
Fax: 0161 625 7299

20 January 2014

Miss Carlene Huck
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London
WC1E 6BT

Dear Miss Huck

Study title:	**Barriers and facilitators in the pathway to care of military veterans**
REC reference:	**13/NW/0436**
Amendment number:	**Substantial Amendment 2**
Amendment date:	**06 January 2014**
IRAS project ID:	**124560**

The above amendment was reviewed at the meeting of the Sub-Committee held on 16 January 2014.

Ethical opinion
Approval was sought to also recruit participants for the semi-structured interview from Combat Stress.

The Committee advised checking the Participant Information Sheet before use as the participants would have been recruited at Combat Stress but there is reference to assessments and files at LVS. This would need changing to combat stress.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents
The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Information Sheet	3.1	06 January 2014

Notice of Substantial Amendment (non-CTIMPs)	Substantial Amendment 2	06 January 2014
Participant Consent Form: Interview	3.1	06 January 2014
Protocol	2	06 January 2014
Participant Consent Form: Questionnaire	3.1	06 January 2014

Membership of the Committee
The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

13/NW/0436: **Please quote this number on all correspondence**

Yours sincerely

On behalf of
Mrs Glenys J Hunt
Chair

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mrs Angela Williams
Camden & Islington NHS Foundation Trust

Professor Chris Barker
University College London

Clara Kalu
University College London Hospitals

NRES Committee North West - Liverpool East
Attendance at Sub-Committee of the REC meeting on 16 January 2014

Name	*Profession*	*Capacity*
Mrs Glenys J Hunt	Lay member	Lay
Dr Peter Walton	Lay Member	Lay

Also in attendance:

Name	*Position (or reason for attending)*
Miss Helen Penistone	Co-ordinator

Appendix 5.

Transcript and Coding Examples

Part of a transcript	Code	Theme	Domain	*Stage*
P16: But over time, the flashbacks, the panic attacks, the nightmares got worse and more often as well. The anger issues. Bonfire night, new year's eve, I'm a wreck to be honest with you. It just seems to have got worse the longer I was out of the army.	*Flashbacks nightmares*	*Emergence of symptoms*	*Acknowledgement and recognition*	
	Worsening of symptoms	*Downward spiral*	Facilitators to acknowledgement and recognition	
I: What did people around say or did they notice?	*Hiding symptoms*	*Coping*	*Acknowledgement and recognition*	
P16: No, I was very good at masking it to be honest. My wife saw a lot of it. But the anger and aggression and the panic attacks only happened over the last year. I never told any of my family as I was embarrassed to admit that I had a problem.	*Significant other noticing symptoms*	*Recognition and feedback from others*	Facilitators to acknowledgement and recognition	
	Embarrassment about admitting problem to others	*Perceived stigma from others*	*Initial help-seeking* Barriers to initial help-seeking	
I: When you say embarrassed, what is it that you were particularly embarrassed about?				
P16: I think what it was that I was always proud of what I did and my parents were proud of their lad being in the army and me being all over the world and doing all sorts of things. And I think the stigma attached to mental illness meant that I didn't tell anyone, because I think deep down I was worried about people judging me. They'd say "he's a nutcase, he cries at the drop of a hat, he's not a man type of thing. He's not an ex –soldier, he's gone, he's not the same." I think there were a lot of things going through my head at the time. Even beating myself, saying I'm not proud of what I do now. I've not got the military. So that was a reason I didn't tell anyone really.	*Fear of being judged*		*Initial help-seeking*	
	Mental health problems mean you are seen as less of a man	*Perceived stigma from others*	Barriers to initial help-seeking	
	Not worthy of being in the military			
I: So that stigma around...				
P16: Yeah, I was always worried about people's opinions and what they were saying	*Concern about others views*	*Perceived stigma from others*	Barriers to initial help-seeking	
I: And how did you view yourself?				
P16: I thought I was a failure, that I'd let people down. Because I had a few friends who were killed and I didn't want to disrespect them in anyway because I had a problem. I used to think I may have an injury, but I'm fine, my friends aren't. I felt embarrassed when I said I had a	*Self as a failure*			
	Letting others down / Not dependable	*Self-stigma*	Barriers to initial help-seeking	
	Guilt			

problem or when I was looking things up on the internet, I did feel like a failure and that I'd let all these people down, I thought I'd let myself down, let my family down. So that was why I kept beating myself up over it really. I: It sounds like a difficult mix of emotions [Yeah]. And you said that you had mainly kept it hidden but that maybe that your wife had noticed?	*Internet for information about symptoms* *Self-critical*	*Sources of help or information* *Self-stigma*	*Initial help-seeking* Barriers to initial help-seeking
P16: My wife she saw a change in me because I wasn't the same person that I was when she met me. I used to be a bubbly, not a care in the world, I didn't mind doing stuff, I always liked socialising and things and then all of a sudden, little things started happening. I started noticing them and then my wife started noticing them. I did the research and then when I was looking at PTSD symptoms, the first one, I was like yup, I've got that, the second, the third, and then eight or nine down the list, I realised I had all of them. So then I said to my wife, right I'm going to say something and I want you to tell me if I've got it. I said hypervigilence, she said yeah you have. Jumpy, yeah, and it was like right ok, it looks like I've got PTSD. And I'd always say, don't diagnose yourself over the internet, because you end up with tumours and things dropping off. And that's when I started going down the professional route. I: And what made you look up PTSD?	*Significant others noticing a change* *Self-noticing a change* *Self-help. Doing research on internet* *Self-diagnosis as a prompt to seek help*	*Recognition and feedback from others* *Sources of information* *Triggers to seeking help*	Facilitators to acknowledgement and recognition *Acknowledgement and recognition* *Initial help-seeking* *Initial help-seeking*
P16: I honestly can't remember. One of the people I work for, I can't remember if an ex-military person there mentioned PTSD or me best friend. I think he was suffering a little bit at the time and he was going through the army to get help at the time. And then I looked up PTSD, and seeing all the symptoms, I went from there really.	*Ex-military suggesting PTSD* *Others with similar problems providing information*	*Sources of help or information* *Information from other veterans or service personnel*	Facilitators to initial help-seeking

Part of a transcript	Code	Theme	Domain	*Stage*
I: can you tell me more about the point where your girlfriend went 'right I'm making this call.'				
P8: well she didn't say anything about making a call, she just made it and handed me the phone.	*Others taking responsibility for help-seeing*		*Initial help-seeking* Facilitator to initial help-seeking	
I: Was there anything going on that you think made her think 'this is the time to make the call...'				
P8: well I was very affectionate to her and then that all dropped off and I wanted to spend time with her and then I didn't want to, you know. There were a lot of different things going on. I'd been very polite, I'd been up and helpful to others and then that would stop and she was thinking 'he's changing, there's something wrong here.' So she rang the number. She didn't tell me, just handed me the phone. She said 'its combat stress'. Well I was stuck between a rock and a hard case. Do I talk or do I switch it off?	*Change in affection in relationship* *Significant other noticing a change* *Significant other actually making the call to seek help*	*Impact on relationships* *Recognition and feedback from others* *Others practically supporting help-seeking*	*Acknowledgement and recognition* Facilitator to acknowledgement and recognition *Initial help-seeking* Facilitator to initial help-seeking	
I: what made you talk?				
P8: I don't know. Politeness I think. I'm not the type of person to just hang up on somebody. And then, they were talking and asking me subtle questions and the answers I was giving: 'yeah, yeah.' They said they'd send someone over to see me, and it was all done subtly. It wasn't like 'we think you've got this and that and the other and someone's coming over to see you and we're going cart you off.' No none of that, it was all done very, very subtly.	*Unobtrusive nature of care providers*	*Caring, unobtrusive, validating, and respectful approach by professional*	*Pathway through treatment* Facilitators to engaging in treatment	
I: Would that have been a concern for you if they had said that? Can you tell me more about what you would have been worried about...?				
P8: Well am I the only person dealing with this? Are they going to cart me off somewhere and give me electroshock therapy and things like that. And I was - I wouldn't say frightened - but apprehensive. It was something new, something different, and something that I didn't know anything about.	*Thinking you are alone* *Fear of what treatment might entail* *Loss of control*	*Isolation* *Fear of the meaning of symptoms, the unknown, of losing control*	*Initial help-seeking* Barriers to initial help seeking	
I: Not knowing something?				
P8: Yeah not knowing. It was something I did not know anything about.	*Lack of knowledge about services*	*Not knowing where to get help*		

I: How did you feel about meeting with the person who came out to see you? P8: He was a welfare officer, and ex-soldier. And if you see two ex-soldiers you can tell. If you see two civilians meeting each other in the street and you see two ex soldiers meeting each other in a street, you'll see a completely different response. I: So did that make a difference for you, that he was ex-military? P8: yeah I: In what way? P8: to me, when I joined the army, I took the oath of allegiance, saw all these other guys. I might not know them, but they're all my brothers. And I'll defend them to the hills. With my life if I have to. And 99% of them would do the same. They might not know you, but it all goes back to your training. You're put into situations with people who have never met each other. You're there to do a job. You're there to protect the man to your left, man to your right, man in front, and man in the back. And that's the way everyone's taught to think. So you become brothers, no matter what regiment, no matter what service, everybody looks out for everybody else. I think that's the thought I had. I: And how was your meeting with him? P8: It went good. He asked me where I'd served and what regiment I'd been in and everything, and how I was feeling and things like that. The trust was there instantly because I knew he was ex military so the trust was automatically there. So I said a lot more to him than I'd ever said to my girlfriend.	*Different from civilians* *Immediate bond with military personnel* *Shared understanding and experience with fellow military personnel* *Trust for fellow military personnel* *Being able to open up*	*Care providers or civilians not understanding* *Respect and trust for professional who have military knowledge/ Experience* *Respect and trust for professional who have military knowledge/ experience*	*Pathway through treatment* Barriers to engagement in treatment *Pathway through treatment* Facilitators to engagement in treatment *Pathway through treatment* Facilitators to engagement in treatment