

Factors that impact on military personnel and military veterans
accessing mental health services

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Introduction

This thesis explores factors that impact on military personnel and military veterans accessing mental health care. It is widely recognised that military personnel and military veterans are at high risk of developing mental health difficulties. Since military operations in Iraq and Afghanistan, the mental wellbeing of military personnel and veterans has featured prominently as a political, media and public health concern.

Military personnel and military veterans do not tend to seek support for their mental health difficulties and consequently do not get the support they may need. In order to address this clinical concern, research has focused on identifying barriers and facilitators to mental health care in this population. This thesis explores these factors within the UK military population in the following two chapters.

Chapter one consists of a systematic review of the literature on perceived barriers and facilitators to mental health care in the UK military population.

Chapter two details an empirical study that explored how military veterans decided to access psychological support, in order to develop a theoretical model to describe and understand this process.

Systematic review of perceived barriers and facilitators to mental health care disclosed by the UK Military population

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Abstract

Aim

This systematic review aimed to answer the question – what factors impact on UK military personnel and veterans accessing mental health care?

Methods

A database search (Web of Science, Medline, Psychinfo and Scopus) for published papers using the following search strategy was conducted:

1. Military OR Army OR Navy OR ‘Royal Air Force’ OR RAF OR Soldiers OR ‘Military personnel’ OR Military veterans. Combined with:
2. ‘United Kingdom’ OR UK OR Scotland OR Scottish OR Wales OR Welsh OR ‘Northern Ireland’. Combined with:
3. Barriers OR facilitators OR stigma OR access OR help-seeking OR ‘help seeking’ OR psychological support OR support OR ‘mental health’ OR therapy OR psychotherapy OR ‘psychiatric services’ OR ‘mental health services’.

Results

Seven articles were reviewed and the results suggested that stigma, particularly the perception of being weak, was the most commonly endorsed barrier to accessing mental health care in UK military personnel. Beliefs associated with internal and external stigma were more commonly endorsed than perceived barriers to care. The most frequently endorsed perceived barriers to care were associated with scheduling and attending appointments.

Conclusions

Research has begun to identify barriers and facilitators to accessing mental health care in the UK military population. However, further research is required to explore how stigmatising beliefs and barriers to care impact on seeking support for mental health difficulties and specifically, to elicit perspectives from military personnel and military veterans using qualitative designs.

Practitioner points

- Results from this review suggest that interventions focusing on overcoming stigma may help facilitate military personnel and veterans accessing mental health care.
- However, interventions to support the military population to access mental health services need to be tailored towards military status and consider the presence of mental health difficulties.

Limitations

- It should be acknowledged that this review has considered a small sample of studies with varying quality ratings conducted with UK military population.

Introduction

The psychological wellbeing of the Armed Forces has been a political concern and has featured significantly in the media since military operations in Iraq and Afghanistan (Jones et al., 2014). Military personnel and veterans are at high risk of developing mental health difficulties (Murphy & Busuttil, 2014; Greden et al., 2010).

Iversen et al. (2009) examined prevalence rates of PTSD and common mental health problems in UK deployed and non-deployed personnel and found weighted prevalence rates of 27.2% for common mental health difficulties and 4.8% for PTSD.

Approximately half of personnel who experience mental health problems seek support (Hoge et al, 2004; Iversen et al., 2005). Iversen et al. (2010) examined help seeking and treatment engagement in UK personnel; the majority of personnel with a mental health diagnosis were not accessing support and more than three quarters of personnel with a diagnosis chose not to access medical help but sought informal support (Iversen et al., 2010).

Research completed with US and UK military personnel and military veterans has examined barriers and facilitators to mental health care for this population. Studies have been conducted with deployed and non-deployed personnel and veteran populations using quantitative, qualitative and mixed method designs. Generally quantitative studies have obtained beliefs associated with stigma and barriers to care (BTC) by respondents rating their agreement with statements provided by the researcher. Qualitative studies have elicited perspectives using semi-structured interviews or focus groups.

Barriers to accessing care

The most frequently identified barrier to care is stigma (Ouimette et al., 2011). Studies indicate that internal and public stigma impact on military personnel and military veterans seeking mental health care (Iversen et al., 2011; Osario, Jones, Fertout & Greenberg, 2013a; Cornish, Thys, Vogel & Wade, 2014). Studies have also indicated that personnel and veterans experiencing mental health difficulties have increased stigmatising beliefs (Osario et al., 2013a; Jones, Keeling, Thandi & Greenberg, 2015; Britt, Jennings, Cheung, Pury & Zinzow, 2015). Also, stigmatising beliefs increase when personnel are deployed (Osario, Jones, Fertout and Greenberg, 2013a).

Other barriers to care are: negative beliefs associated with health care (Pietrzak, Johnson, Goldstein, Malley, Southwick, 2009; Kim et al., 2011), concerns around confidentiality (Iversen et al., 2011); loss of confidence by peers (Iversen et al., 2011), fears of jeopardising their military career (Iversen et al., 2011, Zinzow et al., 2013), difficulty with accepting mental health problems (Pfeifer et al., 2012), avoiding trauma-related difficulties (Sayer et al., 2009) and a lack of knowledge about PTSD and mental health difficulties (Sayer et al., 2009; Murphy, Hunt, Luzon & Greenberg, 2014).

Facilitators of accessing care

Factors identified as facilitating personnel and veterans in accessing support include: social support (Pfeifer et al., 2012; Claver, 2011); Chase, McMahon & Winch, 2016), leadership support (Zinzow et al., 2013), increased severity in mental health difficulties (Zinzow et al., 2013; Murphy et al., 2014), accepting a need for help (Murphy et al., 2014); overcoming feelings of shame (Murphy et al., 2014), an internal locus of control (Murphy et al., 2014) and disruptions in social relationships (Snell & Tusaie, 2008).

A range of studies have identified barriers and facilitators to accessing care in the US and UK military population. As a result of the need to systematically collate available evidence, systematic reviews have attempted to summarise this research (Clements et al., 2015).

Clements et al. (2015) conducted a systematic review in order to understand the impact of mental health related stigma on help-seeking. They reviewed studies facilitated globally, using any population across all age groups (Clements et al., 2015).

Voght (2011) reviewed globally conducted studies examining mental health beliefs associated with mental health service use in the military population. She concluded that concerns related to public stigma and beliefs associated with mental health care were key barriers and recommended that further research should focus on exploring the impact of personal beliefs and seeking mental health care (Voght, 2011).

Also, Sharp et al. (2015) reviewed studies conducted globally that explored stigma and the military population. They concluded that anticipated stigma was not associated with intending to seek help or mental health service use and suggested that this was related to an intention-behaviour disparity, where personnel are inclined to seek help as a consequence of a crisis or being helped to overcome stigma by social support (Sharp et al., 2015). Sharp et al. (2015) suggested further research was needed regarding other barriers to mental health care and the impact of self-stigma or negative perceptions of mental health care.

Rationale for review

Since military deployment in Iraq and Afghanistan, the mental health of UK military personnel and veterans has been a public health concern. The military population is

recognised as being at high risk of developing mental health difficulties; however only approximately half of those who experience mental health difficulties seek support (Hoge et al., 2004). Consequently, there is a clinical need to explore the barriers and facilitators to accessing mental health care in this population in order to support individuals to access available support.

Research conducted globally has focused on exploring barriers and facilitators to accessing mental health care in the military population. Three systematic reviews (Voght, 2011; Sharp et al., 2015; Clements et al., 2015) have focused on studies that have explored the impact of mental health beliefs and stigma on accessing mental health care. However, in order to support UK military personnel and veterans to access services, it is important to review studies that have explored UK military personnel's and veterans' perspectives in relation to seeking mental health care. Collating evidence from studies that have focused on the UK military population will support directions for further research. This has not been completed with studies using the UK military population.

Research question

Consequently, this review aimed to address the question – what factors impact on UK military personnel and veterans accessing mental health care?

Objectives

- To review the literature that focuses on identifying personnel's perspectives of barriers to accessing mental health care.
- To review the literature that focuses identifying military personnel's perspectives on factors that facilitate accessing mental health care.

- To summarise the literature and identify areas for further research.
- To provide the rationale for the empirical study.

Method

Search strategy

With reference to the review protocol, a database search (Web of Science, Medline, Psycinfo and Scopus) throughout all years to June 2016, was conducted using the following search terms:

4. Military OR Army OR Navy OR 'Royal Air Force' OR RAF OR Soldiers OR 'Military personnel' OR Military veterans. Combined with:
5. 'United Kingdom' OR UK OR Scotland OR Scottish OR Wales OR Welsh OR 'Northern Ireland'. Combined with:
6. Barriers OR facilitators OR stigma OR access OR help-seeking OR 'help seeking' OR psychological support OR support OR 'mental health' OR therapy OR psychotherapy OR 'psychiatric services' OR 'mental health services'.

Duplicate articles were removed and the reference lists of articles selected for eligibility screening were appraised to check for further studies. Professionals within the field were also consulted, however, no further studies were identified.

Articles selected for eligibility screening were scrutinised in line with the following inclusion and exclusion criteria and included or excluded accordingly.

Inclusion criteria:

- Published studies in peer-reviewed journals;
- Studies that focused on UK military veterans or military personnel seeking help for mental health difficulties;

- Studies that focused on identifying perceived barriers to accessing mental health care directly from military personnel and / or military veterans;
- Studies that focused on identifying perceived factors that facilitate accessing mental health care directly from military veterans and military personnel.

Exclusion criteria:

- Studies that did not meet the inclusion criteria;
- Studies that focus on identifying barriers and facilitators to mental health care in the military population in other countries.

Data extraction

With regard to study characteristics, data extraction included: the study design, methodology, measures and analysis. Information was extracted that related to participant characteristics such as, the branch of the military and type of military population. With regard to quantitative studies, percentages of the sample population endorsing beliefs associated with stigma, barriers to care and accessing mental health care were extracted as well as additional information relevant to the review question.

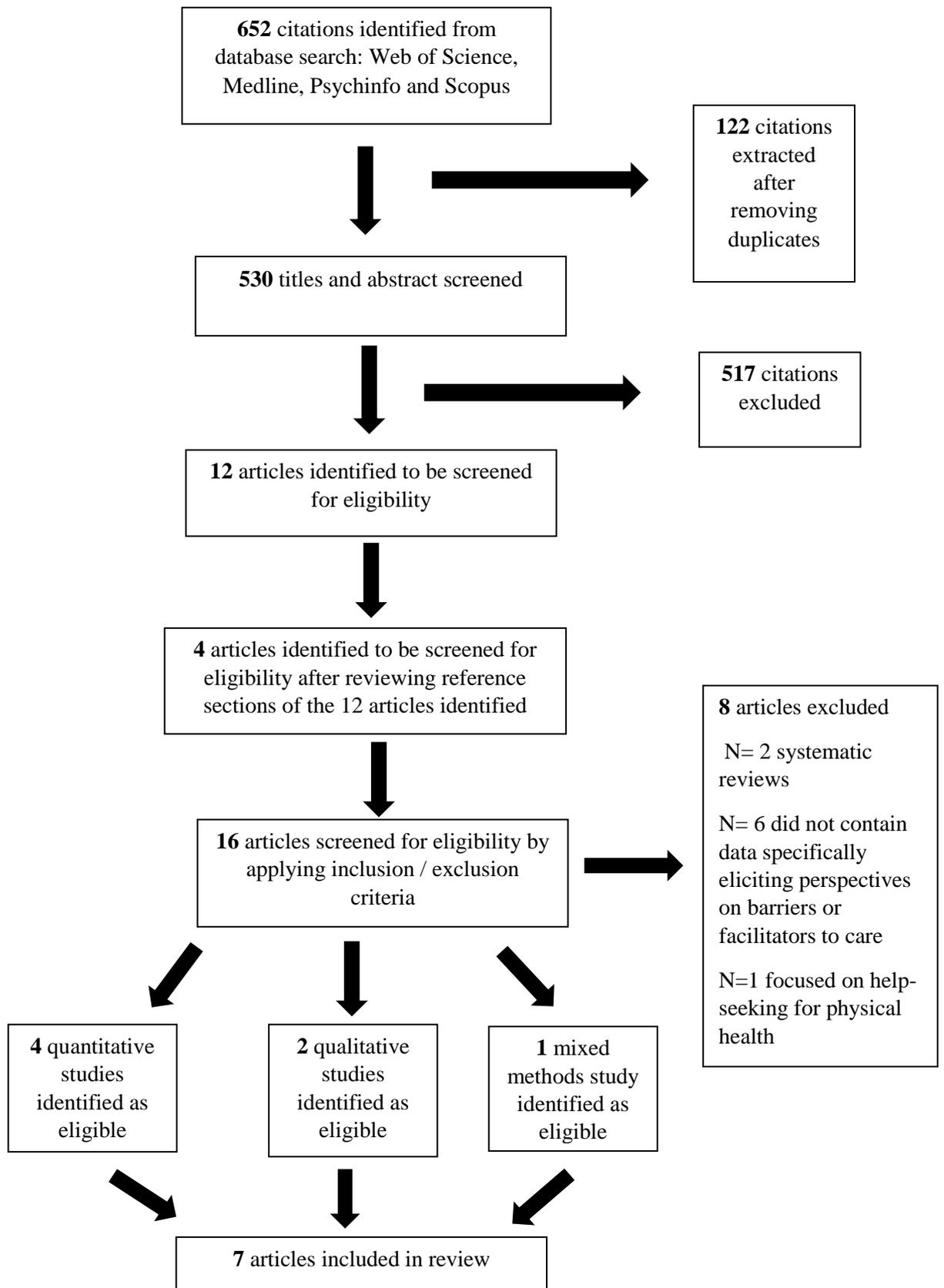
With regard to qualitative studies, themes associated with perceived barriers and facilitators to mental health care were extracted. The data extraction form guided the data extraction after it was piloted using two studies (one quantitative and one qualitative).

Study selection

Database searches yielded 652 citations. After removing duplicates 530 titles and abstracts were screened. Consequently 517 citations were removed and 12 articles were suitable for eligibility screening. To identify potential further studies, the reference sections of the 12 articles were reviewed. Subsequently an additional four studies were identified to screen for eligibility. As a result, the inclusion / exclusion criteria were applied to 16 articles and eight articles were considered not eligible.

Articles were excluded because: two articles were systematic reviews (Voght, 2011; Sharp et al., 2015). One study focused on Gulf War veterans seeking help primarily for physical health problems (Hotopf et al., 2002) and five articles (Osario, Jones, Fertout & Greenberg, 2013b; Jones et al., 2014; Iversen et al., 2010; Hines et al., 2014; Jones et al., 2015; & Murphy & Busutil, 2014) were excluded because they did not explicitly gather quantitative or qualitative data containing military personnel's or military veterans' perceived barriers and facilitators to mental health care. Therefore, seven articles were included in this review (Figure 1 p. 18).

Figure 1: Adapted PRISMA diagram detailing stages of article selection (Liberati et al., 2009)



Results

Overview of studies

The seven studies reviewed varied in their design and aims (Table 1 p. 20-21). However, all studies focused on identifying barriers and facilitators to mental health care. This was achieved by identifying beliefs associated with stigma and perceived barriers to care, attitudes towards stress, stress-related problems and mental health services and perceptions of the individual's role in managing mental health difficulties.

With regard to the methodology, the studies varied in their approach to data collection. The four quantitative studies collected information indirectly from participants by using data obtained from other surveys. Osario et al. (2013a) examined data from nine previously conducted surveys with personnel that were deployed to Iraq and / or Afghanistan between 2008 and 2011. Surveys were conducted with personnel during deployment or immediately post-deployment. Also, Fertout et al. (2015) collected data from three previously facilitated deployment mental health surveys that took place in Iraq and Afghanistan in 2009 and 2010 respectively. In addition, Langston et al. (2010) and Jones et al. (2013) used data that were collected as baseline measurements for evaluating a peer support programme and a stigma reduction intervention respectively. Langston et al. (2010) used a mixed methods design.

In addition, three studies collected data directly in relation to identifying perceived barriers and facilitators to care. Iversen et al. (2011) conducted a telephone interview to collect data using measures; Murphy et al. (2014) interviewed UK personnel accessing a defence mental health service and Wainwright, McDonnell, Lennox, Shaw and Senior (2016) collected data by facilitating a focus group with professionals and semi-structured interviews with veterans.

Table 1**Study characteristics: design, aim, measures and data collection and analysis**

Study	Design	Aim	Sample size	Measures	Data collection	Analysis
Langston et al. (2010)	Mixed methods	To test hypothesis a) that stigmatising beliefs (internal and external) about mental health issues are prevalent in the Navy. To test b) that distressed personnel would express more stigmatising beliefs than non-distressed personnel	1599	GHQ-12 PCL-C	Semi-structured interview	Pearson's χ^2 $P < .005$ Odds Ratio 95% confidence intervals multivariate logistic regression Grounded theory
Iversen et al. (2011)	Quantitative	A) compare barriers to care in regular, reservists and veterans. B) compare barriers to care in those with and without a current mental health diagnosis.	821	PHQ PC-PTSD	-	Descriptive statistics Odds Ratio 95% confidence intervals multivariate logistic regression
Jones et al. (2013)	Quantitative	To answer the question – is there a relationship between perceived barriers to care and help-seeking. If so, what role does current mental health status have in modulating the decision to seek help?	484	AUDIT-C GHQ-12 PC-PTSD RIBS	-	Pearson's χ^2 $P < .005$ Odds Ratio 95% confidence intervals logistic regression
Osario et al. (2013a)	Quantitative	To examine changes in perceptions of stigma / BTC by examining rates of stigma / BTC, combat and PTSD in UKAF personnel. Examine relationship of stigma / BTC during this time and examine changes in components of stigma / BTC.	23,101	PC-PTSD PCL-C	-	Pearson's χ^2 $P < .005$ Odds Ratio 95% confidence intervals logistic regression
Fertout et al. (2015)	Quantitative	Carry out principle component analysis of Stigma / BTC scale and to assess the association of components with mental health symptoms and help-seeking	3405	PCL-C GHQ-12 SF36	-	Principle Component Analysis Pearson's χ^2 $P < .005$ Odds Ratio 95% confidence intervals logistic regression

Table 1 – continued

Study characteristics

Study	Design	Aim	Sample size	Measures	Data collection	Analysis
Murphy et al. (2014)	Qualitative	Investigate factors that support individuals to access services, and where barriers exist, how they overcame them.	8	PCL-C PHQ-9	Semi-structured interview	Interpretational phenomenological analysis
Wainwright et al. (2016)	Qualitative	Explore perceptions of the needs of veterans in prison and factors that influence their help-seeking behaviour and engagement.	15	-	Focus group Semi-structured interview	Thematic analysis and constant comparison

Participant characteristics

Participants across the studies consisted of enlisted military personnel (deployed and non-deployed), veterans and a focus group of professionals that had worked with veterans in a secure or community environment (Table 1, p. 20-21).

Langston et al. (2010) used data from 1599 actively serving Navy personnel and Jones et al. (2013) obtained data from 484 actively serving members of the British Army.

In addition, Iversen et al. (2011) conducted a telephone interview with 821 participants taken from data collected from Phase 1 of the Kings Centre for Military Health Research military health study, facilitated with deployed and non-deployed actively serving personnel.

Participants were randomly selected and 70% of the sample scored above the threshold for GHQ 'caseness' and 30% of the sample scored below this threshold. Participants were stratified by regular (50%) / reserve (50%) status and deployed (50%) and non-deployed status or deployed elsewhere (50%) (Iversen et al., 2011).

Osario et al. (2013a) also obtained data sets from actively serving UK personnel from the Royal Navy, Army and Royal Air Force deployed to Afghanistan and / or Iraq between 2008 and 2011. The sample was stratified by year and location of survey. The 2008 cohort consisted of two post deployment surveys; the 2009 cohort consisted of one survey conducted with personnel deployed in Iraq; the 2010 cohort consisted of three surveys conducted with personnel deployed in Afghanistan, and post-deployment (during a psychoeducational programme) and as part of a Third Location Decompression (TLD) survey; the 2011 cohort consisted of deployed personnel in Afghanistan and also personnel post-deployment during TLD. A total of 23,101 participants were used in the complete data set.

Fertout et al. (2015) used a total of 1,744 participants' data obtained from surveys facilitated with actively serving personnel (Army, Royal Navy, Royal Marines and the Royal Air Force) deployed in Iraq and Afghanistan.

Murphy et al. (2014) interviewed eight UK actively serving service personnel accessing a defence mental health service and Wainwright et al. (2016) completed a focus group with five professionals (two men; three women) who had experience of working with veterans in a community or secure environment; three participants had also served in the military. In addition, Wainwright et al. (2016) conducted ten semi-structured interviews with veterans accessing the mental health service in five adult male prisons.

Assessment of mental health difficulties

Six studies assessed the presence of mental health difficulties and levels of distress (Table 1, p. 20-21). Global health was assessed by Fertout et al. (2015) using the Short-form Health Survey (SF36). The presence of common mental health difficulties was assessed using the Patient Health Questionnaire (PHQ) and the General Health Questionnaire (GHQ-12). The presence of PTSD symptoms was assessed using the Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) or the Primary Care Post-Traumatic Stress Disorder Scale (PC-PTSD) and alcohol use was assessed using the Alcohol Use Disorders Identification Test (AUDIT-C).

In addition, Fertout et al. (2015) assessed non-operational stress (psychosocial / relationship problems) by one question that asked about the presence or absence of these problems (Fertout et al., 2015).

With regard to the presence of mental health difficulties, Fertout et al. (2015) reported that 17.2% of the sample met the threshold for a common mental health disorder and 2.5% met the threshold for probable PTSD. Langston et al. (2010) reported that 27% of the sample were 'stress cases' who scored above the cut-off scores on the GHQ-12 or PCL-C, and that 5% of the sample scored above the cut-off scores on both measures. Osario et al. (2013a) identified that across the sample of 23,101 participants, 4% met the threshold for PTSD caseness. Jones et al. (2013) reported that 25.2% of the sample met the threshold for common mental disorder and 12.5% of the sample met the threshold for PTSD. In addition, 35% of the sample screened positively for potential harmful alcohol use. Also, Murphy et al. (2014) found that 37.5% met the criteria for the presence of PTSD, 25% of the met the criteria for major depression and 12.5% of the sample met the criteria for moderate to severe depression.

It was not possible to determine the proportion of the sample with mental health difficulties from two studies. Wainwright et al. (2016) included participants with or without mental health difficulties. However, they did not assess the presence of mental health difficulties in their sample of veterans. Also, it was not possible to calculate the percentage of the sample that met the threshold for these difficulties from the data provided by Iversen et al. (2011). As mentioned previously, these authors randomly selected their sample from the data collected from Phase 1 of the military health study by selecting 70% of participants who scored above the threshold for GHQ 'caseness' and 30% who scored below this threshold. Consequently, this made it difficult to estimate the rate of mental health difficulties amongst the sample overall.

Identification of barriers or facilitators to accessing care

The quantitative studies elicited participants' beliefs about stigma and barriers to care by their endorsements of statements associated with barriers and facilitators to care and help seeking.

Fertout et al. (2015) assessed potential barriers to care and stigmatisation using an adapted version of a stigma / Barriers to care (BTC) scale used in US research. The scale consisted of 13 items and was adapted to consider the cultural and healthcare differences in the UK. Participants' level of agreement with statements relating to the self, others and perceived organisational and practical barriers to care were assessed using a Likert scale.

In addition, Jones et al. (2013) used an 11 item stigma / BTC to care scale adapted from a measure used in US research other UK studies; participants rated their level of agreement with each statement using a four point Likert scale. Participants rated their agreement with statements eliciting perceptions of an individual's role in managing mental health problems using a four point Likert scale. The presence of discriminating beliefs towards people with a mental health problem was also assessed using items 5 to 8 of the Reported and Intended Behaviour Scale (RIBS) (Jones et al., 2013).

Osario et al. (2013a) assessed the presence of stigma / BTC using seven items that focused on components of internal stigma and three items about perceived barriers to care. Participants rated their agreement using a four point Likert scale.

Iversen et al. (2011) assessed barriers to care by measuring agreement with statements that consisted of practical barriers to care, anticipated public stigma and attitudes towards mental health care providers. Using a Likert scale participants rated how each of the concerns would

impact on their decision to receive mental health counselling or services if they had a problem (Iversen et al, 2011).

Help-seeking

Jones et al. (2013) asked personnel if they were accessing support for a stressful, emotional or family problem and if they were interested in seeking support. They asked respondents to consider nine possible sources of support which represented military medical help (mental health professional, regimental medical officer, doctor or other medical staff) or non-medical help (friend or family, unit chain of command, colleague, TRIM practitioner, chaplain or Big White Wall therapist) (Jones et al., 2013).

Fertout et al. (2015) asked personnel about medical appointments, attendance and admissions to field hospitals and help-seeking was assessed using a list of medical and non-medical resources.

The qualitative studies elicited participants' perspectives using a semi-structured interview and a focus group. Langston et al. (2010) assessed the presence of stigmatising beliefs by asking individuals to respond to the question: *"How do you think your peer group regards stress and stress-related problems?"* Murphy et al. (2014) explored how participants accessed services and what factors enabled them to do so. Wainwright et al. (2016) used a focus group and semi-structured interview to explore participants' perspectives on their needs and factors they perceived influenced help-seeking behaviour for veterans in the prison population.

Quality of studies

The quality of the studies was assessed using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh, Lawton, Gardner & Armitage, 2011), a tool used to compare the quality of studies that have used quantitative, qualitative or a mixed method design (Table 2, p. 28-31). The quality ratings were calculated for each study. The study that employed a mixed methods design obtained a quality score of 39.8%; the quantitative design studies obtained quality scores between 52.4% and 57.1% and the qualitative studies obtained quality scores of 54.8% and 73.8%. These scores indicate that the studies varied in quality ranging from 39.8% to 73.8%.

Table 2**QATSDD scores**

Criteria	Langston et al. (2010)	Iversen et al. (2011)	Jones et al. (2013)	Osario et al. (2013a)	Fertout et al. (2015)
Explicit theoretical framework	3	3	3	3	3
Statement of aims/objectives in main body of report	3	3	3	3	3
Clear description of research setting	2	3	3	3	2
Evidence of sample size considered in terms of analysis	0	0	0	0	0
Representative sample of target group of a reasonable size	3	3	3	3	3
Description of procedure for data collection	1	3	2	2	1
Rationale for choice of data collection tool(s)	0	2	2	2	0
Detailed recruitment data	3	0	1	2	1
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	0	0	0	1	2
Fit between stated research question and method of data collection (Quantitative only)	0	0	2	0	0

Table 2**QATSDD scores**

Criteria	Langston et al. (2010)	Iversen et al. (2011)	Jones et al. (2013)	Osario et al. (2013a)	Fertout et al. (2015)
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative only)	0	-	-	-	-
Fit between research question and method of analysis (Quantitative only)	2	2	3	2	3
Good justification for analytic method selected	0	1	0	1	2
Assessment of reliability of analytic process (Qualitative only)	0	-	-	-	-
Evidence of user involvement in design	1	0	0	0	0
Strengths and limitations critically discussed	1	2	2	2	2
Total Score	19	22	24	22	
Total percentage	39.6%	52.4%	57.1%	57.1%	52.4%

Table 2**QATSDD scores**

Criteria	Murphy et al. (2014)	Wainwright et al. (2016)
Explicit theoretical framework	3	3
Statement of aims/objectives in main body of report	3	3
Clear description of research setting	3	3
Evidence of sample size considered in terms of analysis	1	3
Representative sample of target group of a reasonable size	1	3
Description of procedure for data collection	1	3
Rationale for choice of data collection tool(s)	3	3
Detailed recruitment data	1	3
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	-	-
Fit between stated research question and method of data collection (Quantitative only)	-	-

Table 2 – continued**QATSDD scores**

Criteria	Murphy et al. (2014)	Wainwright et al. (2016)
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative only)	0	3
Fit between research question and method of analysis (Quantitative only)	-	-
Good justification for analytic method selected	3	0
Assessment of reliability of analytic process (Qualitative only)	0	3
Evidence of user involvement in design	2	0
Strengths and limitations critically discussed	2	1
Total Score	23	31
Total percentage	54.8%	73.8%

Quantitative studies

Data extracted from quantitative studies provided percentages of the sample that endorsed beliefs associated with stigma, barriers to care and responsibility of managing mental health difficulties (Tables 3-5, p. 35-37). In addition, odds ratios were calculated across the studies to explore relationships between variables (stigma, barriers to care and help-seeking).

Endorsement of beliefs associated with stigma and barriers to care

To compare data across the studies, items related to the same beliefs were matched across the items in each study. For example, Osario et al. (2013a) included the item *I would not seek help for a mental health problem, my commanders would treat me differently*. This was assessed by Jones et al. (2013) using the item *my unit leader might treat me differently* and by Iversen et al. (2011) using the item *my unit bosses might treat me differently*.

In addition, as Osario et al. (2013a) provided percentages that endorsed each item per year between 2008 and 2011, to compare the percentages with other studies, the percentage of the whole sample endorsing the particular item was calculated (Table 3 p. 35-36 & 5, p. 37).

Two out of four studies provided percentages of the sample that agreed with each item and did not provide percentages of the sample that disagreed with each statement, which impacted on interpreting the results. The results indicated that stigmatising beliefs associated with public stigma were endorsed by the UK military population but these results are variable. The belief they would be treated differently for seeking support was endorsed by 37-71% of the subset that provided percentages of agreements. However, Osario et al. (2013a) reported that 63% of their sample disagreed with this statement. Being perceived as weak was endorsed by 33-52% of the subset that provided percentages of agreements. However, Osario

et al. (2013a) reported that 67% disagreed with this statement. The belief that seeking mental health support would harm their career was endorsed by 30-55% of the subset that provided percentages of agreements. However, Osario et al. (2013a) reported that 70% disagreed with this statement. The belief it would be too embarrassing was endorsed by 25-54% of the subset that provided percentages of agreements. However, Osario et al. (2013a) reported that 75% disagreed with this statement. In addition, 67-73% of the subset that provided percentages of agreements endorsed the belief that peers would lose confidence in them and one study found that 60% believed they would be less likely to be given tasks / roles in responsibility due to their mental health problems.

With regard to the perceptions of an individuals' roles in managing their mental health problems, Jones et al. (2013) found that 62% reported they preferred to manage their difficulties independently. However, 87% of the sample endorsed the view that mental health support would be helpful for someone who needs it and 81% recognised that it took courage or strength to seek mental health support.

With regard to barriers to care, the most endorsed barrier to care was associated with obtaining time off work and scheduling appointments. This was endorsed by 19-22% of the sample across two studies. However, Osario et al. (2013a) reported that 78% disagreed with this statement. Iversen et al. (2011) found that 29% of the sample reported it was difficult to schedule an appointment. In addition, 14-22% of the sample across two studies reported they would not seek help due to concerns about confidentiality. However, Osario et al. (2013a) reported that 78% disagreed with this statement. In addition, 11-16% reported they would not seek support because they do not know where to access help. However, Osario et al. (2013a) reported that 89% disagreed with this statement. Moreover, Jones et al. (2013) found that

13% of the sample reported that mental health services unavailable and 67% of the sample endorsed the belief that the military does not support service members with mental health difficulties.

Iversen et al. (2011) found that less than 10% of the sample endorsed barriers to care associated with transport difficulties, negative experiences and perceptions of mental health care, lack of trust and beliefs that management discouraged seeking support.

Table 3:**Percentage of sample endorsing stigmatising beliefs**

Stigmatising belief	Langston et al. (2010)*		Iversen et al. (2011)**		Osario et al. (2013a)***		Jones et al. (2013)	
	Agree	Disagree	Agree	Disagree	Agree	Disagree	Agree	Disagree
Stigmatising belief								
I would not seek help for my mental health problem, my commanders would treat me differently	-	-	71%	-	37%	63%	68%	-
I would not seek help for my mental health problem, I would be seen as weak	41%	-	41%	-	33%	67%	52%	
I would not seek help for my mental health problem, it would harm my career	43%	-	47%	-	30%	70%	55%	
I would not seek help for my mental health problem, it would be too embarrassing	54%	-	37%	-	25%	75%	33%	
Members of my unit may have less confidence in me.	-	-	73%	-	-	-	67%	
My leaders would blame me for the problem	-	-	15%	-	-	-	25%	
I would think less of a colleague if they were receiving mental health treatment	-	-	11%	-	-	-	17%	
I would be less likely to be given roles / tasks of responsibility	60%	-	-	-	-	-		
My peers would find out and treat me badly or tease me	32%	-	-	-	-	-		

* Neutral comments were omitted; ** Excludes respondents of 'neither agree or disagree' (Iversen et al. 2011); ***Percentages combined for whole sample 2008-2011

Table 3 – continued**Percentage of sample endorsing stigmatising beliefs continued**

Stigmatising beliefs	Langston et al. (2010)*		Iversen et al. (2011)		Osario et al. (2013a)**		Jones et al. (2013)	
	Agree	Disagree	Agree	Disagree	Agree	Disagree	Agree	Disagree
Stigmatising belief								
People who experience a stress-related problem are weak	7%	93%	-	-				
Most people have a mental health problem at some point in their life	51%	49%	-	-				
People with a mental illness should not be given responsibility	-	-	-	-	-	-	31%	-

* Neutral comments were omitted; ** Excludes respondents of ‘neither agree or disagree’ (Iversen et al. 2011); ***Percentages combined for whole sample 2008-2011

Table 4:**Percentage of sample endorsing beliefs regarding personal responsibility and mental health management (Jones et al., 2013)**

Belief	Percentage of sample
Mental health support can be helpful for those who need it	87%
It takes courage or strength to get treatment for a psychological problem	81%
I would prefer to manage my problems on my own	62%
Strong people can resolve psychological problems themselves	45%
Psychological problems tend to work themselves out without help	27%

Table 5:**Percentage of sample endorsing barriers to care**

Barriers to care	Langston et al. (2010)*		Iversen et al. (2011)**		Osario et al. (2013a)***		Jones et al. (2013)	
	Agree	Disagree	Agree	Disagree	Agree	Disagree	Agree	Disagree
Barrier to care								
I would not seek help for my mental health problem, there would be difficulty getting time off work	-	-	19%	-	22%	78%	-	-
I would not seek help for my mental health problem, my visit would not remain confidential	-	-	14%	-	22%	78%	-	-
I would not seek help for a mental health problem, because I don't know where to get help	-	-	16%	-	11%	89%	-	-
Any in-service support would be confidential	61%	39%	-	-	-	-	-	-
It is difficult to schedule an appointment	-	-	29%	-	-	-	-	-
I don't have adequate transport	-	-	4%	-	-	-	-	-
I've had bad experiences of mental health professionals	-	-	9%	-	-	-	-	-
I don't trust mental health professionals	-	-	6%	-	-	-	-	-
My bosses discourage the use of mental health services	-	-	6%	-	-	-	-	-
Mental health care doesn't work	-	-	4%	-	-	-	-	-
The military does not support Service members with mental health problems	-	-	-	-	-	-	67%	-
Mental health services aren't available	-	-	-	-	-	-	13%	-

* Neutral comments were omitted (Langston et al., 2010); ** Excludes respondents of 'neither agree or disagree' (Iversen et al. 2011); ***Percentages combined for whole sample 2008-2011 (Osario et al., 2013a)

Relationships between stigma, barriers to care and help-seeking

Fertout et al. (2015) aimed to identify the key components associated with stigma in the military and examine the relationship with these components and mental health problems and help-seeking. They found that stigma was associated with two components: the potential loss of military credibility and trust (component 1) and negative perceptions of mental health services and perceived barriers to help seeking (component 2) (Fertout et al., 2015). Fertout et al's. (2015) findings indicated that beliefs associated with potential loss of military credibility and trust were more significantly endorsed than beliefs associated with negative perceptions of mental health services and perceived barriers. Fertout et al. (2015) found beliefs associated with loss of credibility and trust were associated with medical help-seeking and admission to hospital. However, beliefs associated with negative perceptions of mental health services and perceived barriers were not related to medical help-seeking (Fertout et al., 2015).

In addition, Osorio et al. (2013a) found deployed personnel reported significantly higher rates of one or more stigmatising beliefs when compared to non-deployed personnel. This is consistent with Fertout et al. (2015) who found significantly higher beliefs associated with loss of military credibility and trust in deployed personnel.

Iversen et al. (2011) found that regular personnel endorsed more stigmatising beliefs when compared to reservists and veterans. Reservists endorsed increased practical barriers to care and veterans endorsed increased beliefs associated with not knowing where to get help and adequate transport (Iversen et al., 2011).

Significantly higher rates of beliefs associated with stigma and BTC were found in participants who met the threshold for mental health difficulties across three studies (Fertout et al., 2015; Jones et al., 2013 & Langston et al., 2010).

Jones et al. (2013) found that potential discrimination and contact with others who have a mental health difficulty were associated with stigma / BTC. They also found that the presence of stigma / BTC was not associated with help-seeking when mental health problems were not present. However, participants who had sought help and met the threshold for experiencing mental health problems had increased beliefs associated with stigma / BTC. The highest rates of stigma / BTC were endorsed in participants who screened positively for mental health difficulties but had not sought help (Jones et al., 2013).

Summary

The results from the quantitative studies suggest that UK military personnel and veterans endorsed increased stigmatising beliefs than beliefs associated with perceived BTC. Also, the presence of mental health difficulties is associated with increased stigmatising beliefs / BTC and increased beliefs relating to potential loss of credibility and trust were associated with medical help-seeking. However, negative perceptions of mental health care were not associated with help-seeking and the presence of stigma / BTC was not associated with help-seeking.

Qualitative studies

The qualitative studies reported themes associated with barriers and facilitators to accessing mental health care (Table 6, p. 41). A key theme identified across all three studies was associated with the presence of stigma. Langston et al. (2010) reported that participants were

concerned with being perceived as weak and Murphy et al. (2014) found that overcoming stigma was associated with accessing mental health services. Wainwright et al. (2016) also found that participants talked about the difficulty of asking for help associated with the fear of being labelled and perceived as weak.

Another theme across the studies was the lack of understanding and knowledge of mental health difficulties. Langston et al. (2010) found a lack of openness and understanding in the Navy; Murphy et al. (2014) reported that participants talked about finding an explanation for their difficulties and being diagnosed facilitated accessing support. Wainwright et al. (2016) reported the importance of staff offering support to veterans in prison having a military awareness.

Table 6**Themes identified through qualitative analysis (Langston et al., 2010); (Murphy et al., 2014); (Wainwright et al., 2016)**

Study	Theme	Subtheme
Langston et al. (2010) Peer perception of stress	Stress perceived as a joke Stigma attached to stress (i.e. being perceived as a weakness Suspicion (i.e. over whether a stressed individual genuine) Lack of openness regarding stress	
	Peer actions and management of stress	Stress would be seen as a joke Individuals would be avoided Tough love Lack of understanding and awareness in the Navy
Murphy et al. (2014)	Recognising something was wrong	Reaching a crisis point Difficulties experienced as physical symptoms
	Overcoming stigma	Shame Stigma related to psychiatric medication
	Finding an explanation	Trusted witness to difficulties Psychological explanation Getting a diagnosis
	Not being alone	Normalisation Safe space Sense of hope Acceptance Understanding
	Control	Autonomy Communication
Wainwright et al. (2016)	Need for variable support, available in prison The difficulty in asking for help The importance of military awareness among staff The importance of preparing for release	

Overall findings

The results are variable and indicate that additional research is required to further assess beliefs associated with mental health and barriers and facilitators to accessing support in the UK military population. The results indicated that stigma; particularly the perception of being weak was the most frequently endorsed barrier to accessing mental health care in UK military personnel. However, this varied across the studies. Also, beliefs associated with internal and external stigma were more commonly endorsed than beliefs associated with perceived BTC. The most frequently endorsed perceived BTC were associated with scheduling and attending appointments. The studies indicated that deployed personnel endorsed increased stigmatising beliefs when compared to non-deployed personnel, and individuals who meet the threshold for experiencing mental health difficulties endorsed increased beliefs associated with stigma and BTC. A few studies examined the relationship between the presence of stigma / BTC and help-seeking, however, the results were variable.

Discussion

This systematic review aimed to answer the question – what factors impact on UK military personnel and military veterans accessing mental health care? Seven studies were subsequently reviewed and overall the results are variable but indicate that stigmatising beliefs were the most frequently endorsed barrier to accessing mental health care, consistent with research that has identified stigma as a key barrier to mental health care (Chase et al., 2016; Cornish et al., 2014).

In addition, stigmatising beliefs were more frequently endorsed than perceived BTC, consistent with previous research (Ouimette et al., 2011). Although it was not endorsed across all of the studies, the most frequently endorsed perceived BTC was related to scheduling appointments. Difficulties in scheduling appointments has also been reported as a BTC in previous research (Zinzow et al., 2013).

The studies highlighted that increased stigmatising beliefs were found in deployed personnel compared to non-deployed personnel, consistent with previous studies (Osario et al., 2013a). In addition, increased stigmatising beliefs were identified in individuals reporting mental health difficulties, also consistent with previous research (Britt, Jennings, Cheung, Pury & Zinzow, 2015).

Studies that examined the relationship between stigma / BTC and help-seeking found mixed results. One study highlighted that help-seeking was impacted by beliefs associated with stigma / BTC and one study reported that it did not impact on help-seeking. Further exploration of how stigmatising beliefs and BTC impact on seeking support for mental health difficulties is needed.

However, when interpreting these results, the context of the studies must be acknowledged. Five studies recruited actively serving personnel and one study recruited military veterans. Also, Iversen et al. (2011) recruited their sample from a pool of data collected from actively serving personnel stratified by regular / reserve status. During the recruitment stage, participants were either actively serving, reserve status or a veteran. However, it is unclear as to what proportion of the sample were actively serving personnel, reserve status or a veteran. Iversen et al. (2011) compared BTC between regular personnel, reservists and veterans and found that regular personnel endorsed increased beliefs associated with stigma, reservists endorsed increased barriers in relation to scheduling appointments and veterans reported increased barriers associated with not knowing where to get support and transport difficulties. Consequently, perceived BTC to care may fluctuate depending on the individual's military status. Therefore, interventions supporting access to mental health care may need to be adapted to the military status of individuals.

Also, a varied proportion of the samples met the threshold for the presence of mental health difficulties. The percentage of the sample of participants who met the threshold for the presence of common mental disorder or symptoms of depression ranged from 12.5% and 27% across the studies. The percentage of the sample who met the criteria for probable PTSD ranged from 2.5% to 37.5% across the studies and the percentage of the sample who met the criteria for potential harmful alcohol use was 35%. The presence of mental health difficulties may have impacted on participants' responses to questions. Likewise, the results suggested that increased stigmatising beliefs were associated with the presence of mental health difficulties. Therefore, in studies where there was a low proportion of the sample meeting the threshold for mental health difficulties one would expect fewer participants to endorse

stigmatising beliefs. This is evidenced by the figures provided by Osario et al. (2013a), where 4% of the sample met the threshold for probable PTSD.

In addition, the designs of the studies may have impacted on the results. The majority of the studies used quantitative methods; participants were asked to rate their agreement with statements provided by the researcher and information was obtained indirectly, using data from other surveys. Only three studies were conducted that explicitly elicited perspectives from participants in relation to identifying barriers and facilitators to mental health care. Also, some studies recruited participants whilst on deployment and increased stigmatising beliefs have been associated with deployment. Furthermore, as the majority of the data was collected by self-report questionnaires the responses may have also been influenced by social desirability. In addition, the quality scores of the studies ranged from 39.8% to 73.8%. Consequently, further research is required within the area.

Clinical implications

As stigma is the most frequently endorsed barrier to mental health care these findings continue to suggest that interventions focusing on overcoming stigma may continue to facilitate military personnel and veterans accessing mental health care. However, the findings suggest that beliefs associated with stigma and BTC fluctuate depending on the military status and mental health of individuals. Consequently, interventions to support military personnel and veterans to access mental health services need to be tailored towards the military status and the impact of the presence of mental health difficulties needs to be considered.

Limitations

Unpublished studies were not included in the search strategy and only four databases were searched and therefore there may be other studies that were not identified.

In addition, this review was completed by one researcher. Consequently, the quality ratings on the QATDSS were based on the researcher's judgement and not discussed with peers in order to check inter-rater reliability.

Conclusions

The results indicate that research has begun to identify barriers and facilitators to accessing mental health care in the UK military population. However, further research is required to specifically elicit the perspectives of military personnel and veterans as they are best placed to identify factors that prevent them from seeking mental health support. Also, further research that explores the extent to which stigmatising beliefs and BTC impact on seeking support for mental health difficulties is needed. Studies have focused primarily on identifying barriers to accessing mental health care and to complement this, further research is required to explore facilitators to mental health care with individuals who have sought support. In addition, research has indicated that observing other military personnel accessing mental health care encourages others to seek support (Zinzow et al., 2013). Consequently, there is a need for further qualitative research that explores these areas with the UK military population.

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Deciding to access psychological support: A theoretical model for the decision-making process for military veterans

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Abstract

Military personnel and military veterans are at high risk of developing mental health difficulties. However, there is limited use of the support available to this population. Studies aimed at understanding and addressing this discrepancy have identified a number of barriers and facilitators to accessing these mental health care pathways for this population. However, little research has been conducted with regard to how military personnel and military veterans engage in the process of making decisions whether to access support. Therefore, this study explored how UK military veterans decided to access psychological support and developed a theoretical model to describe and understand this process, using constructionist grounded theory. Consequently, this study provides further information to explain the impact of known barriers and facilitators to care on veterans' decisions to seek support. It also highlights key stages in a process of accessing care that military veterans encounter when they develop mental health difficulties.

Introduction

Military veterans are at increased risk of developing mental health difficulties as a consequence of their exposure to traumatic events (Vogt et al., 2014, Zinzow et al., 2013; Gould, Greenberg & Hetherington, 2007). They may also experience a range of problems transitioning to civilian life (Hynes, Mottershead & Brett, 2013). Iversen et al. (2005) found 44% of veterans had a psychiatric diagnosis when examining the prevalence of mental health difficulties and help-seeking in UK veterans.

Military personnel and veterans tend not to seek help for their mental health difficulties (Whelan, Kuhn & Pietrzak, 2014; Zinzow, Britt, McFadden, Burnette & Gillespie, 2012; Snyder et al., 2016).

Studies using US and UK military populations have identified factors that prevent or facilitate military personnel and veterans seeking mental health support. Using quantitative, qualitative and mixed methods designs, researchers have obtained data from deployed and non-deployed military personnel and also personnel and veterans accessing mental health services.

Quantitative studies have elicited perspectives on stigma and barriers to care (BTC) by respondents rating their agreement with statements provided by the researcher. However, the methodological limitations of some studies needs consideration. Some studies have not used validated measures (Voght, 2011) but have used data obtained for other purposes (mental health surveys and baseline measures for evaluations). Qualitative studies have used semi-structured interviews or focus groups to obtain information.

Barriers to accessing care

Studies have identified public and self-stigma as barriers for military personnel and veterans accessing care (Zinzow et al., 2013; Chase, McMahon and Winch, 2016; Cornish, Thys, Vogel, & Wade, 2014).

Corrigan (2004) highlighted that stigma can harm individuals labelled with mental health problems by stereotypes, prejudice and discrimination. He made distinctions between public stigma (prejudiced perceptions from others) and self-stigma (internalised prejudiced perceptions towards self) (Corrigan, 2004). However, self-stigma is influenced by public stigma and is best comprehended as an interaction (Corrigan, 2004).

Stigmatising beliefs have been associated with concerns of being perceived and treated differently by others (Zinzow et al., 2013; Holland, Caridad Rabel & Cortina, 2016., 2016; Osario, Jones, Fertout & Greenberg, 2013a); of being perceived as weak (Holland et al., 2016; Osario et al.. 2013a) and that colleagues would lose confidence in them (Holland et al., 2016). Also, loss of credibility (Fertout Jones Keeling & Greenberg, 2015) and loss of trust (Fertout, et al., 2015) have been identified as key factors that prevent military personnel and military veterans from seeking support.

Other barriers to care have included: career concerns (that seeking treatment may impact on their career or lead to discharge from the military) (Zinzow et al., 2013); treatment concerns (side effects of medication, treatment would be ineffective, previous negative experiences of treatment) (Zinzow et al., 2013; Owens, Herrera & Whitesell, 2009); leadership problems (Zinzow et al., 2013); service provision (lack of service provision, access to timely

appointments) (Zinzow et al., 2013, Owens et al., 2009) and concerns about the help-seeking process (Cornish et al., 2014).

In addition, aspects of the military culture were associated with BTC and delaying seeking support. Zinzow et al. (2013) found treatment inhibiting beliefs such as the need to maintain mental toughness and the perceptions that problems should be managed independently in US military personnel. Also, Murphy, Hunt, Luzon and Greenberg (2014) found that UK military personnel talked about the impact of a culture of ‘continuing on despite problems’ that delayed participants seeking support. In addition, negative perceptions of seeking support and that military personnel should not complain, led veterans to delay seeking treatment until it was necessary (Chase et al., 2016).

Zinzow et al. (2013) also found that symptoms such as isolating oneself and substance use, obstructed seeking support and led to avoidance or self-medication.

Facilitators of accessing care

Facilitators of accessing support included: social support from peers, friends or family (Zinzow et al., 2013; Chase et al., 2016; Murphy et al., 2014); practical facilitators, such as schedule availability and knowing where to get support (Zinzow et al., 2013); positive appraisals of support (Zinzow et al., 2013); referral by medical or military personnel (Zinzow et al., 2013) observing peers accessing support (Zinzow et al., 2013) and knowledge of treatment (Zinzow et al., 2013).

In addition, increased levels of distress and symptom severity have been associated with seeking support (Snyder et al., 2016; Zinzow, et al., 2013). This is consistent with findings

from Murphy et al. (2014) who found that military personnel reported they reached a crisis point before they accepted they needed help.

Murphy et al. (2014) identified other themes associated with accessing support such as: overcoming feelings of shame, an internal locus of control and developing a psychological understanding of their problems.

Disengaging with support

Research has also identified factors that lead military personnel and military veterans to disengage from treatment. Chase et al. (2016) found that most veterans initiated treatment-seeking but delayed or discontinued care following negative experiences of care.

In addition, Jennings, Zinzow, Britt, Cheung and Pury (2016) found that a preference to manage difficulties independently, work interference, difficulties in appointment attendance and stigma were acknowledged as reasons for disengaging from treatment. Other concerns were effectiveness of treatment and professionals not satisfactorily caring (Jennings et al., 2016). In addition, functional impairment and symptoms of depression also increased rates of disengaging from treatment (Jennings et al., 2016). Jennings et al. (2016) also found that veterans reported their symptoms improved and therefore did not require further treatment.

Britt et al. (2015) found that perceived career stigma, differential treatment from others and self-stigmatising beliefs about accessing treatment were associated with increased possibility of treatment dropout. However, self-stigmatising beliefs about seeking treatment was the only predictor of treatment dropout (Britt et al., 2015).

Summary

Military personnel and veterans tend not to seek support for their mental health difficulties, despite existing interventions. Consequently, a range of barriers and facilitators to mental health care have been identified, leading to interventions and further research in this area. However, little research has focused on how military personnel or military veterans decide to access healthcare.

Deciding to access healthcare

Lee (2014) explored the process that US Homeless Vietnam Veterans used to decide whether or not to access healthcare services. She created a preliminary theory that the decision to access healthcare stemmed from military experiences, substance use, homelessness, communication via the “grapevine” and access issues (Lee, 2014).

Lee (2014) found that military experiences led to veterans feeling lied to and disillusioned which impacted on their perceptions and interactions of healthcare professionals. Lee (2014) considered that veterans used substances to cope with their experiences after joining the military and continued when they left which potentially contributed to homelessness. Lee (2014) found that veterans shared their experiences of healthcare, valued a sense of community and that decisions about accessing healthcare were based on judgements of friends. Lee (2014) also found that access issues (waiting times, procedures, location and mobility difficulties) impacted on the decision to access healthcare and decisions regarding this were based on convenience instead of quality.

As limited research has focused on exploring how military personnel and veterans decide to access mental health care, the present study aimed to build on the work that Lee (2014) completed by exploring how UK military veterans decide to access psychological support.

Aim

The aim of this study was to develop a theoretical model that describes the decision-making process for military veterans deciding to access psychological support, by addressing the research question: what is the nature of the decision-making process for military veterans when deciding to access psychological support? To achieve this, the following objectives were developed.

Objectives

- a) To explore the decision-making process for military veterans with regard to accessing psychological support.
- b) To explore how military veterans addressed barriers to accessing psychological support.
- c) To explore if the mental health difficulties experienced by military veterans impacted on their decision to seek psychological support.
- d) To explore the role of social support (family, friends, etc.) in seeking psychological services.
- e) To obtain the opinions of military veterans on what services can do to support veterans when deciding to access psychological support.
- f) To develop a theoretical model to increase understanding of the decision-making process to seek psychological support.
- g) To suggest how the theoretical model can be used to inform service development and mental health policy.

Method

The aim was to develop a theoretical model to describe how veterans decide to access psychological support. Therefore, grounded theory was considered the most appropriate qualitative method to use.

In contrast to objectivist grounded theory approaches that attempt to provide an objective true representation of the data in line with positivist assumptions about research, constructivist grounded theory acknowledges the subjectivity of the researcher's construction and interpretation of the data and attempts to provide an interpretation of the data that is open to modification (Charmaz, 2014). Consequently, constructivist grounded theory was used to explore military veterans' perspectives on how they decided to access psychological support.

Guidance by Charmaz (2014) was used as a framework to collect, analyse the data and construct a theory with regard to the research aim. Charmaz (2014) suggested that her framework provided flexible guidelines to applying grounded theory methods without specifying rules or requirements. The results were analysed from the theoretical perspective of symbolic interactionism. Symbolic interactionism perceives human actions as constructing self, situation and society and we act in response to how we view situations (Charmaz, 2014).

Participants

Eighteen participants were recruited from a service which provides evidence-based psychological interventions for mental health difficulties to military veterans in the Northwest of England. To ensure anonymity, this service will be referred to as the NW service.

Purposeful sampling was used to recruit participants (Morse, 2007). Participants were included in the study if they were accessing psychological support from the NW service or they had accessed the service within five years. Participants were excluded from participating if they met the following criteria:

- a) Disclosed current positive symptoms of psychosis;
- b) Had been given a Treatment Order by a Court to seek psychological support;
- c) In circumstances where it had been assessed by a clinician that it would not be clinically appropriate to invite them to take part; for example, when an individual may find it an additional psychological stress to participate in the study which could impact on their overall engagement with the service.

Demographic information was provided by the NW service and percentages were calculated to the nearest whole number. Sixteen participants were male and 2 participants were transgender women; participants were aged between 24 and 65 years old ($M=47.7$, $SD=12.63$). Table 1 shows percentages of the sample for ethnicity, marital status, dependent children and occupancy type.

Table 1**Demographic information**

Demographic	Percentage of participants
Ethnicity	
White British	94%
Caribbean	6%
Marital status	
Single	22%
Married / in civil partnership	39%
Separated	17%
Divorced / dissolved civil partnership	22%
Dependent children	
Yes	28%
No	56%
Occupancy type	
Own property	39%
Privately rented accommodation	33%
Council tenancy	17%
Housing Association tenancy	6%
Lived with parents	6%

Table 2 provides percentages of participants' physical health conditions and mobility. The classification 'other' relates to all other long-term health conditions which are not detailed on the National Improving Access to Psychological Therapies List.

Table 2**Physical health and mobility**

Condition / mobility	Percentage of participants
Long-term condition	
None	33%
Multiple sclerosis	6%
Severe mental health problems	6%
Chronic Muscular Skeletal	6%
Non-Insulin Dependent Diabetes Mellitus	6%
Coronary Heart Disease	6%
Hypertension	6%
Other	28%
Mobility	
Able to carry out normal activity with no restriction.	39%
Able to walk, do light work but, restricted in physically strenuous activity	22%
Able to walk and engage in self-care independently but unable to work up to 50% of waking hours	28%
Requires support with self-care, confined to a bed or chair for more than 50% of waking hours	11%

Table 3 provides percentages on participants' mental health presentation, substance use and forensic history.

Table 3**Participants' mental health presentation, substance use and forensic history**

Category	Percentage of participants
Primary presenting problem	
Post-traumatic stress disorder	61%
Mental and behavioural disorders due to alcohol use	17%
Generalised anxiety disorder	11%
Recurrent depressive disorder	6%
Mixed anxiety and depressive disorder.	6%
Substance use	
Alcohol consumption within recommended limits	28%
Alcohol consumption exceeded recommended limits	22%
No alcohol consumption	28%
Regular illicit drug use	11%
No drug use	61%
Forensic history	
Forensic history yes	22%
Forensic history no	50%
Unknown	28%

Participants were enlisted in the military between 1969 and 2013. Length of service ranged from 3 to 22 years ($M=8$, $SD=5.48$) and 94% of participants were operationally deployed during their career. Table 4 provides percentages of the branch of the military that participants served in and their rank on discharge from the military.

Table 4**Participants' branch of the military and rank of discharge**

Branch / Rank	Percentage of participants
Branch	
British Army	72%
Royal Navy	17%
Royal Air Force	11%
Rank on discharge	
Private or equivalent	61%
Senior Non-Commissioned Officer	11%
Junior Non-Commissioned Officer	22%

Data collection

To explore how veterans decided to access psychological support, a semi structured interview schedule was developed in line with the research aim and objectives. Knowledge of the literature on barriers and facilitators to accessing care for the military population aided the construction of the interview schedule. Also, feedback on the questions was obtained from two veterans known to the NW service and amendments were made accordingly. Additional questions were added as the analysis progressed after consultation with participants when reviewing the model.

Procedure

Ethical approval (15/WS/0188) was granted by the West of Scotland Research Ethics Committee by expedited review. Research and Development approval was granted by the Trust Research and Development Department.

Participants who met the inclusion criteria were selected by clinicians at the NW service. Clinicians informed their clients about the study and provided them with the participant information sheet. The NW service also approached veterans who had agreed to be contacted to take part in research and gave them a participant information sheet.

Twelve individual interviews were completed with participants using interview schedule one. Following initial stages of analysis, two focus groups (N=3) were arranged to obtain feedback on the first draft of the model. Six individual interviews were then facilitated with additional participants following amendment of the interview schedule, in line with the emerging analysis and feedback on the first draft of the model. Finally, four focus groups

(N=3, N=2, N=2 & N=3) and two second interviews were arranged to obtain feedback on the final draft of the model.

Individual interviews

Veterans who wanted to take part in the study were invited to an individual interview with the researcher. The researcher reviewed the participant information sheet and answered any questions raised in order to obtain informed consent. Participants were asked to sign a consent form. They were informed that they could have a break any time throughout the interview and that they could withdraw participation any time.

Individual interviews lasted between 30 and 90 minutes and involved going through the interview schedule. Prompts and further questions were added to aid understanding and clarify participants' responses.

The interviews were audio recorded and 62% were transcribed verbatim by the researcher to aid the analysis. The remaining transcripts were transcribed by a professional known to the Department of Clinical Psychology.

After 12 interviews were completed data gathering stopped in order to facilitate analysis and initial development of the model.

Focus groups for feedback on initial model

Participants were then invited to take part in a focus group (N=3), the aim of which was to obtain their perspectives on the developing model, key areas identified in the analysis and to

identify areas to focus on in subsequent interviews. However, three second interviews were completed with three participants due to other participants cancelling at short notice.

Following transcription, data were added to the analysis and seven questions were inserted into the interview schedule. A further six interviews were completed with additional participants. Data gathering stopped as no new codes emerged and it appeared that theoretical saturation had been reached.

Focus groups for feedback on final draft of the model

All participants were then invited back to take part in a focus group (N=3) to obtain their perspectives on the final draft of the model. Two focus groups (N=3 and N=2) and three additional interviews were completed with 44% of the sample.

Two versions of the model (process and full version) were discussed with participants to aid their understanding and clarify the process; informed consent was gained before obtaining participants feedback and ground rules were established at the beginning to ensure participants' welfare. Participants were asked for their opinion and to reflect on their experience in relation to the model. Data gathered was added to the analysis and aided the development of the final model.

Data analysis

Using guidance by Charmaz (2014) initial codes were developed by defining what was observed in the data through line-by-line coding. Where possible, codes were labelled with gerunds to highlight participants' actions and meanings (Charmaz, 2014). Gerunds are words ending in *ing* developed from verbs and used as nouns (Cambridge Dictionaries Online, 2016). In vivo codes were used to adhere to participants' meanings and actions (Charmaz, 2014).

All codes from each interview were compared with codes from all other interviews to find similarities and differences using the constant comparative approach (Charmaz, 2014). This approach compares data with data to formulate comparisons at each level of analysis (Charmaz, 2014). Significant initial codes which made the most analytic sense in relation to the research aim were developed to form focused codes. During focused coding codes were collated together with codes that seemed related to one another. Analytic memos were used to constantly compare the data within each focused code. Focused codes were then refined by constantly comparing them with other focused codes. Charmaz (2014) advocated questioning what theoretical categories the focused codes leaned towards. Consequently, the focused codes that related to a more abstract category were combined together to form a theoretical category that represented a core element of the decision-making process that veterans endure when deciding to access psychological support. Successive memos were written throughout the research process (Charmaz, 2014).

Reflexivity

Reflection on how the researcher's perspectives interact with the emerging analysis is essential to prevent the researcher applying their own ideas to the data and to eliminate bias. Reflexivity provides a space to do this (Engward and Davis, 2015). The researcher has no direct experience with the military. The researcher's grandfather was in the Royal Navy but he retired before the researcher was born; he did not talk about his experiences. However, the researcher was aware that a bomb exploded near his ship, leaving him partially deaf.

The idea for this study was generated from reviewing research investigating barriers to mental health care in the military population and the researcher has worked with individuals

who have experienced difficulties prevalent in the veteran population. Consequently, the researcher is aware of interventions for these difficulties. These factors led the researcher to question how veterans decide to access psychological support. It appeared that there had been not been any previous research exploring this. Highlighting how veterans decide to access support may help veterans, health professionals, policy makers and their families potentially to aid veterans to access the service they need.

Results

This study explored how military veterans decided to access psychological support in order to develop a theoretical model to describe this process. Ten theoretical categories emerged as relevant to the research aim. These were: Military culture; Leaving the military; Experiencing difficulties; Attempting to manage difficulties independently; Reaching a point where they cannot continue; Accessing services; Negative experiences of service / support; Receiving the right support; Renewed sense of self and Unable to manage difficulties in the future.

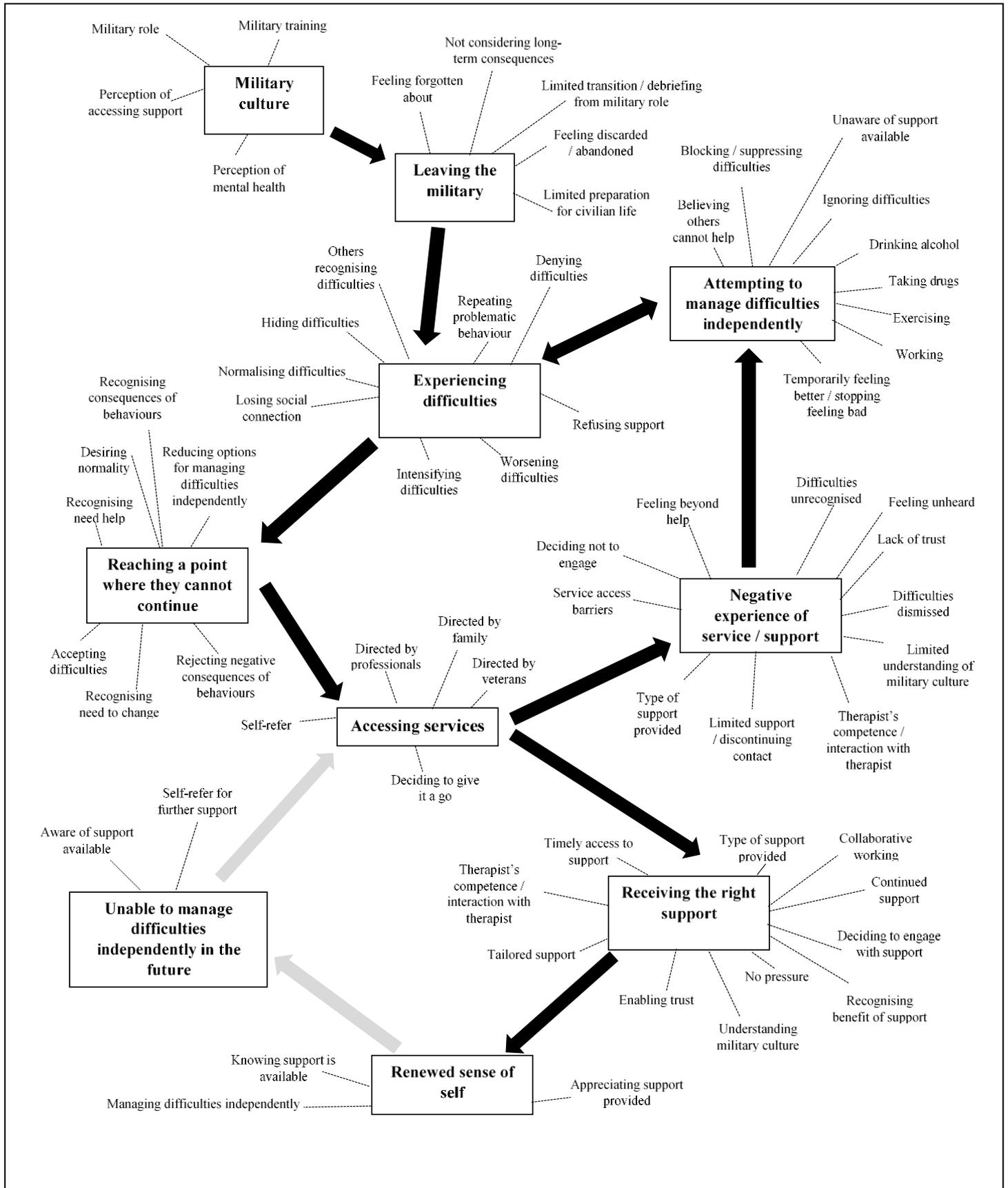
Table 5 details the theoretical categories and subcategories. Subcategories are properties that underpinned the theoretical category. Figure 1 provides a visual representation of this process.

Table 5:

Theoretical categories and subcategories

Theoretical category & subcategories	Theoretical category & subcategories
1: Military culture Military role Military training Perception of mental health Perception of accessing support	2: Leaving the military Feeling forgotten about Feeling discarded / abandoned Limited transition / debriefing from military Limited preparation for civilian life Not considering long-term consequence
3: Experiencing difficulties Repeating problematic behaviour Others recognising difficulties Refusing support Denying difficulties Normalising difficulties Hiding difficulties Worsening difficulties Intensifying difficulties Losing social connections	4: Attempting to manage difficulties independently Blocking / suppressing difficulties Drinking alcohol Taking drugs Exercising Working Ignoring difficulties Temporarily feeling better / stopping feeling bad Unaware of support available
5: Reaching a point where they cannot continue Recognising need to change Recognising need help Reducing options for managing difficulties independently Accepting difficulties Recognising consequences of behaviour Rejecting negative consequences of behaviour Desiring normality	6: Accessing services Directed by professionals Directed by family Directed by veterans Self-refer Deciding to give it a go
7: Negative experiences of support / services Service access barriers Difficulties unrecognised Difficulties dismissed Limited understanding of military culture Type of support Limited support / discontinuing contact Feeling unheard Therapist's competence / interaction with the therapist Lack of trust Deciding not to engage Feeling beyond help	8: Receiving the right support Understanding military culture Therapist's competence / interaction with the therapist Deciding to engage with support Enabling trust Type of support provided Collaborative working Recognising benefit of support No pressure Tailored support Timely access to support Continued support
9: Renewed sense of self Appreciating support provided Managing difficulties independently Knowing support is available	10: Unable to manage difficulties independently in the future Self-refer for further support Aware of support available

Figure 1: Model for the decision-making process for military veterans deciding to access psychological support



Military culture

Participants described how aspects of the military culture impacted on their decision to access psychological support and talked about a culture that was different to civilian life.

“I think it is the world of the forces. It is a totally different world, like a different planet sometimes it really is.” (Participant 4).

Participants described a culture of a work-hard / play-hard approach, consuming alcohol and not discussing negative experiences. In addition, participants described that their role impacted on their ability to trust others and led them to question how prepared they were for combat

“With being young, you come out of school and the next minute you are seeing people being blown up and shot at and you’re like “wow, hang on a minute, was I prepared for this?” Because you are young, you haven’t got that experience I suppose. So, you’re basically you’re in the deep end and that’s it and obviously, that’s your job.” (Participant 4).

Participants described they were trained to continue and deal with their problems and showing emotion is a sign of weakness.

“The first thing that impacts on it is you come from a military culture which is shut up and get on with it. You don’t have a problem, you’re in pain take a pain killer, you’re bleeding put a dressing on it.” (Participant 9).

Participants reported that mental health difficulties were stigmatised and accessing support was viewed as an inability to cope and a sign of weakness:

“There is a big stigma around it.” (Participant 3).

Consequently, participants were less likely to seek support as they were taught to deal with their problems and move on. They viewed accessing support as a sign of weakness, were concerned about being stigmatised and perceived as weak, had difficulty trusting others and they generally did not talk about negative experiences.

Leaving the military

All participants described how they felt forgotten about, discarded and abandoned when leaving the military:

“You are deserted you are literally thrown out and deserted and they don’t want to know or back then in 86 when I left they basically didn’t want to know anymore.” (Participant 16).

The majority of participants reported a limited transition / debriefing from their military role:

“What they do in the Army is they train you to be a killer and they just put you in Civvy Street they don’t untrain you.” (Participant 12).

and a limited preparation for civilian life:

“They might offer job training but they don’t offer civilian training. They don’t help people to transition completely from the army. Until they get that right people are still going to have problems adjusting to civilian life. It is not a case of ‘oh we’ll give you a new trade’ there is a whole lot more about being a civilian that needs to be done.” (Participant 10).

In addition, three participants also reflected on not considering the long-term consequences of being in the military:

“You just don’t think of the long-term effects do you so.” (Participant 3).

Consequently, feeling forgotten about, discarded or abandoned may have led participants to feel lonely and isolated. Also, feeling unprepared for civilian life may have led participants to feel fearful of the future. Therefore, these feelings may underlie difficulties that participants experienced or may have exacerbated their difficulties when they left the military.

Experiencing difficulties

Subsequently, all participants described experiencing a range of difficulties. They described repeating problematic behaviours associated with their difficulties.

“I was getting locked up in a police station once every week and I was locked up for 20 hours.” (Participant 1).

Participants talked about others recognising their difficulties which led them to insult them and deny their difficulties.

“All I could remember is I was down playing my condition. Doctors would see there is something wrong “this man there is something wrong with him” I was insulting them “oh trust me, oh come on there is nothing wrong with me.” (Participant 2).

All participants described losing social connection; they talked about people leaving due to their behaviour, isolating themselves due to concerns around being stigmatised, feeling lonely, being disowned by their family and difficulties in friendships:

“I’ve found that’s a common thing you cut yourself off from everybody.” (Participant 12).

Participants reported that they normalised their difficulties and hid them from others as they did not want to be perceived as weak or stigmatised:

“I thought it was normal to be having flashbacks and that because they are memories.” (Participant 5).

Some participants described refusing support because they were not prepared to get help at this stage:

“All I know is there is help available but I was the one who was not prepared to get that help.” (Participant 2).

At this stage too, participants were likely to continue to perceive accessing support as a sign of weakness. However, participants described that it became increasingly difficult to hide

their difficulties. They depicted their difficulties as progressive and explained intensifying difficulties over time:

“Whereas mine it builds up and then I exploded.” (Participant 8).

All participants reported that their difficulties intensified leading to a point where they could not continue. Participants expressed their intensifying difficulties as a result of a number of adverse events that occurred simultaneously, a build-up of a number of things; or their difficulties increased to such an extent they were unable to manage them.

Managing difficulties independently

Once participants experienced difficulties they described how they attempted to manage their difficulties independently:

“I didn’t seek any help. I don’t know why, I just tried to do it myself again. I tried to sort it out myself.” (Participant 7).

All participants described attempting to block them by either drinking alcohol, taking drugs, exercising or working. Participants also reported that they ignored their difficulties thinking they would get better without intervention:

“I just have to deal with it and this is how my life is and I just have to accept it and get on with it the best I can.” (Participant 10).

This is consistent with participants' descriptions of military training. They reported that they were told to 'deal with it' and carry on. They also described how they attempted to manage their difficulties independently because they were unaware of support available and believed that others could not help them:

"I just thought there is nothing anyone can do for me." (Participant 6).

Participants attempted to manage their difficulties using pre-existing coping strategies they employed in the military. These strategies were underpinned by a work-hard, play-hard culture, using alcohol to relax. They explained how these strategies helped them temporarily to feel better and stop them feeling bad but that it became a vicious circle to help themselves with a few times, although this did not last:

"I'd go through phases of being ok but then things would start coming back to me and I'd drink and once I'd started it was like a vicious circle." (Participant 3).

Participants described reaching a point when they realised these strategies were not working and they needed to seek help. In addition, as mentioned previously, as time progressed participants reported their difficulties got worse leading to a point where they felt they could not continue.

Reaching a point where they cannot continue

All participants described reaching a point where they felt that they could not continue as things were:

“I got to the tipping point of committing suicide then I had to self-refer.” (Participant 2).

They described reducing options for managing their difficulties independently and explained how their options reduced to either get help or commit suicide, become homeless or go to prison:

“Yes yes something had to give and it was either kill myself or get help. Like I said I decided to get help.” (Participant 14).

In addition, one participant reported that he reached a point where he was unable to manage his difficulties through exercise and realised he needed to get help.

Participants reported they recognised a need to change and that they needed help. This was generally after a decline in their health or a number of adverse life events as their difficulties intensified over time. Participants described reaching a point of accepting their difficulties and talked about recognising the consequences of their behaviours, such as, becoming homeless or hurting others, a fear of working themselves to death or committing suicide, or going to prison:

“Yes I was going to; someone was either going to kill me or I was going to kill them.”
(Participant 12).

Consequently, participants described rejecting negative consequences of their behaviours which led them to seek support:

“I was killing myself. I don’t want to be in an orange crate in the Irish Sea somewhere. I don’t want that to happen to me.” (Participant 5).

Some participants also talked about desiring to be and feel normal again.

Accessing services

After reaching a point where they felt they could not continue, participants accessed services. They were either directed there by professionals, their family or other veterans, or they self-referred. At this stage, participants described deciding to give accessing support a go. They described how they thought they would try it, knowing that they could walk away if they did not like it:

“It’s a little bit of dabblement if you like, just to see. “Let’s give it a go” and yes if you are not happy then you are back to square one.” (Participant 4).

Negative experiences of service / support

All participants talked about previous negative experiences of services / support. Some participants recalled difficulties with accessing services:

“She referred me to the local psychiatric centre who sent me a big form ‘we don’t do this, we don’t do that, we can’t help you, we can’t do this, we can’t do that, can’t do the other, fill in this form send it us back’. So, I did what most people who are deep with depression would do screwed it up and threw it in the bin and told them where to go.” (Participant 13).

Participants recalled experiences of professionals not recognising their difficulties and that they felt professionals did not understand the extent of their problems; they were given an alternative diagnosis and it took them years to be diagnosed.

Participants recalled negative experiences of professionals dismissing their difficulties such as being told not to be “daft” and there was “nothing wrong with them”; they also reported they were not provided with appropriate support. One participant explained he told professionals he should be sectioned but this did not happen:

“I used to say to them I need sectioning “oh we’ll put you in there soon” or something like that it was. But it never seemed to happen.” (Participant 1).

Participants recalled negative experiences in relation to professionals’ limited understanding of the military culture:

“But I didn’t feel that understanding of the military, you know. I was saying things and then it came to a halt really and that was it.” (Participant 11).

In addition, participants reported negative experiences in relation to the type of support they were provided. One participant recalled he was advised to continue to engage in the maladaptive coping skills that led him to seek support:

“He said to me he said ‘if you need to use drugs and alcohol to get you through then do it if that is what you need to do.’ I was like ‘that is why I am sat here I would still be in the army

if it wasn't for that' so obviously, I binned him and then self-help again for a few months I was alright and then it happened again a lot worse." (Participant 6).

Participants reported previous negative experiences of a limited amount of support and of services discontinuing contact and feeling unheard:

"My doctor recommended me to other civilian services and again it just felt like, you're not listening to me, you're not listening you don't understand my requirements." (Participant 9).

Participants recalled a range of negative experiences of previously engaging in therapy that related to the therapist's competence and the interaction between them and the therapist such as: perceiving the therapist as unable to manage their difficulties; the therapist appearing out of her comfort zone; conflict arising from different perspectives; perceiving the therapist as patronising and unsympathetic; experiencing further trauma as a result of therapy and feeling an inability to connect with the therapist. Consequently, these experiences led participants to disengage from therapy:

"So it was a bad experience really. I didn't find him very sympathetic which you're looking for to a certain extent aren't you?" (Participant 11).

Participants also reported they were unable to develop trust with some professionals as a result of their negative experience of support:

“A little bit broke down everything and you didn’t get the trust what you needed.”

(Participant 15).

As a result of their negative experiences participants reported they disengaged from the service and decided not access support. One participant decided that his difficulties would get better independently. Also, some participants reported it made them feel they were beyond help or that nobody was able to help them:

“I am beyond help but that was just because of my previous experiences of different therapies.” (Participant 6).

Participants reported that their negative experiences impacted on their perception of other services and they did not seek further support at this time. They reverted back to attempting to manage their difficulties independently, using their pre-existing coping responses of either drinking, taking drugs, exercising or working excessively. However, as these strategies only worked temporarily, as time progressed their difficulties got worse with increasing intensity until they reached a point where they could not continue again. Subsequently, participants described accessing services once more and if they experienced a further negative encounter, participants again reverted back to managing their difficulties independently. One participant said each time he reverted back to attempting to manage his difficulties himself, his options reduced, which led him to reach a point where he felt he could not continue within a shorter period of time. Participants labelled this pattern as an infinity loop and recalled a range of timescales for being in this loop from six months to 31 years.

Receiving the right support

The majority of participants described how once they accessed the NW service they received the right support which encouraged them to engage with the support and decide to ‘give it a go’:

“I thought “these are alright I’ll give them a go.” (Participant 1).

Participants reported that it was important that the therapist understood and had knowledge of the military culture and military background. Participants described it being easier to communicate with therapists who understood military culture.

“When I saw her it was really really good because yes she had a little bit of understanding.” (Participant 18).

Participants talked about the therapist’s competence and their interaction with the therapist; they talked about the therapist’s qualifications and their ability to do their job successfully and how the therapist spoke to them. Participants reported the therapist used a caring, direct, honest and open approach and demonstrated a genuine concern for their welfare. In addition, participants described how the response from the NW service encouraged them to engage with the service and recalled professionals demonstrating an open approach and desire to do their best to help.

Participants talked about trust and the importance of developing trust in the therapist and they explained how trust enabled them to speak openly. As part of developing trust, participants

described how they tested the therapist which helped them to share information and gain confidence in the therapist's knowledge and ability to help them:

"You need to actually trust that person to get yourself better and if you don't have the confidence in them actually knowing the job properly you think to yourself can they really help you." (Participant 15).

Participants said that support was provided for all of their difficulties and achievable goals were set at their pace:

"Because they were able to deal with just about everything I was suffering from, without them I still don't know whether I would have survived" (Participant 14).

In addition, participants talked about collaborative working with their therapist:

"Yes it's not just them going away doing their stuff and giving me homework, it's we're in it together." (Participant 13).

Participants described continuing support and said they could contact the service any time they felt they needed help or were struggling. Participants were told at the end of their therapy they could contact the service if they needed further help:

"I'm at liberty to just ring the doctor straight away because he has given me that opportunity. If you struggle at any point just give me a ring." (Participant 2).

All participants recognised the benefit of the support they received and recalled that once they engaged in therapy they realised it was working, which encouraged them to continue to engage:

“When I started getting the help I started realising this is working for me.” (Participant 1).

Participants described how the therapist did not put any pressure on them:

“Said anytime you’re uncomfortable there’s the door. They’ll think nothing less of you. So there’s no pressure it’s under my own fruition.” (Participant 13).

Participants described how their support was tailored to meet their needs and recognised that not all therapeutic strategies may work for everyone:

“It is pretty much tailored to suit.” (Participant 13).

Participants talked about timely access to the NW service and reported that the service was quick to respond and they were able to access support quickly:

“So I got in touch with the service, they were brilliant dead quick really really quick.”

(Participant 12).

Renewed sense of self

After receiving the right support participants described a renewed sense of self. They described that the support brought their spirit back and renewed their confidence, self-esteem, pride and motivation:

“I was always trying to kill myself and basically when I started seeing these it brought me to my senses you know and I’m thinking ‘my son’s dead, I want a good job’ and that’s what I was thinking and I thought one day ‘I want to be like these’ and it’s like I’m thinking ‘I can do this sort of thing’ so it brought me up to spirit.” (Participant 14).

The majority of participants described how they continued to be thankful and appreciate the support they received from the service after they had been discharged. One third of participants expressed they would not be alive if it was not for the support they had received:

“I just got my life back, thanks to this service cos I would have been dead.” (Participant 1).

Participants reported they had developed skills that enabled them to manage their difficulties independently:

“It is very unpleasant if I cast my mind back to the suffering I have been through. Don’t get me wrong here, I still have a bit of those things but I manage them but better.” (Participant 2).

Participants said that knowing support was available helped them to move forward and described it as crutch, cushion and buffer:

“I’m feeling a bit low, just get yourself home. But if you need them they’re there and that in itself is a bit of help to know that. You know they’re there and they’ll help me so how could I put it, it’s that the fact that I know somebody’s watching my back is that I can move forward.” (Participant 14).

Unable to manage difficulties independently in the future

Some participants also described that they had received support from the service intermittently when required. Participants talked about occasions they had self-referred back to the service for further support. All participants reported that after receiving the right support they knew where to access support if they were unable to manage their difficulties independently in the future and reported they would contact the service:

“Yes because I will access it again if I need help. I know where to go to now, yes it has helped it has impacted.” (Participant 7).

Validation of model

Participants provided their feedback on the final draft of the model. They provided positive feedback and reflected that the model represented their experience:

“It is good, it is like last time when I said as you are talking through it I am applying it to my own personal situation as well. It is like it is bang on, everything is perfect. I think it is anyway.” (Participant 2).

With regard to limitations, participants suggested that more women should be involved in further studies and the model should represent support for family members.

Participants also suggested that the model could aid outreach workers to identify at what stage a veteran may be, in relation to seeking support. Participants also suggested that it could aid veterans explain their difficulties to family members.

With regard to supporting military veterans to decide to access psychological support, participants made a range of suggestions such as: the Ministry of Defence and NHS could facilitate the transition of support when leaving the military; they should inform military veterans of common difficulties; that military personnel and veterans should be informed of what support is available; that the Armed Forces Covenant should be enforced; there should be advertising of the support that is available; that professionals should signpost or refer military veterans to services; that military veterans should receive timely access to support; that civilian professionals should be provided with training and also use veterans who have previously accessed support as mentors.

Discussion

This study aimed to develop a theoretical model to describe the process that UK military veterans endure when deciding to access psychological support.

Participants described how aspects of the military culture impacted on their decision to access psychological support which formed the foundation of their decision-making process. This is consistent with Lee (2014) who found that military experiences impacted on US Vietnam veterans' decisions to access healthcare services. Participants described how perceptions of accessing support was a sign of weakness, which is consistent with previous research on public stigma as a barrier to care (Zinzow et al., 2013; Chase et al., 2016; Cornish et al., 2014; Thys et al., 2014). Participants also reported they were trained to deal with their problems and move on, which is consistent with previous research linking military values of maintaining mental toughness, that problems should be managed independently (Zinzow, et al., 2013).

Participants reported they felt discarded, forgotten about and abandoned when they left the military. This is similar to findings that Lee (2014) reported in relation to military experiences of Vietnam veterans. She found that their experiences led them to feel disillusioned with authority and this impacted on their perceptions and interactions with healthcare professionals. Participants also described a limited preparation for civilian life and limited debriefing from their military roles which may have exacerbated or underlined their difficulties and transition into civilian life.

Participants gave an account of attempting to hide their difficulties from others, due to concerns of being stigmatised and perceived as weak; which is consistent with previous

research (Holland et al., 2016; Osario et al., 2013a). In addition, participants described losing social connection and isolating themselves. This is consistent with Zinzow et al. (2013), who found symptoms such as isolating oneself led to avoidance or self-medication.

Participants described initially attempting to manage their difficulties independently using pre-existing coping strategies they employed in the military, such as drinking alcohol, taking drugs, exercising or working. Participants outlined a military culture of work-hard, play-hard that consisted of using alcohol to relax. This is consistent with Lee (2014) who found that US Vietnam veterans consumed alcohol as a coping strategy when serving in the military and also when they left the military which contributed to their difficulties. Participants also reported ignoring their difficulties as they thought things would get better on their own. Zinzow et al. (2013) found that veterans avoided their difficulties. Participants reported that they attempted to manage their difficulties independently because they did not know what support was available. Inversely, this is consistent with previous research which has indicated knowing where to get support facilitates accessing care (Zinzow et al., 2013).

Participants described their difficulties worsening and intensifying over time until they reached a point where they could not continue. This is consistent with previous research concerning facilitators of care which have identified increased levels of distress and reaching a crisis point before they accepted they needed help (Snyder et al., 2016; Zinzow et al., 2013; Murphy et al., 2014).

Participants reported they were directed to access services by professionals, family members and others veterans. This highlights the role of social support in facilitating or accessing care, again consistent with previous research (Chase et al., 2016; Murphy et al., 2014).

Participants described previous negative experiences that led them to disengage from accessing support. This is consistent with previous findings (Zinzow et al., 2013; Owens et al., 2009) and studies that have focused on exploring reasons for treatment dropout (Jennings et al., 2016).

Participants reverted to managing their difficulties independently as a result of their negative experiences and delayed seeking further support, consistent with Chase et al. (2016).

Participants internalised the idea they were beyond help which further compounded mounting beliefs that others were unable to help them, attempting to manage their difficulties independently until they reached a point where once more they were unable to continue.

However, participants described receiving the right support which encouraged them to continue to engage in accessing care. This is consistent with research that has focused on facilitators to care (Zinzow et al., 2013). Participants talked about developing trust in the therapist, consistent with Jennings et al. (2016) and also reported being put at ease by the therapist using a caring, direct and open approach. This approach may have supported participants to develop a more positive view about themselves and potentially impacted on their self-stigmatising beliefs, which facilitated continued engagement; increased levels of self-stigma can predict disengagement from therapy (Britt et al., 2015). Participants also talked about timely access to support which is also consistent with previous research on practical barriers to care (Zinzow et al., 2013).

Once participants had received the right support they described a renewed sense of self, talked about managing their difficulties independently and knowing that support was

available helped them to move forward. Jennings et al. (2016) reported that veterans disengaged from treatment as they were able to manage their difficulties independently, which is also consistent with military values of managing difficulties independently (Zinzow et al., 2013).

However, some participants described intermittently accessing support when necessary and self-referring for support because they knew where to get it and it helped, consistent with findings from Zinzow et al. (2013). In addition, all participants reported they would seek support from the NW service if they required further support in the future. Zinzow et al. (2013) reported that positive perceptions of treatment facilitated military veterans to seek care.

Summary

This study provides a theoretical model to describe the process that veterans go through when deciding to access psychological support that is consistent with previous research and was validated by 44% of participants who reflected the model was congruent with their experience.

Implications for clinical practice

This study provides a novel contribution to the literature by highlighting the process that veterans go through when deciding to access psychological support. It also begins to suggest how negative experiences of support impact on military veterans engaging with services and what they may do in response to that experience. This study also highlights what veterans perceive as the most appropriate support and what helps them to access services. Finally, it

provides information that the Ministry of Defence, NHS and Charity services could use to support veterans to access mental health services.

This study extends previous research by providing further information on how previously identified barriers and facilitators to care impact on military veterans' decision to access psychological support. Consequently, it provides information that policy makers and healthcare professionals can use to develop services that facilitate veterans accessing effective support.

In addition, the study provides information on veterans' perspectives on what organisations could do to support veterans to decide to engage in accessing support.

Moreover, participants suggested that the model could aid professionals or veterans in identifying at what stage a military veteran may be, in order to support him or her in deciding to access help. Alongside this, consistent with participants' suggestions, this model could aid veterans to explain their difficulties to others.

Limitations

This study used grounded theory to explore participants' perspectives and is developed from the researcher's interpretation of the data, which may be perceived as subjective. However, the model was developed in line with feedback from participants and the analysis was discussed with supervisors.

Participants were recruited from a service in the Northwest of England and data specifically related to how they decided to access psychological support, which has implications for the

generalisability of these findings. The factors that contributed to the decisions made by military veterans in this sample may differ from others. Also, consistent with participants' perspectives, the sample included male participants and two transgender women and may not represent perspectives of female military veterans.

Furthermore, this study recruited participants who decided to access psychological support and therefore did not include participants who have decided not to do so.

Finally, participants reported that the model did not consider the nature of support for family members. However, this was felt to be beyond the scope of this study but is important to consider in future research.

Recommendations for future research

Considering the limitations, further research should be conducted to replicate this study using female military veterans and military veterans who have decided not to access psychological support. It should also be replicated in other areas in the UK and other countries to enhance the generalisability and utility of this model in supporting military veterans to access mental health care.

As participants reported that the model did not consider support required for family members, it is recommended that further research is conducted exploring family members' perspectives and also focusing on their support needs.

Conclusion

The aim of this study was to develop a theoretical model that describes how military veterans decide to access psychological support. The objectives of the study provided a framework for exploring how military veterans decided to access psychological support, which in turn facilitated the development of a theoretical model to describe and understand this process. Consequently, the study provides further information to explain the impact of known barriers and facilitators to care on veterans' decisions to seek support. It also highlights key stages along a sequential process of accessing care that military veterans encounter when they develop mental health difficulties.

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