A Synthesis of Factors Affecting Post-Military Reintegration in Relation to Help-Seeking and Social Support

Word count- 18428

Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

June 2023

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

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| --- | --- |
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| **Initial date of registration** | **September 2020** |

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| **Declaration and signature of candidate** |
| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.  Signed: SAM RICHMOND Date: 28/04/23 |

Acknowledgements

I would like to begin by thanking my academic supervisor, Dr Helen Scott. You have provided me with knowledge, guidance, and personal support throughout the process which at times I would have struggled without. You have been incredibly patient and adaptable to my somewhat hectic style of working and for that I cannot thank you enough. I am truly grateful for your contribution.

Additionally, I would like to thank my clinical supervisor, Dr Vicky Aldridge. You gave me insight into the struggles and pitfalls of producing a thesis which helped me avoid these along the way. I hope our shared intertest of supporting veterans leads to interesting conversations in the future.

It is important to me that I highlight the contribution of Van Barrett. You supported me in collecting data and in producing the executive summary section of this thesis. You provided insight that only a veteran could. I hope your continued work in supporting the veteran community is fruitful. I am indebted for your contributions and only hope that I continue to help veterans as you do.

Finally, I would like to thank my family, my parents for the constant ongoing emotional support, my grandparents for offering calm minds and a calm environment in which I could work, and my partner Lucy for being the constant in my life. You have tolerated my late nights and anxiousness with the patience of a saint!

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# Abstract

Paper one is a literature review of 12 empirical studies which synthesises the current knowledge on help-seeking in female veterans for mental health difficulties. All studies identified were peer reviewed and of sufficient methodological quality. Nine papers were cross-sectional, two were longitudinal and one was qualitative. Results indicated that hypermasculinity of the military culture, military sexual trauma and relationship difficulties were all factors that primarily impacted female veterans help-seeking attitudes and behaviours. Stigma was universal to both male and female veterans in affecting help-seeking for mental health difficulties. Future research is advised to explore differences between a US and UK sample. Clinical implications include veteran specific training in general mental health practices and challenging masculine norms in veteran services.

Paper two is an empirical study exploring factors that predict perceived social support and attitudes towards help-seeking in a sample of 50 UK veterans, who had been deployed to active war scenarios. Cross-sectional internet mediated, regression design was utilised. Predictors included expressive suppression, trauma symptoms, time in service and time since discharge. Time since discharge was found to predict perceived social support with increased time leading to lower perceived support. Expressive suppression was found to predict attitudes towards help-seeking for mental health with greater suppression leading to poorer attitudes. Findings are discussed in the context of comparable research along with the limitations, clinical implications, and possible avenues for future research.

Paper three is an executive summary, written as an accessible summary of the empirical paper. It is intended for dissemination of the background, method, findings, and implications to a veteran population. It has been contributed to and validated by veterans.

# Literature review

An Exploration of Barriers and Facilitators to Mental Health Help-Seeking in Female Veterans: A Literature Review

This paper has been prepared for publication in the Military Psychology Journal. Author guidelines are listed in Appendix A.

Word Count- 7203

# Abstract

Military veterans have higher rates of mental health difficulties than the general population (Talbott, 2011) but they seek less support (Nworah et al, 2014). Previous literature has highlighted reasons for this in existing military personnel and veterans such as stigma and military culture encouraging toughness (Hom et al,2017). There is minimal research examining the impacts of gender in this population. The current literature review synthesises the research on help seeking in female veterans for mental health difficulties to better understand the factors that affect this.

A systematic search of five databases was conducted. Data was extracted and papers were critically appraised using the JBI appraisal tools.

12 papers were identified, nine were cross sectional, two were longitudinal and one was qualitative. All studies were peer reviewed and deemed to be of sufficient methodological quality. Key factors identified as impacting help-seeking among female veterans are: hypermasculinity in military services, military sexual trauma, stigma, and relationship difficulties.

The review suggests that numerous factors affect help-seeking in female veterans, some of which intercorrelate with their male counterparts. It is advocated that future research explores the differences between a US and UK sample due to differing service structures which provide help for mental health. Clinical implications raised focus on the need for more veteran specific training in general mental health services and the need to challenge masculine norms in veteran specific services.

Key Words: Veteran, Female, Help-seeking, Literature review.

Individuals who have served in the military have been shown to have a high prevalence of mental health difficulties (Talbott, 2011). Research suggests that despite this, military personnel underutilise mental health services compared to the general population (Nworah et al, 2014). The ramifications of this are that military personnel and veterans may rely on other methods to manage their mental health issues such as alcohol (Boscarino, 1979), or drugs (Wagner et al, 2007). In addition, military personnel have higher rates of suicide than the general population (Rozanov et al, 2012). This risk is increases in recently discharged veterans (Sokol et al, 2021).

These difficulties have led to a growing body of research into military personnel and veterans help-seeking behaviours. Help-seeking has been defined as “problem focused, planned behaviour, involving interpersonal interaction with a selected health-care professional” (Cornally & McCarthy, 2011). The factors that impact help seeking may vary across cultures (Arnault, 2009), genders (Ang et al, 2004) and between mental and physical health (Garralda, 2004).

Current research into help-seeking behaviour for mental health related difficulties among military personnel has been thorough. Barriers identified include stigma, whereby military personnel may feel embarrassed or weak for seeking help (Schreiber & McEnany, 2015), impact on military career whereby actively serving military personnel may fear that they will lose their jobs or not be promoted (Stecker et al, 2007) and structural barriers such as not being able to book appointments or get time off work (Gibbs et al, 2011). Several facilitators to help seeking were also identified including positive beliefs about treatment, social support, and prior treatment (Hom et al 2017). This study also identified the need for further research to be conducted on female military personnel and on ex-military personnel as the factors affecting these demographics may differ.

Research into help-seeking in veterans for mental health related difficulties was synthesised into a systematic review by Randles and Finnegan (2021). This study highlighted specific barriers for veterans including the role of military culture in which stoicism and self-reliance are endorsed (Fischer et al, 2016) while weakness and emotionality are curtailed (Kiernan et al, 2018). As with serving military personnel stigma was identified as a barrier to seeking help. Barriers such as military career were no longer present and new barriers arose such as perceived lack of understanding from civilian healthcare professionals (True et al, 2014). This highlights the need for greater specificity when assessing help-seeking in different populations. Randles and Finnegan (2021) summarised the literature around help-seeking for mental health in a veteran population and identified clear gaps within the literature base. First, they recognised that research in this area was predominantly produced in the USA. Secondly, they identified a lack of understanding about the role of gender in help-seeking among military veterans.

Previous literature has been clear in identifying the gender differences in help-seeking, with women seeming more likely to seek help (Galdas et al, 2005) and men showing preferences for more functional support such as occupational therapy over psychotherapy (Liddon et al, 2018). There is a paucity of research into female veterans help-seeking, particularly for mental health difficulties. The need for understanding in this population is supported by Cheney et al (2018), who stated a one size fits all approach to veteran mental healthcare may limit female participation. The current literature review aims to collate the papers available on this topic and synthesise the findings. Barriers and facilitators to help-seeking that are specific to female veterans will be identified. By understanding factors affecting help-seeking for mental health difficulties in female veterans, clinical services may be tailored to this population’s specific needs enhancing their mental health treatment.

## Aim

This review will provide a synthesis of the literature to answer the question; what factors affect help-seeking for female military veterans for mental health related difficulties?

# Method

## Search Strategy

Following an initial scoping search in June 2022 searches were conducted between July and August of 2022. The scoping search was conducted to examine the feasibility of the topic and whether it was relevant to the current research base. No published or forthcoming reviews were identified on the topic.

Databases were accessed through Staffordshire University library systems. Initial searches were conducted on the Ebsco Host databases; APA PsychInfo, APA PsycArticles, CINAHL Plus with Full Text, Medline. SCOPUS was searched secondarily. Prisma guidelines were followed throughout this process (Page et al, 2021).

Search terms were identified from Randles and Finnegan (2021) review and modified for the current review. Instead of “help seeking”, “treatment seeking” and “help seeking behavi?r”, the current review excluded "help seeking behavi?r" as "help seeking” captures this. Instead of “veteran”, “ex-forces” and “ex-military”, only the term “veteran” was used. The term veteran encompasses previous military personnel discharged under conditions other than dishonourable (US department of Veteran Affairs, 2019), whereas “ex-forces” and “ex-military” includes individuals who were dishonourably discharged. Research suggests individuals who were not discharged honourably endorse more negative perceptions of mental healthcare and are therefore less likely to seek help (Holliday & Pedersen, 2017). As such possible inclusion of these individuals may distort the findings. “Female” and “women” were identified as the key terms to specify gender. Search terms were combined using the “AND” Boolean operator. Use of the “OR” Boolean operator yielded tens of thousands of results most of which were completely irrelevant to the chosen topic. Thus, it was excluded, and individual searches utilised. A summary of the four searches used can be identified in Table one and an overview of the search process can be found in Figure one. When conducting the searches limiters were applied for peer review and articles available in English. No date limit was applied due to the paucity of research in the area and no prior literature review being conducted.

***Table 1***- Summary of search terms used in searches.

|  |  |
| --- | --- |
| Databases | Searches |
| Ebsco Host Databases-   * APA PsychInfo * APA PsycArticles * CINAHL Plus with Full Text * MEDLINE   Scopus | Search 1- “Help seeking" AND “Veterans" and "Female”.  Search 2- “Treatment seeking” AND "Veterans" AND "Female”.  Search 3- “Help seeking" AND “Veterans" and "Women".  Search 4- “Treatment seeking” AND "Veterans" AND "Women”. |

## Inclusion criteria

* Study must include a veteran sample namely individuals who have served and retired from military service.
* Articles available in English as interpretation was not available.
* Peer reviewed articles to ensure sufficient academic quality.
* Female veteran specific results reported in findings.
* Focus of the study was on mental health help-seeking and explored barriers/facilitators related to this.

## Exclusion criteria

* Help-seeking related to physical, legal, or any other forms of support than mental health needs. Studies with multiple types of help-seeking were screened for mental health specific results and excluded in their absence.
* Sample was on currently serving military personnel or was a mixed sample unable to provide veteran specific findings.

## Search procedure

***Figure 1***- Prisma flow diagram of search procedure

Diagram

Description automatically generated

After screening abstracts and titles, a total of 24 papers remained. Two of these papers required alternative access rights and despite attempting to contact the authors were not able to be accessed. This left 22 papers to be screened in full.

Two papers were excluded for samples being too idiosyncratic thus not generalisable. One sample was focused on homeless female veterans with military sexual trauma and one sample was purely on female veterans help-seeking within a college context and for educational support. One study was excluded as it primarily focused on individuals’ likelihood of disclosing military sexual trauma and did not specifically highlight help-seeking. Three of the studies were excluded as they were unable to yield female specific outcomes. Two studies were excluded for reporting demographics of those presenting to the mental health services and not exploring the gender specific factors to help-seeking. One study was excluded for addressing treatment adherence rather than factors that affected initial help-seeking. Finally, one study was excluded as it focused primarily on help seeking for legal support with minimal secondary exploration of mental health support.

A visual scoping of Google Scholar and relevant reference lists was also conducted but no additional articles were identified. Twelve papers were identified for final synthesis.

## Publication Bias

Publication bias is the phenomenon that papers with significant results have a better chance of being published, are published earlier, and are published in journals with higher impact factors than those without significant results (Kühberger et al ,2014). Only peer reviewed papers were utilised in the final synthesis of the findings. However, the grey literature was searched using the searches documented in Table 1 to qualitatively address publication bias. Grey literature refers to material or information produced outside of traditional commercial or academic publishing (Rothstein & Hopwell, 2009). When searching the Ethos database, the four searches yielded no results. When searching Dart EU three papers were identified following the searches. One paper was excluded due to lack of relevance to the topic. The two remaining papers Reeves (2011) and Huck (2014) failed to provide gender specific results. This indicates that no studies specifically on female veterans and help-seeking for mental health issues have been missed due to publication bias.

## Quality Assessment

Several quality appraisal tools were considered for this review. Joanna Briggs Institute (JBI) appraisal tools were utilised to assess the quality of the final articles (Moola et al, 2020) see appendix B. The JBI have a range of tools which covered the design and methodologies of all studies in the present review. This allowed for comparison across methodologies. JBI tools have been extensively peer reviewed and approved for scientific use (Buccheri & Sharifi, 2017). Versions utilised were the Cohort Study, the Cross-sectional and the Qualitative appraisal tools. The JBI appraisal tools have been shown to function well as a rapid review tool (Tricco et al, 2022) but it is noted that they may be limited by their brief overview of given papers. Little space is offered for further qualitative information and papers are rated as either yes, no or unclear which leaves little room for nuance in evaluation. More specific feedback is provided in Table 2.

Twelve papers were evaluated using the JBI tools: two longitudinal, one qualitative and nine cross-sectional. All papers were scored by assigning yes as “1”, no or unclear as “0”. The longitudinal papers had 11 questions present, the qualitative had 10 and the cross-sectional had eight. The first question on the longitudinal design was not relevant for both papers therefore was eliminated meaning that a maximum score of 10 was available. Scores were then assigned percentages to enable comparison between appraisal tools. It is noted that this is not a formal process recommended by the JBI and therefore comparability of the scores is limited to this review. For a summary of the scores see the scoring table (Appendix C)

# Results

## Overview of Included Studies

An overview of the 12 selected studies can be found in Table 2. Of the 12 studies included in this review 11 were quantitative with the final paper being a qualitative grounded theory exploration (Kelly, 2021). Of the 11 quantitative papers nine were cross-sectional and two were longitudinal cohort studies (Vogt et al, 2019; Williston et al 2020).

Ten of the studies were conducted in the USA while the other two were conducted in the UK (Jones et al, 2019; Godier-McBard et al, 2021). Despite no date limiter eight of the 12 studies were conducted in the last five years. The remaining four were conducted earlier (Forneris et al, 2002; Fox et al, 2015; Garcia et al, 2014; Ouimette et al, 2011). Although three of the studies (Monteith et al, 2021 [1]; Godier-McBard et al, 2021; Williston et al 2020) had the option of completing responses online which meant that location could not be totally verified.

### Sample

In the quantitative studies sample size ranged from 100 veterans (Godier-McBard et al, 2021) to 1448 (Jones et al, 2019). The qualitative study had a total of 14 female veterans take part (Kelly, 2021). Four of the quantitative studies had exclusively female veterans’ samples (Forneris et al, 2002; Monteith et al, 2021 [1]; Monteith et al, 2021 [2]; Williston et al, 2020) while the remaining seven had mixed gender samples. Most of the mixed gender quantitative studies had a relatively even split between male and female. However, two studies were primarily male (Garcia et al, 2014; Jones et al, 2019). Female specific results were reported but caution must be taken when generalising the results to the female veteran population due to small sample size.

Six of the studies recruited from veterans already accessing mental health services, specifically, Veteran Affairs services (Forneris et al, 2002; Garcia et al, 2014; Kelly, 2021; Monteith et al, 2021 [1]; Monteith et al, 2021 [2]; Ouimette et al, 2011). The other six studies used national samples of veterans across their respective countries. Notably (Zhou et al, 2017) sampled exclusively from Hawaii thus their sample might not be representative of the wider demographics of the USA. Of the six studies that sampled nationally three required mental health diagnosis (Fox et al, 2015; Godier-McBard et al, 2021; Vogt et al, 2019), and one sought self-disclosure of “emotional problem or stress in the previous year” (Jones et al, 2019). Williston et al (2020) sought to longitudinally predict health care utilisation based on psychological distress, mental health literacy and stigma. Finally, Zhou et al (2017) sought to validate the Perceived Family Stigma Scale against intentions of seeking help.

### Procedure

The qualitative study conducted semi-structured interviews lasting between 60-180 minutes (Kelly, 2021). They proceeded to collect data until they reached thematic saturation as per grounded theory guidelines (Birks & Mills, 2015). Quantitative data was collected to screen for military trauma and provide context for mental and physical health difficulties. It was reported descriptively.

All quantitative studies utilised survey data collection. Five of the studies collected data utilising mail surveys (Fox et al, 2015; Monteith et al, 2021 [2]; Ouimette et al, 2011; Vogt et al, 2019, Zhou et al, 2017). Two studies collected their survey data in clinics face-to-face (Forneris et al, 2002; Garcia et al, 2014). Two studies utilised online surveys (Godier-McBard et al, 2021; Williston et al, 2020). One study collected data over the telephone (Jones et al, 2019) and one study blended online and mail surveys (Monteith et al, 2021 [1]). The two longitudinal studies both utilised data from two separate time points. Vogt et al (2019) had five years between their two data collections whereas Williston et al (2020) had six months between their two data collection points.

### Measures

Nearly all measures used were previously published, validated, and had excellent psychometric properties. Of note were two studies that created and piloted questionnaires (Garcia et al, 2014; Jones et al 2019). These measures were not validated and thus not comparable to similar measures. Garcia et al (2014) created a measure around barriers to mental healthcare and did not report on its validity or reliability. Jones et al (2019) created a help-seeking questionnaire and did not report measure validity or reliability. Three other studies did adapt some of the measures they utilised (Fox et al 2015; Ouimette et al, 2011; Williston et al, 2020). However, all adapted measures were shown to have good internal reliability. A full compendium of the measures present across the studies can be found in Appendix D. Godier-McBard et al (2021) also collected qualitative data to supplement their analysis.

|  |  |  |  |  |  |
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| **Author(s), date & country**  ***Table 2***- Table of study characteristics. | **Sample and setting** | **Methods & Measures\*** | **Findings** | **Strengths** | **Limitations** |
| **Forneris, Bosworth, & Butterfield**  **2002**  **USA** | **139 female veterans**  **Women’s healthcare centre for veterans** | **Quantitative- Cross- sectional. Survey data and demographics on time served**  **Measures- PQ** | * **Correlation between mental health and physical health** * **Low income** * **Poor insurance** * **Cultural factors** * **Proximity to clinic** * **Benefits afforded by the clinic** | * **Purely female veteran sample** * **Clear aims and appropriate design** | * **Lacked clarity around inclusion/exclusion criteria** * **Failed to account for confounding variables** * **Treatment seeking limited to a year post discharge** * **Not clear procedure on data collection** * **Lacked funding declaration** |
| **Fox, Meyer, & Vogt**  **2015**  **USA** | **278- veterans**  **164- female**  **Participants diagnosed with PTSD, depression, or alcohol abuse. Randomly selected from national sample of Operation Enduring Freedom or Iraqi Freedom veterans** | **Quantitative- Cross- sectional. Survey data.**  **Mail surveys**  **Measures- 17 item PTSD checklist- Military Version, Adapted 7 item BDI, CAGE, Positive perceptions of Veteran Affairs (VA) Care, Perceived fit to VA care, EASI, Use of VA mental healthcare** | * **Perceptions of Veteran healthcare** * **Attitudes towards help-seeking** * **Stigma from loved ones** | * **Sample randomly selected thus controlling for selection bias** * **Clear aims appropriate design** * **Method clearly outlined** * **Results sufficiently clear** | * **Low scale reliability** * **Low response rate to questionnaires** * **Participants were incentivised** |
| **Garcia, Finley, Ketchum, Jakupcak, Dassori, & Reyes**  **2014**  **USA** | **434-veterans**  **37- Female**  **Nine Veterans’ Healthcare Association (VHA) outpatient clinics. One specific to PTSD** | **Quantitative-Cross sectional. Survey data.**  **Measures- self developed measure around barriers to mental health care.** | * **Attitudes towards help-seeking** * **Military cultures effect on perceptions of seeking help** * **Comparison of veterans across eras** | * **Clear aims** * **Appropriate design** * **Method clearly outlined** * **Results clearly outlined** * **Recruited from a range of veteran services aiding generalisability** | * **Small female veteran sample** * **One measure used was not validated** * **Minimal control for confounding variables** |
| **Godier-McBard, Cable, Wood, & Fossey**  **2021**  **UK** | **100- Veterans**  **43- Female**  **Participants self-identified via social media nationally across UK. (post-military). All had been discharged for over a year** | **Quantitative- Cross sectional. Survey data**  **Data was also supplemented with qualitative responses.**  **Online surveys**  **Measures- BACE** | * **Stigma** * **Military culture and weakness** * **Gender related discrimination in service** * **Prejudice against women** * **Types of service help is sought from** | * **Balanced male and female sample** * **Clearly defined sample and eligibility criteria** * **Procedure and analysis appropriate and clear** * **Transparent around funding** | * **Sample age was felt not to be homogenous to veteran population** * **Online surveys meant military background could not be validated** |
| **Jones, Greenberg, Phillips, Simms & Wessely**  **2019**  **UK** | **1448-veterans.**  **219 -female**  **National sample of military who participants experienced stress or an emotional problem in the previous year** | **Quantitative- Cross sectional. Survey data. Participants completed telephone interviews lasting around 42 minutes.**  **Measures- PHQ-9, GAD-7, AUDIT-C, PCL-5, MSPSS, and unvalidated help-seeking pilot questionnaire** | * **Awareness of mental health difficulties increases help-seeking** * **Stigma from family and friends reduces help-seeking** * **Gender comparison discussed** * **Positive perceptions of own ability to solve the problem reduces help-seeking** | * **Study aims clear** * **Methodology clearly outlined** * **Result and analysis clear** * **Large sample size** * **Declared funding and researcher background** | * **Measure of help-seeking was a pilot and thus not validated** * **Possible recall bias due to delay between seeking help and engagement with study** * **Incentives provided** |
| **Kelly**  **2021**  **USA** | **14 female veterans**  **Participants experienced Military Sexual Trauma (MST) and had sought treatment for PTSD from VHA outpatient clinic** | **Qualitative study. Sem-structured interviews**  **Grounded Theory analysis**  **Measures- TEI, CES, PCL, BDI, PH-15, CD-RISC** | * **Military sexual trauma** * **Previous experiences of mental healthcare** * **Services lacking gender specificity** * **Military culture predominantly male.** * **Institutional betrayal** | * **Clear Aims** * **Clear methodological Process** * **Good transparency of analysis process** * **Accounted for rigour using secondary appraisal of data from other co- researcher** * **Transparent around funding** | * **Participants were incentivised** * **Lacked researcher reflexivity** * **Lacked clarity on epistemological stance** |
| **Monteith, Holliday, Hoffmire, & Bahraini**  **2021**  **USA** | **442-female veterans**  **Participants enrolled in VA care randomly selected and stratified by age** | **Quantitative. Cross sectional. Mail and online surveys**  **Measures- GHSQ, VA (MST) screening, SITBI** | * **Prior experiences of utilising services** * **Veteran vs generic mental health services** * **Institutional betrayal** * **Prior suicide attempts** * **Stigma** | * **Disclosed funding** * **Clear aims** * **Clear methodological process** * **Appropriate analysis conducted** * **Effect size reported** * **Limitations clearly discussed** | * **Potential bias introduced due to missing data on the GHSQ** * **Scale predicted future engagement and not actual engagement** |
| **[2] Monteith, Holliday, Schneider, Miller, Bahraini, & Forster**  **2021**  **USA** | **242-female veterans**  **Participants were survivors of MST enrolled in VH clinics** | **Quantitative- Cross sectional. Mail surveys**  **Measures- MST screening questionnaire, IBQ-2, BACE, ISMI** | * **Military sexual trauma** * **Institutional betrayal** * **Veteran vs generic mental health services** * **Compassion** * **Trustworthiness** * **Non-judgmental approach** | * **Disclosed funding and author background** * **Clear aims** * **Appropriate Methodological design** * **Appropriate analysis** * **No incentives** | * **Effect size not reported** * **Sample lacked generalisability** * **Survivorship bias present** |
| **Ouimette, Vogt, Wade, Tirone, Greenbaum, Kimerling, Laffaye, Fitt, & Rosen**  **2011**  **USA** | **490-veterans**  **231- female**  **Participants were outpatients of a VHA clinic with a diagnosis of PTSD** | **Quantitative- Cross sectional. Mail surveys**  **Measures, CES-D, IES-R, BHS (adapted)** | * **Stigma** * **Institutional barriers** * **Male-centric veterans services** * **Race** * **PTSD as a barrier** | * **Funding disclosed.** * **Clear aims** * **Clear methodological design** * **Appropriate analysis** * **Effect size reported** * **Limitations discussed** | * **Internal consistency on the BHS scale was modest** * **Self-selection bias as participants elected to take part in study** |
| **Vogt,, Danitz, Fox, Sanders, & Smith**  **2019**  **USA** | **363-veterans**  **195-female**  **Veterans diagnosed with PTSD from a national sample post 9-11.** | **Quantitative- longitudinal study**  **Participants completed mail surveys at 3 separate time points. Data was used from the second and third timepoint which was 5 years apart**  **Measures- BDI, PCL-5, IPF** | * **Relational difficulties** * **Occupational difficulties** * **Gender differences in relational difficulties** | * **Clear aims** * **Clear methodological design** * **Appropriate analysis** * **Limitations discussed** * **Funding disclosed** * **Accounted for non-response bias** | * **Did not discuss effect sizes** * **Only limitation recognised by study was the use of self-report measures** * **Incentives provided** |
| **Williston, Bramande, Vogt, Iverson, & Fox,**  **2020**  **USA** | **171- female veterans**  **Data taken from a national survey between 2014-17** | **Quantitative- longitudinal. Web based surveys. Two time points 6 months apart**  **Measures- (DAS, PTSD Checklist DSM-V, CESDS amalgamated into a single scale), EASI** | * **Mental health literacy** * **Stigma** * **Perceived need for help** * **Military culture** | * **Clear aims** * **Clear methodological design** * **Appropriate analysis** * **Limitations discussed** * **Funding disclosed** | * **Used a non-validated scale of Mental health Literacy (although good internal reliability)** |
| **Zhou, Whealin, Wang, & Lee**  **2017**  **USA** | **623- veterans**  **97-female**  **Veterans from Hawaii not necessarily in services** | **Quantitative- Cross sectional. (Scale validation) Mail Survey**  **Measures- PFSS, PSBCS, DCS** | * **Family stigma** * **Military rank** * **Gender comparison around family stigma** | * **Excellent Sample diversity** * **Clear aims** * **Clear methodological design** * **Appropriate analysis** * **Limitations discussed** * **Funding disclosed** | * **Sample limited to Veterans residing in Hawaii** * **incentives provided** * **Sample eligibility criteria unclear** |

\*All Measures are provided as acronyms for full names and references of measures see appendix D.

## Quality appraisal

Following appraisal from the JBI tools most papers were of high quality with four papers scoring the maximum score possible (Jones et al, 2019; Monteith et al, 2021 [1]; Monteith et al, 2021 [2]; Ouimette et al, 2011). The lowest score present was the study by Forneris et al (2002) which scored 62.5%. Three of the cross-sectional studies scored highly but did not demonstrate clear ways in which they had accounted for confounding variables (Fox et al, 2015; Godier-McBard et al 2021; Zhou et al, 2017). The aims of all included studies were well-defined, and the design was appropriate.

### Sampling

Sample size across the quantitative studies was positive. Just three studies discussed statistical power. Jones et al (2019) recorded that they achieved the required statistical power, Godier-McBard et al (2021) stated that they had limited statistical power, and Monteith et al, (2021 [1]) stated that they were unable to determine statistical power due to an ad-hoc sensitivity analysis. Transparency around power analysis is important to limit missed results or biases occurring. The qualitative study (Kelly, 2021) achieved a sample size of 14 which satisfies research guidelines (Boddy, 2016). The researchers indicate that saturation was reached but that more could be learned which is slightly incongruous.

Only four studies discussed whether they had a representative sample. Two studies declared they had a representative sample (Ouimette et al, 2011; Zhou et al, 2017), One study used replenishment sampling to maintain representativeness (Jones et al, 2019) and one study declared that its sample was not representative (Godier-McBard et al, 2021). It was noted that the ethnic diversity of most papers was poor with predominantly white US or UK individuals being recruited. Only two studies were able to recruit sufficiently diverse samples to comment on this in their findings (Ouimette et al, 2011; Zhou et al, 2017).

### Measures

All data collected from the 12 studies was self-report. This introduces the risk of social desirability bias. This is the individual’s tendency to respond in a manner by which they will be viewed more favourably (Krumpal, 2013). This may be exacerbated further in data collection that is face to face (Forneris et al, 2002; Garcia et al, 2014) or via the telephone (Jones et al, 2019). Alternatively, the online survey’s (Godier-McBard et al, 2021; Williston et al, 2020) can pose difficulties with confirming their identities (Andrade, 2020) or even misrepresentation of identity (Weisz, 2016). Positively the range of data collection methods was diverse across the studies.

The range of psychometrics used in the twelve studies was large and replication of their use scarce across the studies thus making comparison challenging. As aforementioned two studies even piloted their own measures (Garcia et al, 2014; Jones et al 2019). Unfortunately, neither study attempted validation through factor analysis. Other studies noted that some of their scales lacked reliability such as Fox et al (2015) regarding their VA specific scales (Alpha= 0.71).

### Results & Findings

The standard of result reporting was excellent across all studies. Descriptive statistics were adequately conveyed through use of in text figures and tables. Appropriate analysis was used in all studies with transparent analysis procedures provided. Considering statistical magnitude there were three studies that clearly outlined their effect sizes (Fox et al, 2015; Ouimette et al, 2011; Zhou et al, 2017). All other studies were absent or unclear in reporting effect size. Most studies failed to detail how they addressed non-responders. One study recognised this as a limitation (Ouimette et al, 2011), while two studies addressed non-responses and accounted for this in their analysis (Fox et al 2015; Jones et al 2019). This can be difficult to address in cross-sectional studies as accessing participant data on those who didn’t respond can be implausible (Downes et al, 2016).

The qualitative study accounted for rigour by ensuring that transcriptions were read by multiple researchers. However, there was a lack of clarity around the epistemological stance of the researchers or their reflexivity (Kelly, 2021)

### Discussion of limitations, conflict of interest and ethical considerations

All studies in this review outlined limitations of their research and conclusions that were drawn. These all appeared appropriate to the results they had found. All studies disclosed the researcher’s role, affiliations, and sources of funding aside from Forneris et al (2002). This is highly positive as without declaring conflict of interest reporting bias may be present. Incentives were provided for participants in six of the studies (Fox et al, 2015; Jones et al 2019; Kelly, 2021; Ouimette et al, 2011; Vogt et al, 2019; Zhou et al, 2017). While not innately unethical this can lead to participants engaging when they otherwise would prefer not to (Erlen et al, 1999). Only two studies directly declared that they had gained ethical approval for the research (Godier-McBard et al, 2021; Jones et al 2019). Disclosure of ethical approval would be expected in a peer reviewed paper.

# Findings

Results were synthesised using a narrative approach in which themes from the papers findings were cross compared for similarities and differences. Each paper was evaluated and findings from the results and discussion summarised. Once findings were collated themes from across papers were drawn. Some papers focused specifically on certain aspects of help-seeking while others more broadly appraised service utilisation thus comparison was not always viable.

## Summary of help seeking

There was discrepancy in the findings as to whether female veterans sought help more for mental health reasons than male veterans. Two of the studies (Jones et al, 2019; Forneris et al 2002) indicated that female veterans seek help for mental health related issues more than their male counterparts. However, other papers reported no difference between male and female veterans in help-seeking for mental health related issues (Garcia et al 2014; Jones et al 2019). Perceptions of healthcare services were similar between male and female veterans (Fox et al, 2015). Overall levels of help-seeking between men and women were inconclusive. However, clear gender specific barriers and facilitators were highlighted. There were also more general factors identified that hindered help-seeking in veterans such as higher rates of PTSD symptomology exacerbating all barriers to help-seeking (Ouimette et al 2011), lower socioeconomic status and related factors such as proximity to healthcare settings and benefits related to healthcare use (Forneris et al 2002).

### Barriers- Stigma

The first clear barrier present in the literature was that of stigma. The literature cited this as the primary barrier amongst all veterans both male and female (Ouimette et al 2011). The studies synthesised identified several forms of stigma including treatment seeking stigma (Williston et al, 2020) stigma from family and friends (Zhou et al, 2017) and stigma related to military culture, in that they perceived themselves as weak (Godie-Mcbard et al, 2021). Individuals of a higher rank may perceive greater levels of stigma (Zhou et al, 2017). Gender specific differences in stigma were apparent. With regards to treatment-seeking stigma, it was found that men hold more stigmatic beliefs around mental health treatment, mental illness and seeking help (Fox et al 2015). Williston et al (2020) found that for female veterans, higher rates of this stigma resulted in a lower score in perceptions of need for treatment and therefore reduced access to healthcare services. Military culture such as stoicism may lead to greater treatment seeking stigma. This mediating effect was clearly demonstrated in the female veteran sample. Zhou et al (2017) found that perceived stigma from family increased reported need for help for mental health problems in both male and female veterans. Female veterans appeared to be more sensitive to this phenomenon as for every point they increased on this scale they became three times likelier than men to report a need for support from services. This suggests that family stigma may be a mechanism for female veterans seeking support greater than for male veterans. This was supported by Vogt et al (2019) who found that relationship impairment was a key factor in both male and female veterans, but for differing reasons. For female veterans it appeared that the more difficulties occurring within their relationship the more likely they were to seek help for mental health difficulties. This may be due to female veterans identifying difficulties in relationships as a sign of mental distress whereas male veterans may need support from their partner to access services and reduce stigma. Therefore, more impairment in this relationship likely reduces help-seeking. This hypothesis has not been explicitly tested in the above papers. Stigma from loved ones was one of the most cited barriers to help seeking in male veterans (Fox et al, 2015). Whereas with female veterans they were considerably less likely to seek help when endorsed by family or friends (Jones et al 2019).

### Barriers- Military culture

Perhaps the greatest gender discrepancy in barrier to help seeking was military culture. First military culture in relation to self-reliance, stoicism and concealing weakness was present in all veteran’s female and male alike (Williston et al, 2015; Kelly, 2021; Godier-Mcbard, 2021; Garcia et al, 2014). However, gender differences became apparent in the hyper masculine aspect of military culture. One of the most common findings was that female veterans felt that they had to work harder to be accepted in the military and that gender discrimination was present during their time in service (Kelly, 2021; Godier-Mcbard, 2021). This increased need to convey masculinity appeared to strengthen their concealment of weakness and disparage them from seeking services post-military. This may relate to the increased presentation of somatoform symptoms presented in female veterans (Forneris et al 2002) as physical weakness may be more acceptable than psychological weakness. This difficulty fitting into military culture appeared to be projected onto veteran specific services with female veterans frequently citing that they felt out of place (Ouimette et al 2011; Kelly, 2021). Further veteran specific services were not sensitive to the needs of female veterans and that there was a perception that professionals felt women could not experience the same traumas as male veterans (Godier-Mcbard, 2021).

These issues were compounded by military sexual trauma experienced by female veterans (Monteith et al, 2021). Female veterans who have experienced MST were less likely to access veteran specific services possibly due to feeling unwelcome or even unsafe (Monteith et al, 2021) [2]. It was suggested that a key reason for this was institutional betrayal. This phenomenon occurs when individuals lose trust for a system, they feel they were supposed to be protected by (Smith & Freyd, 2013). Female veterans reported numerous ways in which the military had failed to support them following MST, some of which was committed by fellow soldiers or individuals in leadership roles (Kelly, 2021). As military specific services were seen as an extension of the military this negatively impacted their use as they distrust the service itself (Monteith et al, 2021). Importantly this seemed to lead to an uptake in use of general mental health services by female veterans despite not being equipped for their specific needs (Monteith et al, 2021; Kelly, 2021; Godier-Mcbard, 2021). This was supported by Monteith et al, (2021) [2] who found that female veterans who had never used veteran specific services or who had used them previously were less likely to use them than mainstream services and only veterans currently in veteran specific services endorsed their use.

### Facilitators of Help-Seeking

Most studies in the present review focused on barriers over facilitators to mental health help-seeking in female veterans but some facilitators were identified from extraction. First, services deemed as compassionate, trustworthy, and non-judgemental were deemed to be essential to female veterans (Monteith et al, 2021). Increased mental health literacy in female veterans was found to decrease treatment seeking stigma and therefore increase service utilisation (Williston et al, 2020). The greater the positive perceptions of veteran specific healthcare services the more likely female veterans were to attend (Fox et al, 2015). Emphasising availability of services and the skill of the staff present was found to be of greater benefit to female veterans, whereas focus on attitude change and stigma alleviation may work better for male veterans (Fox et al 2015). Finally, if female veterans realised they had a problem that they could not solve alone, they were more likely to access services whereas in male veterans the inability to solve the issues alone appeared to have no significant impact on help-seeking (Jones et al, 2019).

# Discussion

This review sought to establish the factors that affected female veterans seeking help for mental health related difficulties. Across the 12 papers synthesised several key factors were identified, such as the role of stigma and how this differed between male and female veterans. Specifically, around how men many perceive greater levels of treatment seeking stigma and family related stigma may be a stronger predictor for women accessing mental health services. The greatest difference between male and female veterans accessing mental health services was the role of military culture. Both men and women appear to embrace military culture, the hypermasculinity present appears to isolate female veterans when returning home and discourage them from accessing veteran specific services. This was exacerbated by the presence of MST and the secondary factor of institutional betrayal. Several facilitators were also identified such as the role of mental health literacy in reducing treatment seeking stigma, and services being more compassionate and trustworthy.

The current findings are akin to Randles and Finnegan’s review (2021) such as the focus on stigma, the negative impact of stoicism and self-reliance and the benefit of psychoeducation. Overall, it appears that attitudes towards help-seeking for mental health, may be similar between male and female veterans. But the factors that contribute to this clearly differ between the genders and there is nuance in how each of these factors impacts each gender. Discrepancy remains as to whether female veterans seek help more than male veterans for mental health related issues.

A search of the grey literature revealed that the sparsity of research in this area is not limited to peer reviewed papers. When replicating the search strategy in Dart EU and Ethos only three papers were yielded. One of which was irrelevant and the other two, while focused on help-seeking in veterans, failed to provide any gender specific results. One paper was later identified in the grey literature (Jones, 2018). This paper did not explicitly examine help-seeking in female veterans but identified that female veterans face gender related issues when reintegrating to society and that gender specific services may be useful for veterans moving forward which was in line with recommendations from Godier-McBard (2021).

## Strengths & Limitations

Several limitations were noted in the current literature review. First, the search strategy used of individualising searches rather than using the “or” Boolean operator yielded an extremely high number of duplicates. The search strategy also failed to yield any papers by examining reference lists of other papers identified. There is little evidence for whether this strategy effectively supplements electronic searching, but it is common practice among many systematic reviews (Horsley et al, 2011). It is possible that due to the lack of sourcing through reference lists that a selection bias was introduced. This may have been exacerbated by screening being conducted by a single researcher although this is more accepted when systematic searches using Prisma guidelines are used (Mahtani et al 2020)

Second the JBI appraisal tools, while ideal for cross comparison of methodologies, were brief and perhaps did not provide an in-depth quality review of the papers. As such further critiques of the papers were drawn from the limitation’s sections of the articles. This less structured approach to appraisal is arguably less replicable.

Third, there were only two studies from the current literature review that were conducted in the UK. Given the difference in mental health service structure between the UK and the US there are likely different barriers and facilitators to seeking help for mental health issues; for example, healthcare in the UK is free mitigating the barrier of cost. Fourth a large proportion of the studies recruited from individuals already accessing some form of mental health support and asked them to retrospectively comment on barriers to seeking help. This is problematic as arguably those in service were able to overcome the barriers presented to them whereas those not in services may be better placed to comment on existing barriers. This highlights a form of survivorship bias present in the current review.

Positively the sample within the current review was large (4296 participants) and despite methodology not being an inclusion criteria studies yielded were methodologically similar for the most part. Overall, the quality of the papers was good with all papers being from peer reviewed journals and all except three papers being rates as 85% or above on the JBI appraisal tools. The added nuance of gender when considering help-seeking for mental health in veterans is a valuable addition to the research base.

## Directions for Future Research

Two key areas were recurringly identified in discussions of papers for future research. First was the need for research into continued engagement with mental health services and attrition rather than just initial help-seeking. All the papers in the current review only examined initial help-seeking. Even the longitudinal papers failed to capture engagement with services. To aid veterans’ mental health understanding what maintains their engagement with care is crucial for future research. Secondly several studies noted the lack of ethnic diversity in their samples. It is suggested that future research examine variation in mental health help-seeking among different ethnic groups as culture can be a determining factor in the likelihood of seeking help.

The current review was heavily weighted towards cross-sectional research with only two longitudinal papers. This meant that all that could be measured were the individuals’ retrospective views on help-seeking or individuals’ intention to seek help. Without further longitudinal studies it is impossible to truly determine cause and effect for the factors being measured. All the data collected was self-report data. This can be affected by social desirability and lack on insight. Future research may wish to consider experimental or observational research design to rule out these factors. Finally, there is a clear absence of literature from the UK which is highly important to this topic given that one of the key barriers to help seeking in the literature for all veterans is cost of services, a highly American concept.

## Implications for Clinical Practice

Current veteran specific services are recommended to find a way of challenging the masculine dominant culture carried over from military training and life or to developing female specific environments to help increase the overall safety of the service for female veterans. Alternatively generic mental health services may wish to provide training for staff around veteran specific needs given that female veterans often prefer to access these instead of veteran services. This may include developing cultural competence in existing practitioners. As stigma appears to be the primary reason in both male and female veterans for not seeking help, interventions such as mental health literacy should continue to target the veteran population and perhaps could be prescribed to all veterans upon finishing service. Relational stigma appears to be of particular importance in female veterans therefore should be addressed directly in interventions targeted at this population. Although it is recognised that stigma is a multifaceted and complicated concept which needs further research to fully comprehend.

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# Appendices

## Appendix A- Author guidelines for publication from the Military Psychology Journal

**Preparing Your Paper**

Article Types

Regular Articles

* Should be written with the following elements in the following order: abstract, text, references, tables, and figures
* Should be no more than 30 pages, inclusive of:
  + Abstract
  + Tables
  + References
  + Figure or table captions
  + Footnotes
  + Endnotes
* Should contain an unstructured abstract of 200 words.
* Should contain no more than 5 **keywords**. Read [making your article more discoverable](https://authorservices.taylorandfrancis.com/making-your-article-and-you-more-discoverable/), including information on choosing a title and search engine optimization.
* Authors should prepare manuscripts for blind review in accordance with the Publication Manual of the American Psychological Association (7th ed.). Articles not prepared for blind review in accordance with the Publication Manual will not be reviewed. Each submission must include (1) an unblinded and (2) a blinded copy of the manuscript (described above). All manuscripts should be prepared so that they have clearly articulated goals that serve to organize the introduction, method, results, and discussions. The introduction should review relevant research and theories and conclude with a clear articulation of a testable research hypothesis or research question. The methodology should include a complete description of demographic characteristics (e.g., gender, age, race/ethnicity, education) and military career information (e.g., occupational field, years of service) of the participants; provide a thorough and concise description of all measures (e.g., lead stem with sample items, response alternatives, scoring procedures, and M, SD, reliability, and validity information); and include an explicit statement addressing confidentiality safeguards. The results section should include appropriate descriptive and inferential statistical analyses with reports of effect sizes (or strength of relationships) and confidence interval for significant and non-significant findings. The discussion section should elaborate on the unique contributions of the study to include linkages and extension from previous research and theory and address limitations and future directions. A separate title page should be prepared and include (a) the title of the manuscript; (b) names and institutional affiliations of all authors exactly as they are to be printed; and (c) name, mailing address, telephone and fax numbers, and e-mail address of the corresponding author. An e-mail address must be included on the cover page. Authors should also prepare a cover page that is included with the blind review copy of the manuscript. Public significance statements. As part of your submission, we ask that you prepare an impact statement of two to three sentences that summarizes your study in plain English for the educated public. The statement should be written in simple, nontechnical, and compelling terms that highlight the relevance and implications of your research. Please do not copy the abstract for this purpose. The aim of the statement is to summarize the article’s findings and highlight their importance to human behavior within and beyond the military environment (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). The public significance statement will enable authors to have greater control over how their work will be interpreted by key audiences. A useful guide may be found at: http://www.apa.org/pubs/authors/guidance.aspx. Please include the public significance statement in your manuscript file after the abstract.

**Brief Report**

* Should be written with the following elements in the following order: abstract, text, references, tables, and figures
* Should be no more than 20 pages, inclusive of:
  + Abstract
  + Tables
  + References
  + Figure or table captions
  + Footnotes
  + Endnotes
* Should contain an unstructured abstract of 200 words.
* Should contain between 1 and 5 **keywords**. Read [making your article more discoverable](https://authorservices.taylorandfrancis.com/making-your-article-and-you-more-discoverable/), including information on choosing a title and search engine optimization.

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Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

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   *For single agency grants*   
   This work was supported by the [Funding Agency] under Grant [number xxxx].   
   *For multiple agency grants*   
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
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## Appendix B – JBI Critical appraisal tools.

Cross sectional studies- https://jbi.global/sites/default/files/2021-10/Checklist\_for\_Analytical\_Cross\_Sectional\_Studies.docxTable

Description automatically generated

Cohort Studies- https://jbi.global/sites/default/files/2021-10/Checklist\_for\_Cohort\_Studies.docx

Table

Description automatically generated

Qualitative studies- https://jbi.global/sites/default/files/2021-10/Checklist\_for\_Qualitative\_Research.docxTable

Description automatically generated

## Appendix C- Table of scores for Research paper appraisal

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Paper | Question 1 | Question 2 | Question 3 | Question 4 | Question 5 | Question 6 | Question 7 | Question 8 | Total | % |
| Forenris et al (2002) | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 5 | 62.5 |
| Fox, Meyer & Vogt (2015) | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 7 | 87.5 |
| Godier- McBard et al (2021) | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 7 | 87.5 |
| Garcia et al (2014 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 6 | 75 |
| Jones et al (2019) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 100 |
| Monteith et al (2021) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 100 |
| Monteith, (2021) [2] | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 100 |
| Ouimette, P et al (2011) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 100 |
| Zhou et al (2017 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 7 | 87.5 |

Cross sectional studies

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Paper | Question 1 | Question 2 | Question 3 | Question 4 | Question 5 | Question 6 | Question 7 | Question 8 | Question 9 | Question 10 | Total | % |
| Vogt et al (2019) | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 9 | 90 |
| Williston et al (2020) | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 9 | 90 |

Longitudinal studies

Qualitative studies

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Paper | Question 1 | Question 2 | Question 3 | Question 4 | Question 5 | Question 6 | Question 7 | Question 8 | Question 9 | Question 10 | Total | % |
| Kelly (2021) | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 8 | 80 |

## Appendix D- Glossary of Psychometric Measures

|  |  |  |
| --- | --- | --- |
| Psychometric Glossary | | |
| Abbreviation | Full Name | Reference |
| AUDIT-C | The Alcohol Use Disorders Identification Test | Bradley, K. A., Bush, K. R., Epler, A. J., Dobie, D. J., Davis, T. M., Sporleder, J. L., Maynard, C., Burman, M. L., & Kivlahan, D. R. (2003). Two Brief Alcohol-Screening Tests From the Alcohol Use Disorders Identification Test (AUDIT). *Archives of Internal Medicine*, *163*(7), 821. https://doi.org/10.1001/archinte.163.7.821 |
| BACE | Barriers to Access to Care Evaluation scale. | Clement, S., Brohan, E., Jeffery, D., Henderson, C., Hatch, S. L., & Thornicroft, G. (2012). Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry*, *12*(1). https://doi.org/10.1186/1471-244x-12-36 |
| BDI | Becks Depression Inventory | Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An Inventory for Measuring Depression. *Archives of General Psychiatry*, *4*(6), 561–571. https://doi.org/10.1001/archpsyc.1961.01710120031004 |
| BHS | Barriers to Help-Seeking Scale | Mansfield, A. K., Addis, M. E., & Courtenay, W. (2005). Measurement of Men’s Help Seeking: Development and Evaluation of the Barriers to Help Seeking Scale. *Psychology of Men & Masculinity*, *6*(2), 95–108. https://doi.org/10.1037/1524-9220.6.2.95 |
| CAGE | 4 Item Alcohol Use Questionnaire | Ewing, J. A. (1984). Detecting Alcoholism. *JAMA*, *252*(14), 1905. https://doi.org/10.1001/jama.1984.03350140051025 |
| CESDS | The Centre for Epidemiologic Studies- Depression Scale | Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement*, *1*(3), 385–401. https://doi.org/10.1177/014662167700100306 |
| CD-RISC | The Connor Davidson Resilience Scale | Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, *18*(2), 76–82. https://doi.org/10.1002/da.10113 |
| CES | Combat Exposure Scale | Keane, T. M., Fairbank, J. A., Caddell, J. M., Zimering, R. T., Taylor, K. L., & Mora, C. A. (1989). Clinical evaluation of a measure to assess combat exposure. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(1), 53–55. https://doi.org/10.1037/1040-3590.1.1.53 |
| DAS | Depression, Anxiety and Stress Scale | Norton, P. J. (2007). Depression Anxiety and Stress Scales (DASS-21): Psychometric analysis across four racial groups. *Anxiety, Stress & Coping*, *20*(3), 253–265. https://doi.org/10.1080/10615800701309279 |
| DCS | The Devaluation of Consumers Scale | Chang, C.-C., Su, J.-A., Chang, K.-C., Lin, C.-Y., Koschorke, M., & Thornicroft, G. (2018). Perceived stigma of caregivers: Psychometric evaluation for Devaluation of Consumer Families Scale. *International Journal of Clinical and Health Psychology*, *18*(2), 170–178. https://doi.org/10.1016/j.ijchp.2017.12.003 |
| EASI | The Endorsed and Anticipated Stigma Inventory | Vogt, D., Di Leone, B. A. L., Wang, J. M., Sayer, N. A., Pineles, S. L., & Litz, B. T. (2014). Endorsed and Anticipated Stigma Inventory (EASI): A tool for assessing beliefs about mental illness and mental health treatment among military personnel and veterans. *Psychological Services*, *11*(1), 105–113. https://doi.org/10.1037/a0032780 |
| GAD-7 | General Anxiety Disorder Seven | Ross, S. M. (2013). Generalized Anxiety Disorder (GAD). *Holistic Nursing Practice*, *27*(6), 366–368. https://doi.org/10.1097/hnp.0b013e3182a8eb62 |
| GHSQ | The General Help-Seeking Questionnaire | Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). *General Help Seeking Questionnaire (GHSQ)* [Database record]. APA PsycTests.  [https://doi.org/10.1037/t42876-000](https://psycnet.apa.org/doi/10.1037/t42876-000) |
| IBQ.2 | Institutional Betrayal Questionnaire two | Smith, C. P., & Freyd, J. J. (2017). Insult, then Injury: Interpersonal and Institutional Betrayal Linked to Health and Dissociation. *Journal of Aggression, Maltreatment & Trauma*, *26*(10), 1117–1131. https://doi.org/10.1080/10926771.2017.1322654 |
| IES-R | The Impact of Events Scale Revised | Motlagh, H. (2010). Impact of Event Scale-Revised. *Journal of Physiotherapy*, *56*(3), 203. https://doi.org/10.1016/s1836-9553(10)70029-1 |
| IPF | The Inventory of Psychological Functioning | Bovin, M. J., Black, S. K., Rodriguez, P., Lunney, C. A., Kleiman, S. E., Weathers, F. W., Schnurr, P. P., Spira, J., Keane, T. M., & Marx, B. P. (2018). Development and validation of a measure of PTSD-related psychosocial functional impairment: The Inventory of Psychosocial Functioning. *Psychological Services*, *15*(2), 216–229. https://doi.org/10.1037/ser0000220 |
| ISMI-10 | Internalised Stigma of Mental Illness ten | Boyd Ritsher, J., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*, *121*(1), 31–49. https://doi.org/10.1016/j.psychres.2003.08.008 |
| MSPSS | The Multidimensional Scale of Perceived Social Support | Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, *52*(1), 30–41. https://doi.org/10.1207/s15327752jpa5201\_2 |
| PCL-5 | Posttraumatic stress Disorder Checklist | Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and Initial Psychometric Evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498. https://doi.org/10.1002/jts.22059 |
| PFSS | The Perceived Family Stigma Scale | Chang, C.-C., Su, J.-A., Chang, K.-C., Lin, C.-Y., Koschorke, M., & Thornicroft, G. (2018). Perceived stigma of caregivers: Psychometric evaluation for Devaluation of Consumer Families Scale. *International Journal of Clinical and Health Psychology*, *18*(2), 170–178. https://doi.org/10.1016/j.ijchp.2017.12.003 |
| PHQ-9 | Patient Health Questionnaire Nine | Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A New Depression Diagnostic and Severity Measure. *Psychiatric Annals*, *32*(9), 509–515. https://doi.org/10.3928/0048-5713-20020901-06 |
| PQ | Primary Care Evaluation of Mental Disorders Questionnaire | Tamburrino, M. B., Lynch, D. J., Nagel, R. W., & Smith, M. K. (2009). Primary Care Evaluation of Mental Disorders (PRIME-MD) Screening for Minor Depressive Disorder in Primary Care. *The Primary Care Companion to the Journal of Clinical Psychiatry*, *11*(6), 339–343. https://doi.org/10.4088/pcc.08.m00711 |
| PSBCS | Perceived Stigma and Barriers to Care Scale | Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived Stigma and Barriers to Mental Health Care Utilization Among OEF-OIF Veterans. *Psychiatric Services*, *60*(8), 1118–1122. https://doi.org/10.1176/ps.2009.60.8.1118 |
| SITBI | Self-Injurious Thoughts and Behaviours Interview | Fox, K. R., Harris, J. A., Wang, S. B., Millner, A. J., Deming, C. A., & Nock, M. K. (2020). Self-Injurious Thoughts and Behaviors Interview—Revised: Development, reliability, and validity. *Psychological Assessment*. https://doi.org/10.1037/pas0000819 |
| TEI | Traumatic Events Inventory | Sprang, G. (1997). The traumatic experiences inventory (TEI): A test of psychometric properties. *Journal of Psychopathology and Behavioral Assessment*, *19*(3), 257–271. https://doi.org/10.1007/bf02229182 |

# Empirical Paper

Do expressive suppression, trauma symptoms, and service history predict perceived social support and attitudes towards seeking help for mental health in veterans?

This paper has been prepared for publication in the Military Psychology Journal. Author guidelines are listed in appendix A.

Word count- 8196 (excluding references and appendices)

# Abstract

A challenge for military personnel is the transition from military to civilian life, termed reintegration. This is exacerbated by mental health difficulties developed from adverse military experiences. Two factors identified in supporting veterans with reintegration are social support and utilisation of community services, e.g., healthcare. This study explores factors that predict perceived social support and attitudes towards service utilisation.

A cross-sectional, internet mediated, regression design was employed to determine if expressive suppression, trauma symptoms, time in service and time since discharge predicted perceived social support and attitudes towards help-seeking for mental health. Surveys were distributed through social media sites in veteran specific groups, to veterans who had experienced active combat. Fifty participants, four of whom were female, took part in the study.

Time since discharge was found to predict perceived social support while expressive suppression was found to predict attitudes towards seeking help for a mental health issue. Trauma symptoms and time in service were not significant predictors within either regression model.

Individuals discharged longer perceive themselves as having less social support. Higher expressive suppression predicted poorer attitudes towards help-seeking. Clinical implications include provision of psychoeducational groups pre-discharge and encouraging veterans to maintain connections through community networks. Study limitations include small sample, and use of an unvalidated expressive suppression scale. Future research should explore the impact of gender, along with different methods for measuring expressive suppression such as laboratory or observational measures.

Key Words: Veterans, Trauma, Expressive Suppression, Perceived Social Support, Attitudes Towards Help-Seeking.

The mental health of veterans’, namely ex-members of the armed forces, is a key societal issue. While figures vary immensely, some studies estimate that up to 50% of veterans returning from Iraq and Afghanistan experience diagnosable mental health difficulties and up to 63% of these individuals meet the criteria for PTSD (Young et al, 2022). Veterans are more likely to suffer with common mental health problems, post-traumatic stress disorder, and alcohol misuse (Rhead et al, 2022). One in eight veterans (12.5%) access their GP for mental health related reasons (Ministry of Defence, 2020). A key area to consider when examining the impact of mental health difficulties in veterans is how it impacts on their transition into civilian life from the military post discharge, referred to as reintegration (O’Connell, 2020). Reintegration can pose a challenge to military personnel irrespective of whether they experience physical and mental health difficulties (Sayer et al, 2011; Sayer et al, 2014). These challenges include being caught between civilian and military culture, being alienated from family and friends, and undergoing a crisis of identity. Veterans can rapidly transition between being under fire one day and in supermarkets the next. Assimilation to military culture occurs over time during military training. This process involves separation from an individual’s civilian life, learning and absorbing military culture (as defined below) and then incorporation of this into their identity (Soeters et al, 2006). However, upon discharge the transition between military and civilian life occurs overnight. Civilians cannot comprehend the experiences veterans have faced, and the civilian world has progressed while veterans were away. Children have aged relationships have changed. These factors can lead to veterans feeling isolated and disconnected from the people around them even their loved ones during reintegration (Munroe, 2006). Few civilians recognise their military accomplishments; therefore, veterans require effort to forge a post-service identity (Demers, 2011; Wilson et al, 2018).

Military culture is regularly cited as endorsing hierarchy, strength, courage, resilience, and traditional masculine attitudes (Bryan & Morrow, 2011). Traditional masculinity within the military has been further differentiated into factors including self-reliance (preferring to solve one’s own problems rather than seek help), emotional control (supressing emotions to avoid high levels of affective arousal), and concealment of perceived weaknesses (Jakupcak, et al, 2006). Currently, research on military culture is viewed through the lens of gender with “masculine” and “military” becoming conflated and inseparable (McAllister et al, 2018) even though many women currently serve in the military. The armed forces aim to double its female recruits by 2030 (Beale, 2021). Currently, women make up 10.9% of the regular armed forces, which is an increase of 0.3% from 2019 (Ministry of Defence, 2020). It is the perceptions of serving personnel that without these masculine traits individuals could not thrive or even survive (Higate, 2003). These traits serve a purpose during deployment and active combat; “The ability and willingness to kill is dependent on being emotionally deadened or controlled” (Goldstein, 2003). While these traits are perceived as necessary during deployment and combat, they have been evidenced to be detrimental to veterans’ mental health perhaps none more so than emotional control (Neilson et al, 2020). Emotional control, otherwise termed expressive suppression, stoicism, or toughness was found to have the most consistently negative impact on veterans’ mental health (Neilson et al, 2020; Feingold & Zerach, 2021). It has been evidenced to predict greater severity of PTSD symptoms (Neilson et al, 2020) and lower self-efficacy (Voller et al, 2015). While there are several terms to describe this phenomenon, such as restrictive emotionality, the current study will use expressive suppression henceforth due to its prominence in the literature (Dryman & Heimberg, 2018).

Elnitsky et al (2017), through principal-based concept analysis of 1459 papers, identified four key domains which aid coping during reintegration. These are individual factors (e.g., physical, and psychological health), interpersonal relationships (e.g., social engagement, and support), community systems (e.g., support offered by services such as the National Health Service [NHS]) and societal structures such as the current government and their priorities (e.g., funding for health service and military expenditure). These are identified as being fundamental in aiding reintegration and are suggested as a focus for future research.

Little research has been conducted on how these four domains interact. For example, how psychological factors within the individual may impact on the broader supportive domains of interpersonal relationships and use of community services. The fourth domain of societal structures is intrinsically enmeshed within the other domains making it difficult to measure especially for small scale research projects. Interpersonal relationships are complex multifactorial constructs, difficult to measure in research. However, Virtanen and Isotalus (2012) identified that social support is a fundamental aspect of interpersonal relationships.

## Social Support

Social support can be defined as “*support accessible to an individual through social ties to other individuals, groups, and the larger community*” (Tijhuis et al, 1995). Research has evidenced the benefits of social support to physical and mental health (Ozbay et al, 2008). Social support has been deemed to be crucial when examining a veteran population (Blais, 2021), as less behavioural and emotional support from an individual’s relationships has been associated with increased PTSD symptoms (Sripada et al, 2016), and depression (Bambara et al, 2011). Research has identified two aspects to social support, perceived and received. Perceived support is the recipient’s view of the availability of their support and satisfaction with the support provided. Received support is the specific supportive behaviours provided by the recipients support network. Interestingly, only perceived social support has been consistently linked to health outcomes, indicating that no matter the degree of received support, if perceived support is believed to be low, health outcomes are still poorer (Haber et al, 2007). Research currently focuses on the impact of social support on health-related factors, for example, PTSD (Pietrzak, 2010), rather than examining the factors that predict perceived social support. The current study, therefore, will consider the contributing factors to levels of perceived social support in a veteran population. Perceived social support is important in the interpersonal aspect of reintegration as an individual needs to feel and accept support from their relationships for them to be of benefit (Proescher et al, 2020). Research has demonstrated that individuals who have higher levels of perceived social support are more likely to utilise interpersonal resources (for example, ask their loved one for support) to cope with life stressors and have a greater life satisfaction overall (Kasprzak, 2010).

Higher rates of expressive suppression have been directly linked to lower levels of perceived social support in a population of young civilian adults (d’Arbeloff et al, 2018). Herrera et al (2013) utilised online surveys and found that in a sample of Hispanic male veterans expressive suppression, led to lower relationship satisfaction in personal relationships. Few studies have linked expressive suppression to perceived social support in a veteran population. However, higher rates of expressive suppression have been linked to reduced social support in the general population (butler et al, 2003), and in small samples with veterans (Jakupcak et al, 2006).

Trauma symptoms have also been linked to social support. Trauma is the emotional response to an abnormal, distressing event which can lead to long term psychological symptoms such as nightmares and flashbacks (Weathers & Keane, 2007). Blais et al. (2021) utilised a meta-analysis of 37 studies to demonstrate that social support and PTSD reciprocally predicted each other, with more PTSD symptoms leading to less social support and increased social support reducing PTSD symptoms. It was hypothesised that social support present prior to trauma acted as a buffer against developing symptoms of PTSD, whereas developed symptoms such as agitation and struggling to focus impacted negatively on relationships inhibiting social support. Sripada et al (2016) found that less perceived social support led to worse PTSD symptoms. In contrast, Nickerson et al (2017) found that the relationship between PTSD symptoms and perceived social support may not be bidirectional but unidirectional, with trauma symptoms predicting levels of perceived social support. One study that may explain the differential findings on the relational direction between trauma symptoms and perceived social support is by Kaniasty and Norris (2008). This study indicated that in a civilian population in Mexico, 6-12 months following traumatic experiences, perceived social support predicted development of trauma symptoms, whereas from 18-24 months this relationship appeared to reverse with trauma symptoms predicting levels of perceived social support. It was hypothesised that the social causation mechanism (the theory that social support mechanisms are antecedents to wellbeing) was the driving force immediately following the traumatic event. Whereas the social selection mechanism (the theory that mental health determines individuals’ status or socioeconomic status) affected individuals 18 months following the incident. In a veteran population, Laffaye et al (2008) found results akin to Nickerson et al’s (2017) study with increased levels of PTSD leading to lower levels of perceived social support.

As aforementioned, military culture is cited as embodying masculine traits, therefore, gender may also influence social support. Matud et al (2003) found that in a sample of 3210 adults from a general population there were clear gender differences in perceived social support. Women perceived support as a single factor whereas men saw emotional support as differing from functional support. Further gender differences have been found in social support within a military population (Hsieh & Tsai, 2019). This study found that overall men had higher levels of social support in the military due to it being a masculine dominated environment. This increased level of perceived social support led to less negative physical and mental health outcomes for the men. The researcher hypothesised that this was not due to differences in received support, but the negative perceptions of support held by the women.

## Attitudes to Healthcare Service Use

Utilisation of services by veterans is defined by Elnitsky et al (2017) as the use of support services such as healthcare and support groups like the NHS or The British Legion. The most important factor in utilisation of healthcare services has been the presence and recognition of physical or mental health problems by the individual (Parslow et al, 2004). An individual’s attitude towards seeking mental healthcare support (for example, how effective one believes therapy can be) greatly determines the likelihood of them seeking support, with more positive attitudes towards seeking mental healthcare ultimately leading to greater utilisation of services (Hyland et al, 2014). In a study by Hines et al (2014) 19% of veterans disclosed stress or emotional problems making them twice as prevalent as physical health problems in this population. Despite this, only 29% of veterans sought professional medical help for stress or emotional problems in comparison to 85% who sought help for physical problems. Current research on the barriers to mental health help-seeking suggests that this may be due to fear of stigmatisation by military colleagues and concerns about the therapy process, for example, therapy being offered too soon following discharge and veterans not feeling ready for therapy (Cornish, et al, 2014). Porcari (2009) found that positive attitudes towards help-seeking (e.g., belief that therapy can lead to change) for mental health was the most important predictor in determining service use in a veteran population. Whereas negative attitudes can inhibit service use even in individuals experiencing mental health crisis (Kulesza et al, 2015). In a veteran population increased self-stigma led to poorer attitudes to help-seeking from mental health services (Held & Owens, 2013). By increasing understanding of the factors that contribute to attitudes towards help-seeking for mental health difficulties, services may be tailored to encourage veteran engagement.

Expressive suppression has been found to exacerbate guilt and shame and promote self-stigma in veterans previously deployed to active warzones (McDermott et al, 2017). It was hypothesised that individuals supressed their feelings due to adherence to traditional masculine gender roles. However, if this failed and emotions were conveyed, self-criticism and stigmatisation developed, in turn generating guilt and shame. For male veterans experiencing low-to-moderate distress greater emotional suppression was significantly associated with stigma, one of the most cited barriers towards seeking help from mental health services (Heath et al, 2017). This is supported by Juanto (2014) who found that supressing emotions was a predictor of less positive attitudes towards help-seeking behaviours in veterans previously deployed in active combat.

Research has explored trauma symptoms in relation to attitudes towards help seeking. Murphy and Busuttil (2015) found that untreated PTSD symptoms negatively impacted on attitudes towards seeking mental health support. This was because the veterans held negative beliefs around mental health, such as mental health equating to weakness. Following the development of PTSD these views were internalised *(I am weak*). This self-stigma negatively impacted self-esteem and made them feel unworthy of mental health support, inhibiting service use. This is supported by Limowski et al (2021) who found that individuals with more severe PTSD symptoms had more negative attitudes towards help-seeking. Brewin et al (2011) found that in a population of 153 UK veterans trauma symptoms led to increased alienation from civilian life and in turn reduced use of the NHS.

Gender has also been linked to attitudes towards help seeking for mental health issues (Mackenzie et al 2006). Mackenzie et al found that in a population of 206 British adults, women were more likely to hold positive attitudes towards help-seeking than men. A literature review by Richmond et al. (2023) demonstrated clear gender differences in help-seeking among veterans. This review found that female veterans were more likely to seek help than male veterans. The barriers that affected help-seeking differed between the genders. Women were more likely to avoid help-seeking from veteran services due to military sexual trauma, leading to institutional betrayal and hypermasculinity within the military. This meant that veteran specific services were felt to be unsuited for women.

Demographic data will be collected on the length of time that the individual has spent in military service (time in service [TIS]) and the time since discharge (TSD). These are important as the longer an individual remains in any given culture the more likely they are to adopt its principles with socio-cultural adaptation being found to increase steadily over time. (Wang et al., 2018). The same process of cultural assimilation applies upon entering the military and when returning home after discharge from military service. Length of service has been directly linked to levels of social support as evidenced by Park et al (2014). They found that in a sample of women serving in Vietnam, the longer serving personnel had significantly greater levels of social support than individuals who served a shorter time.

Time since discharge from military service has been studied by Thompson et al (2017) who stated that “veterans identified the need for space and time to help reintegrate” following discharge. This suggests that time is an important factor in the reintegration process. Individuals being discharged from the military can undergo a process of loss when reintegrating and this loss is most prevalent immediately following discharge, thus the shorter the TSD the greater the impact of the loss on the veteran experiencing it. (Romanuick & Kidd, 2018). Lobban and Busittil (2017) states that many of the factors that determine help-seeking in a military population can be understood by examining cultural characteristics of the military. Thus, it can be hypothesised that when veterans are still immersed in military culture immediately post discharge, they are more likely to adhere to these cultural norms and thus less likely to seek help. Busuttil (2017) identifies that by leaving the military secure attachments are broken with the military itself and an individual’s “brothers in arms”. Thus, immediately following discharge may be when veterans perceived levels of social support are lowest.

Based on the previous literature the following study will focus on TIS, TSD, gender, trauma symptoms and expressive suppression and their impact on perceived social support and attitudes towards help-seeking. Previous small-scale studies have struggled to recruit adequate numbers of female veterans to conduct analysis (Aldridge et al, 2019). As such methodological steps will be employed to address this. The current study will focus on veterans who have experienced active deployment. This is defined as being exposed to combat during military service, otherwise termed as an active war scenario. Arguably, those who have been exposed to active combat are more likely to require greater mental health support (Pietrzak et al, 2012). Therefore, absence of active deployment may mitigate the need for mental health support (Spelman et al, 2012). This tends to be the sub-population of veterans in which the greatest number of mental health difficulties arise and thus needs the most study and support regarding mental health difficulties *(Os*orio et al, 2017). Veterans will also be recruited from a UK sample only. This is because the barriers to help-seeking are different even across different western cultures. For example, the UK healthcare system is free whereas the US healthcare system is not. Therefore, it is suggested a UK specific sample is needed to yield UK specific implications for practice.

## Research questions and hypotheses

The research question posed in this study is: Do expressive suppression, trauma symptoms, gender, TIS, and TSD predict perceived social support and attitudes towards seeking help for mental health related issues in a veteran population?

* It is hypothesised that greater expressive suppression, more trauma symptoms, longer TIS and shorter TSD will predict lower levels of perceived social support.
* It is hypothesised that greater expressive suppression, more trauma symptoms, longer TIS and shorter TSD will predict poorer attitudes towards help-seeking for mental health.

# Method

## Design

A cross-sectional design utilising internet mediated research was employed to address the research questions. A power calculation using G\*power (Faul et al, 2009) was used to determine the necessary sample size. To predict perceived social support and attitudes towards help-seeking for mental health using multiple regression and five predictors (expressive suppression, trauma symptoms, gender, TIS and TSD), with a medium effect size (0.15), power set at 0.80 (Cohen, 1992) and an alpha value of 0.05, 91 participants were required (Soper, 2021). A medium effect size was chosen based on similar research by Aldridge et al (2019)

The researcher’s current epistemological position is that of positivism, adhering to the perspective that there are universal truths that can be accessed through quantifiable observation and measurement (Smith & Marysia, 1996). The current research project is positivist in nature due to its quantitative methodology. It assumes that there is a measurable truth. When attempting to understand factors that are predictive, a positivist approach is more suited, as it allows for statistical analysis of large quantities of data. Thus, this approach suited the research questions posed.

## Participants

Participants were veterans who had previously served in any of the UK Armed forces, which includes British Army, Royal Air Force, Royal Navy, and any branch of the special forces such as the Special Air Service. Participants were expected to be 18 and over and to have experienced active deployment during their military service. Participants were excluded if they were unable to read or write in English as resources were not available to support translation.

A total of 50 participants were recruited for the study four of whom were female (8%). Age ranged from 27 to 80 with a mean age of 57.5 (SD = 12.04). The gender ratio is roughly akin to the ratios present in the military with women accounting for roughly 10% of currently serving personnel (Clark, 2022). However, the study intended to recruit a more balanced number of male to female veterans to enable analysis. Despite targeted sampling in female veteran specific groups this was not achieved therefore gender had to be removed from the predictors during final analysis. The mean TIS was 14.06 (SD = 8.04) years and the mean TSD was 24.48 (SD = 14.19) years. An overview of participant demographics can be found in Table 1 below.

***Table 1***. Demographic data: Gender, Age, Time In service, and Time since Discharge

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | N | Mean (years) | Range (Years) |
| Gender | Male | | 46 (92%) |  |  |
| Female | | 4 (8%) |  |  |
| Age |  | |  | 57.5 | 27-80 |
| TIS |  | |  | 14.06 | 2-38 |
| TSD |  | |  | 24.48 | 0-54 |

## Procedure

Ethical approval was gained from the Staffordshire University ethics committee (see appendix B). Participants were recruited from the general population using social media advertising (See appendix C). Facebook was the primary site used but was supplemented with Instagram and Twitter. The study was advertised through public posts and posts in veteran specific groups such as “UK Veterans” and “ForgottenVeteransUK”. Female veteran communities such as “Female UK Veterans” were targeted to increase female veteran recruitment and included tailored advertisements (See Appendix C). Consent was obtained from group administrators for entry into the group and for each post advertised. The link to the study was embedded in each advertisement. Consent forms, information sheets and debrief forms were all contained within the link provided (see appendix D). Participants had to provide consent before they could access the study questionnaires. Consent was obtained in line with the Ethical Guidelines for Internet-Mediated Research produced by the British Psychological Society (Hewson & Buchanan, 2013).

The questionnaire comprised demographic data, specifically, participants’ age, gender, TIS, and TSD (see appendix E), and the four study questionnaires described below. The questionnaires took around 20 minutes to complete and were forced response to ensure no data was absent upon analysis. The questionnaire battery was created using Qualtrics, which is licensed for use by Staffordshire University. Data were collected between November 2022 and March 2023. Overall, around 6000 people were reached through posts and an estimated 150 people accessed the study link (exact numbers cannot be provided) but only 50 completed. This may indicate the study was too long, the questions were too emotive or that participants deselected themselves due to the study criteria outlined in the brief. Following completion of the questionnaires, participants were provided with a debrief form which included their unique participant number. This could be used to withdraw from the study up to the point of data analysis (see appendix B- information sheet) and was made clear in the in the participant information sheet.

## Measures

All psychometrics were freely accessible online. Copies of the measures can be found in Appendix F. Descriptive statistics including mean scores, and ranges for the measures can be found in the results section.

**Emotional Experience and Expressive Suppression Scale ([EEESS]; Bedwell et al., 2018) -** This is a 14-item measure of expressive suppression that focuses on seven emotions such as “fear” and whether participants convey and suppress these. Two seven item subscales are present, emotional experiencing and expressive suppression. Participants are asked two questions for each of the emotions, namely, “In the past year, how often have you felt this way?” (experiencing), and “Generally, when you feel this way, do you tend to hide or show the way you feel?” (suppression). Each item is rated on a 7-point Likert scale, from almost never (1) to nearly all the time (7) with higher scores indicating increased experiencing of emotion or higher expressive suppression. Suppression scores can then be totalled or split into positive and negative effects. For the current study only the suppression subscale was used, and scores were totalled for both positive and negative affects resulting in a minimum score of seven and a maximum score of 49. Currently, there are no normative ranges as the scale is relatively new. However, other scales such as the Emotional Regulation Questionnaire focus primarily on cognitive reappraisal with only four items on suppression making it inappropriate to this study. As such, the EEESS was deemed the most suitable for the current study. Analysis of reliability in the current study found that the EEESS had acceptable (Tavakol & Dennick, 2011) internal reliability (α = .78).

**The International Trauma Questionnaire ([ITQ]; Cloitre et al.,2018) –** The ITQ is an 18-item measure of trauma symptoms in line with the Diagnostic and Statistical Manual five (5th ed.; DSM–5; American Psychiatric Association, 2013). It includes statement such as “I feel numb or emotionally shut down” and participants then rate their answer on a 5-point Likert rating scale from 0 “not at all” to 4 “extremely”. Scores can be summed for an overall score with higher scores indicating greater presence of trauma symptoms. The minimum score for this scale is zero and the maximum is 72. High levels of internal reliability have been found in veteran populations with a Cronbach’s alpha score of 0.9 (Cloitre et al, 2018) making it ideal for this study. Analysis of reliability in the current study found that the ITQ had good (Tavakol & Dennick, 2011) internal reliability (α = .94).

**The Multidimensional Scale of Perceived Social Support ([MSPSS] Zimet, et al., 1988**) - The MSPPS is a 12-item measure focusing on three aspects of perceived social support: family, friends and significant other. It includes questions such as “there is a special person who is around when I am in need”. Each question is scored using a 7-point Likert scale ranging from 1, very strongly disagree, to 7, very strongly agree. Scores can be totalled for an overall score or examined via the individual subscale scores. For the current study the scores were totalled. Total scores range from 12-84 with 12-35 being low perceived support, 36-60 being medium perceived support, and 61-84 being high perceived support. The MSPSS has been shown to have good internal and test-retest reliability (with a Cronbach’s alpha ranging from 0.81-0.98 in non-clinical samples and 0.92 to 0.94 in clinical samples), good validity, and a stable factorial structure (Dambi et al, 2018). Analysis of reliability in the current study found that the MSPSS had good (Tavakol & Dennick, 2011) internal reliability (α = .93).

**The Inventory of attitudes towards seeking mental health services ([IASMHS]; Hyland et al., 2015) -** This 24-item scale measures an individual’s attitude towards seeking help from mental health services. It is divided into three subscales: Psychological Openness (the willingness to share and discuss mental health needs), Help-Seeking Propensity (the likelihood of reaching out when in need), and Indifference to Stigma (the degree to which individuals are affected by negative perspectives of mental health). The three sub-scales can be totalled to produce overall scores, as was the case in this study, with higher scores indicated more negative attitudes towards help-seeking. The scores range from zero to 96. Questions include, “I would feel uneasy going to a professional because of what some people would think” and scoring is on a 5-point Likert scale ranging from 0 (disagree) to 4 (agree). Fifteen items on the scale are reverse scored. Internal consistency for the full-scale IASMHS was α =.87 (Hyland et al, 2014). Analysis of reliability in the current study found that the IASMHS had good (Tavakol & Dennick, 2011) internal reliability (α = .89).

## Data Analysis

Analysis was conducted using the statistical software package SPSS version 25 for OSX Mac. There were no missing data in the 50 cases collected making it suitable for the primary descriptive analysis. Individuals who started the questionnaire but did not complete were deemed to have withdrawn from the study following which their data was not used and deleted.

Prior to completing the regression analysis all statistical assumptions for regression were checked, including normality, linearity, collinearity, data errors and homoscedasticity. All psychometric scales were deemed to be in acceptable ranges for skewness and kurtosis (see appendix G). Homoscedasticity was deemed to be acceptable for analysis. When examining normality both regressions were deemed to have breached normality as their histograms did not form a regular bell curve and their P Plot’s strayed from the line (see appendix H). This could be because distributions can sometimes present as non-normal when there is a small sample size in comparison to the power needed for the study, even if the data is in fact normal (Field, 2018). To account for this the data were bootstrapped. This is a re-sampling technique that estimates the confidence intervals for indirect effects and provides a suitable sampling distribution (Mackinnon et al, 2004). By bootstrapping the data, a more normally distributed sample was generated allowing the results to infer a more accurate estimate of the populations means. This in turn improves the predictive accuracy of the regression model (Chernick & LaBudde, 2014).

When screening for outliers the datasets for both regressions were treated as separate. No datasets were deemed necessary to remove for the perceived social support regression. However, two participant’s data were removed for the attitudes towards help-seeking for mental health regression. This was because their absolute value for the standardised residual score was above 2.5 (see appendix I). Field (2017) advises that no more than 1% of the overall dataset has absolute values above 2.5. The dataset had 50 participants thus not a single case could have residuals above 2.5. The author noted a disparity between the age, TIS and TSD data. Calculations revealed 19 cases with a joining age of 16 or lower. Four of these cases were 10 or lower. As the errors in data entry could be in any of the three variables (age, TIS, TSD) the regressions were run twice; once including the TIS and TSD, once excluding these variables. Precautions should be taken when interpreting the regressions including these variables given that there are errors present which cannot be pinpointed to a single variable.

# Results

The descriptive statistics for the psychometrics (EEESS, ITQ, MSPSS, IASMHS) are presented below in Table 2.

***Table 2***- Descriptive statistics for Criterion Variables (MSPSS & IASMHS) and Predictor Variables (EEESS & ITQ) including mean, standard deviation, and range.

|  |  |  |  |
| --- | --- | --- | --- |
| Psychometric | Mean | Standard Deviation | Minimum- Maximum |
| EEESS | 30.60 | 8.23 | 7-48 |
| ITQ | 32.48 | 15.82 | 0-65 |
| MSPSS | 47.02 | 19.86 | 12-84 |
| IASMHS | 54.46 | 17.23 | 11-92 |

Note- EEESS (Emotional Experience and Expressive Suppression Scale), ITQ (International Trauma Questionnaire), MSPSS (Multidimensional Scale of Perceived Social Support), IASMHS (Inventory of Attitudes towards Seeking Mental Health Support).

Prior to both regression analyses, correlations between the variables were analysed using the Pearson’s r correlation coefficient. Table 3 shows the correlations for the perceived social support regression. It was hypothesised that variables predicting perceived social support would be more highly correlated with the criterion variable MSPSS. A weak negative correlation was found for expressive suppression (-0.23), and TSD (-0.32), and a very weak negative correlation was found for trauma symptoms (-0.18) in relation to perceived social support. This indicates that as expressive suppression, TSD and trauma symptoms increase, perceived social support decreases. A weak positive correlation was found between TIS and perceived social support (0.21), indicating that as TIS increases so does perceived social support.

***Table 3***- Pearson’s correlations for Perceived Social Support Regression

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Perceived Social support (MSPSS) | Time In Service | Time Since Discharge | Suppression (EEESS) | | Trauma (ITQ) |
| Perceived Social support (MSPSS) | . |  |  |  |  | | |
| Time In Service | .068 | . |  |  |  | | |
| Time Since Discharge | .013\* | .001\*\* | . |  |  | | |
| Suppression (EEESS) | .056 | .398 | .205 | . |  | | |
| Trauma (ITQ) | .101 | .170 | .142 | .000\*\* | . | | |

\* p < 0.05  
\*\* p < 0.01

Note- EEESS (Emotional Experience and Expressive Suppression Scale), ITQ (International Trauma Questionnaire), MSPSS (Multidimensional Scale of Perceived Social Support), TIS (Time in service) and TSD (Time since discharge).

Correlations were analysed again to account for the two outliers removed in the Attitudes Towards Help-Seeking regression. Pearson’s r correlations were used and can be seen below in Table 4. It was hypothesised that variables predicting attitudes towards help-seeking would be more highly correlated with the criterion variable IASMHS. A very weak negative correlation was found for both TSD (-.092) and trauma symptoms (-.10) in relation to attitudes towards help-seeking indicating that as TSD and trauma symptoms increase, attitudes towards help-seeking decreases. A very weak positive correlation was found between TIS and attitudes towards help-seeking (.020), indicating that as TIS increases so does attitudes towards help-seeking. A weak negative correlation was found between expressive suppression and attitudes towards help-seeking (-.369). Indicating that as expressive suppression increases attitudes towards help-seeking decreases.

***Table 4***- Pearson’s correlations for IASMHS Regression

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Help-seeking (IASMHS) | Time In Service | Time Since Discharge | Suppression (EEESS) | Trauma (ITQ) |
| Help-seeking (IASMHS) | . |  |  |  |  |
| Time In Service | .446 | . |  |  |  |
| Time Since Discharge | .267 | .001\*\* | . |  |  |
| Suppression (EEESS) | .005\*\* | .405 | .190 | . |  |
| Trauma (ITQ) | .240 | .189 | .102 | .000\*\* | . |

\* p < 0.05  
\*\* p < 0.01

Note- EEESS (Emotional Experience and Expressive Suppression Scale), ITQ (International Trauma Questionnaire), IASMHS (Inventory of Attitudes towards Seeking Mental Health Services), TIS (Time in service) and TSD (Time since discharge).

## Regression analyses

For the perceived social support (MSPSS) regression standard regression analysis was used. All variables were entered into the regression model excluding gender, namely, expressive suppression (EEESS), trauma symptoms (ITQ), TIS, and TSD. The model accounted for 19% of variance (R2 = .19), while the adjusted R2 accounted for 12% (.119). The model was significant, F(4, 45 = [2.65], p = [.045]). When examining the coefficients (see Appendix J) only TSD was found to be significant (ß= -.314, Sig = .042) No other predictor variables were significant. Comparatively the bootstrapped results for time since discharge were non-significant (.062). This discrepancy indicates possible error in the non-bootstrapped data. Regression coefficients can be found below in Table 5.

***Table

Description automatically generatedTable 5***- Regression Coefficients for Perceived Social Support Regression including the bootstrapped coefficients.

Given the discrepancy between the non-bootstrapped and bootstrapped significance for TSD it was decided to re-run the regression. This was done with only TSD to improve the precision of the model. This is shown below in Table 6. However, caution should be taken when interpreting this as the bootstrapped coefficient indicated that TSD was non-significant.

***Table 6***- Regression Coefficients for Perceived Social Support Regression with only significant coefficients.

Table

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When running the regression with only the significant variable of TSD the model accounted for 9.9% of variance (R2 = .099), adjusted R2 (.081). The model remained significant, F(1, 48 = [5.29], p = [.026]). When examining the coefficient TSD was significant in both the normal (Sig = .026) and bootstrapped regression (Sig = .037). The regression was re-run a final time with TIS and TSD removed (due to the possible erroneous data). This left expressive suppression and trauma symptoms neither of which were significant.

For the attitudes towards help-seeking regression (see appendix K), TIS, TSD, expressive suppression and trauma symptoms were added to the regression model as predictors. Overall, the model accounted for 17% of variance (R2 = .168), while the adjusted R2 accounted for 9% (.091). The overall regression was not statistically significant, F(4, 43 = [2.18], p = [.088]) indicating that the culmination of all the variables is no better at predicting attitudes towards help-seeking than chance. When examining the coefficients only expressive suppression was found to be significant (T= -2.73, Sig = .009). This was also the case for the bootstrapped regression (Sig = .014). Regression coefficients can be found below in Table 7.

***Table 7***- Regression Coefficients for Attitudes Towards Seeking Help for Mental Health Regression.

Table

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The regression was then re-run with only the significant coefficient of expressive suppression to improve the precision of the model. The model accounted for 14% of the variance in relation to attitudes towards help-seeking for mental health issues (R2 = .136), adjusted R2 was 12% (.118). The model was now significant, F(1, 46 = [7.27], p = [.010]). When examining expressive suppression as a predictor, it was significant in both the normal and bootstrapped regression which can be seen in Table 8 below. The regression was re-run excluding the TIS and TSD variables. This did not yield any different results to those presented above.

***Table 8***- Regression Coefficients for Attitudes Towards Seeking Help for Mental Health Regression with only Significant Coefficients.

Table

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# Discussion

The current study aimed to establish the predictive power of trauma symptoms, expressive suppression, TIS and TSD on perceived social support and attitudes towards seeking help for a mental health problem. Initially it was intended to include gender in both regression analyses. However, only four female-identifying participants were recruited, therefore including gender as a predictor variable was not viable.

For the Perceived Social Support regression, it was found that only TSD significantly predicted perceived social support. The direction of this correlation was contrary to the hypothesis, as the longer veterans had been discharged from the service the lower their levels of perceived social support were found to be. This directly conflicts with previous research by Romanuick and Kidd (2018) who found that veterans go through a period of loss post military due to the disconnection from their military peers and rapid change in cultural norms, thus suggesting that immediately post-discharge is when perceived social support is lowest. Research by Thompson et al (2017) identified that veterans need time to reintegrate post-discharge thus the shorter the TSD the less supported they feel. One hypothesis for the contradictory findings in this study is that a key support system for veterans is other service personnel. It is possible that the longer they have been discharged the less likely they are to remain in contact with their military peers. It is possible that the relationship between TSD and perceived social support may not be linear. Perhaps there is an initial dip in perceived social support following discharge as per Romanuick and Kidd (2018). Following this perceived social support may increase as support networks are built but then it may fall again as the veterans age increases, as per the current study. The current study identified anomalous data present in the time related variables which may have impacted the results around TSD. Only 8% of the variance was accounted for in the current model (adjusted R2). This meant that 92% of variance was not accounted for. A study by Patrão et al (2018) found that in a general population, factors that predicted higher levels of perceived social support included higher levels of education, absence of depression, higher self-efficacy and ultimately the number of social contacts the individual has.

The Attitudes Towards Help-Seeking regression found that only expressive suppression significantly predicted attitudes towards help seeking for a mental health issue. As hypothesised, increased expressive suppression was found to predict poorer attitudes towards seeking help for a mental health issue. This supports previous research which found that expressive suppression reduced help-seeking behaviour in veterans (McDermott et al, 2017, Heath et al, 2017). It also supports broader literature around military culture which cites that self-reliance and expressive suppression co-exist (Jakupcak et al, 2006). The Attitudes Towards Help-Seeking regression model including only expressive suppression as a predictor accounted for 12% of the variance thus 88% of variance is unaccounted for by the model. A systematic review of 26 papers identified other variables which may predict attitudes towards help-seeking, including a tendency for military culture to encourage self-reliance, degree of combat exposure and health service difficulties such as lack of understanding from civilian services (Randles & Finnegan, 2021).

Findings indicated that trauma was not a significant predictor of either help-seeking attitudes or perceived social support. This conflicts with previous literature by Murphy and Busuttil (2015), Limowski et al (2021), and Laffaye et al (2008) who found that increased trauma symptoms significantly reduced perceived social support and attitudes towards help-seeking. The findings by Murphy and Busuttil (2015) examined untreated PTSD. Previous treatment was not specified in the current study. It is possible that individuals in the current study may have had previous treatment for PTSD which could skew the results. Laffaye et al (2008) found that PTSD symptoms led to lower levels of perceived social support. While the negative correlation points to this in the current study this link was non-significant possibly due to the small sample size.

TIS was found to be non-significant in both regressions. Previous research by Wang et al (2018) would suggest that the longer individuals are in the military the more likely they are to adopt its culture. However, once an individual becomes immersed in a culture this immersion plateaus. More time does not necessarily increase this. For example, if it takes six months to become immersed in the military individuals will be equally immersed at six months as at six years. This more binary view of cultural immersion may not be captured by the linear model.

## Limitations & Strengths

There are several limitations in the current study. Primarily the study was severely underpowered for the analysis chosen, meaning that results of the study cannot be extrapolated to the veteran population without caution. Further it cannot be determined whether the non-significant results, such as trauma symptoms not being predictive in either regression, are due to the low sample size or a lack of a predictive relationship.

Internet mediated research does not allow the researcher to validate people’s military backgrounds. This can be problematic as veterans can sometimes be misrepresented by civilians; a phenomenon coined stolen valour (Lloyd-Jones, 2012). The sample is also self-selecting, which can limit veterans without social media accounts from taking part in the research (Mathy et al, 2003). As the research was online it was also not possible to validate that all cases were from the UK. While advertising was conducted through UK based Facebook© pages and groups (along with other social media sites) and the brief asked for UK veterans, it is possible that veterans from other countries could have taken part. Another issue with online data collection in the current study is that it is unknown how many participants withdrew due to distress caused by the study thus it is unclear the impact that the study may have had on the sample.

The measure of expressive suppression has not been validated in a veteran population and is relatively new to use in research. It may not be generalisable to other studies in this population, though in the current study it was found to have good internal reliability suggesting it may be acceptable for use with veterans which is a strength of the study and may aid research moving forwards. Expressive suppression is challenging to measure through self-report as this only captures conscious suppression of feelings. Individuals who have served a long time in the military or who habitually supress their feelings may not consciously recognise this (Schunk & Zimmerman, 2011). Given the current measure is self-report individuals who unconsciously supress feelings would not be captured.

A strength of the study was its attempt to recruit a greater female sample through targeted sampling. Had this been successful it could have contributed novel information to the literature. However, the female sample while representative of military populations could not be analysed. Therefore, whether gender impacted veterans’ attitudes towards help-seeking or perceived levels of social support remains unknown. It has been found that there are differences in both perceived social support (Matud et al, 2003) and attitudes towards help seeking for mental health difficulties (Juvrud & Rennels, 2017) between men and women in the general population. Thus, it is likely that this variable could have positively contributed to the regression models.

A final strength of this study was that veterans were included in the conducting and writing of this research and the below executive summary. A member of the veteran community aided recruitment through sharing of the research links. They also provided a quote from a veteran’s perspective and read through both papers to ensure that the findings were representative, and the writing was accessible and meaningful to a veteran population. Consultation with people who possess lived experiences ensures the research is grounded and meaningful to the population being studied (Beames et al, 2021).

## Clinical Implications & Directions for Future research

Clinical implications from this study are tentative given the small sample size and possible erroneous data regarding the time variables; specifically, that TSD predicts lower levels of perceived social support. If these results are valid, it suggests that perceived social support is lower in veterans who have been discharged from the service for longer. Clinicians might consider supporting veterans to attend local support groups especially veterans who have been out of service longer. Veterans could also be encouraged to access support through other platforms such as local interest groups or even social media sites to maintain the connections they have with military colleagues or civilian family and friends. The use of social media or technology more generally to maintain social connections has been exemplified by the recent pandemic. This study measured perceived social support. Importantly there is difference between this and social support. Psychological therapists may wish to ascertain whether veterans are struggling with their perceptions of support or are genuinely isolated during assessments. This serves to inform whether individuals need therapy to better address relational issues, such as psychodynamic therapy, or whether practical interventions focused on building support in the community are more suitable, for example a community psychology approach.

The findings that greater expressive suppression predicts poorer attitudes towards help-seeking suggest that individuals who hold back their feelings are less likely to seek help from healthcare services. There was a significant correlation found between trauma and expressive suppression indicating that more traumatised people may have greater levels of suppression. Interestingly this would imply that increased trauma may predict poorer attitudes towards help-seeking, but this was not found in the results. It is suggested that Ministry of Defence run psychoeducational groups pre-discharge could aid veterans in understanding the benefits of seeking help and the importance of expressing their feelings. These in theory would serve as the antidote to their military training which encourages emotional control. Should veterans enter mental health services it may be more advantageous for psychological therapists to utilise less cognitive models of treatment in favour of more affectively focused models, as this study suggests it would aid them in seeking support in the future by enabling them to express their feelings more freely.

Future research should attempt to establish the impact that gender has on veterans with regards to perceived social support and attitudes towards help-seeking. Evidence suggests that gender plays a role in these aspects in the general population, but the emerging evidence base for veterans still leaves conclusions unclear. Targeted sampling was employed in the current study but was unsuccessful. Incentivising female veterans by paying them to take part or accessing them directly through MOD databases may be a better option.

As aforementioned, expressive suppression can be challenging to measure as it has both conscious and unconscious elements. Future studies may wish to examine the unconscious elements of this variable through laboratory studies. Quirin et al (2009) have demonstrated that through use of laboratory measurements unconscious emotions can be determined and do not always coincide with their conscious expression meaning that there may be difference between self-reported suppression and unconscious emotional suppression.

The conflicting findings between the current research and other research relating to time since discharge should be explored further. There were clear errors in the data obtained in relation to the variables of age, TIS and TSD. Future research should employ different data collection methods to prevent this from occurring. For example, obtaining specific dates of enrolment and discharge rather than asking participants to calculate this themselves. Alternatively validating these variables through official military databases could prevent this from occurring.

The current study utilised digital self-report data collection methods.

Future research may wish to utilise other methods of data collection such as telephone questionnaires or even mail surveys to ensure the perspectives of those without digital capabilities are represented.

# Conclusion

The current study is limited by its small sample size and possible anomalous data regarding the time-based variables. Longer TSD was found to predict lower levels of perceived social support. This conflicted with previous literature which suggested that the most difficult time for veterans in perceiving social support was immediately after discharge. Thus, this should be further explored. Higher levels of expressive suppression were found to predict poorer attitudes towards help-seeking which was in line with the previous research. Clinical implications include aiding veterans to maintain social links and psychoeducational groups post discharge. Future research may wish to explore the role of gender, alternative measurements of expressive suppression, alternative methods of collecting data around TIS and TSD, and finally non-digital data collection methods.

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# Appendices

## Appendix A- Author guidelines for publication from the Military Psychology Journal

**Preparing Your Paper**

Article Types

Regular Articles

* Should be written with the following elements in the following order: abstract, text, references, tables, and figures
* Should be no more than 30 pages, inclusive of:
  + Abstract
  + Tables
  + References
  + Figure or table captions
  + Footnotes
  + Endnotes
* Should contain an unstructured abstract of 200 words.
* Should contain no more than 5 **keywords**. Read [making your article more discoverable](https://authorservices.taylorandfrancis.com/making-your-article-and-you-more-discoverable/), including information on choosing a title and search engine optimization.
* Authors should prepare manuscripts for blind review in accordance with the Publication Manual of the American Psychological Association (7th ed.). Articles not prepared for blind review in accordance with the Publication Manual will not be reviewed. Each submission must include (1) an unblinded and (2) a blinded copy of the manuscript (described above). All manuscripts should be prepared so that they have clearly articulated goals that serve to organize the introduction, method, results, and discussions. The introduction should review relevant research and theories and conclude with a clear articulation of a testable research hypothesis or research question. The methodology should include a complete description of demographic characteristics (e.g., gender, age, race/ethnicity, education) and military career information (e.g., occupational field, years of service) of the participants; provide a thorough and concise description of all measures (e.g., lead stem with sample items, response alternatives, scoring procedures, and M, SD, reliability, and validity information); and include an explicit statement addressing confidentiality safeguards. The results section should include appropriate descriptive and inferential statistical analyses with reports of effect sizes (or strength of relationships) and confidence interval for significant and non-significant findings. The discussion section should elaborate on the unique contributions of the study to include linkages and extension from previous research and theory and address limitations and future directions. A separate title page should be prepared and include (a) the title of the manuscript; (b) names and institutional affiliations of all authors exactly as they are to be printed; and (c) name, mailing address, telephone and fax numbers, and e-mail address of the corresponding author. An e-mail address must be included on the cover page. Authors should also prepare a cover page that is included with the blind review copy of the manuscript. Public significance statements. As part of your submission, we ask that you prepare an impact statement of two to three sentences that summarizes your study in plain English for the educated public. The statement should be written in simple, nontechnical, and compelling terms that highlight the relevance and implications of your research. Please do not copy the abstract for this purpose. The aim of the statement is to summarize the article’s findings and highlight their importance to human behavior within and beyond the military environment (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). The public significance statement will enable authors to have greater control over how their work will be interpreted by key audiences. A useful guide may be found at: http://www.apa.org/pubs/authors/guidance.aspx. Please include the public significance statement in your manuscript file after the abstract.

**Brief Report**

* Should be written with the following elements in the following order: abstract, text, references, tables, and figures
* Should be no more than 20 pages, inclusive of:
  + Abstract
  + Tables
  + References
  + Figure or table captions
  + Footnotes
  + Endnotes
* Should contain an unstructured abstract of 200 words.
* Should contain between 1 and 5 **keywords**. Read [making your article more discoverable](https://authorservices.taylorandfrancis.com/making-your-article-and-you-more-discoverable/), including information on choosing a title and search engine optimization.

**Style Guidelines**

Please refer to these [quick style guidelines](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/journal-manuscript-layout-guide/) when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

**Formatting and Templates**

Papers may be submitted in Word format. Please do not submit your paper as a PDF. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

[Word templates](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/formatting-and-templates/) are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us [here](https://authorservices.taylorandfrancis.com/contact/).

**References**

Please use this [reference style when preparing your paper. An](https://files.taylorandfrancis.com/tf_APA.pdf)[EndNote output style](https://endnote.com/downloads/style/tf-standard-apa) is also available to assist you.

**Taylor & Francis Editing Services**

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. For more information, including pricing, [visit this website](https://www.tandfeditingservices.com/?utm_source=HMLP&utm_medium=referral&utm_campaign=ifa_standalone).

**Checklist: What to Include**

1. **Author details.** Please ensure all listed authors meet the [Taylor & Francis authorship criteria](https://authorservices.taylorandfrancis.com/editorial-policies/defining-authorship-research-paper/). All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors’ affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](https://authorservices.taylorandfrancis.com/editorial-policies/defining-authorship-research-paper/).
2. You can opt to include a **video abstract** with your article. [Find out how these can help your work reach a wider audience, and what to think about when filming](https://authorservices.taylorandfrancis.com/research-impact/creating-a-video-abstract-for-your-research/).
3. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:   
   *For single agency grants*   
   This work was supported by the [Funding Agency] under Grant [number xxxx].   
   *For multiple agency grants*   
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
4. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. [Further guidance on what is a conflict of interest and how to disclose it](https://authorservices.taylorandfrancis.com/editorial-policies/competing-interest/).
5. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about [supplemental material and how to submit it with your article](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/enhance-article-with-supplemental-material/).
6. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our [Submission of electronic artwork](https://authorservices.taylorandfrancis.com/publishing-your-research/making-your-submission/submit-electronic-artwork/) document.
7. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
8. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/mathematical-scripts/).
9. **Units.** Please use [SI units](https://www.bipm.org/en/si/) (non-italicized).

**Using Third-Party Material**

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on [requesting permission to reproduce work(s) under copyright](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/using-third-party-material/)

## Appendix B – Ethical Approval from Staffordshire University



## Appendix C- Advertisement posts for study.

Graphical user interface, website

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## Appendix D- Consent form, Information Sheet, and Debrief.



**Consent Form**

I have read and understood the information sheet, had the opportunity to ask questions, and I have had any questions answered satisfactorily.

* Yes
* No

I understand that my participation in this study is entirely voluntary and that I can withdraw at any time up the 1st of June 2023 without having to give an explanation.

* Yes
* No

I understand that the completed questionnaires will be stored securely and in a confidential place with all personal data anonymised.

* Yes
* No

I consent that data collected could be used for publication in scientific journals or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes, and I understand that all data will be anonymised.

* Yes
* No

I am aware that anonymised study data may be accessed by the University for auditing purposes.

* Yes
* No

I understand that all data will be stored safely on secure hard drive, and all electronic data will be stored for 10 years following this period it will be deleted.

* Yes
* No

By participating in this study, I acknowledge that I meet the study inclusion criteria.

* Yes
* No

I hereby give consent to take part in this study.

* Yes
* No



**Information sheet**

**Title of the study**

Does expressive suppression, trauma symptoms, gender, and service history predict perceived social support and attitudes towards seeking help for mental health in veterans.

**Invitation Paragraph**

My name is Sam Richmond, and I am a Trainee Clinical Psychologist on the Doctor of Clinical Psychology Course at Staffordshire University. As part of my training, I am undertaking a piece of research exploring how emotional suppression impacts attitudes to help seeking and relationship quality. I would like to invite you to participate in this research project which forms part of my Doctorate in Clinical Psychology (DClinPsy)research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Contact details can be found at the end of this form.

**What is the purpose of the study?**

This study aims to explore supressing of emotions, trauma symptoms, gender, time in service and time since discharge in military service personnel who have engaged in active combat and been discharged (veterans). Each of these factors are important in understanding ongoing difficulties veterans may have when returning home

**Why have I been invited to take part?**

You have been invited to take part in this study as you have identified as previously serving in one of the British armed forces (British Army, Royal Navy, or Royal Air Force). This means you have participated in Military training. You have also been involved in an active war deployment during your military service.  Please note that you should not take part if you are experiencing severe distress or feel unable to do so without exacerbating any existing mental health issues.

**What will happen if I take part?**

If you choose to take part, you will be asked to follow an online link and complete questionnaires on expressive suppression, relationship closeness, trauma symptoms, and help seeking behaviour, along with providing some brief demographic details such as age, gender, time in military service and time since discharge. This process should take between 15-20 minutes. It is suggested that when completing these questionnaires, you are in a quiet place where you will not be disturbed by other people. Upon completing the questionnaires, you will be asked to submit your answers and will then be provided with a debrief form similar to this but with a few other important details, such as the process to follow should you wish to withdraw your data and a number of details for support agencies should you be struggling after completing the questionnaires.  
 **Do I have to take part?**  
No. Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part, you will be asked to sign a consent form and you will be able to request a copy of the electronic consent form for you to keep should you wish. 

**What are the possible risks of taking part?**  
While it is unlikely that the study will cause you any direct harm, it is recognised that there is a possibility that the completion of the questionnaires may cause some psychological distress. If at any point during the process you begin to feel distressed, please either take a break and return to it at a later time or cease completion of the study. If you feel you need support, please see the potential sources of support listed at the end of this information sheet.

If in the extremely unlikely circumstance that the study elicits severe distress which feels unmanageable, please contact your GP surgery about receiving mental health support. A link to NHS advice is provided below.  
  
https://www.nhs.uk/nhs-services/mental-health- services/where-to-get-urgent-help-for-mental-health/   
  
**Data handling and confidentiality**  
Following completion of the study you will be provided with a participant number which you may use to withdraw your data up until June 2023 should you no longer feel comfortable with your participation in the study. This number will be appended to all of your data in place of identifying details such as your name in order to anonymise everything you have provided. Only I the researcher and you will be able to link your research data to your personal information. All of the data once provided will be entirely confidential with only myself and my two supervisors being able to access the raw anonymised data. All of the data will be stored on an encrypted hard drive and backed up to an alternative encrypted hard drive to prevent data loss in the computer is lost or stolen.  
  
Personally, identifying data will only be kept until the end of the research process (September 2023) whereas the questionnaire data will be kept for 10 years following the research in line with the universities data protection policy. Following which point it will be permanently deleted. While the raw data will be totally confidential the analysed data used in the results may be used in scientific publications or disseminated for audit or teaching and training purposes. In these circumstances it is impossible for anyone to identify you from the data which we would provide. Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a “task in the public interest”. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**What if I change my mind about taking part?**

You are free withdraw at any point in the study, without having to give a reason, up until the data analysis process on 1st of June 2023.  Withdrawing from the study will not affect you in any way.  If you choose to withdraw from the study, we will not retain any information that you have provided us as a part of this study. If you wish to withdraw from the study during completion of the questionnaires, simply stop answering and close down the study. Should you wish to withdraw at a later date, please contact the researcher with your study number and state that you wish to withdraw. 

**What will happen to the results of the study?**

The study will form part of my thesis for my Doctorate in Clinical Psychology and will be stored electronically in Staffordshire University library. It is hoped that the research will be published in a peer review journal and may be used in future research events such as presentations at academic conferences. The results may also be used for future teaching or training events. As such the results for the study may become publicly available. All data will be anonymised and thus it will not be possible to identify your data Following completion of the study, you are entitled to ask for a copy of the executive summary, a brief paper summarising the study and its findings. Simply contact the researcher after participating in the study on the email provided to request a copy.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me or my academic supervisor using the following contact details:  
  
Mr. Sam Richmond  
  
Email- [r024855k@student.staffs.ac.uk](mailto:r024855k@student.staffs.ac.uk)  
  
Dr Helen Scott  
  
  Email- [h.scott@staffs.ac.uk](mailto:h.scott@staffs.ac.uk)

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**What if I have further questions or if something goes wrong?**

If the study has harmed you in any way or you wish to make a complaint about the conduct of the study you can contact the Study Supervisor, Dr Helen Scott, or the chair of Staffordshire University Ethics, Professor Nachi Chickalingam (N.Chockalingam@staffs.ac.uk)  
  
Dr Helen Scott- [h.scott@staffs.ac.uk](mailto:h.scott@staffs.ac.uk)  
  
Staffordshire University Ethics Committee- [ethics@staffs.ac.uk](mailto:ethics@staffs.ac.uk)  
  
If you feel you need support for your mental health, please contact one of the services below  
  
MIND- MIND provide support and information on a range of mental health difficulties and can either offer support or signpost you to a more suitable place  
phone on 0300 123 3393  
Email [info@mind.org.uk](mailto:info@mind.org.uk)  
  
Samaritans – Samaritans offer a safe place for you to talk any time you like, in your own way – about whatever’s getting to you. And specialise in help around suicide  
Phone on 116 123  
  
Combat Stress- Combat Stress offer mental health support to anyone who is currently serving or has previously served in part of the UK armed forces. They also offer a space for carers or loved ones of the armed forces personnel to talk.  
Phone on [0800 138 1619](tel:+448001381619)  
You can also text on [07537 173683](tel:+447537173683)   
email [helpline@combatstress.org.uk](mailto:helpline@combatstress.org.uk)   
  
**Should you feel that you need more urgent care please contact your GP or in extreme cases attended A and E or call 999**

Thank you for reading this information sheet and for considering taking part in this research.

**Debrief**                                                    A red sign with white text

Description automatically generated with low confidence

**Title of the study**

Does expressive suppression, trauma symptoms, gender, and service history predict perceived social support and attitudes towards seeking help for mental health in veterans.

**What is the purpose of the study?**

This study aims to explore supressing of emotions, trauma symptoms, gender, time in service and time since discharge in military service personnel who have engaged in active combat and been discharged (veterans). Each of these factors are important in understanding ongoing difficulties veterans may have when returning home. Expressive suppression is the tendency to push away one’s feelings and has been well documented within military personnel during training and combat. Currently there is little research in the United Kingdom exploring this characteristic. As such it may be useful to study expressive suppression to aid therapeutic support for veterans in the future. The main objective of  this study is to measure expressive suppression in veterans and see what impact it may have on perceived social support and attitudes towards Help seeking behaviour. It is hoped that if a relationship can be established between expressive suppression and relational closeness and help seeking behaviour that treatment may be better tailored to aid veterans in the future.

If you would like to read further on this topic you may be interested in this following article

* Masculinities and emotional expression in UK servicemen: ‘Big boys don’t cry’?

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me or my  academic supervisor using the following contact details:  
  
Mr. Sam Richmond  
Email- [r024855k@student.staffs.ac.uk](mailto:r024855k@student.staffs.ac.uk)  
  
Dr Helen Scott

 Email- [h.scott@staffs.ac.uk](mailto:h.scott@staffs.ac.uk)  
  
**What if I have further questions or if I need further support?**  
If the study has harmed you in any way or you wish to make a complaint about the conduct of the study you can contact the Study Supervisor, Dr Helen Scott, or the chair of Staffordshire University Ethics, Professor Nachi Chickalingam (N.Chockalingam@staffs.ac.uk)  
Staffordshire University Ethics Committee- [ethics@staffs.ac.uk](mailto:ethics@staffs.ac.uk)  
  
Your unique participant ID number is (\_\_\_)

## Appendix E- Demographic Questions

Graphical user interface, text, application, email

Description automatically generated

## Appendix F- Measures

The Emotion Experience and Expressive Suppression Scale (EEESS)

“**Fear: Afraid, Scared”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Hostility: Angry, Hostile”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Guilt: Guilty, Ashamed”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Sadness: Sad, Lonely”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Joviality: Happy, Excited”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Self-assurance: Proud, Confident”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it

**“Attentiveness: Alert, Attentive”**

In the past year, how often have you felt this way?

1-Almost Never

2-Several Times per Month

3-Several Times per Week

4-Nearly Every Day

5-About Once per Day

6-Multiple Times per Day

7-Nearly All the Time

Generally, when you feel this way, do you tend to hide or show the way you feel?

1-I always hide it  
2-I usually hide it  
3-I am slightly more likely to hide it  
4-About half the time I hide it, and half the time I show it

5-I am slightly more likely to show  
6-I usually show it  
7-I always show it







**Attitude towards seeking help**

This scale will ask a number of questions to establish how you feel about seeking help for mental health related issues.   
  
The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians).   
The term psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties.

1-There are certain problems which should not be discussed outside of one’s immediate family.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

2- I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

3-I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

4- Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

5-If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

6-Having been mentally ill carries with it a burden of shame.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

7-It is probably best not to know everything about oneself.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

8-If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

9-People should work out their own problems; getting professional help should be a last resort.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

10-If I were to experience psychological problems, I could get professional help if I wanted to.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

11-Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

12-Psychological problems, like many things, tend to work out by themselves.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

13-It would be relatively easy for me to find the time to see a professional for psychological problems.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

14-There are experiences in my life I would not discuss with anyone.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

15-I would want to get professional help if I were worried or upset for a long period of time.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

16-I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

17-Having been diagnosed with a mental disorder is a blot on a person’s life.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

18-There is something admirable in the attitudes of people who are willing to cope with their conflicts and fears without resorting to professional help.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

19-If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

20-I would feel uneasy going to a professional because of what some people would think.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

21-People with strong characters can get over psychological problems by themselves and would have little need for professional help.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

22-I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

23-Had I received treatment for psychological problems, I would not feel that it ought to be ‘covered up’.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

24-I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems.

* Disagree
* Disagree slightly
* Neither agree nor disagree
* Agree Slightly
* Agree

## Appendix G- Descriptive statistics for psychometric scales including Range, Mean, standard deviation, Skewness and Kurtosis.

A picture containing text, screenshot, font, receipt

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## Appendix H- Histogram and P-Plots for Perceived social support and Attitudes towards help-seeking regressions.

Perceived social support regression.

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Attitudes towards help-seeking regression

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## Appendix I- Residual scores for outliers

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Casewise Diagnosticsa** | | | | |
| Case Number | Std. Residual | HStotal | Predicted Value | Residual |
| 21 | 2.567 | 92 | 47.98 | 44.020 |
| 29 | -2.489 | 11 | 53.68 | -42.676 |
| a. Dependent Variable: HStotal | | | | |

## Appendix J- Multiple regression with bootstrapping (perceived social support)

Table

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Multiple regression with bootstrapping and non-significant covariates removed (perceived social support)Table

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## Appendix K- Multiple regression with bootstrapping (attitudes towards help-seeking for mental health)

Table

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Multiple regression with bootstrapping and non-significant covariates removed (attitudes towards help-seeking for mental health)Table

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# Executive Summary

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Description automatically generatedExpressive Suppression, Trauma Symptoms, Time in the Military, and Time Since Discharge in Predicting Perceived Social Support and Attitudes Towards Help-Seeking in Veterans.

Word count- 2497

**This report has been produced as an accessible summary of the research project focusing on UK veterans. Veterans are those who have previously served in the armed forces. Importantly it has been produced to include a veteran’s voice and has been read by veterans to ensure the paper is clear and accessible. The research examines the roles of expressive suppression, trauma symptoms, time in service and time since discharge, and whether they predict perceived social support and attitudes towards help-seeking. A veteran’s experience and background are initially provided, followed by the method, findings and implications of the research.**

***A Veteran’s Voice****- “My Experience of Transition to Civvy Street*

*I left school in 1970 aged 15 with no qualifications and joined the army as a boy soldier that year. I left the army in 1994 aged 40, married with 2 young children aged 6 & 4.*

*At the time of leaving I was disappointed not to have achieved a higher rank, so I decided that’s it, leave it behind and get on with your new life, it presented an opportunity.*

*My wife (a qualified nurse) and I had a shared view of wanting to ensure our children had the best possible childhood. Happy and well educated, have life nourishing experiences so they could flourish into adulthood. Having that view broadly guided our choices going forward.*

*We chose to buy a house (we already owned a property that was rented out and was able to sell that) and live in an area with good primary and senior schools. My wife and children moved into the house 18 months before I left the army so our children could start school and not be disrupted.*

*The biggest issue I had during this time was deciding on what I was going to do. I wanted work that was meaningful and made a difference to young people’s lives. I managed to get some voluntary work with a national youth organisation and eventually got a job in that field. This work meant I was employed in a FE College and was able to take full advantage of a wide range of learning and educational experiences.*

*My wife and I shifted our work patterns, and very carefully manage our finances to accommodate our own personal development and the way we supported our children.*

*Sport and fitness in particular Rugby has always been a huge part of my life, and I would join a local club wherever we were posted so always had a connection in civvy street. I continued playing when I left and have also got involved in coaching mini and Junior teams.*

*During the early days I often woke up at night shouting, having night sweats - recounting certain events from 6 tours in Northern Ireland and the Gulf war 1990/91. The times I was racially abused by my own colleagues. Having to be better than most to get average.*

*I am currently self-employed, hold a Masters Degree and was awarded an MBE for services to Further Education and Young people. I have recently set up a project to support veterans.*

*My wife is still working and our children (now adults) are thriving”.*

# Background

Above is a quote from a veteran who has experienced the challenges of reintegration. This exemplifies the change in role and culture when transitioning to civilian life. It highlights the importance of support from family and social groups. Despite his nightmares and abuse this veteran never sought help from services. He understands the need for peer support as he has found purpose in offering it to others.

9.5% of the UK population are veterans, 58% of whom have been deployed in overseas duties potentially facing conflict (Johnson & Murariu, 2018). Combat veterans are a group unlike any other, they have faced peril in conflict and then returned to civilian living.

Reintegration post-discharge is the most prominent challenge faced by veterans after service (Elnitsky et al, 2017). Individuals must shift from one culture to another overnight, some whilst experiencing physical and mental traumas obtained from service. Aspects deemed essential to military survival such as emotional control which enables discipline in the chaos of combat and self-reliance which demonstrates reliability to their team, may also become a hinderance when entering civilian life. In fact, supressing feelings (expressive suppression) can be detrimental to veterans’ mental health, as it inhibits individuals from conveying their difficulties and gaining support leading to isolation, even though it is necessary during service (Neilson et al, 2020).

When facing problems during reintegration four areas have been found to aid with coping: individual factors (e.g., psychological resilience), the relationships around the individual (e.g., support from family), community support services (e.g., NHS) and finally societal structures (e.g., whether current governments prioritise veteran needs). The research presented here examined how psychological factors in the individual may impact upon their relationships and use of community services.

To understand relationships the level of support they offer needs to be known to judge whether they are beneficial. This can be done by measuring social support. Social support has an overwhelming number of benefits but significantly only if the individual recognises the support they have, namely, their perception of having support (Kasprzak, 2010). In this way, perceived support is a crucial factor in determining the overall benefits of the relationship. Many factors have been found to affect perceived social support in veterans. Expressive suppression has been shown to reduce levels of perceived support in the general population and in veterans (Manalo, 2018). Hiding feelings may feel safe in battle but can be isolating around family and friends. Engagement in combat can be traumatising, in that it is an event that emotionally overwhelms the individual (Litz, 2007). Traumatic experiences have been shown to make people emotionally withdrawn and fearful of interaction thus they perceive themselves as having less support, leading to isolation (Nickerson et al, 2017).

Community support services for veterans such as “Help for Heroes” can only help if veterans choose to engage with the service. Whether veterans choose to use services is greatly determined by their attitudes towards seeking help. Military culture often encourages strength and self-reliance, which conflicts with the idea of needing to ask for help (Randles & Finnegan, 2021). Traumatic experiences have been shown to negatively affect attitudes towards seeking help (Smith et al, 2019). When veterans feel traumatised shame and guilt often follow, *I should be tougher than this* (Cunningham et al, 2018). This can lead to veterans withdrawing from or not approaching services. Suppressing feelings is also counterintuitive to seeking help, after all the message from military has been “push it down”, not “let it out”.

Other factors which predict perceived support and attitudes towards help-seeking are gender, time in service and the length of time since discharge. Generally, females have been shown to utilise social support more (Turner, 1994) and to seek help from health services more (Doherty & Kartalova-O’Doherty, 2010). Those that have served longer appear more likely to take on values such as self-reliance and toughness (Soeters et al, 2006). Therefore, it seems the longer the time in service the less one might seek support from those around them or community services. Time since discharge is also key, as immediately following discharge is when the transition is most unsettling, making use of services and reliance on relationships for support challenging.

This research focuses on whether expressive suppression, trauma symptoms, gender, time in service and time since discharge do predict perceived social support and attitudes towards help-seeking. Furthering an understanding of which factors predict perceived social support and attitudes towards help-seeking can then help to identify veterans who struggle more when reintegrating and thus help in supporting them.

**It was predicted that greater expressive suppression, more trauma symptoms, longer time in service and shorter time since discharge would predict lower levels of perceived social support and poorer attitudes towards help-seeking for a mental health problem.**

# How was the research undertaken?

The current research was approved by Staffordshire University Ethics Committee. It was cross-sectional, meaning all the data was collected at a single time point. Participants were required to be veterans from any UK armed forces who had experienced active deployment, (being exposed to combat) during their career. Participants were recruited through social media, advertising on sites such as Facebook and Twitter and asked to complete online questionnaires, which included demographic questions such as age, gender, time in service and time since discharge. Given the possibly distressing nature of the topic all participants were informed about the potential risks of the study and provided with contact details for support services prior to the questionnaires. Consent was required for the study prior to completion of the questionnaires.

The questionnaires participants were asked to complete included the following:

**Emotional Experience and Expressive Suppression Scale ([EEESS]; Bedwell et al., 2019) -** This is a measure of expressive suppression that focuses on different emotions (e.g., anger & joy) and the degree to which they are supressed. It asks “Generally, when you feel this way, do you tend to hide or show the way you feel?”.

**The International Trauma Questionnaire ([ITQ]; Cloitre et al.,2018)–** The ITQ is a measure designed to establish the symptoms of post-traumatic stress disorder for example nightmares and flashbacks. It includes questions such as “in the past month have you been bothered by feeling jumpy or easily startled?”.

**The Multidimensional Scale of Perceived Social Support ([MSPSS] Zimet, et al., 1988**) - The MSPPS is a measure focusing on the perceived support provided from family friends and intimate relationships and includes statements such as “my friends really try to help me” to which participants were asked to rate their agreement.

**The Inventory of attitudes towards seeking mental health services ([IASMHS]; Hyland et al., 2015) -** This scale measures an individual’s attitude towards seeking help from mental health services. The type of statements included were “There are experiences in my life I would not discuss with anyone.” and asks participants to what degree they agree with the statement.

# Who took part?

A total of 50 participants were recruited. Information about the participants can be seen in the chart (figure 1- gender distribution) and table below (table 1- age, service length and time since discharge). Despite efforts being made to recruit appropriate numbers of male and female veterans for analysis, this was not achieved, as can be seen in figure 1. This meant that gender could not be included in the analysis. However, the sample was representative of average military populations (Clark, 2022).

**Table 1- Participants’ age, time in service and time since discharge.**

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Average age | youngest | oldest |
| Age | 57.5 | 27 | 80 |
|  | **Average time** | **Shortest time** | **Longest time** |
| Time in Service | 14.1 | 2 | 38 |
| Time Since Discharge | 24.5 | 0 | 54 |

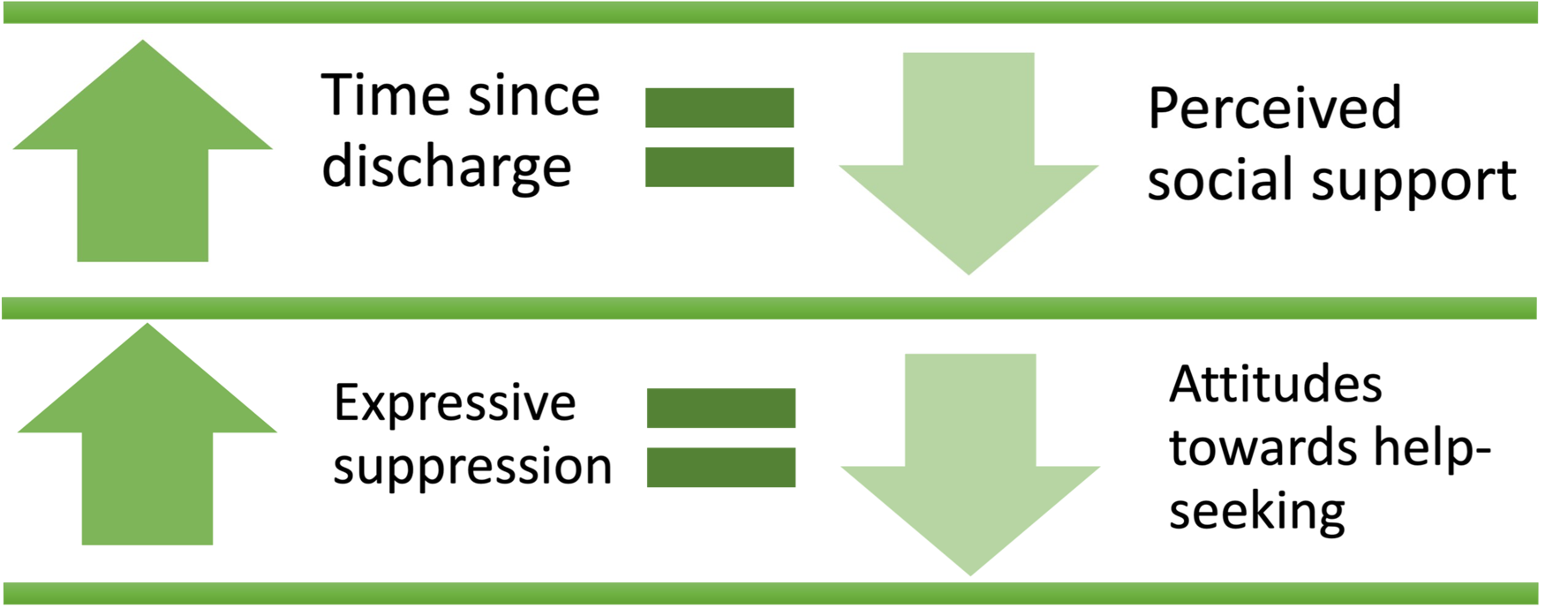
(All time is presented in years)

After data collection was completed, the questionnaire data were analysed to see if trauma symptoms, expressive suppression, time in service and time since discharge predicted perceived social support and attitudes towards help-seeking for mental health.

# What did we find?

For the first analysis, predicting levels of perceived social support, the only significant predictor was time since discharge. Trauma symptoms, expressive suppression, and time in service were not significant. It was found that the longer the time since discharge, the lower the levels of perceived social support.

For the second analysis predicting attitudes towards help-seeking for mental health only expressive supression was found to be a significant predictor. Trauma symptoms, time in service and time since discarge were not significant. This found that the greater the levels of expressive supression the poorer the attitudes towards help-seeking were. The overall results are shown diagrammatically below.



**Longer**

**Less**

**Greater**

**Poorer**

# Clinical Implications

This research indicated that perceived social support is lower in veterans who have been discharged from the service for longer. Therefore, aiding veterans to maintain social connections is crucial. This could be done through encouraging attendance at support groups through signposting, provision of interest groups like the rugby club attended by the veteran above, or even through online support networks on social media. Ultimately any method of building a community around veterans will aid social support. This is especially true of older veterans who have been out of the service longer.

The study also found that individuals who supress their feelings more are likely to have poorer attitudes towards help-seeking. Therefore, aiding veterans to express feelings will support them to seek further help. It is suggested that Ministry of Defence run emotional education groups prior to discharge could support veterans in learning the value of emotional expression. Having spent their military career learning to be emotionally controlled it is understandable that it is difficult for veterans to switch to being able express their feelings when returning to civilian life.

# Limitations

The current study is limited in number of ways and the findings need to be viewed in this context:

* This research was conducted online, so it only represents those with access to the internet and who are utilising social media. This meant that it was not inclusive of the whole veteran population. This is important as those without social media may have less social support.
* Using social media to recruit means that individuals are self-representing therefore their military history cannot be verified.
* The questionnaire used to measure expressive suppression is relatively new and has not previously been used with veterans, meaning it may not be compared to other similar research and thus limiting the findings of this study to the current sample.
* The female sample was representative of military populations, but it was so small in this paper that no analysis could be conducted on whether gender impacted perceived social support and attitudes towards help-seeking. Previous research has shown that gender may predict these variables (Matud et al, 2003; Juvrud & Rennels, 2017).

# Future research

Future research may benefit from including gender as a predictor. Strategies to encourage more female participation could include payment for taking part or recruitment with MOD support.

Time since discharge was a significant predictor of perceived social support in this study, but results are tentative. This is because of the small sample size, and errors found in the data entry of age, time in service and time since discharge. Previous research found that shorter time since discharge was the time when perceived support was lowest which contradicts with the current findings, emphasising the need for further exploration.

Future studies may benefit from more accurate collection of data around age, time in service and time since discharge, perhaps through verified data sources to prevent errors occurring.

Finally, future research may wish to use other methods of data collection such as telephone questionnaires or even mail surveys to ensure the perspectives of those without online facilities are represented.

# Dissemination of findings

Participants in the study can access this executive summary paper by contacting the researcher using the details found in the information sheet disseminated prior to the study. It is also intended that the research is published in a peer review journal.

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