"People like me don't get mentally ill"

A grounded theory study of attitudes towards mental illness and help-seeking amongst police officers with a military background

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List of abbreviations

BACP	British Association for Counselling and Psychotherapy
DSM-V	Diagnostic and Statistical Manual of Mental Disorders (5th edition)
GT	Grounded Theory
IACP	International Association of Chiefs of Police
IPA	Interpretative Phenomenological Analysis
LEO	Law enforcement officer
NCO	Non-commissioned officers
PTG	Post traumatic growth
PTSD	Post Traumatic Stress Disorder
TRiM	Trauma Risk Incident Management
VA	Veterans Health Administration
WWI	World War One
WWII	World War Two

Abstract

Introduction: Both police and Armed Forces personnel are at increased risk of encountering psychological trauma with the prevalence of mental health problems higher than in the general population. Appropriate and effective mental health services are crucial but there is a marked lack of take-up of services. This research considered how the attitudes of police officers with a military background affected their help-seeking for mental health problems.

Methodology: A phenomenological approach was used with the aims of producing rich data with the insider viewpoint and generating theory about the process. Semi-structured interviews were conducted with 11 male ex-Armed Forces police officers. A social constructivist Grounded Theory approach was used to analyse the data.

Findings: Police officers with an Armed Forces background viewed themselves as a discrete social group. There was significant cognitive separation between them and their non-service peers, the police organisation, those with mental illness and mental health services. Four group norms, formed during military service, were identified as relevant to the research topic: a) Mission Focus, b) Strength and Control, c) Cohesion and d) Be the Best. These norms were used to determine the stigma associated with both on-set and off-set responsibility for mental health problems within the group. Group norms underpinned the acceptable strategies for managing mental health problems. Education around mental health was not seen as personally relevant at the time. Accepting a mental health problem was the greatest barrier to care and meant an acceptance of norm violation in oneself often triggering an existential crisis. Potential helpers were judged against the group norms and this either hindered or facilitated the process. As the individual recovered, they reframed the group norms in relation to their experience of mental illness and reported Post Traumatic Growth. A theoretical model for the help-seeking process is proposed.

Implications: Anti-stigma interventionists need to consider the individual's perception of their loss of a valued identity and their violation of group norms. The stereotyping and generalisation of police managers and mental health services as "other" reduces the likelihood of accepting offers of support from those sources. Education must connect with the early beliefs from military service in order to effect change. Organisational denial or ambivalence about the subject needs tackling just as much as the denial in the group and individuals. The group holds much of the solution to the problem within its own membership and peer supporters who have overcome their own mental health challenges can be better used by the organisation to both prevent and manage the problem. They need to able to provide timely, trusted referrals to competent mental health services.

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Finally my thanks go to Gary, Simon and Sophie, who have alternately cheered me on, rolled their eyes and told me to "just get on with it then" – all at the right time and mostly received by me with a lack of grace. Thanks for bearing with me!

"I was in the Falklands and Northern Ireland in the army so I probably don't need to tell you what that was like and what I saw and what I did in those situations. In the police force I've been to you know child murders, horrendous road traffic accidents, stuff like that, I've just about seen it all and I've not had a problem.

I hope I never do, I think I've got the strength of character, the mental strength, not to, but if ever I did get to that point where I did lose it where I couldn't face anything like that I think I would be so disgusted with myself, I'm not quite sure but I wouldn't really think of myself as a person anymore I would just be completely contemptuous of myself.

I hope, and I'm confident, that I'll never get there"

(David)

Part 1: Introduction

This thesis begins with my initial statement of reflexivity. This sets out where I, as researcher, began this study. It continues with an introduction to the context of the study, first setting out the key concepts before offering an overview of mental health within the military and police services. This part then concludes by providing the rationale for the research and clarifying the research question.

Following the introduction, the thesis then continues in part 2, with a Review of the Literature relating to the stigma of mental illness and help-seeking, before outlining the chosen Methodology and Method of data collection and analysis in part 3. The Findings are then presented and discussed in parts 4 and 5 respectively. A closing reflexive statement is included in the Discussion section. Finally the Conclusions are summarised in part 6.

1.1 Initial Statement of Reflexivity

As will be detailed in Part 3, the epistemological assumption of the qualitative paradigm being used is that the researcher has an impact on that being researched, rather than being wholly independent from the subject. My findings are inevitably influenced by my own perspective and values. It was therefore important to be aware of, and open about, my own frame of reference at the outset of this study. I mapped out my initial thoughts and expectations and these are shown in Appendix 1.

I have worked professionally with police and military personnel as a trauma psychotherapist for over 15 years and am now lead of the Uniformed Services Task Force for the European Society for Traumatic Stress Studies. I spent several years working within a large urban police force providing crisis intervention, treatment for psychological trauma, training and pro-active initiatives for police officers. I often had the opportunity to "ride along" and spend time immersing myself in the culture. Having provided a service, that like the police culture itself operated around the clock every day of the year, with frequent emergency call-outs to critical incidents, I believe I have a good understanding of the day to day realities of police work.

Police officers with a military background are a group that I had a lot of dealings with when I worked within the police service. They always seemed somehow different to officers who had come from a civilian background. They usually presented with trauma reactions, not from something horrific that they had dealt with, but because of shattered beliefs related to incidents. Their sense of right and wrong appeared highly defined including their expectation of the organisation backing them through thick and thin. At times, their thinking was very black and white. I became aware that they found it hard to ask for or accept help and often remarked *"This isn't me," "This is not what I do"* when referring to coming for therapy or welfare services. I knew that this was the last resort and that a huge amount of suffering went on behind the scenes and

was uncomfortable with this knowledge. Although I never set out to be a psychotherapist, my childhood dream of becoming a vet probably reveals my "rescuing" nature and a desire to "make things better." Crisis work, and later trauma psychotherapy, being relatively directive and solution-focused, suited my practical nature and this desire to fix. However, with this group I was faced with my inability to help as they simply wouldn't ask. I wanted to know "why" this was and if I could help in any way to change this. Addressing this issue was the driving force behind my research.

We now use the term police service rather than force, and even back then there were active moves to discourage military terminology such as "the troops" and "front-line" policing. One of the interviewees revealed that he had been asked by a senior officer to remove a military tie-pin in case it "caused offence." Anecdotally, I found that some police officers were threatened by ex-servicemen viewing them as tougher, more rigidly disciplined but with a propensity for casual violence if that discipline dropped. I admit I found them initially a challenging group to work with. They seemed to judge me – at that time a young, female civilian (and heaven forbid, blonde to boot) – as the stereotypical opposite to them. I had to adapt in order to build credibility. I slowly built my reputation on honesty, integrity and capability and through showing no fear and felt immensely privileged with each breakthrough. My manager once said to me that *"no matter what you are told, maintain eye contact. If you flinch when you're told the gory details, you've lost them."* This "testing" by them certainly developed my ability to cope with anything and appear grounded and in control!

Since leaving that police force, I have continued to work professionally with military personnel, veterans and other uniformed services as a trauma psychotherapist. I was confident I could communicate and build rapport with potential participants. The big risk was in allowing my own stance to unduly influence the findings, particularly if something was revealed that cast a less than flattering light on the population. Being explicit about this, with myself and my supervisor, would be important.

My research experience at the outset of this study comprised mainly of several published case studies (Keenan and Royle 2008; Royle 2008; Royle, Keenan et al. 2009) and my Masters dissertation: a grounded theory study relating to police firearms officers (Royle 2003). I had undertaken some small research projects in quantitative methods as part of my professional training but found that my curiosity around complex and unknown issues naturally drew me towards qualitative methods. Part 3 of this thesis sets out in more detail my epistemological stance and the reasons I chose grounded theory for this study. Having co-authored a book (Royle and Kerr 2010) I was relatively comfortable as a writer but considered myself a novice researcher and looked back on my Masters dissertation with highly critical eyes. My final reflexive statement in part 5 shows what I learnt about myself during this research and the personal dilemmas and challenges I faced.

1.2 Key concepts: Traumatic events and reactions

1.2.1 Traumatic events

It is common sense that both police and Armed Forces personnel are at high risk of encountering psychological trauma by the very nature of their occupation but just what is meant by a traumatic event? In its Diagnostic and Statistical Manual of Mental Disorders (5th edition), the American Psychiatric Association states that for an incident to be classed as traumatic the person must have been exposed to actual or threatened death, serious injury, or sexual violence (APA 2013) whilst the World Health Organisation's International Statistical Classification of Diseases and Related Health Problems (ICD-10) describes exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (WHO 2010).

The nature of police officers' exposure to traumatic incidents is often complex, intense and cumulative (Papazoglou 2012). However diagnostic descriptions make no distinction between the one-off traumatic event such as a serious assault or accident, referred to as Type I trauma, and Type II trauma (Terr 1994) which involves multiple or repeated traumatic incidents as may be more common across all the uniformed services. They also exclude events that could be described as small t traumas or "those experiences that give one a lesser sense of self-confidence and assault one's sense of self-efficacy" (Parnell 2007 p.4) or disrupt our core beliefs or cognitive schemas (Young 1990). According to Constructionist Self-Development Theory, people will give meaning to events depending on how they interpret them and these interpretations may result in them changing the way they view themselves, others and their world (McCann and Pearlman 1990). Janoff-Bulmans' (1985) "Assumptive World Theory" explains how individuals make assumptions about the world and themselves, for example, *"the world is just and makes sense"* and *"I am basically a good person"*. When exposed to trauma, these assumptions may be "shattered". An example could be a police officer's personal experience of the line of duty death of a colleague and his potentially "shattered" assumptive world; *"I am not invulnerable", "the world does not make sense," "I should have done more."* This shattering of assumptions can lead to psychological trauma (Keenan and Royle 2008).

Using the DSM-V definition is therefore potentially exclusive of events that are equally devastating and that whereas "the spirit of Criterion A is clear it can sometimes be difficult to gauge whether it is met in a particular case." (Scott and Stradling 2001 p.7-8).

This research focused on the individual's own perception of whether they had experienced a traumatic event based on their reaction to, and interpretations of, the event(s) in their life.

1.2.2 Reactions to traumatic events

There are a multitude of symptoms that the individual may experience following a traumatic event and the diagnostic label for the resulting condition will depend on the nature, intensity and duration of these symptoms.

Immediate symptoms are wide ranging in their frequency and intensity but normally reduce naturally and should have greatly subsided by 4 weeks. They can include physiological arousal such as anxiety, anger, sleep disturbance and cognitive impairment; re-experiencing in the form of intrusive thoughts, dreams and images; avoidance of stimuli related to the event and withdrawal from supportive relationships (APA 2013). Whereas Post Traumatic Stress is often described as a normal reaction to an abnormal event, another relatively recent diagnosis in DSM-V is Acute Stress Disorder (ASD). This covers acute symptoms that develop either during the event or shortly afterward.

Where the symptoms of physiological arousal, re-experiencing and avoidance are severe and have lasted for more than a month, the reaction may then be categorised as Post Traumatic Stress Disorder (PTSD) but only if the specific criteria of the DSM-V are met. Such PTSD is classed as *acute* where it is present for less than three months and *chronic* for three months or more (APA 2013).

In addition to directly experiencing a traumatic incident, helping professionals, such as police officers, who are exposed to others' trauma in their daily working lives, can become overburdened by events that happened to others (Martin 2006; Rothschild 2006). This "occupational hazard" is described as Vicarious Trauma (McCann and Pearlman 1990; Pearlman and Saakvitne 1995) although not everyone who is vicariously exposed to traumatic narratives develops symptoms of this (Lerias and Byrne 2003). Vicarious Trauma develops over time and affects a person's professional and social identity (Dane and Chachkes 2001). The symptoms relate closely to other traumatic stress reactions but notably include cynicism and emotional blunting. These effects are cumulative and may be permanent (Pearlman and Saakvitne 1995).

Although much of the media and professional attention is focused on PTSD, this is a narrowly defined condition and can detract attention from other long term reactions such as Generalized Anxiety Disorder, Depressive Disorders, Obsessive Compulsive Disorder, Enduring Personality Change and Dissociative Disorders (WHO 2010; APA 2013). Again, this research did not concern itself with labelling experiences under a diagnostic category but relied on the individual's view of whether they had suffered mental health problems or not.

When discussing the effects of traumatic events, the emphasis is usually placed on mental distress rather than focusing on the positive changes that can occur. Traumatic events do not only have to lead to difficulties and there is a growing interest in the concept of post traumatic

growth (Tedeschi and Calhoun 1995; Linley and Joseph 2004; Tedeschi and Calhoun 2004; Linley and Joseph 2009; Leykin, Lahad et al. 2013). Post traumatic growth (PTG) has been observed in studies of police officers (Paton 2005; Paton and Burke 2007; Chopko and Schwartz 2009; Chopko 2010) and military populations (Benetato 2008; Lee, Luxton et al. 2010; Bush, Skopp et al. 2011; Kaler, Erbes et al. 2011; Kjaergaard, Leon et al. 2013; McLean, Handa et al. 2013). Tehrani (2010) suggests that, for police family liaison officers, the opportunity for formal and informal reflection on their work can facilitate personal growth. PTG does not mean the absence of suffering or the disappearance of distress and some authors suggest a positive association between initial levels of distress and subsequent growth (Kleim and Ehlers 2009; Dekel, Ein-Dor et al. 2012). Five factors have been identified in PTG: Relating to Others (greater intimacy in personal relationships and more compassion for others), New Possibilities (new direction and purpose in life), Personal Strength, Spiritual Change (feeling more spiritually connected), and a deeper Appreciation of Life (Tedeschi and Calhoun 2004).

1.3 The mental health of the uniformed services

1.3.1 Military mental health

In the military, living memory has seen significant combat: World Wars I and II, the Falklands, Northern Ireland and the Gulf War as well as more recent conflicts in Iraq and Afghanistan. The war experience for many personnel results in mental illness, social isolation and maladaptive responses. The prevalence of mental health problems is high and rising (Hoge, Castro et al. 2004; Hoge, Auchterlonie et al. 2006; Seal, Metzler et al. 2009) with reservists often being particularly at risk (Hotopf, Hull et al. 2006; Iversen, van Staden et al. 2009). Even in peacetime, significant numbers of troops deployed as peacekeepers to Bosnia reported needing help with deployment related stress or PTSD (Maguen and Litz 2006). Typical surveys report that between 15% - 44% of troops returning from Iraq experienced some type of mental health problem (Hoge, Castro et al. 2004; Greene-Shortridge, Britt et al. 2007; Milliken, Auchterlonie et al. 2007; Kim, Thomas et al. 2010). In the UK, one report suggests up to 50% of Falklands War veterans are symptomatic for PTSD (O'Brien and Hughes 1991).

In the 3 month period of April – June 2007, 1,380 UK Armed Forces personnel attended a first assessment at one of the Ministry of Defence's Departments of Community Mental Health. Out of the 1,299 for whom information on the presenting complaint was supplied, 996 were identified as having a mental disorder equating to a rate of 5.0 per 1,000 strength (Corbet, White et al. 2007). During 2010, 3,942 new cases of mental disorder were identified within UK Armed Forces personnel, at Departments of Community Mental Health, representing a rate of 19.6 per 1,000 strength (DASA 2011).

Much of the research on prevalence rates comes from the US but it is acknowledged that there may be some cultural variations in reporting health (Ismail, Fear et al. 2011). According to Iversen et al (2009), the most common mental disorders in the UK military are alcohol abuse 18.0% and neurotic disorders 13.5%. The prevalence of PTSD symptoms remains low at 4.8%,

compared with the weighted prevalence of common mental disorders 27.2%, but rates of depression, PTSD symptoms and subjective poor health were similar between regular US and UK Iraq combatants (Iversen, van Staden et al. 2009). Fear et al (2010) reported comparatively lower UK PTSD rates – 4% compared with 20% in the US (Hoge, Castro et al. 2004) – but more common mental disorders 19.7% and alcohol misuse 13%. They emphasised the need to remove the focus from PTSD and consider the wider mental health picture (Fear, Jones et al. 2010).

Thomas et al (2010) did just that stating that previous studies had not assessed functional impairment, alcohol abuse or aggressive behaviour as co-morbid factors occurring with PTSD and depression. They found that the prevalence rates of PTSD and depression after returning from combat ranged from 9% to 31% depending on the level of functional impairment reported and these rates persisted or increased at 12 months post-deployment. Alcohol misuse or aggressive behaviour co-morbidity was present in approximately half of the cases (Thomas, Wilk et al. 2010) and figures for US Army showed that alcohol abuse has increased substantially from 17% in 1998 to 25% in 2005 (Bray, Hourani et al. 2006) with around 12% experiencing serious consequences from their alcohol use in 2008 (Bray, Pemberton et al. 2009).

Historically, alcohol has been used in the military to reward hard work, ease tension and promote camaraderie (Holmes 2003; Gibbs, Rae Olmsted et al. 2011). Generally, the UK Armed Forces have a high prevalence of hazardous drinking (Fear, Iverson et al. 2007; Iversen, Waterdrinker et al. 2007) and there is a well established link between alcohol and violence (Graham and Livingston 2011) often compounded by symptoms of PTSD (Savarese, Suvak et al. 2001; Steindl, Young et al. 2003; Taft, Kaloupek et al. 2007; Capone, McGrath et al. 2013).

The social stereotype of the aggressive, PTSD-afflicted serviceman or veteran, is reinforced through high profile cases in the media (Brooke 2012; Malvern 2012), and certainly the associations between violent offending in this group and combat exposure, substance misuse and poor mental health are well established (Black, Carney et al. 2005; Taft, Vogt et al. 2007; Killgore, Cotting et al. 2008; Elbogen, Wagner et al. 2010; Elbogen, Johnson et al. 2012; MacManus, Dean et al. 2012). Recent research found that 11% of male UK military personnel have a criminal record for violent offending compared with 8.7% of the general male population (MacManus, Dean et al. 2013). A 2009 briefing by NAPO, (the Trade Union and Professional Association for Family Court and Probations Staff) reported that an estimated 20,000 veterans were in the UK criminal justice system making up almost 10% of the prison population and more than double the total British deployment in Afghanistan. They are most likely to have been convicted of a violent offence, particularly domestic violence with the majority having chronic alcohol or drug problems and nearly half suffering from PTSD or depression with very few having received psychological support for this (NAPO 2009). The Howard League for Penal Reform suggest the figure is lower at 3.5% of the prison population but that this remains a

"significant subsection of the prison population." (HLPR 2011 p.13).They caution that the media link between combat, PTSD and offending should not over-shadow other socio-economic and health factors that are common to both veterans and the general population.

The media often reports that more Armed Forces personnel have lost their lives through suicide than combat, particularly veterans (M.O.S. 2009; Cockroft 2010; James 2013) and in the US this has been described as an epidemic (DART 2013). US Army suicide rates are higher than in the civilian population at 22 per 100,000 in 2009 and increasing (Black, Gallaway et al. 2011; Sher and Yehuda 2011; Bryan, Jennings et al. 2012; Hoge and Castro 2012; Hyman, Ireland et al. 2012). In the UK, 438 regular Armed Forces personnel took their own lives between 1993 and 2012 (DASA 2013) and the risk of suicide in young men who have left the Armed Forces is approximately two to three times higher than the risk for the same age groups in the general and serving populations (Kapur, While et al. 2009).

The interpersonal-psychological theory of suicide proposes factors driving suicidal behaviour: feelings that one does not belong with other people, that one is a burden on others or society, and an acquired capability to overcome the fear and pain associated with suicide (Joiner 2005; Joiner, Van Orden et al. 2009). It has been suggested that combat exposure can influence this latter capability through desensitising individuals to the fear of painful experiences such as suicide (Bryan, Cukrowicz et al. 2010; Selby, Anestis et al. 2010).

1.3.2. Police mental health

Police officers, facing an increasingly violent society, encounter traumatic events on a regular basis (Backteman-Erlanson, Jacobsson et al. 2011) although there is comparatively little research on their mental health in what is a relatively new field (Duckworth 1991; McFarlane and Bryant 2007). Some authors argue that it is not the nature of police work that is stressful, rather it is the organisational culture and style of leadership support (Alexander and Wells 1991; Brough 2004; McCaslin, Inslicht et al. 2008; Muller, Maclean et al. 2009; Brough and Biggs 2010; Tehrani and Piper 2011) and van der Velden et al (2010) suggest both critical incident exposure and organisational stressors are targets for intervention.

Whatever the cause, compared with the general population, studies have claimed police officers have higher rates of depression (Lawson, Rodwell et al. 2012), suicide (Miller 2005; Chopko, Palmieri et al. 2013) and post traumatic reactions (Austin-Ketch, Violanti et al. 2012) with some estimating PTSD prevalence as between 3 and 6 times higher than the general population (Carlier, Lamberts et al. 1997; Green 2004; Davidson and Moss 2008). Police officers are at heightened risk of suicide (Violanti, Gu et al. 2011; Violanti, Mnatsakanova et al. 2012) and in the US, the police service suicide rate is comparable to the military. In 2008 rates were estimated at 141 for a police population of 861,000, compared with US Army suicides of 128 out of 675,000 (O'Hara and Violanti 2009). Even here, the authors admit the figures are under-

represented as approx 17% of deaths are misclassified as accidents or undetermined (Violanti 2007; Violanti 2010).

Ballenger et al (2011) found that, in a large sample of urban US police officers, 18.1% of males reported experiencing negative consequences from alcohol use with 7.8% of the sample meeting the criteria for alcohol dependence. Alcohol abuse is linked with PTSD and critical incidents in police officers (Menard and Arter 2013) with subjective post-traumatic distress and the use of avoidance strategies being particularly predictive of alcohol abuse (Swatt, Gibson et al. 2007; Chopko, Palmieri et al. 2013).

However, the bulk of the research comes from Australia and the US and there may be cultural variations as well as differences in the role (e.g. armed or not, level of disaster / rescue work) that play a part in mental health problems. It has proved difficult to get accurate figures in the UK as different forces vary in their recording processes (Hayday, Broughton et al. 2007).

This research aims to look at what I believe is a unique population – the ex-serviceman who becomes a police officer. For many veterans, the police service seems a logical route following their military service, although the UK Home Office does not collect statistics on numbers (Home Office 2010). For many there are expectations that it will be a similar cultural experience "*replicating the policing and restraining functions that warriors filled in traditional societies*" (Tick, 2005 p.261).

Following research into the needs of US veterans either recruited into, or returning to, the police service following a period of deployment, the International Association of Chiefs of Police (IACP) recommended the formation of peer support groups for their law enforcement officers with a military background (Daxe, Robinson et al. 2009). The IACP found that veterans have a unique set of skills that make them ideal for the police service. These include having

- More discipline, higher ethical standards and integrity
- A better ability to make decisions and assess situations
- More life experience and maturity
- Better leadership skills
- Superior tactical and firearms skills
- A greater willingness to involve themselves in dangerous situations and an enhanced ability to remain calm and focused in threatening situations
- Higher physical fitness

The IACP also identified potential critical challenges such as screening for and treating combat related psychological injuries and managing the transition between the two services.

1.3.3 Accessing mental health services

It is clear that our uniformed services are not immune to their exposure to traumatic events and appropriate mental health services are crucial. Clinically effective treatments are available such as trauma-focused Cognitive Behaviour Therapy (Hassija and Gray 2007; Mulick and Naugle 2010; Pietrzak, Harpaz-Rotem et al. 2011; Karlin, Brown et al. 2012) and Eye Movement Desensitisation and Reprocessing (Carlson, Chemtob et al. 1998; Devilley, Spence et al. 1998; Shapiro 2001; Wesson and Gould 2009) but there is a marked lack of take-up of services. General population studies show that less than half of people with symptoms of mental health problems seek treatment (Kessler, Berglund et al. 2001; Alonso, Codony et al. 2007) and this is mirrored in the military. Kulka et al (1990) indicated that only 30% of male veterans with mental health problems ever use mental health services. Rosenheck and DiLella (1998) found that 38% of veterans who are chronically disabled with PTSD from all conflicts do not receive mental health care within the Veterans Health Administration (VA) care system. Hoge et al (2004) found that only 38 – 45% of US troops symptomatic for mental distress (including major depression, generalised anxiety and PTSD) indicated an interest in receiving help. Of these, only 23 – 40% actually sought mental health support (Hoge, Castro et al. 2004). Another study claimed that 54.4% of US Army Special Forces exposed to combat would not seek treatment while serving in the army even if they were suffering from PTSD (Espinoza 2009). According to Combat Stress, the veterans' mental health charity, the average veteran takes 13 years from service discharge to making first contact with them although this is reducing in those who have served in the more recent wars in Iraq and Afghanistan (CombatStress 2012).

This begs the question – what stops this group from accessing much-needed support?

Research has consistently showed that those who are more functionally impaired are less likely to be receiving mental health services (Schwarz and Kowalski 1992; Amaya-Jackson, Davidson et al. 1999) and that stigma, shame and attitudes about treatment are some of the main factors in this (Cooper, Corrigan et al. 2003). In the military, some believe that the stigma is magnified due to the expectation for personnel to be consistently ready to function at a high level and that, while the safety of the unit depends on this readiness, seeking treatment implies a state of reduced functioning (Greene-Shortridge, Britt et al. 2007). Troops who scored positively for a mental health problem were twice as likely as other troops to report fear of stigmatisation and concern about barriers to care (Hoge, Castro et al. 2004). Hoge et al reported that historically only 20% of male Vietnam combat veterans with PTSD ever used VA mental health services and that these rates are comparable with veterans of Operation Enduring Freedom and Operation Iraqi Freedom. Many other studies build on this research paper, conducting studies with related populations such as spouses of serving military (Eaton, Hoge et al. 2008) and peacekeeping forces (Maguen and Litz 2006). Part 2 of this thesis considers the literature relating to the stigma of mental illness and help-seeking and the interventions designed to address this.

1.4 The research aim, question and rationale

This research aimed to explore the reasons behind the decision to seek help, or otherwise, for mental health problems. Several studies have considered the barriers to care but most have relied on questionnaires (Hoge, Castro et al. 2004; Maguen and Litz 2006; Eaton, Hoge et al. 2008). Such questionnaires were based on an original developed without any known psychometric properties regarding relationship to actual behaviours (Britt 2000). For this study, a phenomenological approach was used with semi-structured interviews conducted with 11 male ex-Armed Forces police officers. I believed that, by using a qualitative approach rather than a quantitative one, a depth to the data would be obtained that may be revealing. A social constructivist Grounded Theory approach was used to analyse the data. Part 3 of this thesis describes how my choice of methodology, and methods of data collection and analysis, aimed to maximise the richness of the study.

The main research question asked

How do the attitudes of police officers with a military background affect the help-seeking process for mental health problems?

In order to properly answer this, the following issues needed to be explored:

- Do police officers with a military background see themselves as a specific population?
- If so, are the characteristics through which they self-define a factor in help-seeking behaviour?
- What are their attitudes to mental health issues?
- What are their perceptions of mental health services?
- What are the barriers and facilitating factors in the help-seeking process?

I hoped that this study would inform practice in creating more accessible mental health services for this population. I am not aware of any other studies that focus on the police officer with a military background. Lessons may be learnt that can be transferred to both police and military settings. I believe the research could be of interest to mental health professionals working within the uniformed services whether in proactive educational programmes or reactive crisis intervention services.

Part 1 has covered the key concepts and background to the research, set out the rationale for, and aims of, the study as well as clarifying my stance. Part 2 now goes on to explore the relevant literature around the subject.

Part 2: Literature review

Introduction

For this literature review, the electronic databases of PsycINFO, PubMed and PILOTS were searched for peer-reviewed journal articles published in the English language using the terms "stigma," "barriers to care," "help-seeking," "mental health" and "mental illness." This revealed a vast potential area of literature including models of help-seeking, personal identity issues in stigmatised groups and barriers to care. An editorial decision had to be made in order to contain the literature review within the scope of this thesis. In accordance with the methodological approach (set out in Part 3), I had only conducted a preliminary review of the literature prior to gathering and analyzing my data so for the full review I could focus on the areas of relevance to my results. The decision was to focus on the stigma of mental illness and help-seeking. Articles were selected that contained "stigma" and "mental health," "mental illness," "help-seeking" or "treatment initiation" in the title or abstract and that were published from January 2000 to December 2013.

In addition to the electronic databases, the University of Manchester's library catalogue was also searched using "stigma" and "mental health" or "mental illness" and Google Scholar was searched for citations of articles that I had identified as key to mental health stigma in the uniformed services. Lists of references from selected articles were perused for other sources that may be of interest. I also used my professional knowledge to identify books and articles with some relevance to the topic.

Much of the research literature is based on US military samples and indeed the literature review has a heavier focus on military stigma as this became more relevant following data analysis. It could be argued that this literature review should dedicate a section to organisational culture especially those of the military and police services. Instead I made the editorial decision to weave the relevant cultural literature throughout this part as I wanted to set it within the context of the stigma literature.

Combat related psychological injury is not a modern phenomenon. Accounts of traumatic stress and its associated stigma can be found throughout recorded history. World War One (WWI) (1914 – 1918) in particular brought British attitudes towards military psychiatric casualties into sharp focus and Appendix 2 provides an overview of how soldiers suffering with combat-related mental health problems have been treated over the ages up to the end of WWI.

This section of the thesis is now split into 3 sections: 1) the stigma of mental illness (including public attitudes and how the individual perceives mental illness) 2) the stigma of help-seeking and 3) interventions to address stigmatizing attitudes and facilitate help-seeking. A summary of

the key concepts from the literature is provided at the end of part 2 with figures 2.2 and 2.3 offering separate overviews of the stigma associated with mental illness and help-seeking.

2.1. The stigma of mental illness

2.1.1 The three interacting elements of stigma

There remains a huge stigma to mental illness in our society (Corrigan and Penn 1999; Corrigan, Markowitz et al. 2004; Pescosolido 2013) and we are becoming increasingly aware of how people suffering from a mental illness, can be stigmatised and excluded by members of the public (Hayward and Bright 1997; Byrne 2000; Mehta and Thornicroft 2010).

Corrigan (2004) proposed three interacting factors that contribute towards levels of stigma. Firstly, public or societal stigma comprises society's negative attitudes and beliefs about the attributes of those with mental illness leading to discrimination and prejudice. Secondly, self-stigma is the internalisation of these beliefs resulting in the person believing he is socially unacceptable and thereby leading to reduced self esteem and shame (Corrigan, Larson et al. 2009). Thirdly, structural, or institutional, discrimination relates to the policies of private and governmental institutions that intentionally restrict the opportunities of people with mental illness. It also includes major institutions' policies that are not intended to discriminate but whose consequences nevertheless hinder the options of people with mental illness (Corrigan 2004; Thornicroft 2006).

Crocker and Quinn (2000) suggest that the wide knowledge of collective representations of stigmatised conditions means that the individual does not have to encounter direct discrimination in order for that prejudice to be felt. Thornicroft (2006) describes the difference between actual events of discrimination (enacted stigma) versus the shame of having a mental illness and the fear of encountering actual discrimination (felt stigma). In their international cross-sectional survey, Lasalvia et al (2012) found that felt stigma was not necessarily associated with enacted stigma as 47% and 45% of participants who anticipated discrimination in employment or in intimate relationships respectively had not experienced discrimination. However, anticipated public stigma has been found to negatively influence help-seeking from both formal and informal support networks (Pattyn, Verhaeghe et al. 2013). Iversen et al (2011) found that anticipated public stigma was the most common barrier to treatment-seeking in a large UK military sample. Similarly, Mittal et al (2013) found that US veterans of campaigns in Iraq and Afghanistan believed that they would be stigmatised for their PTSD by the public. Their mental illness would be viewed as self-inflicted and they would be blamed for their situation. The authors suggest that perceptions of public stigma may be more important to veterans as they re-integrate with the community.

Although much of the research about stigma in the military has been carried out with US troops, the patterns of reported stigma and barriers to care are similar in the UK (Gould, Adler et al. 2010). Greene-Shortridge et al (2007) used the concept of societal and self-stigma to illustrate

their model of how the stigma associated with psychological problems can prevent soldiers getting the help they needed. They suggest that exposure to traumatic events leads to development of mental health symptoms. Such soldiers may then encounter a societal stigma within the military culture itself as *"military personnel may begin socially distancing themselves from soldiers they perceive as having mental health problems. These individuals may be uncomfortable around soldiers with PTSD and perhaps even blame them for the development of the problem."* (Greene-Shortridge, Britt et al. 2007 p.159). The internalisation of this societal stigma then results in self-stigma.

2.1.2 Mental illness stereotypes

As stated earlier, public stigma comprises society's negative attitudes and beliefs about the attributes of those with mental illness. Ignorance and negative stereotypical attitudes towards mental illness are key to this (Thornicroft 2006). A stereotype is an *"efficient means of categorizing information about social groups (and) represent collectively agreed on notions of groups of persons"* (Corrigan and Penn 1999 p.766). Stereotyping can be an important factor in the *"development, justification, maintenance, and perpetuation of stigmatization."* (Biernat and Dovidio 2000 p.107). Corrigan & Penn (1999) go on to describe the negative stereotyping arising from ignorance and negative, invalidating beliefs leading ultimately to stigma and discrimination. Underlying beliefs have been identified in attitudes towards those with a mental health problem: (a) Fear and exclusion (a belief that people with severe mental illness should be kept out of the community), (b) Benevolence (they are child-like and should be looked after) and (c) Authoritarianism (they are unable to take responsible for selves) (Taylor and Dear 1981; Brockington, Hall et al. 1993).

When the veteran leaves the armed forces and joins the police service, their new role's interface with mental illness may exacerbate these beliefs and stereotypes. The police are often the first responders in a mental health emergency. People in crisis may be at risk of harm to themselves or others and the police role is to protect those involved and contain that risk. The mentally ill person may be socially disruptive, problematic and aggravating to the officer dealing with them – liaising with mental health services, waiting for response from psychiatric emergency services and the resultant inability to attend to other duties can be challenging for the officer (Lamb, Weinberger et al. 2002). All these factors can affect police officers' attitudes to mental health and reinforce negative stereotypes. In a study of police officers' attitudes towards mental illness, results suggested that where a mental health label (schizophrenia) was provided, police officers had an exaggerated perception of dangerousness and a reduced sense of the individual being a credible and trustworthy victim although the authors agree that this may not generalise to other diagnoses such as PTSD or depression (Watson, Corrigan et al. 2004).

2.1.3 Attributing responsibility for mental health problems

Weiner et al (1988) introduced the notion of on-set and off-set responsibility as factors in determining stigma. On-set responsibility relates to the attribution of the cause and controllability of the mental health problem. Off-set responsibility relates to how successful we

are at dealing with problems when they have arisen as in the oft-repeated quote by Reverend Jessie Jackson *"You may not be responsible for being down but you are certainly responsible for getting back up again."* Interestingly I have seen this quote used in training presentations for Trauma Risk Incident Management (TRiM), a peer support post-incident intervention developed by the Royal Marines (Greenberg, Langston et al. 2008).

If the condition is deemed controllable then the individual will be judged as responsible for its onset and anger and punishment will be directed towards them. If it is not controllable, i.e. it is not their fault, then pity and assistance will be offered (Weiner, Perry et al. 1988; Corrigan 2000; Cooper, Corrigan et al. 2003). Mental health problems relating to events will attract stigma to varying degrees depending on whether they are deemed "earned" or not and malingering will attract high stigma as a character weakness. So there is greater stigma if problems are attributed as self-inflicted (personal or characterological weakness that one should be able to control) rather than predominantly, biological, e.g. medical, physical injury or heredity defect (Stewart, Keel et al. 2006; Boysen and Vogel 2008). Even volunteering for military duties could mean that resulting psychological injuries are viewed as "self-inflicted" by the public (Mittal, Drummond et al. 2013).

Within the military, Gibbs et al (2011) found that deployment related mental illness was viewed as low control but there were high concerns about the risk posed by affected people due to reliability and events had to be "significant". Those affected also had to return quickly to full effectiveness. This study used 48 focus group interviews with US soldiers and revealed wide reporting of malingering and claims that mental illness were being used to avoid duties, excuse behaviour, seek early discharge or, in the case of PTSD, even to attract women! Unsurprisingly, those who reported these perceptions of others feared they would be judged similarly if they sought treatment.

Servicemen who experience stress are viewed as "weak" by many (Greenberg, Henderson et al. 2007) and 40% of US service personnel would not trust a returning stress casualty to be an effective soldier with "shoot him" being expressed as a treatment by a small number. Medics and officers only performed slightly better on knowledge of presentations and treatments (Schneider and Luscomb 1984).

2.1.4 The historical attribution of combat trauma

It seems we haven't completely moved on from the punitive attitudes of the First World War where the established school of thought was that the best cure for combat trauma was *"a little plain speaking accompanied by a strong faradic current."* (Adrian and Yealland 1917 p869). Isolation, deprivation and "hardening" through discipline and supervision were favoured and it was advised that the doctor increased the pain until he got the desired effects and allowed the patient no control or say in the matter (Adrian and Yealland 1917; Mott 1919; Jones, Fear et al. 2007).

Social research should take account of the connections between the social, cultural and historical aspects of peoples' lives and see the context in which particular actions take place (Snape and Spencer 2003). We can learn a lot about current attitudes by looking to the past and the attributions of mental illness in the military can be traced throughout history. The Ancient Greeks believed that there was a link between moral strength and heroism leading to a simple distinction between heroes and cowards. Archaic warriors were permitted to grieve openly amongst their peers but not publicly as this was a violation of *"male ideals of dignity, gravity and authority."* (Sherman 2005 p.136) However, from the Ancient Greeks and Romans to modern day troops, soldiers have become so overwhelmed by fear that they committed suicide, deserted or inflicted wounds on themselves so as to be invalided away from the front (Gabriel 1987; French 2003; Jones and Wessely 2005).

In later years, with the rising profile of military medicine, came an alternative explanation – that combat trauma was caused by some medical condition. Psychological symptoms were often conveyed psycho-somatically and initially explained as a physical complaint, e.g. soldier's heart, exhaustion, concussion or neurological damage (Shephard 2000; Kennedy and McNeil 2006; Moore and Reger 2007). From the 1800's onwards, Traumatic Neurasthenia, a disease *"characterised by enfeeblement of the nervous force"* (Jones and Wessely 2005 p.15) was thought to be caused by blood flow problems, abuse of alcohol, unhygienic environment and infections. During the Boer War (1912-1913), despite no real supporting medical evidence, Disordered Action of the Heart was ascribed to violent, manual labour and poorly designed equipment causing chest injuries. During WWI, the term "shell shock" was initially developed to explain combat symptoms (such as amnesia, strange paralysis, mutism and deafness) organically as the *"state of chronic concussion resulting from continuous artillery bombardment"* (Watson 1980 p.169) with many doctors subscribing to the view that head injury or toxic exposure was behind the condition. Such physical attributions carried less stigma but lead to increased casualty rates and a manpower crisis (Howorth 2000; Shephard 2000; Kennedy and McNeil 2006).

Another way of attributing responsibility has been to look for some fundamental weakness that pre-disposed soldiers to mental breakdown demonstrating that *"In the majority of cases of psychosis the war has only revealed, excited, or accelerated, and not caused the disease."* (Mott 1919 p.200). However, "evidence" of constitutional weakness could be drawn from any careful enquiry and would include any family history of mental breakdown, petty delinquencies, a low wage earning capacity, very low standard of education, being late for parade and even having a dirty gun (Mott 1919). There was a fixed belief that war, in itself could not be the cause, it was the individual's weakness (Howorth 2000).

In 1917 military authorities suggested an association between shell shock and malingering leading to further stigma although not all accepted this link (Myers 1916b; Jones, Fear et al.

2007). Neurologist Frederick Mott offered advice on judging whether a patient fell into this category. *"It is in and around the eyes that we may discern most clearly deceit and cunning. The glance is furtive and the malingerer betrays uneasiness and suspicion when closely watched."* (Mott 1919 p.262)

This negative labelling of those affected as *"socially and emotionally immature"* (Wagner 1946 p.356) and having a "Lack of Moral Fibre" (Terraine 1997) continued into World War Two (WWII) (1939 – 1945). Lack of Moral Fibre was used by the RAF as the *"ultimate sanction, a moral weapon … a diagnostic label as a weapon of deterrence"* (Shephard 2000 p.286-290) to deal with airmen who had reached their psychological limits when flying multiple high risk bombing operations. WWII also saw an increased emphasis on screening out to reduce those deemed vulnerable. The military had so much confidence in this proactive method of screening that they did very little reactive mental health support. The implicit belief was that only those who were fit for purpose should be enlisted and they would require little support (Jones and Wessely 2005). However, the lack of success of this approach with around 40% of early discharges being attributed to battle fatigue and exhaustion (Neill 1993; Jones and Ironside 2010) forced the realisation that there was no simple *"split between the healthily normal and the diseased portions of humanity."* (Howorth 2000 p.225) and that *"Given enough time in combat, every soldier will eventually suffer a mental collapse."* (Gabriel 1987 p.4)

More enlightened military commanders have always recognised that *"there are objective limits to human endurance that cannot be exceeded."* (Gabriel 1987 p.52). This wearing down, also referred to through history as "nostalgia or homesickness," was generally viewed sympathetically by commanders and peers as temporary and "earned" and treated by removal from the front line, food, fluids and rest (Moore and Reger 2007).

Figure 2.1 below offers a quick reference guide to causal attribution and associated level of stigma.

Attribution	Level of stigma
Physical / medical	Reduced
Heredity defect	Reduced
Personality / character weakness	High
Malingering	High
Events based	Variable
Exhaustion	Reduced

Figure 2.1: Attribution and stigma

2.1.5 Cognitive separation

The social-cognitive model of self-stigma is associated with perception of group identity and stereotype legitimacy (Corrigan and Watson 2002; Watson and River 2005; Watson, Corrigan et al. 2007). Labeling and stereotyping of a group cognitively separates group members as being "different to us" and can result in discrimination and reduced status (Link and Phelan 2001).

The psycho-social context of stigma is important to consider, particularly for a strong social group identity such as is found in the uniformed services. However, the field of identity studies is complex and contains diverse theoretical and methodological arguments (Wetherell and Mohanty 2010). Social Identity Theory (Turner and Brown 1978; Tajfel and Turner 1979; Tajfel and Turner 1986; Haslam 2004; Postmes and Branscombe 2010) attempts to explain how the group identity can influence behaviour. In this instance, Tajfel's definition of social identity as it relates to social categorisation is used, i.e. *"that* part *of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership."* (Tajfel 1978 p.63).

Self-categorisation theory (Turner 1985; Turner, Hogg et al. 1987) proposes an Intermediate level of self-categorisation where we self-define and act as members of a specific group. Individuals can define themselves as "us" and "we" rather than "me" and "I." Kroger believed that identity represents the balance between "self" and "other" (Kroger 1989), Knowing who we are requires that we know who we are not. A group can only be a group when it is compared against others, described in Social Identity Theory via the concept of the in-group and out-group (Tajfel 1978). Tajfel further suggested that we over-generalise, or stereotype, a person or group perceiving them to be more like a typical category member than they really are.

Perceptions of "collective continuity" increase the strength of group identification and are built through (a) cultural continuity (the transmission of group values, beliefs and attitudes across generations) and (b) historical continuity (the sense that different phases and events marking the group's history are inextricably interconnected) (Sani 2012). In the military, there is rich tradition with regimental identity being passed through the decades via ritual, uniform, insignia and history of predecessors. From basic training onwards, recruits are conditioned to be the best, the strongest, the toughest mentally and physically. Military mottoes promise membership of an elite group – Be the Best, Rise Above the Rest, In Omnibus Princeps (first in all things), Nulli Secondi (second to none) – and promote team work and courage – The Team Works, Faithful, Sans Peur (without fear), Difficulties be Damned, Death or Glory, Fear Naught (MilitaryQuotes.com 2013). The stronger the group identity, the more likely they are to work towards group goals, needs and standards. Stigmatisation can be a response to those who don't adhere to, and therefore may threaten, that group's values and socialisation messages (Neuberg, Smith et al. 2000).

Where individuals see themselves as members of the same social category, e.g. police officer, soldier, this act of self-categorisation provides them not only with the label but also with the attitudes and behaviours that are appropriate to that group. Solidarity with the group's ideals is important in the development of identity and those we consider very different to us can threaten our own sense of identity (Erikson 1968). Yang et al (2007) hypothesize that stigma exerts its core effects by threatening the loss or diminution of what is most at stake, or by actually diminishing or destroying that lived value.

Social identity salience (Oakes, Haslam et al. 1994) posits that we come to define ourselves in terms of a given social identity (e.g. we ex-services personnel) particularly where we have been "this" for a long time, where it's an appropriate way of understanding ourselves in the current context and where there are striking differences between the in and out-groups. The sense of shared social identity leads to a common interpretative framework that facilitates communication, empathy and group coordination and also provides a foundation for shared expectations as to what is reasonable and appropriate support (Postmes 2003; Haslam 2004). Under these circumstances, group members will be motivated towards enhancing the overall well-being and strength of that group leading to both a high level of support and an optimal interpretation of support available (Haslam, Reicher et al. 2012).

The stereotypical group member, whether ex-services police officer or person with mental health problems may therefore be perceived as "self" or "other" depending on how closely their attributes fit with the individual's social group identity. Members of the uniformed services, be it military or police, are usually perceived as different to the general population both by themselves and those outside that group. Beginning with the *"uniformity of appearance which submerges the recruit's individual identity"* (Holmes 2003 p.34) and denotes difference from civilians and similarity to peers, conforming to the group identity is important. Norms for strength and resilience abound in the uniformed services.
"Attitudes such as toughness, mission focus, and self- and group-based sufficiency are instilled in service members to ensure combat readiness. This belief system contributes to the notion that help-seeking is a sign of weakness and that strong, self-reliant individuals can "tough out" any problem or injury" (Dickstein, Vogt et al. 2010 p.227). In a study of veterans from Iraq and Afghanistan, Jakupcak et al (2013) found an association between extreme self-reliance and the tendency to suppress emotional distress with the likelihood of screening positive for PTSD and depression.

In the police service studies have shown that officers have difficulties in accepting and tolerating negative emotions (Berking, Meier et al. 2010) and are more likely to use denial, suppression and avoidance as ways of coping with these (Pogrebin and Poole 1991; Amaranto, Steinberg et al. 2003; Pasillas, Follette et al. 2006). In a qualitative study, Backteman-Erlanson et al (2011) found officers in Sweden used emotional distancing and compartmentalizing to deal with distressing incidents. The warrior archetype (Jung 1981) is probably closest to this group

identity. These warrior qualities of strength and resilience are far removed from the stereotypical person with mental illness.

2.1.6 Fear and exclusion

Goffman described stigma as a blemish of individual character that designated the bearer as "spoiled" and devalued compared to "normal" people (Goffman 1963). As well as having reduced status, they are generally perceived as dangerous and violent, incompetent and unaccountable (Link, Phelan et al. 1999; Corrigan 2000; Angermayer and Dietrich 2006).

The distancing can be considered in terms of "flight" from the threat of the stigmatised group / individual (Blascovich, Mendes et al. 2000). Media portrayal has certainly had an influence on the public perception of "dangerousness" associated with mental illness stereotypes (Corrigan, Watson et al. 2005; Thornicroft 2006; Corrigan, Powell et al. 2013) although there are signs this is changing (Murphy, Fatoye et al. 2013; Thornicroft, Goulden et al. 2013). Given this stereotype, the response has usually been of fear and a desire to exclude from our communities. These negative opinions contribute towards social isolation increasing distress and employment difficulties faced by those with mental health problems (Crisp, Gelder et al. 2000).

The military has historically reflected this loss of status with expulsion. In the early years of the American Civil War (1861-1865), traumatised soldiers were expelled from the safety of their bases, often *"left to wander … until they died from exposure or starvation."* (Gabriel 1987 p.108). Later they were housed with criminals in the local jails for their own, and others', "safety" (Kennedy and McNeil 2006). In WWI, an unknown number of soldiers were shot by their own officers for displaying fear in order to prevent contagion or contamination of others (Holmes 2003). By 1916, around 3000 soldiers had been discharged to the asylums as lunatics. The uneducated "thick" soldier was seen as worthless and stripped of their uniform on arrival with *"the trappings of his military persona handed over to the escort for return to his unit"* (Barham 2004 p.21). In stark contrast to the treatment of officers who usually carried a less stigmatising diagnosis and more nurturing treatment (Myers 1916a; Gabriel 1987), everything was geared to putting them in their place and reminding of their shame and disgrace to service.
 "There is rarely any expression of compassion, no effort to explore or comprehend … the hardships he had suffered or the fortitude he had shown … his admission to the psychiatric facility was by definition sufficient testimony of how lamentably he had failed as a soldier" (Barham 2004 p.50).

These negative attitudes towards those with mental health problems are reflected in the modern military. Gibbs et al (2011 p.46) used focus groups to investigate attitudes towards mental health and found reports of concern regarding affected soldiers being "fit for the fight" and the active use of distancing from them so as to *"maintain their own reputations for strong performance."*

Crandall (2000 p.126) describes how we use "Justification ideologies" to ease our consciences and allow us to practice this exclusion. As well as making a person responsible for their stigma (attribution), we accept an endorsement of a hierarchical judgment of out-groups whereby the *"elite deserve special privileges and very little social control, while the bas monde receive little in the way of privilege or opportunity, and are subject to significant social control."* Stigma can be seen as attempts to reinforce the social order (Ilic, Reinecke et al. 2013). Hierarchies are present throughout society, e.g. the class system and both the police and military are examples of inherently hierarchical cultures.

However, it's not only stigmatizing to have the mental health problem but also to seek help for it and researchers argue that these are theoretically and distinct constructs (Tucker, Hammer et al. 2013). The next section looks at the stigma of help-seeking and factors that influence the levels of this.

2.2 The stigma of help-seeking

2.2.1 How stigma impacts on help-seeking behaviour

Vogel et al (2006) describe self-stigma as arising from the view that a treatment-seeking person is socially unacceptable and this can include the perception that asking for help is a weakness or an admission of failure (Vogel, Wade et al. 2006; Pietrzak, Johnson et al. 2009). It has certainly been shown that people view those seeking help more negatively (Parish and Kappes 1979). Vogel at al (2007 p.46) differentiate between self-stigma as *"the internalized negative perceptions of oneself if one were to seek help, whereas attitudes toward seeking counseling are the positive or negative perceptions of counseling in general."*

Modified Labelling Theory has been used to explain the relationship between public and self-stigma and how it relates to help-seeking. It asserts that individuals have already internalised cultural stereotypes about mental illness before they themselves have been labelled thus (Link, Cullen et al. 1989). Modified Labelling Theory states that public stigma and discrimination leads to self-stigma and reduced self-esteem for the individual who is labelled (by themselves or others) as mentally ill (Link and Phelan 2010). Vogel et al (2013) conducted a longitudinal survey to address the criticism that the evidence for a link between public and self-stigma came mainly from cross-sectional designs. They found support for Modified Labelling Theory's theoretical assertions. However, other longitudinal surveys have found no significant association between help-seeking and perceived stigma from others (Golberstein, Eisenberg et al. 2009; Schomerus, Matschinger et al. 2009) whereas self-stigma is an important barrier (Schomerus, Auer et al. 2012; Blais and Renshaw 2013). Self-stigma and public stigma augment each other in their effects (Held and Owens 2013) and it is reasonable to expect that perception of public stigma contributes to the experience of self-stigma and the willingness to seek and adhere to treatment. Wright et al (2009 p.109) certainly found that, for soldiers, treatment seeking is avoided as it provokes feelings of *"shame, inadequacy and inferiority."*

Furthermore, if the person directly affected views themselves as being responsible for their condition then they are less likely to seek help as they believe they don't deserve it (Cooper, Corrigan et al. 2003). Even when treatment is accessed, self-stigma may remain high. According to Ehrlich-Ben Or et al (2013), there is a negative correlation between high self-stigma and meaning of life and this can lead to a "why try" approach to treatment. A comparison of perceived stigma amongst soldiers found that those actually receiving treatment for mental health problems reported significantly higher mental health treatment stigma than those receiving substance abuse treatment or no treatment (Rae Olmsted, Brown et al. 2011). This can lead to treatment drop-out or failure (Sirey, Bruce et al. 2001; Interian, Martinez et al. 2007; Royle, Keenan et al. 2009; Fung, Tsang et al. 2010) and challenges the notion that the hardest thing is getting people to engage with services. Ehrlich-Ben et al's (2013) suggestion that anti-stigma interventions should encourage the process of regaining a sense of meaning in life (as a way to support the recovery process) appears relevant here.

Research has consistently showed that, in both military and civilian populations, those most vulnerable, e.g. with the highest levels of mental health symptoms have the greatest concerns around stigma (Kessler, Berglund et al. 2001; Hoge, Castro et al. 2004; Langston, Greenberg et al. 2010; Livingston and Boyd 2010; Kim, Britt et al. 2011). Authors argue that this is because those experiencing problems are more likely to *"consider the potential stigmatising consequences … because of the immediate relevance of the decision"* (Greene-Shortridge, Britt et al. 2007 p.159) and that the timing of offers of support should be considered, particularly where troops are deployed and in a more threatening environment (Osorio, Jones et al. 2012). This is supported by a later survey by Osorio et al (2013a) who found that stigma rates were higher during deployment in UK Armed Forces personnel deployed to Afghanistan and Iraq between 2008 and 2011.

Ouimette et al (2011) examined institutional and stigma-related barriers to care among a large diverse group of Vietnam and Iraq/Afghanistan veterans diagnosed by a VA provider with PTSD and found stigma to be the most salient factor. Their results also supported the notion that PTSD itself is associated with perception of barriers to care. One of the symptoms of PTSD is avoidance and greater severity of PTSD avoidance symptoms was associated with greater perceptions of institutional and stigma-related barriers to care. Avoidance leads to withdrawal from personal relationships that may otherwise support and reassure the individual as to their esteem and worth.

Control is important when help-seeking and Corrigan et al (2011) view loss of self-esteem and self-efficacy as being on a continuum with personal empowerment at the opposite end. Where people feel they will have control over their treatment and the impact of help-seeking on their lives, they will be less likely to suffer from self-stigma. Rosen et al (2011) tested attitudes behind treatment-initiation in US veterans with diagnoses of PTSD and found need factors (greater impairment and / or desire for help) to be associated with help-seeking and contrary to their

expectations, stigma concerns did not prevent help-seeking. As nearly all participants wanted help for their mental health issues, perhaps this indicates an over-riding need to deal with a major problem whatever the associated stigma. These findings also supported earlier ones by Sayer et al (2009)

2.2.2 Structural discrimination

In the general population, situational barriers to care are a factor when making the decision to access treatment for PTSD e.g. uncertainty about where to go, inability to get an appointment, financial constraints or accessibility of services (Kessler, Berglund et al. 2001). Along with fears of stigmatisation, Maguen and Litz (2006) found that lack of confidence in care, and logistic barriers such as cost, access and inconvenience, were barriers to care in peacekeeping forces returning from Bosnia and Kosovo. In two studies examining how perceptions of stigma and barriers to care moderated the relationships between stressors and psychological symptoms, Britt et al (2008) found support for stigma and barriers to care being separate constructs. Additionally, the relationship between overload and depression was stronger when perceived barriers to care were high and the authors emphasise the importance of examining both stigma and barriers to care.

Situational barriers should be comparatively easy to address through education, adequate resourcing of services and organisational commitment to provision and access to services. Structural discrimination can affect this commitment (Thornicroft 2006). The military has always had to strike a fine balance between reducing stigma and maintaining a fighting force and this inevitably continues today (Osorio, Jones et al. 2013a). Originally, the death penalty for cowardice or desertion was intended to make men fear running away, more than they feared the enemy (Barham 2004; Watson 2008) and despite military denial, a fair trial with mental health assessment for those accused was not usual (Shephard 2000). The Russians were the first to accept the link between psychological illness and warfare and to attempt to prevent and treat this. Ironically, their willingness to legitimise psychiatric casualties, thereby reducing the associated shame, led to greater numbers seeking this as a way out from the front-line, severely compromising military objectives (Gabriel 1987). This exemplifies how stigma serves a purpose in maintaining fighting numbers.

The need to maintain military strength and reduce disabled service personnel who would be entitled to compensation or pension, inevitably drives the military and political agenda. Shell shock was a classic example of this as it posed a great threat to the military and government objectives and needed to be controlled. It was generally viewed sympathetically by the public and carried little stigma so steps had to be taken to redress the balance. Permission was denied to publish papers on the disorder, the use of the diagnosis was restricted to avoid war pensions and ultimately the term was banned (Jones and Wessely 2003; Jones, Thomas et al. 2006; Jones, Fear et al. 2007). Following the war, the Southborough committee was set up to

investigate the matter of war neurosis and produced an *"extraordinarily ambiguous cultural document which both exemplifies the power of shell shock as a cultural metaphor, and tries to play down its significance and resonance."* (Howorth 2000 p.234)

Even today, at conferences I have witnessed highly emotive debates between ex-service personnel and their advocates and government representatives, each claiming their "truth" about the extent of the problem. Often change only seems to come from media and family pressure and this is an example of how the media can also be a positive influence (Thornicroft 2006).

A diagnosis of mental health problems is *"one of the most potent ways to remove a person from the workplace"* (Thornicroft 2006 p.50) and a study of British employers showed fewer than 40% would consider employing a person with a history of mental health problems (SEU 2004). As stated earlier, structural discrimination can also include institutions' policies that are not intended to discriminate but whose consequences nevertheless hinder the options of people with mental illness. In a review of the interventions and treatment adaptations that may reduce such barriers to care, Zinzow et al (2012) recommend military mental health policy changes in 4 areas: a) increasing access to health facilities, b) addressing concerns about confidentiality, c) increasing unit cohesion and support to facilitate treatment-seeking and d) mitigating the effect of help-seeking on future career paths.

In a study of Canadian Forces deployed in Afghanistan, Sudom et al (2012 p.424) made the surprising discovery that perceived structural barriers were associated with greater help-seeking. They suggest this could be *"the experience of care seeking or the cognitions that precede it are driving the perceptions of barriers rather than the other way around."*

2.2.3 Group norms and health attitudes
Our social roles have a causal effect on mortality, suicide rates and physical and mental health (Sani 2012) and Jetten et al (2012) recommend we take a psycho-social approach to health and well-being. As stated earlier, the social group is a meaningful entity with a collective mental representation of its nature, structure and cohesiveness and people who feel part of a group will *"strive actively to reach agreement with them and to coordinate their behaviour in relation to activities that are relevant to that identity"* (Yzerbyt, Judd et al. 2004 p.10). Help-seeking is therefore affected by the groups' perceived values and norms and, when deciding what the right things to do are, *"… our relationships with fellow in-group members determine our interpretations and response to key aspects of illness and wellness – including the way that symptoms are perceived and treated …"* (Jetten, Haslam et al. 2012 p.11)

According to this then, whether or not we take part in healthy behaviours such as help-seeking depends on how, as a group, we attribute meaning to those behaviours and will vary from group to group (Haslam, Turner et al. 1992). The social identity model of collective resilience (Drury,

Cocking et al. 2009; Williams and Drury 2009) posits that for those with a shared social identity and therefore shared goals, giving to and expecting support from group members leads to empowered collective action that self-polices, prevents trauma and increases well-being. An unspoken sense of duty to act in the collective interest arises (Drury 2012).

In the military, the collective interest is particularly ingrained, from basic training onwards, as each individual's life may rest in the hands of the group at some point. Solidarity depends on the individual supporting others, but also believing that they reciprocate this support. Trust and respect for the other is required for this. The downside to this is that where the individual breaches the norms of their own group there is no evidence of social support or even acknowledgement that there is anything that requires support laying the path for collective denial. In other words, *"…suffering that affirms identity is bearable, it can be spoken of and it attracts the support of others in the group. Suffering which negates identity is unbearable and unspeakable."* (Kellezi and Reicher 2012 p.228).

In the military, soldiers are expected to "tough out" any problems, be they physical or psychological (Vogt 2011) and studies have found this to influence help-seeking behaviour. Britt et al (2011) found that Reserve Component veterans with mental health problems did not seek help as they felt the problem was not severe enough or that they could handle it. A qualitative study of active-duty US Air Force personnel similarly found that soldiers felt they could handle the problem themselves, preferred to minimise effects and were not ready to talk about it (Visco 2009). This mental toughness, the ability to contain emotions and the use of aggression are desirable qualities in the military but may interfere with the therapeutic alliance and actively working on traumatic memories within therapy (Creamer and Forbes 2004; Forbes, Parslow et al. 2008)

2.2.4 Disclosure and Label avoidance

The historical origins of the term "stigma" emanated from the Greek language. Those defined as having lower moral status, e.g. slaves or criminals, had their flesh burned or cut to provide a visible means of identifying them as flawed or socially unacceptable (Thornicroft 2006). Goffman (1963) distinguished between the stigma of "discredited" (overt, visible) and "discreditable" (not immediately visible but able to be discovered) blemishes of character. An important factor in determining disclosure is whether it can be concealed, or its "know-about-ness," and the potential option of not telling and passing as "normal". However this strategy can cause considerable strain and lead to isolation and fear of discovery (Goffman 1963; Hornsey and Jetten 2011). This can also lead to withdrawal from social relationships or a preference for more superficial social encounters (Derlega and Berg 1987; Smart and Wegner 2000). Individuals may downplay the change in their personal and social identity thereby avoiding discrimination and promoting personal identity continuity but this leads to fear of exposure and an inability to seek and receive social support (Jones, Jetten et al. 2012).

Farina suggested that people behave differently socially when they believe their "blemish" is known to others and that this can adversely affect relationships (Farina, Gliha et al. 1971). Sibicky and Dovidio (1986) found a "self-fulfilling prophecy" effect whereby expectations of others' negative reactions created behavioural changes in stigmatised participants who then were reacted to in the way they had anticipated.

Label avoidance plays an important part in reducing help-seeking behaviour (Corrigan 2004) and is apparent in the military (Stecker, Fortney et al. 2007; Mittal, Drummond et al. 2013). Britt (2000) addressed the experiences of military personnel who were placed in a stigmatizing predicament and found that admitting to a psychological problem was more stigmatizing than admitting to a medical / physical one (in line with attribution theory) and that personnel were much less likely to follow through with a psychological referral than a medical one. Disclosure of a psychological problem was perceived to have a more negative impact than a physical one: 61% felt their career would be affected by disclosure of a psychological problem (c.f. 43% medical) and 45% felt it would cause a co-worker to distance themselves from the individual affected (c.f. 22% medical). The social context of disclosure was a factor with the *"greatest concerns about stigmatization when they scored above the cutoff on the questionnaire and were participating in the screening with their units"* (Britt 2000 p.1609).

In the US, the National Co-morbidity Survey found that over half the participants with an untreated mental health problem did not consider them-self to have a problem needing treatment (Kessler, Berglund et al. 2001). Unsurprising, not recognising a problem is associated with not seeking help. Attempts to protect self-esteem and sense of identity can lead to denial or under-estimating symptoms (Branscombe, Gomez et al. 2012; St. Claire and Clucas 2012) and Pfeiffer at al (2012) found that personal acceptance of a mental health problem was the major barrier to help-seeking in National Guard soldiers. Avoidance and numbing (two common symptoms of post traumatic stress reactions) can be a strategy for coping with anxiety that impede help-seeking and provided *"numbness was effective in curbing anxiety, the soldier did not turn in for help. He usually does only when the precarious balance has been tipped towards intrusion."* (Noy 1991 p.516). Stecker et al (2007) found that "self-induced" barriers such as pride, not being able to admit to having a problem and not being able to ask for support were considered major impediments to treatment seeking.

In their study of decisions to seek mental health care, Snell and Tusaie (2008) found that veterans used avoidance, (keeping busy 33%, using alcohol 48% and isolation 22%) as coping strategies. An important factor in ultimately seeking help was a concern about the potential for negative consequences arising from their aggressive and inappropriate behaviours.

The strain of concealing stigma may be more bearable for those who are highly practiced in controlling their minds and emotions (Smart and Wegner 2000) and this would seem to fit with the military mind.

The decision to disclose is ultimately a balance between the perceived benefits and costs. Benefits include allowing others to offer support, be it emotional, practical, informational or problem-solving; engaging with self-support groups, removing the stress of concealment and having the therapeutic ability to tell one's story. Potential costs are opening oneself up to discrimination and negative attitudes, reducing employment opportunities, exclusion and necessitating dealing with family concerns (Thornicroft 2006). Brohan et al (2012) reviewed the literature around disclosing a mental health problem in the workplace. In addition to reasons for non-disclosure, e.g. fear of discrimination, ability to conceal and seeking privacy, they considered the reasons behind the decision to disclose. These were found to fall into 7 themes 1) a desire to become a role model for others; 2) to gain adjustments within the workplace including time off or a change in duties; 3) positive experience of disclosure; 4) to obtain emotional support; 5) to be honest; 6) to explain behaviour particularly if misattribution was perceived as more stigmatising, e.g. laziness / drugs; and 7) concealing as too stressful to continue. Vogel and Wester (2003) emphasise the importance of self-disclosure (the ability to reveal private thoughts and emotions to another person) as a factor in help-seeking. Where individuals experience discomfort, particularly with disclosing emotional content, they are less likely to seek treatment. As part of their cost-benefit analysis they will also consider risk (negative consequences) and utility (the usefulness of disclosing – discussed further in section 2.2.5).

Perception of subsequent confidentiality is a major concern in disclosure and label avoidance. It is not as simple as whether to tell or not but who to tell, when, what and how much (Jones, Jetten et al. 2012). Worry about the effect on a military career is exacerbated by the facts that medical diagnoses are usually recorded for fitness for duties and that, certainly in the US military, there are moves to increase the sharing of health information (GAO 2009). In a study of UK Armed Forces, in a comparison of identifiable questionnaires versus anonymous ones, anonymity lead to increased reporting of symptoms and stigmatizing beliefs suggesting that the fear of disclosure and further stigma was an influence in reporting (Fear, Seddon et al. 2012). This trend was mirrored by Warner et al (2011) in US soldiers.

Corrigan and Rao (2012 p.467) go on to show the range of disclosure strategies that vary in their risks to the disclosing individual: from Social Avoidance (Stay away from others so they do not have a chance to stigmatize me!), through Secrecy (Go out into the world—work and go to church—but tell no one about my illness), Selective Disclosure (Tell people about my illness who seem like they will understand), Indiscriminant Disclosure (Hide it from no one) to Broadcast (Be proud. Let people know).

It is important to recognise that internalizing prejudice and discrimination is not a necessary consequence of stigma. Many people recognize stigma as unjust and become advocates for change and others are oblivious to stigma (Corrigan and Rao 2012). Some move towards pride in their new identity, converting a "badge of shame" into a "mark of honour" this being more

likely when the new identity cannot be avoided (Branscombe, Schmitt et al. 1999; Branscombe, Gomez et al. 2012). Some studies propose that individuals can construe their suffering as a blessing in disguise, experiencing growth as a result of having confronted and overcome the adversity presented by their membership of the stigmatised group (Crocker and Major 1989; Branscombe, Schmitt et al. 1999; Shih 2004).

Corrigan and Watson (2002) explored this apparent paradox of self-stigma and the reasons why some people respond to the stigma with shame and reduced self-esteem and self-efficacy whilst others remain indifferent or are even strengthened, responding with heightened self-esteem. They conclude that group identification and agreement with stereotypes are a factor: where the individual perceives negative attitudes to the stigmatised group to be legitimate, self-stigma will be high. If they view other's negative attitudes as unjust or irrelevant then they will experience no reduction in their own sense of esteem and efficacy. Additionally for this second group, if they identify with the stigmatised group they will respond to others' prejudice with righteous anger and if they do not identify with the stigmatised group will respond to stigma with indifference. This is an expansion of Link and Phelan's (2001) conceptualization of self-stigma into a hierarchy of awareness (I must be aware of the stereotype), agreement (I must agree with the negative attributions) and application (I must apply the stereotype to myself.

Further considering this in relation to the theory of spoiled identity (Goffman 1963), if the old identity is spoiled by the disclosure, then, if the individual can identify with the new group i.e. those with mentally health problems, they are more likely to seek help (Rusch, Corrigan et al. 2009). However, resistance to change is higher among those who are highly committed to the old identity or to those who have fewer identities and so the bigger the identity, the greater the loss (Jetten, Iyer et al. 2002). It is less stressful if the individual is willing to take on the new identity but more so if the new one is a stigmatised identity, implies a loss of status or is irreversible (Jetten and Pachana 2012) and *"if pre- and post-transition identities are incompatible, it is less likely that individuals can maintain the pre-transition identities in the new context."* (Iyer, Jetten et al. 2008 p.102-3).

2.2.5 Confidence in mental health services
Various models have proposed a theoretical framework for help-seeking and beliefs about mental health and attitudes towards treatment are fundamental (Janz and Becker 1984; Prochaska, Redding et al. 2008; Fishbein and Ajzen 2010) therefore stereotypes and stigmatizing beliefs about mental health professionals, services and treatments are potentially factors in help-seeking.

A population survey in Europe found that almost 1/3 respondents viewed professional care for a serious emotional problem as worse than or equal to no help (ten Have, de Graaf et al. 2010). The police interface with mental health services does little to negate these attitudes. The contact with mental health services and the quality of their collaboration and respect for each

other can lead to the failure or success of the intervention (McLean and Marshall 2010). Reports suggest that the interface between these 2 services warrant improvement (Charette, Crocker et al. 2011; Hollander, Lee et al. 2012) with issues such as communication and lack of collaboration and respect for the other.

Brown et al (2011) found that where soldiers had seen a provider in the past year for mental health care there was a strong association with interest in receiving help for a current issue. Integrating mental health professionals into the military environment is intended to reduce the perception of clinicians as "outsiders" and provide more opportunities for interaction, collaboration and education (Zinzow, Britt et al. 2012) thereby challenging stereotypes.

In the police, education, is being increasingly used as a response to the increasing interface with mental illness e.g. the training of specialised officers for the creation of Crisis Intervention Teams, has helped raise awareness for signposting to mental health services (Watson, Ottati et al. 2010; Canada, Angell et al. 2012; Barillas 2013). Although this undoubtedly helps their police role, whether they then apply that knowledge to themselves is unknown.

It seems that mental health professionals have always engaged in turf wars, from the professional rivalries between Freudian theorists (Myers 1916a; Myers 1916b; Rivers 1918) and proponents of repression (Adrian and Yealland 1917) during WWI, to the recent controversy surrounding Critical Incident Stress Debriefing (an early group intervention) (Koshes, Young et al. 1995; Mitchell and Everly 2001; Dyregrov 2003; Hawker, Durkin et al. 2011). Even now, although there are clear guidelines for the effective treatment of PTSD (NICE 2005; Bisson and Andrew 2007) there are publicly debated rivalries between the two main approaches (trauma-focused cognitive behavioural therapy and Eye Movement Desensitisation and Reprocessing) for the treatment of individuals. It is argued that these professional rivalries have lead to reduced access to evidence-based psychotherapy for PTSD (Russell and Friedberg 2009) and reduced confidence in referrers (Langston, Gould et al. 2007). Additionally, a quick search of the internet will reveal arguments against evidence-based interventions and proposals for other interventions such as using cannabis, ecstasy, Tetris games, pet therapy to name but a few. When mental health professionals can't seem to agree what the best approaches are or even whether PTSD exists (Brewin 2003) and act out their turf wars publicly, it's little wonder the average person may question their competence. Rather shockingly, mental health professionals can themselves hold stigmatizing attitudes towards people with mental health issues (Lauber, Anthony et al. 2004; Thornicroft 2006; Charles 2013).

Another barrier to care is the lack of confidence in the effectiveness of treatment coupled with misconceptions about the nature of mental illness. Studies have found that negative attitudes about mental health care decreased the likelihood of treatment-seeking in soldiers who had deployed to Afghanistan and / or Iraq (Kehle, Polusny et al. 2010; Kim, Britt et al. 2011) and in National Guard and reservists (Pietrzak, Johnson et al. 2009; Kehle, Polusny et al. 2010).

Stecker et al (2013) found that concern about treatment was a factor for 40% of non-treatment seeking veterans of the Iraq and Afghanistan conflicts. Other beliefs include that providers won't understand them or cannot be trusted, that treatment is only for extreme problems and unhelpful and that medication will result in negative side effects (Edlund, Fortney et al. 2008; Sayer, Friedemann-Sanchez et al. 2009; Kim, Britt et al. 2011). Even where individuals are aware of the potential benefits of seeking treatment, Wester et al (2010 p.296) caution that beliefs that treatment could be beneficial *"might not be enough to overcome the socialized and contextual proscriptions against counseling – at least with regards to the stigma associated with such behaviour."*

Brown et al (2011 p.800) point out that education must include recognising problems **and** that treatment is efficacious. They go on to say that recognising a mental health problem may however necessitate *"comparing oneself with an internal notion of other people who have problems."* It is difficult to ascertain whether it is harder to recognise symptoms in another compared with oneself. There are signs that we are becoming better informed. An Australian public survey found evidence that the general ability of people to recognise disorders and beliefs about effective medication and interventions was becoming better informed (Reavley and Jorm 2011). Weine et al (2002) offer guidance on psycho-education for traumatized populations. However, in a study of depressed veterans, Edlund et al (2008 p.588) found little evidence to suggest beliefs that could prevent treatment-seeking (such as I should be able to handle symptoms, they are a normal part of life) were modifiable. They posit that *"beliefs formed over decades and reflecting personal and cultural values are not readily changed by brief educational sessions."*

2.3 Changing attitudes and facilitating help-seeking

2.3.1 Stigma-reduction strategies

Corrigan and Penn (1999) identified 3 stigma reduction strategies: Contact (direct interactions with affected individuals); Protest (the suppression of stigmatizing attitudes) and Education (replacing myths with accurate conceptions of mental illness). However, protest or forced suppression is associated with rebound effects (Macrae, Bodenhausen et al. 1994; Plant and Devine 1998) and has been found to result in no attitude improvement in attributions (Corrigan, River et al. 2001).

Dickstein et al reviewed anti-stigma intervention strategies (with a focus on self-stigma) in returning military personnel and veterans. They recommended that future efforts be focused on five targets: *"(a) Perceptions that care utilization is a sign of weakness; (b) Stereotypes about mental illness and mental health diagnoses (e.g. indicative of incompetence, dangerousness, or "craziness"); (c) self-blame (e.g. Feeling responsible for having a mental illness); (d) uncertainty about the signs and symptoms of mental illness; and (e) uncertainty about the nature of treatment."* (Dickstein, Vogt et al. 2010 p.231)

Sayer et al (2009) examined the determinants of treatment-seeking in a qualitative study of 44 veterans from Vietnam, Iraq and Afghanistan conflicts. They found 4 themes that facilitated help-seeking: a) recognition and acceptance of PTSD and availability of help, b) treatment-encouraging beliefs, c) system facilitation, d) social network facilitation and encouragement. Although this looked more generally at treatment-seeking, results mirror much of the stigma literature in terms of education, social context and support systems.

It should be borne in mind that the urge to tackle the stigma of mental illness has meant that intervention programmes have been implemented prior to evidence for their effectiveness and Corrigan and Shapiro (2010) set out guidelines for the evaluation of interventions that aim to address public stigma. They recommend that 5 measurements can be used to assess stigma change: behaviour (discriminatory or affirming), penetration (recollection of message), attitudes and emotions (stereotypes and behaviours), knowledge and mental health literacy (understanding of illness and treatment) and physiological and information processes (the somatic response to the "threat" of mental illness). Mittal et al (2012) reviewed the literature relating to empirical studies of mental illness self-stigma reduction strategies and identified 6 different strategies for reducing self-stigma on a continuum of simple psycho-education (e.g. written material) through facilitated psycho-education with groups with cognitive restructuring to more complex interventions (Adler, Bliese et al. 2009; Fung, Tsang et al. 2011). Along with limitations due to the research being in an emerging field (e.g. lack of replication, exploratory studies), they found methodological issues such as differences in the conceptualisation of self-stigma, reservations about the efficacy of measures and lack of a theoretical framework for interventions. There is clearly still much research needed in this area.

This section will continue now with a consideration of the influence of Contact, Education, organisational culture and social networks on stigma. Although there have been many community or national campaigns such as the UK's Time to Change (see http://www.time-to-change.org.uk/), word constraints require that the focus of this literature review is best directed towards education for the individual / social group.

2.3.2 Contact

Contact appears to be the most promising of the 3 strategies in the general public (Corrigan, River et al. 2001; Corrigan, Rowan et al. 2002; Evans-Lacko, Malcolm et al. 2013) particularly in relation to perceived dangerousness and desired social distance (Penn, Kommana et al. 1999; Corrigan, Rowan et al. 2002; Alexander and Link 2003). Contact can lead to re-categorising and reducing stereotypes (Couture and Penn 2003).

Contact is most effective when it is targeted, local, credible and continuous (Corrigan 2012; Corrigan and Kosyluk 2013). As well as face to face interventions, Contact may also be successful when done indirectly, e.g. via DVD (Clement, van Nieuwenhuizen et al. 2012; Nguyen, Chen et al. 2012). Imagined Intergroup Contact where participants imagined a positive

encounter with a patient with schizophrenia) led to weakened stereotypes and more willingness to engage (Stathi, Tsantila et al. 2012). Crisp and Turner view this indirect contact as *"a first step on the route toward reconciliation and reduced prejudice."* It allows meaningful intergroup interaction but, although effective and simple, its results are not as powerful or long lasting as direct contact (Crisp and Turner 2009 p.231).

Greene-Shortridge et al (2007) suggested incorporating Contact alongside Education by having soldiers who had been successfully treated for PTSD discuss their experience in a supportive unit environment (similar to an operational debriefing or review) where questions could be asked and myths dispelled. This obviously depends on the ability for that individual to return to their unit and for the process to be handled sensitively.

There is a caution though that "evidence" that is consistent with pre-existing attitudes, will be perceived as more persuasive than that to the contrary (Boysen and Vogel 2008) leading to attitude polarization and biased assimilation (Lord, Ross et al. 2008; Lord and Taylor 2009) and contact with someone who grossly differs from the stereotype can actually reinforce it as they are seen as atypical (Kunda and Oleson 1997). Pinfold et al (2005) reviewed the results of the Mental Health Awareness in Action Programme and considered the evidence base for effective anti-stigma interventions. They found that Contact was not predictive of positive changes in knowledge and attitudes towards mental health for the police officers group. Given the strength of stereotypes and the negative reinforcement that may arise through their occupational role, this is not altogether surprising. Contact with a few "anti-stereotypes" may not be enough to balance their perspective and change attitudes.

2.3.3 Education
Education (replacing myths with accurate conceptions of mental illness) as an anti-stigma intervention has produced mixed findings and, in a review of the literature, Dalky (2012) suggests that many fail to prove a link between the anti-stigma intervention and changes in "real-world" behaviour. Although there has been shown some improvement in attitudes (Holmes, Corrigan et al. 1999; Penn, Kommana et al. 1999; Corrigan, River et al. 2001), the longevity of such changes is unclear due to a gap in longitudinal research.

The concept of psycho-education being generally effective in the treatment of trauma is supported by Scaer (2001) when he suggests that providing information to a client as to why they are having reactions to the traumatic event, in a logical cognitive format, leads to empowerment of the individual, restoring the sense of control for their recovery. Great efforts have been made to provide accessible psycho-education for example through books specifically targeted at members of the uniformed services and their families (Kates 2008; Freund 2011) or through formal educational programmes in the US such as Battlemind (Adler, Bliese et al. 2009; Adler, Castro et al. 2009; Adler, Bliese et al. 2011) and the Defenders Edge Programme (Bryan

and Morrow 2011) both of which reframe mental health learning in a strengths-based framework and promote resilience and health in military personnel.

In the military, Gould et al (2007) found Education improved attitudes towards PTSD, stress and accessing help from peers but had no effect on attitudes towards seeking help from professional support, possibly because of a lack of understanding still about the efficacy and nature of treatments. Education on the management of psychological problems has been associated with increased agreement to seek treatment amongst soldiers post-deployment (Warner, Appenzeller et al. 2008). Their study also found that encouragement from family and friends was seen as important by the soldiers themselves thereby suggesting the importance of education reaching out to those groups too. In a study of veterans' reasons for seeking mental health care, Snell and Tusae (Snell and Tusaie 2008) found that 48% of the participants cited disruptions in relationships, with coercion from significant others to make and keep their mental health appointment. This was often backed by an ultimatum as relationships became strained.

As well as addressing ignorance about mental health symptoms and treatment, education about the responsibility for onset of problems is recommended as an anti-stigma initiative to overcome the negative effects of attribution of cause (Cooper, Corrigan et al. 2003). However, where trauma reactions are presented as a "normal reaction to abnormal experience" (Moore and Reger 2007) there is a danger that stigma may arise if the individual doesn't follow the expected recovery route. In other words issues of both on-set and off-set responsibility need to be addressed.

Momen at al (2012) found that despite educational briefings, misconceptions about combat stress reactions and associated stigma still persisted in US Marine Corps. A short education programme with police officers did produce improved attitudes towards members of the public with mental health problems increasing officers' confidence and awareness of issues. However it didn't successful challenge stereotypes around the link between mental health and violent behaviour (Pinfold, Huxley et al. 2003)

Education can also focus on changing beliefs about treatment-seeking. Cognitive Behavioural Therapy was used with this aim with National Guard soldiers who had deployed to Iraq and resulted in reports that they were more likely to seek treatment (Stecker, Fortney et al. 2011). Corrigan and Calabrese (2005) recommend cognitive techniques (such as psycho-education and reappraisal of stereotypes) and personal empowerment and this has been found to significantly reduce self-stigma (Luoma, Kohlenberg et al. 2008; MacInnes and Lewis 2008). Also effective in a military setting, cognitive reappraisals can break stereotypes and change the perception of help-seeking as an act of weakness into one of strength (Stecker, Fortney et al. 2007). During a visit to a VA hospital in Texas, I noticed posters on the walls of the PTSD clinic waiting room using this method. They proclaimed things such as "It takes real courage to ask for help."

However another study with more recent onset difficulties found no improvements, possibly due to the "newness" of the illness and lack of familiarity with the condition (McCay, Beanlands et al. 2007). Furthermore, Masuda et al (2007) found that educational interventions only reduced stigma amongst participants who were relatively flexible and non-avoidant to begin with. They found that Acceptance and Commitment Therapy worked better with psychologically inflexible participants. This therapy proposes accepting and defusing thoughts rather than challenging them (Hayes, Follette et al. 2011).

Lucksted et al (2011) focused on education around stigma myths, group support and skills training for their Ending Self-Stigma program and reported significant improvements with participants from VA centres who had been diagnosed with schizophrenia. Fung et al's (2011) self-stigma reduction intervention had goal attainment and treatment adherence as its principal target. They found no significant improvement to self-stigma with a multi-modal intervention comprising psycho-education, cognitive behavioural therapy, social skills training, motivational interviewing and goal attainment in their research with participants diagnosed with schizophrenia. However, this was conducted in China so cultural influences may also have had an impact.

2.3.4 Organisational culture
Organisational or group identification can be positively associated with health outcomes and social support is more likely to be provided and to be effective when the two parties have (or are perceived to have) common group membership. In these cases, the provider is more emotionally empathic and genuine in their offers of support so that messages of comfort and reassurance are likely to be more trusted and taken at face value. External offers of support may be viewed cynically and as having an agenda (Haslam, Reicher et al. 2012; Sani 2012).

In both the police and the military, the group mission requires a high level of functioning under challenging circumstances and group cohesion is therefore critical for performance. DuPreez et al (2012) examined the association between unit cohesion and probable post-traumatic stress disorder (PTSD), common mental disorder and alcohol misuse in UK Armed Forces personnel deployed to Iraq. Both unit cohesion and perception of leadership were associated with less probable PTSD and common mental disorder, and in reserve personnel feeling able to talk about personal problems was associated with less alcohol misuse.

Morale, closely associated with unit cohesion and support, is inversely linked to the prevalence of stress reactions (Labuc 1991; Britt, Adler et al. 2013) and may also be a factor in post-traumatic growth (Mitchell, Gallaway et al. 2013). It has been suggested that the initially low stress casualties of the Falklands campaign (1982), at less than 10%, were due to high morale within the fighting force (Labuc 1991). Positive perceptions of unit leadership and the organisation's commitment to welfare of its personnel are inversely related to stigma and barriers to care (Greene-Shortridge, Britt et al. 2007; Wright, Cabrera et al. 2009; Du Preez,

Sundin et al. 2012). Positive leadership has been found to work in conjunction with unit cohesion to reduce perception of stigma (Wright, Cabrera et al. 2009). However it is acknowledged that superior officers sometimes use psychiatric routes as a way of removing personnel they consider to be unsuited to combat (Jones and Wessely 2003).

Britt et al (2012) made the distinction between the levels of organisational support. They found differences in the influence of commissioned officers (leaders) and non-commissioned officers (NCOs) on stigma and help-seeking. They found that NCO behaviour was a primary predictor for both stigma and practical barriers to care and that this was most likely due to their immediate supervisory role. They suggest a focus on what leaders should *not* do as well as what they should do. In the US Army, the Master Resilience Training teaches sergeants skills that build resilience and communication that they then teach their soldiers. It includes addressing stereotypes about character strengths and resilience cultivating empathy and a strength approach to their staff (Reivich, Seligman et al. 2011).

In research conducted into post-incident management in the UK police, 44% of officers described "good, supportive supervision" as the best way they could be helped (HSE 2000 p.9). Hayday et al (2007) reporting on the management of sickness absence within the police, found that organisational changes such as the closure of canteens and removal of gyms (due to pressure on space and health and safety concerns) were seen as the removal of commitment to physical and mental fitness. In contrast short-term well-being measures implemented by the organisation were not taken seriously. Woody (2005 p.528) suggests that the police culture is itself a threat to the individual law enforcement officer (LEO).
"The ever-present political criticisms lead law enforcement administrators to put an LEO's conduct under the microscope, and often the police culture does not shelter the individual LEO from organisational critiques and discipline. In addition, law enforcement administrators commonly issue directives and impose after-the-fact evaluations that can alter an LEO's career."

There is uncertainty that arises through this threat to livelihood, as well as the operational threat from offenders, and this can become isolating for the officer.

2.3.5 Social support networks
The importance, following difficult experiences, of having peer communication and support was rooted in the early military tradition of Historical Event Reconstruction Debriefing: Colonel S.L.A. Marshall was the chief US Army historian in World War II. He used hours of free talk with small units to reconstruct battles as part of his recording of events. Although not a mental health professional, he noted that these meetings were helpful to the individuals as they fostered social support, allowed colleagues to correct misperceptions and repaired and strengthened unit cohesion (Koshes, Young et al. 1995).

Sharing experiences with peers can be a way of normalizing experiences and reactions (and therefore reducing stigma) and several studies have shown the effectiveness of peer support in the modern Armed Forces. Social support from the military unit weakened the association between the stressfulness of new recruit training and Post Traumatic Stress symptomatology in US Marine recruits, and as the military stressors increased, became more important than that from family and friends (Smith, Vaughn et al. 2013). Peer interventions were found to be helpful in reducing stigma amongst National Guard soldiers (Pfeiffer, Blow et al. 2012). Identifying peers in need of support and facilitating treatment is fundamental to Trauma Risk Management (TRiM). TRiM was intended to be delivered by peers and is used across the UK Armed Forces as well as in some police services. Using peers is intended over time to reduce stigma (Jones, Roberts et al. 2003; Greenberg, Langston et al. 2008). Greenberg et al (2011) found that TRiM was viewed by many as supplementing existing leadership support systems although there were concerns about confidentiality in a peer-delivered intervention. Whether peer support is accessed could depend on the nature of the stressor. In their study of service personnel who had deployed to Iraq or Afghanistan, Chapman et al (2013) found that social support actually declined as war-related losses increased. The symptom cluster of avoidance was one of the most endorsed so perhaps in such cases, peers have become a trigger for the traumatic material and are avoided.

Greenberg et al (2007) examined how Royal Navy personnel would deal with severe distress (ideas of deliberate self-harm) amongst peers. They found the majority of individuals would interact positively and actively with a peer, referring them on if problems did not resolve. Most respondents reported they would take positive action regarding immediate management of the ideas of deliberate self harm, referring to either medical or management staff. However, the majority, particularly those from lower ranks, had concerns that reporting this would impact negatively upon the individual's career.

In a study of UK peacekeepers (Greenberg, Thomas et al. 2003), results indicated that about two-thirds of peacekeepers spoke about their experiences with the majority using informal support networks, such as peers and family members, for support. They found that talking through experiences in this way was associated with less psychological distress. Those who were highly distressed did report talking to professional services but what isn't known is at what level of symptoms the help-seeking is accessed and what the reasons are behind this. Could it be that, as with my experience in the police service, only desperate times call for desperate measures?

It appears that unit cohesion and peer support can also be a negative influence where group norms lead people to damaging forms of support e.g. alcohol use, avoidance. Comradeship was associated with greater alcohol misuse among regular personnel (Du Preez, Sundin et al. 2012). Langston et al (2007 p.933) in their study with UK military suggested that *"the close community, reliant on mutual support, therefore may act as a hindrance acting as an*

organisational barrier that prevents personnel from using appropriate support and mental health care to fit in with the existing military culture ethos." They concluded that the real "patient" is not the individual but the organisation or culture itself. Greenberg et al's (2003) study of peacekeepers found that older peacekeepers were less favourable to the idea of formal support preferring social networks and the chain of command. As senior members of the group, any communication of this as a group value could have greater influence on peers' attitudes as to what is acceptable.

This can work both ways. Brown et al (2011) found that the perceived stigma from the in-group (in this case soldiers returning from Iraq) could mean that individuals were less likely to look to their peers for support and consequently more likely to seek external help.

Varker and Creamer (2011) set out to address what they saw as a lack of controlled research trials to support the effectiveness of peer support in improving psychosocial outcomes. They reviewed the evidence and developed guidelines for peer support recommending that peer supporters should be able to listen empathically, provide low level psychological intervention, identify peers who may be at risk and facilitate pathways to professional support.

Summary

Figure 2.2 outlines the main factors involved in the stigma of having a mental health problem. Public stigma comprises society's negative attitudes towards mental illness and is based on ignorance, labelling and stereotypes. People are judged according to whether they are responsible for the on-set of their problem and for how they are perceived to be active in their recovery. Reactions to negative stereotypes of those with mental illness are fear and exclusion, benevolence and authoritarianism.

The cultural sub-contexts of both the police and Armed Forces bring their own dimension to this mix. Military tradition is reinforced throughout service and the social group identity is created. Both police and military are hierarchical organisations with strong group norms. There is cognitive separation into in-groups and out-groups with the latter being inherently dangerous where they are seen to have conflicting values.

In the police service, interaction with severe mental health issues reinforces negative stereotypes around dangerousness and authoritarianism. Exceptions to the rule can be seen as "atypical" and further reinforce negative stereotypes. The occupational interaction with mental health services is not always helpful or respectful from either side's perspective.

In addition to public stigma, structural discrimination can lead to situational barriers to help, such as inaccessible services, fear of confidentiality and reduced employment opportunities. In the Armed Forces, stigma has been used historically as a means to ensure that warriors remained

in combat. Political and military objectives required psychiatric casualties to be minimised to retain fighting numbers and reduce costs. Both these factors can be actually experienced or simply anticipated in order to hinder disclosure and treatment seeking.

Self-stigma is the internalisation of public stigma. Where the person is aware of the negative stereotypes and public stigma, accepts them as valid and applies them to self this leads to shame and reduced self-esteem and self-efficacy.

Figure 2.3 outlines the stigma of help-seeking. The decision to disclose is a consideration of the costs and benefits of help. Whether the "blemish" is concealable will be a factor in this, along with the strain of doing so. Levels of disclosure (such as who, when, how much and what?) must also be considered. Costs, or risks, can include loss of control, how well services can be trusted, if violating group norms, will there be a rejection by their own group (public stigma) and concerns about the impact on career (structural discrimination). On the other side, the benefits or utility of disclosure can be driven by the strain of concealment, level of symptoms and perception of efficacy of services.

Cultural factors can be a barrier or a facilitator. Leadership and unit cohesion can reduce or increase the stigma of help-seeking. Powerful group norms of strength and emotional containment are encouraged within the military and, where coping styles of avoidance, containment or denial are present, there will be a fear of violating group norms and consequently being expelled or stigmatised. Where there is a perception of transitioning to an out-group, the compatibility and status of that group will determine the ease of this.

Anti-stigma interventions attempt to facilitate help-seeking although they are not without their own caveats. As stated earlier, Contact may reinforce stereotypes where they are seen as atypical and Protest is associated with rebound effects. Education needs to cover several aspects – symptoms, treatment and stigmatising beliefs and stereotypes.

It is clear that the issue of stigma is a complex one and more research is needed into how the factors augment each other and which interventions work in which setting. This thesis now moves on to set out the chosen methodology for this particular piece of research into the field of stigma and help-seeking.

Figure 2.2: The stigma of mental illness

Public stigma
Society's negative attitudes to mental illness
Ignorance
Labelling / Stereotyping
Attribution of on-set and off-set responsibility
Fear and exclusion
Benevolence
Authoritarianism

Structural discrimination
Stigma was powerfully and actively constructed in order to ensure people acted against their instinct
Stigma suits political and military needs
Loss of status
Lack of / removal of opportunities

Situational barriers
Lack of trust in mental health professionals
Not knowing where to get help from
Inaccessible services (time, cost, location)
Lack of confidence in treatment efficacy

Military culture
The historical context is reinforced through military tradition
Creation of a strong group identity

Police culture
Interaction with severe mental health issues reinforces stereotypes
Perception of efficacy of services is skewed

Hierarchical organisations

Cognitive separation

Perception of social group identity
In-groups and out-groups (conflicting values represent danger)

AGREEMENT, ACCEPTANCE, APPLICATION?

Indifference
Righteous anger

Self-stigma
Internalised public stigma *leading to*
Shame and reduced self-esteem
Felt v enacted
Persists after problem and impacts on therapy (drop-out / non-compliance)

Figure 2.3: The stigma of help-seeking

Disclosure
Conceal-ability of blemish (discredited or discreditable)
Risk
Trust in services
Violating group norms
Fear of rejection by own group
Loss of control
Concerns about impact on career
Utility (efficacy of services)
Who, when, how much, what?

Cultural factors
Supportive leadership
Unit cohesion
Availability of social support
Coping styles
Group norms (avoid, contain, deny)
Structural discrimination

Anti-Stigma interventions
Contact (may reinforce as seen as atypical)
Protest (may have rebound effect)
Education – symptoms, treatment, stigmatising beliefs

Social identity transition
Incompatibility of old and new identities
Loss of status
Loss of group identity / expulsion

BARRIERS

FACILITATORS

Part 3: Research Design and Method

The first chapter in Part 3 covers the development of the research design including my epistemological stance and the rationale for my chosen methodology.

The second chapter describes how the data was collected, including a pilot study, and explains the recruitment strategy and interview process.

The third chapter sets out how the data was analysed and offers an example of a worked piece of data to illustrate this.

Finally, the fourth chapter outlines the necessary ethical considerations and concludes with a critical review of the quality of my research design including considerations of validity and reliability.

3.1 Research Design

3.1.1 Epistemological approach

This section sets out the three epistemological considerations behind my choice of methodology. For these, I had to question my stance on the nature of reality, how knowledge is acquired and the kind of knowledge I wanted to produce (Robson 2000; Cardinal, Hayward et al. 2004). I also wanted to consider the assumptions being made about the role of the researcher by different epistemological approaches and was looking for a clear fit between my own stance, the research design and the research questions I was asking, whilst ensuring I wasn't merely staying in my "home base" or comfort zone (Lennie and West 2010).

The nature of reality

My first question surrounded my ontological stance – how I viewed the nature of reality and being in the world. My psychotherapy practice has led me to believe that each of us has our unique internal world, shaped over our lifetime, and that reality is made up of diverse interpretations. We create, and are created by, our understandings of the world around us. An example of this would be where two individuals experience the same potentially traumatic event but are affected very differently due to their life history, interpretations of the event and their role in it.

This belief fits with the ontological stance of the phenomenological paradigm in that an external, multi-faceted reality exists and our understanding of this reality is seen as subjective, only knowable through the human mind and socially constructed meanings. Phenomenology is a philosophical approach founded by Edmund Husserl (1859 – 1938) and further developed by others including Martin Heidegger (1889 – 1976). This approach holds that in order to fully understand a phenomenon, we must have an understanding of the subjective experiences of it. The perceiver can have multiple, concurrent and potentially conflicting perceptions of, and

therefore actions towards, a phenomenon. Phenomena are made up of parts and wholes and by looking at the same thing from many angles we reveal more of what it is (Sokolowski 2000; Cardinal, Hayward et al. 2004; Glendinning 2007; Moran 2008).

How we acquire knowledge

My second consideration was how we acquire knowledge. The quantitative approach, traditionally used in many psychological studies, seeks to gain knowledge through testing hypotheses. It is argued that a straightforward relationship exists between the world and our perception or understanding of it and it is possible to understand what is out there by having an impartial, unbiased researcher observe cause and effect in carefully planned experiments (Robson 2000; Coolican 2004).

Previous quantitative studies on this topic have used questionnaires to determine barriers to care (Hoge, Castro et al. 2004; Maguen and Litz 2006; Eaton, Hoge et al. 2008). I could have used a similar quantitative approach to confirm or reject the existing theory on facilitating factors or barriers to care but I wanted to find out what we were potentially missing, i.e. what we didn't already know so can't test quantitatively.

The positivistic approach's methods of data collection and reliance on hypotheses generated by existing theories would give narrow information in an artificial setting (Coolican 2004) and leave no room for generating new theories. Using this as a research design, I would be unlikely to come across entirely new and unexpected insights or see things in a completely new light

According to the qualitative paradigm, knowledge is acquired through induction by looking for patterns and association derived from observations of the world. Social research, in particular, should explore "lived experiences" and the context within with actions take place. It should take account of the connections between the social, cultural and historical aspects of peoples' lives and see the context in which particular actions take place (Snape and Spencer 2003). When working in relatively uncharted territory, such as the chosen research topic, there is a stronger case for using a phenomenological approach (Stern 1994). The goal of a phenomenological approach is to explore subjectivity. It is concerned with *"quality and texture of experience, rather than the identification of cause – effect relationships"* (Willig 2001 p.9). However, we can still move beyond merely describing and go on to derive theory and this was my aim with the right methodology.

The flexible design of a phenomenological approach would allow me to refine and modify my questions and explore different avenues that arose during the process, thereby maximising my chances of finding new insights into this subject (Robson 2000). Qualitative methods *"have the advantage of focusing in on real-life problems, of reflecting the world as it actually is, and are more likely to come up with unexpected results."* (Banister, Burman et al. 1996 p.18)

What kind of knowledge am I seeking to produce?

My third consideration was what kind of knowledge I wanted to produce. The challenge for phenomenology is to grasp the "how." I was concerned with understanding the process of facing a mental health issue and either accessing support for that, or not. I believed that this process was a complex one that occurs over a varying period of time. One of the other, comparatively rare, qualitative research projects undertaken with the uniformed services supported this view and revealed a *"complex interplay between individual, socio-cultural, social network and system-level factors that influence help-seeking for PTSD."* (Sayer, Fiedemann-Sanchez et al. 2009 p.252)

I wanted to explore subjectivity, how people made sense of this process and experienced the events within it. Phenomenological research would seek to produce knowledge of the subjective experience, world-view and language (McLeod 2011) of this population in regards to accessing psychological illness and support. When attempting to make sense of complex phenomena and asking questions such as "what is important when…or how do people feel when?" a phenomenological approach is appropriate (Morse and Field 1998; Denzin and Lincoln 2011). It is applicable to researching a diverse range of experiences, such as ritualised, uncommon, variable, ambiguous and ineffable experiences (van Manen 2005).

The role of the researcher

My final consideration then was how the chosen methodology conceptualised the role of the researcher in the research process. There are varying degrees of emphasis on this (Willig 2001). In quantitative methodologies, the researcher is viewed as impartial and unbiased. I believe that, whatever the epistemology, it is just as important for the researcher not to impose their views and preconceptions on a research issue. If one looks for something and expects to find it, then one usually will find it (Cardinal, Hayward et al. 2004).

As a mental health professional I would be asking questions about my profession and was coming to the study with a wealth of experience of the police culture. This "intimate familiarity" with the topic would lend credibility to my research (Charmaz 2000a).

Within the phenomenological paradigm there is an acknowledgment that the researcher and the social world impact on each other. Facts and values are not distinct and findings are inevitably influenced by the researcher's perspective and values.
"… an interpretation of human existence cannot be neutral, dispassionate, theoretical contemplation but must take into account the involvement *of the enquirer …"* (Moran 2008 p.197).

A phenomenological reduction does, however, require me to suspend my judgments about the subject being researched. I needed to be transparent about, and bracket, my knowledge and any preconceptions but could also use my theoretical sensitivity to the advantage of the research.

It also made sense to use my existing skills to unearth the evidence – the analogy of the qualitative researcher as a travelling reporter (Kvale 1996) could in some ways be compared with the therapist who travels on a transformative journey with their client. My therapeutic skills are directly transferable to a phenomenological approach (Finlay 2011) as I am practiced in stepping into another's frame of reference, listening without judgment and being open to, and curious about, other viewpoints.

In this section, I have described how a phenomenological approach would potentially add to the existing theory and build on the earlier quantitative studies into this complex subject. Although there have been several quantitative studies done on the subject of mental health stigma and barriers to care, my aim was to be open to emergent concepts and ideas. By taking a phenomenological approach, I was hoping to produce rich data with the insider viewpoint, and theorise about the process. My research design would enable me to delve deeper and see if something new could be found rather than simply confirming previous findings to a lesser or greater degree.

Now that I had clarified my epistemological stance as phenomenological, the next section sets out how I chose my methodological approach, a method of data collection that was appropriate to the research question, and how I analysed my resulting data.

3.1.2 My methodological approach

There are several phenomenological approaches that are appropriate to social research commonly including Ethnography, Narrative Analysis, Interpretative Phenomenological Analysis and Grounded Theory (Robson 2000). This section provides an overview of these approaches, and the reasons the first three were discounted, before providing a more detailed explanation of Grounded Theory and the rationale for using it.

Ethnography

Ethnography is a qualitative method that aims to understand and develop theory about cultural phenomena. Originally used by anthropologists, it is now used by social scientists to discover systems of meanings that guide a cultural group. In Ethnography, the researcher is embedded within a specific social setting and collects data, usually through participant observation and interviews (formal and informal). The researcher will observe and engage in social activities over an extended period of time (Brewer 2000; Atkinson, Coffey et al. 2001; O'Reilly 2005; Hammersley and Atkinson 2007)

In some respects, my previous role within the police service may have lent itself to an Ethnographic approach. I was immersed in the culture and observed and engaged in diverse experiences such as traffic patrol, specialist unit training and major incident simulations. However, even with this level of immersion, my professional role had a negative effect on some as they perceived me to be part of the organisation. This inevitably led to thoughts as to whether I could be trusted, manipulated or used as a source of support (Banister, Burman et al.

1996). It could take several years to break down barriers and gain trust. Even if I had unlimited access and time resources, Ethnography could prove unsuitable with this study due to the sensitive nature of its topic. I believed the process under study to be a source of stigma for some and largely invisible. If the participants knew of my research interest, this could have motivated some to further conceal any issues they had for fear of being "outed".

Narrative analysis

Narrative research is increasingly popular in social sciences and looks at the role that language plays in society and in our interactions with each other. Narrative research uses oral or written materials and, through studying the individual's narrative, asks how stories are used to make sense of our world and accomplish social ends. By looking at cultural discourses, actions, core plots and sub-texts we can see how individuals position themselves in their "story" (Lieblich, Tuval-Maschiach et al. 1998; Andrews, Squire et al. 2008) (Riessman 2008).

These narratives offer a richness of explanation through examining "the social in combination with the psychological" (Spong 2010 p.72). However, Narrative Analysis doesn't aim to construct formal theories that move beyond individual cases (Silverman 2011).

Interpretative Phenomenological Analysis (IPA)

IPA follows a phenomenological approach, attempting to enter the personal world of the individual and to explore and describe how they make sense of experiences (Smith, Flowers et al. 2009). IPA seeks to gather rich data and conduct an in-depth, detailed interpretative analysis. The aim is to reproduce the unique individual perspective as far as possible. One of the advantages of taking this approach is that it can be used with small samples, or even a single case study (Smith, Jarman et al. 1997; Smith and Osborn 2008).

IPA is similar to Grounded Theory in its step-wise, iterative analysis. Emergent themes are identified from the data and organised into clusters or primary themes. By consistently referring to the data and allocating titles to themes, a table of themes is drawn up that is organised into the best hierarchy that can be achieved. Unlike Grounded Theory, any early themes that prove weak or unconnected to the final structure may be dropped. For my purposes, one of the strengths of Grounded Theory is its aim to not leave awkward or "rogue" data out of the final analysis thereby reducing the chance of potentially illuminating data being missed.

A colleague, who was using IPA for her own research, gave me the following metaphor. She likened analysing qualitative data to looking at a patch of soil (the data) and observing plants begin to sprout (themes and categories). In IPA, the tallest, strongest plants are highlighted in results and others thrown away like weeds. With GT, lesser seedlings that may be overshadowed are considered just as relevant (Kerr 2012). Thus IPA could describe 3 large, vibrant blooms whilst Grounded Theory would capture these plus the ground cover, lower level plants and soil characteristics, observing the diverse ecosystem with conflicting, symbiotic or parasitic relationships.

The researcher aims to understand what it is like from the individual's point of view and this is one of IPA's limitations. The researcher may have to interpret participants' emotional and mental state from what they say. In this process of immersion on separate case studies, even with a high level of reflexivity, there is a risk that a depth of meaning could be read into a phrase that doesn't actually exist. Because it's more interpretive in its choice of what data to focus on, the effect of the researcher's stance is greater within the analysis (Willig 2001).

IPA is descriptive so would describe the "what" rather than the "how". Its objective is to gain insight into thoughts and beliefs so as to understand the ways the individual views and experiences their world. This would fit well with my phenomenological approach. In IPA each interview is analysed as an individual case and the meanings attributed to phenomena by the individual are explored. Taking an IPA approach could therefore give me useful insights and gather rich, in-depth data. However, I wanted to find out the "how" and build more formal theory. This is not an explicit aim of IPA (Smith, Flowers et al. 2009) and, because my aim was to move beyond description, I discounted IPA.

Grounded Theory
The term Grounded Theory is used to describe a methodological approach as well as a method of data analysis. It means simply the discovery of theory from data (Glaser and Strauss 1967). It is an interpretive method that shares the common philosophy of phenomenology (Webb 1999; Strauss and Corbin 2008). Grounded Theory aims to produce knowledge of contextualised social processes (Willig 2001) and is *"especially helpful … in attempting to study complex areas of behavioural problems where salient variables have not been identified."* (Stern 1994 p.116).

Grounded Theory (GT) differs from other methodologies in that its aim is to develop theory from the data rather than to test hypotheses (Coolican 2004) and to discover processes rather than be merely descriptive (Stern 1994). With GT, the focus is shifted from the observed actions or words of the individual to looking at what the participants are telling me across the board, exploring and explaining the underlying essence or meaning (Silverman 2011).

An important characteristic of GT is that questions evolve during the process of data collection and therefore the stages of collection and analysis run at the same time (Glaser 1994; Glaser 1994). Theoretical sampling is used to *"flesh out the properties of a tentative category"* (Silverman 2011 p.71) and, in theory, this continues until theoretical saturation is achieved, i.e. no new information is being revealed.
"Core theoretical categories, those with the most explanatory power, should be saturated as completely as possible." (Glaser and Strauss 1967 p.70)

Grounded Theory was introduced in 1967 but ensuing rifts and debates about what it is have led to different perspectives on its use. I moved away from the positivistic leanings of GT and took a social constructivist approach where my analyses would not attempt to be simply an

objective reporting of a reality but would reflect my interpretations of it (Charmaz 2008; Charmaz 2011). My research aimed to find culturally useful theories that could be used to influence practice as encouraged by a post-modern perspective (Gergen 2001). The research could be considered a social justice inquiry as defined by its attendance to *"inequities and equality, barriers and access … and their implications for suffering."* (Charmaz 2011 p.359). Grounded theory is a useful method of analysis in such cases.

The social constructivist approach assumes that *"people create and maintain meaningful worlds through dialectical processes of conferring meaning on their realities and acting within them."* (Charmaz 2000b p.521). As the categories are constructed by the researcher and can never capture the complete essence of a concept in its entirety (Willig 2001), reflexivity and transparency at each stage are required. The researcher is a viewer who is part of what is viewed, interacting with the viewed to create the data and interpreting meaning through analysis of the data (Charmaz 2000b). With this research, I was attempting to capture both "the inside out" perspective (the subjective experience) and the "outside in" (identifying the processes) in order to *"capture the lived experience of participants and to explain its quality in terms of wider social processes and their consequences."* (Willig 2001 p.44)

With GT, there needs to be a balance between avoiding theoretical preconceptions and using theoretical sensitivity – described as having an open mind rather than an empty mind (Dey 1999). The researcher should be sufficiently theoretically sensitive (Glaser and Strauss 1967) and my own theoretical sensitivity came from being grounded in the academic literature as well as from my clinical experience (Strauss and Corbin 2008). However, my background knowledge could lead me to seeing what I expected to see and missing out on new insights. For this reason, prior to the interviews, I mapped out my initial thoughts and expectations (shown in Appendix 1). This helped me be aware of my pre-conceptions and demonstrated to me new insights coming through the data.

Data for Grounded Theory analysis may be collected from interview, observation or documents although semi-structured interviews are the most usual method. In the next section, I set out the rationale for choosing this approach.

3.1.3 Choosing a data collection method

This section is concerned with justifying my choice of method as appropriate for the research question and methodology. The section briefly considers alternative methods and reasons they were discounted.

Several methods of data collection would fit with my methodology, including focus groups, interviews and participant observation. Participant Observation was immediately ruled out for the same reasons that Ethnography had been, i.e. the issues of access, resources and the fact that it would not be possible to observe a hidden process.

Focus groups

Focus groups were developed by the sociologist Robert K Merton (1910 – 2003). Rather than a one to one interview, a group of people are asked for their perceptions and attitudes towards a phenomenon. In this interactive group setting, listening to others can stimulate thoughts and memories that may otherwise not be expressed (Lindlof and Taylor 2002). Focus groups have the added advantage of being a good use of limited resources and some research has shown that people may be more likely to disclose experiences where they feel they will be validated by others who have shared that experience (Tracy, Lutgen-Sandvik et al. 2006).

However, the opposite can be true, with group dynamics, peer pressure and social expectations impacting on the openness and honesty of a focus group. Extreme views may either be weeded out or, or if held by dominant participants, may take over. There is a lack of anonymity and confidentiality cannot be guaranteed (Robson 2000; Finch and Lewis 2003). Therefore, because I was researching a sensitive issue, with the added possibility of self-stigma in participants, I discounted this approach.

Interviews

Interviews are the usual method of data collection for Grounded Theorists and are in keeping with a phenomenological approach. The purpose of a semi-structured life world interview *"is to obtain descriptions of the lived world of the interviewees with respect to interpretations of the meaning of the described phenomena."* (Kvale 1996 p.30)

Historically, the interview has been a powerful method of producing knowledge that has changed our understanding of human behaviour, e.g. Freud's analytic theory and Paget's theory of child development (Kvale 1996).

Interviews provide a richness of data (Gillham 2004) and a depth of focus with opportunity to understand motivations and decisions and are therefore appropriate for researching very complex processes (Lewis 2009) providing a *"sufficiently sensitive and incisive grasp"* of interviewees' concerns (Banister, Burman et al. 1996 p.50). They are particularly appropriate where the research aims to provide insight and understanding into sensitive material (Gillham 2004).

Interviews provide structure with flexibility and through active facilitation and a depth of exploration and explanation, new knowledge is likely to be created (Legard, Keegan et al. 2003).

The researcher should aim to achieve a broad coverage of key issues, with deeper exploration of each. This "content mapping" and "content mining" is achieved through different questioning techniques (Legard, Keegan et al. 2003). Questions do not need to be asked in any particular order leaving the researcher the ability to be flexible.

However, it's not just about getting through a set of questions. It is also important that semi-structured interviews leave room for participants to voice the knowledge they have that researchers don't know about. The use of metaphors can also help access tacit knowledge that neither participant nor researcher know about by allowing them to bridge the *"conscious and the unconscious and … access that part of our self we are usually not aware of."* (West 2010 p.224).

Seemingly informal or throw-away comments can produce some of the most memorable information and produce valuable insights. (Coolican 2004). I imagine most therapists would concur with this in the counselling setting. The "hand on the door-handle" comments are often equally profound.

In the interview, the researcher is the main instrument for obtaining knowledge. According to the Constructivist research model, interviewers and interviewees are actively engaged in constructing knowledge (Legard, Keegan et al. 2003; Kvale 2009; Silverman 2011). The interviewer should be open and curious to the participant's experiences as a traveller crossing new territories. Kvale uses his traveller metaphor to describe how the *"potentialities of meanings in the original stories are differentiated and unfolded through the traveller's interpretations in the narratives he or she brings back to home audiences."* (Kvale 2009 p.19-20)

Although usually it is suggested that the researcher approaches the interview with *"a deliberate naïveté as expression of phenomenological reduction,"* (Kvale 2009 p.55), this needs to be adapted for interviews with "elites". Elites, in this context, are defined by Gillham (2004) as people in powerful positions, where the usual researcher – participant power asymmetry may be cancelled out. In order to engage them, the researcher must give something back by becoming an interesting conversation partner. The researcher must demonstrate expertise and gain respect and requires a firm grasp of the subject matter in order to obtain access to privileged information. A *"substantial familiarity with the theme and context of the enquiry is a precondition for the expert use of the interview method."* (Kvale 2009 p.108). This definition appeared appropriate to my participant group. The media and public have a fascination for the uniformed services and these insular cultures generally guard their privacy. My background of working within the police service could help me not only to source participants but to have this "substantial familiarity" to obtain access to the information I was seeking.

Interviews provide a means of hidden agendas being fulfilled. A consideration is why people choose to participate in research. Whose purposes are being pursued? In interviewing an elite group, I needed to be comfortable with role shifts and changes during the interviews. I could expect to be quizzed, "placed" according to who I know or asked for information to establish my credibility. As a therapist, this was less daunting and I could use my existing skills to manage the situation.

However, there are limitations to interviews. Interviews have been criticised as subjective and biased, not inter-subjective or generalisable and focusing too much on thoughts and experience ignoring actions and emotions (Kvale 1996; Kvale 2009). The interview, like any other social transaction, may be anxiety provoking for both interviewee and researcher (Kvale and Brinkmann 2009). Social desirability can lead to participants masking prejudiced behaviour and attitudes. From my own experience, there is a real fear in the police service of inadvertantly breaching equal opportunities regulations through comments that may be interpreted as offensive. This could result in disciplinary action and the potential loss of their job and my impression was that many officers felt it difficult to keep up with the latest guidelines. The term being *"politically incorrect"* was regularly used by them in interviews and was associated with negative feelings of having to watch their language and behavior in a way that was restrictive to the job whilst not always being clear on what the latest rules were. I remember a time when I was training within the police service and was advised I could no longer use the term "brainstorming" for an activity as it was deemed disrespectful to people who had epilepsy. I was left wondering what else I was inadvertently saying that could land me in hot water despite having no intention of offending anyone. This watchfulness is ingrained and could have led to participants censoring their real views around mental health if they felt they were socially unacceptable. Sochan and Singh (2007) refer to the "Told Story" as that which participants feel comfortable and safe in sharing. The "Untold Story" is the interviewer's reading between the lines and, in the pilot study (described in 3.2.1 and more fully in appendix 3), my instinct was that participant 01 held stronger views about those with mental health problems than he expressed. It is important to repeatedly give permission to participants for honesty and open views.

My choice of interviews as a data collection method and my questions could both be considered a risk to validity. On the one hand, leading questions may reduce validity but could conversely by used to test the reliability of responses and any interpretations being made during the interview. Interviews do not tell us directly about a person's experience but about their "indirect representations" of that experience (Silverman 2011). Even the transcripts can be seen as conversations without context and therefore *"an impoverished basis for interpretation"* (Kvale and Brinkmann 2009 p.167).

With interviews, it is important that the researcher is competent. The more unstructured the interview, the more the influence of the researcher comes into play. This can create distortions as can poor interviewing skills (Coolican 2004). I had hoped to use my therapist's skills to build rapport and engage participants whilst avoid turning the encounter into therapy.

Finally, interviewing is *"time-consuming, absorbing and suited to study with only a restricted number of interviews in order to keep the transcription and analysis of material manageable, and to do justice to the material generated."* (Banister, Burman et al. 1996 p.68). Time costs include developing questions, piloting the process, transcribing and analysing (Gillham 2004)

and this will inevitably influence the number of interviews that can be achieved. I had to consider quality (having the time to properly analyse) versus quantity and had aimed for between 10 and 20 participants bearing in mind the law of diminishing return. McLeod (2011) and West (2013) among others advocate between 8 and 20 for grounded theory. In the end I interviewed 11 participants and the next section describes their recruitment and interviews.

3.2 Data Collection

3.2.1 Pilot study

This section sets out how I recruited my participants and organised and conducted my data collection. A pilot study was done as recommended by West (2013) in order to test the appropriateness and practicability of my research design and whether any further ethical issues were raised. The pilot study consisted of two semi-structured interviews with police officers who had both served in the military. They were recruited through a mutual contact in the police Federation and volunteered to be interviewed after receiving information (Appendix 4) about the research. Participant 01, ex-Royal Navy, had never accessed mental health services despite having had what he described as "stress." Participant 02, also ex-Royal Navy, had been diagnosed with combat-related PTSD and had accessed mental health services during his police service.

My original research question asked: **How does the identity of a police officer with a military background affect that individual's help-seeking behaviour?** However, if I was going to explore issues of identity, the pilot immediately threw up questions such as was identity affected by type of military service (e.g. Army, Navy)? What did I mean by identity? In determining whether to concentrate on a psychosocial theory of identity (Erikson 1968), social identity theory (Turner and Brown 1978) or social constructionist theory, the research question started to seem unwieldy and too large a scope for this study. In discussion with my supervisor, the research question was refined to

How do the attitudes of police officers with a military background affect the help-seeking process for mental health problems?

The pilot study was an opportunity to test my choice of methodology and method. The semi-structured interviews worked well. The hour long interview gave sufficient time to delve into the topic and allowed thoughts to be expressed and reflected on without rushing sensitive stories. Both participants were very forthcoming and interested in the subject providing the rich data I was hoping for. They were able to articulate their opinions but I learnt that it was also important to give explicit permission to be honest (as described in 3.1.3).

No ethical issues surfaced but I gained useful insight into how my own professional identity could not be "left outside the door" and that I needed to be very aware of how it played out in the session. One way in which my professional identity could affect the interview was when hearing of participants' views and experiences of my profession. At times I felt ashamed and

even angry and had to resist urges to comment or defend myself as different. As a therapist, I often hear from clients who have had earlier, bad experiences, but in that role, I am in a position to redress things. As a researcher I couldn't intervene or change that opinion in any way.

Secondly, neither participant saw therapy as effective or that it was possible for someone to have PTSD and make a full recovery from it. As a trauma therapist, I am aware that PTSD is treatable and it is important to inspire hope at the outset of treatment. Many individuals even experience Post Traumatic Growth and feel stronger for the experience (Linley and Joseph 2004; Tedeschi and Calhoun 2004; Linley and Joseph 2009). This posed a moral dilemma for me. If participants held potentially damaging beliefs around the treatment of PTSD, did I have a responsibility to address that or not? After all, I was acting as a researcher not a therapist. In an attempt to deal with this, I decided to include a copy of the National Institute for Clinical Excellence's guidelines for the treatment of PTSD in the information pack I offered to participants where appropriate. This is a leaflet that is freely available from the internet and clearly sets out best practice. By providing clear, impartial education that participants could choose whether to read or not, I felt I had done all I could ethically.

Delving further into the topic made me sensitive to the underlying emotions and strengths of beliefs around this subject. The "mental toughness" of this population didn't sit comfortably with having mental health problems and this was interpreted as a weakness. The process of seeking care was fraught with emotions such as denial, fear and anger. Accessing support proved a reality check and impacted greatly on self-esteem. Reaction to being in this position was extreme and demonstrated the level of emotion associated with being labeled. This confirmed my initial instinct and motivation for undertaking this study thereby spurring me on in progressing my research.

Appendix 3 sets out more fully what I learned about the topic and the research design as well as my personal reflections on the process. It confirmed that that the design was appropriate and realistic and that I could proceed with the main research.

3.2.2 Recruitment

Having worked with the uniformed services for some considerable time, I am fortunate in having a range of internal contacts including Federation representatives and health and welfare personnel from several police services. I used these contacts to circulate details of my research. Appendix 4 shows the information that was sent for circulation. By using a third party there could be no perceived pressure to participate. Interested parties were then asked to contact me directly via email or phone and I issued Appendix 5 Informed Consent. I gave the opportunity to ask any questions and advised potential participants, should they wish to proceed, to sign and return the consent form and contact me again to arrange a time for the interview. The time frame between first contact and arranging the interview could be several weeks due to participants' work demands and this ensured a further cooling off period.

All participants were male, had served in the military and were currently serving police officers. When recruiting for research, the researcher should consider who best exemplifies the range of perspectives relevant to the research question. Because I see the phenomenon under study as a process along a timeline, I hoped for roughly equal numbers of those who have accessed mental health services and those who haven't / wouldn't. My intention was that this may give an insight into attitudes as different stages on the continuum. I didn't seek to interview solely male participants but no female participants came forward. This is unsurprising given the gender representation in both settings (particularly the military) and raises issues for generalisability as discussed in 3.4.2 and 5.5.1.

An overview of the ranges of age at interview, age enlisted, length and type of military service is shown in figure 3.1next.

Figure 3.1: Description of participants

Age range at interview	39 – 50
Age range on enlistment in Armed Forces	16 – 20
Length of service	2.5 – 26.5
Type of military service (as identified by participants)	Royal Navy (2) RAF (2) Army (5) Royal Marines (1) Royal Marines Commandos (1)

3.2.3 The interviews

As this was a semi-structured interview, I prepared interview questions based around my research themes. The schedule is shown in Appendix 6 but this was meant as a framework only to facilitate talking as I would be using my skills to encourage less structured, free-flowing conversation.

At the start of each interview I briefed the participant by reminding them of the purpose of the research, the use of a recording device and checking for any questions and that they were comfortable to proceed. There was some jocularity about taped interviews and their police equivalent but participants were confident and comfortable with this. I also again drew their attention to anonymity and the use of the data as set out in the research information and consent form.

Interviews were recorded on a digital recorder to optimise quality and to minimise technical problems such as running out of tape.

Around half of the interviews were conducted face to face but some were telephone conversations due to participants' location. It was interesting that the data from telephone interviews was just as rich as that from face to face. In my professional role, I sometimes use the telephone for clinical supervision and therapeutic work and so am practiced in building rapport and intimacy during such calls. The disadvantage of the telephone interviews was that I lost any non-verbal communication and expressions. However, when dealing with sensitive subjects (particularly if you are concerned about being judged), they can seem less threatening and the added anonymity may have lead to more honesty.

Although I didn't perceive the change in method to have made a difference to the data, I did wonder about its effects on their initial judgment of me. As I reflect on in my final reflexive statement, I hold the position of bridging the police world with the therapy world and can be perceived as more or less "other". Would there be a difference between how I was seen and how I was heard? Visually I can, and will, manipulate my image to suit the in-group through smart, more formal attire and assertive, confident body language. A firm handshake and good eye contact can give an impression that I am not the stereotypical "pink and fluffy" (see page 175) therapist. However, I don't have this option available for a telephone interview. On reflection, with the telephone interviews, there was more general discussion around mental health and the police service and I suspect this was their way of testing me out. By engaging me in conversations about who I knew, my understanding of trauma in the police and the historical aspects of military trauma, they could check I was credible and understood their world. As emphasized in the literature (Gillham 2004; Kvale 2009; Kvale and Brinkmann 2009), this credibility and knowledge of their world was important in allowing me access into their thoughts and experiences.

Interviews lasted between 45 and 70 minutes with most around 60 minutes. This time was needed to explore the issues in order to get in-depth inner knowledge and to reflect on the sensitive subject matter. However, for me, there was a stark contrast between the broad brush-strokes of research data and the rich depth of therapy. As a therapist I am used to working longer term with people and delving even deeper into subjects. Although the research data was rich, in comparison with a therapeutic session, I felt a little as though I was missing this depth and initially wondered whether I was asking the right questions. This was part of my process of coming to terms with the difference between being a researcher and a practitioner and recognising the research interview as a momentary encounter.

Once I had completed my questions and the participant had had sufficient opportunity to talk about any additional material, the interview was closed with a debriefing. Many participants thanked me for the opportunity to take part and validated this as a much-needed piece of

research. Many said they had enjoyed the encounter. I reminded them of anonymity, outlined next steps and normalised the fact that they may be slightly preoccupied with the subject for a while and that this was nothing to be worried about. We talked about sources of support they could access if they were concerned that it had raised issues. Finally I arranged to send them the transcription and my initial thoughts and interpretations emphasising that they could correct me on any matters.

The interviews were transcribed and returned to participants within 2 months along with my initial thoughts and interpretations. Getting the reactions of the participants to my interpretation was important and gave them the opportunity to disagree, add detail or clarify therefore adding to the credibility of the analysis (Banister, Burman et al. 1996). Participants' responses varied from a simple confirmation that all was correct to some quite lengthy additional material. These are shown in Appendix 7 and this was added to the data for analysis.

As the data collection was running concurrently with analysis, the interviews took place over 28 months.

3.3 Data analysis

As stated previously, the term Grounded Theory is used to describe a methodological approach as well as a method of data analysis. Detailed descriptions of Grounded Theory analysis are given in several books and articles (Glaser and Strauss 1967; Glaser 1994; Stern 1994; Wertz, Charmaz et al. 2011). This section offers an example of a worked piece of data shown in figure 3.2 below to illustrate the stages of the data analysis as set out in 3.3.1 to 3.3.6.

Figure 3.2: Text sample (taken from interview 09):

When you were in there, did you ever come across any people who had any issues with mental health or was it referred to at any point?

No. Never. I mean at the point, back in '96, we'd just come out of the first Gulf war. Erm, we had a few inputs on it but there was never any reference to anything, and as you could imagine, officers training, one of the sort of the key things is about your staff and your team and looking after your team, and it was never mentioned. At all. Never referred to. They didn't even mention things like Gulf war syndrome on the sickness side of things, but it never came up in the... and that was even after the Americans had done all the work in Vietnam and stuff.

That's quite surprising really, isn't it, yeah I would imagine as an officer that they would give you that input.

Nothing at all.

Did it surprise you at the time, or did you not really notice?

Erm, no I didn't notice because I wasn't aware of it, but it's just brought something back to my head that when I was there, one of the drivers who was part of a, just one of the regiments that were attached there, obviously doing various bits and pieces for them, he was a corporal or a sergeant but he actually hung himself, and I was at the time, because I was obviously restricted working in the admin office*, it was kind of wildfire going around there, they were attached to us. It was, it wasn't something that was mocked, no it was actually, there was a few jokes went around, erm... but it wasn't something that was referred to, nobody ever said why. It was never questioned as to why he'd done it, I don't even remember them saying that his missus had had an affair or anything, there was nothing, he'd just topped himself and then say the jokes were about, some sick ones and I think it was... I can't remember, there was allsorts going around. But it wasn't referred to that he had issues, I don't know if he'd been in a war, and I'd imagine because he was logistics corps so I'd imagine that he would have been, Signals he was actually so he'd have been in, probably in Bosnia and places like that but it was never referred to ever.

Right, and that kind of humour that you get afterwards, you know, sort of the black humour isn't it.

Yeah.

Was it similar to the black humour that you get in the job now?

Yes. Yeah.

And even after that, no reference to mental health?

No, not at all.

No right, it's interesting.

Yeah I've never had any, all my knowledge from mental health has come from police inputs, never in the army.

And what kind of inputs have they been?

Through various roles in the basic training we sort of had a little bit of an input on some issues, because obviously you need the powers to deal with people and mental health. I was a custody sergeant for a few years and we'd deal with a lot of mental health patients or people coming in so we needed a broader understanding and I kind of always had an issue, this was before I was diagnosed, I had an issue with us looking after people who were mentally ill in police cells and it's a national concern but because of that I kind of, I wasn't a champion but I just kind of got on my soap box with various people, but I did learn a bit more, quite a bit more from it about mental health across the board.

So this was more about the general public?

Yeah, yeah that wasn't, and obviously since I was diagnosed I've sort of gone headlong into it and I'm very, very sort of, well not knowledgeable but I'm sort of reading up on it more and more and getting involved with parts of the organisation.

this was due to a physical injury

3.3.1 Stage 1: Familiarisation with the data

Stage 1 is the researcher's familiarization with the data and initial interpretations. This started during the preparation of the transcript when I made additional notes to capture my experience and memory of the interview. I transcribed the interview myself giving me my first real opportunity to get into the detail of the data. Whereas in the interview, my awareness had been divided between listening to participants and managing the interview process, now by concentrating on each sentence or phrase I was being drawn deeper into the data. The transcription was time-intensive and required listening, and re-listening, to small segments of data at a time. Using headphones and a digital recorder immersed me in the experience and a good quality of sound enabled tone and inflection to be experienced. I read the resulting transcripts several times over the following days with the idea that taking a more leisurely approach to analysis would allow more insights to arise. During these post-interview days, I used a notebook to record my initial interpretations using embodied categorizing, *"an approach to interpretation in which subjectivity is drawn on productively"* (Rennie and Fergus 2006 p.494).

In this phase I drew upon my professional background as a psychotherapist, looking at themes and trying to pick up on the feelings being described as the story was told. I was trying to step into the shoes of the individual. This could be helpful but was also potentially misleading as I was making assumptions and my own stance could get in the way. It was vital that participants therefore had the opportunity to clarify or correct my interpretations. I was keen to ensure I was accurately reflecting their views. I therefore shared these reflections with them, along with the transcription of their interview. Figure 3.3 shows the interpretations sent in respect to the piece of text in Figure 3.2. At this point, they also had the opportunity to add any further views that they had on reflection. Appendix 7 shows the feedback received from participants.

Figure 3.3: Initial interpretations to participant

Mental health issues seemed not to be on the official agenda at all during your time in the military despite being publicised in the media.

Even following the hanging, nothing was spoken about / changed. In essence people just went on as normal. I contrast this in my own mind with how some cultures would strongly react (even back then) with enquiries, panic about litigation, training and awareness-raising activities.

Mental health training in the police service focused on issues external to the force (i.e. members of the public) and how it relates to the job rather than within the force and how the job can cause issues.

It often seems to be the officers who have suffered reactions who are left to champion the cause and take the initiative rather than it coming down from above?

The consequences of mental health, in all the examples you gave (and your own "complete meltdown"), were serious.

3.3.2 Stage 2: Open coding

In stage 2 of the conventional approach to GT, the data is examined line by line and each incident is coded into as many categories as possible. Although if I had been strictly following the embodied categorising approach (Rennie and Fergus 2006), I would not have needed to do this, I felt that this way I may glean more from the data. These codes were created through my own constructions and the language used by the participants. At this stage, the researcher should be asking, *"What is going on? What are people doing? What is the person saying? What do these actions and statements take for granted? How do structure and content serve to support, maintain, impede or change these actions and statements?"* (Smith 2003 p.94)

Charmaz (2000, 2011) advises using active codes to *"give us insight into what people are doing, what is happening in the setting"* (Charmaz 2000b p.515) thereby revealing the process and preserving what is experienced by the participant.

This line by line, paragraph by paragraph, analysis of the text resulted in a deep familiarity with the data. I varied between reading a paper copy of the transcription as well as an electronic copy as I found I saw different things. Codes were used to identify passages of texts that were interpreted as having a particular meaning. I tried to condense the data into a meaningful word or sentence that reflected the context of the interview and the research question. My initial coding was based on common sense, professional experience and the language and emotional emphasis used by the interviewee (Figure 3.4).

Figure 3.4: Open coding
Encountering mental health issues
Lacking formal input / steer on mental health
Recognising responsibility for looking after team
Not being trained to manage mental health problems
Being unaware of mental health issues (blind spot?)
Reflecting on past experience of mental health in peers
Hearing about mental health issues through informal networks
Recognising the existence of mental health within peer group
Hearing others' reactions to mental illness consequences
Hearing the consequences of mental illness
Responding with "black humour"
Attributing cause
Not referring to a death
Brushing things aside
Considering combat as a causal factor
Police training on mental health as part of role
Being trained in mental health issues in others "out there"
Needing to understand mental health issues
Having power to deal with mental health issues
Dealing with mental health patients in role
Locking up mental health patients
Having an issue with systems for mental health care
Raising awareness of issues
Being on a soapbox
Making changes
Challenging practice

Getting involved in mental health arena
Learning about mental health (self-directed)
Becoming knowledgeable – know your enemy?

Some codes were attributed as they were a succinct description of the actual text, for example "hearing others' reactions to mental illness consequences" and "lacking formal input / steer on mental health". Other codes were important as they potentially reflected attitudes to mental health. These included using "responding with black humour" and "attributing cause".

When coding, one difficulty can be in selecting suitable meaning units. A too-broad meaning unit may contain various meanings, for example the following extract could alternately be coded under "formal education provision," "use of authority," "police interface with mental health," "having an opinion on the management of mentally ill people" or "learning about mental health":

"Through various roles in the basic training we sort of had a little bit of an input on some issues, because obviously you need the powers to deal with people and mental health. I was a custody sergeant for a few years and we'd deal with a lot of mental health patients or people coming in so we needed a broader understanding and I kind of always had an issue, this was before I was diagnosed, I had an issue with us looking after people who were mentally ill in police cells and it's a national concern but because of that I kind of, I wasn't a champion but I just kind of got on my soap box with various people, but I did learn a bit more, quite a bit more from it about mental health across the board."

Conversely, coding too narrowly, for example a word or phrase, "a national concern," "got on my soapbox" could lose the meaning of the piece of text.

3.3.3 Stage 3: Clustering the codes

In stage 3 the objective is to cluster the codes and define the categories. A constant comparison was made between incidents and the theoretical properties of each category started to become apparent (Glaser 1994). Categories must come from the data rather than forcing the data into preconceived categories (Charmaz 2000b). I used a software programme NVIVO to capture the codes and begin to organise them into clusters. This process involved a lot of mind mapping and memo-writing as there seemed many ways of categorizing the data. Memos were used to capture any thoughts that arose when I was away from the data. This could be initial impressions and questions arising and anything else that came into consciousness (often when I was occupied on something else). I could then feed this into my subsequent interviews. Memos were used throughout the whole research process to elaborate on ideas about the data and categories. They *"represent the development of codes (and connect) the barebones analytic framework that coding provides with the polished ideas developed in the finished draft."* (Charmaz 1994 p.106)

Figure 3.5 shows an example of the memos written relevant to the example text in 3.2.

Figure 3.5: Example of a memo

Even after significant events (Gulf War, hanging) there seems to be a collective denial of anything to do with mental health
It's almost as though it's just not on the radar

Even when it's publicised in other forces, e.g. US, it's as though people are blind to the concept
What is the difference between being blind / not having awareness / being in denial?
Could there be reasons, e.g. protective, other agendas, behind such collective denial? Does it achieve anything?

Interviewee recognised the need to look after team but what does this actually mean? It's like a huge blind spot
Attributing cause – combat or relationship issues appear to be viewed (understandable? Can relate to self?) as potential causes

Using humour – is this a coping strategy / defence / distancing technique? Or simply a lack of empathy towards a comrade – this seems at odds with camaraderie? Is he not viewed as a comrade / one of "them"?

Nothing changed even after a death, unspoken, in essence get on with things; contrast to civilian health and safety / litigation (fear-based or intended to protect against recurrence). Is there nothing to fear? No need to prevent?

Finding personal relevance and educating self / getting involved

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The more I looked at the data, it seemed the more I worried about getting the right interpretation. The sheer masses of data and categories could be overwhelming.
Each time I attempted to categorise the codes, it seemed that there were several that fitted in more than one category. This meant I had to be very clear on my meaning of a code and cluster in more than one category as the categories were refined and defined. Figure 3.6 shows my initial categorisation of the codes from figure 3.4

Figure 3.6: Initial categorisation of codes

Denial (organisational / individual)
Lacking formal input / steer on mental health

Not being trained to manage mental health problems

Being unaware of mental health issues (blind spot?)

Not referring to a death

Brushing things aside

Becoming aware of MH issues

Recognising the existence of mental health issues within peer group

Hearing the consequences of mental illness

Encountering mental health issues

Reflecting on past experience of mental health in peers

Hearing about mental health issues through informal networks

Attitudes towards those with mental illness

Recognising responsibility for looking after team

Hearing others' reactions to mental illness consequences

Hearing about MH issues through informal networks

Responding with "black humour"

Attributing cause

Considering combat as a causal factor

Having an issue with systems for mental health care

The police interface with mental health

Police training on mental health as part of role

Being trained in mental health issues in others "out there"

Needing to understand mental health issues

Having power to deal with mental health issues

Dealing with mental health patients in role

Locking up mental health patients

Changing attitudes (own and others)

Raising awareness of issues

Being on a soapbox

Making changes

Challenging practice

Getting involved in mental health arena

Learning about mental health (self-directed)

Becoming knowledgeable – know your enemy

3.3.4 Stage 4: Refining and defining the categories

In this stage, the researcher considers inter-category relationships (e.g. the conditions that maximise or minimise the dimensions of a category and the consequences of its properties) and generates a tentative conceptual framework. Having spent many hours scrutinizing the fine detail and producing many hundreds of codes, I felt I could simply end up with a list of factors that was somehow removed from the data. I made the decision to step back from NVIVO and re-immersed myself in the interview recordings and transcription. I felt I had a good understanding of the detail but now wanted to regain a "feel" for the data. I think I was sub-consciously moving from what had become a positivist analysis back to embodied categorisation. I spent many more hours brain-storming and mind-mapping the emerging thoughts reflecting on my earlier memos and interpretations and going back and forth between these and the data. A whiteboard was crucial in this instance by providing a visual and flexible representation of the masses of data. The process diagrams shown in figures 4.1 and 4.9 in the findings section of this thesis were a result of such mapping and led to the resulting categories also shown in part 4.

3.3.5 Stage 5: Delimiting the theory

By now, there will generally be a mass of categories and reduction is used as an inductive process to deal with an overwhelming number of categories. This is described as delimiting the theory. Each category was compared with others to look for clusters and connections with theoretical properties to develop a higher order category. The theory, as outlined in part 5, now begins to solidify resulting in fewer major modifications.

Theoretical sampling continues in efforts to support or disprove the conceptual framework and fill any conceptual holes. In my research, this was limited to refining the interview questions. When no new information is being received that explains that particular aspect of the conceptualised theory, theoretical saturation can be said to have been achieved.

3.3.6 Stage 6: Writing the theory

At this stage, the theory is written. The researcher has coded data, a series of memos and a theory that is backed by two sources - the memos provide the content behind the categories (themes) and the coded data provides illustrations to validate the theory.

The data can be thought of as passing through a funnel from an input of masses of information to a central theme for closer scrutiny. The purpose of the data analysis in this research was to build theory that is faithful to, and illuminates, the area under investigation. The theory was generated by the observations rather than being decided before the study so Grounded Theory fitted with my overall aim and epistemological stance. The constructivist form of GT does not aim to capture a single reality but, in a phenomenological manner, to create an image of the multiple viewpoints within multiple realities (Charmaz 2000b).

3.4 Ethics and Critical Review

Throughout this chapter, it is clear that researching such sensitive issues in a challenging context could pose ethical dilemmas. This is a sensitive topic as it intrudes into a very private and personal experience that is potentially emotionally charged. This next section sets out my risk assessment of ethical implications as well as a consideration of the potential benefits for participants. It moves on to provide a critical review of the robustness of my research design.

3.4.1 Ethical considerations

The Committee on the Ethics of Research on Human Beings at the University of Manchester reviewed and approved this study.

This research involves human participants and ethical considerations were addressed in line with the British Association for Counselling & Psychotherapy's Ethical Framework for Good Practice in Counselling & Psychotherapy (BACP 2010). Research should be undertaken with rigorous attention to quality and integrity and must not adversely affect clients. As such, the following measures were taken:

a) Volunteer participants were recruited via third party advertising through contacts in the police federation. Written information was sent to those who expressed an interest with an invitation to respond if still interested. A further "cooling off period" naturally occurred when the interview date was set. This minimised any perceived pressure to assist with the research.

b) Consent: Participants were fully informed of the aims and nature of the research and were free to withdraw at any stage of the research (up to submission of the thesis). They were made aware that quotes from the interview would form part of the final report on the research and any related published reports but that these would be anonymised. An informed consent form was used that set out the aims and nature of the research, confidentiality and right to withdraw. The information sheet and informed consent form for participants are shown in Appendices 4 and 5 respectively.

c) Deception: No deception was involved

d) Data Protection: Participants were numbered by the researcher and their personal details did not appear on any forms or paperwork. The identity of the participants remains confidential and was not linked to the data collection. All data would be used solely for the purposes of the project.

e) Risks and protection from harm

- Participants: There was a risk that discussing mental health issues or recalling the experience of accessing support could have raised issues for participants. This was minimised by advising participants of the areas I would be asking about, advising them of this risk and reminding them of their right to withdraw. They were offered an individual session with a trauma psychotherapist to address any such issues after the

interview. Although risks were minimised, the researcher accepted that they still existed but that the potential benefits of the research warranted the means.

- Researcher: Although the focus of the interviews was not on traumatic events, it was possible that the researcher would be exposed to such accounts. This had the potential to cause secondary trauma in the researcher. This risk was minimised by the researcher's knowledge of secondary trauma and workplace control measures such as access to clinical supervision, peer support and individual counselling. A further potential risk was that of researcher safety when conducting interviews with individuals. The researcher's employer had clear guidelines on managing this risk. Face to face interviews were held in the company offices where other members of staff were in adjacent offices. If interviews had been requested away from the office, safe visiting protocols would have been followed. The researcher had undertaken training in risk and conflict management.

- The wider population: According to the British Association for Counselling and Psychotherapy, as part of its ethical obligation, research should inform and develop practice but the potential benefits to the wider community needed to be weighed against the risks of research findings being politicised. This research aims to improve the service provision for uniformed services personnel suffering from PTSD and therefore is part of the BACP research commitment. However, this subject is an emotive one for the public and therefore of interest to the media, government and the uniformed services themselves. Renzetti and Lee (1993) suggest that this is a risk to consider at the design stage and on publication. Participants should be aware of the intention to publish findings as part of their informed consent, giving them opportunity to self-censor if need be. At the publishing stage, careful use of prose, restricting publicity to the academic domains and care in any dealings with journalists post-publication is required.

f) Debriefing: Participants were fully debriefed by advising them of the nature of the research, thanking them for their help and asking for any questions or comments they may have had regarding their experience.

g) Participants were provided with the preliminary analysis within 2 months of the interview and offered the opportunity to comment on this and raise any issues that have come up in the interim. As well as providing useful feedback, and ensuring they had an active, empowered stake in the research, this was an additional safeguard and participants could have been signposted to further support if required.

Although the research did not pose any ethical dilemmas, it did raise some moral and personal ones for me as researcher and I cover these in my final reflexive statement in part 5.5.3.

3.4.2 Critical review of the research design

This next section examines the robustness of my research design and how credible my findings were likely to be. The chosen methodological approach is often criticised as being less scientific by those from a positivistic approach and there is global debate concerning how to address this

(Adams St Pierre 2011; Denzin 2011). There has been a move towards evaluation through standards and checklists (e.g. Cabinet Office 2003; Attree and Milton 2006) but Torrance (2011 p.573) cautions that this *"can lead to absurdity rather than serious synthesis as the complexity of qualitative work is rendered into an amenable form for instant appraisal."*

The central concepts in determining the credibility of quantitative research are validity, reliability, objectivity and generalisability (Robson 2011). Many researchers have distanced themselves from the positivist paradigm by using alternative terminology. Guba (1981) proposed four criteria to establish "trustworthiness" in qualitative research, shown below with their positivist equivalent :

a) Credibility (validity)
b) Dependability (reliability)
c) Transferability (generalisability)
d) Confirmability (objectivity)

However, even here there is disagreement within the qualitative camp. The concept of trustworthiness is interpreted as calling into question the moral character of qualitative researchers as this term is not generally applied to quantitative research.
"Untrustworthy persons lie, misrepresent, cheat, engage in fraud, or alter documents. They are not governed by measurement and statistical procedures that are objective and free of bias."
(Denzin 2011 p.651).

I have chosen to use the terms validity and reliability when evaluating my research design.

Validity
The validity of a design refers to the *"degree to which what is observed or measured is the same as what was purported to be observed or measured"* (Robson 2000 p.553). With the absence of standardised measurement tools, a qualitative study could be criticised as not being scientific or objective. I wanted to ensure I was accurately representing the phenomenon I was studying and, according to Silverman (2011), the main risks to the validity of a qualitative study are the values and stance of the researcher and the willingness or ability of participants to be open and congruent with their true thoughts and feelings.

As stated earlier, the chosen methodology acknowledges that findings are inevitably influenced by the researcher's perspective and does not claim objectivity but, through reflexivity, makes my views and stance explicit. I considered first my own values and identity as the researcher. Social constructionist GT acknowledges that the researcher shapes the research process, from the questions being asked and the use of method to their own unique personal and professional background. This will ultimately shape the findings and therefore *"the theory produced constitutes one particular reading of the data rather than the whole truth about the data."* (Willig 2001 p.44). By being highly reflexive and transparent about my initial expectations, I could

minimise the impact of my own values and stance, whilst recognising that this is an issue for all research regardless of methodological stance. This risk of "going native" (Fontana and Frey 2000) and seeing everything from the subject's perspective rather than having a professional distance could stop me asking difficult questions or seeing the wider picture. Interestingly, I often heard this term used by senior managers to describe police welfare officers who were thought to have only the officers' interests at heart and who were deemed to be "emotionally involved." They were deemed to have become advocates and no longer "professional."

I sent participants my initial reflections and interpretations. I wanted to portray their voice not mine and it would be important for the process of analysis to demonstrate how my interpretation of the data was reached. Interpretations should emerge from the data rather than making the data fit my preconceptions. To build validity, it was important for me to seek alternative explanations rather than jumping to conclusions when analysing my data. Using a constant comparative method such as GT was useful here. It required me to always search for instances to test out or refute the emerging theory and actively seek out anomalies or deviant cases (Lewis and Ritchie 2003; Silverman 2005).

As mentioned in the previous section, participants may feel guarded and less able to express views that they perceive are unacceptable so I needed to explicitly give permission for this and emphasise that I was seeking their views "no matter what they are" and that all views were valid. By reassuring that I was seeking to capture their individual voice, and by using my therapeutic skills to build rapport, I had hoped that during this one-off encounter I could build sufficient trust to gain meaningful data. My skills as a therapist were transferable here and I was able to use them to explore and clarify what I was being told but more importantly to use my therapeutic instinct and empathy to recognise emotionally laden content even when this was implicit rather than overt. The fact that I was familiar with police and military terminology meant that this was not a distraction from the underlying message and I could see beyond the (often very interesting) facts of events and "feel" the process.

Reliability

Reliability refers to how consistent the results are. For quantitative research this would be achieved if the results were replicable using different researchers or instruments of measurement. Qualitative research can satisfy reliability by having a transparent process. This required me to provide a sufficiently detailed description of my research and data analysis and to be explicit about the theoretical stance from which I was making my interpretations (Silverman 2011). For transparency, I created an audit trail comprising journal notes, transcripts with details of my coding and analysis. Audio-taping provides a valid description of what was said in interviews, rather than relying on notes. The tape transcripts were sent to participants for them to read and check through. One word, added or misheard, could change the emphasis or meaning of a sentence. Recording the interviews and carefully transcribing them myself added

to the reliability as did using extracts of my data in the final report. This latter action should demonstrate that my interpretation is well supported by the evidence (Lewis and Ritchie 2003).

To further increase the credibility of my research design I could have used triangulation of methods, data or theory. As *"all methods have their limitations, their own validity threats and distortions"* (Banister, Burman et al. 1996 p.147), a pluralistic approach could have removed some of the concerns around a qualitative approach. Data triangulation – getting accounts from other people positioned differently within the context – would allow for *"considerable extension and depth of description"* (Banister, Burman et al. 1996 p.146). I could have interviewed mental health professionals or managers for instance. I felt that both these would have been detrimental due to the scope and constraints of the study meaning I didn't do justice to the research. However, triangulating theory (looking at the issue from different theoretical perspectives) is encouraged in Grounded Theory and forms part of my literature review and analysis.

Generalisability

Due to the smaller numbers generally involved in qualitative studies, another criticism is that findings cannot be generalised. There are three ways in which research findings can be generalised. Generalisations can be representational (can I generalise to the same population?), empirical (can I apply findings to a wider populations or settings?) and theory-building (can I develop the wider theory?) (Lewis and Ritchie 2003). Willig (2001) suggests it's not about seeing what people have in common but about seeing what experiences are available within a culture or group. Findings need to be ecologically valid, in other words fitting the real world, so that they can be generalised. The aim of this research was to achieve an interpretive understanding rather than to generalize and potentially erase "difference and obscure variation" (Charmaz 2011 p.366). The issue of generalisability or transferability of the findings is considered in part 5.5.1.

This concludes part 3, where I have set out my epistemological stance, choice of methodology and method for data collection and analysis. In this part, I described the ethical implications of the research, conducted a critical review of the research design and explained how I collected my data. Part 4 now goes on to present my findings.

Part 4: Findings

Introduction

Here in part 4, the findings from the interviews are presented in relation to the research question ***How do the attitudes of police officers with a military background affect the help-seeking process for mental health problems?***

I wanted this part of the thesis to be about hearing the officers' voices so have kept my comments to a minimum, using my words as the thread to weave theirs together. I have presented them in order of the process as it had emerged. Figure 4.1 sets out my formulation of the six key stages that emerged in the process of help-seeking. It begins with the formation of a social group identity moving through the different levels of awareness of mental illness and the application of that awareness to others then the social group then to oneself. This culminated for some in help-seeking and the subsequent assimilation of this experience into their personal identity and return to the social group. Figure 4.2 then gives a summary of the main categories that can be equated to the phases of the process. Each category is then defined, described and illustrated with vignettes in sections 4.1 – 4.6.

I have used military metaphors to describe the stages. During the analysis it became apparent that the experience of having mental health problems was viewed as a "battle" with PTSD as the reified enemy. As will be seen, participants primarily identified with their group identity as servicemen and this metaphor was a combination of their language and my professional interpretation that is intended to reflect this "battle."

All names are pseudonyms (shown with the page number of transcript) and identifying factors have been removed. Part 5 and 6 of this thesis then go on to fully discuss the findings, evaluate the data in relation to the literature and consider the implications for the development of theory and practice.

Forming a social group identity and identifying shared norms and values

Having awareness of mental health issues in others, stereotypes and attitudes towards those with issues

Rebuilding a sense of self and incorporating the experience into one's identity Re-entering the social group

The Warrior and the Battle Landscape

Identifying the threat

The Battle Veteran

Assessing the risk to self

Engaging with the enemy

Calling for re-inforcements

Considering the risk of group members and self developing mental illness
Group norms for prevention and remedy

Emerging awareness of mental health issues in self and using coping strategies that adhere to group norms

Escalation and existential crisis

Accepting a need for external support
Making a cost-benefit analysis of disclosure and assessment of potential helpers outside the group

Figure 4.1: Key stages in the process of help-seeking

Figure 4.2 Summary of the main categories

Main category	Sub-categories
The Warrior and the Battle Landscape	The group identity • Recognising the police officer with a military background • A new camaraderie • Forming a new "elite" • Being action oriented Mission focus • The job comes first • Being pragmatic
Identifying the Threat	Understanding and awareness of mental health issues • Lack of awareness • Military history • Mental health awareness as part of work-role Determining who is vulnerable • A sign of weakness • Malingerers Being fit for purpose
Assessing the risk to self	Being mentally stronger Preventing injuries • Focus on the job • Strength through emotional control Remedying injuries • Rest and recuperation • Accepting reactions as normal • Black humour • Peer support

Engaging with the Enemy	Becoming aware of a problem in oneself • Ignorance and denial • Others' concerns Escalating problems Existential crisis • Admitting to a problem • Fast action
Calling for Reinforcements	Assessing the risks of calling for support • Fear of disclosure Judging the potential helpers • Trusting the organisation • Feeling cared for by the organisation • Organisational competence Working with foreign forces • The competence of mental health services • Degrees of separation
The Battle Veteran	Making sense of what happened • Changing attitudes and awareness Living with the battle-scars Finding a new mission through helping others • Becoming a role model A new identity • Coming through a dark time • Post traumatic growth

4.1 The Warrior and the Battle Landscape

This category describes the social world of police officers with a military background and how they see themselves fitting within the context of the police culture. It covers participants' answers to the basic questions: Who am I? What does group membership mean? The category comprises the initial formation of the social group identity in the military, through the transition into the police service and the subsequent formation of a new group in that setting. The group brings the rules and standards, learnt in the military, into the police service and expects them to be continued by members in the new setting with norms of Mission Focus, Strength and Control and Camaraderie. In return, members can take pride in being part of an exclusive, cohesive group that prides itself on Being the Best. Part 5 will look more closely at these group norms and their influence on attitudes towards mental illness and help-seeking. Members are identified through their adherence to these standards and non-members are judged according to their lack of them. This reinforces the sense of being "other." Figure 4.3 provides an overview of the sub-categories within this main one.

Figure 4.3 The Warrior and the Battle Landscape: Sub-categories

Main category	Sub-categories
The Warrior and the Battle Landscape	The group identity • Recognising the police officer with a military background • A new camaraderie • Forming a new "elite" • Being action oriented Mission focus • The job comes first • Being pragmatic

4.1.1 The group identity

Recognising the police officer with a military background
Implicit to the research question is the concept of the ex-services police officer belonging to a discrete social group. Without exception, participants considered this to be true
Without a shadow of a doubt, I think we are different, people who've been in the military (Peter:5)

There was usually an instant recognition

You can spot them a mile away. Don't even have to talk to them (David:2)

And an expectation that this was common to service personnel
I can just look at somebody instinctively and I can even tell you what forces they were in. I think most soldiers should be able to (Gary:4)

This was felt to possibly relate to a serviceman's ingrained and intuitive manner of assessing threat from those around them.
I don't know exactly why you can spot ex military but invariably all are able to do so. Possibly threat identification which enables soldiers to differentiate between civilians and hostiles, you hone in on the militaristic individuals as the greater threat. I think it was Socrates or Plato who stated something similar to "soldiers are on a higher plane of understanding on human nature" (Jack: written feedback (wf))

They all walk into a room and they already know everybody that's in that room before they go anywhere else. They don't walk around with blinkers on. They've got a sense of awareness about them (Matthew:7)

The majority of participants had served longer in the police than in the military yet still seemed to identify primarily with the latter group. Participants felt that their young age on enlisting was an important factor in this, forming their subsequent attitudes and behaviours. Being in their formative years allows them to be greatly influenced long term …
It doesn't matter how much time we spent in the military, because they are your formative years of your life when you tend to be growing up doing a lot of changing, basically 18 onwards, even if you just spent, like I did, 5 or 6 years … I compare those to the 22 that I've spent in this job and the time in the military seems far longer because it's formative stuff. So it has a huge influence on everything that comes along later (Steve:2)

These formative years begin with basic training, as the military shapes its recruits into the group identity.
The forces will take anybody and what they do, they break you in training to mould you into what they want. That is how the service works so that they know that they have got, almost like a standard product (Charlie:8)

This shaping could be both mental and physical
The Royal Marines … you know it's why they're called boot necks really, because they've got a particular shape that's, they all do the same fitness regime for their training when they're developing as young adults, that shape holds with them for the rest of their life (Gary:5)

When drilling down into the specifics of group member identification, the qualities instilled throughout military service such as bearing, appearance and self-confidence were initially cited

It's the way they hold themselves, the way they walk, the way they communicate, you know, they've got a lot of individual positive self-confidence and it just, you know, it resonates (Matthew:7)

They've got more confidence to do the job, they're comfortable in uniform and they're comfortable carrying things like the baton, the gas, the firearms, the Taser, that sort of thing … it's just the confidence to do a difficult job and you just see it a mile away. Yeah, it can be almost something as subtle as just the way you walk or the way you open a door, it's just that confidence in yourself (David:2)

Standards at work and pride in appearance were other indicators
You can tell the difference in standards. Not necessarily probably the arrest rates, just the way you go about things, the way you hold yourself, the way you dress, I mean look at me totally bulled shoes and the rest but that's the way we are and you can usually tell if the police officer is ex-military just by the way he is at work, quite easily (Paul:6)

This was compared to non-service peers where *maybe they haven't bothered shaving today or they haven't cleaned their boots one day (Bill:2)*

A new camaraderie
Once identified as ex-services, there was a sense of finding a similar other and being part of a new social group within the police service.

As soon as you find out, there's a fairly instant camaraderie there (Steve:2), and you form a common sort of bond (Jack:3). It's quite ridiculous to be honest, but there's always this bit of a bond … even if it's unspoken (Peter:10)

… the military people sort of gelled together, you know, we would all be out running in the mornings and that sort of thing because that was our whole life, we were a team, you know, we used to work as a team (Bill:3)

In the military, focusing on the mission binds people together as they work towards a common purpose. Cohesion and camaraderie are essential requirements when performing duties. In combat, doing the job well can literally be a matter of life and death.
You fight for the guys who are alongside you. You just happen to be doing as you're told. You have to do it to the best of your ability, if you don't there are potential repercussions, so – do it to the best of your ability and the core task is to get everybody home. Safe and sound. (Charlie:3)

An inherent and unspoken expectation is another soldier will risk their life for you even if you have never met them or like them. This basic trust and expectation is a binding bond that lasts forever. The commonality and oath to the Crown binds you all (Jack: wf)

In the police service, there was a similar need to know that your peers support you in threatening situations and this is where the servicemen's trust in each other was strongly felt.

… ultimately I need to know that whoever you're working with, if the shit hits the fan and you're in a fight, or a situation, that they're going to be there to support you. With an ex-serviceman I know, instinctively that regardless, they will be there (Gary:5)

If there's any sort of confrontation to do then they're probably some of the first people to be in the list, that you would take (Tom:5)

I have come across instances where non-ex-service personnel have not been there when you expect them to be, they'll still been sat in the car or whatever, but (ex services) they're far more forthright in getting involved and getting stuck in and there's no thought process, they're just there and it is just an instinct because it's the way they're drilled isn't it, for years (Gary:5)

The bond forged in military service continues after leaving

Even now, you're never classed as being ex … we used to be called Rock Apes, that was our nickname, but you were never an ex-Rock, you were always a Rock. So it's like this "brotherhood" if you want … my mate who's in for life now and me as a police officer, take him out of prison and me out of the police and put us together, we'd talk all night. You know, there's still that relationship between us. And what's happened in between doesn't negate what happened originally between us (Paul:11)

And this bond now spans all services.
Whether we were Navy, Army, Air Force, doesn't much matter. There's a common background there …we've all done similar kinds of things. (Peter:10)

Earlier rivalries are largely forgotten
Even if you fought like cat and dogs between each other when you were in the military, it's very, very close when you're out, it's just the whole forces thing brings everybody together. I've got a good friend of mine … who was in the Queens Lancashire Regiment. Now if I was in the forces still and he was in the forces still, we wouldn't speak. We wouldn't even walk on the same side of the road. But when we come out, it's totally different (Paul:7)

Without being sentimental

It doesn't mean you like everybody who's been ex-military, but there is that shared experience, background (Peter:10)

In comparison, the police culture was viewed as individualistic and lacking in cohesion.
When you first go into the police you expect to be treated with the same camaraderie as you were in the military and that's not the case, and I think that can catch a few folk unawares (Jack:4)

Team unity (in the police service) *is gone because we've now got various little enclaves (Charlie:3)*

Forming a new "elite"

In the services, for those who make the grade through basic training, there is a sense of pride and of being part of an elite group identity. This is not a sense of being intrinsically a better person than others but in striving to be the best at what they do. This sense of being the best is *drummed into you from day one (David:10).*

That's how you're built up in the forces to think you are the best from being very, very young. You're told you are the best at what you do. You're the best in the world, you're not just the best in the British forces. You're the best in the world (Paul:7)

This is further encouraged by the military through competitive rivalry between regiments although once in the police, the military identity itself is the binding factor.

He was in the Grenadier Guards and I was in the Coldstream Guards, and traditionally we absolutely fought like cat and dogs … you know I give birth to a Grenadier every morning and then I flush it (laughs) … that sort of thing. But, if an outsider ended up saying "ooh Coldstream Guards," you'd have the two of us to deal with (Charlie:2)

In the police service, participants differentiated their social group by comparing themselves in the job to their non-service peers. There was a sense of ex-military being an elite group and having higher standards than their peers

I'd say the servicemen, yeah, definitely have much higher standards in everything they do, just sort of getting the job done. You've got officers who cuff jobs who are sort of lazy and it's generally not the sort of, the ex-serviceman (Gary:5)

Although there was recognition that this was not exclusive
Some people are totally opposite, they've had no military training and they're smart as a carrot and bright as a button (Bill:3)

Such officers were the exception rather than the rule *… there are coppers who are out there who have immense strength of character, immense mental capabilities and immense courage, but what I would say is that the ex military police officers have that to a – all of them have that and it's there and, again I'm being brutal here, I just think that we're a couple of steps up the ladder (David:11)*

There was an element of peer pressure and an expectation that other ex-servicemen would maintain the group standards

I would expect them to be able to erm I don't want to say handle themselves, I'm not talking about physical way, I'm talking about their presence and how they deal with people. I would expect smartness … I served in the military and was very proud to serve my country and again I'm still doing that … quite an old fashioned view maybe, again a lot of the ex service lads are like that (Rob:7)

I think us ex-military would expect other military police officers just to be <u>better</u>, if that makes sense, to be able to handle things better and to be able to do things better, not be so, not complain so much, not whinge or bleat or anything like that and do the job (David:3)

Ex-services were seen as more able to focus on the job and unsurprisingly to accept orders

Generally speaking, we're able to accept (pause) accept things is a bit glib isn't it? Accept the way we do things, more readily than someone who's never had a, been in the military. I don't mean unquestionably, it's just that sometimes there are bad things that happen and I think we tend to accept that, that is life, you get on with it (Peter:5)

In the police, this ability to accept orders and be disciplined and controlled was another way of differentiating between the group and their non-military peers.

I think we're a boss's dream in the police – ex-military. We don't tend to question what we're told – we just do it (Paul:6)

However this acceptance of orders didn't mean they were not able to think for themselves.

Not that we're indoctrinated, but I think we've learnt to accept discipline. I think we've learnt how to question it properly, erm, cos I think you should always be able to question discipline, but I think there's a right, there's a way of doing that (Peter:5)

… a lot of people have the perception that people in the military can't work things out for themselves, have to be told to go here, go there, which really isn't the case because they're probably some of the most proactive people you're ever going to come across (Bill:1)

Non-service peers were often criticised for the impression that *Police officers today are just not disciplined (Rob:6)*

We've gone from being a disciplined, to a not very disciplined service (Peter:4)

And the negative changes were felt to be exacerbated by the cultural style and *the keenness of senior officers to be overly familiar with the rank and file, call them by their first name and stuff like that. It just leads to deterioration in discipline which is now starting to bite the police, I think (Jack:6)*

Several of the longer serving officers had seen their group become more of a minority over the years

when I first joined the similarities were there, there was a lot of ex servicemen … the vast majority of my sort of senior supervisors had done national service and in fact a lot of them had served in the second world war, right towards the end of their service or Korea and Malaya and stuff like that …. so a lot of people had military experience where nowadays very few people have military experience do they? (Tom:5)

Being action oriented
The military maintains and reinforces the group identity by offering excitement and adventure in return for enduring hardship and keeping the rules. Participants still talked about their service with great animation.

A lot of it is very good, you're in a very privileged position to see stuff that very few people on earth ever see, you know to mix with the population of these countries is, and work with them, is fantastic and you know, and if you join as a soldier you want to do the job of a soldier which is good isn't it really? I loved it, I really, really enjoyed it (Tom:4)

I just like the buzz. I like the camaraderie. I like the job, I love the job. I knew it well, I knew it inside out. I just like the thrill of being there. It's a horrible thing to say but I just like being in war. The only thing I know is I'd go out there tomorrow. And I'd go through it all again (Paul:11)

Although the military offered excitement and adventure, many participants left as they felt they were running out of challenges

I'd been to war and done all that, I'd been all over the world, done a few other bits and pieces etc so it was time for something fresh (Jack:1)

This drive for excitement was commonly cited as a reason for being attracted to the police service

All the roughty toughty stuff … that's just the kind of thing that pushes my button, I think that's just who I am (Peter:1)

I wanted to … be involved in operations being on the ground rather than sat in an office somewhere – that would drive me berserk (Steve:1)

You know I'm still at the front edge, I'm still a response officer and I'll do that until I can't do it any longer because that's what I enjoy doing (Bill:2)

4.1.2 Mission focus

The job comes first

In the military, the individual becomes part of a culture where the group's needs and purpose is greater than the individual's. There is an acceptance that the nature of the job means it always comes first no matter what the circumstances

In the Army there's one way – you're sort of given a job and it's got to be done (Bill:2)

You were a very tight bunch of people, and you've all got a job to do (Peter:3)

You just throw yourself into it, erm whereas you know, in the factory or another, you know, it's raining today, we're not going to cut the grass or you know, we can't go and get that done because… we would just get it done. It wouldn't matter. Our psyche would be, well we've been told we've gotta get that done so let's get it done (Bill:2)

There was a clash between how the two cultures perceive the job as paramount and Bill described this as due to the difference in employment terms. In the military, being on a tour of duty meant

… we were paid set rates and fundamentally they could make us work 24/7 for 365 days a year if they wanted to and we knew that, so whether we worked from 9-5 or 1 o'clock in the morning until 1 o'clock in the next morning, we were paid the same and the organisation would think, well sometimes we'll finish a little early and have a little bit of an easy day or when you're going to places like Northern Ireland or Afghanistan or whatever, you know you're going to be working six months damn hard every day so it's give and take really (Bill:4).

This contrasted with the police job relating to a civilian work pattern, meaning that even if the job isn't complete, *then people start thinking, whoa I'm going into overtime or I've got to work late or you know, but you've got to, someone's picking the kids up, you know, all these things which are all factors (Bill:4)*

Mission focus also involved doing the best job you possibly can and this pride in their work was another way of differentiating the ex-serviceman.

The military people will go out against the odds, if you are told to go and bring a particular person in, they will turn themselves inside out until it's done. Certainly officers who have not been in the military will also do that but I think it's more prevalent in military personnel. Because it's almost like they're given an order, they go out and do it and come back in again (Jack:5)

The majority of them have that little bit of spark about them that will always look to take the extra step, to look for a better way of doing something … we can do our jobs more efficiently you know, we might save somebody's life, I like to look at something and think you know, it's a problem, but what can we do about it, I always look there's got to be a solution, there's got to be a better way (Bill:3)

Being pragmatic

The pragmatic, practical approach common to many ex-military was valued higher than theoretical skills. There was a distinction between practical, life skills and academic skills with the latter often being perceived as less relevant to the job.

They've come out of college or university having done a degree in law and come straight into the police, put on a shiny uniform and they go out and they haven't got a clue about how to deal with people. It's not so much about being a police officer because anyone can spout the law but it's how to deal with people (Rob:6)

Dare I say, the leaders that we have nowadays, very, very bright, like a lighthouse in the desert, very bright but no use. Know the square root of a baked bean tin but couldn't open it if they were going hungry (Charlie:2)

It was felt that the ex-serviceman's greater life experience resulted in more common sense and higher resilience

I'm getting old but a lot of young bobbies today haven't got that … Because they've not seen any of the world, So yes, you do tend to see a lot more in the military than people of a comparable age would see, and I think that's one of the things that the police force like in as much as when they get somebody who's ex military they know that they've had all the rough edges knocked off, they've seen a fair bit, they are aware of what can happen (Steve:3)

I think that's the general thing with military people, they come from a harsh environment don't they? (Tom:6)

This experience of the harsh realities of life was felt to add resilience and the ability to act under difficult circumstances and get on with the job

… especially those who have been front line servicemen, when you go to a job and you're dealing with confrontation, will try and take charge over the bobbies who haven't done it before. I've been to incidents before with other bobbies who have been to a large fight, you get stuck in and when you get back to your car there is like two young bobbies sitting there crying and couldn't get out the car, and yet the third young lad that was with them, ex RAF, was straight out … I think experience has got a lot to do with it, if you've never been involved in seeing a large scale fight or 3 or 4 people dead, then it's going to shock you, it's going to stand you back (Rob:7)

To be honest, half the stuff they deal with policing is nowhere near as hard as half of the stuff that they dealt with in Ireland and places like that (Gary:5)

Their previous experience was not always validated in the police service

I was classed as just a very junior bobby, my opinion didn't count, and it was blatantly obvious … I was looking at an individual and thinking, you know, I was actually shooting at people for real when your mother was still changing your nappies and you're staring at me as if I don't know what I'm talking about you clown, and I literally had to bite my tongue and walk away (Matthew:2)

Despite the common bonds, one participant stressed the importance of not stereotyping the military experience

Some of these lads they've been out there, they've done two tours in Afghanistan, they've come back as a sniper with 19 confirmed kills and their life is never going to be the same again. Whereas you've also got people, ex military who're yeah, they've been out and they've done this, but they've been doing logistic work and other stuff but they haven't been front, front line so there is a danger that everyone looks at ex military and they just see one type of person (Steve:3)

Although the participants saw themselves as better in the areas detailed above, they recognised others had useful skills in different areas. This came down to the need for different skills to get different jobs done effectively.

There's a lot of skills groups and personalities that make the police service very different from the forces and it's horses for courses (Charlie:8)

Yes, it's nice to have some ex military in the police force but you have to have the balance, we deal with everyone (Steve:3)

4.2 Identifying the Threat

This category represents the views that participants held prior to having mental health problems themselves and is the initial stage in what can be considered their risk assessment of how relevant the threat of mental illness it to themselves personally. It covers their awareness of mental illness in others – What is mental illness? Who gets it? – ranging from the general population, those they encounter in their police work to police peers and their own group members. It can be thought of as their view looking outwards: mental illness at this point is "out there." The category includes how they became aware of the concept / existence of mental illness, what knowledge (formal and informal) they were given and how they go on to make sense of mental illness in others in terms of causes, consequences and effects. By considering those with mental health problems as "other", the identity of the social group is reinforced through comparison. Figure 4.4 offers a summary of the sub-categories within.

Figure 4.4 Identifying the Threat: Sub-categories

Main category	Sub-categories
Identifying the Threat	Understanding and awareness of mental health issues • Lack of awareness • Military history • Mental health awareness as part of work-role Determining who is vulnerable • A sign of weakness • Malingerers Being fit for purpose

4.2.1 Understanding and awareness of mental health issues

Lack of awareness
At the time of their military service, there was a lack of education into mental health issues provided by the military, even for officers with responsibility for troop welfare
We'd just come out of the first Gulf war … and as you could imagine, officers' training, one of the sort of the key things is about your staff and your team and looking after your team, and it was never mentioned. At all. Never referred to (Gary:2)

Even though we'd just been through (the Falklands), I don't actually recall mental health issues being spoken of very much. Physical health, you were always warned about the dangers of this,

that and the other, and you were shown videos of all sorts of stuff, but mental health. I can't ever recall it being brought up (Peter:5)

And some participants had a similar lack of education even in the police service

You, I mean when I joined you never got any training in it at all, never have had any training in it in the police service (Tom:7)

We don't get any sort of training for it, at least I didn't. My understanding is now that there's a little bit more input in the initial (police) basic training level into mental health but it's really a case of you pick it up as you go along (David:3)

There was a sense of denial or ignoring of the problem amongst peers.

It was just one of those things that it just wasn't talked about or we were, maybe I was just too naïve and blinkered really … it's still not talked about (Charlie:1)

It's certainly never, never ever been mentioned, never ever happened in the military and it certainly was never bandied about in my first few years in my police service (David:5)

It wasn't recognised really, nobody sort of said you know unofficially if you want to come into the office there's somebody there to talk to, that wasn't available in those days it really wasn't available to anybody (Bill:6)

When it came to an awareness of issues within their peer group, it seems as though issues were not noticed until they reached a level where the person was not functioning

It's suddenly someone's no longer there and they're not at work and that's generally the first time you pick it up (David:4)

Virtually all participants offered anecdotes of extreme reactions to mental illness amongst their peers

Another guy that had, that was even more recently, up to 2 years ago … He ended up being on the edge of a cliff for a little bit but then was talked back (Charlie:3)

We had one guy who more or less totally lost it … he covered himself with petrol and was trying to spark up a lighter to set himself and everything around him on fire (Steve:2)

One of the drivers … he was a corporal or a sergeant but he actually hung himself (Gary:2)

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However the response to this was typically of not discussing this and returning to focusing on the job

I do remember a couple of guys going off the rails a little bit in Northern Ireland … But again, a lot of it back then, certainly in the 80s, it was just one of those things where, well … crack on and … crack on and get it done (Charlie:1)

It wasn't something that was referred to, nobody ever said why. It was never questioned as to why he'd done … he'd just topped himself … it wasn't referred to that he had issues, I don't know if he'd been in a war, and I'd imagine because he was logistics corps so I'd imagine that he would have been … but it was never referred to ever (Gary:2)

Military history
Several participants learnt about psychological trauma through their interest in military history
I've always been into history and I'd go out to the western front every year and I'd read about it constantly (Paul:12)

Going back to the First World War, we were recording it in high numbers weren't we then? I've read several books about it (Peter:11)

And most could relate to those who had suffered.

You go back to the poor devils in the First World War that were shot for cowardice and that sort of thing. You think, my God, what must those people go through mentally, months and months of explosions and stuff like that you know, and then, it must have been totally traumatic for them so yeah definitely. Definitely I think that's something you can, well I can identify with (Bill:9)

There was similar recognition of the risk of psychological trauma from modern warfare and empathy towards service personnel.

I think the Falklands probably caused a lot of problems … obviously more people committed suicide over the Falklands than were killed down there (Charlie:1)

You've heard of Afghanisti have you? The Russian sort of, that's the soldiers that joined and served in Afghanistan in 1979 – 89 …They just haven't dealt with them, and there's this whole generation of society, strata of society, that's completely up the ying yang with issues, that they haven't dealt with, and I think in this country, particularly from the more spicy places troops have served in the last sort of 10 years, a few issues coming to the fore, we're still getting problems now with the Falklands, first Gulf War (Tom:12)

Mental health awareness as part of work role

Rob and Jack served in a medical capacity in the military so had encountered peers with mental health issues as part of their role

I came across a couple of guys who had obvious issues, they'd report to the med centre quite often with various bits and pieces and just through a bit of digging about generally went back to stuff in Northern Ireland that were causing them the issues (Jack:2)

I dealt with people who were two or three war veterans and all of a sudden you've got these big men who served in the Falklands and Iraq, Yugoslavia, been to Rwanda, and they're sitting in front of me crying like a baby … Obviously it had taken nearly 10 to 15 years for them to realise they had problems, erm so mental health for me was, was forefront (Rob:1)

However in the police, the interface with the general public was often the primary source of experience of mental health problems and this was a frequent interaction.

Far more than we used to, a hell of a lot more than we used to – I wouldn't say it's daily but it's probably a couple of times a week (David:3)

But such people were often felt to be getting in the way of the real job of policing

There is a level of frustration… at one point it used to be almost standard practice that you just used to arrest someone and sort of like dump them in custody in a police cell and they would be there for hours, sometimes a day, up until the end of their custody limit while the relevant health professionals or services were contacted. It has got better, but it is still tricky, you know it's sometimes a secure unit will refuse for various reasons and you end up, kind of, sitting with someone maybe in hospital for hours on end. It's better but it can still be frustrating (David:4)

People see them as a nuisance. We lock them up 136 Mental Health Act, bring them in and they're urinating on the floor, banging on the cell and we obviously have to take them to whichever institution is deemed fit, and it's just a pain in the arse for (the police officers) *because they're difficult to deal with (Rob:8)*

You have to kind of wonder why these people are not receiving more care than they are so it can be frustrating sometimes and impact directly on the job we're supposed to do which is dealing with crime and criminals and protecting the public (David:4)

But there was also a philosophical acceptance that this was part and parcel of the job
Having said that though I suppose if someone has got mental health problems and they are within the community, by taking some sort of action when you meet them, you are protecting the public I suppose (David:4)

4.2.2 Determining who is vulnerable

There is an acceptance that the risk of psychological trauma is inherent to both the police and military roles and an unavoidable part of the work

I would say the vast majority of people that have been exposed to difficult situations in Afghanistan, Iraq and Ireland and in the police service in certain circumstances would have an element of that at times, now whether it's very low level or whether it's very high level (Tom:13)

It was part of the job to lose people, you were expecting it because that's what soldiers did (Paul:2)

But the police role brings additional stressors

We see and deal with horrendous stuff and equally horrendous as what a soldier sees, if not sometimes more and perhaps we're more vulnerable … whereas a soldier knows that he's going to war and there's a likelihood to get killed, we turn to every day at work and we could get killed and it does happen … So you just don't know what's going to happen in your day to day, which is half of the attraction of the job to be fair (Gary:8)

You know you deal with some nasty things in the police service and I think the problem is, one minute you're dealing with Mrs Miggins and her cat, and the next minute you can deal with an horrendous murder or a road traffic accident which has got, you know, death and destruction involved in it, and the next minute you could be dealing with some sort of, lost handbag or something (Tom:7)

Although there was some acceptance that all were vulnerable

It makes no difference who you are or what line of work you're in, at some stage in your life, you're going to come across something that's traumatic (Matthew:10)

There is a saying that there but for the grace of God, could go to any one of us and I know that statistics say that one of us, or I think it's, we're all going to be at least depressed at some stage in your life …

There was a sense that the individual still had to deal with it correctly
… but it's how you actually deal with it and what level of that depression is (Charlie:5)

And whether the cause of the problems justified the reaction so if *the incident that we're talking about is something that everyone can acknowledge is quite traumatic then absolutely I've not got a problem with those people seeking help and getting whatever they need to get better (Peter:17)*

A sign of weakness

The ex-serviceman had a pride in their *own sort of strength of character, my own mental strength (David:9)*

In contrast, mental health problems were sometimes seen as a lack of this moral strength or an inherent weakness.

Some people still view it as a character weakness … there was a bit of a stigma about it, you know, they couldn't hack it, they couldn't cope (Jack:2) … I think some people are just, of a stronger constitution, shall we say (Jack:12)

I think there is also a group where the mental health difficulties and problems are self inflicted, mainly through drugs and alcohol misuse, my particular view on that is, that is essentially a character flaw from the beginning. No-one forces drugs upon you and we all like a drink. I like a drink as much as the next guy, but I know my limitations so I don't take it to extremes. So I think that mental health or that sort of area of mental health is self inflicted and I'm not saying it shouldn't be dealt with, all I'm saying is that I think you can trace it back to essentially a character flaw, a lack of mental strength, a lack of moral strength (David:9)

Cultural attitudes in the military encouraged this

There was probably a sense of indoctrination and mental health … was shown as a sign of weakness and it was very much an era of physical and mental robustness and showing signs of weakness was not really appropriate in those times (Tom:1)

This attitude continued in the police service
It's generally a bit dismissive and a bit contemptuous. The common theme is stress, we're off with stress … when most police officers hear the word stress there's a rolling of the eyeballs and a kind of a, oh we've got another lightweight who's fallen over attitude (David:5)

Malingerers

Although there was clear compassion towards the genuine *I have a lot of time, a lot of sympathy, and I will spend as much time as it needs with people who are genuinely, genuinely mentally ill through no fault of their own (David:9), it's a good thing that trauma is recognised and it's dealt with properly (Peter:8),* a distinction was made with those who were viewed as weak or even as malingerers. The latter were viewed with distaste particularly when they lacked the mission focus.

Now unfortunately like any public service body, that particular kind of condition can be abused and without a shadow of a doubt there are people out there within the police service who use stress as perhaps just a manner of getting out of doing a difficult job or looking for an easier life within the police service (David:5)

There are always people who will have been affected by an incident who will then call it trauma … and then seek all sorts of kinds of help and assistance and time off work that maybe, maybe they don't really need. I think that it might just be a bandwagon for some people to jump on ... and compensation … because we've got a similar culture to America now I have to say (Peter:9)

You will always have the, what you would class as the shirkers, there will always be people that will manipulate the system, there will always be people that will suddenly become all emotional and upset and play that welfare card (Matthew:10)

Several people expressed fears for the future if the organisations didn't address the risk of people abusing the system

We have people in our organisation now who shouldn't be there but they are cos we are frightened as an organisation to get rid of somebody or sack someone, or put someone on unsatisfactory performance when they cite stress as a factor. We've allowed people to use trauma and stress, two genuine illnesses, and we've allowed them to abuse them and get away with it (Peter:9)

It was acknowledged that it was difficult to determine the genuine from the ingenuine and judgment often rested on how the individual generally performed at work.

When they're a little bit what we call work shy … if someone who doesn't get stuck into doing the job, if someone always turns up second or third to an incident despite the fact that they might have been the closest police officer there, you get an idea ... you just don't believe they're suffering from stress, how can they if they never get their hand out of their pocket (laughs) or do anything, any kind of work? (David:5)

On the other hand I think there's probably a bit more understanding of people who are in the front line role, do their job, work solidly, and suddenly something happens, it might be something at home or something like that and suddenly they're off sick and you know those people to be a good worker, be a good copper, to get stuck in, you know there's obviously a little more, kind of more understanding and a little bit more sympathy (David:5)

There's some people who, for instance, receive a call when they're off duty saying they have been asked to do another job, and then they go off sick for 6 weeks because that call caused them stress, I mean what absolute nonsense and we do pander to things like that. And sometimes, to me, I look at why a person's stressed and I think oh, you know, sort it out (Peter:6)

4.2.3 Being fit for purpose

The acceptance of the heightened risk of psychological trauma was balanced by the opinion that, for the mission to be carried out, the individual must be fit for purpose. This attitude was encouraged from the start in military basic training where those who didn't make the grade were weeded out

You would quite quickly find out those who had the strength of character and the physical attributes to make it, and those that didn't … basic training was basic training and it's supposed to be hard (Charlie:9)

As the successful remaining members of the unit build their sense of individual physical and mental strength, this reinforces the group's identity of physical and mental robustness, vital for engaging in combat.

You're going to have to potentially close with the enemy and kill them and for some people that may be fairly unpalatable but in that environment you must have robustness, physically and mentally (Tom:1)

You've got the ability within that role to cope with the rigours of what you might encounter in that role, for instance if someone is not mentally robust enough to join the front runners to serve in Afghanistan, for instance someone who's a college lecturer, will they need the same level of robustness to do what they do on a day to day basis in a college? Probably not, so I think you need the requisite level in order to carry out your role profile (Tom:2)

There was little cultural sympathy for those who found it tough*… well this is a part of the job, what did you expect, no-one ever said this but it's all sort of the undertones of, you know, you're not a painter and decorator, your job is to kill people erm and everything else was part of the job (Bill:6)*

Yeah, I mean, there was a basic, sort of, understanding, most of us knew somebody who'd been in a combat situation that had suffered mentally, but it was just a case of, right, is this a suitable location for them? (Jack:3)

The "weeding out" process of basic training continued through military service and any "weak links" would be dealt with by removal or exclusion

You couldn't go to anyone and say that you're not feeling too good about what happened at so and so or anything because you'd get thrown out of the door (David:10)

It was fairly well controlled in the workplace and if there'd have been any issues then you were probably moved on to another because the Royal Marines has got a system whereby you do

two years in the job and then you generally move on, so therefore if there is any problems they can get rid of you quicker, if you see what I mean, so they sort of move the problem on (Tom:1)

The removal of an individual from a unit was often justified as the individual being a risk to the unit's effectiveness and standards

The success or failure of a unit depends on its overall strength. If someone is "different" they become a weak link in the chain which could ultimately jeopardise the strength and safety of a unit. It is not a fear of an unknown future, more a fear of being rejected by their unit (Jack:wf)

or even a threat to the safety of the unit or mission

Because of the nature of the work up there, there was a lot of the classified, top secret and beyond poking about, so they would be seen as a security risk … and off the unit (Jack:2)

If I was onboard a ship I would try and get them casevac'd off if I thought they had PTSD or other mental health problems, or if I thought it was stress related they may get very, very light sleeping tablets but then again onboard a ship that can be quite dangerous so … I didn't do it too often (Rob:2)

Obviously if we're transporting folk back in the Hercules or something I wanna know what's going on if they present a risk to me in the aircraft (Jack:8)

When someone was removed from the unit for mental health issues there were few experiences of them returning

Erm, not back out to us no. Some of the other units would take them back but the unit I was posted in X, because of the stresses of being there, it wasn't the place for them (Jack:2)

Removal could be a source of humiliation where individuals were stigmatised by association with other stigmatised groups

I didn't agree with it all because we had an area called G block which was like our mental health unit and it was very old fashioned, rubber room, honestly, and we used to have to send people there for, I would say the wrong things. I mean you know we would send them there for PTSD, nervous breakdowns, but we would also send homosexuals because homosexuals were deemed mentally ill in the armed forces … so we're talking about 92, 93 when it was still a criminal offence in the armed forces to be gay, and we would get people coming into the medical centres saying "I want to get out I'm gay, lesbian" and the first thing they would do was to palm they off to a psychiatrist which I thought was incredibly wrong. (People with PTSD) wouldn't come in. It was shunned a bit I think, mental health (Rob:1)

The need for emotional and mental resilience emphasised in the military was felt to be equally important in the police service

I think that if you've got to be a copper, one of the best characteristics you need is that mental strength or that strength of character to deal with this and if you haven't got that then you probably need to be in a position where you need to rethink your career. I do think that not being able to cope with some of the things we have to see and do is a reflection of perhaps not being as mentally strong or not having the mental aptitude to do this job (David:6)

It's the same as you would train down the gym, you would have a selection process that ensures that people join an organisation that requires physical fitness will also have the mental robustness to cope with the work (Tom:2)

Whereas the military was overt in its messages about being fit for purpose, there was a perception that the police service didn't follow this model of building a strong, resilient workforce. This led to people who weren't of the required robustness being in the job

Maybe we're not employing the right kind of people in this job, because it is a different job being a police officer. I'm not saying it's an awful job and love us because we're heroes, not at all. But it is a different kind of job, and I think you've got be a certain kind of character to do that job, and to do it well and I just think, at the moment, the police are employing a good number of people, because they're very clever, they've got good qualifications, and that isn't wrong either. I think we do need intelligent people in the police service but they're not necessarily mentally fit to be a police officer (Peter:6)

Peter went on to describe a training scenario where a whole class of police recruits revealed they had never faced confrontation of any sort. He felt that the police service was putting people into a job who would be unable to "stand the heat".

Now why, why are we considering employing people who have not had a full experience of life then expecting them to deal with people who are going to be very, very aggressive with them, who are going to fight them, who might want to knock their head off? Why, why are we putting people into that situation where we want them to become a police officer and we think they'll make a great police officer? (Peter:13)

4.3 Assessing the risk to self

This category relates to how participants moved on from looking at outsiders with mental health problems to considering the personal relevance of the threat within their social group and how the group prevents or remedies the problem. It covers how participants felt about the level of the threat and their views on on-set and off-set responsibility for themselves and peers. The group

defence against the threat begins with the initial expectation that group members are mentally stronger than "others" so although they are at higher risk of exposure to traumatic events, the risk of mental illness is naturally reduced. However, there was an acceptance that some could still be affected and the group sets out clear norms on how this should be judged and the measures that should be taken by the individual to overcome the difficulties. Acceptable strategies were learnt in the military setting but didn't always translate well into the new occupational context. This created tensions and further cognitively split the group from "others" within the police service whilst boosting cohesion within the group. Figure 4.5 provides an overview of the sub-categories.

Figure 4.5 Assessing the risk to self: Sub-categories

Main category	**Sub-categories**
Assessing the risk to self	Being mentally stronger Preventing injuries • Focus on the job • Strength through emotional control Remedying injuries • Rest and recuperation • Accepting reactions as normal • Black humour • Peer support

4.3.1 Being mentally stronger
The first line of defence is in being mentally stronger than their peers

I think some people have an innate ability, without being taught or without having a strategy given to them, of being able to deal with trauma. I think a lot of people in the military are well aware of stress and what it can do to you (pause) and maybe they cope with it a little bit better than. That's a generalisation. But maybe a lot of people, can generally, cope with it better than people out of the military or maybe they cope with levels of stress differently (Peter:12)

We tend to be more self-reliant and resilient (Jack:3)

Military people generally have a higher threshold of showing weakness haven't they? (Tom:6)

There was a sense that mental health problems would not fit with the peer group and an individual who struggled needed to be reminded of this in no uncertain terms.

I think my first reaction would be something like, come on mate get a grip, you're army sort of thing, you're ex army, you need to be able to deal with this we've got a job to do. I'm probably a little bit more understanding of it these days but I think my initial reaction would still be that to begin with, and it may take a more in depth analysis of that person and the circumstances and what's gone on before to try and make sense of it but I think unfortunately my first reaction would be er, you know, what the hell are you playing at, get a grip of yourself (David:6).

My views on it were incredibly negative, even to the point where 3 years ago when I was working custody there was a young lad who was a serviceman who'd been arrested for a drunk and disorderly and I was ticking him off at sort of 4 in the morning and he started crying on me, and I said what you crying for, you know, we're letting you go, nothing's happening to you, you've slept it off, and he said oh you don't understand it's what I've seen, and I was like yeah okay, pull yourself together mate and out you go. And that was my approach to it. And I actually sort of remember mocking him to the rest of the team saying what a ridiculous, he's paid to do a job and he can't even do it (Gary:7)

Some felt that support services therefore simply weren't relevant to them

I've been quite dismissive about it thinking, yeah yeah there's counselling available and you're thinking, no sorry, okay fine thanks for coming down, thanks for your concern but I'm absolutely fine, thank you very much. And I think yes, there is part of me that is still ex military … that says yeah fine, I'm roughty toughty I've dealt with things like this, don't need this, thank you very much (Steve:4)

For some, the mere thought of having problems was hugely out of sync with their self concept

I was in the Falklands and Northern Ireland in the army so I probably don't need to tell you what that was like and what I saw and what I did in those situations. In the police force I've been to you know child murders, horrendous road traffic accidents, stuff like that, I've just about seen it all and I've not had a problem. I hope I never do, I think I've got the strength of character, the mental strength, not to, but if ever I did get to that point where I did lose it where I couldn't face anything like that I think I would be so disgusted with myself, I'm not quite sure but I wouldn't really think of myself as a person anymore I would just be completely contemptuous of myself. I hope, and I'm confident that I'll never get there (David:7)

This would prevent them from accessing support

I would see myself as a failure and I probably wouldn't want anyone to give me any sympathy because I don't deserve it, (laughs) because I've failed (David:9)

The drive for action and adventure could alter an individual's perception of whether something is traumatic. Peter described coming under sniper fire

But I find them exciting you see? Me and this lad just dived behind, behind a Heskell bastion, made our weapons ready. We're looking for the sniper who'd shot at us and we looked at each other and we smiled and giggled. And the other lad said to me, "Ah, it's fucking great this Pete. Fucking great. I love it. Love it!" and he was a 50-odd year old ex-policeman, and we were both ex-military. The import of the situation was there and it was ever present but we still found it exciting rather than traumatic (Peter:17)

Whilst accepting that they are exposed to the risk of psychological trauma, the group has methods of minimising the risk.

4.3.2 Preventing injuries

Focus on the job

A common strategy is keeping focused on the job. Throughout military basic training, individuals are taught to do this and build endurance through containing any emotions that may arise *… you could not show any signs of weakness whatsoever, whatever you went through, whatever you did, you were expected just to deal with and get on with it … you did the job, you did it to the best of your ability, if you didn't you were weak (David:8)* And weakness was punished *… a lot of the senior NCO's would resort to a little bit of violence to persuade people to do things (Tom:1)*

You know when I was a young Marine you never went sick, if you went sick you ended up in the cook house peeling bloody potatoes all day which was harder than actually doing the job, so you just never dropped out of anything (Tom:6). It was better to push through the pain … stupidly I would take pain killers, I would strap myself up and go and do something (Tom:6)

I was there because I was doing a job and one of the things that I was expected to do, and should do, is deal with it … (Peter:3)

… war's war, you move on. (Rob)

This military attitude of setting oneself aside and seeing the mission as paramount remains important in the police.

… you turn up at a scene, you deal with what you see, you deal with it correctly and you put your own emotional feelings on hold, it's not about you, it's about dealing, getting paid to do a job, so do the job and then worry about everything else afterwards (Matthew:3)

You know at the end of the day we have a job to do, sometimes it's not a particularly pleasant job to do, but you get on and do it (Jack:6)

I think you've got to be pragmatic about the way you view everything really, and I think if you are you tend to cope, that's your coping mechanism .. if you're a pragmatist you tend to cope with what's thrown at you because it's just another thing and you've got to deal with it (Peter:5)

Focusing on the task in hand and what needs to be done allows them to distance themselves from what would be unhelpful emotions and is vital in a military setting where survival of the unit is reliant on doing the job well.

You're not concentrating and thinking about what's actually going on, you're not just standing there thinking, oh my God I'm going to die, you've got a job to do (Tom:3)

If someone gets killed on patrol which has happened to me, you have to sit the lads together and say right we have got a job to do, there's no point sitting and moaning about it and we get out and do it, you know it's not palatable but unfortunately that's the way of the world and I think if you're out in places that are dangerous like Afghanistan … you are almost mentally prepared for what the worst is going to happen (Tom:4)

Focusing on the job can be a powerful distraction from problems allowing them to be boxed away temporarily

Because you go to work, erm I find in the police force you're a different animal at work, I'm a different guy at work than I am at home and I could go to work click into PC X or police sergeant X mode and it never seemed to bother me (Rob:6)

Basically you have like a work persona and then when you go home, you have your home persona if that makes sense (Charlie:4)

Whatever the cause of the problems, this ability to continue with the structure and routine of work is helpful

I'm not a big advocator of people going off sick or being given gardening leave or that because as far as I'm concerned that would make you worse … Because you're then back in the environment at home. If it had been me I'd have gone back to kicking the dog, swearing at the wife whereas at work I wasn't and I found that being at work being stimulated helped me (Rob:12)

I knew I could always come to work, do the job, go home – might not be particularly happy on some days … What was best for me was to keep doing something. Not to sit down and dwell … yes keep a routine. (Peter:15)

It's what keeps us going, that fear of falling ... not seeking help, getting on with the job, not succumbing to the problems (David:10)

Strength through emotional control

In the police, as in the military, removing the emotions from a high intensity situation is an adaptive response *that lends itself to certain situations. It means that in certain situations I can still take what I think is a reasonably balanced view of what we should do to stay safe or to do whatever I need to do (Peter:19)*

This doesn't necessarily mean that fear is a bad thing *I think a person who's not scared is a dangerous person … you can be reckless in your control, and you see it with the Afghans who I worked with out there, their culture is not to show any form of fear, but they are reckless in what they do, they'll stand up in full front of the enemy and fire off a magazine in the wrong directions, stuff like that ...*

It's controlling that fear that counts
… That's not the way we do things because we've got the discipline, mentally and physically to control and also the command structure is in place to control lads that are not doing things right (Tom:3)

As well as keeping a balanced view so that the job is done, this mission focus continues to allow the ex-serviceman to distance themselves from the emotions of the police job.

We sort of protect ourselves with the cloak, if you like, of doing the job, we are doing the job we're doing a vitally important job and I think that is there for us and helps enormously if you have a job to do and if you don't do it then people could get hurt, people could suffer, criminals could get away so you've got that… Mission focus. And that attitude is not always there to the members of the public so I think we as ex-military police officers are in a better position to deal with it (David:11)

Sudden deaths – they're quite unpleasant but people die and it doesn't matter what it looks like or what it smells like, it's another death. I'm not being cold or heartless, it's a tragic event for the people around that person, but I didn't know them so I can't feel very much about the situation. The more you know about the situation, the more you tend to feel. Well I don't particularly want to know and that's not being uncaring, it's that I've got a job to do and I don't want to mess up all that job by knowing everything about that person (Peter:17)

I've always been able to, I suppose quite brutally almost, control my feelings. I can walk away from things … I like to know that I'm in control (Gary:10)

However, this approach could be criticised by others who didn't understand it

I'm absolutely sure it's a defence mechanism but my response to things will be minimal, and people can accuse me of being a robot or, you're just a robot, you're just on autopilot, you just don't think too much about it (Peter:3)

Or could be at a level where the individual blocked all emotions

I was very ruthless, I would literally have no feelings and no emotions for anything. I wouldn't break into tears about anybody or anything. I'd always been very blasé at fatals, you know, 'get over it', 'it's happened, somebody's dead', 'just a piece of meat,' never had any feelings about it or anything like that. I got quiet when I came home for a bit but I wouldn't bother (Paul:3)

4.3.3 Remedying injuries

Rest and recuperation

Despite the ability to focus on the job, there is recognition that everybody has a limit and it can't be used indefinitely without having chance to rebalance.

Well how I'd equate stress, is I equate humans to a sponge and at some point you can drip water onto a sponge, at some point it'll overflow, once you empty it out you can absorb it again and humans to me are exactly the same as that (Jack:3), you have a bad day and then if you have a good day the next day then that bad day gets wiped out. If you have a bad day followed by another bad day followed by another bad day then, no one can cope with that can they? (Tom:4)

Rest and recuperation needs to be provided in balance to frontline work

I think nowadays there are people that do have problems and at an early stages of the sort of problem, where they can be withdrawn, maybe moved somewhere else or maybe have a quick chat and then pushed back in (Tom:2)

I think when something happens in your life and it does affect you, and you acknowledge and it's affecting you mentally, and your concentration isn't what it should be and you're in a job where you need to have 100% concentration, I think it's right and proper that you make that known to somebody and that you have a break from doing that. I would never for a second criticise anyone for that, it's the right, adult thing to do. It's a good decision (Peter:7)

Give them a sensible life cycle, so they're not at the extreme edge 24/7, 7 days a week, which just destroys people's social life and emotionally it just brings them down and down and down. It's, allow them to, sort of, recoup (Matthew:3)

In combat this is not always possible

You identify it then you've got to make a decision. Do you take them out, do you give them a rest or do you send them out of that environment? And normally, giving them a rest, and that's why R&R's in place, you know rest and recuperation for two weeks. It's important that people get away from that environment, take a little bit of a rest because the hours that you work out there are incredibly long but you, if everyone who had problems out there was sent off the frontline then there'd be no one there (Tom:4)

In the police service, it was felt that this recognition of human limits was ignored in favour of a focus on targets

You could call it burnout couldn't you? I think it will happen more often now to young officers that have just joined and have gone on section. In my force, they are so busy, really genuinely very busy and there is a lot of pressure put on them to perform from the minute they join. And because we're always fighting and reaching for targets, that I think after 2 or 3 years on section, people will start to burn out and start to under-perform (Peter:14)

Too busy looking at facts and figures, you know sergeants and inspectors are bombed by big bosses - you must do this, you must do that, you must do this - so they push their troops on, push their troops on … and probably don't see that it's wearing them down (Rob:15)

Accepting reactions as normal
Once the job was done, the contained response needed to be dealt with and this was often done internally through periods of withdrawal or quiet reflection

When you deal with something kind of traumatic you kind of walk away from it and do think about it, you do dwell on it, you do wonder about it. My particular method of dealing with it is to analyse it myself, and try and see if I could do anything better, or improve what I did, to make the outcome better, and really sometimes I'll analyse it, not constantly, for a couple of weeks until I've satisfied myself that I did the best I could then it's kind of filed away in the war stories (David:8)

Peers could be kept unaware of this self containment

So it's hidden, a lot of it is, very hidden (Rob:11), in the privacy of your own room when you shut the door in the block you did reflect quite a bit, but you never showed it (Paul:2)

or if they were aware would recognise it for what it was

You could see them withdrawing inside themselves because all this stuff is going on, you know, and then we would just take the micky out of them and they would outwardly be fine but deep down you would know that it's still an issue for them (Bill:9)

Some people were quieter than others, when a discussion like that went on and you knew they were there. Some people didn't really, er, bring anything into the conversation, they would just sit and listen (Peter:3)

Where there is a reaction to an event, many participants accepted this as normal even when it was causing difficulties.

I don't really regard sleepless nights or perhaps a bit of reticence, sort of quiet time where you don't really talk to anyone, I don't really regard that as PTSD you know or a manifestation as a reaction to trauma, I think that's just a way of dealing with it, what you need to do to get closure (David:8)

I went through what you go through for any sort of traumatic experience in that sort of 2 months of just feeling like shit, and I recognised that (Gary:8)

I understood why I wasn't happy. It wasn't a mystery to me. So that didn't cause me extra stress or whatever or extra pain… I understood the position I was in, I knew why I was in it and I sort of I understood I wouldn't be feeling happy and cheery every day (Peter:15)

Black humour

"Black humour" was another coping strategy and described the ability to find humour in any emotionally dark or distressing situation, whether in the military

We got scudded one night, and they were coming quite close to us as they were detonating, but we just laughed and joked about it, you know, "that was close" and stuff like that (Paul:1)

We had lots of traumatic things, people getting shot, blown up, you know shooting people and all sorts of things of that nature, but everything that we dealt with at our level, was all done with black humour, we would talk it through, laugh at it and that would be how all that was dealt with (Bill:6)

Or in the police service

It's, police officers have a very, very dark sense of humour. You go and deal with a horrible sudden death next thing you're having bacon and eggs and talking about it and you see these young bobbies now just can't cope with that whereas all the ex service lads sit there and it's not a problem (Rob:7)

… you just get on with it, you laugh and joke about it (Gary:8)

However, in the police service, the use of *"black humour"* could be problematic

Now in police stations there is an air of mistrust where the slightest inappropriate comment or joke can land you in it. There seems to be little differentiation between those who may hold inappropriate beliefs and those who are simply venting (Jack:wf)

In the land of political correctness we don't, you know, there are certain things we don't use and say anymore, but in the military we always used the saying, you've got black humour. And it makes no difference of what the world wants to say about diversity, you know, it still exists today and we still use it today and we still deal with it in a certain way (Matthew:3)

You've got – "oh professional standards" and you've got your, "you can't be saying that, black humour" you know, "keep it to yourself" ... again a lot of the time with ex-Forces guys who'll still rib each other and that sort of thing, which I like, that suits me but it doesn't suit everybody… and of course in this day of all blame and claim and everything else, you could end up losing your job that you enjoy doing, because you're trying to help somebody. Everybody is so wary of stepping outside the boundaries of everything these days (Bill:7)

Peer support

Peer support is a crucial element for coping with the job. Good peer supporters could be trusted not to judge and this would be reciprocated

I am who I am, and the people who know me really well, accept me for who I am and regardless of other outside influences, those that know me really well know me as a good person and I'll do anything to help those that are close to me, you know, anything, I'll go out of my way to help people, so they're the people who care (Matthew:12)

Where peer support worked it was felt to work very well because the supporter could understand the other's experience

I'm a firm believer that there's a big difference between empathy and sympathy. People offer you sympathy and half the time you just want to smack them because it comes across as condescending but when people show you empathy, that you have something in common with that person and it, when somebody shows you empathy because they've come through the same factory that you have, the same mould as you have, they've experienced what you've experienced, then they have a right to nod their head and say I know how you're feeling mate, because they've been there. (Matthew:6)

I'd just want to speak to somebody who understood, you know who'd been through similar sort of trauma so you can relate it to them (Jack:9)

Good peer support could take the place of outside support

I didn't look for it because to me, all the support I needed was all around me, you know, it's the people who were doing what I was doing, understood what I was feeling that, erm, I was more happy being amongst those characters, and it's the one thing I still miss to this day, to be truthful (Matthew:6)

I wondered how this translated to the police service
It doesn't. It doesn't here. If I've got any issues then I speak to like-minded people I know and the people in the police that are closest to me are ex-Marines anyway (Matthew:7)

Much of this peer support was in an informal, social setting and allowed individuals to vent and express thoughts and feelings that had been contained whilst the job was done.

It was all dealt with you know, everybody having some drinks, social black humour, and that for me and for the guys in my peer group, worked a treat, because the next day, you'd have spoken all the stuff that you'd wanted to say, said everything that you were thinking, and you knew that they felt the same as you and that was good. I never had any, or knew any of my friends that had any sort of official treatment, but that's how we dealt with things, you know in those days (Bill:6)

In days of yore, police bars were where decompression occurred as you could openly discuss things in a safe environment. Not all that was said was politically correct or even pleasant (hangman's humour), but officers got it out their system (Jack:wf)

There was a warning though that relying on this alone was risky
Is the right person listening? Is it the right place to be doing it? I mean is it good to be venting off when you're drunk? Again maybe it's me. I would rather do it on a level playing … clear head, give my opinions properly, correctly rather than … your opinions do change when you've had alcohol don't they? I mean I'm sure it works for some people, getting it off their chest that way but it's not going to get recognised is it? (Rob:16)

In the police service, peer support was not always available where the individual didn't work alongside other ex-servicemen
Before that, I had that military support network, all my colleagues were ex-military and we all had that same level of humour and banter so we dealt with things which I couldn't do as a supervisor coming outside. I had my subordinates, but they weren't interacting with me in the same way. I do think that is a big, sort of, correlation. Yeah they were my coping strategy (Gary:10)

The available informal social environments could also be missing.

They've done away with all the police clubs and bars, things where that would have happened, you know, when you would have, you've been to some horrendous car crash or something and at the end of it you, someone would have grabbed you and you know go up to the bar and have a chat and a drink, but that doesn't happen anymore because they've done away with all that. Yeah, at the end of anything that is traumatic obviously they offer you the support and it's there but a lot of people, what do they wanna do, oh well I wanna go home now, you know I just want go to bed. Really I don't know, I mean I think it's a good thing to get it off your chest before you go home to bed (Bill:7)

In days gone by we used to have police bars if you'd had a particularly crap shift you would all go and finish early, go down to the bar and sink a few and talk about it, but now because the bars have been shut, not a lot happens (Jack:10)

The quality of peer support could vary depending on who was expected to provide it

Everybody on my section were all ex-military and they were much older, they'd done a full 22 plus years, most of them had been to the Falklands and things like that and their attitude was very much old school, and it was a case of you just get on with it (Gary:8)

I would say there was very little understanding at ground level between him and his contemporaries, between him and his colleagues, of mental health issues because they haven't come across it before (Steve:3)

Alcohol
The use of alcohol as a social lubricant was encouraged by the military

It still is, the military virtually relies on alcohol to a large extent nowadays (Tom:1)

I mean certainly the way of dealing with it when I was in was confine you to barracks for 24 hours and give you loads of beer, and to some that might seem a bit crude but it actually worked very well (Jack:9)

Outsiders could view this negatively
It's just the view that that's the typical way the forces deal with it. Throw alcohol at it and it'll go away. But I actually think it's quite a clever ploy because the alcohol would relax you, loosen you up, loosen your tongue a bit, and maybe make you speak a bit more about things, and then if there is any issues to be debated, discussed, finalised, any conflicts, it can be sorted out amongst the people you've just spent however long with. We actually found that worked quite well, have a good chat with your mates, especially if somebody was injured or God forbid killed, you had a chance to go through that and talk about it (Jack:9)

However, the use of alcohol as an individual coping strategy was recognised as potentially creating a vicious cycle that lead to abuse of alcohol and further problems

It wouldn't cause mental health problems but it would exacerbate them because people would turn to drink and yes, it was, you have to be constantly aware of it (Steve:2)

There were a few lads that went a bit wonky after having a few beers (Tom:1)

… quite deep mental health problems which actually ended up making him an alcoholic, which the Job then sort of pounced all over him for, which then exacerbated his mental health problems, which then made him go to drink (Charlie:3)

4.4 Engaging with the Enemy

This category relates to the phase where there is an identification of symptoms within self. It looks at how these are recognised and what causal attribution is given. Whereas before mental illness has been rather abstract, "out there," now the threat has become very real to the individual. Previous categories considered the almost clinical perspective of "what do I know about this threat?" and "what do I know about my capabilities to deal with it?" This category covers the embodied experience starting with denial (through ignorance, dismissal of others' concerns and personal non-acceptance). It encompasses the process through emerging awareness and sense-making as the individual attempts to remedy the situation with group-acceptable strategies right through to symptom escalation into crisis and the tipping point where the individual fully accepts there is a problem that requires help from others. Participants describe the very real sense of existential crisis that occurs. Figure 4.6 provides an overview of the sub-categories.

Figure 4.6: Engaging with the Enemy: Sub-categories

Main category	Sub-categories
Engaging with the Enemy	Becoming aware of a problem in oneself • Ignorance and denial • Others' concerns Escalating problems Existential crisis • Admitting to a problem • Fast action

4.4.1 Becoming aware of a problem

Ignorance and denial

The majority of participants had directly experienced problems but *didn't notice them straight away (Charlie:4), you don't realise you're in anything for a start (Paul:12)* and often i*t was too gradual … over the years I wasn't aware of it at all, but looking back I can see it now (Gary:9)*

I didn't know I had it but yes I did … I think it's something that you, you ignore … things like it was lack of sleep, trigger points that would set things off, things, all things that I could tell other people they had – you don't see it yourself, not at all … I think that's very common in servicemen, very common indeed (Rob:4)

Where symptoms were noticed, they were not recognised for what they were *This has been going on for years since I was in the forces. Towards the last years of the forces. I just thought I was normal (Paul:4)* because y*our own perception of what's going on is so slanted and coloured that it's very difficult, it's the old wood for the trees thing (Steve:9)*

Where symptoms did come into conscious awareness, there was a lack of accepting they were a problem that needed more help

There were times definitely where I knew, I think I knew it was an issue, but I wouldn't accept it as an issue (Gary:10)

I knew something was wrong, I knew something was terribly wrong but I think it's … until you admit to yourself … it's a bit like an alcoholic isn't it? Until you admit it to yourself then you don't put yourself forward to get the right treatment. But again it's back to the stigma. If I don't tell people that I'm mentally ill then it doesn't matter because I won't be (Rob:14)

Looking back on it there were hints throughout the 16 months that it was sort of lying dormant where it would sort of sneak out of the closet, there were hints where I'm thinking hmm … Most of the time I couldn't see it (Steve:5)

There was also a belief that the individual could handle it and not coping with symptoms was a failure
I'd always thought of myself as being fairly level-headed, fairly robust, and yes I was going into somewhere that I didn't know but it's one of those, yeah I think I can deal with it. I suppose it was almost a bit like, thinking back, a bit like maybe how a heroin addict gets started. I'll just try the one because I won't get hooked … but I, you know, because you think you can manage it. They think they can manage it … and obviously I couldn't in the end (Charlie:4-5)

This effort to manage came at a high price *You're drained, you're staring and everything else, but you can't pull yourself out (Paul:12)*

Others' concerns

There was a real impact on relationships particularly outside work *I just became quite unpleasant to be with, completely reclusive towards, sort of, the end and just lost all interest, all that sort of disassociation with being in the family and became quite a nightmare to live with ...* but a lack of education disempowered family *… they could see it but they weren't sure what it was so they didn't challenge it (Gary:9)*

The lack of understanding could lead to unhelpful interventions
My mother's quite a hard nut and she often used to say to me "just pull yourself out of it" and I think the worst thing you can ever say to anyone with PTSD is pull yourself out of it. (Paul:12)

Added to this was the need to ignore problems for fear of personal shame
To be truthful I didn't want to taint her image of me, to be truthful (Matthew:4)

Mental health was never a problem in our family because it was always very open about it but it's alright being open until it's you isn't it? Then it makes a massive, massive difference (Rob:6)

It was felt that openly disclosing to family could mean that the problem isn't contained at home

Why traumatise your family members through it? There's no need, and there's sometimes things they need to know and there's sometimes they're better off not knowing (Matthew:3)

It's a mental thing for me to shut my locker door and whatever I've dealt with that day, I turn the key and that's me finished, and I just shut the door on everything, it's all locked in there, good bad or ugly whatever (Bill:7)

We then tried to make the best out of what time we had actually together so again we didn't address the issues that were festering away. Yeah, yeah, which is a foolish and probably a little bit of a selfish way of looking at it, but I don't know … I don't know how else we, what else we would have done really (Charlie:6)

People in the workplace were sometimes aware and attempts were made to confront the issue
There were hints there but it wasn't until talking to colleagues, very good friends and they'd say, look you're saying that you're really wound up and anxious at times, perhaps you ought to speak to somebody from the counselling (Steve:5)

I'm sure there was instances where people had gone, cor he shouldn't have done that, excess force or being abusive to people, erm but it was never really flagged up … a couple of my mates were aware … my supervisor was an ex-Navy man as well and he knew (Rob:6)

Even when concerns were raised, whether at work or at home, the denial often continued

I wasn't listening to anybody. My wife told me for years and years that I needed to see somebody and that used to spark some horrendous arguments because I would never admit to being in this. She's gone through hell for years (Paul:10)

I thought no, there's nothing wrong with me. Thanks for your concern but I think you're being a little bit overdramatic. What on earth are these people on about, they don't know what's going on inside my head like I do, and I'm fine (Steve:12)

Paul even attributed his rage to being an *alpha male … I'm from a typical Northern Irish family, my dad's side are quite strong headed and quite short tempers, so I just thought it was part of life. I thought it was just normal … I thought every bloke was like this (Paul:4)*

4.4.2 Escalating problems

As problems escalated and could no longer be ignored, the individuals continued their use of the group's preferred coping strategies. As these became over-used, they brought their own problems

I was told that I'd burnt myself out because I was constantly working and I thought about nothing other than work (Paul:6)

Some went the other way and lost all interest in the job when mission focus no longer worked as a strategy
I'd lost that drive and incentive, I think is the best way to put it. I didn't have a drive and incentive for a career or a move forward in life (Matthew:5)

For the ex-serviceman, the impulse to take action, whether in the form of fight or flight is strong. The military encourages controlled aggression and anger was a very common way of venting the inner turmoil.
In the forces, you're encouraged and developed to become self-reliant and resilient, that traditional British fighting spirit, when the chips are down you come out with guns blazing (Jack:2)

However this was not controlled anger

I've never been violent towards my wife or the children, but I would think nothing of ripping a door off the hinges. I would think nothing of smashing something up, because I'd just go into this tunnel and everything would go literally black and I would just go into this rage that I had no control over it. No matter what everyone says about you can control your temper, you can't when you're in this state, everything would go black, I couldn't speak to anybody apart from make stupid sounds (Paul:4)

I'd drop my keys on the floor and have this massive rage, huge rage and start trashing things. My language became appalling even towards my two year old child and she would do something wrong and I would be telling her to effing well shut up which isn't me. I'm ex-service I can swear with the best of them but I wouldn't do that at a child (Rob:3)

Individuals could pick fights to have the opportunity to release this anger
It was just lashing out in general. You know, I'd find things … because I'm very, sort of, laid back chilled kind of character, but I would be obstructive and be, I'd disagree for the sake of disagreeing (Matthew:5)

We would have an argument about football, women, whatever and it would move on but this became wanting to, not hurt him but like bollocks to you, I don't want anything to do with you anymore, and it was, the reaction to anything was so over the top from what it should have been (Rob:6)

I was very aggressive. I would … very wrong for a police officer, very wrong at the time, but I would quite happily walk down a street … I would literally walk at somebody if I didn't like the look of them and see if they'd bump into me (Paul:4)

This loss of control and self-discipline brought with it fear and shame
I'm not a small bloke and I'm a little bit scared of what I might do. I've almost been on the precipice of, shall we say, and I've actually sort of withdrawn myself from it and thought, if that had gone wrong and I'd continued then the person who was triggering it, well I would hate to think of what would have happened (Tom:13)

After I'd done it I'd feel immediately guilty (Paul:4)

And the anger could be directed at oneself
I think I was on self-destruct, to be truthful when I look at it (Matthew:5)

As problems escalated, the fight often turned into flight where the individual just wanted to walk away from life and often went AWOL
It all reached a head … I had about 48 hours off the radar. … went to come back home – and didn't (Charlie:4)

Life was crap. It was really crap. There were a couple of times that I'd got into my car and just wanted to drive and just keep going. Although I've never ever thought about suicide and never will do, I can certainly understand why people disappear. Now I could never ever think about that before but now I fully understand how people vanish off the face of the earth (Paul:9)

There were a couple of occasions where I thought that, I'd had enough, I'm just going to go for a bit of a walkabout, I'm going to give everything up and leave everything and just walk off and just go and see the world (Matthew:5)

This could be as intense as dissociative fugue
I just went into complete meltdown and found myself walking around the city centre, didn't know where I was, and lost 8 hours of my day (Gary:9)

As the ability to block out and contain emotions deteriorated, it could lead to re-experiencing of the traumatic material

The nightmares were horrendous. Sometimes I wouldn't eat for a day or so because I'd be able to taste decomposing bodies in my mouth after a nightmare and I still do thrash about in my sleep, so I've been told, cos I wake up although I've not done it for a while, I'll wake up with no sheets on the bed and I'll be on a bare mattress (Paul:5)

The genie's out of the bottle and I'm seeing dead bodies by the side of the road and not having a very pleasant time of it … and it all came to a head when one day this summer, we were having a barbeque outside and the wife gave me a, the meat to put on the barbeque and of course it had been in the fridge, it was cold and I'm handling cold flesh and looking at it and bang I'm right back at the roadside looking for matey's head, to see whether I could give CPR or not basically, which turned out to be a big no. Looking at it and I was right back at the roadside (Steve:5)

Several participants believed that they just needed some rest and recuperation and *thought I must have been really tired (Paul:3). All I need is to be signed off for a few days so I can sort myself out (Gary:11)*

Time would heal things
Yeah, it was always something that I thought right okay I've got a handle on this, I can cope with it, time will sort it out (Steve:6)

One participant talked about how he developed another behaviour (Obsessive Compulsive Disorder) that attempted to control his world
I developed OCD quite badly with different things … I'll put it in military terms, the fear was that I'd appear to be a minger and that I didn't care about anything and everything was dirty. Yeah, I'd be judged on cleanliness. I'd be judged professionally. If I was summonsed to court or asked to go to court to give evidence, that to me would be a question of my professionalism. So if a defendant wanted to go to court that would be him questioning my professionalism at the time it was done, so I'd take that very personally, other people don't, but I did. I took it horrendously personally (Paul:6)

For a serviceman who prizes self control *it was very scary … because it was something that just grabbed hold of me and it basically took over my life (Steve:4)*

Using alcohol was a coping strategy for some
… him and me would sit and drink ourselves to oblivion erm try and clear it that way (Rob:6), yeah drinking too much, that's without a shadow of a doubt (Charlie:4) And instead of having 3 pints and getting my head down, I'd have 12 pints and get my head down (Matthew:5)

and a temptation for others
I think leading up to it, those sort of 6 months that I was walking home from work and I was walking past lots of pubs and it took me every ounce of my self-control not to go into them, and I don't drink anyway, I never have done really, so it took me a lot but I was looking at that as a way out (Gary:11)

You look at an empty wine bottle the next day and think, hmm, yeah, let's try and stay off the wine (Steve:5)

Turning to alcohol was a huge fear in itself as it represented another loss of mental control and *just going mad, literally in a mental sense of the word mad. I was just frightened that it was going to get out of control and I could see … that if I didn't ask for help, that (alcohol) would be a way out (Gary:11)*

4.4.3 Existential crisis
As problems could no longer be dealt with alone, some individuals faced a real existential crisis as the reality of the situation didn't fit with their sense of who they were.
I've always had this issue, I don't know why, but I've always been concerned that I've always said since I was very young, I don't mind if I was ever disabled but I would never want to lose control of my mind, and I would have felt that that was a massive, massive sign of weakness in myself. Not being able to think for yourself or control your feelings (Gary:10)

I've served in wars and in the police, people like me don't get mentally ill. I think you see yourself as indestructible, totally (Rob:3)

How can this be happening to me? It doesn't happen to me, which is a very humbling and shocking thing to admit to yourself (Charlie:9)
Paul literally lost his sense of who he was
I just thought, I got up the next morning, couldn't stand up. So I thought, right, I decided to get some fresh air and put my iPod in, walked into our village and couldn't have told you my name, who I was, where I was (Paul:3)

The level of distress led to thoughts of suicide

I thought, yep, even at one stage I'll end up going head on, straight into a nice big HGV, coming the other way. It's at 100 mile per hour and I'm doing 60, not a lot's going to last. But for whatever reason, thankfully I didn't (Charlie:5)

And I've never been suicidal at all. I've always seen it as a coward's way out … but I could at that stage, and I can now understand why people do it, which I never had done before (Gary:11)

Admitting to a problem

The intensity, and inability to contain these emotions could prove to be a turning point.

Very frightening. I think it was the fear (of not being able to control feelings) which drove me to ask for help. (Gary:10)

It was that point you realise you know time isn't sorting it out, it's now been 17, 18 months and you are no further forward and if anything it's getting worse, and I think that that was the big realisation point (Steve:6)

And it was at that point, I thought, I need help, and I managed to find my way home and my wife was away, she came back that night, and she walked in the house and as soon as she walked in the front door she thought either I was going to leave her or that somebody had died, she could sense it. And I just broke down and said I need help. It took 8 years (Gary:9)

Many initially felt contemptuous towards themselves

Completely worthless. I'd failed, I'd failed myself, I'd failed my family (Rob:3)

At first, very weak, at first, I'd let myself down and let everybody down and just pathetic really. Not now, but I did then (Paul:6)

It's just a big reality check, I sat in my car for about an hour and spent most of it in tears … tears for myself, tears for making my wife's life hell for about a year and a half, again I think it was just everything came into reality of what a complete arse I'd been … I need to get back to the man my wife married not the man I've been for the last 18 months (Rob:5)

Fast action

One thing that was clear was that once the tipping point was reached, action needed to be taken quickly

I think I had the first session within about 72 hours, it was jacked up very, very, very quickly. But yeah it was sort of, you know, get through, soup mode, switched off, unplugged, sort of do what you need to do and then take it forward (Charlie:7)

I remember when I asked for help, my wife knew by chance … a trauma specialist, and she rang her up late this night and said look, this is the situation, he needs, and we need to squeeze him in (Gary:11)

Take action now would fit.... Bang on. When they have admitted a problem, it is a case of right let's get it sorted. Bear in mind the swiftness of a military medical response to a referral where you are talking in a matter of hours or days as opposed to weeks or months (Jack:wf)

4.5 Calling for Reinforcements

This category relates to the phase during which consideration is given to disclosing the mental health issue to another party specifically the police organisation or health professionals or both. It captures the process of making a risk assessment and the individual's decision about who to tell. This revolves around asking who they are in relation to the in-group and considering who is willing and able to help. Potential helpers are judged on perceptions of trustworthiness, respect and competence. The individual's previous experience of organisational processes or interactions with mental health professionals has a bearing in this phase. The role of a trusted peer can facilitate this step into uncharted territory. Helpers are assessed according to the degrees of separation between their standards or way of being and the groups' norms of mission focus, cohesion and strength and control. For some the result of this judgment will be enough to deter them from seeking help from either or both sources. Figure 4.7 provides an overview of the sub-categories.

Figure 4.7 Calling for Reinforcements: Sub-categories

Main category	Sub-categories
Calling for Reinforcements	Assessing the risks of calling for support • Fear of disclosure Judging the potential helpers • Trusting the organisation • Feeling cared for by the organisation • Organisational competence Working with foreign forces • The competence of mental health services • Degrees of separation

4.5.1 Assessing the risks of calling for support

Fear of disclosure

The fear of disclosure related to a sense of admitting to failure, that the individual couldn't cope and this provoked feelings of shame

There was a feeling of dread inside of me. There's always the thought of, oh right okay, I'm going to turn around and say ha ha I haven't been able to cope with this, I need help, and there's always the thought in the back of your mind, well, are people going to look at me like this forever? Now, I should be able to deal with this on my own (Steve:6)

I think they'd say something along the lines of, he's not quite as tough as he makes out to be, you know, he's not quite the copper I thought he was, not quite the person I thought he was, I think that's probably the sort of thing they'd be saying … very shameful (David:8)

My first thought would be no, no-one can know about this … [laughs] It would show my weakness to everyone. Once you've done that it's out in the open isn't it, you've suddenly realised that you can't cope anymore and it would be showing weakness to the outside world … and I don't think I could live with that (David:7)

Minimising the disclosure, and resulting consequences is *important because the control is what I need. It's part of the anxiety isn't it? (Gary:14)*

In the military, containing the issues within the unit was important

Self reliance means not asking for help ... further, not asking for help outside your unit, company, battalion, regiment, force or armed forces. It is like a ripple pool effect, the further outside the ripple spreads, the more embarrassing for the individual (Jack:wf)

They wanted it kept behind closed doors and it is quite pally especially when you're working with people like the Royal Marines and you're their doc, that's it you're their doc and they don't want to see anyone else for anything (Rob:2)

Ex-Marines, they talk to me one on one, but we certainly wouldn't discuss it with other individuals outside that particular group (Matthew:12)

In the military, the more people knew the greater the risk of removal
It's all come out then, he's gone to see (the psychiatrist), he's lost the plot, sergeant major's like get rid of him, don't want him, you know they think everyone who's got mental health problems is going to be a psychopath (Tom:16)

And similarly in the police force, they could be judged as not fit for purpose

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Maybe someone applies for a post or something it'll be oh well are they strong enough to deal with it, and they're going beyond the health and safety concern, or realistic is this the right role for the individual, it's almost sort of derogatory in a way (Jack:6)

I think the problem with reporting anything, you're never going to get a decent job again. If you put down anything to do with that, they look into it, most people, they've got very little understanding of it and they would go on a paper sift, oh, we're not touching him with a bargepole (Tom:8)

Therefore there was a dilemma as to whether it was safer to disclose to external professionals or keep it in-house. Going outside work to *your GP, that's completely and utterly separate from your work life because they can't pass anything on to your force medical advisor. Without your authority can they (Tom:12)*

Retaining this control over disclosure was a big issue because *cynicism and reality are very closely related, if you go within the Job, somebody, somewhere will write it down (Charlie:4)* and *as soon as that's marked down in any sort of documentation that's a disclosable document to the people that require it and I think that, anyone who's seeking any decent work will never get another decent job again. And that's the God's honest truth, that's the way it is, I've had people who've had problems and they've reported it and they've never had a good job again (Tom:9)*

When doing the job has been the coping strategy, dealing with this risk is particularly tough *Dread, absolute dread. Because I knew full well what was going to happen in as much as I knew I would be going into work and the job that I loved doing, I would not be able to do and you think right if I can't do that, what, that was, if you like, the one thing that had been keeping me together, my reason for going to work was, yeah, deal with all this but now I'd be going to work and I wouldn't be dealing with that, it would be, well, what am I going to do? (Steve:6)*

It could be safer not to seek professional support at all so that nothing was official.
When I came back, one of the questions was – have you had any mental health problems or not? I put down no because I hadn't. Is that because, am I lying or am I saying I've never been to see anyone about it? I'm not a mental health professional so I can't say whether I have or I haven't. And that will always be my line, no one else has seen it in me, I haven't reported it to anyone so that's my bottom line (Tom:14)

Controlling the disclosure was also about limiting the number of people who knew *and not every time that you went or spoke to … it was somebody different or somebody you had to explain yourself all over again because I would lose the will to live personally, and I wouldn't bother … because you're asking that one person to divulge their innermost everything and you can maybe do it once to one person but not to have to keep doing it all the time (Bill:10)*

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4.5.2 Judging the potential helpers

Trusting the organisation

When judging the fitness of the organisation and managers to be of assistance, the individual would consider how trustworthy and generally competent they were.

In the military, despite the often negative messages about mental health, there was more of a sense that managers would look after you. There were examples of organisational support at its best

The bosses were very good, we were very close to our bosses unlike some units, this is where the RAF regiment were different as in the Marines they were always quite a close, a close knit bunch of lads and our bosses were very close to us. So there was no "get on with it, don't be so soft" none of that, in fact the day after, one of the Bedford wagons showed up outside the barrack block and the flight sergeant and his wife took us all round to their married quarter and they filled it with beer, got the barbeques going and all the single lads, we were told to just drink as much as you wanted, eat as much as you wanted and then just fall asleep wherever you could, about 30 or 40 of us, erm and as we were there his wife was coming round making sure we were alright, it was very, very close. I'll never forget what they did for us that night (Paul:2)

The military builds a sense of being part of a family – if you endure the hardship, you will be looked after by those in power

… if somebody was injured, (senior officers) would all probably pop in and see the guy, see how they're getting on, but all of them would be updated at least weekly you know on their progress, because they belong to us you know (Bill:4-5)

I know people that would be out in the middle of Germany on some exercise somewhere, middle of some Godforsaken training area, a guy's father died I think it was, helicopter landed and officer jumped out, where's Private so and so? Over here son ... in the helicopter, he was taken back to base, into a car, straight back to camp, changed, washed, into civvies, driven to an airport, put on a plane, picked up in a car and taken straight to his parent's house, you know, and that's pretty good, and you think well that's good welfare, and that sort of self populates because people sort of think well they really looked after him and you think well at least they're going to look after us you know (Bill:5)

I suggested that this was often expressed as "tough love" as recruits were taught to overcome hardships. This rough treatment was acceptable because of the implicit belief that they ultimately had your interests at heart.

It's a known fact the sergeants were devil incarnate and the corporals, Satan's little imps, who would administer tough love as you phrase it. But. They would also make sure you were looked after and not abused by anyone out with their own. Especially civilians (Jack: wf)

This cohesion contrasted with the perception of the police culture as individualistic where everyone was out for themselves

In the rank structure here there's very little downward looking, if you like, once you get above the rank of inspector you never see anybody really, and they're all looking to the next step upwards whereas in the forces, everybody would be, you know obviously there would be officers looking for their next career but they could only rise off the back of the work that the people underneath them had done and if that didn't work then they're not going to go anywhere (Bill:4)

by the very nature of the organisation, the very nature of a lot of the managers, there is a great deal of mistrust between the rank and file and senior management, up to the level of Inspector, yeah it's more or less acceptable, beyond that you know, they're just not trusted generally with the rank and file (Jack:11)

I think a lot of sergeants aren't approachable and inspectors aren't approachable (Rob:15)

Feeling cared for by the organisation
Most participants had a perception that police managers didn't care about their welfare

I mean if somebody is ill or off, it's down to the sergeant to be bothered to phone them at home or if they're a half decent bloke go and visit them, but no, no they'll just say when you're better come back to work (Bill:5)

if you've got somebody that, like a line manager for want of a better word, but whoever's actually supervising at the time that they're aware of and they speak to regularly, takes the time and effort to put their hand on their shoulder, or phone them up and say are you okay? … that should be part of the major responsibility … which is why, in a lot of areas, it's failing, because nobody does care do they? (Matthew:11)

There's supposed to be a hot debrief by our supervisor which 9 times out of 10 doesn't happen (Jack:10)

Matthew contrasted this lack of care in the police with how it would have been done in the military
The skipper, who should have been there to put a bit of time and effort into it, had gone home some 3 hours earlier, didn't even know it had occurred … If I had guys out on the ground doing something, I wouldn't be at home tucked up in bed asleep, I knew where they were, what they were doing, what they'd gone through, who'd had a contact, who hadn't had a contact, and who to speak to. (Matthew:8)

This lack of care was felt to partly stem from a lack of understanding and respect for the frontline officer's exposure to trauma

Senior management have a general lack of understanding as generally they have little comprehension of front line policing. Many have been fast tracked and have spent a bare minimum of time on front line policing. Interestingly many of them still use it as a threat if someone is under performing or on a discipline "If you are not careful you'll end up back on uniform." This and similar derogatory references to front line uniform policing are common. In essence we should have our best officers on the front line as they are the ones who interact with the public and have to make the split second decisions based on very little information (Jack:wf)

Policy, procedures and targets were more important than the individual.

There is no humanistic link between the managers and what the job's all about. They seem to have lost touch with reality, you know, it's all about money, it's about figures, it's about looking good in the public eye, well that's rubbish. Look at the people, look at the welfare of the people, and look at the human beings (Matthew:9)

The lack of support from the Job was absolutely horrendous. At the hot wash, or incident debrief, the post incident manager was not, didn't really give a toss about us. All he wanted was his crime scene, all the rest of it (Charlie:4)

There was a perception that most welfare action was back-covering or lip-service

The police service, they look at it and they do it as a tick in the box, something's happened, someone's probably had a few issues and then it's been highlighted, a report's been written and then they've gone, we've got to do something about this. More of a legal requirement, like they think oh my God someone said we've got to do something (Tom:8)

I'm going to be very cynical and sound like an old bobby being here, they're worried about getting sued by their own people … so that they have things in place where, erm, they will refer you on or, all their needs, they'll write forms that say … all welfare needs dealt with (Rob:10)

To a lot of characters, I think they play lip service to it. We lack inspirational leaders, we've got enough managers who want to get paid for doing nothing and there's a massive shortage of inspirational leaders, and people who actually care, people who care about staff and know how to manage staff correctly, look at the welfare, look at the bigger package (Matthew:8)

Organisational competence

In the police, there was a perception of a general lack of competence amongst managers

I was watching a particular character who was meant to be coordinating running it, running around in circles like a headless chicken, hadn't got a clue what he was meant to be doing … and I couldn't believe that they were paying people, this is I said the reality check, is that people were getting paid an extortionate amount of money in managerial roles not to make a decision. I just couldn't believe that there were people there that could not make a decision as long as they were backside pointed at terra firma … I'm thinking you're dealing with real life situations with people, with lives, it could be with an individual's life, and you're dilly dallying, and you're getting paid to make a decision, so bloody well make one. And I used to get quite frustrated with it to be truthful (Matthew:2)

A major frustration was that the police senior management style was actually seen as getting in the way of the job
You try to do the best that you can within the constraints of the, basically bollocks, that is actually hampering you from doing the job. Managers come out with the policies and procedures because they can get promoted off the back of it but they don't actually think about the knock-on ripple effect and the wider potential implications. Yes, don't get me wrong, I understand that we need policy, procedures and guidelines and things like that, but sometimes they allow the actual day to day general running of a police service, to be clouded by policy and procedure (Charlie:2)

Despite initial fears, the experience for some was of a very supportive organisation
I work very closely with some of the superintendents in the city now, they are very protective over me as well, which is nice to see (Gary:13)

I couldn't say anything better about the force, I've got a new boss, my old boss has left and they've got a new superintendent now and I sent an email just to say look, this is what it is, it's easier for me to write it than to tell you, and I sent him all copies of my reports from the doctor and I just said here's what I can do and I said, whatever you want me to do I will say yes, but it has to be on my terms, not yours. And for a sergeant to say that to a superintendent is… and he just said fine, I don't want to upset what your treatment, and your recovery, you tell me if I'm overstepping the mark (Gary:14)

4.5.3 Working with foreign forces

The competence of mental health services
For many officers, the police interface with mental health services was *slightly coloured, or maybe informed rather than coloured, from when I was in custody. I didn't think we had a very good system of mental healthcare. I don't think we have, still. And we know a lot more about mental health problems and we're extremely knowledgeable now but the practical application of that care is still really poor. A lot of people were caught between the devil and the deep blue sea and then I've seen people kill themselves you know. Afterwards (Peter:11)*

No, I'm not totally confident because at times we get people saying so and so has walked out of X Unit at X or somebody has walked out of X hospital, well how have they walked out and they say well nobody was looking after them, no-one's watching them … they're a bug bear for the police who have to go and round them back up again, go back through the system, get them seen again and get them back again (Rob:13)

For Rob, becoming personally involved raised the spectre of what he had witnessed many years ago as a medic

Probably my state of mind at the time – these people are going to lock me away. Cold sheet, electric treatment, bits of rubber in your mouth (Rob:14)

and there was the fear of treatment getting in the way of doing the job

You've got so many problems where they've used chemical coshes in the past, and is it really appropriate to have those type of intrusive treatments if you're continuing to hold down the job? (Tom:12)

Although there was an awareness of their existence, what they actually do was usually a mystery

I dunno lie on a couch and (laughs) … I dunno, I suppose just, get someone into conversation, and see where it leads and see what comes out from the conversation (Bill:10)

I don't know what the treatment would be, I've never had it, so presumably you'd sit down, I mean I don't know what they do, I've got no idea … I do know people that have been and they always find it quite amusing because, you know, it's a chat isn't it? I don't know what they do – what do they do? (Tom:13)

Obviously you're aware of the existence of these places as you know, there are posters up all over the place. Somebody, I'm pretty sure, it was a long time ago but I'm pretty sure, on the basic firearms course that somebody from the care service turned up, okay, we're here, this is what we do and this is what we can achieve but that would have been possibly half an hour, a long, long time ago (Steve:7)

Some offered their views on whether recovery from mental health issues was possible
I know you don't get an instant cure with these people and I wouldn't expect that. There's no magic pill or potion (Rob:14)

My understanding was, is, that you can recover … so that you can perform a useful role in life, in your own life and in the wider you know public life … I think we can recover people to that extent. I think to say that they can recover fully from any serious trauma I doubt that the human

brain can allow for that to happen. I think you can learn how to deal with it. I think you can teach people a coping strategy (Peter:3)

Hopefully a full recovery, if not a full recovery, coping mechanisms to let it not affect them or minimise the effect that it has on their lives (Jack:12)

If the problem couldn't be fixed then, the question was what could mental health services offer that the individual couldn't do for themselves?

But they can't sort the problem out because the problem's occurred, it's how you deal with the problem isn't it, and that's always the problem, if something traumatic has occurred, it's always going to be there, you can't erase that from your memory and you can't erase, but presumably you can have coping mechanisms which I think is probably what I and other people who are experienced, have put in place themselves rather than going to a trick cyclist, as we call them (Tom:13)

Degrees of separation

For several participants, there was a perception that services would be, in their words, *"pink and fluffy"* and they were *dreading the, right, ok pull up a beanbag and tell me all about it, at which point if it had been that I would have stood up and walked out in disgust because that's not what I was after, at all (Steve:8)*

Is there anything you'd like to share with me, all this sort of stuff that training put in place 15 years ago, which just goes against the grain for most frontline police officers, male and female, most folk just can't abide it, and they're worried that they're going back into that kind of situation, that environment. The pink and fluffy aspect puts up barriers and stops them being honest because they view people in that sort of environment almost as the enemy, you know, there's two sides within the police, the front line operational side and there's the pink and fluffy side (Jack:5)

Some had direct experience of this

I may as well have been in a group of ten people saying my name's Rob, I'm an alcoholic that how it felt. I didn't relate to her at all, which didn't help … very patronising … you sit there, and I'm talking to her and they're looking away and they go (adopts soft tone) "just read this passage from this book". What? "Just read this" It's like a poem or whatever they give you, and I'm like what you giving me this for, (soft voice) "tell me what you're feeling about that" it's a poem about a door or about grass or, are you going to talk to me about my problem and they go no read this, read this.
I asked her and she didn't answer me, why are you getting me to read these things they're nothing to do with why I'm here (Rob:9)

"Pink and fluffy" was in direct contrast to the serviceman's practical, pragmatic nature

I'm a pragmatist, a realist. I was after someone who would almost like taking your car to the garage and saying excuse me, I'm broke, this isn't working, please fix it and then I can go back and do whatever. Yeah if I could've gone down to kwikfit and had an oil change I'd have been fine. I need to know the details. It's not a blithe … I want to know why this is happening – why isn't my brain resetting after this thing, yeah, you can reboot me but I want to know why (Steve:8)

Initial engagement

If admitting to a problem to yourself and your group is hard enough, having external evidence of this could be shocking *Whoa where did that come from? I didn't recognise it as severe as that … and she said well, I think this is going to be at least 3 months, and that took me by surprise so yeah it was a bit of a shock from that respect (Gary:11)*

Bit of disbelief really because I've always been very, very strong so I didn't really understand what was happening. I thought I was just losing it, completely. I thought I was going insane. I just thought I was just tired as well, I had a lot of denial that it was happening to me. I felt very … soft, I thought my bottle had gone, which it had. Thoughts like that really but mainly just very blank. (Paul:3)

and even overwhelming
I flipped and trashed his office … much to my embarrassment now, he just sat there … kicked his table over, kicked the drinks over, he just got his pen and said shall we start again? I can't believe I'm sitting here with a psychiatrist. Why am I here? What am I doing with this man? I'm not mad. I've seen One Flew Over the Cuckoo's Nest. I became very irrational even though I came from a medical background and I understand you don't need to be mentally ill to see a psychiatrist but I became totally irrational in one second, totally irrational. I was embarrassed. I was angry (Rob:5)

Even once they had presented, there was often a struggle to engage because *you're unwrapping people, which is a lot tougher for them than wrapping them up (Jack:12)* and if *I can't look at the person and establish a rapport and communicate, I get the feeling that they're judging me then I wouldn't even bother (Matthew:12)*

It was important that the individual and their coping strategies were accepted as they are
I don't want to sit down in a room with an individual who I think is judging me because they don't agree with my humour or they don't agree with the way I'm talking about something, so if you're there to help me then surely you're there to listen, not judge me (Matthew:12)

There could be an in-built resistance particularly if they had been "sent"

Well obviously I'd probably fight it tooth and nail, I think if I were in the police service situation I couldn't be ordered to go because I don't think it's a lawful order. If I did go then I wouldn't talk about it much … short monosyllabic answers, everything's fine, and that's what it would be like. I wouldn't open up, simple as that (David:7)

I wasn't very happy about it but then again I was kind of coerced by my wife … and it wasn't my regular doctor which didn't help and I was probably blasé about it, probably lied to him to be honest. I can't really remember but probably didn't tell the full story … minimised it (Rob:12)

It's down to, yes you can actually have the systems in place but if they don't want to access them, for whatever reason, then you can't make them (Charlie:7)

Even for those who went willingly, there was sometimes a flight to recovery
In 2005, I was off for about 4 months and I came back, I still wasn't quite right, I pushed myself to come back. 2008 was the last time it hit me, harder than the 2005 episode, and that really did knock me off my feet completely and that's when the doctors they said enough is enough, you've refused medication before but we really think you need to have some (Paul:5)

Despite the arduous process behind the decision to disclose, several participants found their concerns were initially dismissed by the health professionals.
I went to see my doctor who said you know it's just stress don't worry about it it's fine … went to see the force's doctors and again, they said again, nothing wrong it's just stress (Rob:3)

We had an in force counsellor, it's very fluffy but her view was just, well, you know it's just one of those things, nobody likes to see a dead baby, and it was kind of just, you know, if any more issues come back but I think you'll be alright to just let nature take its course (Gary:9)

She didn't believe I was suffering with a recurrence of PTSD which didn't help me at all. She told me that in about two minutes after being in the room (Rob:9)

Where the health professional had a military background, hurdles were eased
What I was absolutely gobsmacked about was when I turned up at counselling was, and this bloke was, yeah I could identify with him, he was ex Job, he was also ex military, he worked with military people and Job people anyway (Steve:8)

Again, our force medical advisor doctor was an ex-Naval doctor so he was very, very aware. He'd worked in America a lot with sufferers so he had a really, really good understanding and he also had a stress related, an anxiety related breakdown so he has been incredibly supportive. I couldn't have been treated better … he's made sure I've been protected (Gary:13)

4.6 The Battle Veteran

This category relates to the final phase during which participants are recovering from previous problems. They describe how they have incorporated their mental health issues into their identity and found a new sense of self. It encompasses how they make sense of what happened and how they accommodate any remaining symptoms into their lives. This phase marked the emergence from mental health problems and the sense of re-integration into the social group. Questions such as *"who am I now? Where do I fit in the group?* are asked in this phase. The category describes their new sense of playing a helping role within their peer group and changes in their attitudes towards mental health. Post traumatic growth is experienced with the move towards a new, stronger identity and the acceptance of what happened. The previous group norms are reframed, and importantly strengthened, in light of the experience. Figure 4.8 offers an overview of the sub-categories.

Figure 4.8 The Battle Veteran: Sub-categories

Main category	Sub-categories
The Battle Veteran	Making sense of what happened • Changing attitudes and awareness Living with the battle-scars Finding a new mission through helping others • Becoming a role model A new identity • Coming through a dark time • Post traumatic growth

4.6.1 Making sense of what happened

Several participants saw the experience as part and parcel of their choice to have a military or police career and *there's nothing you can do about it, it's just there, it's just the life you've chosen to lead (Paul:10)*

It's been part of my life's makeup. I've led my path. I wanted to join the forces. I wanted to go serve in war zones. This happens, shit happens is the old saying (Rob:10)

They accepted there could be long-term consequences to their military experience

It took me about 4 years to listen to fireworks without wanting to hit the ground from being out in Saudi Arabia and Kuwait. It's a natural reaction. Bloody good training from the forces (laughs) (Jack:8)

I hear a loud crack noise and it's a firework going off and I've been out the forces 13 years … still go for a gun, I still do it till this day, still do it to this day, I still search under my car … Maybe it's a survival instinct that's banged into you in the forces (Rob:15)

They made their own sense of what mental health issues were and why they had occurred

You look at your life and the emotional turmoil and things that you take on, and we segregate everything, and if I was to take it as a bucket of water, when somebody gets to a stage where they're dealing with PTSD and it's all gone horribly wrong, it's where one bucket starts to flow into the other one, they've got nowhere else to put it, and it goes wrong (Matthew:11)

We've got to get on with the job here but the mind is saying, I'm seeing all these horrendous things, put it to the back of your mind, later on, when it all calms down, months, years, days later, it can come to the forefront and cause problems when you're outside of that environment and your brain's got to try and sort of relax and download the information (Tom:3)

Changing attitudes and awareness
There was a recognition that attitudes need to change
I think we've got to move away in the police and the military of this indestructibility because I had it, I've seen this, I've seen that and it doesn't affect me ... because it doesn't affect you at the time because you're a professional person but I think people have to realise that 10 years down the line it still can affect you (Rob:15)

And for some the experience had completely changed their perspective on mental health
I thought it was something that was just dreamed up to cover up weakness but I've found out it's not (Paul:5)

Yeah, it's made me stronger, and more aware. Because as I say I've had lots of things happen, done lots of things and it hadn't affected me and was totally and utterly overwhelmed when this just wiped me out (Steve:11)

For many, there was a new awareness of the extent of problems amongst their peer group. Their eyes had been opened
You can see people's faces who have got it … quite easily. I can see the starting with it, I watched Our War last night …it was on about the young lads out there and one of them got killed and I could see there was a young lad interviewed afterwards who was starting to fill up and I thought I knew exactly how you feel (Paul:9)

There's still lots and lots of people that you see out, that are out there who are not correctly diagnosed, that don't get assistance with it and then just persevere in their own world (Matthew:13)

Some developed a genuine interest in becoming better informed
… since I was diagnosed I've sort of gone headlong into it and I'm very, very sort of, well not knowledgeable but I'm sort of reading up on it more and more and getting involved with parts of the organisation (Gary:3)

4.6.2 Living with the battle-scars

At the time of interview, some participants still had ongoing symptoms. They had a heightened awareness and reacted by taking time out and avoiding triggers

The only one I don't like, which again I've purposely tried to ignore is the diesel, because I had the misfortune of dealing with a lot of the young lads, the Welsh lads, that were coming off the Galahad when they were burned and the smell of the diesel on their clothes and everything and it's certain aspects of that I really don't want to go back to, you know, I try to stay away from there (Matthew:14)

When things do get too much, and there's a bit too much coming in, and I do start losing control, that's when I go into a bit of a meltdown and say right, I'm going home for the day (Gary:14)

Others' support was enlisted and this included a new acceptance of their concerns
Luckily I've got a very, very strong wife who recognises the signs and I would say seven times out of ten we can deal with it without having to go to see anybody else … she sits and listens to me vent off, we go for a nice long walk, we go and have a pub lunch, I stop drinking … because that's one thing she does notice is that my drinking increases (Rob:10)

There was an acceptance of symptoms as opposed to fear of them
It's not things that traumatise me, it's not things that throw me all over the place any more, they're just bad memories, if that makes sense. I've got certain things that I've filed away under section 13, and it's there in the closed filing cabinet and every now and then that filing cabinet will open as a result of smelling diesel or something or hearing something, yeah I'm aware of that, but I'm no longer afraid of the cabinet opening (Matthew:13)

I don't think of it as a stigma. When it raises its head, it can be a problem but luckily I've learnt to recognise the signs (Rob:10)

4.6.3 Finding a new mission

Becoming a role model

Several participants were happy to divulge their experience if they felt it would help someone and break stereotypes

I hope it gives them hope. Again it's, probably – fucking hell I wouldn't have thought it would have happened to you because yeah you're one of these sort of ex forces, big TAG, firearms and yet you've still ended up going a little bit wibble, but also, right you've been there, you've got that t shirt, you're back out as normal as you can be, you're back to the old Charlie that we know so it must be right, I'm happy, I'll go for it. Yeah I'm not sort of sat in an admin job trying to knit fog (Charlie:8)

I've absolutely no problem telling anybody that I've had mental health problems. I'm quite again tough at work I'm, nothing fazes me because that's my job, I'm a police sergeant I have to do that and he was quite shocked when I told him I'd had a fair bit of treatment and it does work. People don't believe that you can get over mental health for a start that's one big thing I have found. Once you're mentally ill you're always mentally ill … everybody thinks mental health people are either violent or potentially violent and it's not it's not that at all … and again maybe it's someone in my position who's been there, to say no that's not the case (Rob:8)

Part of my, sort of, mission, if you like now, is to show people that whereas I've done perhaps everything you could possibly do as a police officer, you know, dealt with every type of situation … when they see that someone who has done a lot of things and has been a front line officer for their entire service, you know, I'd say I'm well respected, for them to see that change I think it opens people's eyes and that's what I'm trying to tell people … and I think it's important that there are officers that do that (Gary:12)

The ex-serviceman's norm of cohesion manifested itself as a drive to help others and having been through the experience gave them a passion for this.
I think that also gives me the strength and probably the insight to actually have, really push TRiM, to help TRiM. Some people believe in the product but I gold-plate believe in it (Charlie:9)

There was new empathy for those experiencing mental health problems
At least I know exactly what some of these young guys are going through, what they're feeling, and you know, I've been there (Matthew:15)

I'm very good at identifying and maybe looking at the trigger points, but I think that's a skill I've learnt, not through any studying, through having problems I've had myself in the past and by being in those situations and seeing how stress and trauma can cause problems with people, it can be quite destructive with people (Tom:10)

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4.6.4 A new identity

Coming through a dark time

When incorporating the experience into their life story, it was viewed as a major challenge that they had survived and, through experiencing it, had been strengthened.

It's one of life's experiences, simple as that and I'm a very positive person, erm and I probably wouldn't have it any other way now. I think its made me a stronger person, definitely (Rob:13)

I think to start with it was an incredibly dark moment but I do see it as a transformation of my life, and certainly the family see it that way as well (Gary:15)

It was a glitch. It was a chapter. Not all books read straight the way through as a nice read. I suppose if you were going to put it into a bit of a film context, even like Chitti Chitti Bang Bang, the kids had a wonderful time and then they got caught by the child catcher and then they got let free (Charlie:9)

There was a sense of them having fought the battle and won
I don't like failure, personal failure. We all make mistakes, things go wrong, but if I can think I can change myself to make things better for my kids and my wife, me and my work - I will do it (Rob:13)

It was very, very dark, but I've turned it on its head (Gary:16)

Rather than having been a victim
I see these Americans who seem to hang onto it like a crutch and that's not me (Gary:16)

Post traumatic growth

Coming out the other side, there was a positive impact on family relationships.
The girls think I'm a different dad, totally calm at home, never in a bad mood as such, got quiet, but never in a bad mood. I've never felt (pause) as happy, home life wise. I just think I'm at the right point. I've settled down (Paul:10)

I mean I've been very open with my children anyway, they've known all along really, I think that's important really because they've got to manage me as well. I think it's really, to show them as an example, that you need to talk, because that's what it's all about, sharing, offloading, because you don't, you bottle it up, that's how the problems happen, and I think that's probably the lesson I've learnt from that and that I'd like them to carry through (Gary:15)

My home life is infinitely better. There's a recognition of emotion now, which there never has been so if I'm feeling upset about something I will talk to my wife, I just you know, men don't do. So that's dealt with very, very open, we're a lot closer that we ever were (Gary:13)

New skills were identified in the workplace

Certainly from a personal point of view it's changed me completely. There's a whole creative side I never, ever thought of. People say that it's all about the left hand side of the brain, you know, being opened up now and all the rest of it, but all I know is that from a work point of view it's opened me up to things I never would have considered as an option … I'm naturally very gifted at teaching which, it's taken this to recognise that in myself. I'm quite happy with the future (Gary:13)

And in life generally

I think it's also something that can be applied, not only to a disciplined organisation set up where, but I think you can actually take a lot of positives out of it into your normal every-day, social life – your day to day living skills (Charlie:10)

I've got a lot more caring in the last couple of years, a lot more tolerant of people, a lot more caring. I've softened up, really, now whether that's with age or the realisation of what I've been through and the bravado's certainly gone, as such. I've just grown up really (Paul:10)

It's made me more compassionate, more understanding, (laughs) probably doesn't sound it but more humble. I've certainly got I think more humility and also it's taught me not to be blinkered on my judgement because we are all different (Charlie:9)

I wondered whether the positives could ever outweigh the negatives and if individuals would have avoided the experience if they'd had the chance.

Not having it at all? (long pause) No I wouldn't. Because I think, although it took me out of the loop for a good 10 years or so, I think it's enriched how I feel now. Because I've never ever, at this moment in time, I've never felt quite this strong for a lot of years (Paul:10)

No I don't think I would. The bizarre thing with it is that it's almost a part of my life … it's me and I understand who I am and it's made me the person I am today with the different experiences I've had. And because it doesn't traumatise me, it doesn't… It keeps me alive, emotionally, it makes me grateful for who I am, what I have and where I am, I'm grateful to be here, and there are times when suddenly I'll get a reflection on something and I'll look around and I'll think, some of you people don't know how lucky you are. I'd lose that understanding of how lucky I am to be where I am today, you know, I class myself as a very fortunate individual (Matthew:14)

For every action there is a positive reaction and yeah, I actually do view it quite positively because I've been to the dark side and I've come out (Charlie:9)

Summary

In conclusion then, figure 4.9 uses the six key stages outlined in figure 4.1 at the beginning of this section and summarises the key questions within the stages that impacted on this process. Part five now proceeds to discuss these findings, evaluate the data in relation to the literature and consider the implications for the development of theory and practice.

Attitudes about the relevance of the threat of psychological trauma to the social group
What is mental illness?
Who gets it?

Pre-trauma attitudes towards the social group identity and group norms
Who am I? What does group membership mean?

Post-trauma attitudes towards self, the battle with psychological trauma and the new role in the group
Who am I after this happened?

The Warrior and the Battle Landscape

Identifying the threat

The Battle Veteran

Assessing the risk to self

Engaging with the enemy

Calling for reinforcements

Attitudes towards the symptoms of psychological trauma in the social group
How does the group prevent or remedy this problem?

Becoming aware of a problem in self
Who am I now if I have this?
What are my capabilities?

Attitudes towards disclosure and the competence, trustworthiness and credibility of the police organisation and mental health professionals
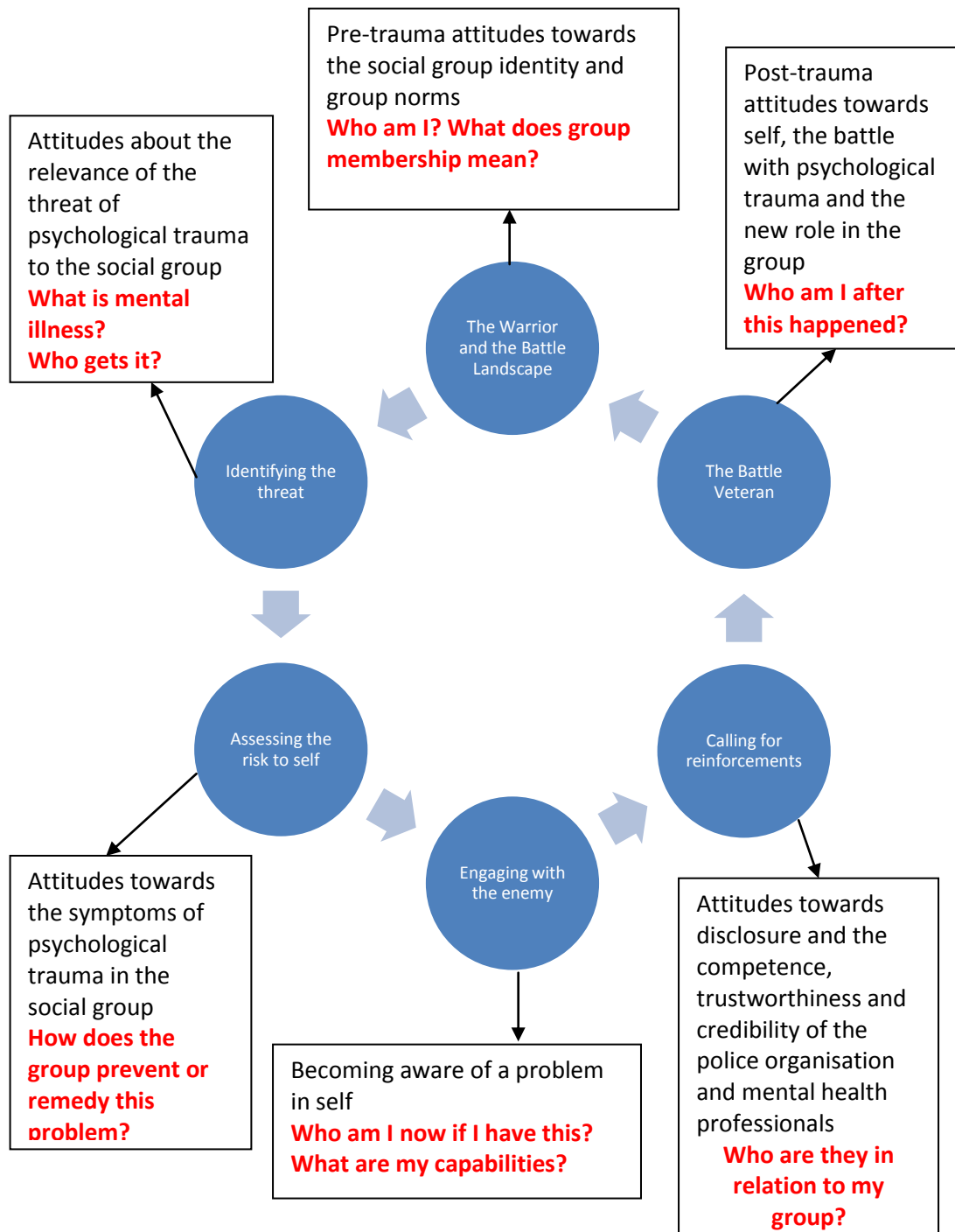**Who are they in relation to my group?**

Figure 4.9: Key Attitudes in the Help-Seeking Process

Part 5: Discussion

5.1 The theoretical model for the help-seeking process

The main research question asked

How do the attitudes of police officers with a military background affect the help-seeking process for mental health problems?

In order to properly answer this, the following issues were considered:

- Do police officers with a military background see themselves as a specific population?
- If so, are the characteristics through which they self-define a factor in help-seeking behaviour?
- What are their attitudes to mental health issues?
- What are their perceptions of mental health services?
- What are the barriers and facilitating factors in the help-seeking process?

This research aimed to explore the reasons behind the decision to seek help, or otherwise, for mental health problems. By using a qualitative approach, the social group identity and associated norms were found to be influencing factors in all the phases of the help-seeking process and a theoretical model for that process is now proposed.

As outlined in part three of this thesis, the aim of Grounded Theory is to develop theory from the data rather than to test hypotheses (Coolican 2004) and to discover processes rather than be merely descriptive (Stern 1994). In part four, I set out the six key stages that emerged in the process of help-seeking from the formation of a social group identity, through the different levels of awareness of mental illness and application to self, culminating in help-seeking and subsequent assimilation of this experience. Within this process, it was apparent that social identity and the associated group norms influenced each stage. I could have individually categorized and discussed the group norms that emerged as themes but would have potentially lost the clarity of the help-seeking process. Instead, the first two sections of the discussion set out my proposed theory of the process, the development of the social identity and group norms before moving on to discuss how the group norms impact on each phase whilst considering how this fits with the literature.

Figure 5.1 provides a visual representation of the proposed model for the help-seeking process for this group. As will be explained, cognitive separation was an important theme arising from the findings and the blue shape represents the social identity of the group with the pink shape representing "other."

Figure 5.1: The proposed theoretical model underpinning the help-seeking process
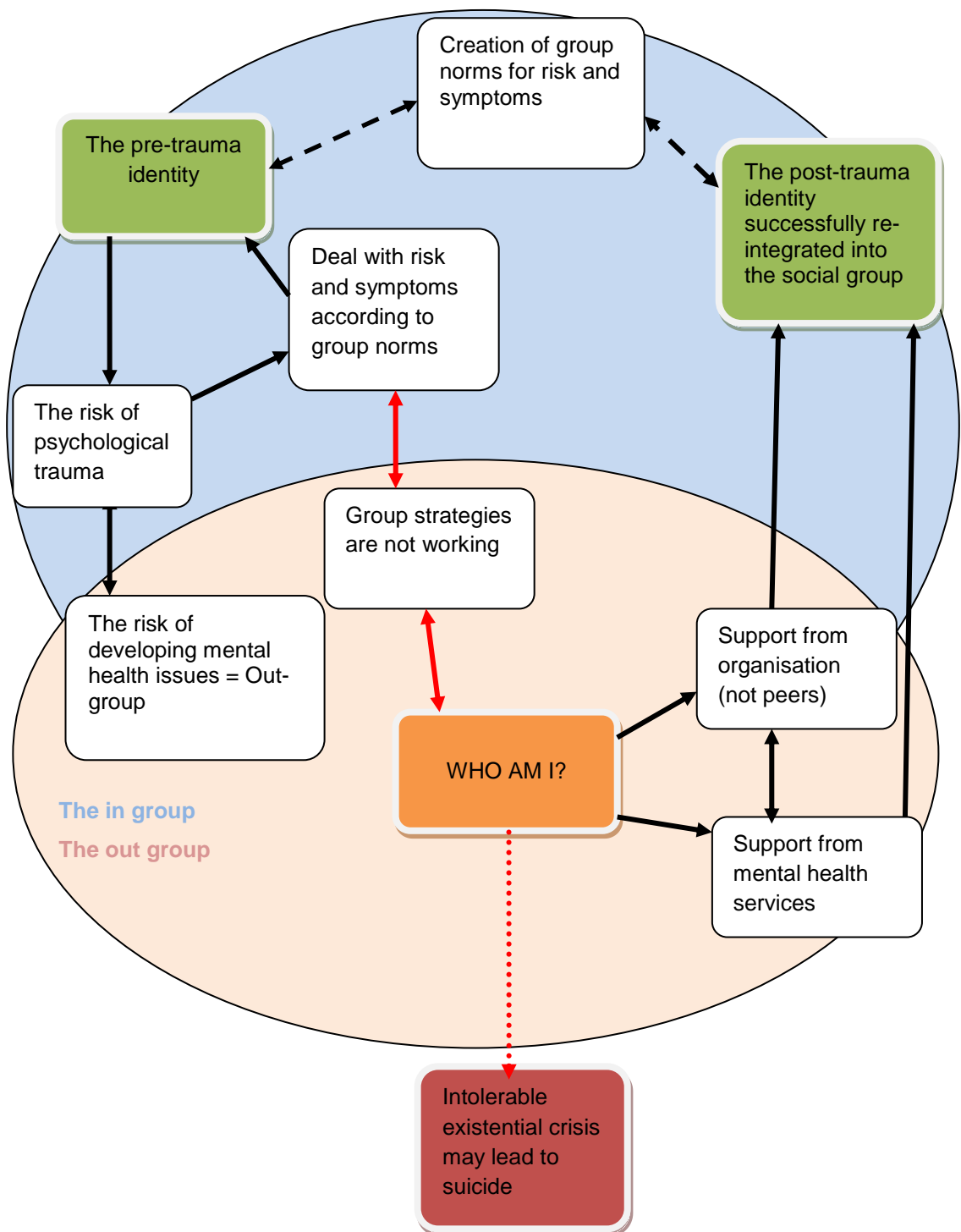
At the outset, the individual has a strong social identity with clear attitudes or group norms. These will be elaborated on in the next section but can be summarised as:

- Mission focus
- Strength and control
- Cohesion
- Be the best

Members vary in their knowledge and understanding of mental health problems, some were completely unaware and others had good, even medical, knowledge. Where the risk of psychological trauma is accepted as inherent to the role, the group has clear attitudes of how this risk should be successfully addressed. Where issues do arise, and the cause is not perceived to have broken the group norms, the individual deals with this in the manner that is acceptable to the social group. This doesn't conflict with the group identity.

The risk of developing mental health issues **that can't be addressed by group strategies, or that violate group norms through on-set responsibility,** is perceived as only relevant to out-group members. When identified within the group, such individuals are deemed not fit for purpose and having no place in the group. There was a sense of them somehow having gained entry when they shouldn't have. They are "weeded out" thereby strengthening the cognitive separation and group identity.

When the individual experiences mental health problems there is a struggle to manage symptoms by persisting, with ever increasing efforts, with acceptable strategies (in order to maintain group norms). A denial or non-awareness of a greater problem stems from the inability to relate the current identity to the existence of a deeper problem that needs external support or alternative strategies (this would make them "other"): *"This can't be happening to me,"* and *"People like me don't get mentally ill."*

At some stage, the individual reaches a point where the symptoms have escalated to the extent that they have no option but to acknowledge that the strategies are not working and they are not doing what their social group identity dictates, i.e. being self-sufficient, in control or coping. The final straw is usually recognition that the norms of "mission focus" and "strength and control" are being violated.

This creates a feeling of becoming "other" and associated self-contempt / worthlessness along with the fear of this becoming known to others – *I'm not the officer they thought I was* – and subsequent shame / rejection / exclusion. The individual has entered unfamiliar territory – something of a no man's land – and perceives they have lost the cohesive support of the group.

They have gone from one end of the group values continuum to the other:

- Mission focus becomes a reduced ability to do the job or the potential loss of the job
- Strength and control become weakness and loss of control
- Cohesion becomes isolation
- Pride in being the best becomes shame

An existential crisis of various degrees arises. This may be at intolerable levels and lead to suicide ideation, the blocking out of reality through alcohol, raging against the crisis with violence or the self-expulsion (withdrawal) from the group.

Using the social-cognitive model of stigma (Corrigan and Watson 2002; Watson and River 2005; Watson, Corrigan et al. 2007), help-seeking therefore requires a transition between social identities. In addition to the stressor responsible for the mental health issue, additional stress comes from

- Giving up a valued identity
- Resistance to the new identity that signifies violation of strong group norms
- Disruption of social networks

The individual has to assess the risks of disclosure and judge who to seek support from outside their group. Their perception of the trustworthiness, effectiveness and competence of potential helpers underlies this decision. Some will go directly to mental health services whilst some will go to the organisation. Sometimes contact between the 2 potential sources of help will result. The group values are important here too as potential helpers are judged against them, either hindering or facilitating the process.

As the individual recovers, they will reassess their identity and make sense of their experience. Where they have survived "the battle", feelings of being stronger and wiser (post traumatic growth) will result.

The group norms will be reframed and the experience will be used to strengthen these.

- Their new mission is to guard against the hidden "enemy" and learn more about it
- They have renewed strength and control having won the battle
- Cohesion is mobilised as a desire to help other group members
- Pride is taken in their new skills and success in overcoming the challenge

They will return to the social group and begin to influence, to greater or lesser degrees, the group norms and attitudes to psychological trauma. By disclosing their experiences they offer a role model for a potential 3rd identity – that of battle veteran.

The discussion now continues by outlining the social identity of the group and key group norms. Consideration is given to how these norms underpin attitudes towards both mental health problems and help-seeking. Throughout the remainder of the discussion, the findings and proposed theory are evaluated in respect of the literature reviewed in part two of this thesis. Part 5 concludes with a critical assessment of the strengths and limitations of the findings and sets out the unique contribution to knowledge made by this research. My personal reflections on the research experience are also described in a final reflexive statement.

5.2. The social group and attitudes towards group norms

According to social identity theory, perception of symptoms and help-seeking depends on how, as a group, we attribute meaning to those behaviours (Haslam, Turner et al. 1992; Jetten, Haslam et al. 2012). In part 1.4, the first consideration was whether the ex-services police officer was indeed part of a discrete social group as I had suspected. The research findings gave a resounding yes to this. There was no question in participants' minds that they were different. Furthermore, they were able to describe the attributes and norms of their group and to give insights into how these developed. This first section considers the group's development and perception of social identity and the group norms that go on to influence their attitudes towards mental health and help-seeking.

The group identity is forged through comparison with out-groups (Tajfel 1978; Tajfel and Turner 1986; Kroger 1989). Cognitive separation, as described in the literature (Corrigan and Watson 2002; Watson and River 2005; Watson, Corrigan et al. 2007), begins on entering the military. The very act of putting on a uniform starts the process of identifying as a group (Holmes 2003). Military tradition and history play a further role in building collective continuity (Sani 2012). During basic training, there is rigorous selection to be accepted into the group. The military requires recruits to be physically and mentally robust and those who aren't are "weeded out" so as to ensure the right fit for the job. Part of this selection is a duty of care – protecting vulnerable people from being put in situations they don't have the resilience for. It is also the next step in comparison with "others." Those who don't make the grade, e.g. through failing basic training, are weaker – setting the foundations for later stigma. The individual must conform to group expectations or leave / get moved on. This expulsion serves a purpose in creating a strong, fighting force and any stigma associated can therefore be justified as acceptable by those remaining (Crandall 2000).

In keeping with Self Categorisation Theory (Turner 1985; Turner, Hogg et al. 1987), the individual now begins to self-define as "us" rather than "I." As the group identity is honed further, individuals begin to get a sense of "others" even within the services and this is encouraged through inter-regiment rivalry. Each unit is encouraged to view themselves as "the best" with regimental mottoes, e.g. Rise above the Rest (MilitaryQuotes.com 2013) and group membership brings real pride. At the end of the process, the military has shaped its recruits

physically and mentally in order to create a standard product with the necessary qualities to do the job. These are often enduring qualities and recognisable to others from those groups. However, the military cannot afford to rest on its laurels if it wants the strongest possible fighting force. Even after basic training, this selection process continues and if someone doesn't meet the regiment standards they will not be tolerated and will be removed so there is always an implicit need to maintain standards. The serviceman's social identity develops as a sense of self built on military-ingrained abilities, character, life experience and philosophical outlook. In return they get the pride of being a member of an elite group.

Continuing cognitive separation was evident within their new environment of the police service as they brought these strong military values and attitudes into the police service. Again, through comparison with differing group norms, a new in-group is formed. Peers are recognised through their self-confidence, awareness and bearing (all prized qualities in the military). They judge their non-military peers, and the police organisation itself, according to their perceived lack of military values – camaraderie, mission focus, structure and discipline. Although they can recognise the existence of, and need for, diverse skills, in their "niche" of frontline operations, these hold limited value and they form a new "elite" team. Ex-servicemen perceive their group to have better personal discipline, more common-sense, a greater ability to apply knowledge, better interpersonal skills and broader life experience in keeping with objective findings from US research (Daxe, Robinson et al. 2009).

Tajfel (1978) suggested that we over-generalise, or stereotype, a person or group perceiving them to be more like a typical category member than they really are. Whereas much of the literature focuses on the stereotypes of the stigmatised group (Corrigan and Penn 1999; Biernat and Dovidio 2000), I would propose that it is not only the collective representation of stigmatised conditions that impact on stigma (Crocker and Quinn 2000) but that the stereotype of the in-group plays just as important a part in the help-seeking process. In terms of social identity salience (Oakes, Haslam et al. 1994) self-definition arises from striking differences between the in and out-groups (appearance, role, lifestyle) and from being "this" for a long time but results suggested that more influence came from the strength and exclusivity of the group and the identity's development in their formative years. In this study, the participants' ages on enlisting in the Armed Forces were between 16 and 20 with the mean being 17. These impressionable years means they identify primarily as ex-military even after serving for many more years in the police service.

It is probably no surprise that this early identity remains so strong. The urge to survive is a basic human instinct yet throughout history warriors have been expected to risk their lives for others. In order to meet this, and other military needs, a group identity must be forged that is strong enough to over-ride the individual's personal values and fear of death. Where Erikson (1968) considered that those who are very different to us can threaten our own sense of identity, in the military this threat is also about survival. In order to survive battle, group members must all

share the same values or norms and be able to predict others' behaviours. However, the stronger the group is, the stronger the need to conform to shared values and attitudes (Tajfel 1978; Turner 1985; Tajfel and Turner 1986). How the group perceives issues such as mental health and help seeking will therefore be a barrier or facilitator to care (Sani 2012). As social identity theorists posit (Tajfel 1978; Tajfel and Turner 1986; Yzerbyt, Judd et al. 2004; Drury 2012), groups create their own norms – rules, attitudes and values that members strive to adhere to. With this group, results suggest that the earlier attitudes are formed, the more resistant they are to change. They may intellectually accept changes but deep down attitudes are ingrained. Any attempts to change attitudes through education, as suggested in the literature (Corrigan and Penn 1999; Gould, Greenberg et al. 2007; Adler, Bliese et al. 2009; Dickstein, Vogt et al. 2010; Bryan and Morrow 2011; Mittal, Sullivan et al. 2012), must first connect with these early beliefs.

Participants described group norms that influenced their attitudes to mental health and help-seeking. An overview now follows of the group norms in terms of key attitudes and underlying military purpose. As will be seen, these group norms are inter-related feeding into each other for maximum impact. At this point, the thesis could have taken a different direction and considered the literature around the military personality and group norms. However, this would detract space, time and attention from the real issue – attitudes towards mental health and help-seeking. I will therefore simply set out the norms below before using them to take a fresh perspective on the research topic and the relevant literature.

5.2.1 Key Attitude: Mission focus

Throughout interviews, participants talked about the importance of getting the job done. This mission focus was an identifier for the social group and the ability to get on with the job was highly valued. In the military, the job is paramount and ultimately lives depend on getting it done – do or die. The core task is getting everyone home making the stakes pretty high if the job isn't done to the best of their ability. The individual must defer to the mission and learn to let their needs come second. They are a tool for the job and should be fit for purpose.

Mission focus equates to being action-oriented, acting quickly and instinctively once an objective is recognised and taking pride in the job. Once given a task, they will be drawn to find better or different ways to get the job done or work more efficiently – the drive is to get the job done the best way it possibly can be, looking beyond how it's always been done if need be. If something's not working they will look for another way and take pride and satisfaction from achieving a job well done fitting with the "be the best" norm. Participants were pragmatic and could objectively look at actions in terms of command tasks. They are used to dealing with what they see but this military thinking is harder to translate with unseen, ambiguous and illogical emotions.

It is during their military service, that individuals seem to develop the "can do, will do" attitude of being solution-focused and taking the initiative. Whether in the military or the police, the team should have one aim – focus on the task and get the job done. This in turn further builds camaraderie and the norm "cohesion".

The military creates such strong mission focus deliberately. Without this, the risk is of mutiny, refusal to follow orders if they conflict with personal values and self-preservation that would over-ride the overall mission. In other words, chaos would ensue as soldiers took an individual perspective and abandoned the collective goal. Mission focus feeds into the norm of "strength and control."

5.2.2 Key Attitude: Strength and Control

In order to maintain control, individuals must be able to handle adversity and endure discomfort and view themselves as having a higher tolerance to pain. Physical and mental strength is forged through hardship and individuals are expected to deal with pain in whatever way they can. For the stereotypical warrior - the aggressive male – there can be no room for softness or weakness. Several talked about pushing through physical pain resulting in long term damage.

The hardening process leads to the group belief that members generally have more experience, resilience and common sense. They have had their "corners knocked off" and can deal with whatever is thrown at them. This bolsters the view that "people like me don't need help." At its extreme, they feel invulnerable.

Control relates to the ability to accept discipline and to be disciplined (self-control). High levels of discipline and self-control are identifiers for the social group and highly valued traits. Ultimately they support the group norm of "mission focus." A lack of control brings danger. If individuals give in to emotion then group cohesion is at risk. Emotional behaviour is less intelligent as the neo-cortex in the brain is suppressed. Where lives are at risk and lethal weapons readily available, emotional urges need to be contained and suppressed. Clear thinking and group action (following orders) is the key to survival.

Whether it's physical, mental or behavioural control, it's down to years of drill. In the military, individuals are drilled to set aside emotions and respond automatically in a particular way. This leads to cooler, logical, common sense vision in a critical incident that is potentially life-saving.

This does not mean that the serviceman is incapable of showing the normal range of emotions and offering empathy. Examples were given of reactions to bereavement and major life changes that were viewed as normal and supported by both the group and the military. On-set and off-set responsibility is important though as will be discussed in 5.3.2.

The reward for enduring the mental and physical hardships comes from the next two group norms "cohesion" and "be the best."

5.2.3 Key Attitude: Cohesion

This group norm relates to maintaining the strength of the unit through standing together. In battle, this united front is essential to survival and successful completion of the mission. Without the collective defensive action (proactively or reactively), it's every man for himself. The trust in the group has therefore to extend ultimately to trusting them with one's life, not through knowing an individual but simply in knowing their social group identity. The basic trust and expectation to be supported in a fight or combat situation, contrasts with the fear of being judged / rejected by peers where a group norm has been violated.

The military knows that individuals must have a higher purpose for sacrificing their safety and the group becomes that higher purpose. Through building camaraderie and loyalty, to the regiment and each other, they ensure peers will be drawn to support each other and persist in the face of severe hardship. Individuals conform to group expectations or leave / get moved on so those with reduced collectivism are naturally selected out. Belonging is a two way street: individuals belong and feel part of something through group cohesion and camaraderie but they belong to the Armed Forces and are controlled through group norms.

Many participants described recreating the military cohesion in the police setting and the fact that they are drawn to similar roles facilitated this. The strength of the bond between ex-service personnel when they join the police was apparent, transcending previous barriers and regimental ties.

5.2.4 Key Attitude: Be the best

The fourth relevant group norm is to strive to be the best. This also links with mission focus (getting the job done to the best of their ability), being stronger and having better self-discipline and self-control. The seeds for this begin in military basic training where pride comes from meeting standards and succeeding where others have failed. Service cements this through regimental pride and competitive rivalry. Appearance was a factor in recognition of members based on visual attributes of bearing, smart turnout and self-confidence. In the military, portraying this image is important. Inspections and parade build self-discipline and pride in the individual that reflects on the unit. Standards are constantly reinforced even to the extent of being better than those who would succeed them historically. Pride in the group identity is one of the rewards for the demands the military sets.

Much of the pride comes from mission focus – a job well done. In the military, a lack of pride in the job could lead to sloppy standards. Again, this could compromise safety if an individual loses pride in taking care of their kit or weapons, or in adhering to drill and procedures.

On joining the police service, there is a belief that ex-military should maintain these higher personal standards. Consequently a new "elite" group is formed. There is intergroup rivalry in the police force, but there is often underlying respect for their non-military peers behind the banter. Different skills are recognised in these groups as necessary for their particular mission but, when it comes to the jobs that need military values, there is still a sense that the ex-military group has superior skills and experience. On the police frontline, practical hands-on, life experience is valued higher than academic skills. There is a sense that few can match the ex-military's hands on experience so they will always be somehow "the best" in that setting. Identity therefore involves being part of the elite and having close identification with the in-group.

As will be discussed next, there is a perception that having mental health issues means violating these group norms and this could lead to the shameful removal from the unit and loss of identity. Tajfel (1978 p.63) suggests there is "*value and emotional significance*" attached to group membership and this is particularly strong in this group. The stigma literature talks about the reduced status of stigmatised groups (Link and Phelan 2001) such as those suffering from mental illness. For this group however, the loss of status extends to ALL outside the in-group, such is the pride in group membership.

Being part of an elite group makes it further to fall when confronted with the notion of joining a stigmatised group. Goffman described stigma as a blemish of individual character designating the bearer as "spoiled" and devalued compared to "normal" people (Goffman 1963). In this case, "normal" people are the peers from the in-group.

The violation of group norms may also be considered from the following two perspectives in the stigma literature: Yang et al (2007) suggest that stigma arises when there is a threat to what is most valued. In other words, the individual perceives they have lost their ability to maintain valued norms resulting in self-stigma and associated shame and worthlessness. Neuberg et al (2000) assert that the stronger the group identity, the more likely they are to work towards group goals, needs and standards and stigmatisation can be a response to those who don't adhere to, and therefore may threaten, that group's values and socialization messages. The group responds to that threat with public stigma. This perhaps explains why group members are treated differently to members of the out-group as they threaten the collective representation of the group and are perceived to violate group norms. The discussion now moves on to look at how mental illness and help-seeking violate the norms set out above and consider how this fits with the literature.

5.3 Attitudes towards mental illness

5.3.1 Awareness and understanding of mental illness

In order to have an attitude towards mental illness, one must first become aware of the issue. According to Thornicoft (2006), ignorance and negative stereotypical attitudes towards mental illness are key to public stigma. Education is therefore recommended as an anti-stigma intervention (Corrigan and Penn 1999) including addressing myths and teaching the recognition of symptoms to facilitate help-seeking (Sayer, Friedemann-Sanchez et al. 2009; Dickstein, Vogt et al. 2010; Mittal, Sullivan et al. 2012). Participants varied in their personal knowledge and understanding of mental health problems – some were completely unaware prior to having their own issues and others had very good knowledge as part of a medical role. However, the level of awareness in participants had no impact on the levels of later attitudes with even medically trained participants experiencing high levels of self-stigma. This lack of effectiveness of education is consistent with findings by Dalky (2012) in a recent review of the literature. If education around the existence and signs of mental illness is to be used as an anti-stigma intervention it clearly needs adapting for this population.

It appears that cognitive separation as discussed in 5.2 and the stereotype of the "invulnerable" group member play a role in this. In the police, where it was provided, psycho-education generally focused on mental illness in the "out-group" – the general public. Efforts to reduce general mental health stigma through educating police officers (e.g. Pinfold, Huxley et al. 2003) may well inadvertently reinforce this sense of "us" and "them." Where steps have been taken to improve the police interface with mental health services, and has helped raise awareness for signposting to mental health services (Watson, Ottati et al. 2010; Canada, Angell et al. 2012; Barillas 2013), there is no correlation that they would then apply that knowledge to themselves as they don't identify with that population. Many researchers warn of attitude polarization (Boysen and Vogel 2008; Lord, Ross et al. 2008; Lord and Taylor 2009) and where the "out-group" is substantially different to the stereotype of invulnerable "in-group" it is less likely that such education will be applied to self.

The few participants who recalled receiving psycho-education around trauma reactions in their peer group had indeed found it difficult to apply the concepts to themselves at that time. Despite an intellectual understanding of vulnerability and exposure to trauma there was a distancing when it came to considering the relevance to self. Even when the signs were there, attribution to problems with mental health didn't always follow. There was some contradiction expressed in views here and I think they are best explained by the difference between the intellectual, rational view – traumatic events accepted as inherent to the role and all are vulnerable – and the emotional belief – it won't happen to me; mental health problems happen to other people. With the hindsight of having had a personal trauma reaction, the need for education in the workplace was perceived as very important. The paradox is that, when challenged, participants

were uncertain how much they would have been taken in, in depth, prior to it being seen as personally relevant.

Corrigan and Shapiro (2010) recommend that "penetration" (recollection of message) is one of the measurements to be used to assess stigma change. I would add "application to self." Without this, the denial – this isn't relevant to me / us – will be unaffected. Perhaps a lack of penetration and self-application explains the findings of Momen at al (2012) where, despite educational briefings, misconceptions about combat stress reactions and associated stigma still persisted in US Marine Corps.

The denial of mental illness being an issue within the group seemed to run through the organisation too. There was a lack of formal education around mental health in the military but given that most (although not all) of their service was not recent, this may well have changed. Participants commonly reported a similar lack of awareness of mental health issues amongst their peers in the military. It was often outside of their experience – probably representative of most young people. It is something of a contradiction that research has shown such high prevalence for mental health problems (Hoge, Castro et al. 2004; Hoge, Auchterlonie et al. 2006; Iversen, van Staden et al. 2009; Seal, Metzler et al. 2009) yet there was so little awareness. I believe this shows the extent of how well the problem is concealed.

Masuda et al (2007) found that educational interventions were only effective with participants who were relatively flexible psychologically. The stronger the attitudes the more rigid they are likely to be and more resistant to change. The individual, the group and the organisation all have vested interests in remaining "unaware" and only applying the concepts to others so that this doesn't threaten the group identity and values (Erikson 1968; Neuberg, Smith et al. 2000; Yang, Kleinman et al. 2007) paving the way for collective denial (Kellezi and Reicher 2012). Then the problem is hidden in the workplace or simply not recognized at all. In the military, even after a crisis had hit, the organisational ethos appeared to be to ignore it and get on with the job. Rather than using the situation as an opportunity to educate and prevent recurrence, there was a real sense of organisational denial.

5.3.2 Attributing causes
When viewing peers with mental health problems, the research found that attributing cause (Weiner, Perry et al. 1988) was a significant factor in determining stigma. In the military, this is a historical theme – from Mott's (1919) search for constitutional weakness onwards – and the belief that it was the individual rather than combat that was responsible for mental illness . In this study, on-set responsibility was similarly important and the violation of group norms (particularly mission focus and strength and control) evoked high stigma as will now be discussed. When exploring attitudes, there were initially a few minor concerns about appearing to be judgmental or saying something I may judge to be socially unacceptable, but participants were quickly reassured that any opinions were valued and that honesty was the most helpful

factor. I suspect that participants were generally strong-minded and forthright so they needed little encouragement to be themselves. Opinions were frankly expressed and the data benefited greatly from this.

In the literature, one of the themes when negatively stereotyping people with mental illness, is that they are incompetent and unaccountable (Link, Phelan et al. 1999; Corrigan 2000; Angermayer and Dietrich 2006). Mission focus is all about being competent and accountable to the operating unit. Individuals that enlist must be fit for purpose and accept that exposure to difficult events is inherent to the role. A subjective judgment was applied to mental illness that was events based. Training (both military and police) had an impact on how events were perceived. Events can be labelled as exciting rather than traumatic possibly based on the individual's belief about their ability and willingness to handle such situations. Participants therefore considered whether *they* would have found the event difficult, and if so, there was little if any stigma. However, if it was deemed just part of the job and nothing out of the ordinary then the individual was considered not fit for purpose and the stigma was high. This echoes the research by Gibbs et al (2011) which found that events needed to be significant and concerns regarding affected soldiers being "fit for the fight."

In the police service, this group is drawn to the "frontline" so is actively exposed to more traumatic events but feels competent and confident to manage this, going so far as enjoying the challenge of high adrenalin operational action. This is a similar role to the military and uses existing skills and attitudes such as courage, resilience and strength. In that environment, officers should also have these skills and be "fit for purpose" and the merit of anyone working here is judged on their presence. "Earned" illness was okay – trench warfare in WWI for example drew great empathy – however, as many mental health professionals will confirm, the surface issue is not always a big "earned" trauma and may be a small straw breaking the camel's back. In this instance stigma will be high.

When organisations consider what constitutes a potentially traumatic event, they often look towards the criteria such as those laid out by mental health professional bodies, with their focus on danger and catastrophe (WHO 2010; APA 2013) rather than the complex, intense and cumulative nature of trauma in the police (Papazoglou 2012) or Vicarious Trauma (McCann and Pearlman 1990; Pearlman and Saakvitne 1995; Dane and Chachkes 2001). This poses difficulties for this group who appear less likely to consider such one-off "dangerous" events as traumatic. Post-incident support that relies on this type of event identification is less likely to be seen as relevant to this group. I would suggest that their psychological trauma is more likely to result from "shattered beliefs" as described in the literature (Janoff-Bulman 1985; Young 1990; Keenan and Royle 2008). However, it can be harder to assess when this has happened. Perhaps a consideration of the strong group norms can help here. Where there are elements of a job not being done well or not having a successful conclusion, or where there is the perception of betrayal by colleagues or the system or the lack of strength, potency and control

in self, these would suggest a greater risk of a traumatic reaction. It does require a more detailed interest and awareness being extended by those responsible for support systems. Fear et al (2010) argue for a reduction on the emphasis on PTSD (and causation) and a wider consideration of mental health. Those offering support need to be sensitive to these issues and this is where peer supporters may come in to their own. Including this perspective in educational programmes about the attribution of mental illness would be useful.

Mission focus required getting the job done and setting the individual needs aside. However, just as good military commanders through the ages have done (Gabriel 1987; Moore and Reger 2007), most participants recognised that everybody has their limits and that sometimes rest and recuperation were needed. In fact, there was criticism when police managers didn't accept this. It wasn't asked, and there was no suggestion offered, of what made for an acceptable "limit" or how long recuperation should take.

Mental illness amongst peers was often attributed to a lack of mental strength. Such character flaws, including the often associated "self-inflicted" problems with alcohol, violate "strength and control" with their perceived weakness and lack of discipline. The literature would indicate this "weakness" would heighten stigma in the general population (Stewart, Keel et al. 2006; Boysen and Vogel 2008) but within a group that values control and self-discipline the effect is amplified. Malingering also attracted very high stigma and can be considered to violate three norms. Firstly, malingerers get in the way of the job and play the system and a weak organisation further jeopardises the mission focus by pandering to them. Secondly, they violate the norm of cohesion as, by putting their individual needs first, they place an additional burden on their peers. Thirdly, they violate "Be the best" as they take no pride in themselves or the mission. This harsh judgment of someone as not fit for purpose or weak was consistent with attitudes found in military studies (Schneider and Luscomb 1984; Greenberg, Henderson et al. 2007; Greene-Shortridge, Britt et al. 2007; Gibbs, Rae Olmsted et al. 2011; Mittal, Drummond et al. 2013). It is easier to understand the punitive attitudes of peers when their group values (and therefore identity) are threatened.

There were clearly double standards applied to in-group and out-group members. Feelings of compassion and pity were often reported towards the members of the public that they dealt with, along with a role requirement to take responsibility for them and / or take control consistent with "Benevolence" and "Authoritarianism" in the literature (Taylor and Dear 1981; Brockington, Hall et al. 1993; Corrigan 2000; Cooper, Corrigan et al. 2003). The findings supported Lamb et al's (2002), assertion that, in the police service, there is a level of frustration that comes with dealing with the mentally unwell as part of the job as this is not seen as "the job" in the same way as managing crime. For someone who is naturally mission-focused this is frustrating. The police role therefore adds to the cognitive separation and negative stereotypes. However, generally, there was little or no stigma expressed towards those members of the public with mental health problems. Officers sometimes saw themselves as necessary advocates for

vulnerable people and didn't apply stigma to them unless the individuals were preventing the mission focus being achieved. It was simply an issue that is relatively common with a reducing taboo, seen as healthy. I would argue that the negative attitudes are less about stigma and more about an out-group threatening the in-group's norm of mission focus.

Although exclusion (people with severe mental health problems should be kept out of the community) was a response to both in- and out-group members, there was no real sense of fear or dangerousness as commonly reported in the literature (Link, Phelan et al. 1999; Corrigan 2000; Angermayer and Dietrich 2006). Risk assessments were made and the danger to the unit or mission considered but this was done in a logical rather than emotional manner. Perhaps this is because a) the military have a different perspective of risk and b) the police feel competent in their power to contain a "dangerous" individual.

Whereas in the general public, exclusion arose for severe mental health problems, in the in-group, the bar was set much lower. As the safety of the military unit depends on a state of readiness (Greene-Shortridge, Britt et al. 2007), the existence of mental health problems is a threat to mission focus. Perceived violation of this group norm then dictates who is a member of the out-group. Peers with any mental health issues are potentially a source of danger that needs to be contained or removed. In reality, there was truth to this in a high risk situation. Examples were given of how the person with mental health problems can be a risk to others and mission objectives through maladaptive coping making them vulnerable or through erratic behaviour. Examples given also violated norms of control and cohesion.

There was a widely held belief that if individuals can't live up to the high standards and group norms then they shouldn't be in the job. The unit is only as strong as its weakest link and if you let yourself down, you'll let the unit down and be disgraced. The military manipulates this fear in order to get the job done. "Failure" leads to public humiliation and removal from the group – being ostracised or expelled – and individuals will fight to remain the best. As in basic training, the belief that people should be "fit for purpose" fits with Crandall's (2000) "Justification ideologies." A duty of care to the individual and the mission eases any conscience and endorses a hierarchical judgment of out-groups whereby the *"elite deserve special privileges"* reinforcing the "be the best" norm.

Revisiting figure 2.1 then in the literature review, there was much less tolerance towards all attribution in the in-group. For me, this fits with where the literature states that if the condition is deemed controllable, then the individual will be judged as responsible for its onset and anger and punishment (in this case, "hardening" discipline or exclusion) will be directed towards them whereas if it is not controllable, i.e. it is not their fault, then pity and assistance will be offered (Weiner, Perry et al. 1988; Corrigan 2000; Cooper, Corrigan et al. 2003). Results showed pre-trauma attitudes were that mental illness was controllable in the in-group (norm: Strength and Control), therefore individuals were deemed not fit for purpose.

5.3.3 Acceptable coping strategies

Weiner et al (1988) differentiated between on-set and off-set responsibility. Even where the cause of problems in the in-group was attributed as lower stigma, e.g. "earned" trauma, there was still a sense that the individual should deal with it properly and the next section looks at what this off-set responsibility entails. Where symptoms did arise, individuals used a variety of strategies to manage them. They described ones that fitted with the group norms from 5.2. By using these strategies, that are acceptable to the social group, then there is minimal conflict with the group identity consistent with the assertion by Yzerbt et al (2004) that group members will actively strive to act consistently with group values.

Focus on the job

Mission focus in itself was a strong coping strategy for participants. Remaining focused on the objective provides a protective cloak effect where structure and action detract from the emotional nature of the situation. There is acceptance that the difficult parts of the job are part and parcel of the life they chose "what you signed up for" just as much as the good parts. This attitude mirrored Mittal et al's (2013) findings where treatment-seeking veterans reported the perception that members of the public would view combat-related mental illness as "self-inflicted" and blame them for enlisting and not being able to cope.

When an individual is having problems, work can be a welcome distraction, providing respite from problems outside work, preventing rumination and offering an opportunity for the person to feel empowered and in control of at least one part of their life. There was reduced stigma where mental health issues were seen to be being dealt with in an "adult" way and didn't unnecessarily impact on getting the job done. Problems are seen as an inevitable part of life and a problem solving approach taken to deal with them. Scaer (2001) recommended psycho-education for trauma reactions leading to empowerment of the individual and restoring the sense of control for their recovery. This has the added benefit for this group of providing tools and concrete advice for managing the "problem" of mental illness.

Part of being "adult" was to recognise where it was necessary to take time out if there would be a negative impact on the job by continuing. Such temporary self-removal from the group was acceptable.

Contain emotions

In keeping with the norm of strength and control, group members were expected to be able to contain emotions and portray a persona of calm confidence. Historically warriors have maintained this stoic presence (French 2003; Sherman 2005) requiring the ability to endure and accept adversity. Controlling emotions is necessary in operational situations and allows high stress situations to be managed with maximum clarity. It is therefore a highly adaptive response when dealing with short term stressors. At those times, "feeling" is a less useful skill than "doing". In military operations, the protective cloak is put on as part of the preparation for deployment and kept on until it is over. The police role brings a fresh dimension to this strategy.

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In the police, the job entails diverse tasks (some needing psychological protection and others not) and the officer can arrive at a scene without their psychological armour fully in place.

Modern attitudes reflect the expectation that soldiers are expected to tough out problems, whether physical or psychological (Visco 2009; Vogt 2011). Their stoic philosophy – *shit happens, get on with it* – adds to suppression and denial that any intervention is necessary. Just as deprivation and hardening through discipline was evident in early "treatment" methods (Adrian and Yealland 1917; Mott 1919; Jones, Fear et al. 2007), so today, generally, mental fitness is dealt with the same as physical fitness. To increase physical fitness you push past limits, to the point of collapse. This strategy is clearly not appropriate for mental fitness so an alternative focus is needed on other ways to build and maintain mental health. Psycho-education programmes, such as Battlemind (Adler, Bliese et al. 2009; Adler, Castro et al. 2009; Adler, Bliese et al. 2011), Defenders Edge (Bryan and Morrow 2011) and the Master Resilience Training (Reivich, Seligman et al. 2011) reframe mental health learning in a strengths-based framework offering alternative ways of building resilience whilst adhering to the group norm of strength and control.

Previous research has shown that police officers similarly use denial, suppression and avoidance as ways to cope with negative emotions (Pogrebin and Poole 1991; Amaranto, Steinberg et al. 2003; Pasillas, Follette et al. 2006; Berking, Meier et al. 2010). The emotional distancing and compartmentalization described by Backteman-Erlanson et al (2011) allows unpleasant things to be dealt with and the internal experience blocked.

This ability to suppress the inner experience of pain was seen as developing strength of character and mental fitness. With the norm that emotions and negative thoughts and feelings must be concealed or contained, members become skilled in putting on a front. However, avoidance and numbing (also common symptoms of post traumatic stress reactions) can be a strategy for coping with anxiety that impedes help-seeking (Noy 1991). Participants attempting to use this strategy in the longer term found that thoughts and feelings were suppressed and never dealt with. As the brain must make sense of a traumatic experience and extract the survival information, this would lead to re-experiencing trauma symptoms in the form of intrusive images and nightmares reflecting the mental strain of compartmentalising traumatic material. The cynicism and emotional blunting symptoms of Vicarious Trauma (McCann and Pearlman 1990; Pearlman and Saakvitne 1995) are the progression of an adaptive strategy to a maladaptive one.

For participants, denial and suppression of emotions could extend to the individual being blind to them or dismissing signs. This raises issues for the potential impact on research into prevalence rates (Iversen, van Staden et al. 2009; Fear, Jones et al. 2010; Thomas, Wilk et al. 2010) and the fact that many mental health programmes rely on screening questionnaires. Personal acceptance of a problem was the major barrier to help-seeking and reflects the

literature (Kessler, Berglund et al. 2001; Stecker, Fortney et al. 2007; Pfeiffer, Blow et al. 2012). Suppression means symptoms can remain undetected (to the individual and to outsiders) at the point of initial support following an incident and the person will be genuine in their belief that they do not need anything. Symptoms may then present months or even years later when support is no longer in place (e.g. veterans) or the individual's functioning has been so gradually eroded that the change in themselves is seen as normal. Anecdotal experience of mental health problems in peers showed a black and white situation with few shades of grey. People were either getting on with things or suddenly not at work. Their higher threshold of showing weakness could mean that symptoms have to have escalated to a serious level before they are recognised and external help is considered.

Examples of how things "suddenly" seemed to come to a peak included knowledge of people who had hit an extreme crisis and it was also the case for many participants that their reaction was not addressed until it was overwhelming. This mirrored my experience when working with ex-service police officers and was one of the motivations driving the research. This escalation of symptoms as controls and defences drop, is supported by the results of research by Thomas et al (2010) when they found prevalence rates of PTSD and depression persisted or increased at 12 months deployment. Combat Stress (2012) reports that the average veteran waits 13 years from service discharge to seeking support from them and this could be a combination of denial, suppression and the erosion of group identity.

Smart and Wegner (2000) assert that the strain of concealing stigma may be more bearable for those who are highly practiced at mental and emotional control and this could be another reason behind the seemingly sudden and dramatic escalation of issues as psychological barriers are finally breached.

"Black humour" is a protective way of distancing the individual from their emotions and disconnecting from the human suffering. Laughing together as a group that implicitly understands the humour as a venting strategy builds cohesion and lifts the mood. As the old saying goes "if you don't laugh, you'd cry." However such banter can dismiss peers' distress and subsequently be perceived as a barrier to peer support. This has also become an unsafe strategy with "offenders" risking disciplinary action for appearing unprofessional or breaching equal opportunities guidelines. Interestingly, one participant claimed he was most concerned about negative judgments and complaints from his non-military peers in the police. Again, this encourages the in-group cohesion but also reduces the support available. Outsiders looking on frown on this type of humour but also on the control of feelings. One participant was criticised for suppressing emotions and viewed negatively by some as a "robot." In the interview, he was actually very self-aware, frank and emotionally articulate. With such lack of understanding from out-group members it is small wonder that in-group members prefer their own support.

When the emotions are too raw for humour to be effective, particularly where different officers have had different subjective experiences of an event, an individual may temporarily retreat from those who use this strategy. Withdrawal from others may also be required to deal with the suppressed emotions and regain control of them. An individual may need a private opportunity to reflect (often on whether the job was done properly) and deal with any arising emotions privately. However, withdrawal is also a symptom of post traumatic stress (APA 2013) with levels on a continuum from normal response to pathological.

The expression of certain emotions was deemed acceptable, e.g. anger and fear associated with the human "fight or flight" reaction to life-threatening situations. Fight is drummed in as the most appropriate response by the military for obvious reasons. Aggression is necessary in the military and the fight response to problems – hit them head on; come out fighting – affirms the norm of strength. It was acceptable to see anger expressed and indeed it is a very normal part of the survival response allowing expression of emotion and release of pent up adrenaline. Anger and rage were common although participants stopped short of the violent / offending behaviour often prevalent in veterans with PTSD (Black, Carney et al. 2005; MacManus, Dean et al. 2012; MacManus, Dean et al. 2013) as their need to conform to the norm of "control" kicked in. Fear is similarly viewed as healthy and to be expected, with a lack of fear actually perceived as dangerous with the potential to lead to reckless behaviour. Although acceptable emotions to admit to, anger and fear should be controlled and not hinder mission focus. One participant had even reframed his growing aggression as a sign of his masculinity and wasn't overly concerned about it until it changed to anxiety and withdrawal (flight) that hindered his effectiveness.

When there is no safe outlet, or relief when it is expressed, then anger can simmer – impacting on families and the job and potentially escalating into violence and rage. The literature shows a clear link between violence and combat exposure, poor mental health and substance misuse (Black, Carney et al. 2005; Taft, Vogt et al. 2007; Killgore, Cotting et al. 2008; Elbogen, Wagner et al. 2010; Elbogen, Johnson et al. 2012; MacManus, Dean et al. 2012).The escalation of problems involves a process of anger changing from controlled aggression (good) to a raging beast (bad) that must be controlled. As this control slips there is a sense of loss of control leading to the urge for flight - fear and withdrawal from triggers. One participant described how his need for control became translated into obsessive behaviour as he attempted to outwardly show he still adhered to high standards. Participants often described wanting to go walkabout consciously or unconsciously (finding themselves wandering).

Cohesion

According to the social identity model of collective resilience (Drury, Cocking et al. 2009; Williams and Drury 2009), where there is a shared social identity, with shared goals, group members expect to give and receive support from fellow members and this leads to collective action with an unspoken sense of duty to act in the interests of that group. The literature asserts

that this can prevent trauma and increase well-being for group members (Drury 2012). The common interpretative framework that arises from the sense of shared social identity facilitates communication, empathy and group coordination as well as building shared expectations as to what is reasonable and appropriate support (Postmes 2003; Haslam 2004). In these cases, group members will want to provide a high level of support and will also expect this to be reciprocated by group members (Haslam, Reicher et al. 2012). Research within the military found that unit cohesion can be a protective factor inversely linked to the prevalence of stress reactions (Labuc 1991; Du Preez, Sundin et al. 2012; Britt, Adler et al. 2013). In this way, peer support can be both preventative and remedial when it comes to mental health.

Accessing peer support is therefore an adaptive coping strategy in line with the group norm of cohesion. Peers are seen as trustworthy – there is little surprise there when they are relied on for survival. They have high credibility as they have *"chewed the same sand."* This is the distinction between empathy and sympathy. Empathy recognises the strength required to face challenges and views the individual as an equal. Peers who have "been there" are more likely to offer this. Sympathy implies "poor you" and is received negatively as it sees the individual as a victim, as weak "other" and dismisses strength. When peers really understood and didn't negatively judge, this was one of the most positive factors in the disclosure experience and subsequent recovery. They affirmed that you were doing the right thing and sometimes normalised reactions. I doubt this level of reassurance would have had the same impact from outsiders. Peer support can help to reduce stigma (Jones, Roberts et al. 2003; Greenberg, Langston et al. 2008; Pfeiffer, Blow et al. 2012) and their interventions may be more influential than that of family when stressors increase (Smith, Vaughn et al. 2013). In a cohesive group, peer support was provided through openness and being comfortable in showing emotions.

However, peer support varies greatly in its quality and the literature is clear that group norms may become maladaptive (Langston, Gould et al. 2007; Du Preez, Sundin et al. 2012). One participant described how he had dismissed a young soldier's distress as it didn't, at that point, fit with his view of a "fit for purpose" group member. More experienced, and therefore potentially more influential, group members may hold such "old school" attitudes. This is supported in the research as units who hold negative messages about "weakness" are at higher risk of developing problems with PTSD (Du Preez, Sundin et al. 2012).

Cohesion can become maladaptive where peers collude in ignoring issues and there was evidence of this happening. Where peers do recognise traumatic events and their aftermath as damaging they may attempt to contain the effects within as small a group as possible preventing the embarrassment of others knowing who may be less supportive, particularly outsiders. If peers are ignorant of mental health issues and how to manage them, it can be a case of the blind leading the blind. Without trusted bridges to higher level care, this peer support simply adds to the denial of an issue.

Another big problem for some was that peer support was unavailable and the loss of this, even temporarily, was keenly felt and allowed problems to escalate. This was more likely to happen within the police service with the absence of support and contact opportunities as existed in the military. I would agree with Daxe et al (2009) who stressed the importance of peer support for what they saw as a discrete social group of US police officers who had served in the military. The Home Office doesn't record figures for how many Armed Force veterans join the police (Home Office 2010) but several participants felt that they were becoming a minority through changing social trends, e.g. the ending of National Service reducing the overall ex-services population and the trend towards a more diverse police service further changing the profile of recruits. This has implications when considering anti-stigma interventions, coping styles and availability of social support. Research with military populations shows that reservists are particularly at risk for mental health issues (Hotopf, Hull et al. 2006; Iversen, van Staden et al. 2009) and I would argue that this is because they lack the same levels of peer support and cohesion. The figures from the Falklands would also support this view. Although initially psychiatric rates were very low (Labuc 1991), studies from 5 years after the conflict (when many individuals had left the cohesion of the military unit) showed this had drastically changed (O'Brien and Hughes 1991).

Whether good or bad, I would argue that peer support will only be available provided the individual is a credible group member. Membership does not come through a particular uniform but via group norms. If group norms are being violated through perceived on-set or off-set responsibility, then that individual by definition is no longer a group member. Kellezi and Reicher (2012) suggest that where the individual breaches the norms of their own group there is no evidence of social support, or even acknowledgement that there is anything that requires support, laying the path for collective denial.

Greene-Shortridge et al (2007) suggested that soldiers may encounter a societal stigma within the military culture itself as their peers socially distance themselves, blame them for having problems and feel uncomfortable around them. They assert that internalisation of this societal stigma then results in self-stigma. Similarly, Gibbs et al (2011) found the active use of distancing from peers with mental health issues. This was not borne out in the experience of participants. Firstly, any distancing came from their own withdrawal and colleagues were usually unaware, colluded in the denial or tried to facilitate support. The self-withdrawal is more consistent with the literature that suggests individuals avoid social relationships for fear of exposure (Goffman 1963; Derlega and Berg 1987; Smart and Wegner 2000; Hornsey and Jetten 2011). The self-stigma came from within rather than as a result of public stigma. Any internalisation of societal stigma was in place well before their own problems occurred. Following their own recovery, officers were drawn to helping their peers who had mental health problems. This could be because the group norms had been reframed as will be discussed in 5.4.5. The desire to do a good job, to "get everyone home safe and sound" could be mobilised

as peer support. Their ability to recognise and assess threat and judge others should better help them spot a colleague in distress *provided* they know what to look for.

Much of the peer support in the military relies on alcohol as a social lubricant and historically the military has condoned and even encouraged this (Holmes 2003; Gibbs, Rae Olmsted et al. 2011). Many participants lamented the closure of police bars as a place to relax and access the support of people who they could relate to. It facilitated cohesion and decompression following operations, whether military or police, and mirrored age-old processes of peer support that fostered unit cohesion (Koshes, Young et al. 1995). This is a difficult subject as the negative physical and psychological effects of alcohol generally far outweigh any benefits. However, along with the closure of police canteens and gyms, there is a real loss of a safe, social workplace zone and one of the most valued coping strategies for this group. The danger is that alcohol is seen as the coping strategy rather than the facilitator for the coping strategy and individuals turn to the bottle in private. Snell and Tusaie (2008) found that alcohol and isolation were commonly used coping strategies amongst veterans. Additionally, the use of avoidance strategies (as preferred by the police) includes avoidance of social support and is predictive of alcohol abuse (Swatt, Gibson et al. 2007; Chopko, Palmieri et al. 2013).

In the UK military, alcohol abuse is high (Fear, Iverson et al. 2007; Iversen, Waterdrinker et al. 2007; Iversen, van Staden et al. 2009), and several participants noticed an increase in their alcohol intake or urge to drink consistent with Thomas et al (2010). Whereas Bray et al (2009) found significant numbers of US military personnel experienced "serious consequences" from alcohol abuse, many participants reported that their urge to use alcohol was tempered by the need to adhere to the norm of Strength and Control and its associated self-discipline.

Perhaps the police role offers some protection here. The military attracts a diverse section of society but only some of them will be attracted to the police service. Many talked of having traditional values, doing the right thing, and so may naturally have a more defined sense of right and wrong. Results showed that recognising a propensity for violence or alcohol abuse was a catalyst for help-seeking. There is also a possibility that participants would not disclose the true extent of any behaviour that could cost threaten their job. Unlike the military, the police service takes a different stance to alcohol and individuals are likely to find their problems are exacerbated with disciplinary action. The police interface with the consequences of violence, alcohol abuse and even suicide could all influence their likelihood to avoid these actions. Doing the right thing is part of mission focus and strength and control (self-discipline). Perhaps the serviceman who joins the police service has naturally higher disposition towards these norms.

As individuals deny a problem in order to preserve their identity, there is a resultant inability to seek and receive social support (Jones, Jetten et al. 2012). This also extends to family support. Family members were often aware of the signs but unaware of what best to do. Family awareness of issues is crucial but their effectiveness at flagging up issues will also depend on

their confidence to do so. Anger is a very common PTSD symptom and this can silence many partners. They can be quite helpless in the face of what's happening if they don't have awareness, education or support. Warner et al (2008) recommend reaching out with education for families as soldiers themselves saw their encouragement to seek help as important. However, family members invariably failed in their efforts to convince the sufferer of a problem. Perhaps the fact that they didn't fully understand, as peers were perceived to, made it easier to dismiss their concerns – although there were also instances of peers' concerns being ignored. The individual's strong sense of identity, and the fact that mental illness did not fit with this, outweighed others' concerns and only once there was a personal acceptance of a problem, did family have much influence. This contrasts with the findings by Snell and Tusaie (2008) who found coercion by family members an important factor in help-seeking. There was often a barrier in relationships as officers tried to contain the issue for fear of contaminating home-space or personal image. Their ability to put on a front, as discussed earlier, and to have different work / home personas helped them do this.

Osorio et al (2012) recommend that the timing of offers of support should be considered, particularly where troops are deployed and in a more threatening environment. In an operational theatre, the need to maintain strong group norms will be more likely to over-ride the individual's need for support. In a police setting, this equates to asking too soon after an incident and then not following up later when defences are lowered.

Figure 5.2 overleaf provides a summary of the coping strategies that fit comfortably with group norms, along with their potential to be adaptive or maladaptive.

Figure 5.2: Coping strategies that maintain group norms

Strategy	Group norm supported	Adaptive	Maladaptive
Focus on the job	Mission focus	Protective cloak Structure Distraction from rumination Empowers through action and perception of control	Use work to distract from issues Avoids opportunity for reflection and downloading of information Burnout
Contain emotions	Strength and control	Necessary in high risk situations Part of the normal survival response during a threat	Emotions never get dealt with Re-experiencing Compartmentalisation and suppression
Access peer support (often facilitated by alcohol)	Cohesion	Credible Trustworthy Containing	Support may be • Unavailable • Unaware • Collusive • In denial Alcohol misuse

5.3.4 Entering the out-group

Symptoms of psychological trauma, whether acute or chronic, include anger and withdrawal from supportive relationships (APA 2013) and there is a continuum between such symptoms as a normal Post Traumatic Stress reaction, as an adaptive coping strategy and as a maladaptive response or symptom of PTSD. There are well-documented relationships between anger, alcohol abuse and PTSD (Savarese, Suvak et al. 2001; Taft, Vogt et al. 2007; Graham and Livingston 2011; Capone, McGrath et al. 2013) creating a downward spiral as symptoms escalate and maladaptive coping is increasingly used. Additionally, the attitude that mental health problems happen to other people "out there," leads to the ignorance and denial that participants invariably reported. Problems often crept on subtly and gradually, sometimes over a

number of years, and were not recognised for what they were. I believe that the denial or non-awareness of a greater problem stems from the inability to relate the existing sense of self to the presence of a deeper problem that perhaps needs external support or alternative strategies. They are facing the possibility of breaking group norms and this would make them "other". This fits with Jones et al's (2012) suggestion that people downplay the change in their social identity in order to maintain the group identity. Denial and under-estimating symptoms protect self-esteem and identity (Branscombe, Gomez et al. 2012; St. Claire and Clucas 2012).

The sense that "this can't be happening" and the dogged belief that their self-reliance will succeed are major barriers to help-seeking. This is an issue within the general population (Kessler, Berglund et al. 2001). Research within the military also found that recognition and personal acceptance of PTSD facilitated help-seeking (Stecker, Fortney et al. 2007; Sayer, Friedemann-Sanchez et al. 2009; Pfeiffer, Blow et al. 2012).

At some stage in the help-seeking process, the individual reaches a point where the symptoms have escalated to the extent that they have no option but to acknowledge that the strategies are not working and they are not doing what their social group identity dictates, i.e. being self-sufficient, in control or coping. The final straw was often the acceptance that the norms of "mission focus" and "control" are being violated. In keeping with this, Snell and Tusaie (2008) found that a factor in ultimately seeking help was the concern about negative and inappropriate behaviours (in this case breaching norms) that were arising from mental health problems and the consequences that were feared.

Rosen et al (2011) and Sayer et al (2009) found that greater impairment was a factor associated with help-seeking and over-rode stigma concerns. This may be because, with greater impairment, there is less opportunity for personal denial that "strength and control" is being challenged. Therefore there is stigma whatever action was taken. Where participants reached the "reality check" they commonly faced a view of themselves as a complete failure. These feelings of weakness and failure are reported in other studies with service personnel (Vogel, Wade et al. 2006; Pietrzak, Johnson et al. 2009; Wright, Cabrera et al. 2009).

This worthlessness is often accompanied by grief, anger, shame and fear. This creates a feeling of becoming "other" – I'm not the person they thought I was – and feelings of self-contempt along with the fear of this becoming known to others and the subsequent rejection from the group.

Contrary to the research by Iversen et al (2011) who found that anticipated public stigma was the most common barrier to treatment-seeking in a large UK military sample, these results showed self-stigma to a bigger factor. Corrigan (2004) proposed that self-stigma is the internalisation of society's negative beliefs and attitudes towards those with mental illness, resulting in the person believing he is socially unacceptable and thereby leading to reduced self

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esteem and shame (Corrigan, Larson et al. 2009). In this case, mental illness would render the individual unacceptable to the group (although it is okay for outsiders to be mentally ill). Results suggest an influencing factor in help-seeking is a rigid belief that it is unacceptable to consider social exclusion as an option for self and that this may be behind the denial. It simply cannot be true that I am mentally ill.

Thus self-stigma (Corrigan 2004) is evident and extremely high. There was also anticipated self-stigma in officers who had not experienced mental illness yet nevertheless held the view that they would be "utterly contemptuous of themselves" and as Cooper et al (2003) described, would not believe they deserved help should they reach that point. The individual has entered unfamiliar territory and perceives they have lost, or risked losing, the cohesive support of their group.

According to Modified Labelling Theory, individuals have already internalised cultural stereotypes about mental illness before they themselves have been labelled thus (Link, Cullen et al. 1989). Findings would tend to agree with this although I believe the more relevant "internalised cultural stereotype" is that of the invulnerable serviceman. There is less agreement in the literature as to the link between public and self-stigma (Golberstein, Eisenberg et al. 2009; Schomerus, Matschinger et al. 2009; Link and Phelan 2010; Schomerus, Auer et al. 2012; Blais and Renshaw 2013; Vogel, Bitman et al. 2013). I would agree with the view that self-stigma and public stigma augment each other in their effects (Held and Owens 2013) and it is a rather "chicken and egg" situation.

As the literature stated, in both military and civilian populations, those with the highest levels of mental health symptoms have the greatest concerns around stigma (Kessler, Berglund et al. 2001; Hoge, Castro et al. 2004; Langston, Greenberg et al. 2010; Livingston and Boyd 2010; Kim, Britt et al. 2011). Authors argue that this is because those experiencing problems are more likely to *"consider the potential stigmatising consequences … because of the immediate relevance of the decision"* (Greene-Shortridge, Britt et al. 2007 p.159). I would argue that it is only when symptoms have escalated to the extent that there is recognition that group coping strategies are not working, i.e. there is a potential violation of group norms, that the possibility of being expelled from the group becomes real. The literature also asserts that the stronger the person agrees with the negative stereotype, the higher self-stigma will be (Corrigan and Watson 2002). I would assert that the stronger the group norms and subsequent belief that out-group members are not fit for purpose, the higher the self-stigma.

Education to address the uncertainty surrounding signs and symptoms of mental illness and the nature of treatment are recommended as anti-stigma interventions generally (Brown, Creel et al. 2011) and with military personnel and veterans (Dickstein, Vogt et al. 2010). These recommendations must carry a caveat. Brown et al (2011 p.800) sets the scene with the suggestion that accepting a mental health problem may necessitate *"comparing oneself with an*

internal notion of other people who have problems" and findings would suggest that this is a major hurdle for this group. The further away the current social group identity is from the stigmatised one, the harder it will be to accept that internal notion. Even if people are better able to recognise disorders and have informed beliefs about effective medication and interventions (Reavley and Jorm 2011) there will be no benefit if the individual believes the education is not relevant to them. This is evidenced starkly by the 2 medically trained participants who reported high levels of denial or non-acceptance of an issue in themselves. Secondly, where the beliefs about identity are long-standing or deep-seated (e.g. strongly and deliberately developed in formative years) they will be harder to amend.

Dickstein et al (2010) advised that anti-stigma intervention strategies focus on the perception that use of care services are a sign of weakness and address stereotypes about mental illness in order to address the sense of failure and self-stigma. I consider it equally important to address the stereotype of the in-group. The bigger the identity, the greater the loss (Jetten, Iyer et al. 2002). It is more stressful if the new one implies a loss of status (in this case no longer being part of the elite group) or is irreversible (in this case, through becoming "other" and weeded out) (Jetten and Pachana 2012) and incompatible (Iyer, Jetten et al. 2008) (in this case, having different norms and values).

An existential crisis of various degrees arises. I would suggest that suicide results where this is intolerable. It is better to die than face the shame. Historically this has been the message for warriors (Gabriel 1987; French 2003; Sherman 2005; Tick 2005). This would fit with the interpersonal-psychological theory of suicide where it is proposed that a factor that drives suicidal behaviour is the "feeling that one does not belong with other people" (Joiner 2005; Joiner, Van Orden et al. 2009). Where thoughts of suicide where mentioned, they took the form of creating a fatal accident adding credence to Violanti's (2007; 2010) belief that this method of suicide amongst police officers leads to under-reporting of true figures. The high figures of violent offending, alcohol abuse and homelessness amongst the veteran population may be a reflection of reactions to this existential crisis. If, as one participant put it *"all we can do is pick up the pieces,"* then for some this option will come too late. The next section looks at the attitudes that were revealed that facilitated or prevented the individual from reaching out for support from outside the group.

5.4 Attitudes towards help-seeking

5.4.1 Disclosure

Disclosure means revealing their perceived shame and failure to others. The individual has to assess the risks of disclosure and there were fears that this would negatively impact on their career or current role – similar to results within civilian (Brohan, Henderson et al. 2012) and military populations (Britt 2000; Greenberg, Henderson et al. 2007). This is described in the literature as "felt stigma" or "anticipated public stigma" (Crocker and Quinn 2000; Thornicroft 2006; Lasalvia, Zoppei et al. 2012) and evident in research with military populations (Iversen,

Van Staden et al. 2011; Warner, Appenzeller et al. 2011; Fear, Seddon et al. 2012). Although clearly a concern, this was not as great as the self-stigma experienced or anticipated and, similar to findings by Lasalvia et al (2012), was not necessarily associated with enacted stigma.

The "anger and punishment" for self-inflicted mental illness (through lack of strength and control) as outlined in both general and military literature (Weiner, Perry et al. 1988; Stewart, Keel et al. 2006; Boysen and Vogel 2008; Mittal, Drummond et al. 2013) was anticipated in the form of exclusion. Having previously witnessed the "weeding out" of peers who had mental health issues, there was evidence of anticipated public stigma amongst participants. The power of expulsion includes the fear of having the label that says you've breached the group norm – "Lack of Moral Fibre," (Terraine 1997), "socially and emotionally insecure," (Wagner 1946), "weak," "not fit for purpose" (my results) – and are now in the out-group. This echoes the implicit belief through the ages that only those who are fit for purpose should be enlisted and they would require little support (Jones and Wessely 2005). Although no longer left to wander in the desert (Gabriel 1987), or sent to the asylums (Barham 2004; Jones and Wessely 2005), the prospect of expulsion was still devastating.

In contrast, to the acceptable temporary self-removal from the mission, there was great fear of removal from the job by others and this certainly delayed and even prevented disclosure for some. Disclosure inevitably means surrendering some control over the future potentially starting a chain of events over which the individual has no control. As Jones et al (2012) state, it's not simply deciding to disclose but it's who you give this control to. Corrigan et al (2011) view loss of self-esteem and self-efficacy as being on a continuum with personal empowerment at the opposite end. All too often though, in a workplace support system, duty of care and risk assessments mean that this control is limited.

The fear of being labelled with a diagnosis prevented one participant from accessing support. Where a medical diagnosis was entered on their official health record, there were heightened concerns for the impact on future roles. They feared being prevented from doing the job or that they will be taken away from a role that carries status and this will inevitably add to the stigma. In my time working with a Tactical Firearms Unit, I became aware of how managers could permanently remove an officer who had had mental health issues, regardless of outcome or time passed, for fear of this fact being used in evidence against the organisation in the case of a police shooting. Research has shown that service personnel are far more likely to disclose issues if they can do so anonymously (Warner, Appenzeller et al. 2011; Fear, Seddon et al. 2012). This label on their health record, a disclosable document, becomes the visible means of identifying them as flawed (Thornicroft 2006) – the blemish on their character (Goffman 1963). Political and organisational motives have always clashed with the individual needs (Gabriel 1987; Shephard 2000; Barham 2004; Watson 2008) and so it is little surprise that cynicism and suspicion are evident. Even in modern days, employers can discriminate against those with mental health problems (Jones and Wessely 2003; SEU 2004; Thornicroft 2006) and it seems

there is a collective representation of the faceless bureaucrat who will write off a person once their blemish is known. Going to outside sources of support, or not seeking help at all, was a way of keeping the blemish concealed for some participants.

This fear of permanent stigma and concern extended to peer reactions. Pattyn et al (2013) assert that anticipated public stigma can negatively influence help-seeking from such informal networks. What is often unknown for the individual prior to disclosure is what social support may be received. Because mental health and trauma is not necessarily discussed amongst peers, their views may not be known.

If mental health professionals are the furthest identity away from the group then there is more risk of being judged as they don't know the group's world. Conversely if there is a fear of public stigma from peers then by taking this issue as far away from them as possible it can be contained that way. By keeping things unofficial some element of control is retained. Containment of how many people knew was important. As one participant described, if help is required, the ripple effect must be reduced so as to minimise the associated embarrassment (to the person and their unit).

Limiting disclosure and facilitating control of the process is therefore important but there is also a particularly strong need for this group that once a problem is identified it should be sorted immediately. "Take action now", fits with the military mission focus yet the mental health services are not always geared up for this. As one participant described, once a problem has been admitted, the response needs to mirror the swiftness of a military medical response. There, help will be accessed in a matter of hours or days as opposed to weeks or months. For many the mental health crisis is perceived as just as life threatening as a physical crisis. I would suggest that there is a clear window of opportunity when the individual has accepted the need for support, before defences are bolstered and old coping strategies including denial are reinstated.

As well as considering the negative consequences in their cost-benefit analysis of disclosure, the literature states that individuals will also consider utility (the usefulness of disclosing) (Vogel and Wester 2003; Thornicroft 2006; Brohan, Henderson et al. 2012) and this is where their perception of the organisation and mental health services comes into play as will be discussed in the next sections.

5.4.2 The stigma of help-seeking

As Gould et al (2007) found in a military sample, education improved attitudes towards PTSD, stress and accessing help from peers but had no effect on attitudes towards seeking help from professional support. It has been suggested that this may be because of a lack of understanding still about the efficacy and nature of treatments or it may be that the stigma of help-seeking is a separate matter as suggested by Vogel et al (2007). According to the

literature, self-stigma can arise from the view that a treatment-seeking person is socially unacceptable. There can be the perception that asking for help is a weakness or an admission of failure (Vogel, Wade et al. 2006; Pietrzak, Johnson et al. 2009) and people view those seeking help more negatively (Parish and Kappes 1979).

There was a seeming contradiction in findings here. Participants certainly often viewed their own help seeking as a sign of failure, as previous research with a military population has shown (Wright, Cabrera et al. 2009) but, unless the individual was abusing the system, then it was also "right and proper" that people sought and received the appropriate support whether in the group or outside. Treatment seeking was not always a big issue for participants but rather the acceptance of a problem that wasn't being dealt with by group coping strategies (the self-stigma described in 5.3.4). For some, once that reality hit home, then it was a problem that they would look for a solution for.

I wondered then what influenced the different attitudes and tentatively propose that it is the perception of treatment-seeking in relation to group norms that make the difference. Help-seeking potentially violates the norms of Strength and Control and Cohesion. Firstly, self reliance means not asking for help and to do so means that you have been unable to control the issue and push through the pain. Accessing support from peers does not violate cohesion whereas going externally may do. Although there is not enough direct evidence from my results due to its qualitative nature, I would suggest that for those who viewed or experienced treatment seeking as taking control facilitated by trusted peers, both these norms remain intact. Where trusted peers facilitated referrals to outside support this was certainly more acceptable as was a mental health worker with a services background. Peers are trusted whether it's recommending research to take part in or sources of support for a problem.

Other research has found that social network facilitation was a factor in help-seeking (Snell and Tusaie 2008; Warner, Appenzeller et al. 2008; Sayer, Friedemann-Sanchez et al. 2009). Additionally, where people feel they will have control over their treatment and the impact of help-seeking on their lives, they will be less likely to suffer from self-stigma and I would frame this again as being due to the non-violation of "strength and control." They are making a choice to solve a problem. Perhaps by changing the view of help-seeking from an act of weakness into one of strength and courage (Stecker, Fortney et al. 2007) and following recommendations for personal empowerment (control) through education (Corrigan and Calabrese 2005; Luoma, Kohlenberg et al. 2008; MacInnes and Lewis 2008), we can better engage this group.

If peers are not available to facilitate referrals, once a decision has been made to disclose further afield, the question is to whom? Despite having a lack of awareness of mental health and services, the findings did not suggest that situational barriers were an issue contrary to studies with civilian and military populations (Kessler, Berglund et al. 2001; Maguen and Litz 2006; Ouimette, Vogt et al. 2011; Sudom, Zamorski et al. 2012). This particular group may be

more resourceful because of their age and knowledge of life and community resources and once a problem was acknowledged there was someone who could help, be it a colleague, family member, GP or other. This supports Britt et al (2008)'s suggestion that stigma and barriers to care are separate constructs.

Potential helpers are judged against the group values and this will either hinder or facilitate the process. This fits with the literature that claims that social support is more likely to be provided and to be effective when the two parties have (or are perceived to have) common group membership (Haslam, Reicher et al. 2012; Sani 2012). Two norms were particularly important in this decision:

- Mission focus – are they competent; do they do a good job?
- Cohesion – will they stand by me; can they be trusted?

For many participants there was a real sense of out-groups initially being stereotyped and this creates a wider gulf. For the purposes of this thesis, these negative stereotypes are of most interest so the discussion will focus on them. This editorial decision should not detract from the fact that there were positive experiences of outside support from both the police organisation and mental health professionals.

5.4.3 The negative police organisation
The literature suggests that the expectation that the police service will conform to military values (Tick 2005) can lead to challenges in transition between the two services (Daxe, Robinson et al. 2009) and, I would argue, even trauma through the shattering of assumptions (Janoff-Bulman 1985) – or in this case, violation of group norms when they are most needed. This would lend further support for authors who argue that the organisational culture and style of leadership support are the greatest source of stress in the police service (Alexander and Wells 1991; Brough 2004; McCaslin, Inslicht et al. 2008; Muller, Maclean et al. 2009; Brough and Biggs 2010; van der Velden, Kleber et al. 2010; Tehrani and Piper 2011). This next section looks at how the negative police organisation measures up to group norms and how this impacts on help-seeking.

When considering the police organisation's adherence to mission focus, events and people were appraised in terms of their ability to facilitate or hinder the job, and respected accordingly. There appeared to be a dissonance between mission focus in the military and in the police service. One participant highlighted how the difference in mission focus is caused by practicalities. In the military, there isn't a work-life balance to be managed as both these aspects are compartmentalised. Work continues until the job is done rather than a specific number of hours completed – there isn't a clash of demands making it easier to focus on the task in hand and give it your all. In the police, daily life has to be juggled and there will inevitably be clashes of priorities – the job becomes a job.

The credibility of police managers' personal mission focus was often poor. Managers were sometimes perceived as lacking the ability to make decisions and not seeing the potential consequences of their inaction. They were more likely to panic in a high risk situation. In the police service, senior management was felt to have a general lack of understanding of front line policing – the natural habitat for the group – and the ex-serviceman could find his abilities dismissed or invalidated. For managers and sometimes non-military peers, there was less experience of the real world, particularly life at the sharp end. Many have been fast tracked and have spent a bare minimum of time on front line policing and a lack of respect for the operational officer was common. Managers were heard to refer to the frontline officers in a derogatory way and this was supported by my own experience in the police service.

Equally, the police service does not appear to actively facilitate the norm of cohesion despite other research finding that UK police officers described "good, supportive supervision" as the best way they could be helped (HSE 2000 p.9). In the police service, there was perceived to be inherently less cohesion due to the enclaves in the service. The organisation was felt to be focused on facts and figures rather than people. There were strong opinions voiced on how this led to a lack of welfare, driving officers on without the opportunity for rest and recuperation, just ever increasing targets. The underlying concern was that the job would suffer if the "tools for the job" were not properly cared for thereby violating mission focus as a by-product.

A sense of belonging is fostered in the military and seeing comrades supported builds that sense of cohesion and expectation of support if and when needed consistent with claims by social identity theorists (Postmes 2003; Drury, Cocking et al. 2009; Haslam, Reicher et al. 2012). In the military, support is generally informal via peers and NCOs (Labuc 1991; Greenberg, Henderson et al. 2007; Pfeiffer, Blow et al. 2012; Smith, Vaughn et al. 2013) through the coping strategies discussed previously. There is less cohesion in the police, support is generally formally organised and officially sanctioned. If you're not in the workplace, you're out of sight and out of mind and support depends on whether someone can be bothered. Military Commanding Officers look downwards as their focus is on getting the job done through their men on the ground (collective outlook). Police Commanding Officers have more of a focus on themselves and their position and a tendency to look upwards (individualistic outlook).

Not everyone is comfortable with a cohesive unit. In the police, I worked with a specialist unit that attracted a high proportion of ex-military police officers. It was also a unit that was part of the standard promotion route for senior managers. I was aware of one high ranking officer tasked with "leading" this unit who was uneasy at being treated as an outsider and took this personally. Attempts were made to reduce the cohesion and change operational functioning in order to exert his control and influence. Suffice to say he was seen as enemy to their norm of not just cohesion but also mission focus and he faced a stone wall. An uncomfortable time was had by all before he eventually moved onwards and upwards. Although one participant described ex-military as "a bosses' dream," I wonder in reality how true this is. It assumes the

"boss" shares the same outlook and values. If not, I imagine the strong, frank ex-serviceman could become the bosses' nightmare!

Just as discipline was a strong identifier for in-group members, through its increasing lack of discipline, the police organisation itself was seen as weak, breaching the norm of strength and control. Allowing recruits who were not fit for purpose further weakened the whole as did the move towards what participants described as *"political correctness"* and *"pink and fluffy"* policing.

It seems that the military was often looked back on through rose-coloured spectacles when comparing managers. This shows how the over-generalisation of stereotypes (Corrigan and Penn 1999; Biernat and Dovidio 2000) works across the groups. If these negative experiences lead to a belief that the organisation does not respect the abilities of the group and value their associated group norms, it creates a sense of the police organisation, and managers specifically, being "other." Social identity theorists assert that "external" offers of support may then be viewed cynically and as having an agenda (Haslam, Reicher et al. 2012; Sani 2012)

At their worst, police managers were perceived as uncaring, back-covering and blaming in an individualistic culture. This perception of "lip-service" to officers' welfare can be fed by the dissonance between the organisational policy and procedure and what actually happens on the ground. As Hayday et al (2007) found the higher organisation were not seen to be committed to well-being through their removal of canteens and gyms. In contrast short-term well-being measures implemented by the organisation were not taken seriously. It was deemed that, provided there was a tick in the box, the quality of care was less important. On the surface, there was no evidence of structural discrimination (Thornicroft 2006) but the practice of organizationally prescribed support systems was often absent suggesting denial or ignorance in managers at best and stigmatising attitudes at worst.

The felt stigma described in 5.4.1 can lead to a culture of fear where individuals fear being judged by an organisation that is also fearful of being judged by outsiders (Woody 2005). Whereas in the military authority is strict, that can also bring a sense of security – you know the rules (norms) and if you stick by them you will be looked after. It's interesting that in the drive to not offend anyone and make allowances for minority cultures, there is a lack of understanding and respect for this particular minority group. In a blame culture that is watching and waiting for you to step out of line and will not protect you when you do so (even inadvertently), where a group does not feel accepted or respected and has had their usual coping strategies removed, the question is *why would you expect it to understand when you break your own high standards and become mentally unwell?*

As Woody (2005) highlighted, the threat to the individual caused by the police organisation can prove isolating for the individual officer, potentially driving the ex-serviceman further into the

safety of their in-group. Whereas, as outlined in the last section, there was no evidence of situational barriers to care (in the traditional sense), this perception of being separate within an out group is a barrier as it reduces those who are available for support. This could be framed as structural, or institutional, discrimination whereby major institutions' policies, that are not directly intended to discriminate, have consequences which nevertheless hinder the options of people with mental illness (Corrigan 2004; Thornicroft 2006). The recommendations by Zinzow et al (2012) are relevant here. Addressing concerns about confidentiality and mitigating the effects of help-seeking on future career paths is crucial. Increasing unit cohesion will both prevent and mitigate reactions (Labuc 1991; Drury 2012; Du Preez, Sundin et al. 2012; Britt, Adler et al. 2013). I would also amend the recommendation of improving access to health facilities to improving response times so that once a referral is made the system responds with military speed and effectiveness.

5.4.4 Attitudes towards mental health professionals

Mental health services were often a bit of a mystery with information coming anecdotally, from films such as "one flew over the cuckoo's nest" but also from the interaction with crisis mental health services. Any evidence or knowledge was used to judge them according to group values.

The purpose of mental health services was felt to be in supporting people towards getting back to providing a useful service, in other words supporting mission focus. Military research however, has found a lack of confidence in mental health care (Maguen and Litz 2006). The literature reveals that crisis mental health services, working alongside the police, often failed to meet the officers' standards and there are issues such as communication problems, lack of collaboration and respect for the other (Charette, Crocker et al. 2011; Hollander, Lee et al. 2012). Participants often supported these views and reported perceptions of an ineffective service based on their police interaction. Liaising with mental health services, waiting for responses from psychiatric emergency services and the resultant inability to attend to other duties also found by Lamb et al (2002) mean a violation of mission focus and cognitive separation between officers and would-be helpers.

The perceived competence, not necessarily of individual workers but of the mental health system generally, did not fare well in the findings prior to use. People who were mentally ill were seen to be in a revolving door system where nothing really changed. A fair assumption then is that services simply contain but don't effectively treat. There were mixed thoughts on whether a full recovery was possible and this throws doubt on expectations of support being effective. This fits with the literature on negative perceptions of mental health care (ten Have, de Graaf et al. 2010) and how this decreased the likelihood of treatment-seeking in military populations (Pietrzak, Johnson et al. 2009; Kehle, Polusny et al. 2010; Kim, Britt et al. 2011). Stecker et al (2013) found that concern about treatment was a factor for 40% of non-treatment seeking veterans of the Iraq and Afghanistan conflicts. Other beliefs from the literature can be framed in terms of group norms and include that providers won't understand them or cannot be trusted

(absence of cohesion), that treatment is only for extreme problems (where strength and control have failed) and that medication will result in negative side effects (impacting on mission focus) (Edlund, Fortney et al. 2008; Sayer, Friedemann-Sanchez et al. 2009; Kim, Britt et al. 2011).

Zinzow at al (2012) recommend using contact as an anti-stigma intervention by integrating mental health professionals into the military environment. This could help balance some of the negative stereotypes that result from the police interaction. However, Edlund et al (2008) in research with depressed veterans found little evidence to suggest beliefs that could prevent treatment-seeking were modifiable. They support the stance that long-standing beliefs are not readily changed. This, and the resistance to changing stereotypes through attitude polarization (Boysen and Vogel 2008; Lord, Ross et al. 2008; Lord and Taylor 2009) does make this an uphill battle.

The desirable military qualities of toughness, the ability to contain emotions and the use of aggression (strength and control) can interfere with the therapeutic alliance and actively working on traumatic memories within therapy (Creamer and Forbes 2004; Forbes, Parslow et al. 2008) as this clash of group norms occurs. Much research has concluded that toughness, self-reliance and suppression are negatively associated with treatment-seeking in both police and military populations (Pogrebin and Poole 1991; Berking, Meier et al. 2010; Dickstein, Vogt et al. 2010; Backteman-Erlanson, Jacobsson et al. 2011; Jakupcak, Blais et al. 2013) and it strikes me that this control of emotions is often framed by others negatively rather than as an adaptive response or even a skill to be encouraged. It's the ability to change state that is important.

Stereotypes of *"pink and fluffy"* were common amongst participants. If *"roughty toughty"* is at one end of the continuum then *"pink and fluffy"* would be at the other. *"Roughty toughty"* is the action oriented, resilient serviceman who enjoys excitement and adrenaline and has dealt with difficult situations. He deals with the rough edge of life (death, hardship and danger) and is tough mentally and physically. *"Pink and fluffy"* described the stereotype of counselling as soft voices, poetry and bean-bags, a caring, sharing environment that wasn't based in the "real world". This, and the perception that therapy is about exposing (and perhaps encouraging) weakness, violates the norm of strength and control and deterred participants from accessing therapy. People associated with this are therefore very much out-group and polar opposite to *"roughty toughty."*

Participants needed to talk to someone who understood their world. Mental health services were usually viewed as somewhere where you either got medication (that gets in the way of the job) or just talked things through. In the latter case, I wondered how talking things through with someone from a different world could possibly be more helpful than peer support? Vogel and Wester (2003) emphasise that the ability to reveal private thoughts and emotions to another person is a factor in help-seeking for mental health problems and Thornicroft (2006) includes

the therapeutic ability to tell one's story as a perceived benefit of disclosure. It seemed that mental health services had little to offer compared to peer support.

In terms of trustworthiness, the perceived power imbalance and lack of control, as considered in 5.4.1, created fear. If the participant felt coerced into attending mental health services, they could retain what little control they had through non-engagement. This sometimes kicked in instinctively and resulted in minimising issues and flight to recovery. There was fear of being judged for existing coping strategies such as *"black humour"* and a fear that the norm for maintaining control would be violated by the "requirement" to expose rather than suppress vulnerability and feelings. Both reveal a perception of meeting someone who wouldn't understand and was therefore "other."

The ex-serviceman wants a pragmatic approach and many offered the metaphor of getting their car fixed at the garage. This kind of directive, advice does not sit well with a person-centred approach and that was a big turn-off for participants. Education on the management of symptoms was associated with increased agreement to seek treatment amongst soldiers (Warner, Appenzeller et al. 2008) and this perhaps is because the garage is perceived as having some relevant skills on offer. This strikes me as similar to the requirement when interviewing elite groups (as defined by Gillham 2004) for the researcher to demonstrate expertise and gain respect in order to engage participants (Gillham 2004; Kvale 2009; Kvale and Brinkmann 2009). One participant described mental health problems as any other problem that can be sorted with the correct help. By teaching skills to manage symptoms, the individual's sense of mastery begins to be restored. This is crucial. However, another dilemma may then arise. Where the individual regains some control, they may then go on a "flight to recovery" as described in the literature (Sirey, Bruce et al. 2001; Interian, Martinez et al. 2007; Royle, Keenan et al. 2009; Fung, Tsang et al. 2010) and not continue with the therapy

It sometimes came as a surprise when health professionals were seen as knowledgeable and expert and coping strategies and education were valued. Sadly not all of them met this standard. From the descriptions, some showed a lack of knowledge of evidence based therapies for psychological trauma and others a lack of respect for the perspective of the individual. Given the huge effort needed to attend services, and the tendency to under-report symptoms and effects, professionals need to be wary of collusion in this minimisation, let alone dismissing concerns. Shockingly, some participants had to persuade health professionals they had an issue often several times before anyone took them seriously. Perhaps we've taken our own advice on normalising symptoms a step too far. Professionals need to consider the previous assertions that individuals have a higher tolerance to distress and may downplay the change in their personal and social identity thereby promoting personal identity continuity (Branscombe, Gomez et al. 2012; 2012; St. Claire and Clucas 2012). This can manifest as minimising symptoms and the real level of need for help.

5.4.5 Post-trauma attitudes towards self

As the individual recovers, they reassess their identity and make sense of their experience. Their metaphors for this gave them their own understanding of what happened – thus giving them meaning and control. Examples of these metaphors included the acceptance that the human mind needs to deal with difficult events, download and store them away and it can reach capacity causing problems. It can take years for this to happen. Ehrlich-Ben et al (2013) recommend that anti-stigma interventions should encourage the process of regaining a sense of meaning in life in order to facilitate recovery and, as a psychotherapist working with trauma, I would agree that this sense-making is vital to recovery.

The previous existential crisis leads to a new sense of identity and this was invariably positive. The experience was incorporated into their life story and many reported a feeling of being fully alive and transformed. There was a philosophical view of their mental health issues and any residual symptoms were accepted, even welcomed, as battle-scars and reminders of their service. Several had ongoing symptoms yet were not seeking treatment for them. I wondered if they believed this was as good as it gets, a stoic acceptance or perhaps some were still in their recovery phase. For remaining symptoms, the old acceptable coping strategies were back in place although this time at adaptive levels. Strategies were used such as taking time out, talking to peers (and family) and controlling exposure to unnecessary triggers. Self-reflection was improved with greater awareness of when symptoms were increasing and the ability to take on board trusted others' viewpoints. There was a sense that any remaining issues could be safely contained and controlled. As stated earlier, for a mental health professional, there is a real dilemma when an individual has recovered sufficiently to regain control over their symptoms and leaves therapy early. Is this treatment drop-out or failure (Sirey, Bruce et al. 2001; Interian, Martinez et al. 2007; Royle, Keenan et al. 2009; Fung, Tsang et al. 2010) or is it a choice to return to minimising symptoms and using old coping strategies and therefore to be respected?

Many participants have opened their eyes to a whole new perspective on trauma and as part of the ethos, know your enemy, made strides to read up on it. With this new awareness, having lived through the battle, they would now see the threat to others. Many had gone from a position of ignorance or vague awareness to a sense of having engaged with an invisible enemy. They were now veterans of this particular campaign.

As they return to the social group they then begin to break stereotypes and influence, to greater or lesser degrees, the group norms and attitudes to psychological trauma. By disclosing their experiences they offer a role model for a potential 3rd identity – that of battle veteran. Becoming a positive role model – being willing to risk others' judgments in order to help and inspire hope – takes real courage. Their message to others is you can get over it – it's not permanent – it happens to the best and toughest of us.

Their new mission often included taking on the role of group sentry, guarding against threat, and protector of the troops' welfare so that the job continues. Given the soldier's innate ability to recognise threat, I would argue that these individuals are the best sentries against the effects of psychological trauma. Their skill lies in recognising the early warning signs (having engaged with the enemy), not giving up or colluding in denial, not judging and having credibility thereby challenging stereotypes. Because they are seen as credible in-group members, they also become well placed to influence "Protest" as a stigma-reduction intervention (Corrigan and Penn 1999); potentially better than any organisational attempts to influence which may be seen as falling into the *"politically correct"* arena and lacking true value.

This type of contact as an anti-stigma intervention is important. The literature shows that contact is one of the most promising of the 3 strategies in the general public (Penn, Kommana et al. 1999; Corrigan, River et al. 2001; Corrigan, Rowan et al. 2002; Alexander and Link 2003; Evans-Lacko, Malcolm et al. 2013) and can lead to re-categorising and reducing stereotypes (Couture and Penn 2003). However contact needs to be targeted, local, credible and continuous (Corrigan 2012; Corrigan and Kosyluk 2013). This is the real value of credible peers who have had direct experience of mental health problems. This supports the view of Greene-Shortridge et al (2007) when they suggest incorporating Contact alongside Education by having soldiers who had been successfully treated for PTSD discuss their experience in a supportive unit environment. I would suggest they need to be particularly credible, fully recovered and part of that unit. It will take a very robust individual to play this important role – ideally someone who has experienced post traumatic growth – and there is no guarantee that they will not reinforce existing stereotypes through biased assimilation as cautioned in the literature (Kunda and Oleson 1997; Boysen and Vogel 2008; Lord, Ross et al. 2008; Lord and Taylor 2009).

Their levels of understanding towards what was a stigmatised group (their peers rather than the general public) have been increased and some have had a complete turnaround in how they view peers with mental health problems. They displayed genuine empathy and an ability to recognise those who may be at risk – two of the recommended abilities for peer supporters (Varker and Creamer 2011). This desire to help group members was certainly apparent post-trauma. The norm of cohesion is strengthened as a desire to help other group members and they talked of letting no-one slip through the net. Several seriously took on the role through learning more about mental health and often becoming peer supporters. Over time, it is intended that peer supporters (such as those trained in TRiM) will reduce stigma (Jones, Roberts et al. 2003; Greenberg, Langston et al. 2008) and this was certainly the intention of participants although how it works in practice was not a focus of the research.

Their disclosure style changed and varied from Selective Disclosure to Broadcast (Corrigan and Rao 2012). The ones who are "fully out" are willing to defend their position robustly and are very forthright in their willingness and ability to do this. In terms of Brohan et al's (2012) review of the reasons for disclosure, the desire to become a role model for others and a positive experience

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of disclosure would seem most pertinent to this group. Indeed for some, there was a sense of duty to act in the collective interest indicating shared goals (Drury 2012) and reintegration into the group. There was no longer evidence of the past difficulties being seen as a blemish (Goffman 1963). Corrigan and Rao (2012) assert that self-stigma is not a necessary consequence of public stigma where the person recognises it as unjust. In those instances, they may react by becoming advocates for change. What is interesting here is that participants who initially had high levels of self-stigma and believed the public stigma to be justified have reframed this.

Pride is taken in their new skills. They see this as another experience they have lived through and that they are better able to talk, be open, and possess emotional intimacy and intelligence. Interestingly, there was a move to balancing the masculine and feminine sides and that this made them a more rounded person. Family units also became closer and relationships were strengthened. Many were taking these softer skills into the workplace whilst maintaining the credibility of being experienced and tough. When asked, they viewed the whole experience as life-affirming and strengthening and given the chance would not have missed it. It was their choice to be exposed to the risk and it has made them who they now are.

As described in the literature, they had turned their "badge of shame" into a "mark of honour" (Branscombe, Schmitt et al. 1999; Shih 2004; Branscombe, Gomez et al. 2012) but I believe this was not due to overcoming the adversity of membership of a stigmatised group as some authors would suggest (Crocker and Major 1989; Branscombe, Schmitt et al. 1999; Shih 2004) but in winning the battle with a reified enemy and returning to the in-group as victors. There is potential here for retention of status which will make this a more attractive identity and motivate people to follow their help-seeking example.

We can look at this in terms of Link and Phelan's (2001) conceptualization of self-stigma into a hierarchy of awareness (I must be aware of the stereotype), agreement (I must agree with the negative attributions) and application (I must apply the stereotype to myself. Do they ever join the stigmatised group or do they create another one – veterans? That would be a better one to identify with and if the individual can identify with the new group i.e. those who fought and won mental health problems, they are more likely to seek help (Rusch, Corrigan et al. 2009). As Kellezi and Reicher (2012 p.228) might put it *"Suffering that affirms identity is bearable, it can be spoken of and attracts the support of others in the group."*

So, the group norms are reframed and the experience will be used to strengthen these. The process was often described in combat terms – battling or fighting with PTSD – and comments such as *"I beat it, I won".* Paradoxically, their knowledge that they are not invulnerable has somehow made them feel stronger. Many of these positive changes were evidence of Post Traumatic Growth (Tedeschi and Calhoun 1995; Linley and Joseph 2004; Linley and Joseph 2009). Tedeschi and Calhoun (2004) identified factors in PTG. Those most apparent in the

findings were Relating to Others (greater intimacy in personal relationships and more compassion for others), New Possibilities (new direction and purpose in life), Personal Strength and a Deeper Appreciation of Life. The first three closely fit with group norms of Cohesion, Mission Focus and Strength and Control.

Researchers have suggested a positive association between initial levels of distress and subsequent growth (Kleim and Ehlers 2009; Dekel, Ein-Dor et al. 2012). I would suggest that "initial levels of distress" also comprises initial levels of self-stigma. Although admittedly highly subjective, my observations were that those with the greatest initial self-stigma described the greatest perception of positive change in themselves.

Part 5 now continues with a consideration of the strengths and limitations of the research before providing key findings and implications in the concluding part 6.

5.5 Summary

5.5.1 Strengths and limitations of the findings

This next section offers a critical assessment of the strengths and limitations of the findings. As outlined in part 3, the validity of a design refers to the *"degree to which what is observed or measured is the same as what was purported to be observed or measured"* (Robson 2000 p.553). Qualitative research can be criticised for researcher subjectivity and this is one of the reasons I involved participants in the early stages of analysis by providing transcripts and my initial interpretations. 8 out of the 11 participants gave feedback and their comments are shown in Appendix 7. Some clearly involved thoughtful reflection considered over time. The accuracy of the transcripts was checked and there was evidence of participants' ability and willingness to clarify my interpretations and correct any errors in this. This adds robustness to my interpretations.

When considering validity, Lewis and Ritchie (2003) suggest the researcher considers whether the data collection proved sufficiently effective in exploring views. I believe I did capture the phenomenon and the interviews provided even richer data than I had expected. This was also potentially a limitation of the study. Due to the immense potential information and avenues to explore, a decision had to be made on the focus of this thesis and important information may have been sidelined. A balance was needed between "zooming out" to the process and "zooming in" on more detailed exploration of phases.

Because not all participants had sought help from mental health professionals, the numbers for this part of the research were slightly lower. This means the available data around the final 2 phases was slightly reduced. However the focus was on looking at the phenomenon (mental illness and help-seeking) from several angles so the research benefited from this multiplicity of perspectives. Having this wide range of participants, located in different forces across the country raises the credibility of the results. One limitation was that participants were not at the

existential crisis stage and indeed this would have raised considerable ethical dilemmas for the research proposal if I had intended targeting that group. Therefore participants were considering either a hypothetical experience or reflecting on a past one. That could mean that their thoughts did not accurately reflect the lived experience.

Qualitative research can satisfy reliability by having a transparent process with a sufficiently detailed description of my research and data analysis and being explicit about the theoretical stance from which I am making my interpretations (Silverman 2011). My reflexive statements, and the information provided in Appendices 1 and 7 are intended to offer this transparency and detail. It was not possible to include full transcripts of the interview within this thesis due to the openness of participants. It would have been relatively easy for them to identify colleagues through descriptions of events and service background. This also prevented me offering more biographical information on participants and is exacerbated by this group's naturally investigative mindset.

As stated in part 3, one of the limitations of interviews as a data collection method can be in trusting how honest the participants are. I couldn't be sure whether participants were telling me what they thought was socially acceptable or their true feelings. In this case, paradoxically this could be considered a strength of the study. Because their group has such a strong norm of conformity, if they were not stating their own personal views then they were most likely stating the group views. There was no reason for them trying to conform to what *I* wanted to hear as I'm not part of their "elite" group so in that respect there is no need to please or impress me.

However, as stated in part 3, interviews can provide a means of hidden agendas being fulfilled and so consideration should be given as to why people chose to take part. My sense was that interviewees had different reasons for participating:
- Some wanted a forum for venting frustration at what they saw as slipping standards for who was in their group and the impact on the job
- Others were passionate about the need to support their group when problems arose
- Many wanted to express their concern about how the police service generally interacted with them

It felt important to hear the emotion behind the words rather than being drawn into the "facts" and to ask what exactly is happening here. There were two things they shared no matter what their agenda – firstly, a strong opinion on the subject (leading to rich data) and secondly a sense of wanting to help their group. By being mindful of these emotions, I gained a sense of their separation and of the group identity and values being threatened. There was also a sense of wanting, even needing, these issues to be heard and this led me to wonder whether they didn't feel heard generally. These gut feelings helped formulate my initial interpretations and develop the theory.

The present research dealt with a unique population – the police officer with an Armed Forces background. In many ways, the findings parallel those of studies with military populations and this raises the question of whether they will generalise more widely. There are inherent limitations due to the lack of biographical information that I have been able to present for confidentiality reasons. I can draw no conclusions as to the impact of gender, ethnic origin, class or other demographical factors. Although the aim of this research was to achieve an interpretive understanding rather than to generalize, I shall nevertheless consider the generalisability or transferability of the findings here in the three ways suggested by Lewis and Ritchie (2003).

Firstly, can they be generalised to the same population? I would be relatively confident that this is the case due to the shared voice expressed throughout the findings and their perception of being a discrete population with strong norms. If it was indeed generalisable in this way, and further research needs to done to determine this, it should not be generalized across both genders. Another caveat would lie in the fact that participants self-selected for the study. If there had been residual shame and self-stigma they may not have taken part.

There is less support for empirical generalisation, i.e. the application of findings to a wider population or settings. Although participants identified as primarily ex-servicemen, there is a possibility that those who are drawn to the police represent a particular sub-group. Servicemen are drawn from a diverse population and although they are turned into a "standard product" they are nevertheless individuals and will have their own attitudes and maintain group norms to greater or lesser degrees. An obvious example of how this group may differ from the general military population is in the fact that they would not have a criminal record. This would exclude them from joining the police service although this is not the case for the military. Willig (2001) suggests it's not about seeing what people have in common but about seeing what experiences are available within a culture or group and this is what I would suggest these findings offer. Interestingly, during the course of the research I presented my initial results to two police officers from Australia (one of whom had PTSD) and they validated the process as an experience which they could relate to. Civilian culture is very different to the uniformed services and results cannot be generalised outside this area. This issue can only be addressed by systematically studying the attitudes towards mental health and help-seeking across a range of work settings.

Thirdly, results may be generalised as theory-building and developing the wider theory. I believe the results add to the wider theory in their consideration of violating group norms. Taking a social identity approach and considering the in-group / out-group transition could be a focus for more research with this population. It could also be a framework for considering some of the adjustment issues faced by those leaving services and transitioning to civilian life. Perhaps the perceived lack of adherence to group norms within civilian life is one of the issues that make

this such a difficult transition. This would be my subjective, anecdotal experience when working with veterans with adjustment issues.

5.5.2 Answering the research question

The success of the research lies in whether the data collection proved sufficiently effective in exploring views. Did I capture the phenomenon?

The research was successful in answering whether police officers with a military background saw themselves as a specific population and identified several of the in-group characteristics that were a factor in help-seeking behaviour. It offered a perspective on their attitudes to mental health issues, including attribution, ways of dealing with them and relevance to self as well as some of the stereotypes applied.

I believe that the findings have successfully provided a theoretical model of the help-seeking process from the perspective of the social group identity. One of the challenges was that I got a wide sweep of data and had to contain it thereby losing rich data from the thesis. There was some indication of participants' experiences of mental health services but this was beyond the scope of this thesis as was a fuller exploration of barriers and facilitating factors. I intend to address this through other written work and publications.

The literature around stigma and mental health focuses on taking on a stigmatised identity rather than the loss of a valued identity and the violation of group norms. The unique contribution of this research falls into two areas:

- Looking at a specific population not researched before
- Formulating stigma as arising from the violation of their group norms

The phenomenological paradigm asserts that an external, multi-faceted reality exists and our understanding of this reality is seen as subjective, only knowable through the human mind and socially constructed meanings. Phenomena are made up of parts and wholes and by looking at the same thing from many angles we reveal more of what it is (Sokolowski 2000; Cardinal, Hayward et al. 2004; Glendinning 2007; Moran 2008). By looking at views from in-group, out-group and return to in-group, a fuller picture was gathered and this is one of the strengths and contributions of the research. By using a GT approach, the research offered an understanding of the *"tacit, the luminal, and the marginal that otherwise might remain unseen and ignored, such as latent sources of conflict."* (Charmaz 2011 p.362)

This research left me with many more questions and there is great scope for further research both within this specific group and the military population generally. Part 6 expands on these recommendations.

5.5.3: Final reflexive statement

In part 1.1, I stated how, according to my chosen research paradigm, the researcher has an impact on that being researched. My findings are inevitably influenced by my own perspective and values. Therefore at the outset of this study I set out my own experience and background. In this next section, I revisit this question and consider how the research has influenced me as researcher.

In my initial reflexive statement, I explained my reasons for choosing this topic and my wish to address the suffering behind non-engagement with support services. However, the research led me into deeper waters of in-groups and out-groups. As I was considering participants' cognitive separation and identity, a parallel process was happening for me as researcher and I was confronted with my own unique position of insider and outsider.

When I started work as a police welfare office within the police service, I immediately felt I was joining a different world. In my particular police force there was a strong emphasis on being operationally involved so I was quickly mixing in the circles and situations that much of our TV is fascinated with. I was involved in breaking news events and the fact I couldn't talk about my job only added to this sense of being an insider with privileged access. Initially I felt out of my depth professionally and threw myself into further study to skill up. On a more inter-personal level, it didn't take long for me to pick up the way of being in that group – calm, practical, mission focused – and adapt my persona to fit. For the majority of police officers this was straightforward – you work for the organisation therefore you're an insider. That felt validating as I think most of us need to feel we belong somewhere.

However, the units with more ex-servicemen weren't so accepting and I was likely to be dismissed as irrelevant to them. I suppose I could have easily avoided working directly with them but instead I actively made links. It's uncomfortable being an outsider when confronted with a strong group and I think I went into fight rather than flight. I recall an inspector who was about to introduce me to one such unit and clearly felt the need to reassure me. *"Don't worry, they may be roughty toughty on the outside but inside they are marshmallow"* to which I replied *"Don't worry, I may be marshmallow on the outside, but I'm roughty toughty on the inside."*

I think it's fair to say I was the stereotypical opposite to them – civilian, female who deals with emotions and distress. Without realizing it at the time, I used the group norms to build trust. Mission focus was demonstrated through having a clear remit and being solution focused. Strength and control was important in my visible demeanour – being calm no matter what. Cohesion meant I was prepared to put my neck on the line and speak up when welfare issues were being mismanaged. I developed an outer persona that was acceptable to the group and wasn't scared of engaging in any banter that was going about. My family background helped there as we children well and truly knocked the corners off each other. However, I had to be sensitive to opportunities to bring out the softer skills and be open and honest. This required an

ability to change gear rapidly based on the person in front of me. I never had a sense of this being incongruent, rather bringing out different aspects of my own personality.

I continued working with police officers and veterans after I left the police service and my background was usually an instant rapport builder with a new client. Although I didn't deliberately divulge this to the research participants, having worked with this group as an insider for many years, I felt relatively certain I could engage them particularly as they were choosing to take part. I minimised the influence of my age and gender by focusing on the task in hand and presenting a confident and open persona. Showing respect, genuine interest and honesty mattered more than age, gender and race. I'm not aware of how much participants knew or cared about my background – some certainly revealed they knew nothing – and I think the main influence on this was that I was personally recommended by my contacts within the police service. There was an implicit level of trust extended to such referrers. One participant appeared to want to "place" me, asking about people I knew and mentioning knowing people from the police service I used to work for. It was challenging not to reveal more of myself when asked a direct question without appearing evasive. I know how important transparency is with this group and so had to strike a balance between researcher detachment and creating trust. Again, the skill of moving between worlds was important – dealing with the banter and not being put off by descriptions of events yet remaining open, curious and sensitive immediately the mood shifted when we moved into deeper reflections.

As discussed in part 3.1.3, I considered the participants to be an "elite" group – as defined by Gillham (2004) – even before the need to "be the best" had come out as a group norm. With such a group, in order to engage them, the researcher must give something back by becoming an interesting conversation partner and must demonstrate expertise and gain respect. Certainly several participants took the opportunity to have an educated conversation about psychological trauma. At times the interview got side-tracked when participants had a genuine interest in discussing trauma. In those cases, we both had to be clear that the interview was paused and then restarted or leave such discussions to the end. Again I was shifting between feeling like an insider with knowledge of the group and being perceived as an outsider looking in as a researcher and / or as a mental health professional. One comment brought this home to me when Bill was talking about soldiers in WWI: *Definitely I think that's something you can,* **well I can** *identify with* (emphasis mine). This subtle differentiation was a reminder that I can never be a real part of the group but can be an "honorary associate".

My insider perspective allowed me to concentrate on the experiences that participants talked about rather than being distracted by descriptions of events or what one participant described as "*war stories.*" Initially when I was doing the interviews they felt superficial compared with a therapy session. It took a little practice feeling comfortable treading the boundaries of wanting a depth to the data but not wanting to probe excessively or open up anything inappropriate. However, as the analysis and collection continued, the richness of the data became apparent

and if anything I was struck by the sheer scope of what I was given – so much data and so many potential areas to explore. I was left with more questions as I analysed and drew together my literature but they were beyond the scope of the thesis – this was frustrating. I could have written several theses and had to rein myself in by mentally committing to writing future journal articles on what wouldn't fit. I think that's my next ten years sorted! The mental task of holding it all together for comparison and reflection in my head was immense and I regularly felt I was "running out of brain" – I made good use of diagrams and whiteboards at those times and that was interesting as the whiteboard in my office drew comments from visitors, some veterans themselves, requiring me to explain my processes and theory and further clarifying my thoughts.

At the outset I had felt that the big risk was in allowing my stance to influence the findings, particularly if something was revealed that cast a less than flattering light on the population. At times, the process did indeed require me to contain my own emotions:

- I was disappointed and angry when I heard about some of the actions of "professionals" and felt an urge to distance myself from that identity.
- I was saddened when I heard about some of the treatment at the hands of police managers and actually shocked by one of the "care" processes described as currently in place in one force. I understood from my own experience how parts of the organisation can clash with welfare needs and pay lip-service to them. I needed to be clear not to bring my own anger and agenda into the findings though.
- At one point, as I researched the history of combat trauma, I found it hard not to be pulled into the emotions of what I read. It was fascinating but also slightly depressing to source papers that were almost a century old and yet find resonance with modern day issues – the power imbalances, political agendas, professional turf wars and lack of real concern. I began to see the area of barriers to care increasingly as a social justice issue (Charmaz 2011).

All these emotions had to be recognised but then contained whilst I concentrated on the task. This was comparatively easier than with emotions generated within a therapy session as I had space to reflect and process them during analysis. I genuinely wanted to do a good job and put my energies into discovering what could be done to make even a small difference. I think I had expected any solution to be "out there" and yet their words *"this isn't me," "this is not what I do"* had given me a clear signal that the change needed to happen "inside" and was closely associated with identity. Perhaps I had naively been hoping for a less complex situation – perhaps some resulting clear-cut guidelines and recommendations that could "fix things".

During the analysis I found myself being drawn further back into the in-group world yet this time as an outsider looking in. There are levels of insiders / outsiders in the therapeutic community that works with the unformed services. Whilst working within the police service, there was a status that gave me instant credibility and set me apart when attending external training events

as a therapist. At conferences, I have been "placed" according to my proximity to the in-group, for example being employed by the police organisation versus working in private practice. The research process made me question where I now belong. It seems that territorial lines are drawn where everybody seems to need to claim their position – e.g. my father was ex-services, I work for the Ministry of Defense, I'm married to a police officer. It's almost like a game of Top Trumps and I wondered why this is. Perhaps my doctorate studies were a way of me positioning myself back in the group by becoming an "expert" and claiming my credibility.

Over the course of the research, my therapeutic work has benefited and also, through my clinical supervision of other therapists, I have found a ripple effect to this as I educate my supervisees. By recognising the violated group norms, I gained a better understanding of why they found it so difficult to access support. I think I had previously under-estimated the impact of these on attitudes. I used this knowledge to improve my rapport building with veterans and explicitly acknowledge the norms, speaking their language.

I have my own "war stories" and throughout the process good and bad memories were stirred up. I missed working so closely with the group and the adrenaline of the work yet knew I couldn't return to working within the restrictions of the organisation. As an outsider I can achieve more personally and professionally and this was one reason I ultimately left the police service.

Although I had suspected this was a discrete social group, the extent of their group identification was stronger than I had initially expected. I think I had previously seen their identity from an individual perspective, i.e. individuals with particular traits who just happen to be linked by group membership and once I had repositioned this as a group identity and got a sense of the group as an entity, my eyes were opened further. One of the things that became clearer ro me during the research process was the the recognition that I shared their norms – perhaps as a result of my own father's Naval service that had clearly been influential to him. As one of 5 siblings, born with only 7 years between the eldest and youngest, the family was run like a tight ship. Naval terminology abounded and discipline, structure and maintaining standards ensured we were an orderly brood. Perhaps this sharing of values explained why I have been drawn to this group.

When I considered their increasing minority status, removal of coping strategies and the lack of understanding often showed, I felt spurred on to tell their story. There was a vulnerability that was at odds with their exterior identity. There is a human being with thoughts and emotions behind the uniform and I think that society unhelpfully stereotypes them as heroes or villains. Wider issues surfaced for me around society's attitudes to both police and military personnel. We send them to do our dirty work and expect them to sacrifice themselves for the common good. They are somehow depersonalized as we see the uniform rather than the human being. Could we bear to do anything else? Is this our own justification ideology?

Paradoxically, through the research I also gained more sympathy and understanding for the military dilemma. It felt as though the military had to create stigma in order to meet their objectives and I had to consider whether there ever could be a solution. As one participant said "maybe all we can do is pick up the pieces." However, knowing that not everyone survives that point means it can't be an option. I once heard that collective acceptance of psychological trauma comes in cycles. We are confronted with and accept the extent of it, are outraged and try to eliminate it, then are faced with the overwhelming inability to do so and so go into denial. I don't remember the source.

When the going got tough with the PhD I knew I would have to complete as I had internalised their disapproval should I fail my mission! I had been allowed back into the group and was acutely aware of the need to get it right and not misrepresent them. That would have felt like a betrayal of trust and was the biggest motivation for not letting myself as researcher unduly influence the findings. All participants will be sent a final copy and I know many will sit down and read it thoroughly. I hope I have done them justice.

This thesis now concludes with a summary of key findings and their implications for the development of theory and practice.

Part 6: Conclusions

6.1 Key findings

6.1.1 Police officers with an Armed Forces background form a specific population

The research found that police officers with an Armed Forces background viewed themselves as a discrete social group. Whereas in the military, they had developed strong regimental pride and seen other regiments as out-groups, in the police they banded together under a new group. Even after many years, the military identity was stronger than the police one and participants put this down to the setting of norms in their formative years. The "shaping" of the military identity is an enduring one.

They had an ability to quickly recognise a group member and were able to describe their characteristics, in both appearance and behaviour. There were common expectations of such peers including trust and standards to be met. These were ingrained attitudes intended to meet the military purpose that were now carried into the police service. Four group norms were identified as relevant to the research topic: a) Mission Focus, b) Strength and Control, c) Cohesion and d) Be the Best.

"Mission focus" describes their collective action, working towards a common purpose, having a focus on the job and being as effective as possible. The job is paramount and over-rides the needs of the individual. They had a shared drive for challenge and excitement and were attracted to roles at the frontline of operational policing, feeling within their comfort zone there.

"Strength and control" is about the ability to be self-disciplined, resilient and able to tolerate pain and hardship. It includes the ability to accept orders, be pragmatic and put personal needs and reactions aside.

"Cohesion" is the norm that builds trust and group camaraderie. There is an expectation that group members will adhere to norms and support one another, even in a life-threatening situation.

"Be the best" is the norm that describes the high standards set by the group. Whether this is about bearing, taking pride in a smart appearance, or doing the job well, it reflects self-confidence and pride in the military identity.

In comparison, they saw their non-military peers, and the police organisation in general, as lacking these values to the same extent and this often caused frustration and exacerbated the cognitive separation.

6.1.2 The group attitudes to mental health issues

There is an acceptance of the risk of psychological trauma due to the nature of the role, but a strong belief that individuals must be "fit for purpose." The attribution of cause for the mental health problems is important to this judgment and must not violate group norms. Attributions such as weakness, lack of resilience, disproportionate reactions or malingering were common and carried high stigma due to such violation.

Group members were perceived to be mentally stronger but there was some acceptance that reactions could still arise from major events, including combat. There was an additional expectation that group strategies would be sufficient to address any mental health problems that did arise. These strategies include

- Focusing on the job: this can provide a "protective cloak" against trauma, distract from rumination and empower the individual through taking action and feeling in control. It fits with the group norm of mission focus but it is acceptable to take rest and recuperation when required
- Containing emotions: this is a necessary ability in an operational setting and participants were skilled at this. It sometimes necessitates temporary withdrawal from others for self-reflection and fits with the norm of strength and control
- Accessing peer support: peers are seen as credible, trustworthy and containing and this clearly fits with the norm of cohesion.

Where these strategies are used, there is no conflict with social identity. However, they all have the capacity to become maladaptive. Focusing on the job can lead to burnout and avoidance of dealing with issues. Containing emotions can become suppression and denial. Peer support may not be available or peers may be unaware of an issue, or in denial, and lack the skills to help with more serious issues.

Where it is perceived that group norms have been violated (due to either attribution of cause or lack of success of group coping strategies at dealing with reactions), then the individual becomes part of the out-group. In the military, they are "weeded out" thereby strengthening the cognitive separation and group identity and in the police service, the group deems them not fit for purpose. This expulsion is accepted and the group justifies the exclusion of former comrades by perceiving them as "other."

There was very little in the way of formal education on mental health. What was given usually related to their police interface with members of the public or was not perceived as personally relevant. There was substantial ignorance and denial amongst their peers particularly in their military service. Participants varied in their knowledge and understanding of mental health problems, some were completely unaware prior to having problems themselves and others had knowledge as part of their medical role. However, this knowledge did not have an impact on the self-stigma that arose when the reality faced them that their problems could not be contained.

Individuals had often persevered for many months or even years using these strategies, increasing their efforts to contain and control the symptoms. Denial or non-awareness of a greater problem was the greatest barrier to care. It seemed to come from the inability to relate the current identity of strong, resilient officer to the existence of a problem that was violating group norms. Beliefs such as "This can't be happening to me," "People like me don't get mentally ill," led to misattribution of cause and denial of others' concerns.

Accepting a mental health problem in oneself meant that, in terms of group norms, they had gone from one end of the continuum to the other. Pride became shame; Control and strength became the fear of loss of control and weakness; Cohesion became isolation and withdrawal from others; Mission focus became a reduced ability to do the job or the potential loss of the job. Feelings of self-contempt and worthlessness were strong and an existential crisis, a real loss of identity, could occur.

There were double standards applied here with little stigma for people in the out-group who have developed problems whereas those within the group (including self) were treated more harshly.

Following this loss of the earlier identity, as the individual recovered, they reassessed their perception of mental illness and made sense of their experience. Post traumatic growth resulted particularly in the areas of strengthened relationships, personal strength, purpose and appreciation of life. Participants who had previously experienced huge self-stigma now felt stronger for the experience and viewed it as character-building.

Returning to the social group, they used the experience to reframe the previous group norms. Their new purpose was to guard against the hidden enemy and some took on new roles as formal peer supporters and were passionate about their mission. They felt renewed strength and control having won the battle and were able to disclose their experience with a sense of acceptance and even pride. Their desire to help other group members improved their norm of cohesion, resulting in determination that others would not undergo the same ordeal alone, and pride came from their new skills and identity. There was a greater awareness of mental health problems and the risk to group members was accepted as real.

6.1.3 Group identity and norms and their impact on help-seeking
The group norms described above, and covered in more detail in the findings and discussion sections, were factors in participants' help-seeking behaviour.

Help-seeking amongst peers was an acceptable behaviour. Peer support was credible, understanding, informal and social (humour and alcohol were commonly involved in this). However, this support was not always accessed due to self-stigma or the individual's non-

acceptance of an issue. In other cases, peers could collude with the denial or be ignorant of how to manage issues.

Acceptance of a greater problem and subsequent help-seeking outside of the group was usually delayed until the symptoms had escalated to the extent that the individual had no option but to acknowledge that the group strategies were not working and they were not doing what their social group identity dictated. The final straw was often the acceptance that the norms of "mission focus" and "strength and control" were being violated.

At this point, there was a fear of this "failure" becoming known to others and subsequent shame / rejection / exclusion (public stigma). A common fear was of being judged "not fit for purpose" and removed from a prized job. There was also fear of longer term consequences through labelling leading to reduced opportunities.

The individual had to assess the risks of disclosure and judge who to seek support from outside their group. The perception of the trustworthiness, effectiveness and competence of potential helpers underlies this decision. Uncertainty about how peers would react was a barrier that caused considerable anxiety. Some participants went directly to mental health services whilst some went to the organisation for support. Sometimes contact between the two potential sources of help resulted. Potential helpers were judged against the group values and this either hindered or facilitated the process.

When considering accessing support through the police organisation, the earlier cognitive separation was a factor. The organisation itself was not always felt to share the groups' norms or value their skills and this led to trust being reduced or completely absent. In particular, they were perceived to lack the norms set out in 6.1 and felt to pay lip-service to welfare. The fact that the organisation did not support group coping strategies, and was even seen to actively remove them, added to this perception.

There was often a real fear of disclosure – this made the shame visible – others would see the change in status (no longer in-group), and there was shame at the perception of self as weak or a failure. Participants at this stage needed to contain the situation and minimise disclosure. The more people that knew, the greater the stigma.

Disclosing a mental health problem was perceived to risk
- A permanent label
- Restricted opportunities in the future (particularly in relation to "decent" jobs)
- Lack of privacy and control (others can now control you)
- Expulsion from the group and loss of peer support
- Receiving very little understanding (even from those who are meant to help)

When considering accessing help directly from mental health services, the gulf between the two groups was even greater. Stereotypes of *"pink and fluffy"* were the polar opposite of *"roughty toughty."* The cognitive separation was exacerbated by a lack of awareness of what they could offer. In life, participants placed higher value on a pragmatic, problem-solving approach compared with academic and softer skills. A person centred approach was met with unease, even derision, whereas an educational, practical approach came as a pleasant surprise.

The police interface with crisis mental health services further coloured perceptions resulting in views that limited resources were available and treatment was ineffective. There was often resistance and minimisation at the onset of therapy and a flight to recovery before symptoms were fully resolved. There were experiences of poor services due to a clash in cultures and problems being dismissed by health professionals. There were fears that medication would get in the way of the job and that providers wouldn't understand the world of participants. It was easier to trust providers when they had a military connection or when referrals came from a trusted peer. Where therapy went well, a new awareness and respect for skills was gained and old stereotypes were changed.

6.2 Recommendations for further research

As well as research to determine generalisability, as already stated, the findings highlight several further areas that could benefit from further research. I would recommend that this generally takes a phenomenological approach as there is still potentially a lot that we don't know about this field.

This research's "zooming out" view of the help-seeking process, and the limitations of a thesis, did not allow for closer inspection of the phases within it. Despite this challenge I would still choose to take this view for this initial piece of work. More focused qualitative studies could now be done on each of the six phases. The areas of disclosure and experiences of external help-seeking, for example, could have been the focus for a whole thesis in their own right. Further research could use a social identity approach to consider how group norms relate to Post Traumatic Growth (PTG) and the relationship between initial levels of distress (viewed as initial levels of self-stigma) and subsequent PTG.

The focus on cognitive separation necessitated looking at difference and negative stereotypes. Further research could focus on what worked well and what was helpful. This is equally important when considering best practice but, again, could have provided the whole thesis. There were questions I would have liked to explore further such as the fact that most participants recognised that everybody has their limits and that sometimes rest and recuperation were needed. However, there was no indication of what made for an acceptable "limit" and how long recuperation should take. Withdrawal from others as a way of dealing with the suppressed emotions was also acceptable and part of being self-sufficient and maintaining

control. The question is how long is withdrawal appropriate for? Again, I didn't get a sense of an acceptable time-frame from participants.

As the participants clearly believed they were a discrete population, research could look more closely at their attitudes and needs and compare them to police officers without a services background and / or ex-servicewomen within the police force. Given their norms of mission focus, cohesion and be the best, this group has much to offer in an operational setting and research can consider how best the organisation utilises and facilitates their skills.

There is a lack of statistics generally for veterans and specifically for veterans in the police force and quantitative research has a role to play here. We need better recording systems in the police service for veterans and for gauging the general mental health of police officers. This may prove difficult due to the fear of disclosure leading to the threat to their job / role. Anonymity should be explicitly assured in such research and given the levels of suspicion and cynicism, external, impartial researchers used. Political and organisational barriers are another potential hurdle here to access and approval.

The fact that participants had formed such a strong and discrete social identity is central to the research and individuals can struggle with this when they no longer "belong." Many veterans face significant adjustment issues. In my experience, many ex-servicemen feel they go from hero to zero in civilian life and that their values are not shared by the general population. Research could consider whether there is a way to translate military norms into civilian life in order to ease the identity transition. It would be interesting to compare those who struggle to adjust with those who successfully make the transition from a perspective of continuing to live by group norms.

Research could consider whether the wording of therapy literature and verbally offered support adheres to or violates the group norms, for example "if you need help …" would potentially be a barrier. This could help services review their "marketing."

Finally, research can focus on evaluating the impact of educational programmes from the aspects of penetration and application to self. I would suggest that, if this is done quantitatively, then an Armed Forces background is included as a variable in the results. Without this evaluation, organisations risk simply ticking a box and wasting resources as well as the opportunity to make a real difference. The impact of education on families and how they can be better helped to facilitate referrals for support is similarly important.

6.3 Implications

6.3.1 The operational context

A fundamental dilemma arising from the research is the balance between the individual's needs and political and operational objectives. Historically, the military (and it could be argued society itself) has deliberately used stigma to maintain fighting forces. The organisation (whether police or military) needs to get the job done and individuals must be "fit for purpose." The perceived model of the military (and to some extent the police) is that the individual will be removed from the group once a problem is disclosed. This is a complex issue involving the organisation's duty of care to its workers and protection against cumulative trauma.

Another difficulty is that where a mental health record becomes part of a disclosable document it may be used in aggressive litigation / defence actions that seek to discredit the individual officer or the organisation. This search for "blemishes" in an officer's background is highly discriminatory and further stigmatises mental health yet is seemingly acceptable in legal circles. There was a belief that this would extend to future employment too. One participant commented that past mental health issues should be treated the same as spent convictions under the Rehabilitation of Offenders Act. For me, this demonstrated the level of stigma and shame attached to such a blemish.

The group norms are formed with the military objectives in mind and it would be naïve to expect them to change. It has to be accepted that whilst there is this conflict between individual and operational needs, there will also be ambivalence from the organisation about dealing with the mental health consequences of the job. Collective attitudes may be resistant to changes seeing them as a threat to the social group. This can lead to organisational denial which needs tackling just as much as the denial in the group and individuals.

6.3.2 Cognitive separation

The development of the military identity, in a necessarily highly influential manner, leads to a propensity for comparison with out-group members, be they civilian, or other regiments. Being in the group brings status and pride and a high motivation for adhering to norms. Once in the police service, there is clearly cognitive separation between participants, their non-military peers and the wider organisation. This can be experienced as a culture clash that reinforces perceived differences and negative stereotypes. Social support is more likely to be accessed where there is a perception of common group membership but stereotyping and generalisation of police managers and the organisation as "other" may mean they are unlikely to accept offers of support from those sources. There is a clear risk that this group can become disenfranchised and that this will prove to be a barrier to care when it is needed.

There is much work done to support the interests of other minority groups in the police service (e.g. with social identities arising from race or sexual orientation) yet I would argue that the ex-services police officer has equally discrete needs. In some quarters, there was a lack of

understanding and respect shown to participants as members of this group – something that would not be acceptable for any other minority group.

6.3.3 Changing attitudes

Participants reported a lack of formal organisational education on personal mental health and this allows the informal messages to be strengthened potentially allowing misconceptions to take hold. Education on mental health was something "you pick up as you go along" but the question then is from whom? And what is the underlying quality of information? This can allow the education on mental health to come from the in-group and be informed by consideration of the group norms.

Generally recommended as an anti-stigma intervention, it appears that the limited education that was provided to participants was not seen as personally relevant. Education doesn't connect with the early, ingrained beliefs from military service and there was a mismatch between the emotional belief of invulnerability and the educational message. Training may be intellectually taken on board but only applied to "others." The more central a belief is to a personal identity, the more difficult it will be to change. The police role leads to reinforced cognitive separation about people who experience mental health problems as well as negative stereotypes about mental health services. Positive role models are greatly out-numbered by negative ones (e.g. myths, anecdotal evidence, media, police work) so any education needs reframing as not generic mental health but something specific to this population.

Several participants were interested in military history and this had provided education on combat reactions that they could empathise with. It is important though that this doesn't simply reinforce attribution, e.g. mental health problems must be caused by major conflict. An important factor for participants was that the cause of the reaction was deemed "earned." Stress and trauma were seen by some as modern constructs and part of the general slide in discipline.

When it comes to offering help, there are implications for organisational policy on trauma support. Organisations need to avoid a simplistic "tick box" approach towards identifying traumatic events. For this group, trauma is more likely to arise from shattered beliefs and group norms but these are obviously more difficult for managers to identify. Attribution of the cause of mental illness was very subjective. Education is also needed for the group and widening the trauma attribution (e.g. education about shattered assumptions / cumulative trauma) may help peers have a more informed opinion.

6.3.4 The impact of group norms

The acceptable coping strategies for the group are on a continuum from being adaptive to maladaptive and the organisation can better play a part in facilitating the adaptive rather than simply removing what is seen as maladaptive. The group norms set out clear acceptable strategies but what happens when these have become maladaptive and there are no effective alternatives being taught?

Mission focus

If the ethos when hitting problems is to "crack on" and get the job done, then work may be seen as a solution to problems and become part of avoidance behaviour. Using work to distract from issues potentially avoids taking time to address and resolve issues and prevents the assimilation of experience, what one participant described as the need to "download" information. Continual strain will inevitably cause issues and possible burnout. Although it was recognised that often what is needed is rest and recuperation, as everybody has a limit, this concept was not always applied to self. Even when it was, individuals didn't always have or take the opportunity for rest and recovery. In today's climate of ever-increasing targets this is likely to become more of an issue as the ex-serviceman continues to put the job first.

Being trained to remain focused externally on the task rather than on your own inner experience discourages the self-reflection that may be necessary to notice the early onset of problems. Where it is perceived that treatment will get in the way of the job, through removal or adverse effects of medication, this is also avoided.

Strength and control

Strength and control dictates that individuals should push through pain and maintain a stoical attitude to any distress. It can lead to symptoms being ignored, denied or suppressed. Personal acceptance of a problem was the biggest barrier to care in these findings. This group is skilled at putting on a front and concealing "weakness." If emotions need to be contained during the mission, then some time after it's over, they may need to be dealt with. The mental strain of compartmentalisation and suppression can lead to distressing symptoms of intrusion. Problems may be ignored and lead to a slow deterioration. A higher tolerance to pain and discomfort means that symptoms will be higher before help is sought. This can result in issues only coming to light at crisis point and even to concealment from self.

How do we time offers of support if it depends on how long it takes for defences to drop? Services are often offered immediately and yet reactions may take months or years to surface. Managers may assume all is well and life moves on for the group.

There are implications too for the mental health services. The whole military identity is built on strength, control and capability. Words such as "support" and "help" denote weakness and an inability to be self-sufficient by their very definition. Treatment seeking may be perceived as a personal failure and giving up of control.

Emotions are illogical, unseen and ambiguous. This makes them harder for the logical, practical and pragmatic person to deal with and therapy can seem to lack structure and control. Therapists with different theoretical backgrounds will bring their own norms and these may clash to varying degrees. For example, a wholly person centred therapist may be uncomfortable with offering advice and be seen as *"pink and fluffy".*

Cohesion

Peer support is very important and peers are more influential than family and non-military peers. The group's need for peer support and involvement was not generally facilitated by the police service. It is important to recognise that the strong bonds of military service may be protective in the police service and encouraging this is therefore in everyone's interests. There is less availability for peer support within the police service and some associated coping strategies have been actively removed (e.g. gallows humour, social networks) without replacing them with an equally acceptable (to that group) and effective strategy.

Withdrawal is an adaptive way to quietly reflect on a challenging event and this strategy is accepted as part of being self-sufficient and maintaining control. Several participants observed this or indeed used this strategy themselves. In the police service, this reflective time may not be as accessible due to the demands of a very busy job. If officers leave work to go straight home they may not wish to contaminate that part of their life with thoughts / talk of work so compartmentalisation may again result. Withdrawal is also a common symptom of post traumatic stress and PTSD but can lead to social isolation. It allows problems to be hidden and removes the vital peer support as they are unaware that anything is amiss.

Alternatively, peers may collude in covering up issues as they try to protect the individual from the embarrassment or discrimination by out-group members. Peer support may not be accessed as the individual uses denial in their attempts to preserve the old identity. This denial may over-ride peer concerns even when they are expressed.

The group norms influence levels of stigma leading to a greater fear of violating them. Support from peers may be non-forthcoming if the individual is perceived to have violated norms (through attribution or unsuccessful coping) and therefore no longer belongs to the group.

6.4 Recommendations for best practice

When addressing the issue of mental health and help-seeking in this population, anti-stigma interventionists (whether in the Armed Forces, police organisations, mental health services or peer groups) need to consider the individual's perception of their loss of a valued identity and their violation of group norms. I would suggest that the group norms are too strong to challenge and so interventions need to work *with* them rather than against them. By framing education and interventions in line with norm adherence, we will be more likely to engage this group. In this final section, I have set out my recommendations for best practice using a social identity approach.

6.4.1 Organisational and managerial actions

Organisations need to be proactive, move away from the "tick in the box" approach and dedicate time and thought towards officers' welfare. Although there appear to be processes in place, in reality they do not always happen or "lip-service" is paid. I would advise that the police

service demonstrates commitment by appointing a high level "champion" for mental health to implement and monitor the effectiveness of any programmes.

In the past, the bar, gyms and canteens offered a valuable space and time for decompression. Sadly, as much as it would be popular, it is unrealistic in today's climate to expect their re-instatement. However, in line with other minority groups, the organisation can facilitate peer networks therefore enabling peer support for those who have reduced levels of this in their workplace setting. This could help them provide their own means of safe, social networks for decompression and build cohesion.

The police service can make best use of this group by first recognising their difference and then considering them a valuable resource with specialist skills. The study by Daxe et al (2009) in the US is a good model for identifying the specific skills and needs of this group.

Organisational processes need to consider what constitutes an event following which support should be offered, particularly regarding the more complex, cumulative traumatic stressors. I would suggest mentally moving away from a generic list of dangerous and catastrophic events and focusing more on the individual's reaction. Managers need to be alert to mental health symptomatology and consider staff care part of their managerial duties. Education in these areas will be important to this.

There needs to be balance in the conflict between mission requirement and the human involved – a message that we get the job done then pick up the pieces. More emphasis can be placed on the importance of psychological rest and recuperation, maybe using the metaphors participants offered (e.g. the brain has to catch up, sponge has to be squeezed) and make this as natural as cleaning a weapon after operations. Where it is provided, early informal intervention should focus on adaptive coping and strengthening cohesion in order to adhere to group norms.

The timing of offers of support needs to be considered. Defences may be too high shortly after an incident and a longer term monitoring should take place. To be effective, managers need to know their staff and this requires taking time and having a genuine interest. If this is not possible, perhaps due to the demands already on managers, peer supporters need to be the eyes and ears (sentinels) on the ground.

Peer supporters, such as those trained in TRiM (Greenberg, Langston et al. 2008), need to be afforded the time to provide a watchful presence on the ground, be locally based and known to the officers they are "responsible" for. Peers who have "been there" are likely to be more vigilant, persistent and less likely to be fooled by concealment. They need to be knowledgeable about mental health and receive additional training on this. The results would suggest that peers who have fully recovered from their own mental health problems, ideally with post traumatic growth, are best placed to both recognise need *and* provide a role model for a third identity.

They should also have high operational experience / credibility. Importantly, where appropriate, they then need to be able to make credible referrals to competent services. Mental health services should forge good links to peer supporters so that they can gain their confidence.

6.4.2 Education

Organisations need to be proactive about education otherwise the group will provide the messages. Education needs to connect with the early, ingrained beliefs (norms) from military service in order to effect change. Perhaps by first reframing mental illness and help-seeking in terms of their relation to group norms, further improvements to personal relevancy will be achieved. The reframing experience of participants who had overcome mental health challenges could be harnessed.

Attributions are one target of education. Educators can explain how trauma can be cumulative or arise from shattered assumptions rather than just considering a tick-box of events that the ex-serviceman is likely to perceive as "part of the job". This could potentially reduce self- and public-stigma by framing reactions in terms the group can relate to. Given many participants' interest in military history and compassion to fellow combatants, it may be helpful to frame mental health issues more specifically so as to make it relevant to this group. However as already stated, it is important that this does not reinforce the "earned" aspect of attribution.

Recognition of symptoms is another target and a factual explanation based on physiological processes provides the "nuts and bolts." We need to educate group members as to where the line is drawn between adaptive and maladaptive responses. Interventions could focus on teaching skills that offer an alternative to pushing through the pain whilst adhering to group norms of mission focus and strength and control.

Education needs to engage the group's naturally pragmatic, problem-solving tendencies by giving them practical, life skills and psycho-education that empowers them. Interventions such as the Defenders' Edge (Bryan and Morrow 2011) and Battlemind (Adler, Bliese et al. 2009; Adler, Bliese et al. 2011) programmes are examples of strengths-based educational programmes that build resilience and offer an alternative to ignoring symptoms.

Mental health services can build credibility through demonstrating competency prior to any need for access through the provision of training in such programmes. This provides the message that they have something of value – they are the credible garage. It is also a valuable opportunity to use contact alongside education to address negative stereotypes around mental health professionals. Education needs to focus on the possibility of effective treatment, what that entails and a return to full fitness. Therapists should be transparent and take the mystery out of therapy thereby allowing control to be experienced by the individual. Therapy should be framed as an equal collaboration to solve a problem. Contact with recovered officers can be

built into educational programmes but again they should be credible in-group members who have made a complete recovery.

Education is best provided in the terms of workshops – discussion groups with formal educational input – rather than a presentation where people have the option of not mentally engaging.

Out-reach programmes to families can provide education on signs and symptoms of mental distress, contact points within services for concerns and education around organisational mental health processes.

6.4.3 Engaging with mental health services

Once a problem is disclosed, fast action is required in order to seize the window of opportunity before defences are bolstered. Organisations should be able to fast-track into mental health services. Disclosure needs to be limited and individuals should have the option of both internal services and approved external support that they can self-refer anonymously to.

Following disclosure of a problem to the organisation, in reality there may be a need to remove an affected individual from a particular role to avoid further harm e.g. through more exposure to trauma or through behaviour that may result in discipline / harm to others. In such cases, managers should already be aware that there is a problem through changes in workplace behaviour or demeanour. Removal from a role should not be a knee-jerk reaction or seen as permanent. The organisation should be explicit about why a duty of care is required and what the route is to effect a return to full functioning, e.g. to return to a firearms role an officer may need to be "signed off" by a psychologist with a clear rationale for any decision.

Any removal from frontline policing into recuperative duties must provide a meaningful role in order to adhere to mission focus. Otherwise, *"sitting in an admin office knitting fog"* is as stigmatising as the mental health problem and help-seeking. A support role that has close connections to operations would be most appropriate. However roles where they may feel de-skilled (e.g. administrative) should be avoided as this will add to their pressure and the stigma. Consultation with the individual is warranted.

Help seeking should be reframed to adhere to group norms, e.g. a practical solution to a problem, rebuilding strength and control, developing skills that support mission focus. How services are presented should be reviewed in light of group values. Services should consider the wording of their marketing and, where possible, avoid anything that could be considered *"pink and fluffy"* and words such as "help" and "support" as the ex-serviceman may not relate to needing this. Perhaps we can use the metaphors that they offered as ways of normalising issues and engaging with services. I would suggest taking advice on the wording from the group themselves.

Where mental health services are provided by the organisation, they should be specialist therapists not generic. Therapists need to have the clinical expertise and theoretical underpinning that allows them to offer appropriate psycho-education and strategies. This may be obvious but from participants' experience was not always evident. It is particularly shocking that in-house police mental health services appeared to lack this sensitivity to group needs. For some therapists this approach may go against their views around not giving advice or being directive. Different therapeutic backgrounds will bring their own "norms." Therapists should consider where their values sit in relation to those of the group before working with this population. As well as having the appropriate skills, awareness training for those wishing to work with this group should be offered.

As stated previously in this thesis, offering coping strategies may result in a flight to recovery. I believe that we, as mental health professionals, have to be pragmatic and respectful of this and prepare for this potential outcome. Modelling a safe, valued place for assistance and being explicit at the outset with our client that this "flight" may happen, we are more likely to be able to contract with them what steps can be taken should it arise, e.g. a follow-up in x months. Without credibility through building skills we are even less likely to engage the individual and they will leave with an impression that therapy was a waste of time and without any benefits at all.

This group undoubtedly has a lot to offer an organisation (by virtue of their mission focus, cohesion, strength and control and pride in a job well done) and the organisation can facilitate and support them in their role by tailoring their interventions to fit the group norms. A cohesive group can be protective against mental illness and so will pay dividends in the long term making this a sound financial investment for the organisation. The group holds much of the solution to the problem within its own membership, particularly via those who have faced and overcome their own mental health challenges. They can be better used by the organisation to both prevent and manage the problem and to provide trusted referral pathways to competent mental health services.

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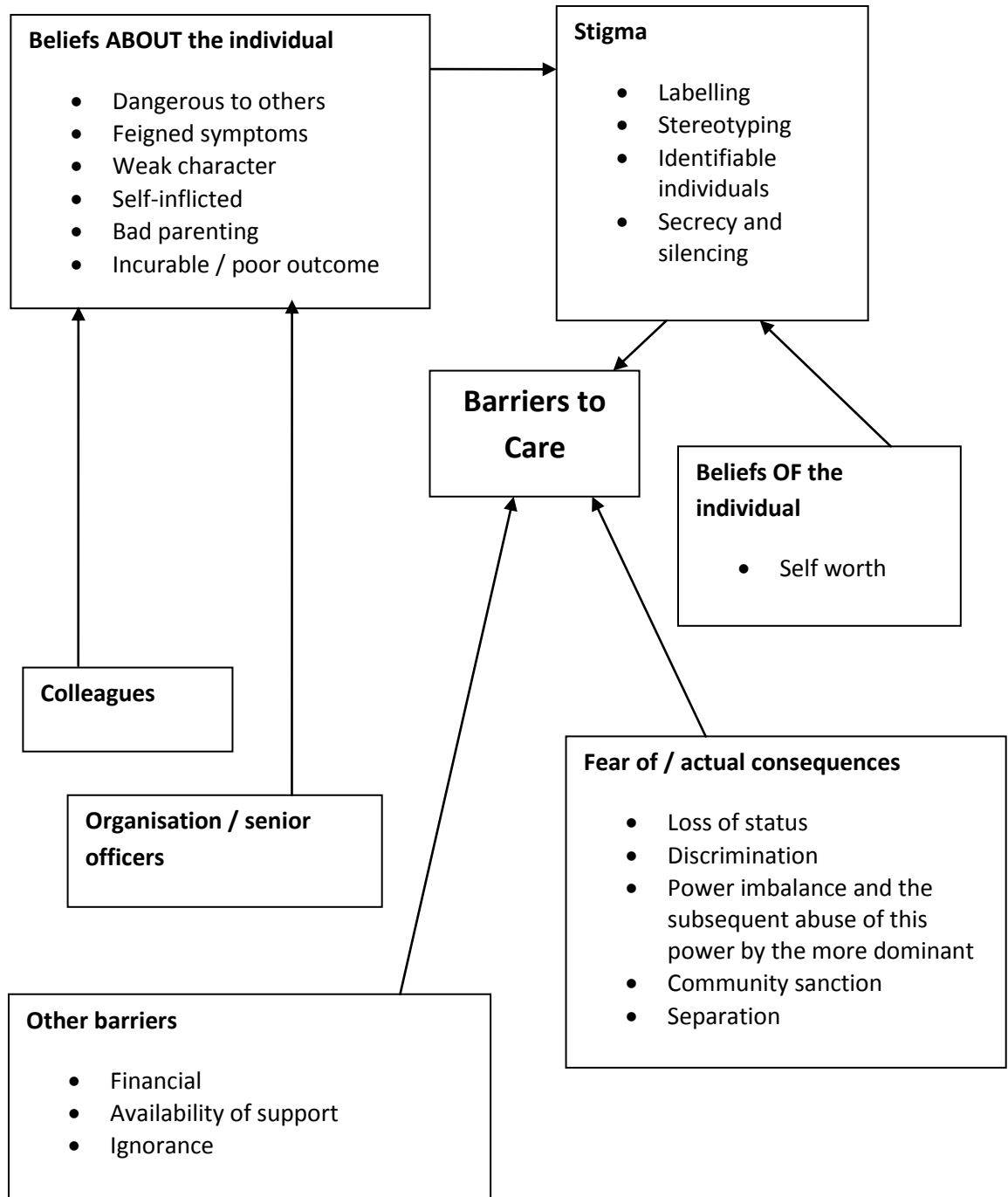
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Appendices

Appendix 1: My initial thoughts and expectations

Beliefs ABOUT the individual

- Dangerous to others
- Feigned symptoms
- Weak character
- Self-inflicted
- Bad parenting
- Incurable / poor outcome

Stigma

- Labelling
- Stereotyping
- Identifiable individuals
- Secrecy and silencing

Barriers to Care

Beliefs OF the individual

- Self worth

Colleagues

Organisation / senior officers

Fear of / actual consequences

- Loss of status
- Discrimination
- Power imbalance and the subsequent abuse of this power by the more dominant
- Community sanction
- Separation

Other barriers

- Financial
- Availability of support
- Ignorance

Appendix 2: War and madness – through history to the end of World War One

It is commonly said that history will repeat itself until its lessons are learned. This section looks at how the acknowledgement, diagnosis and treatment of combat related mental health problems have developed over the ages. It outlines the surrounding controversies and stigma and the tension between caring for the individual soldier versus retaining military objectives. In order to understand current attitudes to mental health in the military, it is helpful to set them in their historical context. Combat related psychological injury is not a modern phenomenon. Accounts of traumatic stress can be found throughout recorded history. Faced with the horrors of war, the warrior was expected to be strong and go against his innate survival instinct. Legend has it that when a Spartan mother sent her son off to war she would say to him, *"Come back with your shield or on it"* (Tick 2005 p.241). Coming back without his shield, meant that he had succumbed to fear and run from battle. The stigma of this was such that it was deemed "better" to be carried back dead or wounded on his shield.

Soldiers, from the Ancient Greeks and Romans to modern day troops, have become so overwhelmed by fear that they committed suicide, deserted or inflicted wounds on themselves so as to be invalided away from the front (Gabriel 1987; French 2003; Jones and Wessely 2005). In 450BC the Greeks believed that there was a connection between moral character and heroism leading to a simple distinction between heroes and cowards with no concept of a hero reaching his emotional limits (Gabriel 1987).

In the early years of the American Civil War (1861-1865), shocked and mentally ill soldiers were turned loose, often *"left to wander … until they died from exposure or starvation."* (Gabriel 1987 p.108). Later soldiers were housed in the local jails for their own, and others,' safety (Kennedy and McNeil 2006). The US Government Hospital for the Insane was created in 1855 due to public outcry at their treatment although the stigma that was attached to being confined therein lead to inmates referring to being at "St. Elizabeth's" (NLM 2010). In Britain, veterans of overseas campaigns were referred to the Lunatic Hospital at Fort Pitt until the creation of "D Block," in 1870, a purpose built psychiatric hospital at the Royal Victoria Hospital in Netley (Jones and Wessely 2005). So it can be seen that, regardless of culture or time, soldiers who reached their limits have been stigmatised, cast out or labelled as mad. Suffering from combat stress inevitably led to separation from the community.

The Russians were the first to accept the link between psychological illness and warfare and to attempt to prevent and treat this. In the Russo-Japanese war (1905), psychiatric casualties were so high that psychiatrists were used for the first time at the frontline and the Russian Red Cross was called in to support troops (Watson 1980). Ironically, their willingness to legitimise psychiatric casualties led to greater numbers seeking this as a way out from the front-line (Gabriel 1987). This exemplifies how stigma serves a purpose in maintaining fighting numbers.

Care of soldiers was traditionally the realm of military physicians and this, along with the fact that psychological and emotional symptoms were often conveyed psycho-somatically, lead to combat stress being assumed to be of organic origin and initially explained as a physical complaint, e.g. soldier's heart, exhaustion, concussion or neurological damage resulting in paralysis and mutism (Shephard 2000; Kennedy and McNeil 2006; Moore and Reger 2007). During the Boer War (1912-1913), despite no real supporting medical evidence, Disordered Action of the Heart was ascribed to violent, manual labour and poorly designed equipment causing chest injuries. Traumatic Neurasthenia, a disease *"characterised by enfeeblement of the nervous force"* (Jones and Wessely 2005 p.15) was thought to be caused by blood flow problems, abuse of alcohol, unhygienic environment and infections. In the Victorian era, neither soldiers nor the medical profession were ready to consider combat stress as a psychological concept.

World War One (1914 – 1918) demanded a rethink in British attitudes towards military psychiatric casualties. Along with the sheer scale of the problem, this war was unique in its nature and stressors. In the constrictive trenches, there was fear of being buried alive and of gas or chemical attacks. War-weariness from the ongoing physical demands, constant risks, loss of friends and the sense of not being understood by those at home added to the pressures. Soldiers were subjected to heavy artillery bombardments in the trenches, with the inevitable *"time delay between their firing and arrival, during which their scream intensified, forcing soldiers to brace themselves, and also to the nerve-jarring effects of the subsequent explosion."* (Watson 2008 p.27). Trench life often consisted of helplessness and lack of control along with the anticipation of impact and its associated evisceration, maiming and disfigurement. Many soldiers engaged in trench warfare suffered from "combat exhaustion," a condition of having been worn down physically and emotionally. Throughout history, more enlightened military commanders have recognised that every human being has a limit to what they can endure (Gabriel 1987). The traditional treatment for this wearing down, also referred to through history as "nostalgia or homesickness," usually involved removal from the front line, food, fluids and rest (Moore and Reger 2007). This was viewed sympathetically by commanders and peers as temporary and "earned."

However, pretty quickly, high levels of psychiatric casualties began to appear in the British Expeditionary Force in 1914 reaching epidemic proportions during the battle of the Somme (July – December 1916) (Howorth 2000). It is difficult to accurately assess the number of casualties due to varying categorisation and misdiagnosis. Annual psychiatric rates were reported to be around 10 per 1000 in 1917 and the war's psychiatric casualties are estimated at 325, 312 (Barham 2004).

Soldiers were presenting in great numbers with symptoms including amnesia, strange paralysis, mutism and deafness and the term "shell shock" was developed to explain these organically as the *"state of chronic concussion resulting from continuous artillery bombardment"* (Watson 1980

p.169). Many doctors subscribed to the view that head injury or toxic exposure was behind the condition. However this was discredited when it appeared in soldiers who had not been near exploding artillery. Concern grew over the numbers of men being lost to the frontline and efforts were needed to retain fighting strength and morale. Forward psychiatry was a French inception although one of its principles, Proximity – treating soldiers close to battle – had been developed by the Romans during the Punic Wars (264-146 BC) (Gabriel 1987). Its aim was to quickly get casualties back to the fight. By creating a network of front-line neuro-psychiatric centres, the French claimed up to 91% of cases were successfully returned to the front although their "treatment" seems to lack compassion. *"Early on, the French distinguished between the shell-shocked, who were sent home, and the emotionally shocked, who were treated near the front line, often by electric shock or threats of death"* (Watson 1980 p.169).

Applying Proximity with the other two principles of forward psychiatry, Immediacy (early intervention) and Expectancy (you will recover, conform to group identity) (Watson 2008), lead to claims of 40 – 80% of soldiers with shell shock returning to active duty (Howorth 2000). Major Thomas Salmon, a reserve US army doctor reported that *"Nothing could be more striking than the comparison between the cases treated near the front and those treated far behind the lines … As soon as treatment near the front became possible, symptoms disappeared … with the result that sixty percent with a diagnosis of psychoneurosis were returned to duty from the field hospital."* (Salmon 1919 p.994)

Although forward psychiatry was implemented it quickly became overwhelmed. Numbers continued to rise and some doctors were unconvinced by the approach and took the view treatment simply "white-washed" victims (Jones, Thomas et al. 2006). Although the statistics were superficially impressive, there were no objective measures or follow up and relapse rates were unknown. There may have been professional bias in reporting as doctors considered their career and credibility. There was also political spin as, for the sake of morale, the military only allowed publication of optimistic studies. It is unclear either whether soldiers returned to combat or support duties (Jones and Wessely 2003).

This was a highly controversial time with conflicting political and moral attitudes and little common ground between health professionals (Howorth 2000). There was a dualism in psychiatry with opinions split over whether human behaviour was rooted in the mind (psychological explanations) or the brain (medical explanations). The medicalisation of psychologically based symptoms possibly lent greater legitimacy to a Cinderella profession (Jones and Wessely 2005). However, psychological and emotional symptoms were often conveyed psychosomatically confusing the diagnosis. Physical problems, especially visible disability or injuries, held less stigma than emotional ones. Many soldiers had hysterical conversion reactions due to their emotional distress that lead to blindness, deafness, paralysis (often in the trigger hand) or mutism. *"Emotional stress builds up in the soldier and, if no*

permissible emotional outlet is allowed, the soldier will "convert" his symptoms into physiological conditions." (Gabriel 1987 p.62).

The poles of debate continued leading to two new classifications of shell shock being authorised by Arthur Sloggett, Director General of Army Medical Services, essentially based on physical (commotional shell shock, where a visible wound existed) or psychological (emotional shell shock) causation (Jones, Fear et al. 2007).

For those with a diagnosis of emotional shell shock, questions were asked about the individual's character. Were they a malingerer or coward seeking an easy way out? The need to maintain fighting numbers and reduce disabled servicemen who would be entitled to a pension, drove the military and political agenda. Shell shock was posing a great threat to the military and government objectives and needed to be controlled. Shell shock was generally viewed sympathetically by the public and carried little stigma. It was time to redress the balance. Part of the problem was in the term, with its physical connotations and by mid 1917 shell shock was being replaced by the military and psychiatrists with the term war neuroses although it continued to be used by soldiers and society generally.

"In November 1917 … Myers was denied permission to submit a paper on shell shock to the British Medical Journal because orders had been issued to the press bureau that nothing regarding the disorder should be released to newspapers" (Jones, Fear et al. 2007 p.1643)

In 1917 military authorities suggested an association between shell shock and malingering leading to further stigma (Jones, Fear et al. 2007). Neurologist Frederick Mott offered advice on judging whether a patient fell into this category. *"It is in and around the eyes that we may discern most clearly deceit and cunning. The glance is furtive and the malingerer betrays uneasiness and suspicion when closely watched."* (Mott 1919 p.262) The death penalty for cowardice or desertion was intended to make men fear running away, more than they feared the enemy (Barham 2004) and despite military denial, a fair trial with mental health assessment for those accused was not usual (Shephard 2000). 3478 British soldiers were tried abroad for self-inflicted wounds before October 1918 and 284 death sentences were passed on soldiers who were found to be deserters, "cowards" or absent without leave (Watson 2008).

Another way of shifting responsibility was to look for some fundamental weakness that pre-disposed them to mental breakdown. This mirrored society's contradictory views at the time. The nature / nurture controversy was topical and this is reflected in the debate as to whether war neuroses were caused by predisposing factors (constitutional defects) or environmental factors (the war). Prior to the war, psychiatric illness was seen as organic and hereditary and this view persisted. *"In the majority of cases of psychosis the war has only revealed, excited, or accelerated, and not caused the disease."* (Mott 1919 p.200) There was some truth that the pressure to recruit had allowed very vulnerable people to be sent to the front-line, including some who had been in the asylums already (Barham 2004). However, "evidence" of

constitutional weakness could be drawn from careful enquiry and would include any family history of mental breakdown, petty delinquencies, a low wage earning capacity, very low standard of education, being late for parade and even having a dirty gun (Mott 1919). There was no grey area between a competent, functioning soldier and the lunatic. Combat couldn't possibly cause neurosis in a "normal person" so those who had been affected were somehow weaker (Howorth 2000).

Such individuals were described as "feeble-minded, mental defectives," "thick, idiots" or "worthless material" who should never have been recruited and should be discharged from the army. There were major concerns that they should be wrongly entitled to pensions / gratuity (Mott 1919; Jones and Wessely 2005). The decision regarding treatment and entitlement to a war pension hinged on whether a disability was caused "in service" or "by service" (Jones and Wessely 2005). Fiscal pressures sent the Pensions Authorities into denial of a problem caused by service, shifting responsibility onto the individual instead and therefore dodging responsibility to pay pension (Shephard 2000). Additionally, the idea that warfare was a cause would seriously affect morale (Barham 2004). In effect a moral diagnosis took the place of a medical one.

Patients were categorised as hysterics or neurasthenics and the debate continued as to the best treatment. There was a stigma attached to the diagnosis of hysteria whilst neurasthenia, with its reference to nervous exhaustion (an earned illness), was more flattering and deemed respectable.

The established school of thought was that hysterics were weak willed and best cured by *"a little plain speaking accompanied by a strong faradic current."* (Adrian and Yealland 1917 p.869). Strong electric shock had been used to treat surdomutism in the Russo-Japanese war. The suggestion that the patient *will* get better, reinforced by strong electric shocks to the affected part was recommended. It was strongly suggested that the doctor increased the pain until he got the desired effects and allowed the patient no control or say in the matter (Adrian and Yealland 1917; Mott 1919). The traditional school of thought also favoured isolation, deprivation and "hardening" through discipline and supervision (Jones, Fear et al. 2007). Treatment for neurasthenics was often more nurturing as, unlike the hysterics, they were deemed to be more deserving of sympathy. Continuous warm baths, sedatives and tonics were used to soothe nerves, hypnotic drugs promoted sleep and diverting activities were encouraged. These were usually traditional women's activities, knitting, bead and basket work, and I wonder what impact this had on a soldier. These treatments aimed to cover up reactions. Such repression was a Victorian ideal, the "stiff upper lip" (Shephard 2000).

However, during the Great War, Freudian theories began to gain ground. A small group of professionals opposed the ideal of repression and stated that it was important for individuals to regain their repressed memory and that they shouldn't be considered as malingering just

because there was no organic cause (Myers 1916b). Dr William Rivers described how many patients had been encouraged to use repression and detailed the effects of this. The realisation of *"the impossibility of forgetting their war experiences … the hopeless and enervating character of the treatment of repression, they are often induced to attempt the task in obedience to medical orders."* (Rivers 1918 p.173)

Captain Charles Myers, consultant psychologist with the British Expeditionary Force, sparked debate with various papers on shell shock (Myers 1916a; Myers 1916b) detailing the use of hypnosis to successfully treat stupor, amnesia and mutism. His treatment methods gained ground in 1916 and offered an opportunity to return soldiers to combat. However, they were criticised as being too time intensive and unrealistic (Adrian and Yealland 1917). The proponents of Victorian repression rejected talk of Freud and his associated sexual theories. There was animosity towards psychotherapy as it was seen to indulge and reward the individual (Barham 2004).

Professional rivalries led to exaggerated claims of success and criticisms of others' practice. Tensions arose when volunteer Royal Army Medical Corps doctors from different backgrounds questioned established procedures. Depending on their outlook, professionals could be isolated and have little respect from those peers who worked alongside them. (Shephard 2000) Whilst the medical and military remained firmly entrenched, embroiled in political and professional arguments, the men in the real trenches struggled on.

The British class system was evident in the two tiered system that operated for the treatment of soldiers. Psychiatrists usually learned their trade working within asylums and teaching hospitals with individuals who had serious mental health problems. This work was unpaid and held little status. The Poor Law remained the only source of state aid for those who couldn't afford private medicine and was intentionally stigmatising. For the majority of people, the only access to mental health care was through the *"stigmatised and degrading pauper lunatic system."* (Barham 2004 p.35) Individuals sent to the asylums were stripped of personal identity and social status, losing their place in society. Having learned their profession in this environment, the psychiatrist would then move into well paid, private practice with wealthy patients who had minor problems but, as fee paying customers, expected to be treated with respect. This lead to a tradition of treating different classes differently (Shephard 2000) and was evident in choice of treatment, e.g. clinical recommendations to avoid the use of a particularly distressing drug with those of higher social grades whilst deeming it appropriate for patients belonging to lower classes (Barham 2004).

In 1915, the first war mental health hospital was built, "The Special Hospital for Officers," where officers were allowed to keep their uniforms and often had treatment available. They were found to display different symptoms, for example mutism was *"extremely rare among commissioned officers"* (Myers 1916b p.461). Officers had higher rates of breakdown and this was accorded to

their level of responsibility. In 1914, 7-10% of officers and 3-4% of other ranks had a nervous or mental breakdown (Shephard 2000) but officers were more likely to get a diagnosis of neurasthenia, a provisional diagnosis that offered a chance of recovery, whilst rank and file were considered hopeless cases, labelled as "certifiable lunatics" or hysterics.

For the hysteric, everything was geared to putting them in their place and reminding of their shame and disgrace to service.

"There is rarely any expression of compassion, no effort to explore or comprehend … the hardships he had suffered or the fortitude he had shown … his admission to the psychiatric facility was by definition sufficient testimony of how lamentably he had failed as a soldier" (Barham 2004 p.50)

However, it became obvious that it was unrealistic to keep people in mental hospitals for indeterminate times with limited beds and resources. The War Office wanted their removal to asylums and, by 1916, around 3000 soldiers had been discharged as lunatics. Many others were sent to be cared for at home where families found it hard to cope and often requested the soldier was certificated and sent to the asylum. The uneducated "thick" soldier was seen as worthless and put in asylums by mistake or by design, stripped of their uniform on arrival and *"the trappings of his military persona handed over to the escort for return to his unit"* (Barham 2004 p.21)

Against this backdrop, a public outcry grew at the treatment of husbands, sons and brothers. Previously the army was seen as the dustbin of society but WWI saw a change in the profile as volunteers and conscripts comprised a wide demographic range to create a Citizens' Army. In the UK, before the war, there had been great moves towards social reform and a desire to move away from the class divisions of British society. The Citizens' Army saw a breakdown in barriers as soldiers mixed outside their class and formed strong bonds. Public pressure mounted to keep mentally disturbed servicemen out of the asylums. *"Public opinion was demanding mental health facilities for soldiers commensurate with their status as citizens … and the military were obliged to provide them."* (Barham 2004 p.46). The public wanted "The Service Patient," (a scheme intended to appease the growing pressure), to have better treatment and be kept separate from "lunatics." In reality it was questionable as to whether this happened. Certainly by the end of the war, the public profile of the Service Patient had rapidly diminished.

The Great War lead to changes in the social attitudes towards mental health in the Armed Forces and saw radical changes to diagnosis and treatment. However, these changes were soon forgotten. In the early 1920s, professionals continued to argue over causation, diagnosis and treatment and the result of these conflicting opinions was the reinstatement of the 2 tier system where officers had neurasthenia and the rank and file were constitutionally inferior and was silenced. Public opinion returned to its hierarchy and the war's class alliances dissolved. By 1923, the Treasury had determined that service lunatics comprised over 50% of the cases who would have to be permanently supported by the state. They were hidden from society with no

presence at remembrance parades, visits from welfare organisations were blocked and their war pension was used to pay for "treatment" even when the NHS ultimately took over the cost (Barham 2004). The Ex-Services Welfare Society founded in 1919 (now Combat Stress) championed them offering hope and rehabilitation programmes and promoting alternatives to the Mental War Hospitals were soldiers could be detained or from which they could be sent to the asylum.

Following the war, the Southborough committee was set up to investigate the matter of war neurosis. Debate lead to the removal in 1930 of the death penalty for cowardice and desertion. However, the military was keen to put shell-shock behind it and reinstate a more traditional view of combat. The War Office used the Southborough enquiry to represent shell shock to the public and produced an *"extraordinarily ambiguous cultural document which both exemplifies the power of shell shock as a cultural metaphor, and tries to play down its significance and resonance."* (Howorth 2000 p.234).

Many of the Great War dynamics continued to play out in later conflict and, I would argue, can even be seen to some extent today.

Appendix 3: Reflections on pilot study

Before embarking on the main study, I wanted to ensure that my chosen methodology was appropriate and my method practicable. A pilot study was conducted and this section sets out what I learned about the topic and the research design as well as my personal reflections on the process and ethical implications. The pilot study consisted of two semi-structured interviews with police officers who had both served in the military. Participant 01, ex-Royal Navy, had never accessed mental health services despite having had what he described as "stress." Participant 02, co-incidentally also ex-Naval, had been diagnosed with combat-related PTSD and had accessed mental health services during his police service.

My original research question asked: **How does the identity of a police officer with a military background affect that individual's help-seeking behaviour?**

A pre-supposition that needed to be explored was whether this was indeed a population with a specific identity. In the pilot study, the ex-military police officer was immediately confirmed as a discrete population by both interviewees although they had to reflect on why this was. Compared with their fellow police officers, ex-military, whatever their age, were seen as mentally tougher, better able to cope with the demands of police work and having more pride in what they do. In addition to their group identity, both interviewees had a well defined sense of personal identity as someone strong and capable and this potentially is at odds with someone who needs to seek external assistance.

However, if I was going to explore issues of identity, the pilot immediately threw up questions. For instance, did the fact that both participants had served in the Royal Navy, affect their sense of group identity? Does the Royal Navy have a different outlook to the Army or Air Force? I had not consciously decided to focus on males but in reality they would form the majority of any sample of police officers with a military background due to the make-up of both services. Did the fact that both participants had served as custody officers have an effect? They potentially had greater interface with mentally ill prisoners. My group identity was potentially becoming narrower. In determining whether to concentrate on a psychosocial theory of identity (Erikson 1968), social identity theory (Turner and Brown 1978) or social constructionist theory, the research question started to seem unwieldy and too large a scope for this study. In discussion with my supervisor, the research question was refined to

How do the attitudes of police officers with a military background affect the help-seeking process for mental health problems?

The pilot study also aimed to test my choice of methodology and method. As stated in the chapter on methodology, I had chosen a qualitative approach and semi-structured interviews as I wanted an insider viewpoint into a sensitive and complex subject. The semi-structured

interviews worked well. Participants were very forthcoming and interested in the subject. They were able to articulate their opinions.

Delving further into the topic made me sensitive to the underlying emotions and strengths of beliefs around this subject. The "mental toughness" of this population didn't sit comfortably with having mental health problems and this was interpreted as a weakness.

The process of seeking care was fraught with emotions such as denial, fear and anger. Accessing support proved a reality check and impacted greatly on self-esteem. Reaction to being in this position was extreme and demonstrated the level of emotion associated with being labeled.

A qualitative approach was confirmed to me as the most appropriate when dealing with such sensitive and challenging topics. The hour long interview gave sufficient time to delve into the topic and allowed thoughts to be expressed without rushing and leaving stories half told.

I had been interested in whether the professional interaction between police officers and mental health professionals affected their opinions on people with mental health issues and the services that were called in to care for them. Both interviewees had experience of mental health services as part of their job. This didn't give them confidence in the effectiveness of treatment and certainly seemed worth exploring further in the main study.

Both interviews lasted for one hour and this time was needed to explore the issues in order to get in-depth inner knowledge and to reflect on the sensitive subject matter. However, for me, there was a stark contrast between the broad brush-strokes of research data and the rich depth of therapy. As a therapist I am used to working longer term with people and delving even deeper into subjects. Although the research data was rich, in comparison with a therapeutic session, I felt a little as though I was missing this depth and initially wondered whether I was asking the right questions. This was part of my process of coming to terms with the difference between being a researcher and a practitioner and recognising the research interview as a momentary encounter.

I also reflected on how my professional identity may affect the interview process. This appeared to be two-fold. Firstly, there may have been some reticence on the part of participant 01 in being totally frank. I felt at times that he was choosing his words carefully and keen not to appear to be judgmental. Emphasising that I was interested in his real opinions, whatever they may be, seemed to help here and this was a lesson learned for the main study. From my own experience, there is a real fear in the police service of being *"politically incorrect"* and getting disciplined. This is ingrained and could lead to participants censoring their real views if they feel they are socially unacceptable. Sochan and Singh (2007) refer to the "Told Story" as that which participants feel comfortable and safe in sharing. The "Untold Story" is the interviewer's reading between the lines and my interpretation was that participant 01 held stronger views about those with mental health problems than he expressed.

The second way in which my professional identity could affect the interview was when hearing of participants' views and experiences of my profession. At times I felt ashamed and even angry and had to resist urges to comment or defend myself as different. As a therapist, I often hear from clients who have had earlier, bad experiences, but in that role, I am in a position to redress things. As a researcher I couldn't intervene or change that opinion in any way.

Neither participant saw therapy as effective. Neither participant believed that it was possible for someone to have PTSD and make a full recovery from it. As a trauma therapist, I am aware that PTSD is treatable and it is important to inspire hope at the outset of treatment. Many individuals even experience Post Traumatic Growth and feel stronger for the experience (Linley and Joseph 2004; Tedeschi and Calhoun 2004; Linley and Joseph 2009). This posed a moral dilemma for me. If participants held potentially damaging beliefs around the treatment of PTSD, did I have a responsibility to address that or not? After all, I was acting as a researcher not a therapist. In an attempt to deal with this, I decided to include a copy of the National Institute for Clinical Excellence's guidelines for the treatment of PTSD in the information pack I offered to participants where appropriate. This is a leaflet that is freely available from the internet and clearly sets out best practice. By providing clear, impartial education that participants could choose whether to read or not, I felt I had done all I could ethically.

The pilot study confirmed for me that the choice of method was both appropriate and practical. It was crucial in refining the research question and giving me confidence that the research design was appropriate. No ethical issues surfaced but I gained useful insight into how my own professional identity could not be "left outside the door" and that I needed to be very aware of how it played out in the session. The interview data from the pilot study was included in the main study.

Appendix 4: Information sheet

INFORMATION SHEET

This letter is to invite you to participate in a piece of research that asks:

What are the attitudes of ex-military personnel, who have joined the police service, towards seeking help with mental health problems?

As part of this research, you would be asked for your views on mental health problems in the police and military cultures, in particular Post Traumatic Stress Disorder. During the interview, the researcher will ask specific questions and give you the opportunity to add anything that you consider relevant to the subject. The interviewer will not be asking you about the type or details of any traumatic events you may have encountered.

If you have never accessed trauma support, questions will focus on your opinions and beliefs around these services and the people who use them. If you have accessed trauma support, services, I will ask about your experience of that process.

If you choose to participate in this research, you will have a telephone / face to face interview at a mutually convenient time / location with the researcher. The interview will be recorded for later transcription and analysis.

Following analysis, the researcher will contact you again. This is for 3 purposes:

- To gather any further thoughts you may have had on reflection
- To offer you their preliminary analysis of the interview so that you can comment on their understanding and accuracy of representation of your views.
- To answer any questions or address any concerns you may have following the interview

The following information is intended to help you decide whether you wish to take part in this research.

1) Anonymity

Quotes from the interview will be used when presenting the results of the research. These will be anonymised. Any material that would identify you as a participant will not be included in the quotes or final research article. You will be allocated a participant number and your name or identifying information will not appear on any written material such as tape transcripts. All written material, e.g. tape transcripts, and the recording itself will be destroyed 2 years after the study ends. If you would like a copy, this will be made available to you. Co-researchers or other

people involved in the preparation of this research paper will not have access to your personal information.

2) Right to Withdraw

You can withdraw from participation at any stage up to submission of your results to the University of Manchester. You do not have to give the researcher any reasons for this.

3) Results of the Research

The research will be submitted to the University of Manchester as part of the researcher's PhD studies and may be submitted for publication in a professional journal. If you would like to see a copy of the final thesis or related publication this will be provided by the researcher.

4) Protection of Participants

There is a risk that recalling experiences of problems with mental health will raise issues for participants. Participants are reminded that, should they feel this may raise any undue emotional reaction, they should withdraw from the research.

5) After Participation

Participants will be offered an individual session with a trauma psychotherapist to address any issues that may have arisen after the interview. A list of agencies that can provide additional support is also available.

If you are not interested in participating, you do not need to do anything. You will not be contacted for your decision otherwise.

If you are interested in participating, I will be happy to answer any questions you may have now and following your participation. Please sign below to confirm that you understand and accept the above conditions.

Thank you for your help.

Liz Royle
Researcher

Contact details:

Email   liz.royle@krtraumasupport.co.uk
Telephone   07795 183904

Appendix 5: Informed consent

CONSENT FORM

Research Title: What are the attitudes of ex-military personnel, who have joined the police service, towards seeking help with mental health problems?

If you are happy to participate please complete and sign the consent form below

	Please initial box
I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service	
I understand that the interviews will be audio-recorded	
I agree to the use of anonymous quotes	
I agree that any data collected may be passed to other researchers	

I agree to take part in the above project

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

Appendix 6: Schedule of questions

How long did you serve within the armed forces?
What were your reasons for leaving?

How do you think mental health problems are viewed within the military?
Did you hear peers / commanding officers make reference to mental health problems?
Was this positive / negative / indifferent?

Did you witness / personally experience the military's attitude towards people with mental health problems?
Can you describe this?

What attracted you to the police service?
In your opinion, what are the similarities / differences between the military and police cultures?

Are police officers who have previously served in the military, a different breed to their peers? If so, how?

How do you think mental health problems are viewed within the police service?
Did you hear peers / supervising officers / civilian staff make reference to mental health problems?
Was this positive / negative / indifferent?

Did you witness / personally experience the police force's attitude towards people with mental health problems?
Can you describe this?

What has been your experience of personal contact with people who have suffered from mental health problems?
- Within your family and friends
- Within the military
- Whilst serving in the police

Have you ever experienced difficulties with mental health?
How did you recognise this?
Did you access help for this?
What would help / deter you?
Or
If you were experiencing difficulties with mental health would you access help for this?
What would help / deter you?

Appendix 7: Feedback from participants

Interview 1

Thanks Liz,

That seems reasonably accurate. I really must stop 'erming' however! I can only apologise for my incoherent ramblings. Hope they have been of some limited value.

Best regards

Interview 2
N/A

Interview 3

Thank you Liz - that's fine.

If you need any more help please let me know.

Thanks

Interview 4

Liz, firstly can apologise for the really late reply. I have been away doing various bits and pieces but I have also been contemplating the text and wording replies/observations to your points raised from the interview.
In reply to your first question what does strength of character/mental fitness look like and sound like I will try to answer it the following way.
Strength of character/mental fitness would manifest itself by the individual themselves. For example; when the guys are cold and wet on exercise they would show self discipline/ character to keep motivated, try and improve their situation and not feel dejected or sorry for themselves. They may make themselves a hot drink, change into dry clothing and make light of a poor situation. This I feel is done by having a fit mental state and not wanting to shy away from what to most would be uncomfortable or away from their usual habitat. I realise that this may seem clichéd but try as I may I cannot seem to illustrate this point in any other way.
Your final question about qualities is very hard to quantify but really it would be how you initially approach the person needing TRIM and be flexible to their needs but also knowing your own capabilities and limitations.

I hope this assists you and I have to say that the interview was very good. The précis I think was a very accurate reflection of my thoughts and feelings and this was conveyed in the text and how it was presented.

If I can be of any further help I would be more than happy to assist. I wish you well with your study and research and look forward to hearing from you again.

Interview 5

Hi Liz,

So sorry – just got back after a few weeks leave and picked this up. I will sit down and read thoroughly over the next few days and get back to you. I enjoyed taking part and I hope it helps with your research.

With best wishes

(Additional comments)

Hope you're well. Right, I've had a good read through and it's all ok with me.
Seeing some of my responses in writing makes me realise I'm probably a bit of a callous, arrogant and uncaring individual. I shall try and make an effort to be a little more 'fluffy' in the future!! Your last comment on initial reflections is the only one where I would have a very slight disagreement. I don't really see it as a contradiction. For me, it's just a simple case of being better able and equipped (through training) to deal with personal trauma and MH problems. 'I can so I ought' Therefore, I shouldn't let myself get into a position where I would let myself and other people down. I enjoyed taking part and would be interested in seeing your final PhD paper when it is published.
With all best wishes

Interview 6

Hi Liz,

Thank you very much for the feedback, it made very interesting reading and you clearly have a very good ear. I have read through your initial reflection several times and it hits the nail on the head.

It is enlightening looking at someone's interpretation of your thoughts.

Thank you again

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Interview 7

N/A

Interview 8

N/A

Interview 9

Hi Liz,

Thanks for the feedback – the (correct) transcript is very accurate, wasn't aware how much I say 'sort of'!

Nice to see your own reflection, I think it is fair and accurate also. I will look for those negative people you are seeking to interview, but I would like to think they are getting fewer and farther between!

With regards to the follow up session from the original incident – no I was never offered one, but I think I would have taken it if offered as I had already recognised I needed help.

If you are happy I may well be in touch as my own research continues!

Interview 10

Hi Liz

Yes all good, thanks for that if I can be of any further help let me know.

Cheers

Interview 11

Have gone through the transcripts and reflections and all seems fine.

You have raised a couple of points I would like to answer.

Owning up to a problem- the success or failure of a unit depends on its overall strength. If someone is "different" they become a weak link in the chain which could ultimately jeopardise the strength and safety of a unit. It is not a fear of an unknown future, more a fear of being rejected by their unit.

Self reliance means not asking for help - Further, not asking for help outside your unit, company, battalion, regiment, force or armed forces. It is like a ripple pool effect, the further outside the ripple spreads, the more embarrassing for the individual. Interestingly if you are from a different service on the same unit (I was air force in an army unit), this does not happen as you have the commonality.

Take action now would fit.... Bang on. When they have admitted a problem, it is a case of right let's get it sorted. Bear in mind the swiftness of a military medical response to a referral where you are talking in a matter of hours or days as opposed to weeks or months. I sometimes wonder if they relate me to a military medic with the contacts to speed things up.

Ability to handle threat ... My body is telling me something I need to heed. I have the ability to stand outside myself and look in with a clinical mind to see objectively what is going on. Backed with some medical knowledge it makes it easier to understand, explain and rationalise. Physician heal thine self.

Ex military easily identifiable ... I don't know exactly why you can spot ex military but invariably all are able to do so. Whether it is something as simple as their bearing or how they talk or what I don't know. It is something that you can just do. Possibly threat identification which enables soldiers to differentiate between civilians and hostiles, you hone in on the militaristic individuals as the greater threat. Possibly it's the mark left on you having completed military service. I think it was Socrates or Plato who stated something similar to "soldiers are on a higher plane of understanding on human nature." A similar concept going back to ancient times.

Leap of faith.... I'm one of them. An inherent and unspoken expectation is another soldier will risk their life for you even if you have never met them or like them. This basic trust and expectation is a binding bond that lasts forever. The commonality and oath to the Crown binds you all.

Analogy..... Again, no problems. They know me now as a sergeant as I was in the air force as well. It's a known fact the sergeants were devil incarnate and the corporals, satans little imps, who would administer tough love as you phrase it. But. They would also make sure you were looked after and not abused by anyone out with their own. Especially civilians.

Is that where TRiM comes in now.... Yes! In days of yore, police bars were where decompression occurred as you could openly discuss things in a safe environment. Not all that was said was politically correct or even pleasant (hangmans humour), but officers got it out their system. Again I think there were more ex military in the service then and certainly discipline was more regulated as you knew where you stood with the bosses. Most had done their time on the "front line" of policing and knew how it was for the rank and file. They would also frequently come out on patrol and on occasion effect an arrest. Now in police stations there is an air of

mistrust where the slightest inappropriate comment or joke can land you in it. There seems to be little differentiation between those who may hold inappropriate beliefs and those who are simply venting. In days of yore, it was the sarge who would deal with any inappropriate comments and issues and also the welfare side post incident. Sergeants are seen almost like a parent figure and are frequently referred to as adults or grown ups by the PC's.

The move to TRiM has been a positive move for officers health. There has always been and always will be a need for professional post trauma support. Senior management have a general lack of understanding as generally they have little comprehension of front line policing. Many have been fast tracked and have spent a bare minimum of time on front line policing. Interestingly many of them still use it as a threat if someone is under performing or on a discipline "If you are not careful you'll end up back on uniform." This and similar derogatory references to front line uniform policing are common. In essence we should have our best officers on the front line as they are the ones who interact with the public and have to make the split second decisions based on very little information.

Good luck with your research and if I can be of further assistance, please do not hesitate to contact me.