

THE UNIVERSITY OF HULL

Managing different roles: The experiences of female nursing reservists  
who have deployed with the UK armed forces.

being a Thesis submitted in partial fulfilment  
of the requirements for the degree of Doctor of Clinical Psychology

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by

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## Overview

This thesis is divided into three parts.

The first section is a systematic literature review focusing on the British literature regarding attitudes towards mental health in the military, and what stops British military personnel from accessing care. Eleven papers were identified and reviewed. Each paper is examined and discussed in relation to each other, along with findings from abroad. The current literature base is thought about and comments regarding suggestions for future research are made.

The second part is the empirical paper which, explores the experiences of women in health professional roles in both civilians and military environments and have completed one operational tour. This uses the qualitative methodology of Interpretative Phenomenological Analysis (IPA) in order to understand lived experience. Nine civilian women who are also members of the Army Reserve took part in the research. Three super-ordinate themes with nine sub themes were identified from the analysis.

The third part comprises the associated appendices that are referred to throughout the text along with a reflective statement.

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PART ONE  
SYSTEMATIC LITERATURE  
REVIEW

This paper is written in the format ready for submission to The British Journal of Clinical Psychology. Please see appendix A for the author guidelines.

**An investigation into stigma surrounding mental health problems in the British military, and barriers to care for personnel: A systematic literature review**

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## **Abstract**

### Objectives

It is generally thought that given the circumstances in which military personnel work, including being deployed on operational tours, they are ‘at risk’ of developing mental health problems. This is of concern to both the military and wider society. It is also thought that there are a number of barriers that stop personnel from accessing mental health services including stigma surrounding having a mental health problem. At present there are no systematic literature reviews (SLR) focusing on attitudes towards mental health and barriers to care solely based on the British literature. The present review synthesises and critiques the British literature on this topic, answering the question: what do British military personnel think about mental health problems and accessing mental health services?

### Methods

Databases (Ebscohost: MEDLINE, PsycINFO, PsycARTICLES, CINAHL Plus), Web of Science, King’s College London website, and reference sections of articles were searched. Search terms included: (British OR UK OR U.K. or “united kingdom” or “great Britain” or england) N3 (Army\* OR forces OR Military OR soldier\* OR “active duty”) AND “Mental health” OR emotion\* OR wellbeing OR psych\* AND attitude\* OR view\* OR perception\* OR opinion\* OR prejudice\* OR stigma\* Or judgement OR “help-seeking” OR “health promotion” OR barrier\*. Or slightly adapted versions to suit the database specific preferred layout. The papers were screened with specific inclusion and exclusion criteria. The final papers were subject to a quality assessment.

### Results

A total of eleven papers were reviewed. Six papers were the result of one large scale investigation using over twenty three thousand participants. One paper used

Interpretive Phenomenological Analysis (IPA), while the rest were either quantitative or used a mixed methods approach. The main outcome measures used were: PC-PTSD, PCL-C, PHQ-12 and the GHQ-12.

### Conclusions

It was found that attitudes in the military were not significantly different to those within the general population. The main worries regarding mental health problems surrounded commanders treating individuals differently, and General Practitioners (GPs) said they thought service personnel were concerned about mental health problems interfering with career progression. It was found that rates of internal stigma were common, however, were higher in those with more distressing problems.

Further research is needed to understand why some people access mental health care and others do not within this population, along with reservists and veterans. More research needs to be undertaken purely focusing on the British experience.

Qualitative research should be undertaken to add a deeper level of understanding to the data.

### Practitioner Points:

- It is generally accepted that stigma surrounds mental health problems in the military and in the general population.
- It is a widely held view by military personnel that having a mental health problem would affect their service career, therefore people in the military prefer to seek informal means of support.
- More distressed naval personnel reported higher stigmatising beliefs, meaning this population could be extremely hard to engage.

- Depending on what stage of deployment a person is at, their beliefs and views surrounding mental health may change.
- Alcohol use is highly prevalent in the British Armed Forces, and it is suggested that those consuming harmful levels of alcohol, struggle to recognise that they have a problem.

## **Introduction**

Men and women in the military face hazardous environments when deployed on an operational tour, and are at risk of developing mental health issues (Gould, Greenberg & Hetherington, 2007; Gould, Adler, Zamorski, et al., 2010). Gould et al. (2007) suggest that there are more people with mental health issues in the military who do not seek help, in comparison to those who do. They go on to say that, although the military endeavours to ensure personnel remain healthy, many service personnel do not wish to access support for these types of problems. The stigma of having a mental health problem has been generally identified within the literature as a major reason for this. The military wish to address this problem according to Gould et al. (2010). Since the more recent military missions in Iraq and Afghanistan, which have attracted vast media attention, the psychological wellbeing of personnel has become of great concern to the wider public (Jones, Mitchell, Clark, Fertout, Fear & Wessley, 2014).

It has been reported that engagement of military personnel in mental health services can be a challenge, due to individuals not engaging in help-seeking behaviour (Murphy & Busuttil, 2014). In a study examining the mental health needs of British veterans, it was found that 58.4% of people who had a mental health problem in their sample, were seeking support (Iverson et al., 2005). Iverson et al. (2005) state that the vast majority of their participants who were accessing help, were doing so via

their GP, with a much smaller percentage actually accessing psychiatric or psychological specialist support. They report that the main reason that people in their sample did not access services, was the belief “I could deal with it myself”. Those who reported difficulties while in active service also described not wanting to seek help.

Goffman (2009) defines ‘stigma’ by stating, it means an “attribute that is deeply discrediting” (Goffman, 2009, p3). It is widely known that stigma surrounds mental health problems. Gould et al. (2007) suggest that stigma can occur at any point of the psychological problem (development or treatment). Schulze, Richter-Werling, Matschinger & Angermeyer (2003) suggest that stigma can be worse, and more damaging than the initial problem. Furthermore, delaying the treatment of psychological difficulties can potentially have damaging consequences (Clement et al., 2015).

To the best of the author’s knowledge there is not one systematic literature review (SLR) focusing on stigma and barriers to care purely for members of the British Armed Forces. There are systematic literature reviews summarising British and American, or purely American studies. Regarding purely UK research, there are a number of narrative reviews, and a small number of critical reviews. A narrative literature review which has partly the same focus as the present review, has been conducted by Walker (2010), however, that review includes both UK and USA data, and there have been papers published since its publication. From the UK literature that is reviewed Walker suggests that stigma is identified as the main reason why people in the forces do not access services for mental health problems. This, it is suggested, is influenced by the stereo-typical ‘macho’ culture of the military, along

with a suggestion that having a mental health problem would be detrimental to a service career.

The present review focuses specifically on the British experience. The results will be useful to compare with other countries. A systematic review on stigma and help-seeking behaviour in the general population has been completed (Clement et al. 2015), and within this, there is some consideration for minority populations including the military, though this paper uses a search strategy that included papers published up to 2011. The present SLR will help summarise the literature, critique it and provide an opportunity to identify findings to date. This in depth scrutiny of the quality of the literature, is not present in narrative reviews, meaning the current paper should provide an up to date critique of the research to present, and identify areas for future research.

There have been a number of papers examining the evaluation of interventions aimed at changing attitudes towards mental health problems within military populations, though stigma and the barriers that people face when accessing care, are still not fully understood (Gould et al., 2010; Clement et al. 2015). The aim of the present review was to answer the question: what do British military personnel think about mental health problems and accessing mental health services? This should provide mental health practitioners, working with serving personnel, in both military and civilian settings, with an informative overview of issues around stigma and barriers to care that this population face.

## **Method**

### Search Strategy and screening process

Initially King's College London's (KCL) website, King's Centre for Military Health Research (KCMHR) and Academic Department of Military Mental Health (ADMMH) publications found at: <http://www.kcl.ac.uk/kcmhr/pubdb/> was reviewed for titles of papers. This is due to KCL conducting the vast majority of British Military Research. Searches were then conducted on EBSCOhost including the journals: MEDLINE, PsycINFO, PsycARTICLES and CINAHL Plus, on Web of Science and by reviewing the reference sections of articles.

Search terms were generated in order to specifically answer the review question. Article titles, abstracts and key words were reviewed in order to inform the terms. Searches included the following terms on EBSCOhost: (British OR UK OR U.K. or "united kingdom" or "great Britain" or england) N3(and/or) (Army\* OR forces OR Military OR soldier\* OR "active duty") AND "Mental health" OR emotion\* OR wellbeing OR psych\* AND attitude\* OR view\* OR perception\* OR opinion\* OR prejudice\* OR stigma\* Or judgement OR "help-seeking" OR "health promotion" OR barrier\*. The search in Science Direct had a slightly different layout (see appendix B for search terms and limiters).

Limiters on EBSCOhost were: peer reviewed journals, English language, UK specific, special interest: military or uniform studies and no dissertations. Peer reviewed journals only were included as this provides a first step in quality assurance. Date of publication was not used as a limiter. See Appendix C for a screen shot of the limiters used on EBSCOhost.

Inclusion criteria were: UK military papers including papers on active service personnel. Reservists and veterans were included if the sample also included British

personnel currently serving in the Armed Forces. Given this review is focused on the British experience, research focusing on other countries e.g. America was excluded.

#### Article selection

Titles of articles were reviewed, if it was unclear from the title whether the paper should be included then the abstract was read. If it still remained unclear, then the full article was read and a decision as to whether to include the paper or not, based on the inclusion and exclusion criteria was made. Duplicate papers were discarded as they had already been included or excluded from the review. From the King's website, 7 papers were identified from their titles and 5 were included. Ebscohost generated 108 results. Of these, 6 were duplicates, 1 was a correction to a paper, 87 were not relevant, 14 articles were read in full and 3 were included in the present review. Web of Science generated 40 results. Of these, 2 were duplications, 2 were not relevant, the remaining 36 met the exclusion criteria so none were used. From the reference list search, 12 papers were identified, all were read in full and a total of 3 were used in the review (see figure 1 for an overview of the selection process).

#### Data Extraction

The final papers were read and the key findings were noted down using the data extraction sheet (see Appendix D for data extraction sheet), see Table 1 for an overview of the included articles.

#### Quality Assessment

From reading the papers within the field, a quality checklist for surveys was constructed (see Appendix E). The quality assessment used, was devised by combining elements from Downs and Black (1998) and the British Medical Journal's "critical appraisal checklist for questionnaire study" (The British Medical Journal, BMJ.com) to suit the needs of the present review.

A sub-set of papers (n=5), were reviewed by a peer in order to check the reliability of the scores. All five paper's scores were two or less than two points difference (60% had the same score n=3 papers, 20% had a one point difference n=1 paper and 20% had a two point difference n=1 paper). The two papers that obtained different scores were checked again by the author and either kept or amended. This was due to the differences in scores being identified as human error, i.e. the author or reviewer had missed something and marked a zero rather than awarding a point. The two papers that obtained a different score were re-reviewed once more by the author, the mistake was highlighted and a final quality score was awarded.

### Data analysis

Each paper was appraised and synthesized in order to provide an overall summary of the data within this particular field. Each study was evaluated in terms of its strengths and weaknesses to provide a picture of the quality of the research conducted thus far. The analysis highlights themes, consistencies and inconsistencies within the data to see what conclusions can and cannot be made from the current research. The following section presents the results of the analysis.

### **Results**

In total, eleven papers were included in the review (see Table 1 for summary of included papers). There was one qualitative study (Murphy, Hunt, Luzon, & Greenberg, 2013). The rest of the papers were quantitative or mixed methodology; with six of the papers coming from one large scale sample (a two phase survey stemming from OMHNE, using an initial data set with follow up data) (Fear, Seddon, Jones, Greenberg, & Wessely, 2012; Forbes, Boyd, Jones, Greenberg, Jones, et al. 2013; Iverson, Staden, Hacker Hughes, Browne, Greenberg et al., 2010; Iverson, Staden, Hacker Hughes, Greenberg, Hotopf et al., 2011; Osorio, Jones,



Fertout & Greenberg, 2012; Osorio, Jones, Fertout & Greenberg, 2013). The other papers focused on GP's perspectives (Finnegan, 1997), one sought commanders' perspectives (Cawkill, 2004), one focused on naval personnel (Langston, Greenberg, Fear, Iverson, French et al., 2010), and one took place in a garrison setting with Army personnel (Jones, Twaedzicki, Fertout, Jackson & Greenberg, 2013).

### Study designs

One qualitative study using Interpretative Phenomenological Analysis was reviewed (Murphy et al., 2013). The rest of the papers were quantitative or mixed methodology. Six papers used questionnaire based surveys (Osorio et al., 2012; Osorio et al., 2013; Fear et al., 2012; Cawkill, 2000; Finnegan, 1997; Jones et al., 2013) and four used data from both questionnaires and interview (Langston et al., 2010; Iverson et al., 2010; Iverson et al., 2011; Jones et al., 2013).

### Participant demographics

Overall participants were recruited from all three areas of the Armed Forces i.e. the Army, Navy and the Royal Air Force. Five papers used deployed personnel or personnel in Third Location Decompression (TLD) (where military personnel are deployed post war zone, in order to de-brief<sup>1</sup>), this included regular and reserve personnel. One paper recruited from purely naval personnel on board Navy ships, one used Army personnel in a garrison setting and one used Ministry of Defence general practitioners (GPs). One paper used personnel who were accessing mental health care. Overall there was a mix of ranks and services.

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<sup>1</sup> During TLD personnel start to psychologically 'unwind' by engaging in social activities, contact home and undergo psychoeducation programmes (Jones, Burdett, Wessely & Greenberg, 2011).

Measures of Attitudes towards mental health and barriers to care:

Four of the papers report selected findings collected from one data set, using a “sigma/BTC scale” adapted from Hoge et al. (2004), which is a 4 point Likert scale covering the areas of “practical barriers”, “anticipated stigma”, and “attitudes to mental health care” (Fear et al., 2012; Jones et al., 2013; Osorio et al., 2012; Osorio et al., 2013). Forbes et al. (2013) used 5 statements (5 point Likert scale) to measure military attitudes towards mental health. These statements were taken from a list of 27 statements, included in a Department of Health evaluation, into wider, societal attitudes towards mental illness.

Cawkill (2004) devised a questionnaire, which, in part, asked about participant’s experiences of stress, whether they sought help, what the outcome was and whether they received support from their peers and /or commander. Finnegan (1997) used one open question about whether service personnel sought help following traumatic incidences. Langston et al. (2010) used one open question subject to qualitative analysis, in a semi-structured interview on how participants thought their colleagues viewed stress and related difficulties. Langston et al. (2010) also reports using a quantitative measure about how participants viewed stress and related difficulties.

Measures of rates of mental health difficulties

The following measures were used in the research papers included in the present review (see Table 2).

**Findings**

Rates of mental health issues

In a study examining the relationships between stigma, barriers to care, combat exposure and post-traumatic stress disorder (PTSD), a year on year reduction in cases

of PTSD following deployment was reported (Osorio, Jones, Fertout, & Greenberg, 2013). It has been found that anonymity does not significantly increase the likelihood that military personnel will report symptoms of mental health conditions (Fear, Seddon, Jones, Greenberg, & Wessely, 2012). Fear, et. al, (2012) noted a probable PTSD rate of 3.3% within their sample, and this was more commonly found in those who had completed the anonymous questionnaire. In a sample of 484 British Army participants, about one third reported 'potentially harmful' alcohol use (Jones, Twardzicki, Fertout, Jackson, & Greenberg, 2013); within that, the majority did not think that this was of a problematic level. Approximately one quarter of the sample scored within the range of a 'probable metal health problem' (Jones, Twardzicki, Fertout, Jackson, & Greenberg, 2013). Iverson, Staden, Hacker-Hughes, et al. 2010, reported that military personnel identified symptoms of PTSD more often than problems with alcohol. They also noted that people who have difficulties with alcohol are least likely to get help for their problem, which is significant given that this is one of the most common problems within the military. This paper reports that of those who recognised they had a psychological problem, over 80% had accessed either informal or formal support (Iverson, Staden, Hacker-Hughes, et al., 2010).

#### Attitudes / Stigmatising beliefs

A common theme surrounding attitudes towards mental health in the papers was stigma and how individuals with mental health problems would be negatively perceived by others. Osorio et al. (2013) sampled all three areas of the armed forces and found that beliefs of a stigmatising nature were more widely held, in both deployed and post-deployed samples, than other barriers to care. This paper also reports that the most frequent stigma belief was that personnel would be treated differently if commanders knew that they had a mental health problem. They also

note that being perceived as ‘weak’ was the second most endorsed view, and that stigmatising beliefs surrounding mental health continue to be prevalent in military personnel.

In a sample of purely naval personnel distressed individuals reported more stigmatising beliefs than those who were less distressed (Langston et al., 2010). The overall findings suggest that stigma is common in the military and increases when an individual is distressed. Furthermore, this study found that distressed naval participants were more likely to report having less confidence in services within the military. It was also found that personnel reported fewer stigmatising beliefs of others with difficulties in comparison to commonly held feelings of internal stigma.

The tendency to hold stigmatizing beliefs about the self rather than towards others is also indicated by Cawkill (2004) who studied commanders’ attitudes towards stress and related difficulties. Commanders across the tri-services were more likely to say that they would help others with mental health problems than they would help themselves. Cawkill (2004) found that junior ranks stated that they had a preference for speaking to senior ranks about their problems, rather than discussing with peers (Cawkill, 2004). This paper reported that within this sample, there was a general negative attitude towards mental health problems, though the concept of ‘stress’ and suffering from stress, was regarded as fairly acceptable. The paper also notes that approximately half of their sample reported experiencing stress related to the workplace; many would not wish to disclose suffering from stress as they did not believe that others would view them favourably. There was concern that colleagues knowing that individuals were suffering from stress could result in obtaining a negative reputation or being perceived as a weak character. Participants thought that it would not be favourable in influencing their career progression. Many reported

worries surrounding how confidential the treatment would remain, and the majority reported most likely disclosing their difficulties to their partner (Cawkill, 2004).

Jones et al. (2013) found that people who did not access mental health care, did not report more stigmatising beliefs than those who had sought help.

In a paper comparing attitudes towards mental health, Forbes et al. (2013) found that attitudes within a military sample were not significantly different to those in a sample of the general population. This paper used the Office for National Statistics data to compare the results to their own, and there is a query around how comparable the two data sets are. This is because the survey completed with the general population was conducted 'face to face' while the military research was conducted over the telephone. Furthermore, the participant demographics in the general population sample are not stated. This means that it is unclear whether individuals with a military occupation were included in the sample and if they were, it would not make for an accurate comparison. The details of the Office of National Statistics report is no longer available in the government archives online as it was conducted eight years ago. Finally, the comparison of the two samples is based purely on five statements from larger surveys, which it could be suggested provides quite a narrow perspective.

Osorio, Jones, Fertout and Greenberg, 2012 found that personnel in the reserve forces reported significantly less stigma or fewer barriers to care in comparison to regular forces. When GP's were asked to report whether they considered military personnel hesitant to access mental health services, Finnegan (1997) found that they described stigma as a factor that prevented personnel from seeking help. The themes identified within Finnegan's paper were the military having a manly 'macho' image, perceived detriment to their career, derision from others, along with a culture denoting widespread denial of a problem.

### Barriers to care

In the only qualitative study that was reviewed IPA was used to examine the lived experience of actively serving personnel in southern England who were accessing departments of community mental health (DCMH) services. These services are the military equivalent of community mental health teams who see personnel in active service. They refer personnel on to NHS services if they leave the military (Murphy, Hunt, Luzon, & Greenberg, 2013). It found the following themes: “recognising something was wrong”, “overcoming internal stigma”, “finding an explanation”, “not being alone” and “control”. The paper notes that participants had found it difficult to identify early warning signs of PTSD, and that usually a person’s difficulties escalated to the point of crisis before they received help. The paper describes the participants talking about their reluctance to take medication and their perceived ideas of the stigma they would face from others in comparison to their actual experience which was not as they imagined. Furthermore, it was noted that the explanation for their difficulties meant that participants could accept or realise that they needed help and understood what they were going through. This was also described in terms of helping others understand too. Personnel’s family and friends have a vital role in noticing and supporting their difficulties.

Iverson et al. (2011) found that when comparing barriers to care in active service, reservist and veteran populations, members of the regular Army were more likely to report worries over confidentiality, whereas veterans and reservists were more likely to state that they would not know where to access support (Iverson et al., 2011). A very small percentage of the sample reported the belief that mental health treatment does not work. A higher proportion reported that comrades would have less confidence in them and commanders would treat them differently if they were known

to have a mental health problem. This paper reports that distressed participants were more likely to say that they would not know where to access help, along with pragmatic difficulties surrounding attendance of appointments.

One paper reports that of their sample who scored within the probable mental health problem range, around 40% had not accessed any support (Jones, Twardzicki, Fertout, Jackson, & Greenberg, 2013). This was the case, even though the majority of the participants viewed mental health treatment as supportive of recovery.

There was a large scale survey (made up of nine individual surveys) conducted by the military between 2008 and 2011. Questionnaires were distributed while personnel were either on deployment in Iraq or Afghanistan, or post deployment at Third Location Decompression (TLD) (Cyprus), usually 24-48 hours following coming out of the war zone. Some participants had completed BATTLEMIND (a programme aimed at supporting military personnel to transition between a war zone and civilian life) which is undertaken on TLD, and a small sample of participants in the large scale survey were approached at 6 months follow up. From this data, barriers to care were reported by one paper to be higher while on deployment, than post deployment, but this was not a significant difference (Osorio, Jones, Fertout & Greenberg, 2012). Another suggests similar attitudes in both samples (Osorio, Jones, Fertout & Greenberg, 2013). It was identified that males with combat exposure and probable PTSD were most likely to report the most barriers to care (Osorio, Jones, Fertout & Greenberg, 2012).

Osorio et al. (2012) conclude that personnel attitudes towards mental health vary depending on the stage of deployment. They also describe the conditions while on deployment under which personnel would be treated for mental health problems,

based in a medical hospital, where it would be obvious that an individual had an appointment to others, meaning worries over confidentiality are probably more realistic while serving on deployment.

### Quality assessment

All of the included papers were subject to quality assessment. Most of the papers' abstracts provided an informative summary of the whole paper (N=10). All of the papers included the relevant scientific literature in their introduction, stated their aims or hypothesis clearly, and used instruments suitable for their sample population. All papers presented results sections clearly and discussed their main findings in relation to their aim or objective.

Of the papers reviewed ten clearly described the measures used and nine could be repeated from the method sections. Just over half (n=6) of the papers discussed validity of the measures used and three reported the reliability. The majority of papers (n=8) clearly described their participants' characteristics. A minority of papers (n=2) considered the views of a sample of their target population prior to commencing the research and just over half (n=6) discussed response bias.

There was a large data set of which six of the reviewed papers reported the results. On the whole, the majority of results are consistent with each other, however, given over half come from the same participants, this would be expected.

### **Discussion**

The aim of the present review was to evaluate papers focusing on the views of personnel in the British Armed Forces. The review asked the following question: what do people in the British military think about mental health problems and



accessing mental health care? The present paper identified results that fall into three categories: rates of mental health issues, stigma, and barriers to care.

It emerged from the papers that there were varying degrees of reported rates of mental health problems within military samples, though these papers were relying on screening measures to identify ('cases' of) anxiety, depression, PTSD and harmful alcohol use. Problematic alcohol use was one of the most common problems in the military, and this difficulty was the least recognised by individuals (Iverson, et al. 2010). Sharp et al. (2015) suggest that people need to be able to recognise that they have a problem, in order to initiate accessing care. It has been said that in comparison to women, men are less likely to recognise that they have a problem within the general population (Addis & Mahalik, 2003). With the vast majority of military samples being male, this could possibly explain why the present review found that this population struggled to recognise that they had a difficulty. The present review proposes that military personnel struggle to recognise problems related to alcohol use. This may be explained clinically due to what we know in mental health services, about the reasons why some people use alcohol as a means to cope (Nishith, Resick & Mueser, 2001), i.e. numbing emotions and attempting to block out distressing symptoms, which can give short term relief. However, this can mean that identifying unhelpful aspects of using alcohol can be difficult as it feels as though it helps the problematic or distressing symptoms, though it is merely masking symptoms. Individuals can subsequently struggle or be reluctant to reduce their alcohol use as drinking has become relied upon in order to cope.

The prevailing view from the literature reviewed suggests that the main concerns about mental health problems were that individuals would be treated differently, and that they would be perceived as weak. Gould et al. (2010) compared data already

gathered from five western countries (UK, USA, Canada, Australia and New Zealand) regarding items from Hoge's "perceived stigma and barriers to care" questionnaire. Hoge's questionnaire included three items on stigma: receiving mental health care might "hurt my career", "leadership might treat me differently", and possibly being perceived as "weak" and two items on barriers to accessing mental health care: "I don't know where to get help" and "I might have difficulty getting time off work to attend appointments". Gould et al. (2010) found similarities across nations. They suggest that personnel were most concerned with the stigma surrounding mental health problems, over barriers to care. Gould's findings suggest that the stigma items most commonly rated surrounded being treated differently and being seen as weak, in line with the present review, though they noted that Canadian personnel were less inclined to suggest that they would be seen as weak. It is noted that the Canadian sample had just completed mental health awareness training prior to undertaking the survey which could explain these results. Sharp et al. (2015) comment that the worries described are not necessarily unfounded since personnel, particularly if prescribed medication, can be taken off weapons handling and other duties associated with potential risk. Sharp et al. (2015) note that stigma could be associated with the culture of the military being viewed as a patriarchal and typically 'macho' system. Therefore, the finding in the present review that personnel would rather speak to their commander about mental health (Cawkill, 2004) is an interesting one given senior staff would be reporting on their occupational performance, which in turn influences their career progression.

Gould et al. (2010) suggest that people who scored higher than the cut-off scores on measures of ('cases' of) mental health problems, were more likely to endorse stigmatising views than people who scored below the thresholds on the measures.

Though they note that New Zealand did not follow that trend in the data. This finding could be explained by a number of possibilities. Firstly, the sample taken from New Zealand was smaller than those of the other countries which could impede the reliability of the findings (Gould et al., 2010). Secondly, Gould suggests that the average age of the New Zealand cohort could have been younger than that in the other countries samples, as only 12% of the New Zealand participants were married at the time of data collection. This would have potentially created a cohort effect based on age. Finally, the personnel in the New Zealand sample had completed a peace keeping mission, while participants from all of the other countries had completed deployments to Iraq and Afghanistan. This means the New Zealand participants experiences were significantly different to the other samples and could have skewed the results. Sharp et al. conducted a systematic review and meta-analysis of papers with data on military personnel (internationally) who scored above cut offs on measures screening for mental health difficulties and their self-reported views of stigma. They found that the majority of the data did not support the notion that stigma surrounding using mental health treatment was associated with whether personnel would actually seek mental health support (Sharp et al., 2015). This, they suggest, is not consistent with literature from civilian populations. However, Forbes et al. (2013) suggest that in general, attitudes towards mental health were not significantly different to the general population. This is an interesting contradiction, and given the methodological shortcomings in the Forbes paper i.e. the question of whether their data from the civilian and military population is actually comparable, it would seem that their findings do not fit with the wider literature.

As in Gould et al's (2010) paper, all of the papers presented in this review rely on self-reported data for mental health screening and attitudes towards mental health

stigma. This means that they are potentially biased by the influence of social desirability (Gould et al., 2010). Furthermore, the research team that conducted the large scale survey, along with the other papers reviewed, was made up of military personnel or ex-service personnel. This too could have influenced how participants decided to answer the questions on the surveys. Iverson et al. (2010) suggests that on follow up from the large scale two part survey technique, the most vulnerable people may have been missed. Presumably this is suggested for a number of possible reasons including: people with complex difficulties can be more chaotic, may not open their post in order to receive the questionnaire, or answer the telephone to speak to researchers, or may have been medically discharged from the military making the sample of personnel included in their follow up sample biased (Iverson et al., 2010). This means that the follow up data could be biased towards the less vulnerable personnel. It does not state whether steps were in place to ensure that deployed personnel only completed the questionnaire once in this large cohort sample, and did not duplicate their answers. Since the vast majority of research is conducted by two departments at King's College London, KCMHR (Kings Centre for Military Health Research) and ADMMH (Academic Department for Military Mental Health), funded by the Ministry of Defence, it means that the same group of researchers conduct the majority of the military research in the UK. This has certain benefits given it allows this group of researchers to develop specialist knowledge and expertise within the field. However, it also means that potentially British military research is conducted from one perspective or paradigm. It has been suggested that this way of researching a specific area can give an incomplete picture or narrow view of what is a complex and multifaceted reality (Gioia & Pitre, 1990). Gioia and Pitre (1990) discuss the fact that different paradigms have different underpinning epistemological

assumptions, meaning research is approached quite differently from one paradigm to the next. Allowing research to be gathered from many different perspectives can provide a more comprehensive picture of the topic under discussion (Gioia & Pitre, 1990).

The present papers reviewed used different screening measures (some within one paper) to assess rates of potential mental health problems, which makes it difficult to compare the data (Gould et al., 2010). Furthermore, the measures are not clinically 'sound' in that if assessed by a mental health professional, it is probable that these people would not be diagnosed with a "significant mental health problem" (Gould et al., 2010). This means that the papers may firstly over estimate rates of mental health problems, but also they make comparisons to those who do not score above such measures when in reality the two samples could be similar in presentation and not as distinct as the paper suggest. The majority of the papers relied on screening assessments to predict possible and probable ('cases' of) mental health problems. In Iverson et al. (2010, p150) 'mental health problem' is defined as: "emotional, stress related, an alcohol problem or family problem". It is not clear how a family problem constitutes someone having a mental health problem, or why they would need to access services, for example see their GP, for this type of difficulty. This means that the finding: the majority of military personnel do not access care for their problems may be overstated, given that not accessing care or support could be the right decision for that specific individual.

As noted in their review, Sharp et al. (2015) suggest that most of the present data investigates whether stigma or other barriers 'might' deter personnel from accessing treatment, however, it does not mean that this is necessarily the case. Given that it was found that attitudes of those who were accessing mental health support were not

dissimilar to those who were (Jones et al., 2013), it still remains unclear as to why some people access services while others do not (Addis & Mahalik, 2003). The papers reviewed give an insight into the factors surrounding what might deter personnel from accessing mental health services but there are no definitive conclusions. Since the number of men far outweigh the number of women in the British armed forces, it may be useful to think about the influence of gender on help seeking. Typically in western culture men are seen to be reluctant to seek help when they are in need (Addis & Mahalik, 2003). Furthermore, there is much research, in line with this suggestion in relation to men seeking medical support (Addis & Mahalik, 2003). Brannon and David (1976) suggest that identifying and admitting that you need to rely on another for help, conflicts with subtle gendered messages that boys and men receive throughout their lives. It is thought that society on the whole values characteristics of strength (physical and emotional) and independence in men (Brannon & David, 1976). These are certainly values that the military institution endorse. The image of a 'soldier' is suggested to be a symbol of masculinity (Morgan, 1994). The theory of 'masculinity ideology' (Betz & Fitzgerald, 1993) looks at male characteristics and how much they are endorsed in specific individuals. Good and Wood (1995) suggest that the more different male characteristics are embraced by men, the less likely that individuals would be to ask for help. 'Masculine Gender Role Conflict Theory' (Good, Borst & Wallace, 1994) suggests that endorsing some masculine ideologies such as 'men should not be seen to express emotion' can be detrimental to wellbeing. Though, these theories still do not clarify why, in specific circumstances men do indeed seek help (Addis & Mahalik, 2003). An insight is given in the one qualitative paper reviewed suggesting that the military personnel they interviewed reached crisis point before accessing

services (Murphy, Hunt, Luzon, & Greenberg, 2013). This could have been a last resort, or the only available option. It would seem that more qualitative research, with different samples across the tri services might provide further understanding of some of the other reasons people do not access treatment, or under what circumstances they do.

Addis and Mahalik (2003) suggest that general help seeking can be understood psychologically by thinking about the normality of the problem, whether the problem is perceived as intrinsic to an individual, who the helper is, whether an individual has a sense of control or the social groups to which the individual belongs. Regarding social group membership, the characteristics of members of the social group is important to help seeking. Thinking about the military context, if individuals are surrounded by people who endorse masculine ideologies it could discourage individuals from seeking help even more. Wengers (1998) suggests that people develop their sense of identity in what he calls 'communities in practice'. Within this model, it is thought that learning is facilitated through interactions with other group members. It is highly likely then, that members of the forces, who belong to the military community construct their identity in relation to each other, but also develop ideas surrounding help seeking within that specific context. Another model of help seeking is the 'Equity Model' (Hatfield, Walster, Walster & Berscheich, 1978). This model suggests that humans want their relationships to be reciprocal. If relationships are not mutual, or inequitable i.e. one person receives more than the other, it causes distress. Thinking about this model in relation to the military, which as an organisation value groups of people with a diversity of skills in order to depend on one another, this way of 'being' very much promotes mutual helping (Hale, 2012). It must therefore be difficult for military personnel to seek one sided help,

when they are very much used to being in the position of giving and receiving support.

In order to combat stigma, the military have implemented a number of interventions (Murphy & Busuttill, 2014), one being a programme called TRiM (Trauma Risk Management), used by other public sector organisations (Greenberg et al., 2011). In a paper evaluating the acceptability of this programme, based on a sample of naval personnel, they report that of 159 interviews, 57 personnel mentioned TRiM (50 people based on a ship where TRiM had run, and 7 people from the control ships). Of the 57, the authors suggested that 43 participants had an in-depth knowledge of the programme, with 35 viewing TRiM in a positive light and 8 personnel making negative comments about the programme. Some of the concerns reported were surrounding confidentiality of TRiM and whether the personnel running the programme had the necessary skills and ability to do so (Greenberg, Langston, Iverson, & Wessely, 2011). To date, it has been reported that there is no significant evidence to suggest the interventions used have influenced the rates of personnel accessing mental health treatment (Murphy & Busuttill, 2014). As noted earlier, the papers reviewed investigate what ‘might’ deter service personnel from accessing care and the review has found that individuals who access care are not dissimilar to those who do not. Therefore, it could be that the intervention though maybe helpful as an education tool, may not be targeting the specific deterrent and hence changing the actual numbers of people who access care when they need to, or before they reach a crisis point.

### **Suggestions for future research**

From the research base, it seems that further exploration is needed in order to fully understand why the processes behind why some people in the military access mental



health services and others do not. Also, it is unclear whether other barriers to care exist and what they are. Further research with qualitative methodology is needed to understand this population, as the one qualitative study reviewed added richness and a deeper level of understanding to the data. Different research departments in the UK could offer diverse approaches and stances to researching this population, which could provide a multitude of perspectives on the subject.

### **Strengths & Limitations of the review**

The review question is broad, given the limited numbers of specifically British articles on this topic. Multiple databases were searched, and a comprehensive search of reference sections took place. Given this, grey literature was excluded meaning some data may have been missed. Review papers were excluded from the present review, however, they were scoped prior to commencing the review to ensure the present review was not a duplicate of previous work. The reviewed studies included both qualitative and quantitative methodology, highlighting how much of each type of research has taken place. The inclusion criteria meant that actively serving personnel were required to be participants. This means that veteran and reservist research was only included if they were part of this sample. The quality checklist used, was constructed by combining information from two different sources. This limits its utility, however it was used in this review as a guide to discussing the literature rather than purely reporting of scores. A peer-review process was adhered to for a selection of articles, to ensure reliability of quality scores and as a quality assurance on rating quality of the papers.

### **Conclusion**

In conclusion, the answer to the question ‘what do people in the military think about mental health problems and accessing mental health care’ is multifaceted. On the whole, it would appear that there are considerable stigma and negative attitudes surrounding mental health in the military. This could inhibit people from firstly admitting they have a problem and secondly seeking help for that difficulty. The main concerns regarding others knowing that one has a mental health problem is that of being treated differently and perceived of as being weak. The potential for being ostracised could also deter individuals from seeking help. Personnel have concerns regarding how seeking mental health treatment might affect their career, which in reality is a legitimate worry. It seems that on the whole, it is generally acceptable to support someone else with their mental health, but not seek help for oneself.

Actually, the situation may have to reach crisis point before personnel accept support. A number of other reasons exist why personnel struggle to access care. It is suggested that individuals can find it difficult to identify alcohol misuse problems (the most prevalent difficulty in the military). Military personnel prefer to speak informally to others such as partners or spouses about their mental health. This could be due to concerns reported regarding confidentiality. Though, attempting to keep mental health matters private is an interesting finding given that it was also suggested that individuals would rather speak to a senior colleague rather than their peers about their difficulties. Finally, it is possible that there could be an impact of social desirability influencing the results obtained given the researchers were ex-military themselves. Different research designs and departments of researchers who perhaps do not purely focus on the military are needed to provide different stances and approaches to examine this issue further and substantiate the claims made to date.

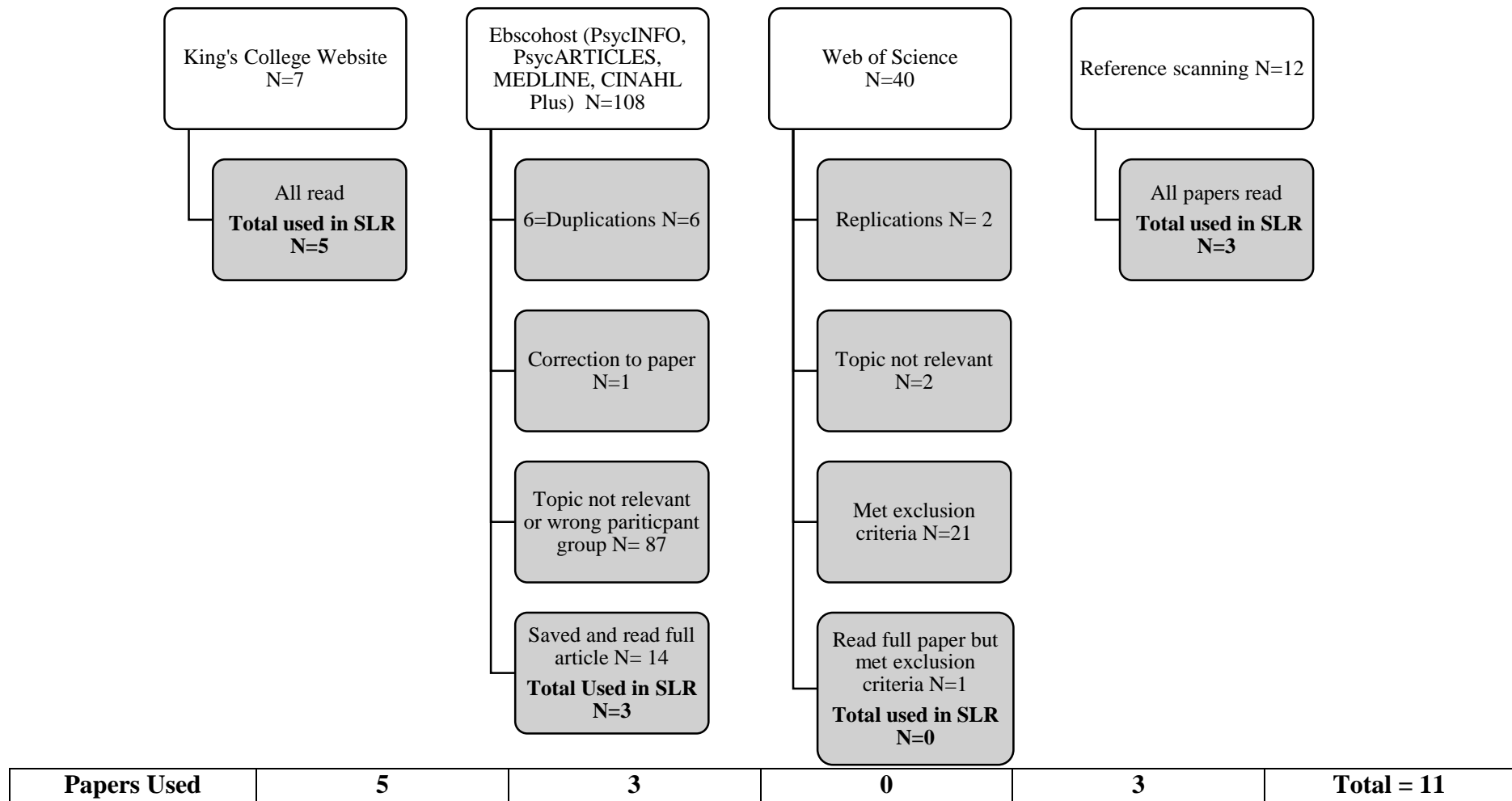


Figure 1. Diagram to demonstrate search strategy and outcome.

Table 1. Included papers in the review.

<b>Authors</b>	<b>Design</b>	<b>Participants</b>	<b>Measures</b>	<b>Key findings</b>	<b>Quality assessment score (maximum=18)</b>
Osorio, C., Jones, N., Fertout, M. & Greenberg, N. (2013)	9 surveys	23,101 Tri service personnel deployed to Iraq / Afghanistan between 2008-2011 (deployed and post deployed data)	Perceived stigma/BTC scale 4 items, PC-PTSD or PCL-C.	The main reported stigmatising belief was that 'commanders would treat them differently' for having a MH problem, or that they would be 'seen as weak'. Most common BTC was getting time off work to attend and issues around confidentiality. Stigma and BTC was fairly similar at both time points.	15
Fear, N. T., Seddon, R., Jones, N., Greenberg, N. & Wessely, S. (2012)	Survey	611 Tri Service personnel deployed in theatre	GHQ, PCL-C, 11 Stigma statements, Combat exposure questions (17 Items).	Probable PTSD was identified in 3.3 of the population (n=20). Anonymity did not increase reporting of MH symptoms, probable PTSD was more likely in those who completed anonymous questionnaires.	15
Langston, V., Greenberg, N., Fear, N., Iverson, A., French, C. & Wessely, S. (2010)	Questionnaires and interviews	1599 Q's, 374 interviews Naval personnel on board naval vessels	GHQ-12, PCL-C	Internal stigma was significantly higher for distressed personnel, but common for all participants, Commanders reported that they would help others but not necessarily themselves and junior ranks reported being more uncomfortable discussing emotional issues with peers compared to their seniors.	13

Murphy, D., Hunt, E., Luzon, O. & Greenberg, N. (2013)	Qualitative semi-structured interviews (IPA)	8 active service personnel attending MH services	PCL-C, PHQ-9	Themes identified were: “recognising something was wrong, overcoming internal stigma, finding an explanation, not being alone and control”.	14
Cawkill, P. (2004)	Questionnaires	4921 Tri service personnel of corporal to captain rank		Stress and related problems viewed negatively by commanders. Around half of the participants had experienced stress related to their occupation. Overall view that stress was acceptable.	13
Iverson, A. C., Staden, L., Hacker Hughes, J., Browne, T., Greenberg, N., Hotopf, M., Rona, R. J., Wessely, S., Thornicroft, G. & Fear, N. (2010)	Two phase survey technique. Telephone Interview	Phase 1 KCMHR, 281 of 821 Military personnel	PC-PTSD, PHQ,	Over ¾ of participants with a MH diagnosis chose not to access medical help but prefer to use informal sources of help. Participants with alcohol problems were least likely to seek help.	14
Jones, N., Twardzicki, M., Fertout, M., Jackson, T. & Greenberg, N. (2013)	Questionnaires	484 Serving members British Army – Garrison setting	AUDIT-C, GHQ-12, PC-PTSD, BTC scale, RIBS, Managing own symptoms Statements	Around 1/3 reported potentially harmful alcohol use. Approx. ¼ screened positive for probable MH disorder, of those around 40% had not sought help despite reporting that support would be helpful / necessary.	16
Forbes, H. J., Boyd, C. F.	Two phase	Phase 1 KCMHR data,	Office of national	Attitudes towards MH are not significantly different in	13

S., Jones, N., Greenberg, N., Jones, E., Wessely, S., Iverson, A. C. & Fear, N. (2013)	survey technique. Telephone Interview	821 military personnel & 1729 people from the general population	statistics data, 5 statements of attitudes towards MH	the general and military populations. The majority of people have positive attitudes towards MH and similar proportions reported negative attitudes in both samples.	
Iverson, A. C., Staden, L., Hacker Hughes, J., Greenberg, N., Hotopf, M., Rona, R. J., Thornicroft, G., Wessely, S. & Fear, N. T. (2011)	Two phase survey technique. Telephone Interview	821 Military Personell	GHQ-12,	In regulars the most reported barriers were stigma related. Reservists reported more pragmatic barriers along with veterans. Participants with a diagnosis of depression reported more barriers than those without.	14
Osorio, C., Jones, N., Fertout, M. & Greenberg, N. (2012)	9 surveys	23,101 Tri Service personnel deployed in theatre	PCL-C or PC-PTSD	Personnel on deployment report more stigmatising beliefs and barriers to care than those post deployment. Males with combat exposure and probably PTSD reported higher levels of stigmatising beliefs and barriers to care.	15
Finnegan, A. P. (1997)	Postal questionnaire	16 MoD GP's		GP's reported stigma being a barrier to service personnel accessing psychological help. With the following main 'stigma categories': being perceived as weak, worries that it would affect their career, ridicule from peers, and peer pressure to deny a problem exists.	10

Table 2. Measures.

Measure	Author	Referenced in paper
The PC-PTSD Primary Care Post Traumatic Stress Disorder Checklist	Prins, Kimerling, Cameron, Oumiette, Shaw, Thrailkill, et al. (1999)	Osorio et al., (2012); Iverson et al. (2010); Jones et al. (2013); Iverson et al. (2011)
PCL-C (PTSD checklist civilian version)	Blanchard, Jones-Alexander, Buckley & Forneris (1996)	Iverson et al. (2010), Osorio et al. (2012), Murphy et al. (2013), Langston et al. (2010) and Fear et al. (2012)
PHQ (Patient Health Questionnaire)	Spitzer, Kroenke & Williams (1999)	Iverson et al. (2011)
PHQ-12		Iverson et al. (2010)
PHQ-9		Murphy (2013)
AUDIT-C (Alcohol screening tool) increased cut off scores	Bush, Kivlahan, McDonell, Fihn & Bradley (1998)	Jones et al. (2013)
The GHQ-12	Goldberg & Williams (1988)	Jones et al. (2013), Iverson et al. (2011), Langston et al. (2010) and Fear et al. (2012).

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**PART TWO**  
**EMPIRICAL PAPER**

This paper is written in the format ready for submission to the 'British Journal of Psychology' See Appendix F for author guidelines.

**The Exploration of 'identity' for women with roles in differing civilian and military environments: Experiences, self-perceptions and wellbeing.**

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## **Abstract**

One group of women who have numerous roles in differing environments are female health professionals who are in the Reserve Army Medical Services (AMS). The objective of this research was to explore the experiences of women health professionals, who also occupy roles in civilian and military settings. The research asked how these women view themselves and how they manage to hold multiple roles. Interpretative Phenomenological Analysis (IPA) was used in order to answer this question. Nine female health professionals, who were also members of the Army Reserve were recruited and completed a semi-structured interview. The interviews were transcribed and analysed in accordance with IPA principles. The following superordinate themes were identified: ‘In group-Out group (always being the outsider)’, ‘The Reserves offering something more’ and ‘Managing the roles’. To the best of the author’s knowledge, this is the first qualitative analysis of the experiences of female health professionals who are also members of the Army Reserve. It was found that overall it was easy for them to negotiate roles, though the women had different strategies for completing this, including separating the roles and focusing on the task in hand. Future research would be needed to see if this is the case for younger or less experienced women in similar roles.

## **Introduction**

Traditionally, within western culture women’s responsibilities were fundamentally perceived as care giving, mothering and homemaker roles, not professional occupations (Weiss, Freund, & Weise, 2012). Silva (2008) asked questions surrounding the cultural recognition of gender and how “performing gender”, or acting in specific gender normed ways contributes to how a person views themselves

at the deepest level. If this is true, she questions what happens when people act or “perform gender” in ways which oppose these traditional views. An example of “performing gender” in a way that opposes traditional views may be women working in traditionally ‘masculine’, or male dominated environments.

Watts (2009) conducted a qualitative study investigating work-life balance and strategies used to maintain this of 31 female civil engineers in the UK. She found the main issue regarding work-life balance was the culture surrounding long working hours, producing a work-family conflict. Watts suggests a strategy the women used to help maintain what they considered a ‘healthy work-life balance’ was to be able to mentally switch off from work, while at home. This also extended to giving their family as much time as they could, outside of work. Finally, she notes that her participants used a strategy of knowing at that moment in time what the main priority was for them, whether it was family, or an important deadline and focusing on that particular thing.

Self-Discrepancy Theory (Higgins, 1987) proposes three aspects of the self, including: the ‘actual self’ which is a representation of the attributes one identifies themselves to have, the ‘ideal self’ which is made up of the aspirations one has for oneself and finally the ‘ought self’ which consists of the obligations and responsibilities one deems oneself to have (Strauman, 1996). Discrepancies can arise between the self-guides (ideal / ought) and the ‘actual self’ through self-evaluation. This process, the theory would suggest, can have an emotional impact on the individual. The greater the discrepancy or congruency between self-guides, Strauman states is likely to impact positively or negatively on a person’s emotions. Furthermore, he notes this (discrepancy or congruency) can drive or maintain the emotional state. For example someone with a negative emotional state would be

more likely to critically or negatively self-evaluate, which in turn would further increase the discrepancies. This cognitive process may have consequences for mental health and wellbeing in the longer term, for example people experiencing a depressed mood (having a negative view of themselves, the world and the future) (Beck, Rush, Shaw & Emery, 1979). This theory suggests congruency between self-guides and the actual self would promote positive emotional wellbeing, positive judgements of the self and would seek to strengthen how the person views themselves (Strauman, 1996).

One group of women who have numerous roles, in differing environments, are civilians who are also members of the Reserve Armed Forces. More specifically, female health professionals including nurses and midwives, who are in the Reserve Army Medical Services, potentially have very contrasting roles in both female and male dominated environments.

Hale (2012) suggests that the military might have provided women with a way of constructing an identity, maybe more masculine in nature, that they may not have been able to in their civilian life. This suggests the Armed Forces may offer an alternative way of life for those women seeking to escape, or partly escape, the traditional gender roles imposed by society (Silva, 2008). Silva's paper questions: how or if these women retain a sense of their 'true' identity, while undertaking roles requiring features traditionally viewed in the opposing manner. Silva questions whether women in the military define new models of being a woman and whether this alters present meanings of femininity, within the context of the armed forces (Silva, 2008). In conclusion she suggests that the topic of women in the military is of great social interest, especially due to the assumptions society makes in regards to

the transformation or challenge these women face by entering into this masculine environment.

Discussions in regard to the Reserve Forces is topical since the nature of their role has changed significantly and reservists now make up numbers for the country's overall defence capacity following the re-structuring of the UK armed forces (Reserves in the Future Force, 2013). This means that reservists are more likely to deploy with the military i.e. operationally than perhaps in the past as they can be deployed for up to six months in any five year period. Reservists will experience leaving their families and friends behind like members of the regular forces, but may also have additional stressors such as leaving their civilian work and the associated friends and possible social elements to this behind when they go on operational tours. Furthermore, it has been suggested that reservists perhaps do not get the same recognition from the public as regular forces and families and friends may be less 'socialised' to the military way of life and have less of an understanding of what their family member or friend faces while away on tour (Browne, Hull, Horn, Jones, Murphy et al., 2007).

As a much under researched group, not much is known about the experiences of female reservists in general. There are speculations around families and support networks of reservists being different, possibly less encouraging or supportive of people wanting to join the reserve forces and deploy overseas (Dandeker, Greenberg, & Orme, 2011). However, to the author's knowledge, investigation into female reservists experience specifically has not been researched in the UK.

In light of the existing literature, it would seem there is a gap for the present research which has the overall aims: to explore and understand how 'identity' is defined for

female reservists in the AMS (Army Medical Service) who have been deployed on at least one operational tour, explore whether discrepancies occur between the “selves” for women in this group and how easy or difficult it is for them to negotiate the different roles they have. The research adds to the knowledge base of females holding multiple roles, and military research, which at present seems mostly focused on combat exposure, trauma and ‘Post Traumatic Stress Disorder’ symptomology. Furthermore most of the military research, to date, is based on male participants (or vast majority male) within a quantitative framework. The present study requires a qualitative design in order to investigate the lived experience of women who have roles in both civilian and military settings.

### **Method**

Ethical approval was obtained from the University of Hull, Faculty of Health & Social Care, Research Ethics Committee (see Appendix G).

### Design

The study sought to investigate identity and managing roles in differing environments. In order to investigate this it was thought that women living with multiple roles would need to be asked about their personal lived experience. This meant that a qualitative methodology was deemed most appropriate. Of the qualitative research methods, Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) was considered to be most suitable given it strives to make sense out of an individual’s perspective of their lived experience within a specific context (Smith, Flowers & Larkin, 2009).

### Participants

Participants are purposively selected for an IPA study with the aim of having homogeneity within the sample due to focusing on a specific lived experience (Smith, Flowers & Larkin, 2009). Between four and ten interviews are recommended for a doctoral level research project (Smith, Flowers, & Larkin, 2009). Smith et al. (2009) state that due to IPA being ideographic investigating specific phenomena, smaller sample sizes are used in order to conduct in depth detailed analysis. Nine participants were available at the time of data collection which suited the study design. In other techniques, the researcher will stop interviewing when they reach 'saturation point', there is no comparable concept within an IPA framework (Smith et al. (2009). Participants were women health care professionals, who were also members of the Army Medical Services, in the Army Reserve, in their spare time. The women volunteered to take part and were acting within their civilian capacity for this research.

The following inclusion criteria were adhered to: Women, English speaker, Health care professional, Army Reservist, had been deployed on at least one operational tour. An operational tour refers to being deployed for duty and includes a number of missions such as peacekeeping, providing humanitarian aid, or going to a war zone. Participants were excluded if they met any of the following criteria: men, non-medical professionals, had not been deployed operationally.

### Procedure

Participants were recruited via the circulation of an advert for the research (see Appendix H), by a health care professional contact. Eleven people contacted the researcher to express an interest in participating and to seek further information.

Two participants were not available at the time of data collection to participate. The

remaining nine people took part in the research. Smith et al. (2009) suggest that sample size in IPA research depends on a number of factors including the depth of analysis, and the richness of each interview. This they also consider within the context of which the researcher is working. The general guiding principle of conducting IPA research is quality not quantity (Smith, Flowers & Larkin, 2009). Supervision was used to think about what each interview was contributing and when to cease data collecting with the IPA framework in mind.

Participants read the research information sheet (see Appendix I) and gave fully informed consent to participate. Interviews were then arranged between the primary researcher and the participant. Interviews were conducted both in person and over the telephone for reasons of mutual convenience.

The interview was semi-structured, with a schedule devised by the researchers (see Appendix J) . Interviews took between 50-80 minutes and were recorded using a dictaphone. The electronic version was transferred onto an encrypted memory stick using a unique non-identifiable code to maintain anonymity and transcribed by the primary researcher. Some demographic information was recorded. All participants were given closing information (see Appendix K).

### Analysis

The data was analysed and interpreted using IPA, in accordance with its guiding principles of reading and re-reading the transcripts (data), initial noting (making descriptive, linguistic and conceptual notes), developing of emergent themes, making links across themes and patterns across interviews (Smith, Flowers, & Larkin, 2009).

The researcher maintained a neutral curiosity as per the stance IPA takes to research as suggested in IPA, and through supervision was able to step back and put aside

presumptions and preconceptions in order to remain open minded (Smith, Flowers & Larkin, 2009). IPA recognises that the outcome of the analysis is created by both the researcher and the participant, given the method relies on the account of the participant, it is their 'truth', their attempt to make sense and give meaning to their experiences that is the core essence of the research. This double hermeneutic, whereby it is the researcher's job to interpret the individual's account of their experience, means that this methodology relies on 'second order' sense making (Smith, Flowers, & Larkin, 2009). However, by following the guiding steps, the analyst can be reflective throughout the process (Smith, Flowers & Larkin, 2009). The researcher attended monthly IPA reflective practice groups to think about the whole process of IPA from start to finish with peers also conducting IPA research. This meant that the researcher had another forum to reflect on the research process to avoid potential bias. The continuous reading and noting over time identified themes of the interview. The researcher then established possible links along with contradictions in themes (Biggerstaff & Thompson, 2008). Finally, the researcher structured the analysis, which resulted in groups of themes being arrived at. This process was repeated, starting from the beginning for each transcript, again reviewing and re-reviewing the text as further themes were identified (see Appendix L for example of analytic process and Appendix M for table of developing themes). These themes were then adjusted and consolidated in light of the continuing process. Quotes from participants are used to give the reader a sense of the data (Smith, Flowers & Larkin, 2009). Some participants are quoted more than others purely because they might have summarised a point, in a way that encapsulates the meaning of what has been said by the group. Research supervision was integral throughout the process.



Steps have been taken to ensure the anonymity of participants.

## **Results**

Table 3: Participant Demographic Data

<b>Demographic</b>	<b>Mean</b>	<b>SD</b>
Age (years)	52	4.15
Children (number)	1	1.17
Number of Operational Tours (number)	2	1.27
Length of time as a reservist (years)	21	7.04
Length of time as a regular (years)	4	2.16

The average age of the participants was 54 years. All participants were White British women. There was a mix of married, divorced and single participants, of which some had children. Each participant had completed at least one operational tour, some had completed more, and length of time spent as a reservist was on average 21 years. Some participants had previously been in the regular Army. Due to maintaining participant anonymity further details cannot be given in regards to specific participants.

### Qualitative analysis

#### Theme one: In group – out group (always being the outsider)

There was a sense amongst participants of being a ‘separate’ or ‘different’ group of women, who weren’t necessarily like civilians, as they had very different experiences (from them) and wanted to achieve different things, perhaps a sense of ‘more’ with their lives. However, these women were not in the regular Army. Some of the women had previously been in the regular Army, or worked as a civilian for the

Ministry of Defence, and therefore perhaps felt slightly more included in a regular 'in group' than others. It was clear that some of the women had felt demeaned by members of the regular Army, due to them being in the reserve forces. Furthermore, there was a strong sense among participants, that as a woman in the reserves, you are 'in competition' with your male counterparts, meaning you show a 'stronger' more 'independent' you. This 'competition' and independence seemed to stem from when participants were children, but also was encouraged and valued in the armed forces. This could have been a factor that attracted these specific women to join the armed forces.

*Civilians not having an understanding*

There was a sense that this group of women faced questions from their civilian friends and family as to why they actually wanted to be in the Reserve forces, in particular with regards to being deployed to a war zone

*"They think I'm stupid, they don't, they didn't want me to go to Iraq, and they didn't think I should go", (P7, 12-26)*

or completing tasks associated with being a reserve as the women got older

*"They think I'm getting too old, and that I shouldn't be doing that kind of thing anymore". (P5 5-14)*

Some of the women described returning home from operational deployment, and having to return to their previous life, and almost pick up where they had left off, for example doing the washing and the cooking for the family on their return

*"When I got home from Iraq, [gap] as soon as I walked in, it was oh mum you're home, and it was like that's it, there's the washing machine, what's for tea? That's it!" (P7 16-19)*

For other women, there was a sense that they initially thought regular society was not as safe as a war zone, where they had been surrounded by people they trust. This made adjusting back to civilian life difficult for some of the women,

*“Everyone’s been through it, and understand you, know what you saw, what your living conditions were [gap] you go back to civilian world, they haven’t got a clue”.*

*(P2 24-20)*

Furthermore, some of the women spoke about their frustrations with civilian colleagues, particularly if there was work to be done

*“In my civilian role, I’ve got, erm, some colleagues who really like to chat a lot, and I’m not keen on that if there’s work to do” (P1 6-26)*

suggesting that the women like to get the work done and then will chat, or socialise, while perhaps their civilian colleagues would chat while there was work to be done. There were suggestions about civilian colleagues not being as disciplined, or as well presented as this group of women, who pride themselves on being smart and well turned out:

*“They just ring in sick, they don’t care about their team, or they turn up late and don’t look smart, or just really really little things, that are hard to define, but you don’t get that kind of behaviour in the military”.* (P6 3-39)

One participant commented that the military had *“Better teamwork and shared visions”* than civilians. There was a strong sense among the women that they go the extra mile, or over and above their duties, something perhaps they viewed their civilian colleagues, not to do

*“When I was on tour, if there was a mass casualty problem, then you all went back to work, regardless, so if you’d only left work for ten minutes, if you were called back, you would always go back and work through, until the casualties were sorted”. (P1 3-22 )*

Some women spoke about differences in communication too with civilians, with some suggesting they preferred less “Woolly” or “Flowery” language that was concise and straight to the point.

*How included or accepted the reservists felt by the regulars*

A number of the women spoke about being individually augmented i.e. when deployed with the Army they went alone rather than with their unit, and their experiences of this. As could be imagined, this was experienced by most as an uncertain, nerve wracking time, but faced as a challenge to be ‘got on with’. Though it seemed that this was not fully appreciated by colleagues who were members of the regular Army:

*“I don’t think the regulars realise what it’s like for us”. (P7 17-12)*

It was talked about that this was really where their skills and attributes as a ‘strong individual’ came in to action. One participant described facing difficult experiences with her regular colleagues whilst deployed.

*“The regulars hated us”, “We were called STABS, stupid TA bastards”, (P7 2-1)*

She described the reservists being perceived as lower in rank, in comparison to their regular colleagues. This was illustrated when a regular commander said “She’s TA, she’s equivalent to a corporal”, in front of her (she was higher in rank) (P7 4-1).

In contrast, some of the women who had previously been regulars perhaps did not share the same viewpoints. For these women, there was a sense that being in the reserves maintained their connection to the Army, something some of them missed, or longed to be back a part of. A small group of women had also worked as civilians for the MoD, outside of their reservist duties, and for these women, there was a sense of connection too to the “Green machine” that they talked about. This seemed to still be as an ‘outsider’ but slightly more ‘in’ than ‘out’,

*“And I can also communicate better with the military personnel, because I speak the same language!” (P2 5-14)*

It was mentioned that when reservists are deployed, they become members of the regular army, though it was thought, that perhaps the regulars did not view it in this way. The reservists spoke about valuing being a ‘part of the team’ while deployed and really missed their colleagues when they returned home. There also seemed to be a sense of competition between the regular and reserve forces (while speaking to the participants), in terms of clinical and soldiering skills.

*Families of reservists being treated differently*

It was discussed that one of the participants felt her family had been treated differently to the regulars’ families while she was deployed.

*“I’ve just come back from Afghanistan and they [Army] never bothered with my family”. (P715-8)*

She expressed a sense of bias towards regulars’ families who she felt were more supported, and got invited to family events like BBQ’s to socialise with other people in a similar situation. Another reservist spoke of her child being bullied, teased and tormented by other children at school, while she was on deployment

*Being a woman is also being an outsider*

What it is like to be a woman in the military was spoken about. There was a sense of having to be as good as, or better than a man to be seen as equal

*“If a man can do something, a woman has got to do it at least, 1 ½ to 2 times better to be equal”.* (P7 10-26)

There seemed to be a competitive edge to comparing oneself to a man. There was a sense of these women having and valuing their own status, without a man,

*“You wear your own rank, I don’t have to wear my husband’s rank on my handbag”.*(P2 17-14)

and not having to rely on a man

*“I’m totally independent”.* (P2 16-15)

For a few, there was a strong mother figure influence, or definite role model, influencing their ideas of how women should be;

*“My mum did all that, I think my mum was quite an independent sort of woman as well”.* (P7 12-23 )

For some of the participants, this meant in the Army, becoming

*“More manly [than the men], just to say, I’m not a weak and feeble female”.* (P9 11-37)

This ‘self-reliance’, and complete ‘independence’ was contrasted by a lot of the participants, by a sense of having to get permission, or at least agreement from a man (usually their husbands) in order to join the reserves in the first place. They also talked about having to join the reserves, due to being in the regular forces, while

married to a man in the regulars, was not compatible. Therefore, the woman in these instances took the step back, to pursue a civilian career and maintained their interests by becoming a reservist.

Similarly, some of the women who didn't have children, talked about how hard it must be for women to juggle being a reservist with having a family

*"I'm quite respectful of people who can juggle a family and be a reservist. I don't know how they do it", (P1 11-20)*

This gave the impression that they talked about women differently to themselves, i.e. it is not like that for men, or 'me'

*"I thought, if you have a child, that's it, out. You should be out", "I feel that you can't give 100% to the Army if you have children". (P9 12-23)*

There was a definite sense of a maternal obligation to looking after and caring for members of the forces by this group of women. This was both in the sense of having children the same or a similar age to the younger members of the forces, and having a patriotic connection, or sense of duty to look after the people who serve and protect our nation. The language used in the interviews was interesting, as some women referred to everybody in the military as "Chaps" (meaning men and women), another referred to soldiers (or the people they were there to look after) as "Our boys".

#### Theme two: The reserves offering something more

There was a sense of wanting adventure, and more from life:

*"It's that sort of, tiny bit of excitement, that you don't know what you're going to do next", (P3 17-4).*

There was a strong theme of escaping something either at home, or the possibility of not ‘doing’ something with life. For some of the women, there was a sense of re-evaluating life which then led to them joining the forces. For others this re-evaluation occurred following joining and ‘seeing things’, possibly facing life and death and severe casualties whilst deployed. Both roles as a nurse and a nurse in the AMS (Army Medical Service) were described passionately, with a real sense of pride and love for the jobs.

*Escaping the everyday norm*

Going away with the reserves was described by a number of woman as a bit of a break or escape:

*“It’s my other world, it gets me away from home”.* (P3 17-40)

Participants talked about being able to switch off from thinking, as the plan is already set:

*“Funnily enough, when I’m away with the military, it’s all planned for you, so I just switch off”.* (P5 11-8)

Participants also spoke about escaping some of the tasks they have to complete while at home, including domestic tasks

*“You don’t have to worry about the washing, shopping, the cleaning”.* (P9 13-16)

*“It’s nice not to have to think about what you have to make for tea, or what you have to wear, or anything like that, because they tell you, and you’ve got to do it”.* (P5 11-14)

A sense of getting away from the duties associated with one’s life, and roles in it:

*“We all laugh about it, and say, let’s become sheep for a week”.* (P5 11-13)



Furthermore, joining the reserves, and for some this initially was the regular Army, there was a sense of not wanting to be trapped in a civilian life with no possibilities, or limited possibilities. Joining the regulars, or reserves, was seen as a way to broaden ones horizons, see the world, do more with life and live a fuller, more fulfilling life:

*“Do I want to be here in 30 years’ time? [gap] No, I want to do something with my life”. (P9 8-36)*

There was also a sense of gaining perspective, both when joining and following a deployment, where the women described changing something in their existing civilian life or career:

*“I came back realising that my job, in the NHS, wasn’t the be all and end all, and there were other things out there that were better”. (P6 13-26)*

#### Work as play

There was a sense that completing work in the reserves was not just work, it was work that the women enjoyed, and it felt like something of a hobby too:

*“Work in the military was like, ooh, I’ll just do eight hours work and then I can play for the rest of the time”. (P9 10-7)*

There was talk of comradeship:

*“You realise why you like going, you know, it’s the relationships”, (P6 10-10)*

There was a sense of finding or pushing yourself as a person, and for the women who had joined as a regular at a younger age, there was a sense of ‘growing up’ in the Army. There seemed to be a huge social element to being in the reserves and for those who had been in the regulars, they seemed to talk about this more prominently,

*“It’s the buzz that you get when you go and meet your colleagues, the comradeship, erm, its very educational, you do some very interesting things, and the social life is fantastic”.* (P8 12-32)

A few of the women spoke about enjoying the dinners, and dressing up smart for social events, with one participant describing it as very glamorous and

*“It’s almost like yesteryear”.* (P8 12-39)

Being a nurse was also spoken about in a similar sense, in terms of doing a job that the women loved:

*“It wasn’t like a job, I didn’t feel like I was going to work, I was doing something that I absolutely loved doing”.* (P7 8-15)

Though each participant had different experiences of being a nurse, with some having more difficulties than others, there was a theme of knowing they always wanted to be a nurse, since childhood.

This was contrasted with being faced with life and death, both in work and as a civilian and a reservist. The injuries the women saw in their time with the reserves were significantly worse than what they saw in civilian life:

*“I saw horrific things, and had nightmares when I came back”.* (P7 17-33)

There was a sense that meant that participants were better prepared for their civilian work:

*“I go to work now, and I don’t think there’s much I can see in my civilian life, that will rock me, because of what I have experienced on both my operational tours”.* (P4 8-15)

Theme three: Managing the roles

There were a number of ways in which participants spoke about ‘managing’ the different roles they held:

*“Adjusting from one to another is quite something”. (P2 23-37)*

This included a sense of having an external self, where participants described appearing different to their inner or true self.

Exterior as a façade

A number of times, participants spoke about appearing cool, calm and collected on the surface, while underneath they felt something completely different while in the reserves. This was described as:

*“A bit like ducks on water” (P3 4-11) and “The swan effect” (P9 16-21).*

This was contrasted to civilian life, where participants described a sense of ‘flapping’ or ‘ripples in the water’, i.e. things not running as smoothly, or appear to be running as smoothly as in the military context, or feeling like one can show a bit more of one’s less composed self out of the military.

There was a strong sense of ‘holding back’ inner felt emotions in the interviews:

*“You’ve got to be emotionally strong. You can’t, particularly as an officer, you couldn’t be seen to be in tears, [gap] that shows weakness”, (P7 10-19)*

This implied that the women showed a stronger side of themselves in the military, however, it was felt that there was a more sensitive side underneath.

Swapping clothes

There was a sense that uniforms were a kind of external trigger that helped them switch between the roles

*“I just switch on, just change my clothes”. (P2 8-28)*

Uniforms were also spoken about in terms of guiding how these women should behave, particularly in the military

*“Once you put your uniform on, you’re taking orders, everything” (P2 9-6).*

Also, the uniform was seen to be a protective barrier, or shield, that could actually influence participant’s internal state:

*“You would actually think I was a different person, if I put my uniform on” (P9 16-5).*

Some women spoke about feeling more relaxed in their civilian clothes, and feeling a bit different in their nurses uniform,

*“I think when you put your nurses uniform on, you feel and act slightly different” (P1 19-5).*

### *Separate the two*

A number of the participants talked about knowing which role they were in by concentrating on the task at hand, and by focusing purely on that rather than anything else

*“You’re living in the [here and] now, not the now back at home”, (P5 6-11)*

*“On deployment, you have to be able to leave what’s at home, at home”. (P1 16-17)*

There was a sense that the women did not think about home while they were away with the reserves.

One participant described it as:

*“It’s almost like having a split personality”. (P3 16-4)*

There was a general sense that swapping roles was pretty easy to do on the whole, but also that it had maybe become easier with time and experience. Furthermore, the fact that the military kept the women very busy, while away, made it easier for them to not think about life at home. Some women said it was harder to do this, when something stressful or difficult was occurring at home, in their home life, however, for others this acted as an escape from stressful home situations.

One woman spoke about conducting herself in a manner that would be acceptable to any organisation, NHS or Military, in a sense merging the two aspects of her life so there did not feel like there was any sense of separation. Similarly, some women spoke about the environment switching, rather than the individuals switching. For them, this meant that they knew they could work effectively in any situation as they had the skills to do so.

## **Discussion**

This research offers an insight in to the experiences of female reservists who have multiple roles in both civilian and military environments.

It has been speculated within the literature that families of reservists, their spouses, friends and work colleagues may be less understanding and or supportive in comparison to support networks of people in the regular forces (Dandeker, Greenberg & Orme, 2011). The present research highlighted a theme “Always being the outsider” with a sub theme of “Civilians not having an understanding”, which is in line with this suggestion. This may be due to a number of reasons. Firstly, depending on the age which an individual signs up to the reserve forces, along with their experiences prior to joining will depend on how much their family has to adapt. This could be their family of origin (i.e. the family in which they was raised) or their

own family having settled, married and had children. The 'Family Adjustment and Adaptation Response Model' (Patterson, 1988) suggests that families 'adjust' by negotiating family demands (e.g. daily disruptions and stressors) with the capabilities of the family (i.e. their internal and external resources) along with the sense the family makes of the particular experience they are trying to adapt to. Around half of the women in the present study had been in the regular Army prior to joining and some participants had family members in the military, which could mean that their families may well be 'socialised' to the military way of life. For others, who perhaps joined the reserves from a non-military family, and or later in life, it could be possibly viewed as a greater adjustment to negotiate.

Dandeker et al. (2011) highlight the possibility of reservists wanting to leave the forces due to inadequate family welfare support from the military. In the present findings, it was identified that reservist's families were not as 'included' or 'supported' as families of members of the regular armed forces while they were away on operational duties. This is in line with data from the USA that stated, 75% of participants when asked, recommended that the military could better support them and their families during deployment (Castaneda et al., 2008).

The present results suggest that there have been tensions between regular and reserve colleagues, in line with Dandeker et al. (2011). Given that humans organise the world into social categories (Aronson, Wilson & Akert, 2007) it can mean that individuals identify with 'in-groups' and subsequently have prejudice attitudes towards 'out-groups' i.e. groups in which the individual does not identify themselves (Aronson, Wilson & Akert, 2007). It has been suggested that humans have a tendency towards "in-group bias" favouring this group, along with "out-group homogeneity, whereby individuals 'tarnish' all members of the out-group with the

‘same brush’ seeing them as alike or even the same (Aronson, Wilson & Akert, 2007). Leung & Bond (1984) suggest that members of collectivist cultures are more concerned with in-group members, i.e. are only collectivist in relation to those members, rather than towards out-group members. This can be thought about in terms of the present results with this group of women having identified themselves as ‘outsiders’ or perhaps members of differing ‘out-groups’ in their civilian and military lives. If the military is thought about as a collectivist culture, whereby there is interdependence on one another, primarily for survival, this may suggest why the present results noted the regular members of the army having a prejudice towards reservists. This divide could possibly contribute to the sense of competition between the two groups. Similarly this in group – out group bias could explain why there was a sense of competition between the female participants and the men in the military and why they felt they had to exert extra effort in order to be viewed as equal.

Social Learning Theory (Michel, 1973) proposes that children learn of their gender through various rewards and punishments, ultimately conditioning children to identify themselves as a particular gender and act in gender normed ways. The concept of ‘gender’ is related to an overall societal definition of what it means to be masculine or feminine (Bem, 1984). The present data suggests that being in the reserves is an escape, enabling the women to switch off and ‘follow someone else’s plan’. Within that, there was a contradiction between being a strong independent individual, and having to transition into an environment where following orders and having a ‘greater good’ was essential. Interestingly, this can be thought about like a family, where the children follow guidance from their parents. The possible break from life could be thought about in terms of escaping the tasks associated with being a woman, or in terms of escaping the demands of being an adult. Silva (2008) paper

describes reserve training as an 'escape' from being traditionally feminine. Silva talks about her female participants progressing as individuals, being neither female nor male. Interestingly, the women she spoke to distinguished being a woman from being a person i.e. I am a person not specifically I am a woman. Within the present research the language used by the participants was often in line with this, i.e person instead of woman. Women in the reserves could be viewed as more androgynous than traditionally feminine. Bem (1984) talks about androgynous individuals who organise their social worlds not focused around gender, and who actually flexibly embody both female and male characteristics. It has been hypothesised that individuals who endorse androgyny could be more likely to be more adaptable meaning their ability to be effective in different situations increases (Bem, 1975).

Some of the participants in the present study had more senior positions in the military in comparison to their civilian jobs. For others it was the opposite and a few held relatively similar positions in both. Participants spoke about feeling empowered in the military, as it was suggested that if one is in charge of making the decisions, things can be promptly achieved. The participants in the present study discussed knowing in the military when not to speak. This seemed like a real difference between the two organisations. Military health care professionals (MHCP) work with civilian health professionals in Military Hospital Units in preparation for operations overseas (Kelly, 2010). Though the two work along-side each other, it has been reported that conflict in how decisions are made arises between the two professional groups. MHCP's follow their rank structure (hierarchy), where orders and decisions come from the top (top down decision making), whereas civilian health professions are said to make decisions jointly, between professionals (Kelly, 2010). Traditional bureaucracies tend to have the steepest hierarchical structures (Acker,



2006). Decisions in these organisations are made based on the rules, rather than personal judgement (Davies, 1996). Bureaucratic structures are ‘masculine’ in nature given emotion and tenderness are not encouraged (Davies, 1996) and hierarchical structures of any kind of organisation are typically ‘gendered’ meaning males dominate the higher positions at the top (Acker, 2006). The ‘glass ceiling’ metaphor, originated in the 1980’s describes the under-representation of women in senior leadership, management and board positions (Bendl & Schmidt, 2010). It has been suggested that flat team structures, where teams are encouraged to make some or the majority of decisions can provide more equality for women in the workplace, however, this was thought about only if women act like men, for example if they put work first (Acker, 2006). Interestingly there was a sense of complete dedication to the Army in the present study when one participant said that she would question a woman’s dedication if she had a family, specifically children. Silva (2008) found that the women in her study saw the military as an opportunity to be empowered “strong, assertive and skilful” (Silva, 2008, p943).

The sample of women in the present study all had on average 21 years’ service as a reservist along with being a health care professional in their civilian lives. Schein (1983) wrote about ‘career anchors’ in terms of how individuals define their self-concept in relation to their occupational experience. Schein’s model has nine stages, however, pertinent to the present research are stages four ‘basic training and socialisation’ and five ‘gaining membership’. Within stage five, Schein describes individuals creating a coherent image of the self as a group member. Schein says that ‘identity’ can be an anchor when individuals identify with their occupation or organisation. For the women in the present research it could be suggested that stage four is imperative within the context of the armed forces, in order to reach stage five,

but also a strong identification is required with the Armed Forces, particularly for reserves in order to fulfil one's duties over and above their day to day roles. Schein suggests that in order to have a mature self-concept, one requires occupational experience in order to gain insight into one's desires, motives, drives, strengths and weaknesses. It could be suggested that this sample of women would be more inclined to have a mature self-concept than perhaps a younger or less experienced group of women.

The present research highlighted a sub theme of "Exterior as a façade". Within this, it was spoken about appearing different on the outside, to how the women felt on the inside, while in the military. Culver (2013) reviewed the American literature regarding women in the military and gender identity and proposed a theory whereby women who join the military go through a number of phases. These include: "Feeling the need to put on a mask", "Wearing the mask", "Consequences of wearing the mask" and "Establishing an authentic gender identity". Though there are numerous limitations to her theory as it was adapted from a model used to describe college men assimilating into fraternities and it is questionable how this is generalised to the experiences of women in a different context. The theory is interesting though as it does seem to reflect some of the issues the women in the present study were expressing. This is a contradiction to how the women expressed that they felt about themselves.

Regarding 'Self Discrepancy Theory' (Higgins, 1987), it appeared when talking to the women that their 'ideal' selves, i.e. the attributes they would ideally like and admire in others, was extremely close to their 'actual self'. The women spoke about feeling that they would strive to be the best person they could be, and if they admired something about other women, for example being independent, then they would do

it. There was not a sense of failure of any kind, like failure was not an option for these determined women. There seemed to be little discrepancy between self-guides, which as the theory describes, means that views of the self would be coherent with a strong sense of identity. This was definitely the case for this particular group of women, however, the average age of the participants was 54. Within Erikson's stages of development, middle adulthood is when an individual is between the ages of 40 and 65 years old. Participants' social context may be more settled, for example any children are more likely to be older as per Carter and McGolgrick (1989) Family Life Cycle Model.

Future research would be needed to explore what it is like for younger or less experienced women holding dual roles, since it may be very different for them. Also, research conducting purely face to face interviews may provide different data. The present research conducted both face to face and telephone interviews. The researcher found that although all of the interviews were fruitful, the ones conducted face to face had a more personal and emotional feel to them. Rapport and trust may have been established slightly easier while sitting in front of the participants in comparison to being one step removed over the telephone. This could have meant that interviewees potentially held back or did not disclose as much as the participants did in person, which could have influenced the data collection and subsequently the analysis and results of the present research.

## **Clinical Implications**

This paper is a starting point on which to build future research. Since not much is known about female reservists, it is important to examine their experiences. The present research gives an insight into how this group of women view themselves, and provides a context to this particular population. For clinicians working with women who have similar experiences and roles, the present paper gives clinicians points to think about and consider in the course of their work. In order to research specific mental health problems that this group of women may face, it is important to first gain an understanding of what it means to hold such roles.

## **Strengths, limitations and future research**

The present paper has both strengths and weaknesses. To the best of the author's knowledge it is the first paper of its kind that explores the experiences of female health professionals who are also in the Army Reserve. It provides a starting point for the literature base for this type of research. The present research has a relatively homogenous sample which IPA requires due to focusing on a specific lived experience (Smith et al., 2009) which is of suitable size for IPA methodology. There were a mix of married, single and divorced participants which gave an interesting insight into the similarities and differences in experiences and views, however, future research could be conducted focusing on these specific sub groups of women in order to more closely examine their individual experience. The average age of the participants in the present study was 54. As discussed, this may have influenced the present data as the women in this study have had long periods of time spent in and out of the roles described and have significant experience transitioning between roles. It may be the case that younger women or women who have perhaps just joined the reserve forces have different experiences. Future research would also be required to examine what it is like for women in different occupations both in civilian and military life, and in the other reserve forces: the Navy and Royal Air Force. Furthermore, research into the experiences of men in the reserve forces is required in order to give a more rounded view of balancing different roles.

The present study used both telephone and face to face interviews to collect the data. As discussed, this could have influenced the openness of participants and subsequently the depth of the interviews. Future research should be consistent in the approach with face to face interviews recommended as an outcome of this research. This research provides a beginning for the literature base for future enquiries to build upon.

## **Conclusion**

To the best of the author's knowledge, this is the first qualitative analysis of the experiences of female health professionals who are also members of the Army reserve.

It was found that the women felt in competition with their male counterparts and definitely displayed what could be considered traditionally masculine characteristics such as being physically and emotionally strong, skilful and independent. The women in the present study described the reserves as providing them with the opportunity to challenge themselves, succeed and grow as an individual. It would seem the concept of androgyny encapsulates the identity of this group of women who described having a strong sense of who they are, with a mature self-concept and congruency between their self-guides.

It was generally described as easy for the participants to negotiate roles, though the women had different strategies for completing this, including separating the roles and focusing on the task in hand. Though, cumulatively these women had an average age of 54, with long durations spent in both roles, this will have influenced how able they are to swap between roles, in different environments. With regards to environment, it seemed that this was the key factor that changed, rather than anything integral to the women.

It was identified within the present research that civilians within the context of these reservists' lives possibly did not have as much of an understanding of the challenges that the women faced, but also the great satisfaction that it gave. There seemed to be a bit of split or divide between members of the regular and reserve forces and it was felt that families of reservists could be more included and supported. If this was to occur, it could possibly help families and friends better support and understand the experiences and way of life of their loved one who is a member of the reserve forces.

**Reflexive Statement**

(See Appendix N)

Table 4. The super-ordinate and sub themes identified.

Super-ordinate Themes	Sub Themes
Always being the outsider (in group – out group)	<ul style="list-style-type: none"> <li>• Civilians not having an understanding</li> <li>• How included or accepted the reservists felt by the regulars</li> <li>• Families of reservists being treated differently</li> <li>• Being a woman is also being the outsider</li> </ul>
The reserves offering something more	<ul style="list-style-type: none"> <li>• Escaping the everyday norm</li> <li>• Work as play</li> </ul>
Managing the roles	<ul style="list-style-type: none"> <li>• Exterior as a façade</li> <li>• Swapping clothes</li> <li>• Separate the two</li> </ul>

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# PART THREE: APPENDICES

# Appendix A: British Journal of Clinical Psychology Author Guidelines

## British Journal of Clinical Psychology

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### Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
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- Brief reports and comments

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The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

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The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the

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All manuscripts must be submitted via <http://www.editorialmanager.com/bjcp/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#).

### 4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
  - Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
  - The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
  - Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
  - Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
  - All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.
  - All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
  - For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
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  - In normal circumstances, effect size should be incorporated.
  - Authors are requested to avoid the use of sexist language.
  - Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.
- ### 5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

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#### 10. Author Services

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The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

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Appendix B: Search Terms for Science Direct:

(British OR UK OR U.K. OR "United Kingdom" OR "Great Britain" OR England)  
near/3 (army\* OR forces OR Military OR soldiers\* OR "active duty")

AND "mental health" OR emotion\* OR wellbeing OR psych\*

AND attitude\* OR view\* OR perception\* OR opinion\* OR prejudice\* OR stigma\*  
OR judgement\* OR "help-seeking" OR "health promotion" or barrier\*

## Appendix C: Screen shot of limiters used in EBSCOHOST.

The screenshot shows a web browser window with the URL [web.b.ebscohost.com/ehost/resultsadvanced?sid=a479f9db-cc59-41f7-b3c7-f187b225e894%40sessionmgr111&vid=4&hid=103&bquery=\(\(British+OR+UK+OR+U.K.+C...\)\)](http://web.b.ebscohost.com/ehost/resultsadvanced?sid=a479f9db-cc59-41f7-b3c7-f187b225e894%40sessionmgr111&vid=4&hid=103&bquery=((British+OR+UK+OR+U.K.+C...))). The page displays search results for the query `((British+OR+UK+OR+U.K.+C...))`. On the left, the 'Refine Results' panel shows the following filters:

- Current Search:** ((British OR UK or U.K. or "united kingdom" or "g...))
- Boolean/Phrase:** ((British OR UK or U.K. or "united kingdom" or "g...))
- Limiters:**
  - Peer Reviewed
  - Journal Subset\*
  - Geographic Subset\*
  - Language\*
  - Publication Type\*
  - Special Interest\*
  - Publication Type\*
  - Exclude Book Reviews\*
  - Publication Type\*
  - Language\*
  - Exclude Dissertations\*
  - Journal Subset\*
  - Geographic Subset\*
  - Language\*
  - Publication Type\*
  - Special Interest\*
- Clear All**

The main content area shows 'Search Results: 1 - 10 of 108'. Three results are visible:

- 1. The presentation of depression in the British Army.**  
 (includes abstract) Finnegan, Alan; Finnegan, Sara; Thomas, Mike; Deahl, Martin; Simpson, Robin G.; Ashford, Robert, *Nurse Education Today*, 2014 Jan; 34 (1): 83-91. (journal article - research) ISSN: 0260-6917 PMID: 23537941, Database: CINAHL Plus with Full Text  
 Summary: Background: The British Army is predominately composed of young men, often from disadvantaged backgrounds, in which Depression is a common mental health disorder. Objectives: To construc...  
 Subjects: Military Personnel Psychosocial Factors; Depression Epidemiology; Depression Therapy; Mental Health Services  
 [PDF Full Text] (265.6KB)
- 2. Stigma and mental health in the Royal Navy: a mixed methods paper.**  
 (includes abstract) Langston V, Greenberg N, Fear N, Iversen A, French C, Wessely S, *Journal of Mental Health*, 2010 Feb; 19 (1): 8-16. (journal article - research, tables/charts) ISSN: 0963-8237 PMID: 20380493, Database: CINAHL Plus with Full Text  
 Background: US research suggests that military personnel suffering from mental health problems are reluctant to seek help because of stigma. Aims: First, to identify the prevalence of mental heal...  
 Subjects: Help Seeking Behavior; Mental Disorders; Military Personnel Psychosocial Factors; Stigma; Stress, Psychological, Adult: 19-44 years; Female; Male  
 Show all 5 images  
 [PDF Full Text] (265.6KB)
- 3. Factors affecting help seeking for mental health problems after deployment to Iraq and Afghanistan.**  
 Hines, Lindsey A; Goodwin, Laura; Jones, Margaret; Hull, Lisa; Wessely, Simon; Fear, Nicola T.; Rona, Roberto J., *Psychiatric Services*, Vol 65(1), Jan 1, 2014, pp.98-105. Publisher: American Psychiatric Assn [Journal Article], Database: PsycINFO  
 Objective: This study assessed the prevalence of general medical problems, stress or emotional problems, and alcohol problems reported by members of the armed forces of the United Kingdom after d...  
 Subjects: Help Seeking Behavior; Mental Health; Military Deployment; Military Personnel; Adulthood (18 yrs & older); Young Adulthood (18-29 yrs); Thirties (30-39 yrs);

The Windows taskbar at the bottom shows the date and time as 11:41 on 18/09/2014.

<b>Appendix D: Data Extraction Form</b>	
<b>Article title</b>	
<b>Author and date</b>	
<b>Research aims</b>	
<b>Population</b>	
<b>Sample size</b>	
<b>Research design / methodology</b>	
<b>Methodological quality check list score</b>	
<b>Intervention? (delivery, duration, no. of conditions etc).</b>	
<b>Outcome measurement (who completed what, when, baseline? Follow up? Reliability and validity?)</b>	
<b>Statistical analysis (what, follow up data?)</b>	
<b>Main findings</b>	

<b>Reported limitations</b>	
<b>Conclusions</b>	

Appendix E: Quality Checklist

	Question	Total that do	That don't	notes
1	Does the abstract provide an informative summary of what was done and what was found?	10	1	
2	Is the scientific background and rationale clearly described?	11	0	
3	Is the hypothesis / aim / objective clearly stated?	11	0	
4	Are the characteristics of the participants in the study clearly described?	8	3	
5	Are the participants representative of the entire population from which they were recruited?	5	6	
6	Are the tests / measures used clearly described?	10	1	
7	Does this appear to be appropriate methodology?	10	1	
8	From the methodology could the study be replicated?	9	2	
9	Has the author made claims of validity of the test / measure and is this justified?	6	4	
10	Has the author made claims of reliability of the test / measure and are they justified?	3	8	
11	Was the instrument used suitable for all of the participants?	11	0	
12	Were the views of a sample of the population considered in the study design?	2	9	
13	Is there information on drop-out rates / partial or incomplete data?	8	3	
14	Have any potential response bias been discussed?	6	5	
15	Are the results clearly presented?	11	0	

16	Is the type of analysis used appropriate?	10	1	
17	Are the main findings of the study described in relation to the aims and objectives of the study?	11	0	
18	Does the author consider the limitations of the study?	9	3	
	<b>TOTAL SCORE</b>			

## Appendix F: British Journal of Psychology Author Guidelines

### British Journal of Psychology

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Edited By: Stefan R. Schweinberger

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ISI Journal Citation Reports © Ranking: 2013: 16/129 (Psychology Multidisciplinary)

Online ISSN: 2044-8295

#### *Author Guidelines*

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

- (a) reports of empirical studies likely to further our understanding of psychology
- (b) critical reviews of the literature
- (c) theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

#### 1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

#### 2. Length

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

#### 3. Submission and reviewing

All manuscripts must be submitted via <http://www.editorialmanager.com/bjp/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#).

#### 4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

## 5. Supporting Information

BJOP is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

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#### 7. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

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Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

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OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see [http://wileyonlinelibrary.com/onlineopen#OnlineOpen\\_Terms](http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms)

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## 11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

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Further information about the process of peer review and production can be found in this document: [What happens to my paper?](#)

Appendix G: University of Hull Ethical Approval



Appendix H: Advertisement for participants.



**The Exploration of ‘identity’ for women holding dual roles in differing environments: Experiences, self-perceptions and wellbeing.**

Hello,

My name is Katie Topp and I am a Trainee Clinical Psychologist studying at the University of Hull.

As part of my Doctoral Course in Clinical Psychology, I have to conduct a piece of research (thesis). It is hoped that at the end of my course, the research will be able to be published in an academic journal order to share the knowledge the study has generated.

I am interested in finding out about what it is like to be a woman working in a perceived paternalistic environment such as the military and what it is like balancing different roles including, for example, being a woman, perhaps a wife, mother or sister, having a medical/nursing role and any other roles you may have. This is why I am interested in finding female medical/nursing staff who happen to have more than one role to take part in a research project that I am currently in the process of planning.

I would like to recruit between five and ten women to hold ‘interviews’ with, though it will hopefully feel more like a conversation not just ‘questions and answers’. During this interview I will ask questions such as “how would you describe yourself?” in the roles described above. The interview will last around one hour.

I am hoping to meet participants at their convenience; perhaps their home, a local coffee shop near to where you live or work, or the University where I am based. All travel expenses can be agreed beforehand and reimbursed following taking part.

A few details would need to be taken from each participant including name, age and current job role to name a few; however all this information would be kept confidential and never revealed. Once interviews are complete, I would be looking to see if there were similarities and differences between them and then would write it up in an article to hopefully get published in an academic journal. No names would be used in the article but quotations from the interviews would be used without breaching any identity. We would discuss beforehand if there was anything that the participant would not want to be included.

Participation is voluntary. We would ask you to sign consent form beforehand prior to commencing any interview. Anyone who wished to could withdraw from taking part up until the point of data analysis (so when the interviews were being looked over for similarities and differences). This is because the analysis is very time consuming and altering it once it is complete completely changes the results.

If this sounds like something you would be interested in doing then please email one of us on the contact details below and I can put you on a list to be contacted when the research starts. If you have any comments on how the research could be adapted or changed or any general thoughts or questions about the project then please do not hesitate to contact either Dr Janet Kelly or myself on the email addresses provided below.

Before commencing any interview, the study will be first approved by the Faculty Health and Social Care Research Ethic Committee. This information sheet at this stage is to gauge initial interest.

Thank you.

Katie Topp (Researcher)

Trainee Clinical Psychologist  
University of Hull  
[K.Topp@2012.hull.ac.uk](mailto:K.Topp@2012.hull.ac.uk)

Dr. Janet Kelly (Supervisor)

Lecturer in Healthcare Law &  
Ethics  
University of Hull  
[J.Kelly@hull.ac.uk](mailto:J.Kelly@hull.ac.uk)

**FACULTY OF HEALTH AND SOCIAL  
CARE**

Title of Project: **The Exploration of identity for women with roles in differing civilian and military environments: Experiences, self-perceptions and wellbeing.**

Name of Researcher: **Katie Topp** (Contact email: K.Topp@2012.hull.ac.uk)

Supervisors: Dr Claire Wilson, Dr Lesley Glover, Dr Tim Alexander & Dr Janet Kelly

You are being invited to take part in a research study which aims to learn something about the experiences of female healthcare professionals who are also members of the Army Reserve and have been deployed on at least one operational tour.

Before you decide to take part, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and let us know if there is anything that is not clear.

**Once you have read this information, you should take a few days to consider whether you would like to take part. During this time, if you think of any questions please do not hesitate to contact me on the details above.**

**Once you have decided whether you would or would not like to take part, please let me know. If I do not hear anything after one week, I will contact you to ask your decision.**

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

Research is very important in order to generate knowledge.

At present, there is very little known about the experiences of women who have different roles (personal and professional) in civilian and military environments. Varying roles include being for example a mother, wife, sister, aunt, nurse or other health professional and being a member of the Army reserve.

The purpose of this study would be to gather information on your experiences, what it is like to have these different roles and how it is you view yourself in relation to these roles.

It is hoped that this research will give insight into what it is like for women with varying roles as the government are aiming to increase the Army Reserve by over 10,000 people by 2020. Hopefully, this research will be helpful to educate others about the experiences you have had and what it is like to balance these roles.

**Who are we looking to recruit?**

We are looking for between 5 and 10 women (over the age of 18) who are health care professionals and are also members of the Army Reserve.

**What happens if I volunteer to take part? What will I have to do?**

If you volunteer to take part then I will arrange a convenient time and location to meet with you. Your travel expenses will be reimbursed. Alternatively, it might be that we arrange to talk over the telephone.

I will ask you to sign a consent form if we meet in person, if we talk over the phone verbal consent will be obtained. Following which, I will take some brief information such as: your

age, relationship status, whether you have children, previous and current job roles and ethnicity.

We will spend around an hour discussing your experiences. I will have some questions to ask like “how would you describe yourself?” This will be technically called an ‘interview’ but should feel more like a discussion. It will be audio recorded on to a dictaphone, immediately transferred onto an encrypted (password protected) memory stick and deleted off the dictaphone.

I will type up the conversation using an anonymous identifier instead of your name and then will delete the digital version of the conversation. Only my supervisors and I will have access to the typed version of the conversation.

We will discuss parts of the interview to see if there is anything you wouldn’t want to be directly quoted. You will be offered a copy of the final written paper, though whether you wish to receive this is optional. There will also be an opportunity for you to attend the conference where the research will be presented at the University of Hull, however again this is optional.

### **Do I have to take part?**

**No.** This research is on a volunteer basis only.

You can, if you wish discuss taking part with others e.g. your family or friends, though it is not essential.

You can also withdraw from the research up until the time of data analysis without giving any reason. It is estimated that analysis will take place during February 2014. This is because once the analysis has started it is difficult and time consuming to take data out. It also would change the results of the research. If you decide to withdraw, your information will be deleted.

### **Expenses**



If you have to travel to take part in the research, your expenses **will be** reimbursed. This will be mutually agreed prior to us meeting. Transport costs are based upon standard public transport rates.

**What are the possible disadvantages or risks of taking part?**

It takes up some of your time (1hour minimum, plus any travel time).

It can be difficult talking to a stranger about personal experiences.

Though it is completely up to you how much you want to say, there is the possibility that something might come up that may be upsetting. It will be discussed and agreed at the start of the interview, if this occurs what we shall do, for example: take a break from the interview or carry on. All participants will receive an information pack at the end of the interview containing information on where you can turn to for support should you wish to.

**What are the benefits of taking part?**

Research is very important in order to generate knowledge and learn.

At present there is very little research focusing on identity in women. There is even less in regards to women who have both civilian and military roles and have been deployed. You would be contributing your experiences which are vital for wider society to understand and learn about what it is like for this group of women.

This could possibly enable professionals and different community agencies to understand the

types of experiences faced by women healthcare professional reservists. In turn, it could allow them to better meet the needs of this group of women.

Previous research has found that it can actually be quite helpful to discuss your experiences and as previous people have found, you might enjoy it.

**What if I do the interview then I decide I don't want to take part?**

You are able to withdraw up until time of data analysis (that is when all the written up discussions are looked at in order to see if there are similarities and differences between them) without giving a reason. As above, it is very difficult to take data out once the analysis has started.

If you wish to withdraw from the research you can let me know by email, though following the interview there is no requirement for you to contact the researcher should you not wish to.

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

All the interviews will be written up and analysed. This means they will be compared to one another to find similarities or themes. These themes will be written up in a final paper.

**Confidentiality**

Keeping information confidential is very important in research.

Everything we discuss during the research will be confidential between myself and my research supervisors. If we meet in a public place then we can discuss prior to meeting how

best to maintain privacy and confidentiality though, in public places this cannot be guaranteed by the researcher. The information you provide will be compared to other discussions in order to generate a final report. Direct quotes will be included in the final report but it will be ensured that from the data you cannot be directly identified. At the end of the discussion you can tell me if there is anything you don't want directly quoting in the final report.

Your name will only be on the consent form. This form is kept separate to the research data (written discussion) and will be in a locked drawer which only my supervisors and I will have access to.

Your name will not appear on any of the typed interviews or in the final report.

**Who has approved this research?**

Ethical approval has been sought and granted the University of Hull Faculty of Health and Social Care's, Research Ethics Committee

**Who is organising and funding this research?**

The research is part of a Doctoral Degree in Clinical Psychology and is therefore funded and organised by the University of Hull.

**Who do I contact if I have any questions or I want to make a complaint?**

In these instances – please contact the researcher on the contact details above.

Should you not wish to contact the researcher directly, you can contact one of the research supervisors on:

Dr. Tim Alexander

Email: [T.Alexander@hull.ac.uk](mailto:T.Alexander@hull.ac.uk)

## Appendix J: Interview Schedule

How would you describe yourself?

Can you tell me about the roles you have?

Can you tell me what it is like to be a (insert role)? Explore experiences.

How do you have to be in the role of X? How is this similar or different to being in the role of Y?

Explore how this helps or hinders being in that role.

How does this affect how you think / feel about the roles?

How does this affect how you think / feel about yourself? (Explore wellbeing).

How would you describe yourself in and out of work? Are they similar / different...? (explore differences in roles?)

What would your idea of an ideal woman be? How would you describe her? What would she look like / characteristics would she have?

Do you recognise any of these characteristics in yourself? What's that like?

How do thoughts of the self, fit with the participant's ideals?

Are there any characteristics you would ideally want? What would they be?

Do you think any of these [named characteristics] are they similar or different to you? In what roles?

Appendix K: Participant Closing Information

**FACULTY OF HEALTH AND SOCIAL  
CARE**



**CLOSING INFORMATION FOR PARTICIPANTS**

Thank you for taking the time to participate in this research, your contribution is extremely valuable.

If you feel upset or distressed about anything we have discussed, or that has arisen from our discussion today, then please arrange to see your GP (general practitioner) at your earliest convenience.

Alternatively, the following organisation is contactable by telephone should you wish to talk to someone over the phone.

**SAMARITANS**    08457 90 90 90 (UK number)

Thank you.

Katie Topp

## Appendix: J: Epistemological Statement (reflexive statement)

When embarking on research it is essential to think about what the goals of the research are, and how one plans to achieve said goals (Willig, 2001). In order to do this, one must have an epistemological stand point (Willig, 2001). Epistemology is essentially concerned with the nature of knowing, and how we know what we know. The present research aimed to investigate the experiences of women holding multiple roles in both civilian and military environments, essentially, what it is like to do that, how the women see themselves (identity, sense of self), how they manage that, and the implications it has on them and their wider context. It seems rational that one would need to ask said women, who live that, what it is like, in order to gain insight into their experience. This is in line with the fundamental assumptions of phenomenological approaches using qualitative methodology. In order to utilise a qualitative approach, one must believe that there is a 'phenomenon' to investigate. Phenomenology refers to the "philosophical approach to the study of experience" (Smith, Flowers & Larkin, 2009 p11). Critical realists, or post-positivists, being ontological realists believe that 'data' does inform reality, though there is a need to go further than purely the data, in order to construct a wider picture (Harper, 2011). Phenomenologists are neither realist nor relativist, and find themselves toward the middle of both ontological positions, however, they do go beyond the text, in order to interpret meaning (Harper, 2011). Given that I have been studying for a doctoral degree in clinical psychology, and having interests in psychodynamic psychotherapy which both are primarily concerned with analysing the experiences of others (Smith, Flowers & Larkin, 2009) the qualitative way seemed to fit naturally with my clinical models of choice and seemed imperative to answer the research question posed.

Interpretative Phenomenological Analysis (IPA) is a way of examining lived experiences, i.e. the sense that someone has made of their experience, their perceptions, thoughts and reflections (Smith, Flowers, & Larkin, 2009). This is not with the agenda of fitting it into a pre-existing, or predetermined set of ideas, but rather to explore subjective experience with curiosity, in order to create new meaning and understanding (Smith, Flowers, & Larkin, 2009). Reminiscent of the process of therapy, Hinshelwood (1991) describes rather than hypotheses being formed and the evidence collected in regards to that specific theory, the hypothesis is ongoing, idiosyncratic and changing with new information, he described the ‘evidence’ being the fate of the hypothesis in the interpretation between patient and therapist. Nor though is IPA a quest for ‘the truth’, given the method relies on the account of the participant, it is their ‘truth’, their attempt to make sense and give meaning to their experiences that is the core essence of the research. This double hermeneutic, whereby it is the researchers job to interpret the individuals account of their experience, means that this methodology relies on ‘second order’ sense making (Smith, Flowers, & Larkin, 2009). This means that the researcher is an integral part of the process, since, being human they approach the situation through their lense, bringing with them their experiences, pre-conceived ideas, and ‘schemas’ in which they organise the world they live in. Again, this approach seemed and continuously seems to fit logically within the field of clinical psychology, or how I view the field, given that it seems to be the fundamentals of our work. Once again, the cross overs to therapy, from my perspective cannot be ignored. The process of knowing one’s self and what the therapist brings to the therapeutic encounter is integral, just as it is with the process of research. Holding these perspectives in high regard to all aspects of my work, meant that the qualitative methodology, more specifically IPA for this



specific piece of research was the only way. I have suspicions that this will be the first of many qualitative endeavours.

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## Appendix: L Segment of Transcript

- 1 K: I was just wondering, because the military seems like quite a  
2 daunting task I think, for anybody, possibly to sort of join in,  
3 P: mmm  
4 K: the challenges and things like that, yeah im just wondering what  
5 that was like for you?  
6 P: well I loved it. To me it was a hobby and a way of spending, work  
7 in the military was like, ooh I'll just do 8 hours work and then I can  
8 play, for the rest of the time, and that was basically what it was. It  
9 wasn't work, it was playing as well. It didn't seem like work to me, it  
10 was just fun.  
11 K: so your reservist role over the years, has that been fun?  
12 P: that is fun, always has been. Mmm. Has its moments. As  
13 everything does.  
14 K: what do you think is particularly fun about it?  
15 P: well its, im in the nationally recruited reserves, so normally, they  
16 meet er for 19 days over the year, and over the years you build up  
17 friendships, and you can be, not see each other for 4/5 months, you  
18 come together and its like just yesterday when you were last  
19 together, and you carry on a conversation that you hadn't quite  
20 finished when you left each other. And they are friends. And they  
21 are friends for life, whenever you need them, and one of my best  
22 friends, I met, we actually served in the same hospital as regulars,  
23 but I didn't realise that until she came to the reserves, and were in a  
24 unit now, just the best of friends. It's marvellous, so you do make  
25 good friends.  
26 K: do you think you've got erm, similar types of friendships in civilian  
27 life?  
28 P: no, no  
29 K: ok  
30 P: I haven't. Erm, ive, I think, I've got more friends in the military  
31 than I have in civilian life.  
32 K: uh hu  
33 P: people you can phone up and you know if you've had a bad day,  
34 you just talk to, and vice versa she will phone me and say life is not  
35 very good, and you just help each other along, whereas, I could not  
36 do that with any of the people I even work with, I, call them  
37 colleagues, they're not friends.  
38 K: mmm. So yes, it seems like longer and more intense friendships.  
39 P: yes, yeah most definitely, mmm,

didn't feel  
like work  
play time +  
fun.

pick up  
where you  
left off  
-never been  
apart  
making  
long  
enduring  
friends.  
Friends  
for life.

different  
to civi  
friends.

civi -  
colleagues  
not  
friends

Relationships  
strong  
bonds

weaker  
relationships  
with civis.

uniform  
as a  
shield  
- protection  
- barrier  
view of self =  
different to  
how others  
view me.  
(which one  
is it?)  
which  
feels  
authentic?

persuasive  
(powerful  
control)

clinical -  
OK to be  
a woman  
in command  
- be manly  
more so  
than the  
men -  
something to prove -  
not weak + feeble  
(who would think you are?)

1 K: ok, and how would you describe yourself in and out of the  
2 military, when you say shy and quite quiet, is that how you would  
3 describe yourself in and out of the military?  
4 P: quiet still, erm I feel more comfortable when im in the uniform. I  
5 think it gives you a sort of shield. That to me is like a shield.  
6 K: what is it shielding against? Or what is it doing?  
7 P: giving you confidence.  
8 K: ah ok the uniform gives confidence.  
9 P: yes, id say that, erm having said that, I know, other people will  
10 think I'm quite forceful, but I consider myself quite quiet.  
11 K: mmm so maybe military friends, or colleagues might say  
12 P: see me differently. Oh yes, I think they probably would.  
13 K: how do you think they might describe you?  
14 P: one described me very accurately, a few years ago, in so far as she  
15 said, I was in command at the time, and I, we were having a meeting  
16 and I put forward a suggestion, and everybody had their say, and  
17 different suggestions, and so we talked, and in the end she turned  
18 round to me and said, I don't know how you do it, but from  
19 opposing views, you can turn everyone round to your own way of  
20 thinking and get your own way in the end. Without any argument or  
21 whatever, so I would say I'm persuasive. Not quite sure how it  
22 worked, but I was.  
23 K: yes, so persuasive, yes, that takes a lot of skills, listening to  
24 people, but also getting everybody to see your perspective. Mmm  
25 OK, there was a question on the top of my head and its just [pause],  
26 oh, what's it like being a woman in the military? In the reservists?  
27 P: erm, mmmm, I think depending on the type of job you're doing It  
28 makes a difference.  
29 K: ok, could you tell me about that  
30 P: so, I was doing my clinical role, that has no bearing on it  
31 whatsoever, whether you're male or female, so long as your, the  
32 clinical skills are there. There are times, when I feel, ive been doing  
33 an administrator type role, like a staff officer type post, or a  
34 command, you've got to, I feel one has to be more, more military  
35 than the men almost  
36 K: more manly than the men?  
37 P: more manly, just to say, im not a weak and feeble female, I am  
38 just as good as you are. But it is very difficult sometimes. Some

nurse OK to  
be a woman  
soldier -  
NOT OK

sexism?

Be good -  
be better  
work harder  
than the  
men.

changing  
world.  
culture?

question -  
woman in  
the Army?  
really?

children -  
questions  
your loyalty  
as a mother

- what about  
the men?

- one thing  
that does  
separate

men + women  
- ability to  
have

children!

- you a  
woman -  
realisation

- go! leave

less need  
to prove self as  
you get higher in rank . 12

1 men might look at you and say oh she's just a woman. That type of  
2 attitude, so you've got to overcome that

3 K: how do you do that?

4 P: just be good. You've got to be, and sometimes, you've got to  
5 work harder than you would, than you feel the men have to work, to  
6 get the same results. And I don't mean intellectually, you've got to  
7 be seen to be doing more, almost, erm I feel.

8 K: does that change with time do you think? As you get sort of  
9 [promoted]

10 P: things have changed an awful lot over the years, I, from going  
11 back [redacted] so going back, those days, to now,  
12 totally different Army. Different world.

13 K: what is it like now?

14 P: it's a lot better, much better. Mmm far more equal, everybody is  
15 considered equally, apart from, I still think there is that little bit,  
16 female in the Army. There was an awful lot of resentment, and on  
17 my part, resentment, about females being allowed to serve even  
18 after they've had children. I think the feeling was, where does their  
19 loyalty lie, with the Army or with their family? and I think it must be  
20 a very difficult situation for a female to be in, to have children and  
21 go on operations. I've never had that problem. And there were, are  
22 people who thought, and I thought, if you have a child, that's it, out.  
23 You should be out.

24 K: right, so you feel that

25 P: yeah, I feel that you can't give 100% to the Army if you have  
26 children. Well that's my view.

27 K: yep, yeah, well, having a family, must add a whole, other level

28 P: a while different dimension to it. Yes, very very difficult when you  
29 see these young mums on operations, and it's very very difficult for  
30 them.

31 K: mmm do you think it changes as you get higher in the ranks?  
32 What its like to be a woman?

33 P: erm [pause] do you mean attitudes towards you?

34 K: yeah, attitudes towards you, or how, I suppose what you were  
35 saying before it sounded like you have to prove yourself a bit more,  
36 than the men. Does that change?

37 P: I don't think I need to prove myself as much now. But I am  
38 coming towards the end of my career, ive only got another [redacted]  
39 to serve.

Skills  
over come  
gender  
equality.

All or  
nothing

big ask  
- devote  
your life.

Appendix M: Table of Emerging Themes

Constructing identity	Notes	Quotes
Gender identity	Comparing yourself to a man / competition / being just as good or better than a man Women as equal	“If a man can do something, a woman has got to do it at least, 1 ½ to 2 times better to be equal” “More manly [than the men], just to say, I’m not a weak and feeble female”
		“my brothers were all in the army at the time, so it was well, I could do that”
Defy stereotypes / gendered expectations?		“do what you want to do, don’t be held back” “don’t listen too much to what other people think you should be like”
Independence	Not needing a man	“you wear your own rank, I don’t have to wear my husband’s rank on my handbag” “im totally independent”
Professional identity	Being a nurse first above military self ?	
Influences on identity development	Some Strong mother figures Vs sense of rebelling against mother	“my mum did all that, I think my mum was quite an independent sort of woman as well”
The false self / military self?		“a bit like ducks on water” “the swan effect”
Ideal self	(very close to actual self)	“ive just described my ideal person, its me!” (person) doesn’t define gender.
Gender commitments (ought self? – responsibilities, etc.	women (not letting it hold you back Vs making sacrifices) Prioritising	“you’ve got to have agreement from your husband, and to look after your children” “it was a case of, married life, or being separated, in different countries even” “I like being near my family, my mum and dad, but it doesn’t stop me from going off and doing lots of things, but I like to come home”.

<b>Escaping reality</b>	But also cutting of from reality / new reality when away with the army	“its my other world, it gets me away from home”.
Tasks and demands of gender role		“It’s nice to go and play with the boys”
Escaping busy life / relinquishing control		“you don’t have to worry about the washing, shopping, cleaning...” “break from everyday life”
	Don’t even have to think very much... Follow the plan, go with the flow / fit in	“funnily enough, when im away with the military, it’s all planned for you, so I just switch off”
Military as another world / country with own set of cultural norms...	Speaking a different language	“my father was military, so ive been military all my life” “and I can also communicate better with the military personnel, because I speak the same language!”
<b>Culture</b>  In group out group of civi and military then in group out group of regulars and reserves?	Individualist vs collectivist. Individuals in a collectivist...  More than collectivist – ‘as one’? so that’s why it feels so disappointing, when they ‘regulars’ leave, abandon you as a reservist – you have to go home, not surrounding by your ‘mates’  Used and abused?  Adjustment for reservists... sense of it being hard to settle after op tours, and the circumstances don’t help.	“in the military, you can’t be out there for yourself, you’re out there for a shared cause really” “everyone’s been through it, and understand you, know what you saw, what your living conditions were [gap] you go back to civilian world, they haven’t got a clue” “you miss the people you were with” [deployment] “I don’t think the regulars realise what it’s like for us” “the hardest thing, is when your not particularly well looked after” [by reserves or regulars]
Division of army regulars vs reserves	“The regulars hated us” (past tense) “we were called STABS, stupid TA bastards” “She’s TA, she’s equivalent to a corporal” – actually captain rank	

<b>Role switching</b>	Easier the more military experience you have?	
Separate the two lives		
Compartments		
Practicalities to switching / balancing		“its difficult because of the time”
	Sense of knowing you can do the job, just in a different environment	“all im going to be doing is nursing, but the environment is going to be very different”
Uniform as a symbol?	Indicating the role	“its called putting your uniform on” “I just switch on, just change my clothes”
	More than just a uniform... representation of inner self?  Ideal self = smart uniform	“I think it gives you a sort of shield” “ I could never go to work without my tights on, putting my hair up, and looking smart” Gives you confidence, gives others confidence in you  Pride in uniform, respect in uniform – courage.
Hierarchy changes when you’re in uniform – formalities		“I have to salute him, or remember that he is a colonel, so he is very very important today, but tomorrow, its just [name] and [name]”
Women having more to balance...		“people who can juggle a family and be a reservist, I don’t know how they do it” (don’t know how women do it or people) “Its difficult to balance” [being a mother abroad] “I think women do have a lot to juggle don’t they”
<b>Army as your whole life...</b>		
Being both work and play (glamour, comradeship..)		“the good thing about the army of course is there are lots of exciting extra-curricular activities”
Loyalty element means I stay  (Everyone’s in together, you’re not alone in	Hesitation to speak ill of the military – though Not like that in civi street	“you belong to a unit, and you become very loyal to that particular, the name of the unit, and to that particular group of people”



anything, supported)		
<b>Hierarchy</b> Unquestionable loyalty / don't rock the boat		<p>"we never really bothered too much about rank" Vs "its all about the rank" "if you've been in the TA for a few years, you just learn not to make waves" "If you give someone an order, they carry it out regardless, they don't argue, or debate. They just do it".</p>
Attitudes towards mental health and emotions in general / wellbeing...  Emotions as a sign of weakness Distracting / minimising	<p>Should be a big grown up woman... don't cry Don't be phased.</p> <p>Family and friends, keeping busy, helps – more formal check-ups wanted for reservists.</p>	<p>"I wouldn't cry in the military, at all" "I didn't tell anyone I'd got PTSD [gap] I kept it a big secret" "if im down I find something to do" "im quite happy with my mental health"</p>
Over arching themes of go over and above, and just get on with it		
Life review / gaining perspective on life Following deployment:		<p>"I came back and thought, do you know what, I can do a bit more, and that was it" " I came back realising that my job, in the NHS, wasn't the be all and end all, and there were other things out there that were better" "do I want to be here in 30 years time? {gap} No, I want to do something with my life" (on joining originally)</p>

## Appendix N: Reflective statement

### Picking a research topic

I remember thinking at the start of my clinical training, what on earth do I want to research? For my undergraduate dissertation, I had looked at family members' perceptions of memory in older adults, in comparison to young people. This was in my mind, for something to build on, as I had enjoyed that. I had enjoyed 'testing' participants, and analysing the data. Then I arrived onto the clinical course, and had my eyes opened to the opportunity of interviewing participants, and attempting to capture their lived experiences. This interested me more. I think as clinical psychologists, we are naturally inclined to be curious about what something means to an individual, and attempt to create understanding. This way of approaching research radically changed my outlook, and seemed to fit with my way of thinking. Given there was a number of research supervisors to choose from, my choice for a research project was significantly narrowed, however, there were still a number of options that caught my eye. Following an email that fell short of leading to an exchange of ideas, and being a firm believer in, 'everything happens for a reason', I contacted Dr Claire Wilson, and arranged a meeting. Thinking back, this was a decision, which would shape my training and career in ways I could not imagine at that time.

### Getting the research off the ground

It was following that meeting, the research became a tangible entity, and not just a conceptual vision. The research changed significantly, over the course of the journey from its origin, as I will go on to explain. When I started to review the literature, it was evident that the vast majority of the military research was American, with a smaller evidence base for British Services. Within the literature women had been either included in majority male samples, or had been completely overlooked

altogether. Furthermore, the vast majority of the British research conducted, was from King's College London who have 'KCMHR' which is King's Centre for Military Health Research and 'ADMMH' their Academic Department of Military Mental Health. However, I had read publications from other Universities, so knew it was possible to do something within the field.

I emailed the lead author of the publications from another University and spoke with her about how she had gone about conducting her research. This led to email correspondence with the chair of the MODREC (Ministry of Defence Research Ethics Committee), who said that in order to have active serving members of the armed forces take part in research, the proposal must go through MODREC. This led to toying with ideas of different participants, maybe veterans. A submission was in the end sent to MODREC with a focus on women in active service, which eventually, was rejected. This was a frustrating and disheartening process, which prolonged receiving my ethical approval. It seems that a qualitative piece of research like the present one would not be of benefit to the MoD, in terms of outweighing the cost to the business. This approach to research made me question the way in which military research was commissioned and undertaken in this country. Submitting my ethics application to MODREC felt like a pointless exercise. In my opinion, there should not be such constraints on completing research you want to, particularly when you feel that the research field would benefit from it. Access to participants should be easy and they should be able to make up their own minds whether to participate or not.

Following a meeting with my research supervisors that led to a shift away from focusing on active serving personnel, and making contact with Dr. Janet Kelly, who is herself in the reserve forces, it was decided that a focus on civilians who were also signed up to the Army reserve, would be more appropriate. Interestingly, at this time

my relationship with the research changed. Given the recent government changes, that mean that the Reserve forces make up the overall defence capacity in the UK, it felt like this research was well timed, and of even more importance to me. It felt exciting, after a period of uncertainty and disappointment.

University ethics was applied for, and sought fairly quickly following this (see appendix E). I feel so very grateful to my research supervisors, for their encouragement, fast turnaround of checking proposals, and working to ensure I produced my best work.

### Conducting the research

Given, I had a contact in the Army reserves, recruitment seemed like a really fast process. I am very grateful for the hard work that went in to this. The participants were spread all over the country and abroad, so it was decided that both face to face or telephone interviews would be offered to participants, for convenience. Two participants opted for face to face interviews. On reflection, I wish it had been possible to meet all of the participants in person. The face to face interviews had a different quality to them. There was a lot more emotion, and I felt a real connection to both women. The telephone interviews, though rich, and fruitful, felt one step removed. I also wondered about what these women looked like, and about their mannerisms. I think, sitting in front of me, the two women who were interviewed face to face, were able to connect with me, and both actually cried during the interview. This made me wonder about my influence on the process of the interview. When I was asking about their perspectives on women, and what an 'ideal' woman should be like, measuring success was thought about in different ways, however, all participants knew this was my doctoral thesis, and I wonder what that told them about me as a person. The two women I interviewed face to face, will have visually seen me, being fairly young, blonde, I wear make-up and I present myself as smart

but feminine. I wonder how this shaped the dynamics of the interviewer, interviewee relationship. I felt that sitting in front of someone telling their story made me feel a greater level of compassion, and a real sense of connectedness with their experiences. In the future, I would hope to see all of my participants face to face. Particularly with this group of women, I felt that by meeting with them face to face, there was more of a sense of trust and openness. This gave me the boost that I needed, and I felt a duty to capture as best I could, the lived experiences of these women. Interestingly, I saw a lot of myself throughout the interviews. Being a woman who values equality, and independence, I recognised how much I could relate to my participants. I grew up in a household with parents who had been in, or were at that time in the police force. I recognised some of the same values, including being organised, on time and looking smart, that I grew up with.

### Writing up

The process of writing this thesis, has had its ups and downs. The major saving graces have been the small steps and deadlines put in place by the course. Without those smaller stages, I think the process would have been overwhelming. It has consumed many areas of my life, including my time, however, I could not be more proud of this work. My research supervision has been incredible, and Dr. Lesley Glover has been a very calming, containing influence on me. It was a strange transition from usually interviewing or assessing people in mental health services, to interviewing participants about an aspect of their life, for research purposes. I wasn't purely a clinical psychology trainee at work, I was also a researcher, interested in exploring and seeing where the interview took us both. Throughout the process of 'doing' the research, I was constantly in a state of wondering if I was doing it right. It felt like there had been such a build up to the moment of interviewing my first participant, I felt I put a lot of pressure on myself to do it well. Over the course of

the interviews I felt that I settled into it, I grew more familiar with the types of things I wanted to ask, so it felt like a natural progression, as I found a rhythm. Similarly, as I started the analysis, I was consumed by details, reading sections of the IPA book over and over to ensure it was the 'right way'. This is where my supervision helped so much, and talking the process through with peers, as it emerged everyone was doing it slightly differently, but that was OK. I think I underestimated the time it would take me to analyse the data. This was a much longer process than I had anticipated. However, over time, I felt like I knew each transcript inside and out, even though they were all coded with anonymous identifiers, I could hear each participant's voice, or see their faces. Each interview was unique, with moments of laughter and tears.

Throughout the process of writing up, I found myself longing for a 'perfect' piece of work. An 'ideal' thesis with two papers, I longed to publish. Interestingly, this on a number of occasions gave me writers block and a sense of wanting to stop writing and avoid it altogether. I thought about this in terms of 'Self Discrepancy Theory' as described in my empirical research. The more I was putting down on paper, the more it was becoming a real 'thing'. This 'actual' thesis was there, to be compared to the 'ideal' I had created in my mind, and the sense of it not living up was making me uncertain and anxious about the final product. Once I had made a parallel link between the processed and thought about it, I was able to let go of the 'ideal' and focus on the 'actual'. I did not struggle to write following that.

Thinking about the above and to what extent my inferiority complex surfaced and disappeared, it was clear when I thought about it, that I was comparing myself to the women in my study, or perhaps looking up to them. Either way, these women are people who get things done. They 'administrate' themselves and take care of things. I think the part of me that identified with them was seriously conflicted. Part of me

was wanting to get on with it, full steam ahead and complete the task, where the other side knew there was a process, knew that it takes time to complete research of this nature, to be thoughtful and reflective. This was an ongoing struggle to balance, however, when undertaking a piece of research like this, I knew that balance was key.

### Systematic Literature Review

I arrived at my question fairly quickly actually for my SLR. I think there is something in both my pieces of work about 'starting from the beginning'. It seems to me that research has been conducted in the field, however, for me I felt that some of the early steps were missing. It seemed like such a basic question: what do people in the British military think about mental health problems and what stops them from accessing care? However, there was not an SLR focusing on purely this. I mentioned earlier in the reflective statement that I couldn't have imagined at the time, when I contacted Dr Claire Wilson, (Humber Traumatic Stress Service) what the future held, and by this I meant that I went on to have a placement with Claire, and secure a job as a fully qualified member of staff following the course. The SLR now, has even wider implications for me working clinically with ex-military personnel and reservists who have been traumatised. It made me realise that the people we see, are more than likely the small minority and it makes me wonder how many other people out there are suffering in silence due to the factors discussed. I hope to continue investigating this issue in the future.

### Choice of Journals

I really struggled choosing a journal for my empirical research paper. I toyed with the idea of nursing journals, but most of them wanted 'practitioner points', useful for

nursing practice. I read the articles that had been published in the field and they had been published in a variety of journals. I ultimately thought to myself – where does my research fit, who would it be of value to and there was an element of practicality too i.e. word count. I decided on the British Journal of Psychology.

My systematic literature review, personally, I wanted to be in a prominent clinical psychology journal. I opted for the British Journal of Clinical Psychology in line with this.



