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BASIC RESEARCH ARTICLE

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'Man up and get on with it': a qualitative exploration of UK ex-serving personnel's experiences of seeking help for self-harm and suicidal behaviours

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ABSTRACT

Background: A substantial proportion of UK military personnel experiencing mental health problems do not seek professional support. Although the promotion of help-seeking is a key suicide prevention strategy, little is known about help-seeking for self-harm and suicidal behaviours among the UK Armed Forces.

Objective: This study aimed to explore UK ex-serving personnel's experiences of seeking help for self-harm, suicidal ideation, and suicide attempts.

Method: Participants were recruited via an existing longitudinal cohort study exploring the health and well-being of the UK Armed Forces. A subgroup of ex-serving personnel reporting lifetime self-harm and/or suicidal behaviours was invited to participate in semi-structured interviews and 15 individuals participated, representing help-seekers/non-help-seekers and formal/informal support. Interviews were analysed using reflexive thematic analysis.

Results: Five distinct but related and interacting themes were developed: (1) military mindset; (2) stigma; (3) fear of consequences; (4) access to and awareness of support; and (5) facilitators to help-seeking.

Conclusions: Help-seeking decisions and experiences were influenced by several barriers and facilitators. Providing an environment where military populations feel willing and able to access support for self-harm and suicidal behaviours could lessen the impact on their health and well-being and ultimately save lives.

'Sé un hombre y sigue adelante': una exploración cualitativa de las experiencias de exmilitares del Reino Unido en la búsqueda de ayuda para autolesiones y conductas suicidas

Introducción: Una proporción considerable del personal militar del Reino Unido con problemas de salud mental no busca apoyo profesional. Si bien, promover la búsqueda de ayuda es una estrategia clave para la prevención del suicidio, se sabe poco sobre la búsqueda de ayuda para las autolesiones y las conductas suicidas en las Fuerzas Armadas del Reino Unido.

Objetivo: Este estudio tuvo como objetivo explorar las experiencias del personal militar retirado del Reino Unido en la búsqueda de ayuda por autolesiones, ideación suicida e intentos de suicidio.

Método: Los participantes fueron reclutados a través de un estudio de cohorte longitudinal existente que exploraba la salud y el bienestar de las Fuerzas Armadas del Reino Unido. Un subgrupo de exmilitares que reconocieron haber tenido autolesiones o comportamientos suicidas a lo largo de su vida fue invitado a participar en entrevistas semiestructuradas, participaron 15 personas representando a quienes buscaban ayuda, quienes no la buscaban y quienes recibían apoyo formal e informal. Las entrevistas se analizaron mediante análisis temático reflexivo.

Resultados: Se desarrollaron cinco temas distintos, pero que se relacionan e interactúan entre sí: (1) mentalidad militar; (2) estigma; (3) miedo a las consecuencias; (4) acceso y conocimiento del apoyo; y (5) facilitadores en la búsqueda de ayuda.

Conclusiones: Las decisiones y experiencias de búsqueda de ayuda se vieron influenciadas por diversas barreras y facilitadores. Brindar un entorno donde la población militar se sienta dispuesta y capaz de acceder a apoyo para las autolesiones y las conductas suicidas podría reducir el impacto en su salud y bienestar y, en última instancia, salvar vidas.

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PALABRAS CLAVE

Autolesiones y conductas relacionadas; suicidio; personal militar; veteranos; comportamiento de búsqueda de ayuda; investigación cualitativa

HIGHLIGHTS

- This qualitative study explored UK ex-serving personnel's experiences of seeking help for self-harm, suicidal ideation, and suicide attempts.
- Five themes were developed, highlighting positive and negative experiences, and barriers and facilitators to help-seeking: military mindset, stigma, fear of consequences, access to and awareness of support, and facilitators to help-seeking.
- Providing an environment where personnel feel willing and able to access support for self-harm and suicidal behaviours could improve health and well-being, and ultimately save lives.

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1. Introduction

Members of the Armed Forces encounter unique occupational experiences (e.g. deployment on combat operations) which can affect their health and well-being during and after service (Stevelink et al., 2018). This potentially increases the risk of self-harm and suicidal behaviours, as mental health problems are a risk factor for these behaviours (Williamson et al., 2024). For instance, a systematic review identified several health-related factors that increased the risk of self-harm among UK military populations (making it approximately two to eight times more likely) (Williamson et al., 2024). These included a clinical or probable diagnosis of post-traumatic stress disorder (PTSD) (Bergman et al., 2019; Jones et al., 2019; Pinder et al., 2012), depression (Jones et al., 2019; Pinder et al., 2012), and anxiety (Bergman et al., 2019; Jones et al., 2019), and a history of suicidal ideation (Jones et al., 2019).

Although self-harm and death by suicide are relatively rare among the UK Armed Forces, rates have increased in recent years, but typically remain lower than or comparable to those in the UK general population (Ministry of Defence, 2019, 2024; Office for National Statistics, 2024; Rodway et al., 2023). A 2024 report from the Ministry of Defence reported seven coroner-confirmed deaths by suicide in 2023 among UK Regular Armed Forces serving personnel, representing less than one death per 1000 personnel (Ministry of Defence, 2024). Across the 20 year period between 2004 and 2023, there were 283 suicides among UK Regular Armed Forces serving personnel, including an increase of 21 deaths since 2018 (Ministry of Defence, 2024). Suicide deaths among UK ex-serving personnel have not been as well recorded. In 2021 in England and Wales, there were 5175 suicide deaths in those aged 16 years and older (Office for National Statistics, 2024). Of these, 253 suicides (4.9%) occurred in ex-serving UK Armed Forces personnel, equivalent to 15 per 100,000 ex-serving UK Armed Forces personnel (Office for National Statistics, 2024). Existing literature also suggests that many people who die by suicide have previously engaged in self-harm (Carroll et al., 2014; Chan et al., 2016) and suicidal behaviours (Favril et al., 2023), and that a history of self-harm is the strongest risk factor for dying by suicide in high-income countries (Knipe et al., 2022).

Several groups at risk of suicide within military populations have been identified; for instance, suicide risk was two to three times higher among UK ex-serving personnel aged < 25 years, compared to the same age group in the UK general population (Rodway et al., 2023). Additional risk factors have been identified for self-harm and suicidal behaviours among military populations, including childhood adversities, being single or in an ex-relationship (i.e. separated, divorced, widowed), junior ranks, shorter length of service, exposure to deployment-related traumatic events, and clinical or probable mental health diagnoses (e.g. PTSD, anxiety, depression) (Williamson et al., 2024).

Despite the vast interest in help-seeking for mental health problems, there remains no agreed definition or conceptual framework (Rickwood & Thomas, 2012). One proposed definition for help-seeking for mental health problems is 'an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns' (Rickwood & Thomas, 2012, p. 180). Help-seeking can encompass formal support typically received from professionals [e.g. clinical psychologist, general practitioner (GP)] or informal support from social networks (e.g. friends, family) (Rickwood & Thomas, 2012).

Across the past decade, the (under-)utilization of mental health services by serving and ex-serving personnel has received growing research attention (Jones et al., 2015; Rafferty et al., 2020; Sharp et al., 2015; Stevelink et al., 2019; Williamson et al., 2019). Existing systematic reviews have identified several barriers to help-seeking for mental health problems, including stigma, stoicism in military culture, and self-resilience; and facilitators, including reducing help-seeking stigma and receiving peer support (Coleman et al., 2017; Randles & Finnegan, 2022; Sharp et al., 2015), but the majority of included papers were quantitative and from the USA, where health services vary and the structure and processes of the Armed Forces are notably different from those in the UK. For instance, in 2024, the strength of the UK Armed Forces was approximately 180,000 serving personnel (Ministry of Defence, 2024), whereas the strength of the US military was over 1,300,000 serving personnel (Department of Defense, 2024).

To the best of our knowledge, there are no existing qualitative studies which explicitly explore UK ex-serving personnel's experiences of seeking help for self-harm and suicidal behaviours, which may involve different help-seeking barriers than mental health problems owing to the stigma associated with these behaviours. The 2024 Ministry of Defence Armed Forces Suicide Prevention Strategy and Action Plan for UK serving personnel highlights eight focus areas to reduce the incidence and impact of suicide (Ministry of Defence, 2024); however, there is currently no equivalent strategy for ex-serving personnel. Therefore, there remains a need for UK qualitative data to help to inform future policy, prevention, and support services. This study aimed to explore UK ex-serving personnel's experiences of seeking help for self-harm, suicidal ideation, and suicide attempts.

2. Method

2.1. Sample

Participants were recruited via an existing longitudinal cohort study, the King's Centre for Military Health Research (KCMHR) cohort study, set up to explore the long-term health and well-being of the UK Armed Forces. The cohort includes Iraq- and Afghanistan-era serving and ex-serving personnel (Regulars/Reservists, tri-services), and has been conducted over four phases of data collection between 2004 and 2023 (Fear et al., 2010; Hotopf et al., 2006; Sharp et al., 2023; Stevelink et al., 2018). In Phase 4 of the KCMHR cohort study (2022–2023), there were 4104 participants. Participants were eligible to take part in this qualitative study if they:

- participated in Phase 4 of the KCMHR cohort study
- self-reported lifetime self-harm, suicidal ideation, and/or suicide attempts via the Clinical Interview Schedule – Revised (CIS-R) (Lewis et al., 1992)
- consented to future contact
- held a permanent UK address, allowing the risk protocol to be followed responsively and responsibly
- had left the UK Armed Forces [i.e. ex-serving/veteran, having served a minimum of one day paid employment in the UK Armed Forces but no longer serving (Office for Veterans' Affairs, 2020), irrespective of deployment experience and discharge type].

A subsample of Iraq- and Afghanistan-era ex-serving personnel meeting the above inclusion criteria was sampled, resulting in the recruitment of a diverse sample in terms of sex (male/female), service branch (Army/Naval Services/Royal Air Force), enlistment status (Regular/Reservist), experience of behaviours (lifetime self-harm/suicidal ideation/suicide attempts), help-seeking status (help-seeking/non-help-seeking), and mode of help-seeking (formal/informal/both). Only ex-serving personnel were recruited to explore self-harm and suicidal behaviours across time (i.e. before/during/after service).

2.2. Procedure

A semi-structured interview schedule (Supplementary material 1) was constructed based on the study aims and informed by existing qualitative research about help-seeking for mental health problems and other sensitive topics among UK military populations. The interview schedule was reviewed by the KCMHR Veterans' Research Advisory Group and clinical staff at KCMHR to direct the phrasing of questions. Terminology for study materials was discussed with a self-harm lived experience expert and the NATO Research Task Group 277 'Leadership Tools for Suicide Prevention'. Pilot interviews were conducted with research and clinical professionals working with ex-serving personnel experiencing mental health problems, which further shaped the language and order of the interview schedule. Interviews consisted of three broad sections: (1) military history; (2) reasons for engaging in self-harm and/or suicidal behaviours; and (3) help-seeking experiences.

Recruitment took place between July 2023 and January 2024. Overall, 32 UK ex-serving personnel were invited to participate by e-mail or text, including weblinks to the Participant Information Sheet and Signposting Booklet, which detailed relevant support services. Non-responders were contacted up to two further times. Interested individuals completed an online questionnaire via Qualtrics to check their eligibility and collect data on help-seeking status and mode of help-seeking in relation to self-harm and suicidal behaviours. Eligible participants completed an online consent form.

Overall, 19 consented, one declined, and 12 did not respond. Reasons for non-response remain unknown, but may include incorrect contact details or the individual not being interested in participating. Of those who provided consent ($n = 19$), 15 went on to be interviewed and four withdrew or were withdrawn. Reasons for not completing an interview after providing consent included: lost contact with the participant while scheduling the interview ($n = 1$), the participant withdrew before the interview owing to a misunderstanding of the study aims (i.e. wanted clinical support; $n = 1$), and the participant being withdrawn by the researcher during the interview as they were not eligible to participate (i.e. the participant stated in the interview that they had never experienced self-harm and/or suicidal behaviours, despite self-reporting at least one behaviour in the Phase 4 questionnaire; $n = 2$). A flowchart of the study procedure is provided in Figure 1.

Fifteen interviews were conducted via telephone or a Microsoft Teams audio call. Interviews ranged from 30 min to 1 h 40 min (mean = 57.5, $SD = 22.6$). Participants were sent a £25 e-voucher to thank them for their time and were followed up with a well-being call, e-mail, or text to check how they were feeling after the interview and whether they required support.

To ensure participant safety, a robust risk protocol was developed, which included guidelines to follow if risk was identified (e.g. clinical risks, abuse). Interviews were audio-recorded and transcribed verbatim by the lead researcher (CW) ($n = 8$) and an independent professional transcriber who had signed a confidentiality agreement ($n = 7$). Participants agreed to this sharing of data in the consent form. All interview data and transcripts were stored using a unique

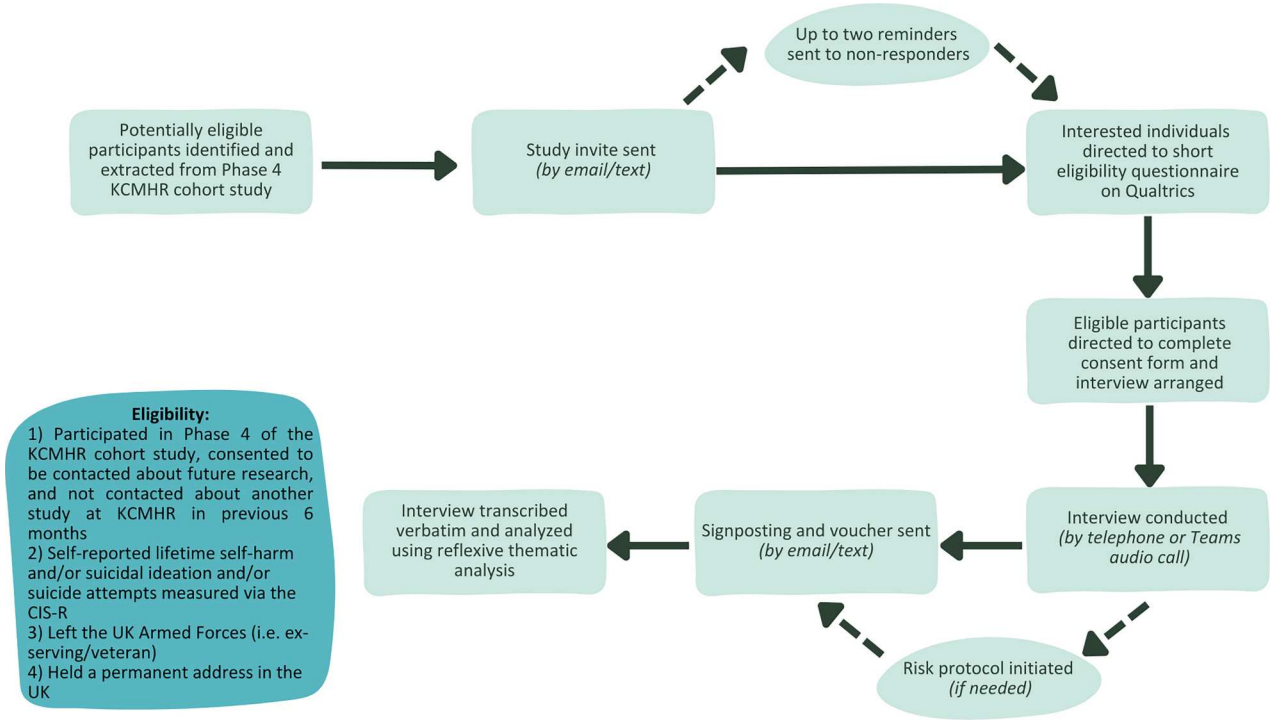

Figure 1. Flowchart of qualitative study methodology.

Note. Dashed lines represent additional steps taken if applicable. KCMHR = King's Centre for Military Health Research; CIS-R = Clinical Interview Schedule – Revised.

identifier and separately to identifying information, and pseudonyms were applied.

2.3. Analysis

Reflexive thematic analysis (RTA) (Braun & Clarke, 2019) was used to analyse data. RTA is useful for identifying, analysing, and interpreting (sub)themes across participant responses, but emphasizes the researcher's interpretive engagement with the data (Braun & Clarke, 2019). Reflexivity involved reflecting on how the researchers' experiences and perspectives potentially influenced the work. A reflexivity statement is included in Supplementary material 2.

RTA was conducted on interview transcripts following six phases: (1) data familiarization; (2) data coding; (3) initial theme generation; (4) theme development and review; (5) theme refining, defining, and naming; and (6) writing up (Braun & Clarke, 2022). Primarily, an inductive (i.e. 'bottom–up') approach was adopted to allow for the identification of patterns within the data. However, analyses were also influenced deductively (i.e. 'top–down') owing to vast knowledge of research in the field, which may have subconsciously shaped the (sub)themes developed. Interview transcripts were coded using NVivo14. Preliminary (sub)themes were developed from groups of initial codes, and a thematic map was created by the lead researcher (CW), which was reviewed by the research team, and (sub)themes were further revised and refined.

2.4. Ethical approval

This study was reviewed and approved by the local ethics committee of King's College London (Ref: HR/DP-22/23-33994).

3. Results

Sample characteristics are outlined in Table 1. The average age was 51.2 years (range 37–62 years). Among ex-Regulars, the number of years since leaving service ranged from 4 to 25 years. The sample included help-seekers ($n = 8$) and non-help-seekers ($n = 7$).

Participants detailed what they believed to be the reasons behind why they engaged in self-harm, suicidal ideation, and/or suicide attempts. Some of these reasons were military related (e.g. trauma from deployment, medical discharge from service), but many reflected issues experienced by wider society (e.g. marital breakdown, bereavement, loneliness). Several participants also reflected that their self-harm and/or suicidal behaviours related to comorbid existing mental health problems, such as PTSD, anxiety, and depression. For many, self-harm and suicidal behaviours occurred after experiencing multiple stressors or a combination of several circumstances all together.

Participants also described their self-harm and suicidal behaviours manifesting in various ways and methods included self-harm (e.g. cutting, head banging, excessive alcohol or drug use), passive suicidal

Table 1. Sample characteristics.

	Consented ($n = 19$)	Interviewed ($n = 15$)
Sex (baseline data)		
Male	14	10
Female	5	5
Nation (Phase 4 data)		
England	15	12
Wales	3	2
Scotland	1	1
Northern Ireland	0	0
Service branch (baseline data)		
Naval Services	2	1
Army	11	8
Royal Air Force (RAF)	6	6
Enlistment status (baseline data)		
Regular	12	9
Reservist	7	6
Rank (Phase 4 data)		
Commissioned officer (CO)	4	3
Non-commissioned officer (NCO)	13	10
Other ranks	2	2
Behaviours experienced (Phase 4 data)		
Self-harm only	2	0
Suicidal ideation only	11	10
Suicide attempt(s) only	0	0
Multiple behaviours[a]	6	5
Help-seeking status (eligibility questionnaire data)		
Non-help-seeking	11	8
Help-seeking	8	7
Help-seeking mode[b] (eligibility questionnaire data)		
Formal only	3	3
Informal only	0	0
Both	5	4

Notes: Baseline data refer to administrative database variables from entry to the King's Centre for Military Health Research (KCMHR) cohort study. Phase 4 data refer to data collected during Phase 4 (2022–2023) of the KCMHR cohort study. Eligibility questionnaire data refer to data collected when checking eligibility for the present qualitative study. Naval services include the Royal Navy and the Royal Marines.

[a]'Multiple behaviours' includes experience of two or more behaviours of self-harm, suicidal ideation, and suicide attempts.

[b]Restricted to help-seekers only.

ideation (e.g. thoughts of being better off dead), active suicidal ideation and/or suicide planning (e.g. planning to overdose, stabbing or cutting, reckless driving), and suicide attempts (e.g. overdose of tablets).

Participants' experiences of help-seeking for self-harm and suicidal behaviours were split into five distinct but related and interacting themes, each of which was further divided into subthemes (Figure 2).

3.1. Theme 1: Military mindset

The military mindset was a dominant barrier theme, referred to directly or indirectly by help-seekers and non-help-seekers, and separated into subthemes of masculine norms and help as a weakness. The military mindset is generally regarded as a set of values, principles, and frameworks cultivated in the Armed Forces to guide the individual towards a successful military career, and was summarized by one participant as:

> It's almost that you just gotta get on with it and it that sort of don't be weak mentality … it was very much a man-up attitude and that was all the way through my Army career. (Ryan, Army, ex-Regular, help-seeking)

3.1.1. Subtheme 1a: 'Man up': masculine norms

Although under increasing scrutiny in recent years, masculine norms (i.e. the set of societal beliefs and expectations about how men should behave) are engrained in society, and these norms,, particularly attributes such as emotional stoicism and autonomy, are heightened in the global military context (Abraham et al., 2017). Participants explained that masculine norms and the expectation of self-resilience during service were part of the mindset: 'Yeah you keep it to yourself sort of thing … it all used to be like just man up and get on with it' (Rebecca, RAF, ex-Regular, non-help-seeking). Societal masculine norms were reinforced by the male-dominated environment and military training: 'I think that's probably reinforced it, the macho stereotype kind of thing' (Ben, Army, ex-Reservist, non-help-seeking).

Masculine norms encouraged stoicism and self-resilience, and were a help-seeking barrier owing to contradiction with the engrained military mindset, which slowed or prevented disclosure of self-harm and suicidal behaviours, and therefore delayed or prevented the individual recognizing the problem and seeking help.

3.1.2. Subtheme 1b: Help as a weakness

Another element to the military mindset was considering seeking or receiving help as a weakness, a view initiated in service: 'Well, definitely the military mindset … it definitely was a sign of weakness (to ask for help), without a shadow of a doubt' (Ryan, Army, ex-Regular, help-seeking), and remained post-service. This view was further shaped by military identity. Specifically, those in senior ranks (e.g. commissioned officers) or medical roles battled being help providers versus receivers, and so did not seek help: 'The overwhelming feeling I've got is that asking for help is a weakness and therefore it's not something that urm, when you've been in a sort of slightly senior role that that is not something that you would do' (Steve, RAF, ex-Regular, non-help-seeking).

This was a barrier for help-seekers and non-help-seekers owing to concerns about how their own and others' perceptions of them might deviate from the military expectation of being 'strong', physically and mentally.

3.2. Theme 2: Stigma

Another barrier theme was stigma, comprising several subthemes and encapsulating various types and aspects of stigma: organizational stigma, anticipated stigma, the societal hierarchy of health conditions, and self-stigma. Stigma was experienced by help-seekers and non-help-seekers on an organizational, societal, and individual level, with reference to stigma associated with self-harm and suicidal behaviours,

Figure 2. Overview of help-seeking themes and subthemes.
Note. Dashed lines represent interactions between themes.

with mental (ill-)health, and with help-seeking for either of these problems. Feeling embarrassed or ashamed about these behaviours and the societal hierarchy of health conditions were key elements to these stigma-related help-seeking barriers.

3.2.1. Subtheme 2a: Organizational stigma

Reflecting the military mindset, participants described the effects of stigma within the organizational context of the military: 'I've always felt while I've been in the military, there is always that stigma of people that go sick, one with injuries, but two with mental injuries as well' (Ryan, Army, ex-Regular, help-seeking).

Although asked specifically about help-seeking for self-harm and suicidal behaviours, participants shared that mental health was a taboo subject while serving: '[mental health] was taboo, it didn't get talked about' (Ben, Army, ex-Reservist, non-help-seeking). One participant explained that, in their experience, it was assumed that personnel were 'faking' mental health problems to get out of exercise, therefore impacting upon personnel's decisions and experiences surrounding help-seeking:

> The natural assumption is you're faking it … the majority of the time the chain of command will be questioning whether or not it's true or not … it was always, is he just doing this because he doesn't wanna go on exercise next week? (Ryan, Army, ex-Regular, help-seeking)

This taboo was a barrier among non-help-seekers owing to negative perceptions about mental ill-health and the expectation that personnel should be self-resilient and keep emotions and problems to themselves. This encouraged a lack of disclosure and discussion around mental (ill-)health, resulting in a lack of help-seeking for mental health and related behaviours. For some, the taboo shifted after transitioning to civilian life. Although the mindset remained in some respects (e.g. work ethic), in other ways it eased, allowing for open discussion:

> I actually started talking to people as in talking to them about stuff. Not saying that I wanted to top myself but saying that, you know sort of actually was opening up a bit more instead of bottling it all up and keeping it to myself. (Rebecca, RAF, ex-Regular, non-help-seeking)

3.2.2. Subtheme 2b: Anticipated stigma

Help-seekers and non-help-seekers described the anticipated effects of stigma from others as a help-seeking barrier. These beliefs demonstrated some level of reinforcement of negative societal stereotypes about being 'mad' or 'weak' if they disclosed self-harm and suicidal behaviours or sought help. Participants described concerns about stigma from others if they sought help:

> Again I think it's just the shame side of it. I just don't want people to think that of me. You get this image in your head of you are the strong one, you are doing a responsible job, you know you're above this and you don't want to admit to them … it's easier for me to keep things to myself because I don't, I can't bear the thought of coping with all people knowing and people talking about me. (Pete, RAF, ex-Regular, non-help-seeking)

Participants anticipated others to view them as weak for seeking or receiving help and were concerned about additional judgements that might be made if they disclosed self-harm and/or suicidal behaviours, such as assumptions that might initiate clinical consequences:

> I didn't want people to assume that because I was self-harming that I was a real serious risk to myself or others. I didn't want people overreacting and I didn't want to be judged and I didn't want to be the, I didn't want to be sectioned or carted off to hospital. (George, Army, ex-Reservist, help-seeking)

3.2.3. Subtheme 2c: Societal hierarchy of health conditions

The societal hierarchy of health conditions was described by participants, including the severity of conditions and experiences, and who deserved support. Although considered a broader societal view, this was evident in the military context: 'And I think the problem in society, and in the military, is it's still like a metric of urm [sigh], an equation of when you're entitled to have mental health problems' (Ben, Army, ex-Reservist, non-help-seeking). This view often presented itself with participants feeling undeserving of support:

> I'm struggling every day don't get me wrong but I don't seek help because I feel I'm taking that help away from someone who needs it more … I know guys who, they've lost their legs, they've lost an arm, or an arm and both legs … they need that care more than I do. (Owen, Army, ex-Regular, help-seeking)

This downward comparison, where participants compared themselves to others who they perceived to be worse off than themselves, prevented help-seeking for self-harm and suicidal behaviours.

3.2.4. Subtheme 2d: Self-stigma

Participants also expressed self-stigma, which included the internalization of negative societal stereotypes and stigmas about mental ill-health, and self-harm and suicidal behaviours, contributing to negative self-concept and a lack of self-efficacy. Self-stigma was accentuated in certain roles (i.e. medical) that provided help to others, as they felt they should not require help themselves: 'Oh I felt very embarrassed initially. I was thinking come on, you're a [medical] professional, you shouldn't need this' (Sarah, Army, ex-Reservist, help-seeking).

Both help-seekers and non-help-seekers discussed the specific self-stigma of embarrassment and shame of disclosing difficulties, and of seeking help, as a barrier to help-seeking: 'And the, suicidal, I mean, there's I think there's the shame, the fear that you're going to get thrown in a "looney bin" … obviously more recently I know that that's not the case, but you still feel ashamed' (Ben, Army, ex-Reservist, non-help-seeking). Embarrassment and shame appeared to stem from the engrained military mindset, anticipated stigma, and perceived severity of self-harm and suicidal behaviours compared to other health conditions. This prevented disclosure of self-harm and suicidal behaviours and impacted on help-seeking. Overcoming embarrassment and shame was important to access help: 'So I did tell the doctor eventually but when I was in a better mental place, so I don't feel ashamed for being judged' (Maryam, RAF, ex-Regular, help-seeking).

3.3. Theme 3: Fear of consequences of help-seeking

Help-seekers and non-help-seekers expressed concerns about the consequences of help-seeking as another barrier, including unintended negative career consequences, and burdening others. Therefore, participants did not disclose self-harm and suicidal behaviours, and did not seek or access, or did not want to seek or access, any help.

3.3.1. Subtheme 3a: Concern about burdening others

Help-seekers and non-help-seekers were concerned about burdening others: 'I deployed again to Afghanistan and when I got back to battalion, my head was still in a bad way. I didn't tell anybody. I didn't want to be [a] burden to anybody' (Owen, Army, ex-Regular, help-seeking). Instead of talking to others, participants preferred to cope alone: 'So yeah urm I do tend to keep my emotions to myself more urm than I should do perhaps. I feel I just don't want to burden anyone with what I'm feeling' (Sarah, Army, ex-Reservist, help-seeking). This links closely to the military mindset and the expectation of self-resilience which can be important in some military contexts to manage and regulate emotional responses effectively in high-pressure situations, often without relying on external support.

3.3.2. Subtheme 3b: Fear of consequences to military or civilian career

Non-help-seekers and help-seekers expressed concerns about the potential negative career impacts of disclosing their difficulties, and of help-seeking, including differential treatment from peers and negatively affecting their professional standing, future opportunities, or being regarded as unfit for service:

> There's definitely some level of reinforcement from the military … being judged by people within the military, and as in your peers, and possibly having your career terminated, and permanently, to the point where you couldn't even be a cadet instructor

> or anything. (Ben, Army, ex-Reservist, non-help-seeking)

During service, some were worried that a disclosure of self-harm and suicidal behaviours would not remain private and would reach their commanding officers, and that they would automatically be deemed unfit for service, leading to medical downgrade and/or discharge. These fears were justified during service because in the UK, personnel with a history of two or more episodes of self-harm would generally be regarded unfit for service (Ministry of Defence, 2018). These confidentiality and career concerns persisted in civilian life:

> I don't want to speak about it (my suicidal behaviours) because I'm a police officer, I've got responsibilities, urm I don't want to speak about it because I know it will affect my career if I say that I'm feeling these things if that makes sense … There's that confidentiality thing. I like to talk to someone knowing that there will be no consequences, if I talked to my GP or to anybody in the NHS (UK National Health Service) or anything like that it gets marked on my medical records and my job can access my medical records as part of my job that I have to disclose my medical records to them. So I'm very much in that position where I can't tell anybody professional because it gets written down and then it'll get disclosed to my job. And all of a sudden that triggers a whole load of other things that will happen in my life. (Pete, RAF, ex-Regular, non-help-seeking)

3.4. Theme 4: Access to and awareness of support

Access to and awareness of support were barriers to help-seeking for help-seekers and non-help-seekers. Subthemes consisted of practical barriers to accessing support, lack of insight of problem or need for support, and negative experiences of help-seeking.

3.4.1. Subtheme 4a: Practical barriers to accessing support

A lack of awareness of support during and after service was a practical barrier to help-seeking for self-harm and suicidal behaviours. Sometimes participants were unaware of the mental health support and resources available to them within the military: 'Air Force wise I don't think you knew anywhere (to get support)' (Rebecca, RAF, ex-Regular, non-help-seeking), and this persisted post-service. Lack of awareness of support was sometimes due to unwillingness to access support: 'I mean I wasn't really aware of what help was available in the military or civvy [civilian] life. But I also didn't want to access it' (Ben, Army, ex-Reservist, non-help-seeking).

Availability of support was another practical barrier to help-seeking, with some participants highlighting that the expectation and reality of available support differed, at least in civilian life: 'They (the Community Mental Health Team) said I was a veteran and I had my own services, and they just didn't exist down here, there still wasn't any. It existed on paper but it actually in reality they weren't there' (George, Army, ex-Reservist, help-seeking). This lack of available support prevented help-seeking or led to negative experiences which deterred future help-seeking.

3.4.2. Subtheme 4b: Lack of insight of problem or need for support

Several non-help-seekers lacked insight of the problem that needed addressing, so help-seeking was not explored: 'I mean the self-harm at the time I didn't really see as a problem … I think that was a barrier, a barrier to seeking help was not realizing that I needed help' (Ben, Army, ex-Reservist, non-help-seeking).

Despite awareness of available support, some lacked recognition that support was needed, so were unwilling to access it: 'I knew urm the services were available. Absolutely. But I just, urm I didn't want to contact anybody, I didn't think there was a need … you know I'm a bloke, I don't need help' (Dave, Army, ex-Reservist, non-help-seeking). To avoid potential stigma, participants preferred to cope with their difficulties alone, therefore preventing help-seeking. At times, insight into a problem or a need for support related to the participant's self-perceived severity of their own self-harm and suicidal behaviours:

> I didn't actually recognize that I was actually going through anything of that process, so I didn't recognize I needed to talk to anybody because I was quite happy in terms of the thought processes that I was in a planning stage, I wasn't in an action stage. So at that point it was kind of a you know, okay, almost a bit of 'fun'. (Matt, Army, ex-Reservist, non-help-seeking)

3.4.3. Subtheme 4c: Negative help-seeking experiences

Having negative experiences of help-seeking was another barrier for help-seekers. Some were refused help after waiting for months or years for mental health support, exacerbating their symptoms: '… at that appointment I was told oh you were on the wrong waiting list … that spiralled me out of control' (Maryam, RAF, ex-Regular, help-seeking).

Help-seeking for self-harm and suicidal behaviours in civilian life was made more complex with a military history. Participants expressed a lack of understanding of the military context from clinicians: 'The psychologist, she did not understand PTSD from the military perspective' (Dawn, RAF, ex-Regular, help-seeking), and was intensified for those with specific or specialized military experiences: 'There was the fact that because my military history was different, urm some practitioners struggled to under[stand] didn't get

that either, at all. They couldn't grasp it' (George, Army, ex-Reservist, help-seeking).

Participants described experiences of being turned away by services for not being 'severe' enough, feeling as though services were almost encouraging them to be more suicidal to get support:

> All the referrals were getting refused … because I wasn't on drugs and I wasn't drunk and I haven't been arrested and I hadn't hurt anybody and I hadn't been taken to hospital having tried to seriously kill myself, nobody would engage … But the trouble is everyone just keeps closing their doors on you and if the CMHT (Community Mental Health Team) say you are not serious enough you get pushed into being serious enough. You're actually pushed by the system into becoming more suicidal. (George, Army, ex-Reservist, help-seeking)

Yet, having a military history also meant being labelled 'too complex', and services refused to provide support: 'I came into contact with a lot of not very good services and people were just saying you are too complicated' (George, Army, ex-Reservist, help-seeking). The complex eligibility criteria for support were a barrier to help-seeking, especially because of confusion about where and when to access support.

Despite this, some had positive help-seeking experiences, which were ultimately life-saving:

> I thought what they did was absolutely amazing. I mean, it completely sorted me out, allowed me to sort of settle my brain and even though now like I'm getting choked up because I'm thinking about it and that sort of stuff, but I do wonder where I would be if I hadn't done that, if I hadn't reached out, I do wonder if I'd even be sat here. (Ryan, Army, ex-Regular, help-seeking)

3.5. Theme 5: Facilitators to help-seeking

This theme encapsulates facilitators to help-seeking, including the value of informal support and mutual experience sharing. Social support among military communities plays an important role in well-being, particularly when transitioning to civilian life (Barnett et al., 2022; Grover et al., 2024). Participants discussed the supportive nature and strength of their social network (e.g. friends, family, colleagues, pets).

Both help-seekers and non-help-seekers described the value of informal support, often received directly from family and/or friends: 'I was fortunate that I do have that network, I've got a big group of mates, I've got enough true friends, you know that that can do it [support me]' (Matt, Army, ex-Reservist, non-help-seeking). Several participants also highlighted the value of pets, including the unconditional love they provide, as an informal source of support, which was particularly important during crises:

> My two dogs they stopped me hanging myself in the woods because I couldn't do that to them urm and I was very close to my dogs. Whenever I couldn't control it (suicidal thoughts), I would go downstairs and lie on the floor with them … they got me through the very, very worst nights. (George, Army, ex-Reservist, help-seeking)

Sharing mutual experiences with social networks helped participants to feel less alone. Having left service, some overcame the embedded military mindset and shared their experiences:

> We'd all said that we'd had suicidal thoughts … when I talked to the guys about it they said they had similar experiences and thoughts … it's something that when we were serving, we would, we would never ever have discussed. (Dave, Army, ex-Reservist, non-help-seeking)

These shared experiences fostered a sense of understanding and trust within their social network, and influenced participants' decisions to seek help from informal sources of support.

4. Discussion

Although help-seeking behaviours of ex-serving personnel with mental health problems have been studied extensively, to the best of our knowledge this is the first qualitative study explicitly exploring UK ex-serving personnel's experiences of seeking help for self-harm and suicidal behaviours. The findings centre around five themes, which encompass positive and negative experiences, and barriers and facilitators to help-seeking. The military mindset, stigma, and fear of consequences fed into a lack of access to and awareness of support, and social networks were a key facilitating factor (Figure 2).

The findings generally align with existing research on help-seeking for mental health problems among military populations, which identified barriers, including stigma, military culture and masculine norms, lack of recognition of a need for support, difficulties accessing support, and career concerns; and facilitators, including social networks and social support (Coleman et al., 2017; Randles & Finnegan, 2022; Sharp, 2016; Sharp et al., 2015). However, this study extends understanding where we have explicated some barriers to help-seeking that may be specific to self-harm and suicidal behaviours and warrant attention.

4.1. Help-seeking barriers for self-harm and suicidal behaviours

Participants highlighted embarrassment and shame as aspects of self-stigma that were specific to help-seeking for self-harm and suicidal behaviours. Stigma is a key determinant of health and health inequalities because of its impact on health-enabling resources and stress exposure (Bolster-Foucault et al., 2021). It is well understood that any type of stigma creates a reluctance to seek help and treatment, and reduces

the likelihood of staying in treatment (Clement et al., 2015; Schnyder et al., 2017). Embarrassment and shame are inherent in many mental disorders, but may be exacerbated for self-harm and suicidal behaviours owing to societal views that these behaviours are unacceptable, an internalized sense of worthlessness or failure, and feeling weak or unable to cope (Goffman, 1964; Sheehy et al. 2019).

The societal hierarchy of health problems (i.e. the way in which certain health conditions are prioritized, stigmatized, or viewed as more or less legitimate and deserving of support) was another stigma-related barrier specific to help-seeking for self-harm and suicidal behaviours. Comparison between different types of conditions and injuries has been identified elsewhere in the military literature (Caddick et al., 2021). Given that self-harm, suicidal ideation, and suicide attempts are some of the strongest predictors of death by suicide (Carroll et al., 2014; Hubers et al., 2018), arguably they sit at the more severe end of this hierarchy. However, society regularly devalues mental health conditions, perceiving them as less urgent or important, and as more of an individual responsibility, than physical health conditions (Schomerus & Angermeyer, 2008), therefore discouraging individuals with mental health problems from seeking help, including among military populations (e.g. Hines et al., 2014).

4.2. Help-seekers versus non-help-seekers

There were some differences in help-seeking barriers identified between help-seekers and non-help-seekers. For instance, mental health as taboo during service (within organizational stigma) and lack of awareness of support in military and civilian life were discussed by non-help-seekers only, and negative help-seeking experiences were discussed by help-seekers only. However, overall, the barriers and facilitators to help-seeking were relatively similar among help-seekers and non-help-seekers. Potentially, the similarities could be due to difficulties in measuring help-seeking status (Coleman et al., 2017), which was self-reported in the eligibility questionnaire and did not necessarily match reporting during interviews, making comparisons difficult. For example, one participant self-reported as non-help-seeking despite disclosing in the interview that they had accessed a suicide prevention helpline, which was the turning point to preventing the continuation of their suicidal thoughts. Potential explanations for this mismatch may relate to temporality, non-linear help-seeking pathways, or differing views as to what help-seeking and types of support mean to them.

4.3. Strengths and limitations

The qualitative design enabled participants to voice aspects of their lived experience, allowing for understanding of the nuances and complexities of help-seeking for self-harm and suicidal behaviours, which may not have been possible using a quantitative design. Unlike much existing work on help-seeking for mental health problems, this study is strengthened by the inclusion of help-seekers and non-help-seekers, allowing for the exploration of both experiences.

However, the findings were developed from interviews with 15 participants recruited via Phase 4 of the KCMHR cohort study, who served during the Iraq- and Afghanistan- era and may not represent those who served in a different era, such as older ex-serving personnel. Lifetime self-harm, suicidal ideation, and suicide attempts were self-reported via the CIS-R in a quantitative questionnaire rather than the gold standard clinical interview, introducing potential reporting bias. Recruited participants reported experience of suicidal ideation only or multiple behaviours, but no participants reported experience of self-harm only or suicide attempts only; therefore, (sub)themes are presented across all behaviours. There were inconsistencies in self-reporting of help-seeking status by participants between the eligibility questionnaire and interview, therefore making it challenging to identify whether there were similarities in the barriers and facilitators encountered by help-seekers and non-help-seekers. Reporting of self-harm and suicidal behaviours was across the lifetime, so not all behaviours or help-seeking experiences were attributable to the military context.

4.4. Implications

This study provides much-needed UK qualitative data on help-seeking behaviours for self-harm and suicidal behaviours among ex-serving personnel, which can inform future policy, prevention, and support services, such as an equivalent Armed Forces Suicide Prevention Strategy and Action Plan (Ministry of Defence, 2024) for UK ex-serving personnel. The military mindset was highlighted as an engine for stigma and organizational cultures that are not conducive to help-seeking, and therefore focus on altering the negative aspects of such a mindset is important for the successful uptake of prevention and intervention. Given that many of the barriers and facilitators to help-seeking identified in this study reflect those found for mental health help-seeking, it is important to continue to promote broader mental health awareness and support services available among military populations through dedicated training and communication campaigns. The lack of military cultural competency from health professionals raised by ex-serving personnel in this study must be addressed. The introduction of the NHS Veteran Aware (NHS, 2025) and Veteran Friendly GP Practice (Simpson & Leach, 2022)

accreditation programmes is a positive step towards improving understanding and better meeting the needs of the Armed Forces community; therefore, the continuation of these initiatives should be encouraged.

5. Conclusions

The findings from this study highlight several barrier and facilitator themes that may influence help-seeking decisions and experiences, including barriers to help-seeking that may be specific to self-harm and suicidal behaviours. Continued efforts are required to tackle the enduring mental health-related stigma, during and after service, that acts as a key barrier to help-seeking. The study illustrates the need to provide an environment where military personnel feel willing and able to seek help for self-harm and suicidal behaviours. Various suggestions for policy and clinical practice are discussed, which have the potential to encourage personnel to access support sooner, therefore lessening the impact on their health and well-being, and ultimately to save lives.

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Author contributions

CW proposed the study. SAMS secured the funding for Phase 4 of the King's Centre for Military Health Research Health and Wellbeing cohort study. CW, MLS, and SAMS contributed to the design of the study. CW, LP, MLS, and SAMS contributed to the study materials (e.g. interview schedule, participant invitations) and ethical approval (including risk protocol). WB and AS contributed to the risk protocol and acted as the study clinicians. CW was responsible for project administration and participant recruitment, provided the main point of contact for participants and conducted all interviews. CW produced the majority of the interview transcripts. CW performed analysis of data, with support from MLS and SAMS. MLS and SAMS provided supervision. CW wrote the first draft, and all other authors (WB, AS, LP, SAMS, MLS) contributed to each revision and approved the final manuscript.

Ethical approval and consent

This study was reviewed and approved by the local ethics committee of King's College London (Ref: HR/DP-22/23-33994). All participants completed an online consent form prior to the interview, which included consent for the use of pseudo-anonymized direct quotes in research outputs.

Data availability statement

Data are available upon reasonable request from the corresponding author. Data will be processed in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. The authors will not make any data publicly accessible because they need to protect the confidentiality and security of participants. Readers are welcome to contact the investigators with proposals for collaborative research, which will be considered on a case-by-case basis, and which will only occur as part of a legal collaborative agreement and after the collaborator has put in place the relevant research ethics, data protection, and data access approvals.

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References

Abraham, T., Cheney, A. M., & Curran, G. M. (2017). A bourdieusian analysis of U.S. Military culture ground in the mental help-seeking literature. *American Journal of Men's Health*, *11*(5), 1358–1365. http://journals.sagepub.com/doi/10.1177155798831559603 7

Barnett, A., Savic, M., Forbes, D., Best, D., Sandral, E., Bathish, R., Cheetham, A., & Lubman, D. I. (2022). Transitioning to civilian life: The importance of social group engagement and identity among Australian defence force veterans. *Australian & New Zealand Journal of Psychiatry*, *56*(8), 1025–1033. https://journals.sagepub.com/doi/10.1177000486742110468 94

Bergman, B. P., Mackay, D. F., Smith, D. J., & Pell, J. P. (2019). Non-fatal self-harm in Scottish military veterans: A retrospective cohort study of 57,000 veterans and 173,000 matched non-veterans. *Social Psychiatry and Psychiatric Epidemiology*, *54*(1), 81–87. Retrieved January 26, 2022, from https://link.springer.com/article/10.1007s00127-018-1588-9

Bolster-Foucault, C., Ho Mi Fane, B., & Blair, A. (2021). Structural determinants of stigma across health and social conditions: A rapid review and conceptual framework to guide future research and intervention. *Health Promotion and Chronic Disease Prevention in Canada*, *41*(3), 85–115. https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-41-no-3-2021/structural-determinants-stigma-health-social-conditions.html

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. Retrieved February 6, 2023, from https://www.tandfonline.com/doi/abs/10.1080215967 6X.2019.1628806

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. (A. Maher, Ed.). Sage Publications.

Caddick, N., Cooper, L., Godier-McBard, L., & Fossey, M. (2021). Hierarchies of wounding: Media framings of 'combat' and 'non-combat' injury. *Media, War & Conflict*, *14*(4), 503–521. https://journals.sagepub.com/doi/10.1177175063521989911 0

Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: Systematic review and meta-analysis. *PLoS One*, *9*(2), e89944. Retrieved July 29, 2022, from https://pubmed.ncbi.nlm.nih.gov/24587141/

Chan, M. K. Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., O'Connor, R. C., Kapur, N., & Kendall, T. (2016). Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *British Journal of Psychiatry*, *209*(4), 277–283. Retrieved July 29, 2022, from https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/predicting-suicide-following-selfharm-systematic-review-of-risk-factors-and-risk-scales/C9D595168EDF06401A823E2E968915E1

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://www.cambridge.org/core/product/identifier/S0033291714000129/type/journal_article

Coleman, S. J., Stevelink, S. A. M., Hatch, S. L., Denny, J. A., & Greenberg, N. (2017). Stigma-related barriers and facilitators to help seeking for mental health issues in the Armed Forces: A systematic review and thematic synthesis of qualitative literature. *Psychological Medicine*, *47*(11), 1880–1892. https://www.cambridge.org/core/product/identifier/S0033291717000356/type/journal_article.

Department of Defense. (2024). DoD personnel, workforce reports & publications - strength summary. DMDC. https://dwp.dmdc.osd.mil/dwp/app/dod-data-reports/workforce-reports

Favril, L., Yu, R., Geddes, J. R., & Fazel, S. (2023). Individual-level risk factors for suicide mortality in the general population: An umbrella review. *The Lancet Public Health*, *8*(11), e868–e877. https://linkinghub.elsevier.com/retrieve/pii/S2468266723002074

Fear, N. T., Jones, M., Murphy, D., Hull, L., Iversen, A. C., Coker, B., Machell, L., Sundin, J., Woodhead, C., Greenberg, N., Landau, S., Dandeker, C., Rona, R. J., Hotopf, M., & Wessely, S. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces? A cohort study. *Lancet (London, England)*, *375*(9728), 1783–1797. Retrieved July 28, 2021, from https://pubmed.ncbi.nlm.nih.gov/20471076/

Goffman, E. (1964). Stigma: Notes on the management of spoiled identity. *Social Forces; A Scientific Medium of Social Study And Interpretation*, *43*(1), 127. http://www.jstor.org/stable/2575995?origin=crossref

Grover, L. E., Williamson, C., Burdett, H., Palmer, L., & Fear, N. T. (2024). Level of perceived social support, and associated factors, in combat-exposed (ex-)military personnel: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, *59*(12), 2119–2143. https://link.springer.com/10.1007s00127-024-02685-3

Hines, L. A., Goodwin, L., Jones, M., Hull, L., Wessely, S., Fear, N. T., & Rona, R. J. (2014). Factors affecting help seeking for mental health problems after deployment to Iraq and Afghanistan. *Psychiatric Services*, *65*(1), 98–105. http://psychiatryonline.org/doi/abs/10.1176appi.ps.004972012

Hotopf, M., Hull, L., Fear, N. T., Browne, T., Horn, O., Iversen, A., Jones, M., Murphy, D., Bland, D., Earnshaw, M., Greenberg, N., Hacker Hughes, J., Tate, A. R., Dandeker, C., Rona, R., & Wessely, S. (2006). The health of UK military personnel who deployed to the 2003 Iraq war: A cohort study. *The Lancet*, *367*(9524), 1731–1741. https://doi.org/10.1016/S0140-6736(06)68662-5

Hubers, A. A. M., Moaddine, S., Peersmann, S. H. M., Stijnen, T., van Duijn, E., van der Mast, R. C., Dekkers, O. M., & Giltay, E. J. (2018). Suicidal ideation and subsequent completed suicide in both psychiatric and non-psychiatric populations: A meta-analysis. *Epidemiology and Psychiatric Sciences*, *27*(2), 186–198. https://www.cambridge.org/core/product/identifier/S2045796016001049/type/journal_article

Jones, N., Keeling, M., Thandi, G., & Greenberg, N. (2015). Stigmatisation, perceived barriers to care, help seeking and the mental health of British military personnel. *Social Psychiatry and Psychiatric Epidemiology*, *50*(12), 1873–1883. http://link.springer.com/10.1007s00127-015-1118-y

Jones, N., Sharp, M.-L., Phillips, A., & Stevelink, S. A. M. (2019). Suicidal ideation, suicidal attempts, and self-harm in the UK Armed Forces. *Suicide and Life-Threatening Behavior*, *49*(6), 1762–1779. Retrieved

November 19, 2021, from https://onlinelibrary.wiley.com/doi/10.1111sltb.12570

Knipe, D., Padmanathan, P., Newton-Howes, G., Chan, L. F., & Kapur, N. (2022). Suicide and self-harm. *The Lancet*, *399*(10338), 1903–1916. Retrieved July 1, 2022, from http://www.thelancet.com/article/S0140673622001738/fulltext

Lewis, G., Pelosi, A. J., Araya, R., & Dunn, G. (1992). Measuring psychiatric disorder in the community: A standardized assessment for use by lay interviewers. *Psychological Medicine*, *22*(2), 465–486. https://www.cambridge.org/core/product/identifier/S0033291700030415/type/journal_article

Ministry of Defence. (2018). Jsp 950 medical policy leaflet 6-7-7: Joint service manual of medical fitness.

Ministry of Defence. (2019). Deliberate Self Harm (DSH) in the UK Armed Forces. 1 April 2010–31 March 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/919761/20181221_Adhoc_Statistical_Bulletin_DSH_in_the_UK_Armed_Forces_O.pdf

Ministry of Defence. (2024). Armed Forces suicide prevention strategy and action plan 2024. https://assets.publishing.service.gov.uk/media/672a18b6541e1dfbf71e8ba6/Armed_Forces_Suicide_Prevention_Strategy_and_Action_Plan.pdf

Ministry of Defence. (2024). Quarterly service personnel statistics 1 October 2024. *GOV.UK*. https://www.gov.uk/government/statistics/quarterly-service-personnel-statistics-2024/quarterly-service-personnel-statistics-1-october-2024

Ministry of Defence. (2024). Suicides in the UK regular Armed Forces: Annual summary and trends over time - 1 January 1984 to 31 December 2023. *GOV.UK*. https://assets.publishing.service.gov.uk/media/660bdecbfb0f770011ec665e/UK_armed_forces_suicides_1984_to_2023.pdf

NHS. (2025). NHS Veteran Aware. Retrieved July 31, 2024, from https://veteranaware.nhs.uk/

Office for National Statistics. (2024). Suicides in UK Armed Forces veterans, England and Wales: 2021. Census 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/suicidesinukarmedforcesveteransenglandandwales/2021

Office for Veterans' Affairs. (2020). Veterans Factsheet 2020. *UK Government*. Retrieved August 16, 2022, from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874821/6.6409_CO_Armed-Forces_Veterans-Factsheet_v9_web.pdf

Pinder, R. J., Iversen, A. C., Kapur, N., Wessely, S., & Fear, N. T. (2012). Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. *International Journal of Social Psychiatry*, *58*(4), 433–439. https://doi.org/10.1177/0020764011408534

Rafferty, L. A., Wessely, S., Stevelink, S. A. M., & Greenberg, N. (2020). The journey to professional mental health support: A qualitative exploration of the barriers and facilitators impacting military veterans' engagement with mental health treatment. *European Journal of Psychotraumatology*, *10*(1), 1–14. Retrieved February 9, 2023, from https://www.tandfonline.com/doi/abs/10.108020008198.2019.1700613

Randles, R., & Finnegan, A. (2022). Veteran help-seeking behaviour for mental health issues: A systematic review. *BMJ Military Health*, *168*(1), 99–104. https://militaryhealth.bmj.com/lookup/doi/10.1136bmjmilitary-2021-001903

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, *173*, 173–183. http://www.dovepress.com/conceptual-measurement-framework-for-help-seeking-for-mental-health-pr-peer-reviewed-article-PRBM

Rodway, C., Ibrahim, S., Westhead, J., Bojanić, L., Turnbull, P., Appleby, L., Bacon, A., Dale, H., Harrison, K., & Kapur, N. (2023). Suicide after leaving the UK Armed Forces 1996–2018: A cohort study. *PLOS Medicine*, *20*(8), e1004273. https://dx.plos.org/10.1371journal.pmed.1004273

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *British Journal of Psychiatry*, *210*(4), 261–268. https://www.cambridge.org/core/product/identifier/S0007125000281105/type/journal_article

Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: What do we know? *Epidemiologia e Psichiatria Sociale*, *17*(1), 31–37. https://www.cambridge.org/core/product/identifier/S1121189X00002669/type/journal_article

Sharp, M.-L., Jones, M., Leal, R., Hull, L., Franchini, S., Molloy, N., Burdett, H., Simms, A., Parkes, S., Leightley, D., Greenberg, N., Murphy, D., MacManus, D., Wessely, S., Stevelink, S., & Fear, N. (2023). Health and well-being of serving and ex-serving UK Armed Forces personnel: Protocol for the fourth phase of a longitudinal cohort study. *BMJ Open*, *13*(10), 1–8. Retrieved November 6, 2023, from https://bmjopen.bmj.com/content/13/10/e079016

Sharp, M. (2016). *Social influences and barriers to seeking healthacre for mental health problems Among UK military personnel: Qualitative and quantitative investigations* [Doctoral thesis]. King's College London. https://kclpure.kcl.ac.uk/portal/en/studentTheses/social-influences-and-barriers-to-seeking-healthcare-for-mental-h

Sharp, M., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews*, *37*(1), 144–162. https://academic.oup.com/epirev/article-lookup/doi/10.1093epirev/mxu012

Sheehy, K., Noureen, A., Khaliq, A., Dhingra, K., Husain, N., Pontin, E. E., Cawley, R., & Taylor, P. J. (2019). An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. *Clinical Psychology Review*, *73*, 101779. https://linkinghub.elsevier.com/retrieve/pii/S0272735819302910

Simpson, R. G., & Leach, J. (2022). UK military veteran-friendly GP practices. *BMJ Military Health*, *168*(1), 88–90. https://militaryhealth.bmj.com/lookup/doi/10.1136bmjmilitary-2020-001734

Stevelink, S. A. M., Jones, M., Hull, L., Pernet, D., Maccrimmon, S., Goodwin, L., MacManus, D., Murphy, D., Greenberg, N., Rona, R. J., Fear, N. T., & Wessely, S. (2018). Mental health outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: A cohort study. *The British Journal of Psychiatry*, *213*(6), 690–697. Retrieved July 7, 2021, from https://pubmed.ncbi.nlm.nih.gov/30295216/

Stevelink, S. A. M., Jones, N., Jones, M., Dyball, D., Khera, C. K., Pernet, D., MacCrimmon, S., Murphy, D., Hull, L., Greenberg, N., MacManus, D., Goodwin, L., Sharp, M.-L., Wessely, S., Rona, R. J., & Fear, N. T. (2019). Do serving and ex-serving personnel of the UK Armed

Forces seek help for perceived stress, emotional or mental health problems? *European Journal of Psychotraumatology*, *10*(1), 1556552. https://doi.org/10.1080/20008198.2018.1556552

Williamson, C., Croak, B., Simms, A., Fear, N. T., Sharp, M.-L., & Stevelink, S. A. M. (2024). Risk and protective factors for self-harm and suicide behaviours among serving and ex-serving personnel of the UK Armed Forces, Canadian Armed Forces, Australian defence force and New Zealand defence force: A systematic review. *PLoS One*, *19*(4), e0299239. https://doi.org/10.1371/journal.pone.0299239

Williamson, V., Greenberg, N., & Stevelink, S. A. M. (2019). Perceived stigma and barriers to care in UK Armed Forces personnel and veterans with and without probable mental disorders. *BMC Psychology*, *7*(1), 1–7. Retrieved September 27, 2021, from https://bmcpsychology.biomedcentral.com/articles/10.1186s40359-019-0351-7