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Mental health in the military: A mixed methods investigation of mental health and help seeking behaviours in the Irish Defence Forces

School of Nursing and Midwifery, Trinity College Dublin

Supervisors: Professor Louise Doyle and Professor Brian Keogh

PhD Candidate: Dan Fitzpatrick

Student ID: 16308378

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other

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Dan Fitzpatrick

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this research, I often reflected on the conversations we never got to finish. I hope, in some small way, this work honours your memory and the spirit of compassion and integrity you carried. I hope I made you proud.

Table of contents

List of Tables

List of Figures

Abstract

This doctoral research investigates the mental health experiences and help-seeking behaviours of currently serving personnel within the Irish Defence Forces. Against a backdrop of limited empirical evidence in the Irish military context, this study aims to fill a critical gap by exploring how soldiers navigate mental health challenges and what factors influence their decisions to seek or avoid professional support. The study adopts a sequential explanatory mixed-methods design, integrating quantitative survey data from 687 participants across the Army, Navy, and Air Corps with qualitative data from 6 semi-structured interviews conducted with key Defence Forces stakeholders involved in mental health service provision. This dual-phase approach allowed for a deeper, more contextualised understanding of both the prevalence of psychological distress and the barriers impeding formal help-seeking within the organisation.

The quantitative strand revealed concerning levels of self-reported mental health difficulties, including symptoms of anxiety, depression, Post Traumatic Stress Disorder, alcohol use, self-harm, suicidal ideation, and suicide attempts. Notably, the prevalence rates identified in this study are higher than previously reported in Irish Defence Forces research and are broadly consistent with findings from comparable international military populations. Despite these elevated levels of distress, formal help-seeking remains low. Over 90% of participants indicated that disclosing a mental health issue to a military medical officer would negatively impact their careers, and a significant proportion expressed concerns about confidentiality, stigma, and being perceived as unfit for duty. Instead, many participants expressed a preference for peer support and external civilian services, particularly those perceived as offering greater discretion and psychological safety.

The qualitative findings supported these patterns, with key stakeholders acknowledging the existence of a culture in which seeking mental health support is often viewed as incompatible with military identity. Several participants in this phase were surprised by the scale of avoidance revealed in the survey, and many expressed concerns about the absence of a formal, Defence Forces-wide mental health policy. Interviewees highlighted that, although peer-led mental health providers were the most utilised sources, they are not adequately equipped to deal with serious mental health issues. The findings also underscore the need for structural reform, including the development of a holistic standalone mental health service, stronger protections for confidentiality through independent control of medical records and GDPR-compliant data management, and clearer safeguards to ensure patient autonomy, meaning that personnel retain genuine choice in how they disclose and access care rather than having decisions imposed by command-linked grading systems.

This research is grounded in Scott's (1990) Hidden Transcripts Theory, which provides a theoretical lens for understanding how military personnel may resist

institutional norms by concealing distress and avoiding formal mental health pathways. Within this framework, acts of non-disclosure and avoidance are interpreted as strategic responses to perceived coercion and surveillance within hierarchical systems. These behaviours are not necessarily signs of disengagement but reflect an internal negotiation between self-preservation and professional identity. The theory also illuminates the discrepancy between outward conformity and private dissent within the Defence Forces, where compliance with institutional expectations often masks unresolved psychological struggles.

Key recommendations emerging from the study include the immediate development of an inclusive and research-informed Defence Forces mental health policy, the establishment of a multidisciplinary mental health unit incorporating both military and civilian expertise, and investment in research-informed educational campaigns to reduce stigma. A revised medical grading system that reflects the complexity of mental health recovery, along with the expansion of confidential external services, is also proposed.

This study makes an original contribution to the understanding of military mental health in an Irish context by exposing the complex interplay of organisational culture, structural limitations, and individual psychological coping strategies. The findings highlight the urgent need for systemic reform to ensure that help-seeking is supported, stigma is dismantled, and the mental health and wellbeing of Irish Defence Forces personnel is safeguarded. Without such action, the continued underutilisation of support services poses risks not only to individual soldiers but also to the operational readiness and ethical integrity of the institution.

Chapter 1: Introduction to the Thesis

1.1 Introduction

This thesis investigates the prevalence of mental health issues within the Irish Defence Forces and examines the barriers and facilitators that influence help-seeking behaviour among military personnel. The study employs a sequential mixed methods design, allowing for a comprehensive exploration of the research objectives through the integration of both quantitative and qualitative approaches. While the international literature has extensively documented the presence of mental health difficulties within military populations, there remains a notable gap in national-level research specific to the Irish context. In particular, few studies have addressed these issues using insider perspectives from within the Irish Defence Forces.

The existing body of international research indicates that military personnel often avoid seeking help for mental health problems, particularly from within military-provided support systems. Although low levels of help-seeking are widely acknowledged, few studies have gone on to explore this phenomenon in-depth through qualitative inquiry. In Ireland, there is a scarcity of research in this area, and to date, studies specifically investigating help-seeking behaviours among Defence Forces personnel are limited or absent. This thesis was developed in response to these research gaps, with the aim of contributing new empirical knowledge and offering insights that can inform military policy and practice.

This introductory chapter outlines the rationale for the study and provides background to the research problem. It includes an overview of how the research topic was selected, presents the study's aims and objectives, and offers a summary of the structure and contents of the thesis.

1.2 Selecting the Research Topic

The selection and refinement of the research topic for this thesis emerged as a natural progression from my earlier academic and professional experiences within the Irish Defence Forces. From 2001 to 2023, I served in the Air Corps, holding several roles throughout my military career, including firefighter, medic, and, subsequently, practitioner within the Personnel Support Service (PSS). The PSS is composed of Personnel Support Officers (mostly enlisted personnel) and Social Workers (civilian) who provide confidential assistance to military personnel on a wide range of issues, including family and relationship difficulties, alcohol misuse, and mental health concerns.

Over the course of seven years in the PSS, I worked closely with soldiers experiencing a broad spectrum of psychological difficulties, such as depression, anxiety, Post Traumatic Stress Disorder (PTSD), substance misuse, and suicidality. Through this role, I developed a nuanced understanding of the realities of help-seeking within the Defence Forces. It became increasingly apparent that, while support systems existed, cultural norms surrounding masculinity, operational readiness, and institutional loyalty created an environment in which seeking help for mental health concerns was often stigmatised. Help-seeking was frequently perceived as a sign of weakness and therefore became a concealed behaviour, implicitly discouraged by cultural norms surrounding masculinity, operational readiness, and loyalty, rather than by any formal prohibition

My experience operating within this system, at the intersection of military law, organisational expectations, and the ethical obligations of care, highlighted the complex dilemmas faced by help-providers. The dual role of serving both the organisation and the individual service member often produced moral tensions that were not easily reconciled. These experiences prompted a desire to explore how other military organisations internationally navigated similar challenges, and whether there were more effective ways of balancing care provision with operational requirements.

This growing interest in the psychological dimensions of military life was first formalised through my master's thesis, which examined post-traumatic growth in the Irish Naval Service following Operation PONTUS in 2016. This operation was initiated in response to a major humanitarian crisis in the Mediterranean, following a significant loss of life in April 2015. Ireland's contribution to the European response involved deploying Naval Service vessels under Operation PONTUS, and this context provided a foundation for exploring the psychological impact of military service, particularly in humanitarian and peacekeeping missions. Building upon this academic inquiry, I became increasingly interested in whether the Defence Forces were fulfilling their stated ethos, as articulated by General Richard Mulcahy (Irish Defence Forces, 2016):

> "Óglaigh na hÉireann [Irish Defence Forces] has been the people, is the people and will be the people. Our green uniform does not make us less people. It is a cloak of our service, a curtailer of our weaknesses, an amplifier of our strengths."

General Richard Mulcahy played a foundational role in the establishment and evolution of the Irish Defence Forces. A key figure in Ireland's struggle for independence, he fought in the 1916 Easter Rising and later served as Chief of Staff of the Irish Republican Army during the War of Independence. Following the death of Michael Collins in 1922, Mulcahy became Commander-in-Chief of the National

Army during the Irish Civil War, overseeing its consolidation at a critical juncture in the formation of the new state. His leadership during this turbulent period was instrumental in laying the organisational and strategic foundations of what would become the modern Irish Defence Forces. Beyond his military contributions, Mulcahy's vision and commitment to a professional, apolitical Defence Force had a lasting impact on the structure and ethos of the institution.

This reflection led to the formulation of a more focused research agenda aimed at investigating both the prevalence of mental health issues within the Irish Defence Forces and the cultural and structural factors influencing help-seeking behaviours. A preliminary review of relevant literature confirmed that psychological distress is widespread among military personnel, regardless of whether they serve in combat or peacekeeping roles. However, in the Irish context, there was a marked absence of research exploring these issues, particularly from the perspective of someone with lived, insider knowledge of the organisational setting.

The decision to pursue this topic for my doctoral research represents a convergence of professional experience, academic interest, and a strong commitment to improving mental health outcomes for those who serve. This study offers an opportunity to contribute to a deeper understanding of the role military culture plays in shaping psychological wellbeing and access to support and to critically examine the adequacy of existing systems in meeting the needs of military personnel.

1.3 Background and significance

This section situates mental health within the military context and outlines the rationale for examining the study's core concepts of mental health and help-seeking. The research focuses on these issues as they arise within the Irish Defence Forces, which is comprised of the Army, the Naval Service, and the Air Corps. Military service presents a distinctive occupational environment marked by exposure to multiple stressors. Personnel engage in diverse operational deployments, both overseas and at home. Internationally, these include peacekeeping and stability missions such as UNIFIL in Lebanon, UNDOF in the Golan Heights, and EUTM Mali, as well as observer roles in operations like UNTSO in the Middle East. Domestically, the Defence Forces support the state through Aid to the Civil Power, including armed escorts and counter-terrorism duties, and Aid to the Civil Authority, which encompasses assistance during crises such as severe weather events or the COVID-19 pandemic. In addition to these duties, service members contend with long-term family separation, sustained physical demands, and the continuous requirements of discipline and readiness, all of which shape the context in which mental health challenges and help-seeking behaviours occur.

Understanding military culture and its associated subcultures is essential for those who work with or intend to work with military populations. While military personnel are drawn from diverse ethnic, educational, and socioeconomic backgrounds, they are nonetheless bound together by a distinct institutional culture shaped by shared values, norms, and practices. This culture fosters a strong sense of collectivism, where cooperation, interdependence, and conformity are emphasised. From the earliest stages of training, personnel are taught to respond instinctively to authority, as exemplified by the assertion that members are instructed "from their first moments in uniform to instinctively obey" (Pendlebury, 2020, p. 166).

The collectivist ethos is clearly reflected in various aspects of military life, including standardised uniforms, grooming regulations, and the development of a unique internal vocabulary. Within this system, identity is closely tied to group affiliation, requiring emotional reliance on others and often necessitating self-sacrifice for the benefit of the collective. A central characteristic of military structure is its hierarchical distribution of power, which diverges significantly from more egalitarian models. Authority is maintained through rank, which determines an individual's status, responsibilities, and expected behaviours (Hofstede, 2001). This hierarchy is supported by formal chains of command, where authority and accountability are passed through clearly defined channels. Risk and uncertainty are managed through strict adherence to institutional policies, rules, and standard operational procedures (Hofstede, 2001).

International research consistently indicates that military personnel experience higher rates of mental health disorders than their civilian counterparts (Hoge et al., 2014). The cumulative impact of military stressors can contribute to increased vulnerability to conditions such as depression, anxiety, PTSD, substance misuse, and suicidal ideation (Hom, et al., 2017). While these challenges have been documented extensively in international military populations, the specific mental health experiences of Irish Defence Forces personnel remain significantly under-researched.

Historically, the Irish Defence Forces have engaged in both domestic duties and international peacekeeping or humanitarian operations under the auspices of organisations such as the United Nations and the European Union (Burke & Marley, 2015). Although these missions differ from conventional warfare, they nonetheless involve exposure to traumatic events, morally complex decisions, and long-term operational stressors (Schorr et al., 2018). Despite this, the psychological impact of such service remains insufficiently examined in the Irish context.

Help-seeking for mental health difficulties within military contexts remains a complex and multifaceted phenomenon, shaped by a unique interplay of cultural,

structural, and psychological factors. While mental health challenges such as depression, PTSD, generalised anxiety disorder, and substance misuse are prevalent among military populations, a consistent body of international research has demonstrated that the majority of affected personnel do not seek professional support (Hoge et al., 2004; Hom et al., 2017). This pervasive treatment gap has raised critical concerns about the efficacy of existing military mental health support systems and the broader cultural environment in which these systems operate.

A central obstacle to help-seeking is the prevailing military culture, which often valorises stoicism, self-reliance, and emotional suppression. These values, while adaptive in combat and operational contexts, can have detrimental implications when transferred to the domain of psychological health. Many service members internalise beliefs that seeking psychological support is indicative of weakness, and that disclosure may adversely affect their career progression, operational responsibilities, or the trust placed in them by peers and commanding officers (Britt, et al., 2008; Greene-Shortridge, et al., 2007). Consequently, attitudinal barriers such as fear of stigma, perceived loss of credibility, and anticipated negative judgement frequently outweigh concerns related to access or availability of services.

In addition to the prevalence of mental health difficulties, a growing body of literature points to the existence of substantial barriers to help-seeking among military personnel. These barriers are often reinforced by longstanding cultural norms within military institutions (Kim et al., 2011). Military culture tends to value toughness, endurance, and self-reliance, traits which may inadvertently discourage help-seeking and stigmatise mental health difficulties. Service members are frequently socialised to "tough it out," and are taught that acknowledging emotional or psychological distress could be perceived as a weakness or liability (National Alliance on Mental Illness 2012).

Although behavioural health initiatives have been introduced in various military systems to address these challenges and promote engagement with mental health care, the rates of psychological distress remain high, and suicide rates have remained consistently alarming (Ganz et al., 2021). International literature from countries such as the United Kingdom, United States, Canada, and Australia has explored these challenges in depth, identifying themes such as stigma, confidentiality concerns, and fears over career consequences as primary deterrents to formal help-seeking (Jones, et al., 2013). However, comparable research in the Irish context is scarce, and while this study incorporated qualitative perspectives from key stakeholders, there is still a need for deeper qualitative inquiry that centres on the lived experiences of Defence Forces personnel.

An additional layer of complexity arises from the structural and ethical tensions faced by help-providers within military institutions. Waitzkin et al. (2018) argue that help-provision within the military is shaped by a form of double agency, whereby professionals are expected to serve both the individual and the military command. This dual responsibility can result in ethical ambiguity and lead personnel to bypass internal systems in favour of civilian mental health services. However, when such support is sought outside of formal military channels and remains undisclosed, it creates a hidden cohort of serving personnel who may be experiencing significant psychological difficulties while simultaneously holding positions of high responsibility. These roles often include access to firearms, oversight of weapon systems, military-grade information technology, and the operation of heavy machinery. The potential risks associated with such unreported distress highlight the need for improved visibility, trust, and cultural change within the military help-provision systems.

The significance of this study lies in several key areas. Firstly, it contributes to the limited empirical literature on mental health in the Irish Defence Forces by providing national prevalence data and insight into the dynamics of help-seeking. Secondly, the use of a sequential mixed methods design allows for both quantification of mental health challenges and a qualitative exploration of the cultural, structural, and personal factors that shape how support is accessed or avoided, based on the perspectives of key stakeholders involved in providing and managing mental health care within the Defence Forces. Thirdly, this research is informed by the researcher's own experience as a former member of the Defence Forces and as a practitioner within the Personnel Support Service. This insider perspective enables a level of contextual understanding and access to institutional knowledge that enhances the study's validity and depth.

A further contribution of this research is the integration of Hidden Transcripts Theory (Scott, 1990) as its theoretical framework. This theory provides a lens through which to examine the tension between official military discourse and the informal, often suppressed, narratives of those who experience mental health distress within the organisation. Hidden Transcripts Theory distinguishes between the "public transcript", the dominant, institutionally sanctioned narrative, and the "hidden transcript," which represents the subversive or silenced perspectives of subordinate groups. In the context of the Defence Forces, the theory allows for the exploration of how personnel manage their psychological distress within the Irish Defence Forces. The Hidden transcripts theory provides a powerful analytical tool to understand how soldiers navigate the dissonance between institutional expectations and their lived realities, particularly when their help-seeking behaviours remain concealed due to stigma or fear of reprisal.

By applying this framework, the study moves beyond conventional behavioural models of help-seeking to engage critically with questions of power, silence, and resistance within military culture. The use of Hidden Transcripts Theory is especially valuable in illuminating the informal strategies and coping mechanisms that exist outside of formal support structures, contributing to a more holistic understanding of mental health dynamics in the Defence Forces.

This study extends the international literature on military help-seeking by focusing specifically on the Irish Defence Forces, where empirical research on mental health support remains scarce. Drawing on global evidence of barriers such as stigma, confidentiality concerns, fear of career impact, and limited institutional responsiveness, it examines whether similar obstacles affect Irish service members. Using a sequential mixed methods design, the study integrates extensive survey data from Defence Forces personnel with qualitative insights from key stakeholders responsible for providing and managing mental health support. This approach enables an assessment of the degree to which international trends are mirrored in Ireland while situating the findings within the organisational and cultural context of the Defence Forces.

Given the Defence Forces' commitment to readiness, professionalism, and respect for human dignity, these findings are both timely and essential. They will inform future policy development, guide the creation of culturally sensitive interventions, and ultimately strengthen both the operational capability and psychological wellbeing of all personnel.

1.4 Aim and Objectives

The aim and objectives of this study were developed in direct response to the gaps in knowledge briefly outlined in this chapter and further examined in detail in Chapters 2 and 3. They are as follows:

1.4.1 Study Aim

The primary aim of this research was twofold: first, to identify the mental health issues affecting Defence Forces personnel, and second, to understand how Irish military personnel interact with the help-providing services delivered by the military.

1.4.2 Study Objectives

1. To study what mental health issues are affecting soldiers in the Irish Defence Forces.

2. To investigate how Irish military personnel address mental health concerns.
3. To determine how soldiers of all ranks currently seek help for mental health issues.
4. To investigate the factors that impact help-seeking.
5. To explore the perspectives of key stakeholders in help-provision regarding mental health and help-seeking behaviours of soldiers, and to examine their views on addressing key issues.

1.5 Structure of the Thesis

This thesis is structured across nine chapters, each contributing to a comprehensive exploration of mental health and help-seeking behaviours within the Irish Defence Forces. The organisation of the chapters reflects the logic of a sequential mixed methods design and follows a clear trajectory from theoretical grounding to practical application, data analysis, and interpretation.

Chapter 1: Introduction

This chapter introduces the study, outlining the background, rationale, aim, and objectives. It describes the personal and professional motivations that informed the research topic and provides an overview of the prevalence of mental health difficulties and help-seeking behaviours, followed by the structure of the thesis. The chapter concludes with a reflexivity section that addresses the researcher's positionality, professional background, and the influence of these factors on the research process. This reflexive account establishes the importance of transparency and critical self-awareness from the outset, particularly given the researcher's insider status within the Irish Defence Forces.

Chapter 2: Literature Review Part 1: Mental Health in Military Contexts

Chapter two reviews relevant international and national literature on the prevalence of mental health issues among military personnel. It considers the psychological impact of military service, the risk factors associated with operational and occupational demands, and the limited research available within the Irish Defence Forces.

Chapter 3: Literature Review Part 2: Help-Seeking in Military Populations

This chapter explores the key literature on help-seeking behaviours in military contexts. It examines the cultural, structural, and psychological barriers to accessing support, including stigma, career-related fears, gendered expectations, and institutional constraints. The chapter also identifies research gaps and supports the case for a mixed methods approach.

Chapter 4: Methodology

Chapter four presents the study's philosophical foundations and methodological design. It justifies the use of a sequential explanatory mixed-methods approach. The chapter also identifies the theoretical framework. In this study, James C. Scott's Hidden Transcripts theory is applied to investigate decision-making processes related to help-seeking behaviours among soldiers experiencing mental health challenges. Finally, the chapter addresses ethical considerations and outlines the overall research strategy guiding the project.

Chapter 5: Methods

This chapter presents how the methodology was operationalised in practice. It details the implementation of the quantitative and qualitative phases, including sampling strategies, survey design, data collection procedures, and the conduct of semi-structured interviews with key stakeholders. It also outlines how the data were managed and prepared for analysis.

Chapter 6: Quantitative Findings

Chapter six presents the statistical findings, and the findings of the open-ended survey responses derived from the survey completed by serving personnel in the Irish Defence Forces. It reports on the prevalence of mental health symptoms and summarises descriptive and inferential data related to help-seeking behaviours, mental health conditions, and patterns of service engagement.

Chapter 7: Qualitative Findings

This chapter provides a thematic analysis of the semi-structured interviews conducted with key stakeholders involved in the provision of support services within the Defence Forces. It explores stakeholder perspectives on systemic and cultural challenges to help-seeking, including stigma, medical grading, peer reliance, policy gaps, and operational pressures.

Chapter 8: Integration of Findings and Discussion

Chapter eight integrates the quantitative and qualitative findings through a mixed methods interpretation. Drawing on Hidden Transcripts Theory as the study's

theoretical framework, it critically examines the relationship between formal institutional narratives and the lived experiences of personnel, identifying key tensions and implications for mental health support systems.

Chapter 9: Conclusions and Recommendations

The final chapter presents the study's conclusions and outlines its key contributions to knowledge, policy, and practice. It offers evidence-informed recommendations for improving mental health support in the Irish Defence Forces and proposes directions for future research. The chapter also reflects on the study's limitations and the implications of the researchers insider positioning.

1.6 Reflexivity: Navigating Insider Knowledge and Research Integrity

Reflexivity has served as a cornerstone throughout this doctoral research, guiding not only the design and analysis but also the ethical stance from which this inquiry was undertaken. Rooted in traditions of qualitative and mixed-methods research, reflexivity is understood as the continuous and deliberate examination of the researcher's role, positionality, assumptions, and potential influence on the study (Finlay, 2002; Berger, 2013). For this thesis, which explores help-seeking behaviours and mental health challenges within the Irish Defence Forces, reflexivity was not an abstract concept but an embodied and necessary practice, one that required sustained critical reflection on both personal experience and institutional proximity.

Components of reflexivity include self-focused reflexivity, which involves a deep engagement with the researcher's own positionality. This requires critical reflection on how one's social location, professional identity, and lived experiences influence both the interpretation of data and the construction of meaning (Cayir et al., 2022). In this study, such reflexivity was grounded in my own service in the Irish Defence Forces from 2001 to 2023. Over two decades in uniform instilled in me a profound awareness of the cultural and structural dynamics that shape soldiers' experiences, including the persistent stigma surrounding mental health, the rigid expectations of operational readiness, and the informal ways personnel navigate support systems. This insider perspective afforded me privileged access to the unspoken norms and organisational language that govern everyday military life. It enabled me to ask questions with cultural fluency and interpret data through an informed lens. For many participants, I was not an external observer but a trusted peer, someone who had 'been there' and could be confided in without the need to explain military life in basic terms.

However, such closeness also carried risks. My previous affiliations, relationships, and emotional investments in the organisation required me to remain constantly alert to the potential for bias. The dual role I occupied, as both researcher and former participant in the system under scrutiny, demanded careful boundary management and a willingness to question my own interpretations. I had to remain open to critical perspectives that challenged my prior beliefs, and to the possibility that participants' experiences of the institution might differ sharply from my own. To support this process, I maintained a reflective journal throughout the study, documenting not only methodological decisions but also emotional reactions, tensions, and evolving insights. Regular supervisory dialogue and peer review sessions helped interrogate assumptions and uphold analytical rigour.

Reflexivity also extended to the design and implementation of the study. As part of the sequential explanatory mixed methods design, Phase 2 interviews with key stakeholders were always planned, but reflexive practice shaped how these were carried out. My insider knowledge helped identify which appointments would provide the most relevant contextualisation of the survey findings, and it informed the framing of interview questions to reflect the Defence Forces' cultural and organisational language. Reflexivity also influenced practical decisions, such as adapting the original plan for on-site, paper-based surveys to an online format during the COVID-19 pandemic, balancing accessibility with confidentiality concerns. These examples demonstrate that reflexivity informed not only how findings were interpreted, but also how data were gathered and contextualised across both phases of the research.

Another component of reflexivity, known as relational reflexivity, highlights the significance of interpersonal dynamics and the influence of collaborative perspectives within the broader scholarly dialogue (Cayir et al., 2022). It invites critical reflection on how differing viewpoints, whether from co-researchers, supervisors, or peer reviewers, shape the interpretation of data and the overall research narrative. In this study, although I conducted the research as a sole author, the input of supervisors as academic advisors, and critical peers functioned as a de facto research team. Their insights and challenges contributed to the credibility, interpretive depth, and ethical rigour of the analysis. At times, their perspectives introduced new avenues of interpretation or questioned implicit assumptions, prompting me to re-examine my analytical stance. This process of relational engagement was not limited to academic dialogue alone. There were moments during the research that provoked personal discomfort, times when participants' testimonies reflected my own experiences of distress or exposed institutional shortcomings within a system I had once defended. These encounters served as a powerful reminder that this research was not merely an academic exercise, but a deeply ethical endeavour. It involved listening to and amplifying

voices often marginalised within rigid hierarchies, and doing so with the awareness that my position as an insider could either empower or constrain those voices. Such moments demanded a heightened reflexive stance, one that recognised the potential for both insight and bias and sought to remain accountable to the complexities of representing lived experience.

The adoption of a mixed methods design in this study further underscored the importance of reflexivity. In mixed-methods research, where qualitative and quantitative components are integrated to develop a more nuanced and comprehensive understanding of the phenomenon under investigation, reflexivity must extend beyond the qualitative strand to encompass the entire research process (O'Cathain et al., 2008). The interplay between statistical trends and narrative accounts revealed both areas of alignment and divergence, prompting critical reflection. Reflexive consideration was given to each methodological decision point, ensuring that the integration of data was guided by both empirical insight and theoretical coherence. In some instances, the quantitative data indicated patterns that challenged my personal assumptions or might otherwise have gone unnoticed, while the qualitative findings illuminated systemic issues that required me to confront uncomfortable realities within a culture I had long belonged to. This inherent tension between insider familiarity and the need for critical distance was not a limitation, but a methodological strength, so long as it was approached with openness, humility, and a commitment to transparency throughout the research process.

Importantly, reflexivity also shaped how I approached ethics within the study. Given the sensitivity of discussing mental health in a military context, I was mindful of the risks participants might face in speaking openly. My insider status could either encourage trust or elicit caution, depending on each individual's perception. To mitigate this, I prioritised informed consent, anonymisation, and the assurance that participation held no consequence for any individual's standing. These measures were not only procedural but rooted in a deep commitment to honouring the trust placed in me.

In conclusion, reflexivity has not been a discrete stage of this research, but a continuous, iterative, and deeply personal process. It has required me to move between roles, as former soldier, researcher, witness, and at times, critic, with care and integrity. Through this process, I have sought to balance the depth of insight afforded by my lived experience with the objectivity and rigour demanded of academic scholarship. This thesis, therefore, stands not only as a contribution to knowledge but also as a personal reckoning with the culture, values, and responsibilities that continue to shape the lives of those who serve.

Chapter 2: Literature Review Part 1: Mental Health in the Military

2.1 Introduction

This chapter, together with Chapter 3, presents a narrative literature review, a methodological approach selected because it allows for a broad, flexible and critically interpretive synthesis of research on military mental health and help-seeking. Given the diversity of sources drawn from psychology, sociology, organisational studies and Defence Forces policy, a narrative approach enables the integration of heterogeneous evidence while identifying themes, conceptual linkages and gaps in knowledge. The Irish literature is notably limited, and the scarcity of peer-reviewed studies necessitates the inclusion of organisational reports, surveys, policy documents and internal reviews, which provide essential contextual detail not captured in international academic work.

Unlike systematic reviews, which prioritise exhaustive searches and strict inclusion criteria, a narrative review supports contextual interpretation and enables the incorporation of military reports and grey literature that would otherwise be excluded. Systematic review methods require a stable and methodologically comparable evidence base, which does not currently exist for Irish military mental health research and research designs are fragmented across international literature. The available evidence varies in methodological rigour, diagnostic measures and sampling criteria, and frequently located in non-academic organisational sources. As such, a narrative review is the most appropriate and methodologically defensible approach for synthesising material that is heterogeneous in scope, format and epistemological orientation (Sukhera et al., 2022)

Excluding grey literature would risk omitting the only available data on organisational processes, cultural dynamics, medical-classification practices and internal stressors within the Irish Defence Forces, thereby producing an incomplete or distorted evidence base. The narrative approach therefore maintains methodological integrity while enhancing contextual understanding. This method is also consistent with established practices in military organisational scholarship, where interdisciplinary and unevenly distributed evidence requires integrative synthesis rather than restrictive filtering (Kunisch, Heinze and Kieser, 2023)

To support clarity and coherence, the literature review is divided into two chapters. Chapter 2 (the present chapter) examines mental health issues within military populations, including prevalence, risk factors, branch differences, cultural

influences and the unique characteristics of military service. Chapter 3 then concentrates on help-seeking, exploring formal and informal pathways, barriers, military help-providers and the structural and cultural determinants that shape behaviour. This structure reflects the aims of the study by enabling a distinction between mental health burden and the systemic conditions that influence access to care.

The search strategy used to collate a comprehensive and relevant body of literature involved consulting several key databases, including PubMed, PsycINFO, CINAHL, the Cochrane Library, BioMed and the King's College London repository. Manual reference-list searches were conducted on reviewed articles, and relevant texts held within the Defence Forces Military College and Trinity College libraries were examined. This multi-stage search strategy ensured the inclusion of both international evidence and Irish-specific material that is essential for contextualising the mental health experiences of Defence Forces personnel.

2.2 Background

Mental disorders represent a major global public health concern and are among the leading contributors to the burden of disease (Schuch and Vancampfort, 2021). By 2019, around 12% of the world's population was affected by a mental disorder, accounting for 5% of all disability-adjusted life years (DALYs), which capture both premature mortality and years lived with disability (Rehm and Shield, 2019). According to the Global Burden of Disease study, mental disorders ranked among the ten most prevalent health conditions worldwide in 2019 (Charlson et al., 2019). Their contribution to DALYs rose from 13th in 1990 to 7th in 2019, reflecting the increasing global impact of mental illness (GBD 2019 Diseases and Injuries Collaborators, 2020).

Within military populations, the risk of developing mental health conditions is heightened due to combat and deployment-related exposures. Evidence consistently links military service to elevated rates of post-traumatic stress disorder (PTSD) (Thomas et al., 2010; Eisen et al., 2012), major depressive disorder (MDD) (Sareen et al., 2007; Kessler et al., 2014), and suicide attempts (Nock et al., 2015). Although military training aims to prepare personnel for combat and peacekeeping, the psychological consequences of trauma exposure are well documented. Historical data from the Vietnam and Persian Gulf war's show mental health problems at two to three times the rate of non-deployed personnel (Steele, 2000), with subsequent conflicts reinforcing the long-term psychological toll of service (Axelrod, 2006; Forbes et al., 2016).

More recently, rising rates of anxiety disorders, depression, PTSD, substance misuse, and suicide have been reported across global military organisations (Hom

et al., 2017; Perez et al., 2021). These findings challenge the notion of the 'healthy soldier effect', which assumes that rigorous pre-enlistment screening should produce better-than-average mental health outcomes (Ganz et al., 2021). In reality, data suggest otherwise. In 2019, approximately 8.4% of the U.S. military were formally diagnosed with a mental disorder, equating to 1.9 million outpatient encounters. Of these, 3.8% were diagnosed with PTSD, 7.3% with an anxiety disorder, 7.5% with depression, and 2.6% with alcohol or substance-related disorders (Department of Defense [DoD], 2019).

Suicide has emerged as one of the most pressing mental health concerns within military populations. Since the conflicts in Iraq and Afghanistan, suicide rates among active-duty US personnel have reached their highest levels since systematic monitoring began, signalling a sustained and deeply concerning trend (Orvis, 2019). This pattern underscores the scale of the problem and the urgent need for comprehensive strategies to understand and address suicide risk within military settings.

Differences in branch structure, role, and operational demands also shape mental health risks. The Army, Navy, and Air Force each face distinct stress profiles, with varying exposure to traumatic events (Kennedy, 2020). While risk-taking may enhance operational effectiveness, it can also lead to harmful behaviours in personal life (Adams, 1995; Robinson et al., 2021). Exposure to combat stressors, atrocities, and human suffering can precipitate depression, anxiety, self-harm, and substance misuse (Armed Forces Health Surveillance Centre, 2012; Kings Centre for Military Health Research, 2016). Even peacekeepers in non-combat roles report elevated distress compared with civilians (Forbes et al., 2016).

A further area of concern is moral injury, which arises when military personnel perceive themselves as having violated their moral values, or as having been betrayed by leaders or comrades (Litz et al., 2009; Williamson et al., 2019). Moral injury has been associated with PTSD, depression, suicidality, and substance misuse. Accounts from peacekeeping missions in Rwanda (Dallaire, 2003) and Somalia (Gray et al., 2004) illustrate the ethical complexities and morally injurious experiences that extend beyond conventional combat (Agazio and Padden, 2024).

Spirituality, although historically peripheral within military culture, is increasingly recognised as an important factor in psychological wellbeing. For some personnel in the UK Armed Forces and the Irish Defence Forces, spirituality provides resilience, meaning, and a means of coping with trauma (Kopacz et al., 2016; Currier et al., 2018). Conversely, morally injurious experiences may disrupt belief systems, leading to spiritual distress or loss of faith (Seddon et al., 2011). Conventional PTSD treatments, such as Prolonged Exposure or EMDR, largely target behavioural and cognitive symptoms, often overlooking existential and

moral suffering (Williamson et al., 2019). Nonetheless, EMDR has shown robust and sustained benefits across multiple domains, including anxiety and depression, particularly among displaced and conflict-affected populations such as military personnel (Wippich et al., 2024).

Suicidality and self-harm represent persistent concerns within military populations, shaped by a complex interplay of occupational, psychological, and cultural factors. Evidence suggests that substance misuse, particularly alcohol and drugs, is closely linked to increased vulnerability, with alcohol use often intersecting with other mental health difficulties such as depression and post-traumatic stress disorder (Moradi et al., 2021; Gromatsky et al., 2022). Self-harming behaviours, including non-suicidal self-injury (NSSI), are also increasingly recognised as under-researched yet clinically significant issues among both active personnel and veterans.

Alcohol misuse is especially embedded within military culture, where it is often normalised as a mechanism for managing operational stress, trauma exposure, and the challenges of reintegration (Bray and Hourani, 2007; Sharp et al., 2024). This pattern of substance use not only complicates diagnosis and treatment but also reinforces cultural barriers to help-seeking, making early identification and intervention more difficult. The interconnections between suicidality, self-harm, and substance misuse highlight the importance of considering both cultural norms and comorbidities when addressing mental health within military settings.

Gendered experiences further influence vulnerability. Hendrikx et al. (2023), studying UK female veterans, reported high levels of adversity: 22.5% experienced sexual harassment, 22.7% emotional bullying, 5.1% sexual assault, and 3.3% physical assault. Each was significantly associated with adverse mental health outcomes. For example, sexual harassment and bullying increased the risk of PTSD (odds ratios 2.30 and 2.06, respectively), sexual assault was linked to both PTSD and harmful alcohol use (OR = 2.73 and OR = 2.88), and physical assault carried the strongest association with PTSD (OR = 4.31). Younger women, officers, and those in combat or combat-support roles were particularly vulnerable.

Finally, the transition from military to civilian life introduces further psychological strain. Derefinko et al. (2018) noted that many personnel continue to experience or develop difficulties after service, including PTSD, substance use, emotional dysregulation, and interpersonal conflict. Wilson et al. (2018) highlighted loneliness and social isolation, resulting from separation from the close-knit military community, as critical factors shaping both mental and physical health in reintegration.

In summary, the international literature demonstrates a clear and consistent association between military service and elevated mental health risk. Patterns of anxiety, depression, PTSD, suicidality, self-harm, and substance misuse are evident across military populations. These outcomes are shaped not only by combat exposure and deployment stressors but also by structural, cultural, and gender-specific adversities inherent in military service.

2.3 Mental Health in the Irish Defence Forces: International Comparisons

The Irish Defence Forces are widely acknowledged for their professionalism in humanitarian and peacekeeping roles. Since 1958, they have contributed to over 70 United Nations (UN) or UN-mandated missions, accounting for approximately 85,000 individual overseas deployments (Harvey & Myers, 2017). Despite this long-standing record of international service, research on mental health within the Defence Forces remains comparatively limited. Emerging evidence indicates that symptoms of mental health difficulties can develop early in the military career trajectory for a substantial proportion of individuals (Dell et al., 2023).

Understanding mental health in the Irish Defence Forces requires an appreciation of how the organisation differs from other militaries in structure, culture, operational function and the way mental health care is delivered. International research consistently demonstrates elevated rates of anxiety, depression, PTSD, suicide and substance misuse among service members (Sharp et al., 2023; Stevelink et al., 2019; Jones and Wessely, 2014). However, these patterns cannot be interpreted without considering how the Irish Defence Forces differ in size, mission profile, deployment structure and healthcare systems. The distinct nature of Irish military service, characterised by a long-standing peacekeeping rather than combat orientation (Department of Defence, 2022), a comparatively small force structure (EDA, 2022) and a medical system shaped by classification rules that affect career progression (Independent Review Group, 2023), creates a psychological landscape that diverges from that described in larger international studies. This contextual foundation is essential for interpreting both the global evidence and the particular vulnerabilities experienced within the Irish Defence Forces.

The Irish Defence Forces are among the smallest militaries in Europe and operate largely within a humanitarian and peace-support framework (Department of Defence, 2022; EDA, 2022). Their operational identity has historically been shaped by United Nations missions rather than high-intensity warfighting, which influences training regimes, deployment structures, and the meaning attached to exposure, adversity and resilience(Cosgrave, 2020). High familiarity within units, a

natural outcome of small-force cohesion, strengthens interpersonal relationships but may also intensify concerns about confidentiality, stigma and career visibility when disclosing mental health difficulties (Britt et al., 2008).

Much of the global literature on military mental health derives from large, combat-oriented forces such as the United States, United Kingdom, Canada and Australia. Studies from these settings often draw on cohorts with extensive combat exposure, multiple high-intensity deployments and highly developed surveillance systems for mental health reporting (Hoge et al., 2004; Fear et al., 2010; Zamorski et al., 2014). As a result, direct transferability to the Irish context is limited because of differences in operational demands, deployment cycles, occupational roles, force size, gender composition and data collection practices (EDA, 2022; IRG, 2023). The Irish Defence Forces, for example, have one of the lowest proportions of women in Europe (European Institute for Gender Equality, 2023), which shapes organisational culture in ways that differ from more gender-diverse forces.

Mental health care within the Irish Defence Forces is predominantly framed through a medical model. Presentation to a Medical Officer can initiate changes in medical classification that may affect career progression, deployment eligibility and promotion opportunities (Independent Review Group, 2023; Irish Defence Forces, 2015). This structural link between disclosure and potential occupational consequences has consistently been identified as a barrier to help seeking in Irish studies (Mitchell et al. 2023; Mac Mahon et al., 2016). The organisation does not routinely embed mental health professionals within operational settings and does not employ the forward mental health or occupational mental health teams commonly used in larger militaries. In forces such as the United Kingdom and the United States, forward psychiatry and Combat and Operational Stress Control units provide rapid assessment, stabilisation and early intervention close to the point of breakdown (Jones et al., 2017; Benedek et al., 2007). These systems are designed to support operational readiness and prevent acute stress reactions from progressing into long-term morbidity (Greenberg et al., 2007). The absence of such proactive and embedded structures in the Irish Defence Forces further differentiates its approach from international practice and reinforces a predominantly reactive model of care.

Although international studies offer consistent patterns of military mental health risk, contextual differences in exposure profiles, methodological approaches, cultural norms and organisational pressures limit their direct application to Ireland. Variations in sample characteristics, deployment intensity, trauma type, baseline occupational stressors, gender distribution and surveillance systems all influence prevalence estimates and behavioural outcomes (Sharp et al., 2023; Stevelink et al., 2019). These differences underline the need for contextualised interpretation

of international findings and reinforce the importance of developing an evidence base that reflects the specific structural and cultural realities of the Irish Defence Forces.

Doody et al. (2021) provide valuable qualitative insight into the lived experiences of Irish Defence Forces personnel during deployment, highlighting both acute and chronic stressors alongside protective influences such as training, family support, and belief in mission purpose. Their study illustrates the wide range of potentially traumatic events encountered by service members, including naval rescue missions involving migrants, armed confrontations, and prolonged operational pressures. Chronic work-related stress and interpersonal conflict were also reported as significant factors undermining resilience and psychological wellbeing. By focusing on resilience as well as trauma, the study provides an important counterbalance to deficit-focused research, though its small sample (n = 12), self-selection bias, and retrospective design limit generalisability, and its context-specific focus leaves broader structural and cultural barriers insufficiently explored. Separately, Pflanz (2001) found that military mental health clinic outpatients frequently perceived occupational stress to have a substantial adverse impact on their emotional wellbeing, further underscoring the role of workplace factors in shaping psychological outcomes.

Unlike other nations such as the UK, (Moradi, et al., 2021; Ministry of Defence, 2022) the Irish Defence Forces does not routinely collect or publish annual data on the mental health of its personnel . However, some research does occur, notably the 2015 Climate Survey, which examined stress and well-being across the organisation (Mac Mahon, et al., 2016). In total, 1,055 Defence Forces members completed the survey (11% response rate), with respondents broadly reflecting the organisation's demographic profile: nearly 90% were men, 6% were women, and the rank distribution followed the expected pyramid structure. Service tenure was weighted toward experienced personnel, with more than half serving over 11 years. Branch representation also mirrored the overall force composition, with almost nine in ten from the Army, 8% from the Naval Service, and 3% from the Air Corps (Mac Mahon et al., 2016). Complementing these survey data, Mac Mahon, et al., (2016) reported widespread concerns among Defence Forces personnel regarding morale, workplace conditions, leadership, and equality, based on focus groups with over 600 participants. Poor living quarters, high workloads, declining training standards, and safety concerns were frequently highlighted, alongside perceptions of hierarchical abuse and a lack of supportive leadership. Gendered experiences also emerged, with women reporting unequal treatment and exposure to negative workplace behaviours. Taken together, these findings suggest that organisational climate issues, particularly low morale, poor working conditions, and strained power dynamics, may act as significant psychosocial

stressors, increasing vulnerability to mental health difficulties such as anxiety, depression, and burnout. The study reinforces the view that workplace climate is not only an occupational or cultural concern but also a determinant of psychological wellbeing, with clear implications for retention, resilience, and help-seeking within the Defence Forces.

International research consistently demonstrates that military personnel face distinct occupational stressors, often reporting higher levels of stress from their military duties than from personal or family sources (Hourani et al., 2006). These pressures also extend into the family environment, with early work by Kamm (1951) already identifying psychological disorders among military families at rates of 3% to 15%, including depression, obsessive-compulsive symptoms, paranoia, interpersonal difficulties, and aggression. Contemporary studies confirm that certain groups, particularly younger personnel, women, and married members separated from spouses during deployment, are disproportionately vulnerable to poor mental health and reduced productivity (Hoge et al., 2004; Vogt et al., 2011). Financial insecurity has also emerged as a recurring concern, with socioeconomic pressures such as austerity and reliance on state supports compounding psychological distress (Corcoran et al., 2015). Reports indicate that over 120 Irish Defence Forces members relied on social welfare supports to meet basic needs (Micheál, 2020).

These international findings resonate with the Irish Defence Forces, where similar themes of occupational stress, gendered vulnerability, family strain, and financial pressure are evident. Together, they highlight the commonality of mental health challenges across military contexts, underscoring that the difficulties faced by Irish personnel form part of a wider international pattern of risk.

Mac Mahon et al. (2016) also identified concerns regarding the Defence Forces' medical system. Many personnel reported fears that disclosing mental health difficulties could jeopardise career progression, contributing to reluctance in seeking support even for legitimate medical needs. Officers tended to express more favourable views of the system than enlisted personnel; however, dissatisfaction was widespread, particularly in relation to the perceived impact of medical consultations on eligibility for training or overseas deployment. In parallel, chaplains voiced concern over the severity of stress-related problems, arguing that the Defence Forces had not sufficiently addressed the psychological wellbeing of its members (Mac Mahon et al., 2016).

Recent Irish research has begun to examine resilience and mental health within the Defence Forces during unique operational contexts. Mitchell et al. (2022) investigated psychological wellbeing during the COVID-19 pandemic, comparing personnel deployed on pandemic-related duties with those who were not.

Contrary to expectations, no significant differences were observed in mental health outcomes between the two groups, suggesting that stressors extend beyond specific operational deployments and are embedded more broadly within military life. Importantly, the study found that depression was negatively associated with resilience, while exposure to multiple traumatic events predicted higher resilience, reflecting the complex interplay between risk and protective factors also noted in international research (Hourani et al., 2006; Forbes et al., 2016). These findings align with wider evidence that resilience is not simply the absence of symptoms, but a dynamic process shaped by prior experiences, coping resources, and organisational context. For the Irish Defence Forces, this underscores the need to consider resilience as both an individual and systemic capacity, and to ensure that supports extend to all personnel rather than focusing solely on those deployed in high-profile operations.

Doody et al. (2021) highlighted earlier, sought to explore both protective and risk factors shaping Irish Defence Forces personnel's experiences of potentially traumatic events. Using one-to-one, semi-structured interviews with 12 participants, the study found mixed views on available psychological support. While some valued aspects of preparation, many criticised pre-deployment training as superficial and inadequate in fostering emotional readiness for traumatic exposure. In response to such concerns, Doody et al. (2025) introduced the Resilience Skills Training Programme (RIPSTOP), a structured pre-deployment intervention for Irish Army personnel. By embedding resilience within the training cycle, RIPSTOP reframes psychological preparedness as a routine military competency rather than an individual trait. This development is a welcome contribution to the field, as it carries the potential to reduce stigma, strengthen organisational credibility in mental health provision, and align resilience-building directly with operational readiness.

In recent years, staffing shortfalls have compounded existing challenges within the military. By September 2020, the strength of the Irish Defence Forces had declined to 8,529 personnel, falling short of the approved establishment of 9,500. This reduction in workforce led to increased workloads, more frequent deployments, and heightened operational pressure and stress on remaining personnel (House of the Oireachtas, 2020). Hourani et al. (2006) demonstrated that U.S. military personnel experiencing depression and anxiety were three times more likely to report elevated stress across both occupational and family domains, with those recognising a need for mental health care also reporting significant productivity loss. These findings expose a systemic shortcoming: while militaries demand psychological endurance, the structures in place often fail to mitigate the compounded pressures of work and family life. Similar patterns emerge in the Irish Defence Forces. Lalor et al. (2024) found that personnel framed resilience as both

innate and shaped through training, often described as an internal “switch” that enabled perseverance. Yet this rhetoric of resilience was contradicted by the reality of limited institutional support. Soldiers reported that disclosure of stress or mental health difficulties risked stigma, exclusion from overseas deployments, and loss of career opportunities, with leaders sometimes perceived as dismissive or unsympathetic. Structural pressures, including financial strain and family separation, further exacerbated these challenges. Collectively, the U.S. and Irish evidence illustrate a persistent contradiction in military culture: resilience is valorised as a core attribute, yet organisational practices and cultural barriers undermine support, leaving personnel vulnerable and discouraging formal help-seeking.

2.4 Depression & Anxiety

Anxiety is characterised by persistent nervousness, worry, and tension that affect cognition, physical responses, emotional state, and behaviour. While it may be a normal reaction to stress, it becomes problematic when frequent, without clear cause, or when it significantly disrupts daily functioning (College of Psychiatrists of Ireland, 2018). Prolonged anxiety, particularly without an evident trigger, can be clinically concerning. Several disorders fall within the anxiety spectrum, including generalised anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (OCD), phobic disorder, acute stress, and anxiety not otherwise specified, each defined by excessive and irrational apprehension that interferes with functioning (American Psychiatric Association, 2013).

International research indicates that General Anxiety Disorder (GAD) rates increased steadily between 1999 and 2015, peaking around 2006 before declining slightly from 2017 to 2018. Although the trend began before the September 11, 2001, terrorist attacks, it became more pronounced in their aftermath, with repeated deployments and combat exposure identified as key risk factors (Crum-Cianflone et al., 2016). Global data further show a modest rise in anxiety disorder incidence from 579 per 100,000 in 1990 to 585 per 100,000 in 2019 (Wang et al., 2020). In contrast, increases within military populations have been far sharper. Between 1999 and 2018, GAD diagnoses rose by 620.43%, reflecting a substantial and growing burden of anxiety-related conditions among service members (Russell et al., 2022).

Comparative research highlights consistently higher prevalence of GAD in military populations, reflecting the unique occupational and cultural stressors of service life (Macdonald-Gagnon et al., 2024). GAD, a chronic condition marked by excessive worry, affects an estimated 6.8 million adults in the United States, with prevalence ranging from 6.3% to 32% depending on demographic factors and measurement tools (Momin et al., 2023). Women and older adults are especially

vulnerable, and comorbidity with depression and substance misuse is common, complicating treatment (Szuhany and Simon, 2022; Lawhorne-Scott and Philpott, 2015). Military prevalence rates are notably higher: a U.S. study found self-reported GAD rates of 13.9%, while the Canadian Armed Forces reported 12.1% compared with 9.5% in the general population (Taillieu et al., 2018). These conditions were also associated with greater functional impairment, particularly within family contexts. The relationship between anxiety and depression is also significant. A meta-analysis by Moradi et al. (2021) estimated depression prevalence among active-duty personnel at 23%, higher than the general population rate of 15–20% (Zandi et al., 2011; Mohammadi et al., 2020). Major depressive disorder (MDD) is among the most frequently diagnosed mental health conditions in U.S. veterans, with comorbidity between MDD and PTSD reported in more than half of cases (Hankin et al., 1999; Williamson et al., 2018).

Mood disorders, particularly depression, represent a significant public health concern and are characterised by substantial shifts in emotional state (Kerr, 2018). Despite being treatable, depression often remains under-recognised and undertreated (Macritchie, 2024). Globally, an estimated 3.8% of the population are affected, including 5% of adults and 5.7% of adults over 60, with women approximately 50% more likely than men to experience the condition (World Health Organization, 2023). In Ireland, prevalence estimates for major depressive disorder (MDD) are around 6%, and for generalised anxiety disorder (GAD) approximately 5% (Barry et al., 2009; Hyland et al., 2021). Antidepressant use has risen, with 6% of the population reporting use in the past year and the largest increase in prescriptions occurring between 2019 and 2020 (McCool et al., 2022). While recovery rates for depression are high, with about 80% achieving full remission, severe cases carry a lifetime suicide risk of 10–15% (College of Psychiatrists of Ireland, 2019).

Military personnel face a heightened risk of mood and anxiety disorders compared with civilians. During periods of conflict, aggregate prevalence rates of depression and anxiety have been reported at 28.9% and 30.7% respectively (Lim et al., 2022), while post-deployment depression affects approximately 14% of service members. These difficulties extend beyond the individual, with spouses and children shown to be at greater risk of emotional, behavioural, and relational problems, including higher rates of divorce, domestic strain, and family violence (Defence Manpower Data Centre, 2006; James and Countryman, 2012; Kerr, 2018). Research in the British Armed Forces further indicates that depression may manifest differently in military contexts, with Finnegan et al. (2014) arguing for a military-specific conceptualisation and the development of predictive models to guide clinical practice. Importantly, they noted that women were often more willing to seek help yet were sometimes inappropriately labelled as depressed.

Despite these findings, there remains limited research on depression in the Irish Defence Forces.

Irish data reinforce this concern. Mitchell et al. (2022) found that 19% of Defence Forces personnel reported moderate-to-severe depression and 11.4% moderate-to-severe anxiety. Notably, outcomes did not differ significantly by gender or rank, suggesting that distress is widespread across demographic groups. Broader research indicates that military personnel are also more likely to present with multimorbid conditions, including PTSD, depression, anxiety disorders, and substance use disorders, underscoring the cumulative psychological toll of service (Rosellini et al., 2015). Taken together, these findings highlight a consistent pattern: while anxiety and depression are common in the general population, they occur with greater frequency, complexity, and impact in military environments, shaped by combat exposure, operational demands, and organisational stressors

2.5 Post-Traumatic Stress Disorder

Pop-Jordanova (2022) defines psychological trauma as an individual's response to a negative event or persistent condition that overwhelms their capacity to process emotional experience. Traumatic exposure is widespread, with Kessler et al. (1995) estimating that around 50% of adults will experience at least one traumatic event in their lifetime. Global prevalence has likely increased with rising exposure to conflict, terrorism, and natural disasters, and more recent studies suggest that over 70% of adults encounter significant psychological trauma at some stage (Benjet et al., 2016; National Council for Behavioural Health, 2023). The DSM-5 defines traumatic events as direct exposure to, witnessing, or being confronted with incidents involving serious injury, threatened death, or sexual violence (American Psychiatric Association, 2013). Importantly, the likelihood of developing post-traumatic stress disorder (PTSD) is shaped not only by individual susceptibility but also by occupational role and the frequency and intensity of exposure to trauma (Berger et al., 2012).

In military contexts, personnel are routinely exposed to a broad spectrum of stressors during both overseas deployments and domestic operations, with the type and severity of reactions often varying by service branch (Army, Navy, or Air Force) and operational environment. Individual characteristics can further shape vulnerability. Research on other trauma-exposed groups, such as firefighters, shows that elevated masculinity-femininity discrepancies and higher social introversion predict greater susceptibility to PTSD (Chung et al., 2015), pointing to the potential influence of personality traits and culturally reinforced masculinity within military populations. Despite its clinical significance, PTSD remains a complex and contested diagnosis, largely due to the heterogeneity of symptom presentation. No single symptom is pathognomonic, and individuals may present

with markedly different clinical profiles. The DSM-5 identifies 636,120 potential symptom combinations leading to a PTSD diagnosis, a dramatic rise from the 79,794 combinations listed in DSM-IV (Galatzer-Levy and Bryant, 2013). This diagnostic variability presents a challenge in military settings where trauma exposure is frequent and multifaceted. Military research underscores these complexities: in the New Zealand Defence Force, being male, older, and having experienced multiple traumatic events predicted higher levels of PTSD symptoms (Richardson et al., 2020), while in the Irish Defence Forces, almost one-fifth of personnel met the threshold for probable PTSD, a prevalence substantially higher than that reported in comparable peacekeeping cohorts (Mitchell et al., 2021; Greenberg et al., 2008). Given this variability, its reasonable to suggest that PTSD should be measured using military-specific instruments that are sensitive to operational contexts and occupational exposures, such as the PTSD Checklist-Military Version (PCL-M), was developed for this purpose, providing a validated tool that accounts for the unique stressors and experiences of military personnel and veterans (Weathers, et al., 1991). Employing such tailored measures strengthens diagnostic accuracy, reduces the risk of misclassification, and enhances the credibility of research and clinical interventions within military populations.

A major challenge in assessing PTSD prevalence in military populations is that many stress reactions go unreported or undocumented. This issue is evident in Mitchell et al. (2022), whose study of resilience and mental health in the Irish Defence Forces during the COVID-19 pandemic provides useful insights but requires cautious interpretation. The cross-sectional design and modest sample size (n = 231) limit generalisability, while reliance on self-report measures heightens the risk of underreporting in a culture where stigma and career concerns often discourage disclosure. Furthermore, the study's focus on pandemic-related duties does not capture the combat and overseas deployment stressors more commonly associated with PTSD, and the absence of longitudinal follow-up prevents identification of delayed-onset cases. Taken together, these limitations suggest that PTSD prevalence in the Irish Defence Forces is likely underestimated and that larger, longitudinal, and context-specific research is needed.

Beyond methodological concerns, cultural and institutional factors also shape underreporting. Protective elements such as strong leadership, pre-deployment training, and norms that normalise exposure to abnormal events may buffer against distress but simultaneously contribute to concealment of symptoms (Kennedy, 2020). Similarly, psychosocial resources such as high morale and unit cohesion have been linked to lower rates of common mental health disorders and PTSD (Jones et al., 2012), yet they can also mask underlying difficulties by

sustaining outward performance despite internal strain. These dynamics indicate that routine screening alone may not adequately capture the true prevalence of PTSD, as cultural and organisational contexts can both mitigate and obscure psychological distress. Effective assessment therefore requires approaches that move beyond symptom checklists to address the hidden nature of underreporting within military environments.

Post-traumatic stress disorder (PTSD) affects approximately 7% of U.S. veterans over their lifetime, compared to about 6% in the general adult population. Prevalence is considerably higher among those deployed overseas, with between 10% and 18% of returning service members likely to develop PTSD (U.S. Department of Veterans Affairs, 2025). Variation in reported prevalence across studies is influenced by differences in research design, screening instruments, and methodological approaches. Nonetheless, several risk factors have been consistently identified, including a history of suicide attempts, identifying as trans-masculine, exposure to military sexual trauma, low income, younger age, and co-occurring behavioural health conditions (Schein et al., 2021). These findings highlight how vulnerability to PTSD is unevenly distributed across military subgroups.

Comparable trends have been observed internationally. In the United Kingdom, PTSD prevalence among current and former military personnel rose from 4% in 2004- 2006 to 6% in 2014- 2016, while rates of alcohol misuse declined from 15% to 10% over the same period (Stevelink et al., 2018). Importantly, PTSD is more common among veterans who have left service than among those still serving, reinforcing the cumulative impact of deployment on long-term wellbeing. Similar patterns are evident in the United States, where between 7% and 13.5% of personnel returning from Afghanistan developed PTSD following deployment (Hines et al., 2014). While peacekeeping and humanitarian operations are generally associated with lower PTSD rates, the presence of certain risk factors, ncluding lack of social support, social isolation, and lower military rank, can significantly increase vulnerability to PTSD and other adverse mental health outcomes following critical incidents. Enlisted personnel appear particularly susceptible, largely due to their increased likelihood of direct combat exposure (Xue et al., 2015). Collectively, these findings demonstrate both the international consistency of deployment-related PTSD risk and the influence of demographic, psychosocial, and service-related factors on prevalence rates. These international patterns provide an important context for examining PTSD within the Irish Defence Forces, where research is still emerging but early findings suggest comparable vulnerabilities.

PTSD is often accompanied by substantial functional impairment, reduced quality of life, and broader disability (Alonso et al., 2004). It frequently co-occurs with other mental health conditions, most notably depression, anxiety, and substance misuse (Kessler et al., 1995; Romano and Luba, 2024), while also being linked to physical health problems such as cardiovascular and metabolic disorders (Ahmadi et al., 2011). These high levels of comorbidity highlight the clinical complexity of PTSD and reinforce the need for comprehensive, multidisciplinary approaches to assessment and treatment, particularly within military and veteran populations where multiple health challenges often intersect.

2.6 Suicide and Self-harm

Recent data from the National Self-Harm Registry Ireland by Joyce, et al., (2025), show concerning trends in self-harm and suicidal behaviour, particularly when considered alongside demographic patterns in the Republic of Ireland. In 2022, there were 12,705 self-harm presentations by 9,748 individuals to emergency departments, increasing slightly to 12,792 presentations by 9,786 individuals in 2023. A gendered breakdown reveals a 6% reduction in the female self-harm rate since 2021, with 2023 figures marking the lowest rate for women since 2014 (217 per 100,000). Conversely, male self-harm rates rose slightly, from 168 per 100,000 in 2022 to 167 in 2023, which represents a 5% increase from 2021. These findings align with longstanding concerns about male suicidality, particularly among Irish men aged 40 to 59, who have consistently recorded the highest suicide rates over the past decade. Within this age group, self-harm peaked at 207 per 100,000 in 2012 and remains a significant public health concern due to the elevated lethality of suicide attempts in Irish men and the heightened risk of suicide following self-harm (O'Donnell and Richardson, 2018).

O'Donnell and Richardson research in Ireland, further identify several gender-specific risk factors, including the use of more lethal methods, reluctance to seek psychological support, higher rates of substance misuse, and the influence of rigid sociocultural norms around masculinity. These risks are particularly relevant to the Irish Defence Forces, where 93% of personnel are male. With an average age of 36.8 years and 60.3% of members under the age of 40, the demographic composition of the Defence Forces places a substantial proportion of personnel within the age range most at risk. Given that enlistment is capped at 39 years and the mandatory retirement age has only recently been extended to 60, with future plans to raise it to 62, a significant portion of serving members fall within the critical window for targeted mental health intervention (Irish Defence Forces, 2022).

Research on suicide within the Irish Defence Forces is limited, with the most substantial study conducted by Mahon et al. (2005). This retrospective case-

control analysis examined all deaths among regular-duty DF personnel between 1970 and 2002 (n = 732) and identified 63 suicides, representing 8.5% of all deaths. The average annual suicide rate was estimated at 15.3 per 100,000 personnel, broadly comparable to or slightly above the general Irish population at the time. Notably, firearm suicides accounted for 53% of cases, highlighting the occupational risk posed by access to lethal means. The study also identified key risk factors, including a history of psychiatric illness, previous self-harm, medical downgrading, and situational features such as suicides occurring shortly after the commencement of duty (Mahon et al., 2005).

Despite the value of this research, no updated peer-reviewed studies have been published in the two decades since. More recent discussions of suicide in the Defence Forces continue to reference these historical data. For example, Mitchell et al. (2022) noted that the Mahon et al. findings remain the most reliable published figures, with the estimated rate of 15.3 per 100,000 often cited as a benchmark for understanding suicide risk within the Irish military. However, reliance on outdated data presents a serious limitation, particularly given organisational, cultural, and operational changes in the Defence Forces since 2002. More recent insights come primarily from media sources. Sheridan (2019), for example, reported that non-combat deaths peaked at 17 in 2009, with further increases noted in 2011 (13 deaths) and 2016 (14 deaths), though the specific causes, including suicide, were not disclosed by the Defence Forces. While such reporting draws attention to mortality trends, it also underscores the lack of transparent and systematically published data on suicide within the Defence Forces.

Recognition of this gap has emerged in recent policy discourse. In 2023, the Independent Review Group on dignity and equality in the Defence Forces recommended a comprehensive investigation into deaths by suicide among both serving and former personnel over the past twenty years. The government subsequently committed to commissioning this study, acknowledging the urgent need for updated and transparent data (Independent Review Group, 2023; The Journal, 2023). While this initiative is welcome, findings are not yet available, leaving a critical evidence gap. Compared with international militaries, where suicide surveillance is more comprehensive, the Irish context remains reliant on retrospective studies or media-derived figures, limiting the accuracy of current understanding.

In this regard, the addition of Indian Armed Forces data offers valuable comparative insight. Between 2014 and 2021, a total of 787 personnel from the Indian Armed Forces died by suicide. When considered against the overall military size during this period (approximately 3,000,000 personnel annually), these

deaths represent a relatively small but deeply concerning proportion. The Indian Army accounted for the overwhelming majority of these cases, with 591 deaths (75.1%), followed by 160 in the Air Force (20.3%) and 36 in the Navy (4.6%) (The Print, 2021). This branch-level pattern highlights the disproportionate burden carried by Army personnel, reflecting broader international findings that greater exposure to combat and operational stress is linked to higher suicide risk. While Ireland has a relatively small force, comparison with one of the largest militaries in the world demonstrates recurring patterns that transcend size, particularly the heightened vulnerability of Army personnel. Such evidence helps to illustrate structural and occupational differences in suicide risk across branches and underscores the pressing need for similarly transparent and systematic reporting within the Irish Defence Forces.

While research on suicide in the Irish Defence Forces remains limited or outdated, international research provides a far more detailed picture of suicide risk in military populations. Moradi et al. (2021), in a systematic review and meta-analysis of studies published between 1990 and 2020, reported pooled prevalence rates of 11% for both suicidal ideation and suicide attempts among active military personnel. Subgroup analyses revealed striking variations: suicidal ideation was higher among veterans (14%) than serving personnel (10%) and more prevalent among women than men. Branch-level differences were also evident, with Air Force personnel showing the highest prevalence of suicidal ideation (19%), compared to 8% in the Army and 1% in the Navy. Suicide attempts followed a similar pattern, with the U.S. military reporting higher prevalence (14%) than the Canadian (1%), Australian (2%), British (5%), and Korean (4%) armed forces. Additional findings highlighted increased vulnerability among those with co-occurring behavioural health conditions, while lower prevalence was observed in groups such as military personnel living with HIV/AIDS (5%) or those consuming alcohol (9% ideation; 8% attempts).

Overall, these findings highlight a stark contrast between the Irish and international contexts. Irish research has focused predominantly on completed suicides, with limited data on suicidal ideation or attempts, and no branch-specific or gender-disaggregated analysis. In comparison, international studies such as Moradi et al. (2021) provide nuanced insights into demographic, occupational, and branch-level differences in suicide risk, allowing for more targeted prevention strategies.

Research from both the United Kingdom and the United States concerning operations in Iraq and Afghanistan has demonstrated a clear association between deployment and adverse mental health outcomes, including suicide (Axelrod, 2006; Hotopf et al., 2006). Bullman and Schneiderman (2021) underscore the

severity of this issue in the U.S., reporting an average of 20 veteran suicides per day alongside approximately one per day among active-duty personnel, a paradox whereby more service members die by suicide than in combat operations. Beyond combat, peacekeeping deployments have also been linked to psychological strain and suicidal behaviour, with Bartone et al. (1998) highlighting the negative repercussions of exposure to such missions.

In the United Kingdom, suicide rates among veterans are considerably lower in absolute scale, reflecting a smaller veteran population and differences in surveillance practices. In 2021, 253 suicides were registered among veterans in England and Wales, equating to a rate of around 15 per 100,000, with risks elevated in younger age groups but not approaching the daily totals reported in the U.S. (Office for National Statistics, 2021). This divergence reflects not only demographic and population size differences but also more systematic approaches to data collection in the UK, where veteran suicides are now routinely tracked, allowing for more precise monitoring of at-risk groups.

Suicide among active-duty personnel represents a critical and growing concern. According to the U.S. Department of Defense (2024), suicide rates in the active component of the U.S. military increased from 24.3 per 100,000 in 2021 to 28.2 per 100,000 in 2023, with the Army consistently recording the highest rates, peaking at 36.1 per 100,000 in 2021 before rising again to 34.8 in 2023. In contrast, the Navy and Air Force maintained lower rates overall, though both demonstrated upward trajectories, with the Navy increasing from 17.0 to 21.0 and the Air Force from 15.3 to 22.5 across the same period. These figures highlight the persistence of suicide risk across all branches, with the Army particularly affected.

Several psychological and occupational factors contribute to this vulnerability. Depression has been identified as the most significant predictor of suicidality among service members (Ramsawh et al., 2014), while a history of childhood abuse has also been linked to increased risk in military contexts such as the Canadian Armed Forces (Holens et al., 2021). The role of alcohol misuse remains contested. On one hand, studies by Jones et al. (2019) and Kim et al. (2012) found no significant association between alcohol use and self-harm or suicide attempts among active-duty personnel. On the other hand, Moradi et al. (2021), reported that alcohol and substance misuse increased the prevalence of depression and, in turn, contributed to higher suicide rates within military populations. This discrepancy suggests that while alcohol misuse may not always directly predict self-harm, it can exacerbate underlying mental health conditions that elevate suicide risk. Occupational status is also relevant: commissioned officers report significantly fewer lifetime suicide attempts than junior ranks, with non-commissioned officers resembling junior personnel in risk profiles. Branch

differences further reinforce these disparities, as Army and Navy personnel show higher rates of suicide attempts compared with the Royal Air Force (Jones et al., 2019).

These findings emphasise that active-duty personnel are not only at-risk during service but also share vulnerabilities with veterans, where Army personnel and those with psychiatric histories similarly emerge as high-risk groups (Moradi et al., 2021). This continuity across service and post-service populations underscores the need for prevention strategies that address both acute operational stressors and longer-term psychosocial risk factors.

The United States Air Force Suicide Prevention Program (DAF-SPP) remains one of the most frequently cited examples of a comprehensive, evidence-based military strategy. Originally launched in the mid-1990s, the programme is now managed through the Air Force Integrated Resilience Office and continues to incorporate population-level initiatives such as the ACE (Ask-Care-Escort) training model, routine mental-health check-ups, family-focused education, and "time-based prevention" to reduce access to lethal means (Department of the Air Force, 2024). RAND has supported its evaluation and refinement through tailored *Getting To Outcomes* (GTO) toolkits (RAND, 2021), while the Department of Defense's *Annual Report on Suicide in the Military* highlights the Air Force approach as part of broader efforts to address persistently elevated suicide rates across the Services (DoD, 2023). Importantly, the programme is not itself a SAMHSA product; rather, it has informed the Substance Abuse and Mental Health Services Administration's (SAMHSA) Suicide Prevention Resource Centre model, now recognised nationally as a framework of best practice (Suicide Prevention Resource Centre, 2023).

For the Irish Defence Forces, the structured, empirically supported nature of the Air Force programme offers a valuable foundation. Three components are particularly transferable to smaller forces: (1) leadership-driven culture change and postvention protocols, (2) routine population screening with targeted follow-up, and (3) policies emphasising means safety and peer/family engagement. Adapting these to the Irish context would address current gaps in surveillance and prevention, while signalling institutional commitment to mental health as a component of operational readiness.

Research indicates that military service members are at heightened risk of self-harm, although gender differences appear less pronounced than in civilian populations. Halverson et al. (2022) found only small disparities in the prevalence of non-suicidal self-injury (NSSI) between male and female service members, suggesting that military culture and occupational stressors may act as equalising factors. This contrasts with general population data, where Abbasian et al. (2021) reported significantly higher prevalence of NSSI among women (26.8%) compared

to men (17.9%). These gendered patterns align with broader evidence that women are more likely to internalise emotional distress (Nolen-Hoeksema, 2012), a process often exacerbated by societal expectations of caregiving and emotional expression, as well as exposure to interpersonal violence and inequality (Brunner et al., 2013).

A systematic review of 47 samples across five countries estimated the lifetime prevalence of NSSI at 15.8% among active military personnel and veterans, a rate notably higher than many civilian benchmarks (Gromatsky et al., 2022). Risk factors identified within military populations include female gender, junior rank, and service in the Army, with the latter reflecting higher exposure to combat and operational stressors (GOV.UK, 2018). In terms of psychiatric comorbidity, probable diagnoses of depression, anxiety, and PTSD, but not alcohol misuse, are consistently associated with lifetime self-harm (Jones et al., 2019). Importantly, all forms of self-harm are linked to prolonged psychological distress and an elevated likelihood of eventual completed suicide (Copper et al., 2005).

International findings further reinforce these patterns. In the Canadian Armed Forces, Holens et al. (2021) demonstrated that adverse childhood experiences significantly increased the likelihood of self-harm and suicide-related behaviours in adulthood, showing that pre-service vulnerabilities persist into military service. In the United States, Williamson et al. (2024) emphasised that NSSI is both under-researched and under-reported, despite its strong predictive relationship with suicidal ideation and attempts. Protective factors are equally critical: Bryan and Hernandez (2013) identified positive social support as the most substantial buffer against both self-harm and suicide attempts, underscoring its role in resilience.

By contrast, within the Irish Defence Forces, almost no published research has directly addressed self-harm. Existing literature focuses largely on completed suicides (Mahon et al., 2005; Sheridan, 2019; Mitchell et al., 2022), leaving a critical gap in understanding behaviours that frequently precede or co-occur with suicide. This absence contrasts with the growing body of international evidence and prevents the Irish Defence Forces from aligning with best practice, where militaries such as those in the U.S., UK, and Canada have begun to integrate self-harm monitoring into broader suicide-prevention frameworks.

Taken together, the evidence highlights that self-harm among military personnel is shaped by a complex interaction of gender, rank, service branch, and psychiatric comorbidity. It also reinforces the importance of protective mechanisms such as social support and unit cohesion. The lack of equivalent data in the Irish context represents a significant research gap, particularly given the strong links between NSSI, prolonged mental distress, and eventual suicide. Addressing this omission is

essential for developing effective prevention strategies within the Irish Defence Forces

2.7 Alcohol Misuse in the Military

The Healthy Ireland Survey 2023 reported that 70% of people aged 15+ consumed alcohol in the past year, a decline from 75% in 2018, with weekly drinking remaining stable at 38%. Men continue to drink more frequently than women (43% versus 34%), while binge drinking is especially concentrated among younger adults, with 36% of those aged 15- 24 engaging in this behaviour compared to only 7% of those aged 75+ (Department of Health, 2023).

Ireland remains one of the higher consumers of alcohol internationally. According to the OECD Health at a Glance 2023 report, per-capita alcohol consumption in Ireland was 9.5 litres of pure alcohol per adult (15+), compared with an OECD average of 8.6 litres (OECD, 2023). Alcohol-related harm continues to place a significant burden on the healthcare system. In 2023, there were 17,507 hospital discharges with an alcohol-related diagnosis, with a similar figure recorded in 2022 (17,512) (Health Research Board, 2024). In 2021, alcohol-related diagnoses accounted for 177,230 bed days in Irish acute public hospitals (Alcohol Action Ireland, 2023).

Treatment demand for alcohol problems also remains high. The National Drug Treatment Reporting System recorded 11,651 treatment cases in 2024 where alcohol was reported as a main or additional problem, indicating that hazardous use continues to affect a substantial proportion of the population (Health Research Board, 2024). Collectively, these findings highlight both the cultural acceptance of alcohol use and the enduring public health challenge it represents in Ireland, a backdrop of particular relevance when examining alcohol misuse within the Defence Forces.

In military populations, alcohol is frequently used to manage stress, trauma exposure, and co-occurring mental-health symptoms (Blakey et al., 2021). Former service members are particularly vulnerable: Ashwick and Murphy (2018) found that veterans are twice as likely as civilians to develop alcohol dependence. Transition to civilian life itself may act as a trigger, with Porter et al. (2020) showing that female ex-service members were especially prone to heavy drinking following discharge compared to their male peers. These findings complement prevalence-based research, such as Fear et al. (2007), who reported hazardous drinking in 67% of male and 49% of female UK personnel versus 38% and 16% in the general population, additionally, Research by the King's Centre for Military Health Research (2014) demonstrates that alcohol misuse is not evenly distributed across branches of the UK Armed Forces. Hazardous and harmful drinking is consistently

highest among Army and Royal Navy personnel, whereas prevalence rates are lower among Royal Air Force members. This branch variation is partly explained by differences in operational culture: the Army and Royal Navy tend to have younger profiles, longer periods away from home, and a stronger "macho" drinking culture that normalises heavy consumption (Jones & Fear, 2011).Furthermore, and Seal et al. (2011), found that 11% of U.S. returnees from Iraq and Afghanistan met criteria for alcohol or drug dependence. Collectively, these studies indicate that alcohol misuse is not only elevated during service but also represents a persistent post-service risk, with distinct gender and branch patterns and structural triggers.

These occupational disparities are plausibly maintained by frequent relocations and operational tempo that erode social support (Bray et al., 1991), and by "macho" drinking norms associated with cohesion and competitiveness (Keats, 2010; Jones and Fear, 2011). The best recent Irish study of serving personnel, Mitchell et al. (2022), administered the AUDIT-C alongside mental-health scales, but did not publish detailed subgroup prevalence for hazardous or harmful drinking; they noted alcohol was only weakly correlated with resilience, depression, anxiety and post-traumatic stress in their sample

Post-deployment increases in substance use may also reflect maladaptive coping strategies, used to process traumatic experiences and avoid formal mental health services. Jacobson et al. (2008) support this interpretation, while Seal et al. (2011) found that 11% of U.S. service members returning from Iraq and Afghanistan met the criteria for alcohol or drug dependence. The consequences of such behaviours often extend beyond the individual. Military families, particularly during deployments, face elevated stress levels due to sole parenting responsibilities, reduced emotional support, and strained communication and intimacy (Werner & Shannon, 2013). While leadership, morale, and unit cohesion can serve as protective factors, domestic stressors, especially relationship conflict, have been shown to impact alcohol abuse as severely as combat exposure (King's Centre for Military Health Research, 2014).

2.8 Summary

This chapter used a narrative literature review to synthesise evidence on mental health in military populations, drawing across psychology, sociology, organisational studies, policy reports, and Defence Forces documentation. The narrative approach enabled the integration of diverse forms of evidence and the identification of conceptual gaps, recurring themes, and implications for military mental health practice. International research consistently shows elevated rates of anxiety, depression, PTSD, substance misuse, suicide, and self-harm among service members, shaped by deployment exposure, moral injury, organisational culture,

gendered norms, and branch-specific demands. These risks are further influenced by the complex interaction of individual, occupational, and cultural factors, with spirituality, leadership, cohesion, and identity each playing variable roles in vulnerability and resilience.

However, these international patterns cannot be interpreted in isolation from the specific characteristics of the Irish Defence Forces. The Irish military differs markedly from larger combat-oriented forces in size, mission profile, organisational structure, deployment patterns, and healthcare systems. Irish service is characterised by humanitarian and peacekeeping operations rather than sustained combat, a smaller and more familiar force structure, and a medical system in which mental health disclosure may influence classification and career progression. These features create a psychological and organisational context that diverges considerably from that described in the international literature. Consequently, global evidence provides an important frame of reference, but it cannot be generalised directly without considering these distinct contextual factors.

Within Ireland, published research remains limited. Existing studies and organisational surveys highlight notable occupational stressors, concerns regarding leadership and workplace culture, apprehension about career impact following disclosure of difficulties, and mixed views of psychological support systems. Evidence on suicide relies on older retrospective analyses and media reports, with updated national investigation work still pending. There is almost no Irish research on non-suicidal self-injury, and little Defence Forces-specific data on alcohol misuse despite high levels of population-wide consumption. These gaps stand in contrast to the extensive surveillance systems used in other militaries, reinforcing the need for more systematic data collection within the Irish context.

Overall, the literature indicates that while many international patterns of military mental health risk are likely to apply in Ireland, critical differences in organisational culture, deployment experience, healthcare processes, and structural pressures shape how distress manifests and how personnel seek help. The chapter highlights the need for measurement that is sensitive to Irish military context and for system-level responses that address culture, leadership, stigma, suicide prevention, and family supports. Chapter 3 builds on this foundation by examining help-seeking pathways, barriers, and the role of military help-providers and services within the Irish Defence Forces.

Chapter 3: Literature Review Part 2: Help-seeking in the Military

3.1 Introduction

This chapter reviews the literature on help-seeking among military personnel, drawing on both national and international studies that explore how service members experiencing mental health difficulties engage, or fail to engage, with military support systems and services. The sources discussed were identified through the comprehensive search strategy outlined in Chapter 2, which included electronic databases, grey literature, and manual reference screening. Adopting a narrative review approach enables the integration of diverse forms of evidence, from military reports to qualitative accounts, while also facilitating international comparisons. This approach highlights the complex interplay between stigma, organisational structures, and available supports in shaping help-seeking behaviours within military contexts.

3.2 Background

As previously discussed in chapter 2, military personnel face an elevated risk of developing a range of psychiatric conditions. Access to mental health services is essential for symptom reduction and recovery. However, there is consistent evidence of significant underutilisation of these services among military populations (Kim et al., 2010; McKibben et al., 2013; Hom et al., 2017). Approximately 60 percent of military personnel experiencing mental health difficulties do not seek any form of assistance, whether through formal healthcare systems or informal support networks (Sharp et al., 2015). Various factors influence this pattern, including branch of service, rank, unit culture, deployment history, stage of career, perceived quality and accessibility of services, and geographical location (Hom et al., 2017).

International literature suggests that despite the introduction of evidence-based, military-specific mental health interventions, many personnel continue to avoid formal help-provision (Department of Veterans' Affairs & Department of Health and Human Services, 2013). Recent findings reaffirm this pattern of underuse, alongside the persistent cultural association between help-seeking and perceived weakness (Fikretoglu et al., 2022). Stigma, concerns about confidentiality, potential impacts on career progression, and fears regarding future deploy-ability remain prominent deterrents (Gould, et al., 2010).

To better understand how to engage military personnel in psychological care, researchers have investigated service utilisation rates, the barriers and facilitators

to accessing treatment, and targeted interventions to encourage help-seeking (Hom et al., 2017). Kennedy (2020) notes that many personnel avoid not only mental health services but medical care more broadly, often due to a prevailing ethos of self-reliance. This reluctance is further exacerbated by concerns about losing operational status, such as being declared unfit for armed duties, grounded from flight operations, or repatriated during deployment.

A systematic review by Hom et al. (2017) found that only 23.3% of service members who acknowledged a need for psychological support went on to access care. Yet the mechanisms that underlie this avoidance remain poorly understood. In addition to stigma, other barriers include a lack of knowledge about available treatment options, difficulty in securing time away from operational duties, and widespread mistrust of mental health professionals (Gold et al., 2016; Haugen et al., 2017; Kennedy, 2020).

Service members who experience suicidal ideation face particular challenges. Due to their routine access to firearms, they are often deemed unfit for continued service, which can lead to their immediate medical downgrading or administrative separation (discharge) (Ursano, et al., 2015). Anticipation of such consequences may deter individuals from seeking any type of formal mental health diagnosis resulting in them turning to civilian providers instead; (Fear, et al., 2010) (Sundin, et al., 2014). Greene Shortridge et al. (2007) further argue that even minimal contact with military mental health services can jeopardise opportunities for overseas deployment and advancement, creating powerful disincentives for disclosure. These findings highlight how organisational structure, and institutional culture can collectively discourage help-seeking behaviour.

Within the context of the Irish Defence Forces, these dynamics are shaped by military law and medical policy. According to current regulations, personnel must seek medical assistance through the Defence Forces' medical system. While limited circumstances allow for consultation with a local general practitioner, the full nature of any such engagement must be disclosed to the military medical officer (Irish Defence Forces, 2015). This transparency requirement carries significant implications for a soldier's medical classification. Maintaining an up-to-date and validated medical category is essential for eligibility for overseas deployment, promotional opportunities, and access to training and education programmes. Failure to meet the required medical standard may result in exclusion from these opportunities and, in some cases, discharge on medical grounds (Irish Defence Forces, 2015). As a result, many personnel may avoid seeking care altogether or may engage with external providers without disclosing it to the military system. In such cases, the absence of official documentation renders the help-seeking invisible and without consequence, thereby reinforcing

avoidance behaviours and reducing formal system engagement for mental health issues.

Ajzen's Theory of Planned Behaviour (1991) offers a well-established framework for understanding help-seeking behaviour. The model posits that behavioural intentions, shaped by individual attitudes, perceived social norms, and self-efficacy, are the strongest predictors of whether a person will engage in a given action. This theory has been applied within military contexts to examine the factors influencing soldiers' behaviour (Engelhardt et al., 2023; Chang et al., 2025). However, while it provides valuable insights into conscious decision-making, it may not fully account for the more covert dimensions of behaviour in hierarchical and highly regulated institutions such as the military. In contrast, Scott's (1990) Theory of Hidden Transcripts offers a conceptual lens to interpret behaviour under systems of domination. It focuses on the ways in which subordinate groups conceal dissent or distress in the presence of authority. Applied to military settings, this theory helps contextualise the normalisation of abnormal experiences, such as trauma or emotional distress, and the strategic concealment of mental health difficulties from those in power. This perspective may therefore offer a more nuanced understanding of help-seeking behaviour among soldiers, particularly where silence or inaction functions as a form of resistance or self-preservation. Scott's Theory of Hidden Transcripts, which provides a valuable framework for understanding the subtle, covert ways individuals navigate systems of authority and control, holds particular relevance in military contexts characterised by rigid hierarchies and institutional discipline. Its theoretical and practical application to military populations, particularly in relation to how personnel may conceal psychological distress, dissent, or vulnerability in the presence of authority, is explored in greater detail in the following chapter of this thesis, where it underpins the interpretive framework for the findings.

3.3 How Military Culture Shapes Behaviour

Military culture is a powerful and evolving system of shared beliefs, values, behaviours, norms, and symbols that profoundly shape the identities, perspectives, and social interactions of those who serve (Geertz, 2017). Through its traditions, rituals, language, training, and deployment cycles, military culture functions as a comprehensive socialising force that transitions individuals from civilian to military life (Atuel & Castro, 2018; Thompson et al., 2017). These mechanisms are intentionally designed to instil discipline, foster resilience, and promote conformity to collective goals.

Goffman (1961) famously described the military as a "total institution," a setting that strips away previous identities and resocialises individuals into conformity with organisational norms. Within this process, military recruits undergo what he

termed the “mortification of the self,” where personal autonomy is diminished and collective discipline is prioritised. This dynamic both constrains individuality and offers the potential for transformation, often framed in terms of character-building and resilience (Brookes, 2003). The expression “knuckle down,” widely used across military contexts, encapsulates this ethos of toughness and perseverance under pressure (Hale, 2008). In such environments, qualities such as strength, endurance, and mental toughness become not only valued attributes but also symbolic assets through which masculine identities are performed and validated (Zittoun et al., 2003).

Basic training serves as the primary vehicle for instilling these values. Callahan (2009) notes that repeated exposure to physical, cognitive, and moral stress is designed not to eliminate emotion but to regulate and channel it into controlled action. This structured exposure prepares recruits to manage the emotional volatility inherent in combat situations. In this sense, emotional management becomes an essential element of what (Hochschild, 1983) terms ‘emotional labour’, the internal regulation and external display of emotions expected of individuals in professional roles. Within military life, this emotional labour is both routine and integral to operational effectiveness.

Importantly, military culture extends beyond the scope of initial training and institutional doctrine. It is embedded in the organisational structures, power hierarchies, and informal social norms that govern daily interactions and influence individual behaviours. This cultural matrix significantly affects health-related behaviours, including attitudes towards mental health and help-seeking (Abraham et al., 2017). For example, studies have linked military culture to elevated rates of alcohol misuse (Ames & Cunradi, 2005) and to the unique stressors experienced by military spouses, these include frequent relocations that disrupt employment and social ties, prolonged separations during deployment, and the challenge of managing family life under conditions of uncertainty and risk (Watson, 2005).

Understanding military culture is essential for effective therapeutic engagement with service members. Koenig et al. (2014) argue that clinicians must develop a nuanced appreciation of the cultural dynamics within military settings to build rapport and deliver contextually relevant care. Cultural norms not only shape perceptions of trauma but also influence how service members evaluate the legitimacy and consequences of seeking psychological support (Zinzow et al., 2013). Each branch of the military, Army, Navy, and Air Force, develops its own subculture, complete with distinct rituals, jargon, and identity markers. These subcultures further entrench shared values and behavioural expectations, often making organisational change particularly difficult to achieve (Reger et al., 2008). The rigid hierarchical structure of the military also plays a critical role in

perpetuating collective attitudes, including those related to mental health stigma and service utilisation (Skerker et al., 2019; Lang et al., 2019).

Nonetheless, Abraham et al. (2017) caution against overly deterministic interpretations of military culture that focus exclusively on institutional values. Such perspectives risk neglecting the ways in which individual behaviour is also shaped by external influences, including personal histories, family dynamics, and broader societal expectations. A more comprehensive understanding of military culture therefore requires attention to both institutional norms and the complex interplay of individual and contextual factors that shape how personnel engage with mental health and support systems.

Building on this recognition of cultural complexity, masculinity theory provides a useful conceptual framework for examining how broader societal gender norms intersect with military institutional values to shape identity, behaviour, and responses to psychological distress. In doing so, it offers a structured lens through which the interaction between individual influences and organisational culture can be more clearly understood.

Masculinity theory encompasses a broad field rather than a unified model, spanning sociology, psychology, anthropology, and gender studies. Its core principle is that gender is socially constructed through culturally embedded expectations that shape behaviours, identities, and status within social groups (Connell, 1995; Schippers, 2020). Hegemonic masculinity, the most influential concept within this field, refers to culturally dominant ideals of manhood that legitimise male authority, privilege emotional control, toughness, and self-reliance, and stigmatise vulnerability (Connell & Messerschmidt, 2005). Military organisations have been repeatedly identified as some of the most powerful producers and enforcers of these norms (Bulmer, 2020).

Contemporary research demonstrates that traditional masculine norms strongly suppress help-seeking among service members. Behaviours such as emotional restraint, endurance, and self-sufficiency are culturally valorised, while expressions of distress may be dismissed as weakness or incompatibility with the ideal soldier identity (Lehavot et al., 2020; Fox et al., 2021). These expectations are reinforced through training, operational demands, peer surveillance, and hierarchical evaluation systems. As a result, personnel may avoid psychological support to preserve credibility, operational readiness, or career prospects (Sharp et al., 2023; Fikretoglu et al., 2022).

Recent studies show that adherence to hegemonic masculinity predicts lower mental health literacy, reduced trust in clinicians, and greater reliance on private coping or alcohol use rather than professional intervention (Cole et al., 2023;

Stevelink et al., 2019). This pattern is especially pronounced among junior male ranks, who experience higher peer pressure to conform to culturally acceptable emotional behaviour.

Although constructed around male norms, military culture also shapes the identities and behaviours of women in service. Research shows that women often engage in what Herbert (1998) called “gender performance work”, adopting masculine-coded behaviours to be perceived as capable and legitimate within male-dominated environments. Recent research in military contexts confirms that women in service continue to align themselves with dominant masculine norms, often suppressing emotional expression, minimising distress, or distancing themselves from behaviours viewed as feminine in order to avoid judgement, marginalisation, or exclusion within armed forces environments (Duncanson, 2023; Godfrey et al., 2021).

Women in military environments face distinctive help-seeking challenges that intersect with organisational culture and gendered expectations. Research shows that some women avoid formal mental health services to prevent reinforcing stereotypes of emotional fragility or reduced resilience (Winslow and Dunn, 2020). Within overwhelmingly male units, such as those in the Irish Defence Forces, the pressure to conform and “fit in” can intensify the internalisation of stoicism and silence around distress (Ray and Heffernan, 2020). Experiences of sexism, social isolation or institutional betrayal further diminish trust in organisational support structures, increasing the likelihood that women will rely on external or informal sources of care (Kamarck, 2021; LeardMann et al., 2021). For those who experience sexual harassment or assault, additional barriers arise, including fear of retaliation, reputational harm or disbelief, all of which can significantly deter disclosure and engagement with formal support pathways (Sadler et al., 2020). Thus, while masculine norms suppress help-seeking among men, they also impose additional burdens on women, who must negotiate both gender stereotypes and masculine organisational expectations.

With one of the lowest proportions of women in a European military (approximately 7 %) (Independent Review Group, 2023), the Irish Defence Forces represent an environment where masculine norms are especially dominant. Recent Irish research shows that personnel often equate help-seeking with weakness, unreliability, or poor soldiering, and fear that disclosure will result in negative career consequences (Mac Mahon et al., 2016; Mitchell et al., 2022). Women report heightened scrutiny, a need to “prove themselves” continually, and concerns that seeking help may reinforce stereotypes about women’s suitability for operational roles (Ray & Heffernan, 2020).

These dynamics reveal that gender and culture are deeply intertwined drivers of help-seeking behaviour. Understanding masculinity as a social and organisational force, rather than an individual trait, provides a more complete explanation for patterns of silence, avoidance, and reliance on informal supports. Integrating contemporary masculinity theory into analyses of military help-seeking deepens understanding in several important ways. First, it clarifies why emotional suppression and non-disclosure continue to function as normative behaviours within military settings, even as formal mental health programmes expand. Second, it demonstrates that the help-seeking barriers faced by women arise not only from general stigma but also from gendered organisational pressures embedded within masculine institutional cultures. Third, masculinity theory reinforces the critical role of leadership, culture change and inclusive policy development in challenging harmful norms and creating environments in which all personnel can safely disclose psychological distress and access support.

Recent evidence shows that interventions incorporating gender awareness, vulnerable leadership modelling, and normalised emotional communication are more effective at reducing stigma and increasing engagement with care (Theriault et al., 2019). As the Irish Defence Forces move toward a more holistic mental health approach, integrating gender-sensitive frameworks and challenging traditional masculine norms will be essential for improving both cultural climate and help-seeking outcomes.

3.4 Extent of Mental Health Help-Seeking in the Military

Research consistently demonstrates that military personnel are less likely to seek help for mental health difficulties than their civilian counterparts, despite being at heightened risk due to the psychological demands of service. Across international contexts, a large proportion of those experiencing distress do not engage with either formal care systems or informal supports (Sharp et al., 2015). This gap is especially concerning given the established associations between military service and conditions such as post-traumatic stress disorder (PTSD), depression, substance misuse, and suicidal ideation (Hom et al., 2017; Stevelink et al., 2019).

However, the difficulty does not rest solely with the help-seeker. The sustainability and credibility of military mental health provision are also shaped by the wellbeing of those who deliver care. O'Brien and Bogue (2025), in their Delphi study of Irish Defence Forces clinicians, found that growth, recognition, communication, and self-care were central to professional effectiveness. Where these needs went unmet, clinicians reported burnout, reduced motivation, and poorer treatment outcomes. Such pressures mirror the cultural and systemic barriers faced by

service users, including stigma, mistrust of confidentiality, and organisational silence around stress.

The interaction between these dynamics creates a cycle: soldiers may avoid formal services they see as ineffective, while strained clinicians struggle to deliver care that builds trust. Barriers to help-seeking and help-provision thus reinforce one another, sustaining disengagement and reliance on peer support. Reform must address both sides by reducing stigma and encouraging help-seeking, while also supporting clinicians with recognition, resources, and structures that protect their wellbeing. This helps explain why many personnel turn instead to informal care from peers, family, or chaplains, which is often perceived as more accessible and trustworthy than military services.

3.4.1 Formal Help-Seeking

Understanding the distinction between formal and informal care is central to examining help-seeking behaviours in military populations. Formal care refers to professional services provided by trained clinicians, including military doctors, psychologists, and psychiatrists (Martinez et al., 2023). In contrast, informal care encompasses support from family, friends, peers, social workers in most cases, or immediate supervisors (Fikretoglu et al., 2022). Although both forms of support play an important role, research consistently shows that military personnel demonstrate a preference for informal sources of help (Stevelink et al., 2019).

This preference indicates that many personnel feel safer accessing support outside the military system, largely due to fears of stigma, breaches of confidentiality, and the perception that seeking internal help could jeopardise career advancement or future deployment opportunities. Confidentiality concerns, in particular, remain a persistent barrier to care. Research shows that service members often worry that information disclosed during mental health evaluations- especially during deployment screening, might be shared with their chain of command (Wong et al., 2025). Such fears commonly focus on the potential consequences for career progression or deployment eligibility (Nazarov et al., 2024). These concerns reveal a broader mistrust of military mental health systems, underscoring the importance of transparent policies and secure, confidential pathways to care. International research echoes these findings, consistently pointing to the enduring role of stigma in shaping help-seeking behaviours within military populations (Sturgeon-Clegg & McCauley, 2019; Gould et al., 2010).

Formal help-seeking remains particularly limited. Hom et al. (2017) found that only 23.3% of service members who recognised a need for mental health care went on to access professional services. Similar trends are evident in the Irish Defence Forces: Mitchell et al. (2022) reported that while 19% of personnel met the

threshold for probable PTSD, just 8% sought internal counselling, compared with 26% who accessed external support. This preference for external providers underscores broader concerns about confidentiality, stigma, and career consequences. Comparable findings have been reported in the British Armed Forces, where engagement with formal services varies by branch and rank, with Army personnel, particularly younger men in junior ranks, more likely to rely on informal supports (Iversen et al., 2010; Stevelink et al., 2019). Such reliance reflects the wider perception that psychological support is stigmatised, both within the military and in society more broadly, and that disclosure of mental health difficulties could adversely affect career prospects (Sturgeon-Clegg & McCauley, 2019; Gould et al., 2010).

Similar patterns are evident within the Irish Defence Forces. Doody et al. (2021), in a qualitative study, found that many soldiers held negative views of formal psychological services. Pre-deployment mental health training was often described as superficial and procedural, failing to prepare personnel for traumatic realities such as encountering fatalities. As a result, formal services were frequently perceived as disconnected from the lived experiences of soldiers.

A strong ethos of self-reliance further reinforces this scepticism. Formal care is often regarded as unnecessary or ineffective, not because need is absent, but because cultural norms within the military discourage emotional openness and valorise toughness under pressure (Zinzow et al., 2013; Mathers, 2018). These attitudes are not unique to Ireland. U.S. studies similarly show that negative perceptions of mental health treatment are strongly associated with avoidance of services (Stecker et al., 2007; Pury et al., 2013). Brown et al. (2011), for instance, found that among 477 veterans screening positive for PTSD, depression, or anxiety, those holding negative attitudes toward treatment were significantly less likely to seek help. This dynamic contributes to reliance on informal supports, such as peers, family, or chaplains, which are often perceived as more trustworthy and less stigmatising, a theme explored in the following section.

3.4.2 Informal Help-Seeking

Informal help-seeking is widely recognised as more accessible and less stigmatising than formal care. Yet, reported reliance on such support varies markedly across contexts. For example, Stevelink et al. (2019) found that 86% of UK military personnel turned to informal sources such as family, friends, or peers, whereas only around 20% of Canadian service members reported doing so (Statistics Canada, 2013). This discrepancy may reflect methodological differences in survey design, cultural variation in attitudes toward family involvement, or differences in how informal care is defined across studies. It may also signal greater institutional barriers in one setting compared with another, prompting

personnel either to rely more heavily on close social networks (as in the UK) or to under-report such reliance if it is less culturally normative (as in Canada).

Regardless of these differences, the literature consistently highlights the value of informal care. Fikretoglu et al. (2022) emphasise that family members can play a pivotal role in detecting emotional or behavioural changes, particularly during reintegration. Wilson et al. (2015) note that support is most effective when it preserves the soldier's autonomy and sense of resilience, while Mikolajczak-Degrauwe et al. (2023) highlight the validating and non-judgemental qualities of informal relationships. Families are often the first to recognise psychological distress and can encourage formal engagement when needed (Spoont et al., 2014). Informal care therefore operates as both a protective factor and a bridge to professional intervention.

Informal support networks play a crucial role in facilitating access to mental health care among military personnel. Family members, peers, and close colleagues are often the first sources of support, offering both emotional validation and encouragement to seek help when needed (Fikretoglu et al., 2022). Research consistently shows that service members prefer these informal pathways, particularly when stigma or career concerns discourage engagement with formal services. In the United States, informal support has been shown to reduce distress and strengthen willingness to acknowledge mental health needs (Adams et al., 2017). Similarly, systematic reviews highlight that family and peer networks are among the most commonly relied upon sources of assistance in both serving and veteran populations (McGuffin et al., 2021). This pattern extends to other contexts: in the Australian Defence Force, personnel frequently favour self-management or support from trusted peers and relatives over formal clinical services (Lawrence et al., 2018), while in the New Zealand Defence Force, friends, partners, and family are similarly identified as the primary sources of informal mental health support (Boyd, 2017).

Within military communities, chaplains are widely recognised as a trusted, informal source of support, and are often the first port of call when personnel face emotional or spiritual distress (Schuhmann et al., 2023). Spiritual fitness, defined as the ability to draw meaning, purpose and inner strength from one's beliefs and values (Jonas et al., 2010), is now seen as a core element of psychological resilience (Worthington & Deuster, 2018). Modern military resilience frameworks explicitly incorporate spiritual coping strategies as part of readiness training (Hufford et al., 2010), and chaplains stand at the centre of this effort. Within the Irish Defence Forces, chaplains are widely regarded as a trusted, confidential and readily accessible source of informal support, often approached for emotional or spiritual concerns and working alongside clinical services when needed

(Department of Defence, 2023). Far beyond leading religious services, chaplains provide confidential pastoral care, moral guidance and holistic support to service members and their families (Frederich et al., 2011; Joint Chiefs of Staff, 2018). In the U.S., 64 % of personnel report moderate to high levels of spirituality, a factor linked to lower rates of heavy drinking and smoking (Barlas et al., 2013). Group religious activities combat loneliness and foster belonging, while individual spiritual engagement helps regulate negative emotions (Drescher et al., 2007).

Chaplains also play a vital role in addressing "moral injury," or the profound distress that follows perceived ethical breaches in combat (Carey, 2018). Conventional PTSD treatments can miss these spiritually rooted wounds, yet studies with veterans find that spiritual coping buffers trauma-related stress and reduces suicidality (Kopacz et al., 2016; Currier et al., 2018). By collaborating with mental health professionals, chaplains help bridge gaps in care and deliver truly holistic support (Seddon et al., 2011; Buttner et al., 2016).

While the chaplaincy's contributions are sometimes underappreciated, particularly in contexts where spirituality has historically played a lesser role (Iversen et al., 2010; Litz et al., 2009), their informal, non-clinical presence remains one of the most accessible and trusted pathways to help for many service members. Within the Irish Defence Forces, chaplains themselves have called for more robust organisation-wide support structures to complement their work, underscoring the importance of integrating pastoral care with broader mental health initiatives (Mac Mahon et al., 2016).

3.5 Barriers to Help-Seeking

Frank and Born (2021) identified several key barriers to mental health care for soldiers in the Canadian Armed Forces. These included: (1) limited knowledge and ability to access care, categorised under opportunity; (2) inadequate staffing and workload resources; (3) insufficient organisational and social support; (4) low motivation; (5) discomfort with accessing care in the workplace; (6) perceived conflict between seeking treatment and achieving career goals; (7) personal treatment preferences, such as a tendency to self-manage symptoms; and (8) concerns about privacy and confidentiality.

In a subsequent study, Born and Frank (2022) emphasised that weak general intentions to access mental health services represented one of the strongest predictors of non-engagement among soldiers. This finding aligns with a broader body of evidence suggesting that intentions, shaped by attitudes, norms, and perceived behavioural control, are central to understanding help-seeking behaviour in military contexts. Together, these findings suggest that barriers to care within military populations are primarily cultural and attitudinal rather than

logistical. Consistent with this interpretation, Table 1 summarises perceived barriers to care among US and UK personnel, showing that concerns about career impact, stigma, and trust remain the most prominent obstacles to engaging with mental health services.

Table 1 Barriers to care US & UK active personnel

Country	Authors	N	Branch of Service	Harm Career	Seen as Weak	Embarrassment	Treatment Does Not Work	Provider Trust
US	Hoge et al. (2004)	6 153	Army and Marines	27.0 %	35.3 %	20.6 %	11.2 %	19.3 %
US	Holland, Rabelo & Cortina (2015)	1 558	Active duty	32.5 %	46.4 %	32.4 %	–	–
US	Kim et al. (2010)	3 589	Active duty	28.4 %	38.9 %	24.5 %	–	–
US	Warner et al. (2008)	2 678	Active-duty soldiers	18.5 %	17.8 %	14.6 %	–	–
US	Warner et al. (2011)	1 712	Active-duty soldiers	16.2 %	–	–	–	–
US	Gould et al. (2010)	2 241	Armed forces	20 %	–	–	–	–
UK	Gould et al. (2010)	4 713	Armed forces	23 %	26 %	–	–	–
UK	Iversen et al. (2010)	821	Armed forces	47.3 %	41.0 %	37.1 %	3.6 %	–

Country	Authors	N	Branch of Service	Harm Career	Seen as Weak	Embarrassment	Treatment Does Not Work	Provider Trust
UK	Jones et al. (2013)	484	Army personnel	54.6 %	51.5 %	32.7 %	–	–
UK	Osorio et al. (2013a)	23 101	Armed forces	29.7 %	25.0 %	25.2 %	–	–
UK	Osório et al. (2013b)	23 101	Armed forces	30.2 %	34.0 %	25.4 %	–	–

- "–" indicates that the study did not report that particular barrier.

3.5.1 Stigma and Its associations

Stigma consistently emerges as one of the most significant obstacles for soldiers to access care (Vidales, et al., 2021). Although it is widely recognised as a key deterrent, the precise pathways through which stigma influences service utilisation are not yet fully understood (Sharp et al., 2015). Stigma is a well-documented, self-reported barrier to mental health care among military personnel (Acosta, 2014). As shown in Table 1, U.S. service members frequently identified embarrassment (reported by 9 – 35%) and concerns about being perceived as weak (14 to 46%) as principal reasons for avoiding available mental health services. Among military survivors of sexual assault, for instance, one-third (34.4 %) believed that contacting a mental-health professional would damage their career prospects. A systematic review by Hom et al. (2017) reported that 7–31 % of soldiers feared blame from unit leaders, 16–60 % anticipated differential treatment, 12–52 % expected a loss of confidence from superiors and peers, and nearly 10 % believed their promotion prospects would suffer if their difficulties became known.

Findings from large international surveys, Hoge et al., (2006), consistently indicate that attitudinal and cultural barriers play a prominent role in preventing military personnel from accessing mental health support. Despite screening positive for mental health disorders, many service members do not engage with professional care. Rather than citing structural barriers, such as limited appointment availability, personnel frequently report concerns rooted in military culture and perception. Commonly cited reasons include fears of being perceived as weak or concerns that their commanding officer would treat them differently (Hom et al., 2017). This reluctance is closely linked to a deeply ingrained ethos of self-reliance,

underpinned by the belief that psychological challenges should be managed independently (Britt et al., 2011). Moreover, the military's cultural emphasis on resilience and emotional suppression, often shaped by traditional notions of masculinity, further reinforces this resistance to help-seeking (Wray et al., 2016). Service members experiencing suicidal ideation face particularly acute challenges. Because routine access to firearms raises immediate concerns about risk, disclosure often results in medical downgrading or administrative separation from service (Ursano et al., 2015). Within the Irish Defence Forces, similar concerns exist, personnel frequently report that disclosing mental health difficulties may jeopardise their eligibility for deployment, career progression, or even retention in service (Mitchell et al., 2022; Mac Mahon et al., 2016). The anticipation of these consequences reinforces a strong stigma around engaging with formal military mental health care. Fear of being labelled unfit for duty or excluded from operational opportunities deters many from seeking internal support, leading them instead to turn to civilian providers, where confidentiality and career safety are perceived to be more assured (Fear et al., 2010; Sundin et al., 2014).

Within military contexts, Britt et al. (2011) observe that the avoidance of help-seeking is frequently normalised within peer groups, thereby reinforcing a collective reluctance to access care. However, exposure to credible information, such as statistics, personal narratives, or psychoeducational interventions, can shift perceived norms and strengthen individuals' intentions to seek support. In contrast, perceived stigma and negative beliefs about mental illness have been shown to predict avoidance of psychological treatment, particularly among veterans (Britt et al., 2011). Notably, such attitudinal barriers are not limited to mental health; they also deter personnel from engaging with physical healthcare services (Britt et al., 2020).

3.5.2 Structural Barriers

Structural barriers to care have been consistently identified as significant impediments to help-seeking among military personnel. In their systematic literature review, Hom et al. (2017) reported a range of structural challenges that drive avoidance of engagement with mental health services. These include difficulties in scheduling appointments (reported by 9% to 29% of personnel), and challenges in obtaining time off work (3% to 41%), particularly among those deployed in operational settings. Additionally, concerns surrounding the documentation of mental health issues in military medical records were prevalent, with 20.9% to 42.9% of personnel identifying this as a deterrent. A further 3.5% to 11.9% reported uncertainty regarding where to seek help, and between 13.5% and 20.4% cited a lack of trust in the help-provider as a barrier.

While most militaries have established mental health services, these are often insufficiently resourced, inconsistently applied, or inadequately embedded within broader healthcare systems. In some contexts, administrative procedures, lengthy referral pathways, or the absence of confidentiality assurances further discourage engagement. Additionally, concerns regarding medical classification and fitness-for-duty assessments can deter personnel from disclosing psychological distress, as diagnoses may lead to medical downgrading, restricted duties, or exclusion from promotion and deployment opportunities (Cigrang, et al., 2014).

Respect for individual autonomy is a pervasive concern in military ethics, specifically, the perceived lack of confidentiality surrounding medical records (Collen, et al., 2016). Military personnel commonly fear that the chain of command will be informed if they seek mental health support, particularly in the context of pre- and post-deployment screening. This fear is closely linked to concerns about career implications, including reduced eligibility for deployment and negative impacts on promotion or retention (Jones et al., 2013). Evidence from the United States reinforces these concerns. In a study conducted with the U.S. Air Force, approximately one-third of individuals who had consulted with a mental health professional subsequently received recommendations that negatively affected their careers (Ghahramanlou-Holloway et al., 2019). Similarly, research within the U.S. Marine Corps found that members diagnosed with a mental health condition experienced a shortened military career (Ghahramanlou-Holloway et al., 2018). In the United Kingdom, while three-quarters of personnel who were referred to mental health services during deployment in Afghanistan returned to duty, one-third of that group still experienced negative occupational outcomes, such as medical downgrades or discharges (Jones et al., 2017b). Fikretoglu et al. (2022) conclude that structural barriers, particularly concerns about confidentiality, career progression, and deployability, are credible and legitimate. These concerns cannot be dismissed. Rather, they must be addressed transparently by military institutions if they are to successfully encourage personnel to seek help when needed.

Worryingly, many service members are not regularly seeking the care they need when experiencing mental health problems. Without appropriate treatment, these issues can have wide-ranging and detrimental effects on the quality of life and the social, emotional, and cognitive functioning of affected individuals. Of particular concern is the underreporting of mental health symptoms and substance use, which often results in these issues going undiagnosed and unaddressed (Dabovich et al., 2019). The combination of low reporting and low uptake of services compounds the risk of deterioration, potentially leading to adverse outcomes such as relationship breakdown, impaired operational effectiveness, or increased suicide risk.

In the context of the Irish Defence Forces, the primary responsibility for the health of personnel lies with the Director of the Medical Branch (Irish Defence Forces, 2020). The systemic model of healthcare adopted within the Defence Forces is grounded in the traditional Medical Model. While broadly used, this model has been subject to extensive critique for its limitations in addressing mental health. Scholars such as Shah and Mountain (2007) and Rogers and Pilgrim (2014) have criticised the Medical Model as being overly reductionist and paternalistic. They argue that this approach places a narrow focus on diagnosing and treating symptoms, often overlooking the value of collaboration between healthcare professionals and service users. Huda (2020) further emphasises that such a model may hinder the provision of holistic, person-centred care, particularly in cases where psychological distress does not conform neatly to established diagnostic categories. In military contexts, this can contribute to reluctance in help-seeking, as service members may feel that their experiences are not adequately acknowledged within the clinical framework.

Several European military forces are moving toward more holistic, resilience, and wellbeing-oriented approaches. For example, the Netherlands Armed Forces have integrated psychological resilience models tied to social support and reintegration from injury or deployment, rather than relying solely on diagnoses (Kamphuis, Venrooij and Van den Berg, 2012). The UK's ARENA training, peer support programmes (e.g. Combat Stress), and its 2022–2027 Health & Wellbeing Strategy similarly emphasise environmental, social, and psychological dimensions of health (Jones et al., 2025). Compared to the U.S. and Canada, where the shift beyond the medical model is strong but largely localised in specific programmes (Meredith et al., 2011, Zamorski and Rusu, 2018), these European approaches tend to be more embedded in structural policy and military culture. Building on these developments, Boulter et al. (2024) advocate for the use of social prescribing within the military as a more inclusive and supportive alternative. By directing personnel to community-based services tailored to their broader health and wellbeing needs, social prescribing shifts the focus away from institutional requirements and toward individualised care. This reframing not only widens access to support but also aligns with resilience- and recovery-oriented models increasingly recognised as essential for addressing the complexity of military mental health.

Evidence of these structural barriers within the Irish context is reflected in the findings of Mac Mahon et al. (2016) who conducted a climate survey within the Irish Defence Forces with the purpose of examining organisational culture, morale, workplace conditions, and the experiences of personnel across branches and ranks. The study aimed to identify structural and cultural barriers affecting wellbeing, including leadership practices, equality issues, and the perceived

impact of organisational stressors on mental health. Its findings provide insight into how institutional dynamics shape the lived experiences of Defence Forces members and highlight systemic challenges to addressing psychological wellbeing. Their results revealed widespread dissatisfaction with military medical services, especially in relation to how medical issues, particularly mental health concerns, can affect eligibility for courses and overseas deployment. The survey also highlighted significant disparities in perceptions: while officers generally viewed the medical system more favourably, enlisted personnel reported greater reluctance to engage with services, even for "real medical issues." This reluctance was especially pronounced in relation to mental health, where many participants expressed fears that disclosing a problem would negatively impact their career. Participants in the Mac Mahon et al. (2016) study also noted that many instances of stress and mental health difficulties remained "under the radar" due to widespread fears about potential consequences. These findings suggest that structural barriers, such as confidentiality concerns, limited autonomy in healthcare decisions, and perceived career risk, continue to inhibit help-seeking behaviour within the Defence Forces.

Structural barriers to care in military contexts are not confined to access or availability but extend to psychological obstacles that undermine trust in treatment. A U.S. study found that many personnel doubted the efficacy of mental health interventions or perceived clinicians as untrustworthy, limiting their willingness to seek care (Adler et al., 2015). Comparable attitudes have been documented in Canada, where scepticism towards psychotropic medication contributed to widespread avoidance of formal services (Statistics Canada, 2013). In the United Kingdom, Iversen et al. (2011) highlighted that poor problem recognition, rather than logistical constraints, often prevented service members from accessing support. Considered as a whole, the evidence suggests that cultural scepticism, mistrust of clinicians, and low confidence in treatment outcomes constitute structural barriers in their own right, reinforcing avoidance of formal care even when services are technically available.

3.6 Reforming Military Mental Health Systems: International and Irish Perspectives

Evidence suggests that service utilisation among military personnel has improved over time. Quartana et al. (2014), analysing data from 22,627 U.S. Army soldiers between 2003 and 2011, reported that mental health service use among those screening positive for PTSD or depression nearly doubled, partly due to reduced stigma. In response to ongoing needs, militaries have introduced a range of interventions, which Hom et al. (2017) group into four categories: psychoeducation, screening, referral systems, and peer support. Together, these

provide a structured framework for tackling barriers to care, though challenges such as resource limitations, low mental health literacy, and stigma continue to constrain scalability.

In recent years, reforms have sought to embed resilience and early intervention within broader organisational systems. These include integrating mental health training into leadership development, promoting resilience-building initiatives, and expanding peer support schemes (Sharp et al., 2015; Smith et al., 2017). Yet, sustained cultural change and strong organisational commitment remain necessary for long-term impact.

Within Ireland, the Mental Health and Wellbeing Strategy 2020–2023 reflects this shift, committing to universal service delivery, career-long education, multidisciplinary training, and enhanced clinical access (Óglaigh na hÉireann, 2020; Irish Defence Forces, 2022). Importantly, the strategy acknowledges the role of families in sustaining wellbeing, signalling a more holistic approach. However, no formal evaluation of its outcomes has yet been published, leaving its effectiveness unknown.

International evidence highlights both progress and limitations. The U.K.'s Trauma Risk Management (TRiM) provides peer-led, post-incident support (Jones et al., 2017b), Canada's Road to Mental Readiness (R2MR) adapts Ajzen's (1991) Theory of Planned Behaviour to reduce stigma and strengthen resilience (Fikretoglu et al., 2019), and the U.S. has piloted group-based interventions to normalise treatment-seeking and foster peer encouragement (Britt et al., 2018). These approaches reflect a shift towards theoretically grounded and outcome-oriented strategies. Yet, as Hom et al. (2017) caution, many programmes remain under-evaluated, and the evidence base for their effectiveness in improving service uptake is still limited (Adler et al., 2015; Thomas et al., 2016).

3.6.1 Leadership and Help-Seeking in Military Contexts

Military leadership plays a decisive role in shaping attitudes toward mental health and influencing whether personnel engage with support systems. Leaders set the cultural tone of their units; when they actively endorse psychological wellbeing and model openness about seeking help, they can reduce stigma and legitimise the use of formal services (McGurk et al., 2014; Mattie et al., 2024; Britt et al., 2012; Adler et al., 2014). Leadership practices that foster unit cohesion are particularly powerful, helping to reframe help-seeking as both acceptable and necessary (Kidd, 2023).

Evidence from Canada illustrates this dynamic: over 90% of Canadian Armed Forces personnel reported believing their leaders would support them if they sought mental health care (Statistics Canada, 2013). This aligns with research

showing that effective leadership qualities, including empathy, moral integrity, and sensitivity to individual circumstances , are critical determinants of psychological wellbeing in military settings (Griffith, 2012; Kolditz, 2007). However, Pflanz (2001) found that personal and domestic stressors, such as relationship breakdowns, can impact mental health as severely as combat exposure, underscoring the need for leaders to adopt a holistic view of wellbeing that addresses both operational and personal challenges.

At the same time, rank itself can create barriers. Soldiers with mental health difficulties are often perceived as lacking leadership qualities, discouraging disclosure and undermining career progression (Cloutier & Barling, 2023). Higher-ranking personnel in Canada and the U.S. were significantly less likely to seek care than junior ranks, reflecting fears of reputational damage and cultural expectations of invulnerability (Fikretoglu et al., 2008; Brown et al., 2011; Britt et al., 2019). Nonetheless, leadership can also be the key to reversing these patterns. When commanders normalise mental health care, reward help-seeking, and promote the message that "it takes courage to seek help," service use increases significantly (Theriault et al., 2019; Adler et al., 2015). In the U.K., Stevelink et al. (2019) found that 71% of personnel who accessed care did so after simply acknowledging "I had a problem," reflecting how cultural permission and self-recognition interact. By challenging stigma, providing accurate information, and embedding openness into leadership practice, military leaders can reframe help-seeking as a professional strength rather than a weakness. This top-down cultural shift is central to closing the treatment gap that continues to persist across armed forces.

3.7 Summary

This chapter integrates international and Irish evidence on how service members engage, or avoid engaging, with mental-health support. Despite elevated exposure to psychological risk, formal service use remains low across forces. The most consistent deterrents are attitudinal (stigma, fears of being seen as weak, mistrust of clinicians) and structural (confidentiality concerns, career and deployability implications, time and access constraints). These barriers are mutually reinforcing and help explain the persistent treatment gap.

Two complementary theories help explain these patterns. First, Ajzen's Theory of Planned Behaviour shows that help-seeking depends on three things: what a person believes about care (attitudes), what they think important others expect (social norms), and how much control they feel they have over accessing support (perceived behavioural control). Second, Scott's Theory of Hidden Transcripts explains why, in strict hierarchies, people often mask distress in front of authority: silence, understatement, or private coping become protective strategies to avoid

sanctions or career harm. Together, these lenses show how choices that make sense within military culture, such as staying quiet or relying on peers, can be psychologically understandable yet clinically risky if they delay or prevent timely treatment.

Military culture, what Goffman termed a "total institution", powerfully socialises norms of stoicism, self-reliance and emotional control. These norms are reproduced through training, unit hierarchies and branch subcultures, shaping perceptions of legitimacy, consequences and timing of help-seeking. In this context, many personnel prefer informal pathways, family, peers and chaplains, which feel safer, more confidential and congruent with identity. Informal networks frequently act as a bridge to formal care, but their prominence also signals mistrust of internal medical systems.

The Irish Defence Forces provide a clear example of how institutional regulations can heighten avoidance of care. Mandatory disclosure to the military medical system, combined with the direct link between medical categorisation and career opportunities, makes confidentiality concerns and occupational risks especially prominent. Evidence from climate surveys reinforces this dynamic, showing that personnel anticipate career penalties and are reluctant to disclose difficulties, findings that closely mirror international patterns. However, as outlined in Chapters 2 and 3, direct comparisons with other militaries must be interpreted cautiously, as the Irish Defence Forces differ in scale, resourcing, organisational structure and maturity of mental health systems. International evidence is therefore used in this chapter to illuminate shared mechanisms and patterns rather than to imply equivalence of context or capacity.

The chapter also foregrounds the provider perspective. Clinicians report workload pressure, limited recognition and constrained resources, conditions that can erode therapeutic trust and effectiveness. When soldiers perceive services as unsafe or ineffective and clinicians practise under strain, a feedback loop sustains disengagement and reliance on informal supports.

Reform efforts are growing. Militaries have expanded psychoeducation, screening, referral pathways and peer programmes (e.g., TRiM in the UK; R2MR in Canada; group-based initiatives in the US). Ireland's Mental Health and Wellbeing Strategy (2020–2023) aligns with this shift, emphasising universal provision, family involvement and multidisciplinary care, though formal outcome evaluation is pending.

Leadership is the lever that cuts across all levels. Commanders who normalise help-seeking, protect confidentiality, and frame care as professional courage can shift norms, increase uptake and reduce stigma. Overall, the chapter argues that

effective change must target both sides of the system: lowering barriers for help-seekers while resourcing and protecting help-providers embedded within broader, leadership-driven cultural change.

Chapter 4: Methodology

4.1 Introduction

This chapter begins by outlining the theoretical framework employed in this study, detailing its application and relevance to the unique cohort of currently serving members of the Irish Defence Forces. The chapter also explains the rationale for using a mixed methods approach, specifically designed to explore the prevalence of mental health issues and help-seeking behaviours within this military context. An overview of the history of mixed methods research is provided, followed by an explanation of the philosophical foundations that inform this study's approach.

The sequential explanatory design is introduced, with a justification of its structure, including the considerations for data collection, the prioritisation of phases, and the integration of findings. Sampling strategies and analytical methods for both quantitative and qualitative data are also outlined to illustrate the study's comprehensive approach to capturing and interpreting complex data. Finally, the reasoning for selecting a sequential mixed methods approach is discussed, highlighting its suitability for this research context. Limitations inherent to mixed methods research are also addressed, providing a balanced perspective on the approach used in this study.

4.2 Hidden Transcript Theory: A Theoretical Framework

A theoretical framework provides a structured scaffold for research, consisting of interconnected premises and concepts that ground the study and guide its interpretation of findings (Grant & Osanloo, 2014). This study employs James C. Scott's Hidden Transcript Theory to investigate the decision-making processes surrounding help-seeking behaviours among soldiers experiencing mental health challenges. James C. Scott, a political anthropologist, developed Hidden Transcript Theory to examine power dynamics and resistance within hierarchical systems. He argues that societal structures are shaped by relationships of domination, where power is exercised by a minority over the majority. In response, subordinates engage in acts of resistance that remain concealed from the dominant group (Scott, 1990). The theory distinguishes between:

1. **Public Transcripts**: refer to the visible behaviours, language, and attitudes displayed by subordinates in the presence of authority. They typically convey outward compliance with organisational expectations, even when such compliance does not fully reflect private beliefs. In military contexts, public transcripts might include soldiers saluting officers, formally agreeing with command decisions, or outwardly affirming resilience and readiness during official briefings. For example, a soldier who is experiencing severe anxiety may nevertheless tell their commanding officer they are "fine" and continue to perform duties without complaint, thereby reinforcing the appearance of discipline and conformity. Similarly, completing mandatory resilience training without questioning its effectiveness would constitute part of the public transcript, as it demonstrates alignment with organisational norms, whether or not individuals privately agree.
2. **Hidden Transcripts**: capture the alternative conversations, coping strategies, and forms of resistance that occur out of view of authority. These transcripts allow subordinates to voice dissent, share concerns, or act in ways that challenge official expectations without directly confronting power. In the Defence Forces, hidden transcripts might take the form of soldiers confiding in trusted peers or family members about their mental health difficulties, while avoiding disclosure to the military medical system due to fears of career repercussions. Another example could be personnel seeking help from civilian GPs or private counsellors, despite regulations requiring disclosure of external medical treatment. Joking, coded language, or dark humour about command decisions or the stigma of "going sick" can also be part of the hidden transcript, as these expressions indirectly resist official narratives while maintaining plausible deniability in the eyes of authority.

Hidden transcripts can manifest through coded language, gestures, or covert practices that challenge dominant systems while remaining concealed (Scott, 1990). Historical examples, such as enslaved individuals in the nineteenth-century United States, demonstrate this dynamic: outward submission to masters contrasted with private cultural resistance and strategies of survival (Scott, 2012). Marche (2011) similarly describes hidden transcripts as expressions that contradict official narratives, existing beyond the direct observation of power holders.

More recent work extends Scott's framework. Massoumi and Morgan (2024) highlight that elites also develop hidden transcripts, which they call "transcripts hidden in plain sight". These consist of coded rituals, euphemisms, or discourses that appear benign but sustain domination. This is particularly relevant to military

contexts, where leadership publicly promotes resilience and wellbeing, while privately embedding practices that reinforce stigma, conceal contradictions, or delay reform. Incorporating this expanded view allows the present study not only to analyse how soldiers resist dominant norms in private but also to interrogate how institutional actors sustain legitimacy through their own concealed discourses.

The hierarchical and rank-based structure of the Irish Defence Forces aligns with Scott's conceptualisation. Subordinates (enlisted personnel) must outwardly comply with superiors (officers), often through visible courtesies such as salutes, which reinforce authority. Yet, beneath this public transcript, private dissent persists. In addition, Defence Forces Regulation A12 structures medical attendance and medical grading under the Defence Act (Government of Ireland, 1954; Irish Defence Forces, 2015). This system influences perceptions of help-seeking, as disclosure is often seen as carrying potential career and grading risks. Such policies act as public transcripts of organisational control. Where personnel seek external medical assistance without disclosure, their behaviour constitutes a hidden transcript, reflecting both resistance and self-preservation.

Stigma, cultural norms, and fear of repercussions act as significant deterrents, driving some soldiers to seek external, non-military assistance (Britt et al., 2008; Coleman et al., 2017). These dynamics echo findings in organisational silence literature, which shows that employees withhold concerns when the perceived interpersonal or career risk is high (Morrison & Milliken, 2000). Hidden transcripts therefore provide the conceptual bridge: soldiers' outward alignment with readiness expectations contrasts with covert coping practices and external help-seeking.

This study operationalised Hidden Transcript Theory across two phases. In **Phase 1 (survey)**, anonymity enabled participants to disclose acts of resistance safely, such as consulting external civilian GPs without disclosure to military authorities. Affirmative responses to these items represent hidden transcripts, offering empirical evidence of divergence between official expectations and private behaviour. In **Phase 2 (stakeholder interviews)**, senior officials within help-provision systems provided accounts that were anonymised for ethical reasons. Their narratives, while reflective and sometimes critical, also exhibited features of what Massoumi and Morgan (2024) term the hidden transcripts of the powerful. For example, coded language around "readiness," "career progression," or "resourcing challenges" simultaneously highlighted systemic issues and sustained institutional legitimacy.

The decision to anonymise stakeholders was made to foster candour, consistent with Gibson's (2021) observation that Irish Defence Forces officers can balance professional identity with critical reflection. At the same time, anonymity could not entirely neutralise the influence of rank and institutional culture, as responses may still have been moderated by perceived risk. This duality reinforces that stakeholder accounts must be interpreted not only as professional expertise but also as situated expressions of power within Defence Forces systems.

While Scott's *Hidden Transcript Theory* remains, the central framework guiding this research, Hirschman's (1970) *Exit, Voice, and Loyalty* framework offers a useful complementary perspective for interpreting the behavioural choices evident in the findings. Hidden transcripts explain why personnel conceal dissent or distress in the face of hierarchical power, but Hirschman helps clarify the specific pathways available to them. In this context, disclosure to Defence Forces medical officers represents a form of voice, while seeking external treatment without disclosure can be seen as a partial exit. Silence, in turn, reflects a suppressed voice, sustained through loyalty and constraint within the military system. This triad illuminates why some personnel, despite clear mental health needs, avoided official pathways altogether, while others attempted to manage their difficulties outside military oversight. Positioning Hirschman alongside Scott therefore strengthens the analysis by linking the covert nature of hidden transcripts to the observable help-seeking behaviours reported in this study.

Hidden Transcript Theory provides a powerful analytical tool for exploring power, resistance, and compliance within the Defence Forces. By distinguishing between public alignment and hidden dissent, the framework sheds light on how soldiers and leaders construct and negotiate mental health discourse. The mixed-methods design of this study enabled subordinate hidden transcripts to be surfaced through anonymous surveys, while also interrogating the concealed discourses of powerful actors through qualitative interviews. This dual focus reveals how power is produced, reproduced, and contested in help-seeking, and identifies leverage points for change, such as strengthening confidentiality, reducing career penalties, and reframing help-seeking as professional courage. A discussion of the findings in the context of the Hidden Transcript theory is provided in Chapter 8.

4.3 Mixed Methods Research

Mixed methods research, as defined by Tashakkori and Creswell (2007), involves the collection, analysis, and integration of both qualitative and quantitative data within a single study to address complex research questions comprehensively. This approach combines the structured, statistical insights of quantitative data with the

in-depth, contextual understanding provided by qualitative data (Bowers et al., 2013; Greene et al., 1989). By leveraging the complementary strengths of these methodologies, mixed methods designs enable researchers to explore diverse perspectives, identify nuanced relationships, and achieve a deeper, more holistic understanding of phenomena than either qualitative or quantitative methods could offer independently (Creswell et al., 2003).

Mixed methods research is increasingly applied within the social, behavioural, and health sciences and has been recognised as the "third research paradigm" (Johnson & Onwuegbuzie, 2004, p. 14) or the "third methodological movement" (Tashakkori & Teddlie, 2003, p. 5). Its growing popularity can be attributed to its practical utility in applied research settings (Creswell & Plano Clark, 2018), as it enables researchers to address complex research problems comprehensively (Teddlie & Tashakkori, 2009). Additionally, mixed methods research is valued for its capacity to generate increasingly robust and valid meta-inferences, enhancing the depth and reliability of research findings (Greene & Caracelli, 1997).

Qualitative and quantitative components traditionally yield distinct types of conclusions. Quantitative methods rely on numerical data, while qualitative data, in this study obtained through semi-structured interviews, captures descriptive, non-numerical characteristics (Creswell, 2003). Mixed methods research, therefore, offers the unique advantage of integrating these two distinct data types, allowing for a more comprehensive examination of the phenomenon from multiple perspectives. This approach enables researchers to capture both the measurable aspects, and the nuanced, contextual experiences related to the research topic, providing a richer, more detailed understanding (Teddlie & Tashakkori, 2009).

4.4 Brief History of Mixed Methods Research and its Emergence

Most research aims to generate new knowledge that is demonstrable, explainable, and aligned with established truths, principles, or insights derived from thorough investigation and experience. Over the past century, strategies for social inquiry have developed into a wide range of approaches, including grounded theory, phenomenology, multi-method designs, and mixed methods. Grounded theory seeks to build theory directly from data, phenomenology explores the lived experiences of individuals, multi-method designs combine several research strategies within a single study, and mixed methods integrate both qualitative and quantitative approaches to capture complexity. Social inquiry is particularly focused on the logical processes and procedures involved in creating new knowledge, with an emphasis on the philosophical and theoretical frameworks

that shape understandings of social reality and the mechanisms by which this reality is constructed and understood (Creswell & Plano Clark, 2018).

The combination of quantitative and qualitative strategies, now termed mixed methods research, can trace its systematic development back to 1959, with Campbell and Fiske's work on triangulation (Flick, 2017, p. 340). Mixed methods research expanded further in the 1980s, when researchers from various disciplines began advocating for an approach that transcended the strict separation of qualitative and quantitative methods as independent strands within a study (Maxwell, 2016).

While Tashakkori and Teddlie (2010) suggest that purely quantitative or qualitative methods may be the best approach for certain research within human sciences, Bryman (2006) argues that the research question or problem should dictate the methodological choice. As Creswell and Plano Clark (2018) explain, the fundamental distinction between quantitative and qualitative data lies in the nature of the information each provides: quantitative data are numerical and measurable, while qualitative data are descriptive and observational, often capturing aspects that cannot be quantified, such as language and context. The interplay between these data types has implications for the underlying philosophical traditions guiding research.

The “paradigm wars” of the late 20th century, marked by debates on the incompatibility of quantitative and qualitative methods, argued that these approaches were irreconcilable due to conflicting philosophical assumptions (Tashakkori & Teddlie, 2003b). This conflict, primarily between proponents of qualitative and quantitative methods, centred on each perspective's perceived merits and limitations. Purists maintained that the paradigms were fundamentally distinct worldviews that could not operate in unison (Tashakkori & Teddlie, 2003, p. 87). However, mixed methods eventually emerged as a transformative paradigm, enabling the integration of these previously separate knowledge sets. Pragmatism was subsequently embraced as a bridging philosophy that allowed the blending of data types, facilitating the simultaneous exploration of phenomena through numerical data and the nuanced perspectives of participants (Williams, 2020). As the field has developed, social sciences have come to embrace diverse philosophical assumptions, challenging the notion that mixed methods research requires allegiance to a specific foundational paradigm (Abbott, 2001; Maxwell, 2010).

The mixed methods design used in this study adopts pragmatism as an inclusive philosophical framework, integrating a quantitative component underpinned by post-positivism with a qualitative component grounded in constructivism. This

pragmatic approach allows the study to utilise the strengths of each methodology to gain a comprehensive understanding of mental health issues and help-seeking behaviours within the military context.

4.5 Philosophical Underpinning for Mixed Methods Research

The development of a mixed methods research design requires a foundational philosophical assumption, providing a broad and abstract paradigm or worldview to guide the research process (Morgan, 2007). Selecting an appropriate philosophical framework to align and integrate the study can prompt extensive debate, as discussed by Tashakkori and Teddlie (2003) and Greene (2008). Tashakkori and Teddlie (2003) outline various philosophical approaches applicable to mixed methods research, including dialectical, single-paradigm, and multiple-paradigm perspectives. Conversely Greene, et al., (1989) underscores the practicality of pragmatism as a philosophical stance, emphasising its relevance in shaping and guiding research practices.

Pragmatism, a philosophy originating in the late 19th century United States, asserts that ideas are true if they work effectively in practice. Influenced by John Dewey, William James, and later Richard Rorty, pragmatism impacts fields such as education, psychology, and sociology (McDermid, 2021). Pragmatists see reality as both singular and plural, valuing multiple perspectives to fully understand phenomena (Creswell, 2007). Greene (2008) and Creswell and Plano Clark (2018) identify pragmatism as particularly suitable for mixed methods research due to its practical orientation, emphasis on research implications, and flexibility in incorporating diverse data types. Pragmatism was chosen for this study because it supports a flexible and comprehensive approach to addressing research questions, integrating both subjective and objective knowledge (Creswell & Plano Clark, 2018; Johnson & Onwuegbuzie, 2004).

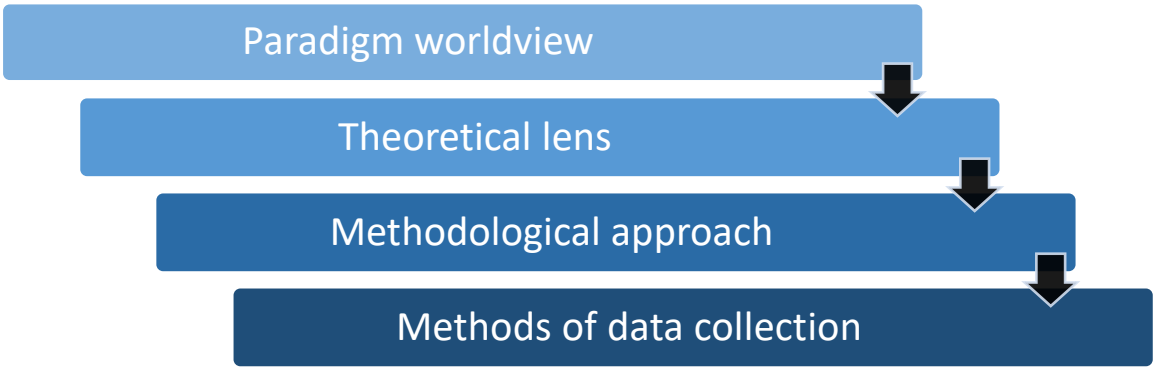
Pragmatism provides a flexible and integrative approach conducive to addressing complex research questions by allowing the combination of diverse methods within the mixed methods design framework. To achieve a deep understanding of the research topic, a philosophical justification is essential. This justification acts as a vital component for gaining logical knowledge and directly informs the methodological approach and the specific methods used to carry out the study (Tashakkori & Teddlie, 2003).

Morgan (2007) views philosophical models or worldviews as systems of "shared belief" that shape the types of knowledge researchers seek and influence how that knowledge is interpreted and transformed into evidence. Within this study, the pragmatic worldview underpins the research design, offering a pluralistic perspective that prioritises the research problem and employs the most effective

tools and methods to explore it comprehensively. This alignment ensures that the philosophical foundation supports the overarching aims of the study and informs every aspect of the methodological framework. Mixed methods design requires a guiding philosophical stance to frame and integrate the research (Morgan, 2007). While various perspectives exist, including dialectical or multiple paradigm approaches (Tashakkori & Teddlie, 2003), pragmatism has been emphasised as particularly suited to shaping the practical application of mixed methods research (Greene & Caracelli, 2003).

In mixed methods research, Crotty's (1998) conceptual framework is adaptable to position a philosophical paradigm that aligns with the study's design. This conceptual model outlines four core elements that contribute to the construction of a research project, guiding the research process from the philosophical foundation to methodological execution.

Figure 1Crottys four levels for developing a research study



Pragmatism, as the guiding paradigm of this study, provided a flexible and problem-centred approach that prioritises practical insights over strict allegiance to a single methodology. This orientation directly informed the choice of Hidden Transcript Theory as the theoretical framework, as it offers a means of uncovering the concealed dynamics of compliance, resistance, and help-seeking within the hierarchical structure of the Defence Forces. In this way, the paradigm and framework are aligned: pragmatism values theories that are not only explanatory but also practically useful, and Hidden Transcript Theory meets this requirement by revealing the concealed dynamics of help-seeking while generating insights that can guide organisational and policy change within the Defence Forces. With this theoretical foundation in place, the next step was to determine the strategy or plan of action. This is where mixed methods were selected as the optimal research design, providing a comprehensive approach to addressing the research questions. Finally, specific methods were chosen, encompassing the techniques and instruments used for data collection, analysis, and interpretation (Creswell & Plano Clark, 2018).

Creswell and Plano Clark (2018) propose that researchers can integrate different philosophical assumptions to accommodate the use of contrasting data types. This non-purist approach enables researchers to select design components that best address their specific research questions (Johnson & Onwuegbuzie, 2004). This mixed-methods design aligns well with pragmatism as a worldview, as it centres on the research problem within its historical and social context rather than on methodological purity. Consequently, this framework allows for multiple, relevant data collection methods to comprehensively address the research question (Creswell, 2007). For this reason, each part of the study operates under its own distinct philosophical assumption, tailored to the type of data and analysis required in each phase.

4.6 Quantitative Data and its Philosophical Assumptions of Post Positivism.

In this study, the quantitative component of the mixed methods design is underpinned by post-positivism. Post-positivism builds on, but also departs from, traditional positivism by recognising that while an objective reality exists, our ability to measure and understand it is always partial and fallible (Ryan, 2006). This stance maintains the importance of empirical testing and statistical analysis, treating knowledge as provisional and probabilistic rather than absolute. Unlike constructivism, which emphasises the co-construction of meaning through subjective experience, post-positivism prioritises the systematic collection of evidence to identify generalisable patterns of behaviour. For example, behavioural outcomes observed in one group may, with appropriate caution, be predictive of similar outcomes in other comparable populations (Musa & Aldiabat, 2024). Thus, while acknowledging the influence of context and interpretation, post-positivism retains a strong commitment to quantitative inquiry, hypothesis testing, and the search for patterns that can inform broader explanations.

Post-positivism is frequently associated with quantitative research, where deductive reasoning is used to formulate and test hypotheses (Creswell & Plano Clark, 2018). In this study, a survey was developed by the researcher using peer-reviewed validated instruments to measure the prevalence of common mental health issues in the Irish Defence Forces. Participants were invited to self-assess based on their individual experiences. The post-positivist approach allows these self-assessments to serve as interpretative acts, where participants' personal experiences directly contribute to the production of knowledge, aligning with the post-positivist view of research as a means of expanding understanding.

4.7 Qualitative Data and its Philosophical Assumptions

The qualitative component of this research is grounded in a constructivist perspective. Constructivism embraces the possibility of multiple realities coexisting within a single social context, asserting that these realities are shaped by the diverse ways in which groups interpret, inherit, and create meaning in their worlds. According to constructivist theory, reality emerges from individuals' efforts to make sense of their interactions with the physical environment and with others (Blaikie, 2007).

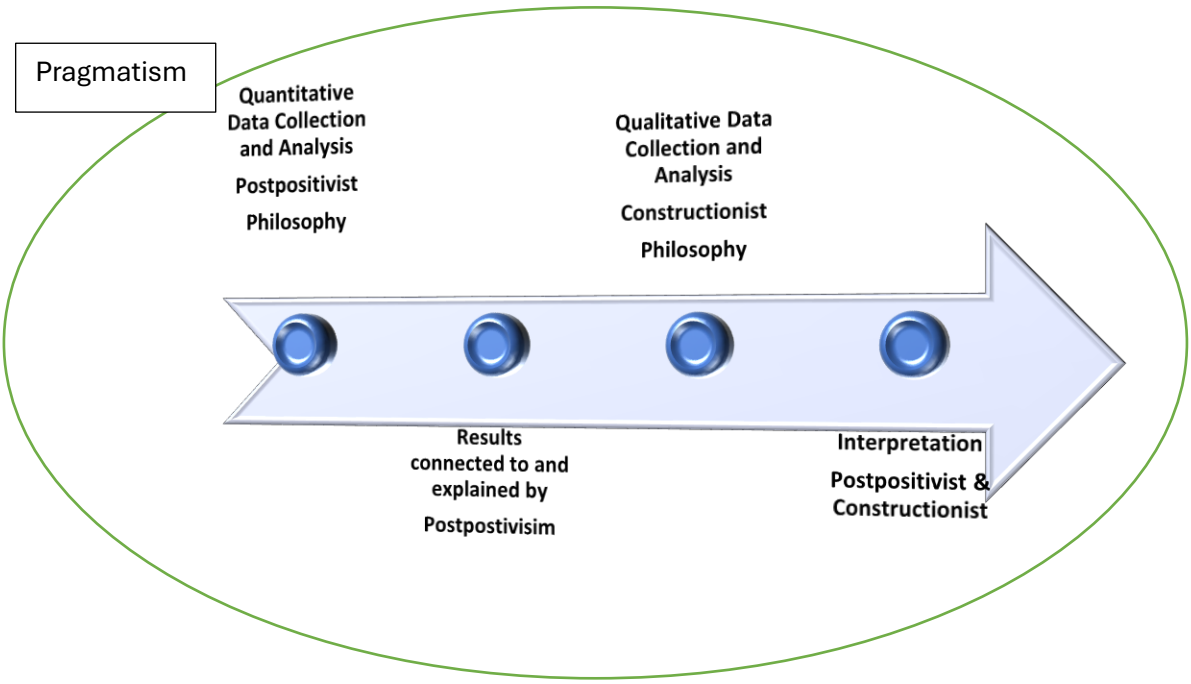
Through a constructivist lens, data analysis assumes that much of what is considered "reality" is built upon shared assumptions (Tashakkori & Teddlie, 2003). Harré, (2012) describes social episodes as products of the cognitive frameworks that social actors bring to them. In a military context, these social episodes encompass culturally embedded attitudes, biases, and beliefs, including political views and moral attitudes toward conflict (Litz et al., 2016). This philosophical assumption is particularly relevant here, as it provides a nuanced way of interpreting how members of the Defence Forces perceive and respond to mental health challenges within their organisational culture.

The qualitative component of this study consists of interviews with both military and civilian individuals within the Irish Defence Forces identified as key stakeholders because of their senior roles in the help-provision system. While the inclusion of these participants was not based on their personal health care pathways, it is important to recognise that military personnel who occupy such positions are uniquely situated. In addition to their responsibilities as gatekeepers of support services, they are also bound by Defence Forces Regulations that require them to use the same medical and mental health systems, including compulsory annual medical examinations. This dual position, experienced only by military stakeholders, provides them with a perspective not accessible to their civilian counterparts, who are not subject to the same regulatory obligations. Although not universal to all stakeholders, this intersection of provider and user roles enriches the study's findings, as it reveals how organisational policies are both administered and personally experienced within the military system. This perspective adds depth to the analysis by highlighting tensions between authority, compliance, and lived experience in the operation of help-provision services.

As illustrated in Figure 2, the final interpretation of the two analysed data sets, quantitative and qualitative, will be based on a logical framework that acknowledges the individualised realities of Post-positivism and Constructivism. However, to achieve a comprehensive understanding of the research problem from multiple perspectives, Pragmatism will serve as the overarching

philosophical worldview, integrating these approaches and facilitating a pluralistic, inclusive analysis.

Figure 2 Pragmatism as a philosophical underpinning



4.8 Research Paradigms

Before undertaking any research project, Alele & Malau-Aduli, (2023) highlight how important it is for researchers to consider the philosophical foundation that will guide their approach. Research paradigms provide this foundation and are composed of four key elements: epistemology (the nature and scope of knowledge), ontology (the nature of reality), axiology (the role of values in research), and methodology (the strategy for inquiry). Together, these elements shape how knowledge is understood, interpreted, and gathered. A clear understanding of these components enables researchers to position their study within an appropriate paradigm, ensuring alignment between the research questions, design, and methods. Consequently, selecting a suitable paradigm is a critical step in the development of any rigorous and coherent research study.

4.8.1 Epistemology

Epistemology serves as the philosophical foundation for determining what kinds of knowledge are possible, what can be known, and the criteria for assessing knowledge as adequate and legitimate (Crotty, 1998). Keeney (1983) argues that epistemology investigates how individuals or systems of individuals acquire and validate knowledge, probing the nature of knowledge itself, the standards for its validity, and the qualifications of a "knower." In complex decision-making contexts, intellectual rigor and integrity are essential, requiring a critical examination of personal assumptions about knowledge, what it is, how we create it, and the means by which we evaluate it (Brewer, 2017).

In the military context, where approximately 60% of personnel facing mental health issues refrain from seeking formal or informal support (Sharp et al., 2015), understanding the epistemological basis of decision-making becomes particularly pertinent. Decision-making involves choosing between options, each with potential outcomes. Therefore, making informed decisions requires an understanding of not only the available knowledge but also the causal relationships and anticipated consequences of each choice (Dewey, 1933).

The distinctive nature of military life impacts decision-making, especially under conditions of uncertainty, which are commonplace in the military and can obscure clear choices (Brewer, 2017). This research focuses on the prevalence of mental health issues and explores help-seeking behaviours among members of the Irish Defence Forces. These central aspects align with objectives 1, 2, 3 and 4, as detailed chapter 6. Although a single-method approach might have sufficed for this research, adopting a constructivist approach alongside quantitative data collection enabled a mixed methods inquiry. This integration provided a more nuanced and comprehensive understanding of the data, allowing for richer

insights into the complexities of help-seeking behaviours within the Defence Forces.

4.8.2 Ontology

Ontology, a branch of philosophy concerned with the nature of existence, examines the essence of what constitutes social reality (Blaikie, 2007). In research, ontological assumptions shape the foundational worldview, implicitly or explicitly suggesting what entities and relationships exist, as well as how they interconnect (Crotty, 1998). Ontology is central to a research worldview, as it frames an understanding of what elements compose reality as it is known (Scott & Usher, 2004).

This study aims to explore social reality from multiple perspectives, particularly within the structured environment of the military. In conventional military systems, a clear delineation of rank and social division exists between two primary groups: Officers and Enlisted personnel. Military culture, and its various sub-cultures, plays a crucial role in shaping how soldiers construct meaning and interpret their experiences. The study's ontological approach thus focuses on understanding the varied viewpoints and influences on decision-making within this structured context, specifically examining factors that shape help-seeking behaviours among soldiers. This examination is essential to addressing research objective 2, as it considers how military personnel navigate personal and organisational factors in deciding whether or not to seek help

4.8.3 Axiology

Axiology, the philosophical exploration of values within research, addresses the ethical considerations of value-based decisions, including whether these decisions are correct or appropriate (Finnis, 1980). According to the Australian Research Council (2015), a researcher's axiological stance should clearly engage with essential ethical questions, such as:

- Which cultural, intercultural, and moral issues may arise, and how will the researcher address them?
- How can the researcher minimise or prevent risks, whether they be physical, psychological, legal, social, economic, or other? (These ethical issues are further discussed in Chapter 5)

Although the researcher is conducting this study independently, their extensive 22-year service within the Defence Forces highlights the importance of upholding organisational ethical values and participant trust. To achieve this, the researcher aligns with the Defence Forces Leadership Doctrine, an aspirational guide based on the philosophy of Mission Command. This doctrine promotes mission success,

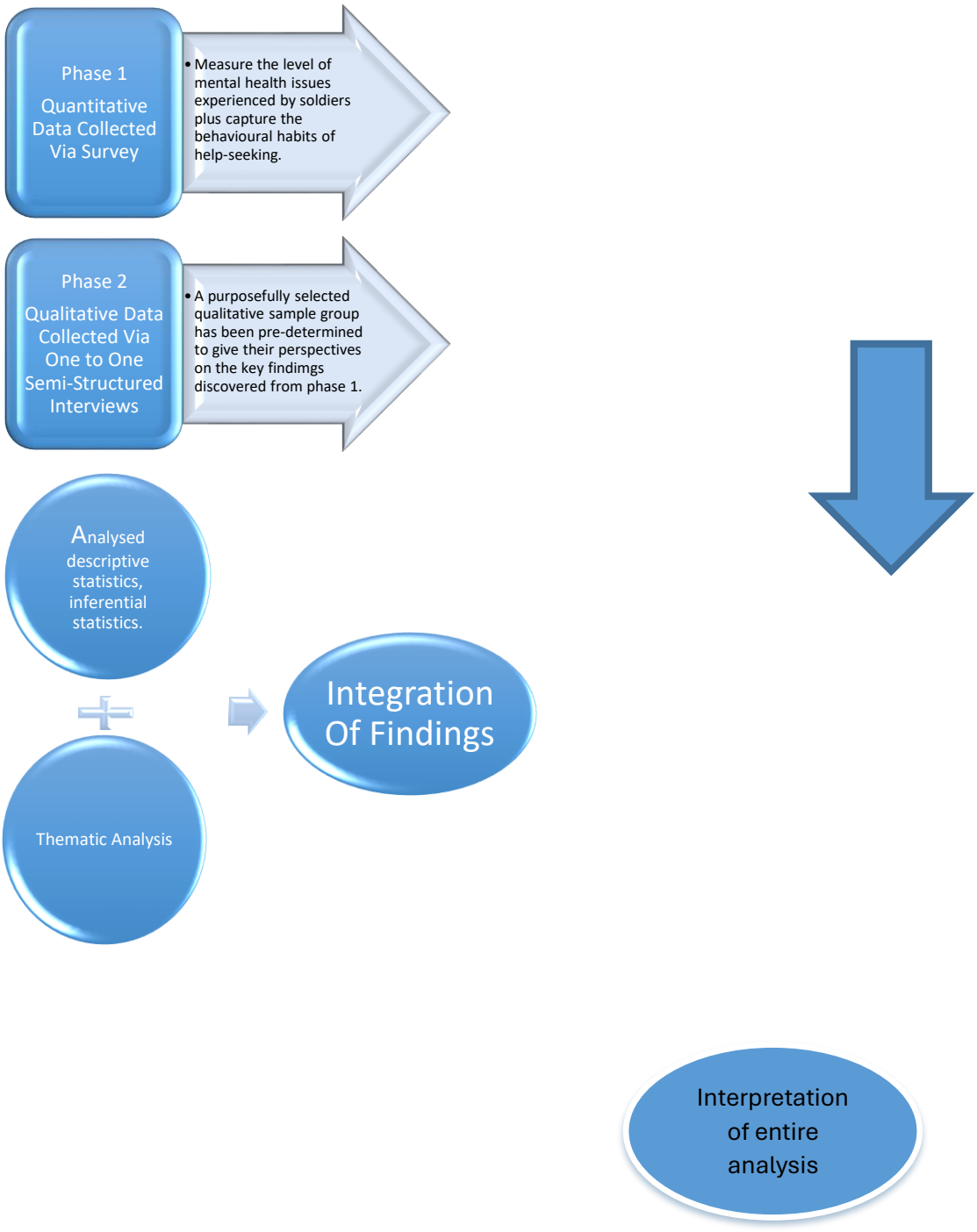
personnel welfare, and organisational growth, viewing all personnel as leaders regardless of rank or position (Defence Forces Ireland, 2016). The doctrine specifically encourages leaders to critically question long-standing practices by asking, "Why do we do it this way?" If the response is simply, "Because we've always done it that way," leaders should reconsider and seek improvements. This emphasis on critical inquiry and continuous improvement provides a clear ethical foundation for conducting responsible research into mental health within the Defence Forces, ensuring consistency with organisational values and fostering constructive evaluation of existing practices (Defence Forces Ireland, 2016).

4.9 Sequential Explanatory Mixed Methods Design

Mixed methods design often emphasise sequential approaches, notably sequential triangulation (Morse, 1991) and the sequential model (Tashakkori & Teddlie, 1998). These sequential frameworks apply to any two-phase approach, with the term explanatory design specifically referring to a model that begins with a quantitative phase (Creswell et al., 2003). The explanatory sequential design, as applied in this study, is a mixed method approach that starts with a quantitative phase to produce detailed findings, followed by a qualitative phase designed to further explore and clarify these results. Here, the term explanatory signifies how qualitative data serve to interpret and deepen understanding of the initial quantitative outcomes (Creswell & Plano Clark, 2018).

Illustrated in Figure 3, the mixed methods explanatory sequential design employed in this research follows a procedural path from quantitative to qualitative phases. This sequential design was chosen to achieve an integrated interpretation of two distinct data sets, providing a comprehensive view of the research findings. Through this approach, the study attains a deep understanding of the central phenomenon, an understanding that would be challenging to reach through a single-method design alone (Creswell & Plano Clark, 2018).

Figure 3 Sequential explanatory design



The primary data collection, depicted in Figure 3, will involve deploying a survey designed to collect data on mental health and help-seeking within Defence Forces personnel. Given the quantitative orientation of the research problem, this phase is prioritised to establish a comprehensive baseline of mental health concerns among participants. Tashakkori and Teddlie (2003) suggest that in a sequential explanatory mixed methods design, the second phase should be informed by insights gained from the initial quantitative data. While in many studies using this

design elaboration and explanation of these insights is provided by a sub-sample of Phase 1, a different approach was chosen here and as shown in Figure 3, this study places significant emphasis on exploring these initial findings from the perspectives of the key stakeholders within help-providing services, capturing their views through qualitative data collected via semi-structured interviews.

While the explanatory sequential design is widely favoured for its clarity, several challenges accompany this approach. By far the biggest challenge is the fact that implementing both phases requires an extended timeline, as sufficient time must be allocated to complete both data collection and analysis phases.

4.10 Considerations in the Selection of a Mixed Methods Design

Creswell and Plano Clark (2018) recommend that researchers gain experience in both quantitative and qualitative methods before conducting mixed methods research. For quantitative work, this includes proficiency in data collection, statistical analysis, and understanding key principles such as reliability, validity, bias, and generalisability. In qualitative research, researchers should be able to define the phenomenon under study, apply data collection methods, and use analysis techniques like coding and theme development. Competence relating to awareness of quality measures such as credibility, trustworthiness, and triangulation are also important to ensure rigorous and reliable results.

When deciding on the most appropriate mixed methods research design for this study there were a number of key considerations to consider with Creswell and Plano Clark (2018) emphasising 3 key issues: the importance of considering the timing of data collection, the prioritisation of each phase, and the integration of quantitative and qualitative data as primary factors in making a design choice. These considerations are essential in selecting the most suitable mixed methods approach. In the case of this research, each of these elements, timing, prioritisation, and data integration, supports the choice of a sequential explanatory design, as discussed in the following sections.

4.10.1. Timing of Data Collection

The timing of the different phases in mixed methods research has a significant role to play in determining the mixed methods design to be utilised (Creswell, 2003). In this study, data collection needed to be carried out sequentially. The first phase involved administering a carefully designed survey focused on mental health and help-seeking behaviours, to members of the defence force. The second phase of the research, interviews with key stakeholders, could only come about when data collection and analysis of phase 1 was complete as the analysis of quantitative data

informed the interview guide. The requirement for a sequential process lent itself naturally to utilisation of a sequential explanatory design.

4.10.2 Priority for Each Phase

In constructing a mixed methods design, Creswell (2003) emphasises the importance of determining whether greater or equal priority should be assigned to the quantitative or qualitative component. In this study, a fixed mixed methods design was employed, meaning that the use of both quantitative and qualitative methods was pre-determined. However, due to the sequential nature of the design, the qualitative phase was entirely dependent on the quantitative phase, as it served to provide further exploration and explanation of the initial findings. Without the quantitative data, the qualitative phase would have no independent function.

As the qualitative results were used primarily to explain the quantitative findings, and because the quantitative data collection involved a substantially larger dataset, priority was given to the quantitative phase (Creswell & Plano Clark, 2018). This prioritisation aligns with the explanatory sequential design, ensuring that the findings from the first phase effectively guided and shaped the subsequent qualitative exploration.

4.11 Integration in Mixed Methods Research

Integration is the phase in mixed methods research where the qualitative and quantitative components intersect, creating a cohesive set of findings. Yin (2015) describes integration as the central idea that sets mixed methods apart from other research methodologies. In an explanatory sequential design, the purpose of integration is to connect the quantitative and qualitative phases, allowing the follow-up qualitative phase to offer in-depth explanations of specific quantitative findings, particularly those that are unexpected, surprising, or complex. This approach is termed the sequential integration approach (Creswell & Plano Clark, 2018).

Despite its critical role, integration is often poorly described or entirely omitted in the literature, as some researchers mistakenly treat mixed methods as merely the parallel collection and analysis of quantitative and qualitative data (Bryman, 2006). However, contemporary thinking positions integration as the centrepiece of mixed methods research, as it is the significant and meaningful merging of datasets that distinguishes mixed methods from other methodologies (Creswell & Plano Clark, 2018).

4.11.1 Points of Integration in This Study

This mixed methods study incorporates four key points of integration, each strategically positioned to ensure coherence between the quantitative and qualitative components and to maximise the depth and breadth of understanding of the research questions.

1. Design Level: Integration was first established at the design stage through the deliberate selection of a mixed methods approach. This methodological choice was critical in addressing the study's research objectives comprehensively. Objectives 1 to 4 (as outlined in chapter 1) necessitated quantitative analysis, while Objective 5 could only be meaningfully explored through qualitative inquiry. Furthermore, the adoption of a guiding theoretical framework at the design stage supported conceptual alignment and facilitated integration throughout the study.
2. Methods Level: A sequential explanatory design enabled integration at the methods level. Data collected during the quantitative phase, focusing on the prevalence of mental health issues and help-seeking behaviours among military personnel, directly informed the development of the semi-structured interview guide used in the qualitative phase. This ensured that the qualitative interviews targeted key areas that required deeper contextual exploration based on the survey findings.
3. Interpretation and Reporting Level: Although many mixed methods studies report quantitative and qualitative findings in separate sections, recent methodological developments encourage a more integrated approach to data interpretation. In this study, findings were initially analysed independently, followed by a strategy known as "following a thread". O'Cathain et al., (2010), identify this process as where a specific themes or questions identified in one data set are systematically traced and elaborated across the other. This method of weaving findings together enabled a nuanced understanding of emerging patterns and supported the synthesis of complementary insights.
4. Discussion Level: At the discussion level, the integration of both data strands was consolidated. Quantitative findings from Phase 1 and qualitative insights from Phase 2 were examined together to develop meta-inferences that address the study's overarching research questions. This synthesis is presented both in the narrative of the discussion chapter and visually supported through a joint display (see Chapter 8), offering a clear representation of how data sets converged to inform conclusions and implications.

4.12 Justification for Choosing a Mixed Methods Design

Historically, researchers have argued that merging qualitative and quantitative approaches yields richer and more in-depth understandings (Jick, 1979). Padgett, (2009) highlights that mixed methods research fosters synergy and knowledge growth that mono-method studies cannot match, while Mason (2006), points to its capacity for generating creative opportunities and theorising beyond the traditional qualitative-quantitative divide. As Creswell and Plano Clark (2018) explain, mixed methods are particularly suited for addressing research questions that cannot be fully answered by either quantitative or qualitative approaches alone. By combining elements of both methods and integrating the data, mixed methods enable the generation of insights that might otherwise remain inaccessible. Bryman (2006) also notes that mixed methods researchers can utilise the full range of data collection tools, offering a flexibility that surpasses the limitations of single-method research.

Bryman (2006) provides several justifications for employing mixed methods research. Firstly, mixed methods can enhance the explanation of findings by combining quantitative and qualitative approaches, thereby verifying results and increasing confidence in the conclusions. Secondly, the use of mixed methods broadens the scope of research by enabling the exploration of multiple dimensions of a research question and incorporating diverse perspectives. Furthermore, mixed methods can enhance research findings by resolving contradictory evidence or facilitating investigations into areas where existing knowledge is limited. By integrating the objective, variable-focused insights from quantitative research with the rich, participant-centred narratives from qualitative inquiry, mixed methods uncover both statistical relationships and contextual meanings. Lastly, mixed methods contribute to the completeness of research by leveraging the complementary strengths of different methodologies, leading to more comprehensive and nuanced understandings of complex research problems.

The research question and aims of this study necessitated a methodological approach capable of capturing both numerical prevalence data and deeper, nuanced insights from diverse, insider perspectives. A mixed methods design was thus selected to meet these dual requirements. Specifically, this research sought to quantify mental health issues and related behavioural patterns among Defence Forces personnel, and capture insights from key stakeholders as to their perceptions of the results

A further rationale for employing mixed methods in this study was the scarcity of existing published data on mental health within an Irish military context. Consequently, establishing baseline prevalence data required initial quantitative

data collection. Moreover, the predominantly quantitative international literature in this area typically lacks qualitative explanatory elements derived from the perspective of help providers within the military highlighting a methodological gap this research sought to address. Mixed methods were therefore deemed particularly suitable, given the multi-dimensional nature of the research question. Creswell and Plano Clark (2018) argue that mixed methods research provides additional layers of insight and context that singular quantitative or qualitative approaches cannot deliver independently. The aim of this study was to assess the prevalence of mental health difficulties among members of the Irish Defence Forces and to examine the factors shaping their help-seeking behaviours. This involved exploring the types of mental health issues affecting personnel, how soldiers across ranks address these concerns, and the pathways they currently use to seek support. The research also considered the perspectives of key stakeholders within the help-provision system, providing additional insights into the organisational and cultural influences on mental health and help-seeking.

Thus, the choice of mixed methods not only enabled a quantitative measurement of mental health phenomena but also contextualised these findings through rich qualitative insights drawn directly from key stakeholders' experiences. This approach allowed for a deeper exploration of culturally sensitive issues, effectively integrating diverse data types to yield a more holistic understanding of the research problem. Consequently, mixed methods research ensured that findings from this study are robust, contextually informed, and reflective of the lived realities of Irish Defence Forces personnel.

4.13 Sampling, Data Collection, and Data Analysis in Mixed Methods Research

4.13.1 Sampling

A detailed overview of the sampling techniques, data collection methods, and data analysis procedures for both phases of this study is presented in Chapter 5. This section, however, specifically addresses the unique considerations and challenges associated with implementing a mixed method design.

This research employed a combination of sampling techniques to achieve two main objectives: first, to identify the mental health issues and help-seeking behaviours within the Defence Forces, and second, to contextualise and explain these results from the perspectives of key stakeholders. The sampling process involved determining who the participants would be for both phases, the number of participants required, their selection criteria, and the selection of site locations for the research (Creswell & Plano Clark, 2018).

In a traditional mixed methods explanatory sequential design, the same individuals often participate in both phases so that the qualitative stage can directly elaborate on the quantitative findings (Creswell & Plano Clark, 2018). In this study, however, the design differed. Civilians were excluded from the Phase 1 survey, but military personnel who later became Phase 2 participants may also have completed the survey, as they were not explicitly excluded from doing so. Importantly, selection for Phase 2 was based on participants' positions as key stakeholders able to contextualise the survey results, rather than on whether they had personally taken part in Phase 1. This approach is consistent with Creswell and Plano Clark's (2018) guidance that Phase 2 participants need only have a strong connection to the Phase 1 data in order to provide meaningful explanations, since their insights are grounded in lived experience of the same organisational systems and rules that shaped the quantitative findings.

4.13.2 Data Collection

The data collection process began sequentially with the administration of a survey, followed by semi-structured interviews. In this sequential style, the quantitative and qualitative phases are interrelated rather than independent (Creswell, 2007). The survey collected quantitative data on self-assessed mental health issues and behaviours related to help-seeking within the Defence Forces. Key areas included the willingness to use available services, perceived barriers to accessing help, consequences of engaging with the medical system, and the stigma surrounding mental health in the military. The interviews then followed this phase, and key-stakeholders gave their perspectives on key findings of the survey.

4.13.3 Data Analysis

In an explanatory sequential design, data analysis occurs at multiple levels. For the quantitative phase, the analysis is guided by the research questions, with appropriate statistical tests applied to describe trends, compare groups, and assess relationships among variables (Creswell, et al., 2003). These analyses provide a broad overview of the prevalence and characteristics of mental health issues and help-seeking behaviours.

For the qualitative phase, data analysis involves identifying the most suitable approach to address the research questions. This typically includes coding data, identifying themes or categories, and developing descriptions based on these codes. The analysis can be conducted manually by annotating transcripts or with software packages such as NVivo or MAXQDA (Creswell, 2015).

Integration at this point, begins after the quantitative and qualitative datasets have been independently analysed and summarised. Quantitative findings are

typically represented through tables, figures, or descriptive statistics, while qualitative findings are presented as discussions of themes, visual diagrams, frameworks, or models. Integration strategies involve combining these data sources to create a cohesive narrative. This includes:

- Using subthemes or subcategories to connect data.
- Incorporating specific quotes to illustrate qualitative findings.
- Citing multiple sources of evidence across datasets.
- Highlighting divergent perspectives and providing rich descriptions.

The integration process is crucial for achieving the primary aim of mixed methods research: to synthesise data from both phases to generate a more comprehensive understanding of the research problem. In this study, integration occurred by linking the statistical results from the survey with the thematic insights from the interviews, ensuring the findings addressed the complexities of mental health and help-seeking behaviours within the Defence Forces (Creswell & Plano Clark, 2018).

4.14 Limitations of Mixed Methods Research

As Creswell and Plano Clark (2018) emphasise, mixed methods research is not a universal solution to all research problems, nor does its application diminish the value of mono-method studies. However, it demands competence in both quantitative and qualitative traditions and requires significant time and resources for data collection, analysis, and integration. Sequential mixed methods designs, in particular, is time-intensive, as the phases depend on one another, and they often require extended access to participants. For this reason, O'Cathain et al. (2008) recommend that large-scale mixed methods projects are best undertaken by research teams, where expertise and labour can be distributed.

In this study, a notable limitation of the mixed methods design was the considerable demand on time, resources, and logistical coordination. The choice to adopt a physically present, hands-on approach to data collection was deliberate, reflecting the unique military context. Both Dixon (1994) and the Independent Review Group (2023) highlight the persistence of cultural anti-intellectualism within military organisations, where research and academic inquiry may be viewed with scepticism or even resistance. Although this is not an inherent limitation of mixed methods research, it significantly shaped methodological decisions in this study. To counteract potential disengagement, the researcher adopted a visible presence in data collection activities, reinforced by endorsement from senior Defence Forces authorities. This strategy-built credibility and trust, but introduced constraints on efficiency, scalability, and sustainability.

In addition, the quantitative phase of the study carried limitations common to large-scale surveys. Participation was voluntary, raising the possibility of non-response bias, and the cross-sectional design limited causal inference. Although validated instruments such as the PHQ-9 and GAD-7 were used, these remain screening tools rather than diagnostic measures. Concerns about confidentiality, even in anonymous surveys, may also have led to under-reporting of sensitive issues such as alcohol misuse or suicidal ideation. Furthermore, any variation in branch participation suggests that the findings are best understood as context-bound, reflecting the specific circumstances of the Irish Defence Forces

4.15 Summary

This study employed the theory of Hidden Transcripts, developed by anthropologist James C. Scott, as its theoretical framework. This theory provided a lens to explore and understand the social dynamics within hierarchical structures such as the Irish Defence Forces. The framework is particularly relevant in examining how soldiers navigate the formal and informal systems of help-provision while managing the pressures of rank and authority. Theoretical frameworks serve as the foundation or "scaffolding" of research projects, offering a means to contextualise and explain findings within a structured interpretative model. In the context of mixed methods research, this framework proved invaluable in linking the quantitative and qualitative phases, ensuring a cohesive understanding of the data.

Mixed methods research was selected for its ability to overcome the limitations of singular methodologies, such as the restricted scope of quantitative and qualitative approaches when used in isolation. The adoption of Pragmatism as the overarching philosophical worldview provided the flexibility needed to integrate diverse approaches. Pragmatism allows for methodological pluralism, enabling researchers to address complex research questions that cannot be fully explored through one method alone. At the same time, it honours the distinct philosophical foundations of each method. In this study, the quantitative phase was guided by the principles of post-positivism, focusing on the objective measurement of phenomena, while the qualitative phase embraced Constructivism, which prioritises understanding subjective experiences and multiple realities.

The quantitative component of the study employed a survey to investigate the extent and nature of mental health issues among serving members of the Irish Defence Forces. This phase also explored barriers to care and the extent of engagement with military help-providing services. The survey provided a broad and detailed dataset, capturing key trends and variables related to mental health and help-seeking behaviours. The qualitative component, consisting of semi-

structured interviews with key stakeholders, offered an in-depth exploration of the quantitative findings. These stakeholders provided insights into the context and underlying reasons for the trends identified in the survey, allowing for a richer and more nuanced understanding of the barriers and facilitators to help-seeking within the military.

The research design followed a sequential explanatory mixed methods approach, prioritising the quantitative phase (Phase 1) while using the qualitative phase (Phase 2) to explain and contextualise the quantitative results. The quantitative phase generated a large and detailed dataset, which served as the foundation for the qualitative inquiry. The interviews were designed to explore critical themes, proposed in key-findings, and anomalies identified from the analysed survey findings, such as the stigma associated with mental health, cultural perceptions within the Defence Forces, and the practical challenges soldiers face when engaging with formal help-providing systems. This integrated design enabled the study to achieve a comprehensive understanding of the research problem. By placing greater emphasis on the quantitative phase, the study ensured that the qualitative phase was well-informed and focused on areas requiring deeper exploration. The sequential explanatory approach facilitated the synthesis of numerical trends with personal narratives, providing a balanced and holistic perspective on mental health issues and help-seeking behaviours within the Irish Defence Forces.

In conclusion, the study leveraged the strengths of both quantitative and qualitative methods to address a multifaceted research problem. The combination of a robust quantitative dataset and detailed qualitative insights created a layered and expansive view of the prevalence of mental health issues, barriers to care, and the complexity of cultural and organisational factors influencing help-seeking behaviours. By employing a mixed methods approach grounded in a pragmatic philosophical framework and the addition of a theoretical scaffold, this research offers a comprehensive and nuanced contribution to understanding mental health and help-seeking within a military context

Chapter 5: Methods

5.1 Introduction

This chapter outlines the research methods used in this study, and how those methods were applied, including the study design, sampling approach, data collection and analysis procedures, and the application of the methodological assumptions discussed in Chapter 4. It also details the measures taken to enhance validity and rigor. Ethical considerations related to the study's sensitive topics and potentially vulnerable participants are examined, with a particular focus on the precautions implemented to minimise distress and ensure participant well-being.

This chapter integrates reflections on the procedures and challenges encountered during the study's design and implementation. These insights offer a critical perspective on conducting a mixed methods study within the structured and hierarchical environment of the Irish Defence Forces. The reflections highlight adaptations made to overcome logistical constraints, ethical considerations, and unforeseen obstacles while maintaining methodological rigor and alignment with the study's objectives. By adopting this reflective approach, the chapter enhances transparency and provides valuable guidance for future research in similar contexts.

5.2 Study Design

This study adopts a sequential explanatory mixed methods design to investigate Irish soldiers' mental health and their help-seeking behaviours within military services. This approach incorporates two phases of data collection and analysis:

1. **Phase 1**: The quantitative phase involved collecting and analysing survey data to identify the prevalence and types of mental health issues and barriers to help-seeking among Defence Forces personnel.
2. **Phase 2**: The descriptive qualitative phase consisted of semi-structured interviews with key stakeholders responsible for military help-providing services. These interviews, following analysis, were designed to explain, and contextualise findings from phase 1.

The explanatory sequential design structured this study by using analysed quantitative findings to guide the qualitative phase, particularly in shaping interview questions. This approach allowed for a deeper exploration of key trends identified in the survey, ensuring that the qualitative data complemented and expanded upon the survey results.

5.3 Study Aim

The primary aim of this research was twofold: first, to identify the mental health issues affecting Defence Forces personnel, and second, to understand how soldiers interact with the help-providing services delivered by the military.

5.3.1 Study Objectives

1. To study what mental health issues are affecting soldiers in the Irish Defence Forces.
2. To investigate how Irish military personnel address mental health concerns.
3. To determine how soldiers of all ranks currently seek help for mental health issues.
4. To investigate the factors that impact help-seeking.
5. To explore the perspectives of key stakeholders in help-provision regarding mental health and help-seeking behaviours of soldiers, and to examine their views on addressing key issues.

5.3.2 Approach to Objectives

- **Objectives 1-4**: These were quantitative in nature and were explored through phase 1 of the study, using survey data to measure the prevalence and impact of mental health issues and to understand help-seeking behaviours and coping mechanisms among soldiers.
- **Objective 5**: This was qualitative in nature and was addressed in phase 2 of the study. Semi-structured interviews with key stakeholders provided deeper insights into the systemic and organisational perspectives on mental health and help-seeking behaviours, as well as potential solutions to the identified challenges.

5.4 Study Context and the Irish Defence Forces

This study was conducted within the Irish Defence Forces, which consists of three primary branches: the Army, Navy, and Air Corps. The quantitative phase included a cross-sectional sample from all three branches, ensuring diverse perspectives and experiences were represented. Unlike conventional sequential mixed methods designs, where qualitative participants are selected after the quantitative phase, the potential participants for Phase 2 were pre-determined due to their specific roles within help-providing services. Their established positions made them directly relevant to the study's objectives, enabling targeted preparation and alignment of the qualitative phase with the overarching research aims. The

organisational structure of the Irish Defence Forces is shaped by its geographical distribution and operational focus:

- **Army**: Divided into two brigades, further distributed across eight locations nationwide, reflecting its primary role in land-based defence and support missions.
- **Navy:** Operates from a single base in Cork, serving as the central hub for maritime security and patrols.
- **Air Corps**: Based at one location in Dublin, focusing on aerial defence and support operations.

This distribution highlights the distinct operational roles of each branch while maintaining a unified organisational framework. The Army's widespread presence allows it to respond to national and international security demands, while the Navy and Air Corps' centralised locations reflect their specialised maritime and aerial functions.

Understanding the structure and geographical spread of the Defence Forces was crucial in designing a sampling approach that captured perspectives across all branches and operational areas. The organisations operational framework also influenced the accessibility of personnel for data collection, ensuring the study effectively examined mental health and help-seeking behaviours within the Defence Forces

5.5 Study Population and Sampling Approach

5.5.1 Population

The study population included personnel from all three branches of the Irish Defence Forces, the Army, Navy, and Air Corps. At the beginning of data collection (Jan 2020), the total number of personnel in the Defence Forces was 8,568 (Irish Defence Forces, 2020), However by June of this year the total population had dropped to 8,519 (see Appendix 1 for Defence Forces strength 2019-2025) Branch distributed was as follows:

- Army: 6,878 personnel June 2020 6,912
- Air Corps: 752 personnel June 2020 729
- Navy: 899 personnel June 2020 879

This total population formed the sampling frame for Phase 1, ensuring broad representation across all three branches. However, by the time Part 1 of the study was completed, the total Defence Forces population had decreased to 7,550 personnel (Óglaigh na hÉireann, 2025).

5.5.2 Phase 1 Sampling scheme

Phase 1 employed a total population sampling strategy to capture a diverse representation from the three branches of the Defence Forces. The survey was voluntary and anonymous, allowing participants to respond without fear of identification or repercussions. While this approach generated a comprehensive quantitative dataset, its voluntary nature introduced the potential for self-selection bias, a phenomenon in which individuals who opt into a study may not accurately reflect the broader population (Elston, 2025). As a result, it is acknowledged that the findings may be influenced by the perspectives of those more willing or motivated to participate, potentially limiting the overall representativeness of the sample. This highlights the inherent challenge of voluntary participation in research and the difficulty in fully mitigating biases associated with sample selection.

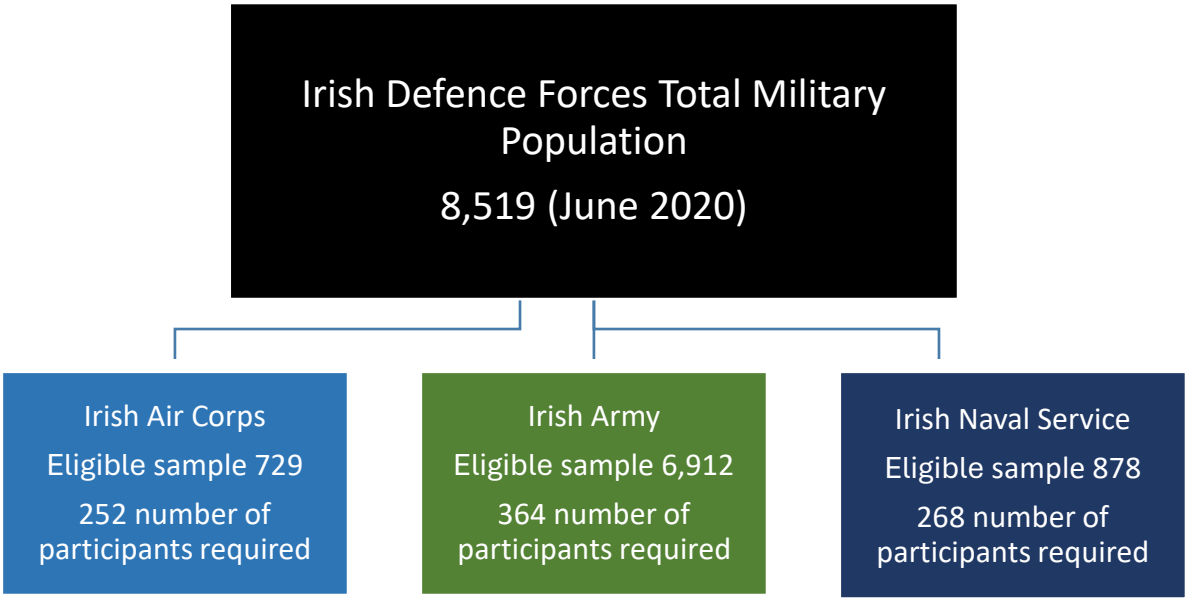
5.5.3 Determining Sample Size

To calculate the ideal survey sample size for phase 1, the online Qualtrics sample size calculator was utilised. The calculation considered the total population size and aimed for a 5% margin of error with a 95% confidence level. A 3% margin of error, while more precise, would have required nearly double the number of participants, which was deemed impractical due to logistical constraints regarding data collection. The decision to select a 5% margin of error was influenced by the practical limitations of administering a hard-copy survey across multiple Defence Forces sites. This approach balanced the need for statistical reliability with the logistical realities of data collection, ensuring a manageable recruitment process while maintaining a robust and representative sample. By applying a structured sampling framework and carefully considering practical limitations, the research achieved a sample size that was both statistically valid and feasible within the available resources and timeline. This ensured that the quantitative phase provided reliable data to inform the subsequent qualitative phase**.**

5.6 The Sampling Frame

The sampling frame outlines the total sample population (June 2020) and the necessary participant distribution across each branch to achieve statistical relevance. This structured approach ensures that the study captures a representative cross-section of the Defence Forces, enhancing its ability to draw meaningful and generalisable conclusions applicable across all branches.

Figure 4 Sampling frame



This proportionate sampling approach provided a representative cross-section of personnel, ensuring the study accurately captured mental health issues and help-seeking behaviours across the Defence Forces while maintaining practical feasibility in recruitment and data collection.

The sample for Part 2 of this study consisted of a pre-determined pool of senior appointment holders involved in both formal and informal help-provision systems. The selection aimed to ensure representation across all forms of help-providers, necessitating a minimum of six participants to meet this objective.

5.7 Eligibility Criteria

The eligibility criteria for this study were carefully developed to focus exclusively on full-time, permanent serving members of the Defence Forces, reflecting the aims of the research to examine mental health and help-seeking behaviours within the active military culture. Both the Reserve force and civilian employees, while integral to the broader Defence Forces structure, were excluded. Civilian employees, though entitled to utilise some of the help-providing services, do not operate under military law and therefore were outside the scope of this study. The focus remained on full-time soldiers across all ranks, actively engaged in military culture and bound by military regulations.

Table 2 Inclusion and Exclusion criteria Phase 1

Inclusion Criteria Phase 1	Exclusion Criteria Phase 1
Any serving permanent member of the Irish Defence Forces	**Retired and reserve personnel**
All ranks	**Civilian employees**

Table 3 Inclusion and Exclusion criteria Phase 2

Inclusion Criteria Phase 2	Exclusion Criteria Phase 2
Senior appointed person in charge of a help-providing service or system	**Any person who does not meet the inclusion criteria**

5.8 Access to and Recruitment of Survey Participants

5.8.1 Phase 1: Quantitative Survey Recruitment

Access to potential participants for Phase 1 began with the submission of a research proposal to the Director of Personnel Support Services, where permission to conduct the study was granted (Appendix 2). Recruitment efforts commenced in March 2021, involving collaboration with Support Service Officers (SSOs) at various military installations. These officers acted as gatekeepers for the quantitative phase, facilitating the process of gaining local approval from Commanding Officers to operate within their barracks.

After initial phone discussions with the Senior Staff Officers (SSOs), follow-up emails were sent containing a brief information sheet about the study (see Appendix 3). These emails provided details on the study's purpose, procedures, and ethical considerations and included a request for further dissemination along the chain of command. Commanding Officers (COs) distributed the information to unit Adjutants, who then shared it with all staff officers. Simultaneously, the Sergeant Majors, the highest-ranking Non-Commissioned Officers (NCOs), received the same information with instructions to distribute it throughout their respective locations, ensuring that enlisted personnel were also informed.

To enhance visibility and generate interest, the study was advertised on the Defence Forces' intranet platform, Information and Knowledge Online (*IKON)*, as

well as the Defence Forces' external website, military.ie. These platforms allowed the researcher to display a digital photograph of the survey cover, along with detailed information about dates, times, and survey administration locations.

On each survey day, reminder flyers (Appendix 4) were placed at the entrances of participating military locations, and the survey was administered in catering centres between 0900 and 1200 hours, a familiar, central setting for personnel. The researcher remained at the entry point to provide information, manage materials, and answer questions, while deliberately avoiding movement around the room to minimise any perception of surveillance or influence. Covid-19 precautions were followed: seating was set out as single, physically distanced tables; hand sanitiser was provided at entry and exit; and tables and pens were sanitised between uses. Before receiving a paper questionnaire, participants were given a brief script covering the study purpose, inclusion criteria, voluntary participation, anonymity, data confidentiality, GDPR compliance, and the right to withdraw prior to depositing the form. No names, service numbers, or other direct identifiers were collected. Participants picked up a questionnaire after sanitising their hands, completed it privately at their table, and deposited it in a sealed collection box positioned beside the exit. To reduce any risk of coercion, the presence of commanders in the room was discouraged, participation was not recorded, and no incentives were offered. The final survey page thanked participants listed the researcher's email and phone number for queries and provided a directory of mental health supports should any distress arise. At the end of each session the researcher sealed the collection box, recorded the site, date, start and finish times in a chain-of-custody log, and transported the box directly to a locked, tamper-evident cabinet in a secure office on a military base. Only the researcher held the key, and hard copies remained in secure storage in line with the ethics approval and data retention schedule. Due to Covid-19 restrictions during the fieldwork period, the study subsequently transitioned from hard copy to a digital format to ensure continuity; the modified administration, data protection, and duplicate-response safeguards for the digital phase are described in Section 5.8.3.

5.8.2 Distribution of the Hard Copy Survey

Table 4 presents the initial survey response rates during the hard copy data collection phase. The original plan aimed to visit every military location nationwide; however, the table highlights the challenges of engaging soldiers in person on the topic of mental health. This difficulty in direct engagement emerged as an unforeseen barrier due to Covid-19 restrictions.

Table 4 Flyer distribution & survey response rates

Location	Date	Flyers Distributed	Responses
Air Corps	22 March 2021	62	49
	23 March 2021	82	-
	24 March 2021	76	78
	7 April 2021	60	-
	8 April 2021	70	-
	9 April 2021	60	22
Cathal Brugha Barracks	14 April 2021	60	-
	15 April 2021	80	-
	16 April 2021	60	6
McKee Barracks	21 April 2021	0	-
	22 April 2021	40	5
DFTC (Curragh)	24 Nov 2021	0	-
	25 Nov 2021	0	24
TOTALS	—	**650**	**184**

5.8.3 Recruitment Challenges and Digital Transition

Due to Covid-19 workplace restrictions, the initial plan to collect data outlined above was interrupted, as barracks reduced staffing to essential personnel only. This disruption made it impossible to achieve the target sample size from each location during this period.

Following discussions with the PhD supervisory team, a decision was made to transition the survey to a digital format. This change presented challenges, including limited access to military computers and email addresses, which could potentially hinder involvement. After obtaining amended ethical approval in February 2022(Appendix 2), the survey was converted into a digital format using the Qualtrics platform. It was subsequently made accessible on the Defence Forces intranet (IKON) and military.ie. To further promote the survey, it was distributed by

the Internal Communications Officer from the Public Relations Branch and through the Women's Defence Network.

5.8.4 Adaptations for Part 1 Participants

To address the challenges of limited access to military email addresses and computers, anonymity concerns associated with military email, confidentiality issues with personal emails, and ethical considerations regarding emotional triggers, the following measures were implemented:

The survey was hosted on the Defence Forces' intranet platform Information and Knowledge Online (*IKON*) and accessed through a QR code, which directed participants to a mobile-friendly version of the survey. This format enabled participants to complete the survey securely on their personal smartphones, either on military premises or in a location of their choice. To maintain anonymity, surveys were not emailed directly to individuals. Instead, the QR code was prominently displayed on noticeboards and physical posters placed in high-traffic areas throughout the three branches of the Defence Forces (Appendix 20). The QR code directed participants to a secure survey link hosted on a trusted platform with robust privacy protections, ensuring confidentiality and promoting participation. The IP locator on Qualtrics was turned off to ensure the researcher could not locate the original source of the submitted survey.

To address potential ethical concerns, a clear pre-survey disclaimer outlined the nature of the questions and the possibility of emotional triggers, allowing participants to make informed decisions about their participation. Additionally, detailed information on accessing support services, such as Defence Forces welfare officers, helplines, and external mental health resources, was prominently displayed before and after the survey. An optional follow-up was also offered, where participants could request a confidential check-in with a welfare officer or counsellor if needed. These measures collectively ensured that the study maintained its integrity and ethical standards while maximising participation and inclusivity within the digital format.

5.9 Sample Identification, Recruitment & Access Part 2

Phase 2 employed purposive sampling to select participants who could provide in-depth perspectives on the Phase 1 survey findings. Drawing on over 20 years of Defence Forces experience, the researcher identified a pool of 15 potential participants occupying senior roles in formal and informal help-provision systems. This was intended to secure at least six interviews, allowing for non-responses or withdrawals (Guest et al., 2006; Saunders et al., 2018). Recruitment began with individual email invitations from the researcher to potential participants, outlining the study and its relevance. Those who expressed interest were subsequently sent

a Participant Information Leaflet (PIL), a consent form (Appendix 21), and a summary of key survey findings (Appendix 19). The PIL (Appendix 6) provided details of the study's aims, procedures, voluntary nature, confidentiality safeguards, and GDPR compliance.

On the day of the interview, participants reviewed and signed the consent form and any relevant Defence Forces permission forms in person, ensuring that informed consent was secured prior to participation. In the case of one participant deployed overseas, ethical approval was obtained to conduct the interview remotely (Appendix 5) , with the same consent process followed electronically. Some invitees declined or did not respond, and in these instances the next most senior individual in the relevant chain of command was approached, maintaining alignment with the purposive sampling strategy.

Ultimately, six participants were recruited, each occupying senior roles within the Defence Forces' network of help-provision. While the qualitative phase of the study was designed to capture insights from a range of systems such as medical, mental health, chaplaincy, social work, peer support, and personnel management, the specific services represented by the participants are not disclosed here to protect anonymity. Instead, it is sufficient to note that all participants held positions with direct relevance to the provision and oversight of support within the organisation, allowing them to contribute informed perspectives on the structures and cultures surrounding mental health and help-seeking.

5.10 Sample Achieved

Part 1 of the study initially collected a total of 706 survey responses from personnel across the Army, Navy, and Air Corps. However, after excluding 19 incomplete surveys, the final dataset comprised 687 fully completed responses, including 165 hard-copy surveys and 522 digital submissions. A detailed breakdown of participation rates is provided by branch, outlining both the number of completed surveys and the proportionate percentage of each branch relative to its total population. It is important to highlight that by the conclusion of data collection in late 2022, the total personnel numbers within each branch had decreased compared to the original sampling estimates from the sampling frame, thus adjusting the required sample sizes accordingly.

The participation analysis indicates that, across the Defence Forces as a whole, 687 valid survey responses were achieved from a total personnel strength of 7,987, a slightly increased figure from the released 7,966 figure released in February 2022, While Defence Forces strength has been declining overall, the slight variation between the February 2022 figure (7,966) and the return at the time of survey

administration (7,987) likely reflects normal fluctuations associated with recruit intakes, retirements, and reporting cycles. The difference of 21 personnel is minor (<0.3% of total strength) and does not alter the interpretation of participation rates. Therefore, this sample represents an overall participation rate of 8.6%. This comfortably exceeded the minimum required total Defence Forces sample size of 367 to achieve a 95% confidence level with a 5% margin of error, with the achieved sample producing an improved margin of error of 3.6%. At branch level, however, variation is evident. The Army, with 6,478 personnel, returned 409 responses, meeting the required sample of 363 and providing reliable estimates at 4.7%. The Air Corps, with 184 responses from a population of 709, achieved a strong participation rate of 26%, though this remained below the required 250 responses, resulting in a wider confidence interval of approximately 6.2%. The most significant limitation arose in the Naval Service, where 94 responses from 800 personnel represented only 11.8% participation, well below the required 260 responses and yielding a margin of error of approximately 9.5%. These differences highlight that while the survey provides robust findings at the Defence Forces level, branch-level results, particularly for the Navy and to a lesser extent the Air Corps, should be interpreted with caution due to reduced statistical precision.

Table 5 Participation analysis by Branch and DF Total

Branch	Total Personnel (N)	Survey Responses (n)	Participation Rate (%)	Achieved MOE (95% CI)	Target MOE (±5%)
Army	6,478	409	6.3%	4.7%	±5%
Navy	800	94	11.8%	9.5%	±5%
Air Corps	709	184	26.0%	6.2%	±5%
DF Total	7,987	687	8.6%	3.6%	±5%

5.11 Data Collection Part 1

5.11.1 Survey Methodology and Rationale in Mental Health Research

Surveys are a central tool in social research, providing structured and quantifiable means of linking theory to practice and enabling the systematic study of complex social phenomena (De Vaus, 2013). In mental health research, they typically incorporate validated psychological scales, questionnaires, and open-response items to assess symptoms, behaviours, and attitudes (Herbert et al., 2021). Key advantages include cost-effectiveness, broad demographic reach, and efficiency in data collection, particularly when administered online, which facilitates access to dispersed populations and larger, more balanced samples (McClelland, 1994; Rice et al., 2017). However, limitations remain, including reduced participant engagement, lower response rates, and limited opportunities for follow-up.

The survey for this study was designed to examine factors influencing help-seeking behaviours among Defence Forces personnel. It combined established, psychometrically robust mental health instruments with a small number of open-ended questions and was structured to take approximately 15 minutes to complete. Permissions were obtained for all copyrighted scales. Anonymity and confidentiality were central to the design. Respondents were assured that their answers could not be linked to them personally, encouraging candour when discussing sensitive topics such as stigma, barriers to care, or experiences of distress. Open-ended items added qualitative depth to the quantitative findings by allowing participants to expand on their perspectives. This approach was particularly important in a military setting where concerns about confidentiality, career repercussions, and cultural stigma frequently inhibit openness. The use of anonymous self-report surveys is well established in military research. Compared with identifiable surveys, which tend to produce higher response rates but more socially desirable and pro-organisational answers (Fuller, 1974), anonymous formats are more likely to elicit honest disclosures (Balamurugan, 2024). Prioritising anonymity in this study therefore aligned with both ethical imperatives and methodological best practice, minimising fear of repercussions and reducing the influence of hierarchical pressures.

Nonetheless, self-report surveys have inherent limitations. Social desirability bias can persist even under conditions of anonymity (Krumpal, 2023), and data may be affected by memory inaccuracies, subjective interpretation of items, or non-response bias, where individuals with stronger views are more likely to participate (Pauli & Lang, 2024). The absence of researcher supervision also leaves responses vulnerable to distraction or external influence (Chann, 2008). Additionally,

anonymity restricts the ability to verify responses or follow up with participants who may have disclosed distressing experiences, raising ethical concerns when addressing sensitive issues such as suicidal ideation or self-harm. To mitigate these challenges, the survey design incorporated validated instruments, clear instructions, and ethically robust safeguards. These measures enhanced data reliability, reduced ambiguity, and ensured that participants could engage with confidence in the confidentiality of the process.

In summary, the use of an anonymous, self-report survey was a deliberate and appropriate methodological choice for this study. It fostered trust, encouraged honest disclosure, and generated valuable insights into mental health and help-seeking among Defence Forces personnel, while acknowledging the methodological and ethical trade-offs inherent in this approach.

5.12 Survey Instruments and Structure

This study utilised a comprehensive survey structured across 11 sections, each designed to assess specific aspects of mental health, help-seeking behaviours, and potential barriers to care among Irish Defence Forces personnel. The instruments were drawn from both international military and non-military research and have undergone rigorous peer review to establish their reliability and validity. Each instrument was selected to reflect the Defence Forces' operational context, with full permission obtained for their use.

Section 1: Demographics

The demographic section was specifically developed for this study and is the first Defence Forces survey to include three gender options: Male, Female, and Other. This was an intentional step to move beyond the traditional binary categories that dominate military data collection, offering participants a choice outside conventional norms. Including an “Other” option acknowledged gender diversity, promoted inclusivity, and ensured that all respondents could engage with the survey without feeling misrepresented. Ranks were categorised into Officer and Other Ranks, this categorisation avoids further granularity to ensure the anonymity of participants, given the sensitive nature of the subject matter. Additional information collected included age, marital status, military branch (Army, Navy, or Air Corps), length of service, number of overseas deployments, registration with a GP, and parental status. These variables provided essential contextual data for interpreting participants’ responses.

Section 2: Generalized Anxiety Disorder 7-Item Scale (GAD-7)

The GAD-7 is a widely validated tool that assesses the severity of generalised anxiety symptoms over a two-week period. The scale uses a 4-point Likert response format, ranging from 0 (“Not at all sure”) to 3 (“Nearly every day”),

yielding total scores between 0 and 21, with higher scores indicating greater severity of anxiety symptoms. The scale showed excellent internal consistency in this study (Cronbach's alpha = .875), supporting its application in both military and civilian populations, reinforcing its utility and applicability across diverse populations (Spitzer et al., 2006; Stevelink et al., 2018). Scoring guidelines for the GAD-7 are provided in Appendix 7

Section 3: Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a widely used, self-administered instrument derived from the broader Patient Health Questionnaire (PRIME-MD), which was developed to screen for common mental health disorders (Spitzer et al., 1999). Comprising nine items, the PHQ-9 is specifically designed to assess the presence and severity of depressive symptoms, with each item corresponding to a diagnostic criterion for depression as outlined in the DSM-IV. Responses are scored on a four-point Likert scale ranging from 0 ("not at all") to 3 ("nearly every day").

The PHQ-9 is recognised for its strong psychometric properties and is among the most commonly employed tools in both clinical practice and research settings to evaluate depression, particularly within primary care. It has demonstrated excellent internal reliability, with Cronbach's alpha values ranging from 0.86 to 0.89, (0.89 in this study), and robust test-retest reliability, affirming its consistency and dependability across diverse populations (Spitzer et al., 1999). In the context of this study, the PHQ-9 was used to reliably assess depression severity among Defence Forces personnel, supporting the identification of individuals potentially at risk. Its relevance to military populations is further supported by its successful application in previous research with service members (Gould et al., 2010; Stevelink et al., 2018). Scoring guidelines for the PHQ-9 are provided in Appendix 8

Section 4: PTSD Checklist – Military Version (PCL-M)

The PTSD Checklist (PCL) is a widely used self-report tool aligned with DSM-5 criteria, designed to assess PTSD symptoms. It is versatile in format and can be completed independently or administered verbally, typically taking 5–10 minutes. The PCL exists in three versions tailored to different contexts: PCL-M (Military) (Weathers, et al., 1991), PCL-C (Civilian (Weathers, et al., 1993), and PCL-S (Specific) (Weathers, et al., 1993). This study employed the PCL-M version to evaluate PTSD symptoms linked to military-specific trauma.

The PCL-M consists of 17 items scored on a five-point scale, producing a total score ranging from 17 to 85. Cut-off thresholds vary based on population prevalence and clinical context, with lower scores recommended for general screening and higher scores for clinical diagnosis. In this study, a cut-off of 35 was used, based on the estimated low PTSD prevalence (≤15%) in civilian primary care, Department of

Defense screening, or general population samples (Larsen et al., 2025). The PCL-M has demonstrated excellent psychometric properties, including a Cronbach's alpha of 0.94 in this study, indicating strong internal consistency. It complements diagnostic tools like the Clinician-Administered PTSD Scale (CAPS) and aligns with the DSM-IV criteria by requiring endorsement of specific symptom clusters. Validity has been confirmed through multiple studies, with strong sensitivity and specificity (Morrison et al., 2021). Its effectiveness in monitoring symptom severity and treatment outcomes makes it particularly valuable in military research and clinical settings. Further information on the scale is provided in Appendix 9

Section 5: Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) and Drinking Motives Questionnaire-Revised (DMQ-R)

The Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) (Appendix 10) is a brief, three-item screening tool designed to assess alcohol misuse. Developed as a streamlined version of the original AUDIT, it offers improved feasibility and practicality, particularly in large-scale or survey-based research (Yarnall et al., 2003). Although it has demonstrated strong validity in specific contexts, such as Veterans Affairs (VA) outpatient settings, its optimal cut-off scores and generalisability across varied clinical populations remain subject to ongoing evaluation (Bradley et al., 2007).

The AUDIT-C has demonstrated greater accuracy than single-question screeners for detecting hazardous drinking, though face-to-face settings may still encourage socially desirable responding (Bush et al., 1998; Inoue et al., 2021). In contrast, its use in anonymous, self-administered formats, such as in this study, enhances the likelihood of honest disclosure. Maintaining respondent anonymity was therefore critical to maximising the tool's validity and reliability, encouraging more accurate reporting of alcohol-related behaviours. In tandem, the DMQ-R explores motivations for alcohol use, including social, coping, enhancement, and conformity motives. This dual approach enables a deeper understanding of alcohol-related behaviours and their psychological underpinnings within the Defence Forces, a topic previously underexplored in the Irish military context.

Section 6: Suicidal Thoughts, Attempts, and Self-Harm (CIS-R)

This section addresses self-reported experiences of suicidal ideation, suicide attempts, and self-harming behaviours, issues strongly associated with mental health conditions such as depression, anxiety, substance misuse, and trauma-related disorders (Brådvik, 2018). The goal is to explore the prevalence and context of these behaviours among Defence Forces personnel.

To achieve this, the study employs the Clinical Interview Schedule-Revised (CIS-R) (Hassiotis et al., 2016), which includes three key questions:

1. Suicide Attempts – “Have you ever made a serious attempt to take your life, by taking an overdose of tablets or in some other way?”
2. Suicidal Ideation – “Have you ever seriously thought of taking your life, even though you would not actually, do it?”
3. Self-Harm Without Suicidal Intent – “Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?”

Each question is accompanied by a time frame; within the last week, the last year, or more than a year ago, to provide insight into both recent and historical behaviours. The CIS-R has demonstrated robust validity and reliability across international studies in diverse populations (Subramaniam et al., 2006). While it offers good specificity, its sensitivity is limited because it may fail to capture more subtle presentations, such as passive suicidal ideation (*“I’d be better off not here”*), fleeting self-harm urges, or indirect expressions of distress (*“wanting to sleep and not wake up”*). These milder or less explicitly reported symptoms can be easily minimised or overlooked in structured formats. Indeed, a meta-analysis by Liu et al. (2020) highlights that passive suicidal ideation is relatively understudied and less consistently detected than active ideation, implying that standard instruments may lack sensitivity for these subtler presentations. Nonetheless, the CIS-R remains a valuable instrument for detecting suicidal behaviours and self-harm, particularly in contexts where such information is often under-reported.(Appendix 11)

Section 7: Stigma and Barriers to Care

This study incorporated two well-established measures: the Barriers to Care Scale (Hoge et al., 2004) and the Perceived Stigma and Barriers to Care for Psychological Problems Scale (Britt et al., 2008). These instruments, widely used in both military and civilian research (Hoge et al., 2004; Sharp et al., 2015), assess two related dimensions of help-seeking reluctance: stigma and practical obstacles. The combined 11-item measure includes six stigma items (e.g., “It would be too embarrassing,” “I would be seen as weak”) and five barrier items (e.g., “I don’t know where to get help,” “It is difficult to schedule an appointment”). Items are rated on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree), with higher scores reflecting greater perceived stigma or barriers. Subscale scores can be summed or averaged, yielding ranges of 6–30 for stigma and 5–25 for barriers (or 1–5 when averaged).

The scales have demonstrated strong psychometric properties across settings. Reliability coefficients range from $\alpha = .82$ for stigma and .70 for barriers in civilian student samples to $\alpha = .94$ and .85 respectively in military cohorts, with studies also confirming good construct validity (Britt et al., 2008). These properties

support their use as concise, robust tools for examining cultural and structural impediments to mental-health help-seeking. Research consistently shows that stigma and barriers play a significant role in deterring service members from accessing care, with military organisational culture often amplifying fears of disclosure and concerns about career impact (Hoge et al., 2004; Britt et al., 2008). These dynamics underscore the importance of addressing both cultural stigma and systemic accessibility in efforts to normalise and support help-seeking within the Defence Forces. (Appendix 12)

Section 8: Self-Stigma and Willingness to Use Services

The Stigma and Self-Stigma Scale (SASS) (Dockesy et al., 2022) (Appendix 13) was developed as a single, comprehensive instrument to assess both external stigma and internalised self-stigma associated with mental health. Unlike using multiple separate scales with varying formats, the SASS streamlines measurement, offering an efficient tool for evaluating stigma and mental health literacy, particularly in workplace contexts (Gray et al., 2020). It is applicable to individuals regardless of their personal history with mental health difficulties, making it a flexible and inclusive instrument for examining perceptions and attitudes across diverse populations. By capturing both external stigma (social attitudes and perceived discrimination) and internalised stigma (negative self-beliefs), the SASS provides valuable insights into how stigma shapes individual help-seeking behaviour and wider organisational culture. In this study, the SASS was administered in a five-item format, with responses recorded on a five-point Likert scale ranging from 1 (Strongly Agree) to 5 (Strongly Disagree). This adaptation was tailored to evaluate internalised stigma and perceptions of mental health within the context of military life. Research has demonstrated its effectiveness across varied populations, including homogenous military cohorts where stigma is a critical barrier to help-seeking (Teh et al., 2014; Williamson et al., 2019).

In Part 2 of this section, participants were also asked whether they had engaged with any of a pre-determined list of help-providing services: the Medical Service, Personnel Support Services, Chaplain Service, Civilian Social Worker, Chain of Command, Peer Support (military), Military Mental Health Specialist, and Inspire Counselling Service (civilian). An additional open-ended question (6.B) explored the mental health issues that prompted participants to seek help and invited explanations for choosing particular providers. This item aimed to capture individual decision-making processes and preferences, offering deeper insight into how Defence Forces personnel perceive and engage with available support systems.

Section 9: Emotional Literacy (Emotional Intelligence)

Validated measures of emotional intelligence, such as the Emotional and Social Competency Inventory (ESCI), the Emotional Quotient Inventory (EQ-i), the Trait Emotional Intelligence Questionnaire (TEIQue), and the Mayer–Salovey–Caruso Emotional Intelligence Test (MSCEIT), are widely employed in psychological research and organisational studies and offer robust psychometric properties with extensive validation across diverse populations (O'Connor et al., 2019). However, these instruments are typically lengthy, require paid licences, and are less suited to large-scale survey administration.

For this reason, the present study employed the publicly available self-assessment developed by McKee (2015), a leadership-focused tool that operationalises five competencies consistent with the Goleman- Boyatzis model: emotional self-awareness, emotional self-control, adaptability, positive outlook, and empathy. The instrument consists of 25 self-report items, with participants rating statements on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Scores can be calculated for each of the five subscales, producing a profile of an individual's relative strengths across the competencies, and may also be combined into a global emotional intelligence score. This format enables both an overall assessment of emotional intelligence and insight into specific dimensions relevant to leadership, interpersonal interactions, and the regulation of stress.

The instrument was designed as a practitioner tool for leadership and workplace development rather than as a validated diagnostic measure with published military norms. No peer-reviewed validation specific to Defence Forces populations was identified, and major reviews of emotional intelligence instruments do not include this assessment among established scales. This is therefore acknowledged as a methodological limitation. Nonetheless, the briefness, accessibility, and alignment of McKee's instrument with widely accepted emotional intelligence frameworks made it a pragmatic choice for inclusion in this large-scale survey. Its conceptual fit with themes of leadership, interpersonal dynamics, and help-seeking behaviours provided a relevant lens for examining potential links between emotional intelligence and mental health within the Defence Forces. Additional details regarding the scale are provided in Appendix14

Section 10: Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item self-report instrument designed to measure perceived social support from three primary sources: family, friends, and a significant other. It has been widely validated across diverse populations and is recognised for its simplicity and strong psychometric properties (Zimet, 1998). The MSPSS demonstrates excellent test–

retest reliability and internal consistency, with Cronbach's alpha values typically reported between 0.91 and 0.95 (Ekback et al., 2013). Its validity has also been confirmed in both civilian and military contexts, including research involving service personnel (Stevelink et al., 2018).

While the original MSPSS employs a five-point Likert response format (Zimet et al., 1990), this study followed the recommendation of Yurdakul (2018) by adopting a seven-point Likert scale. Yurdakul's findings suggest that expanding to seven response categories can enhance reliability, with results demonstrating a 95% confidence level in the improved format. Accordingly, each item in this study was rated from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree), producing total scores ranging from 12 to 84, where higher scores indicate greater perceived social support.(Appendix 15)

Section 11: Disclosure of Mental Health Problems within the Military

This section was developed to examine the attitudes, perceptions, and behaviours of Defence Forces personnel in relation to disclosing mental health issues within a military context. It was designed to evaluate perceptions of how disclosure might affect careers, assess the adequacy of mental health training, and explore the availability and perceived effectiveness of help-providing services. Through the use of both closed and open-ended questions, participants were given space to elaborate on their personal experiences and opinions, contributing to a more nuanced understanding of these issues.

The section explored several key areas. First, it assessed the willingness of personnel to disclose mental health concerns to the military medical system, offering insight into levels of trust and confidence in internal support structures. Second, the survey investigated training and awareness by asking participants whether they had received formal mental health training. If so, an open-ended prompt allowed them to describe the nature and content of that training in their own words, offering a richer view of current educational practices. In addition, participants were asked whether they were aware of the existence of a formal Defence Forces mental health policy, helping to assess organisational communication and transparency regarding mental health initiatives.

Third, the perceived outcomes of disclosing a mental health condition were examined, including both positive and negative impacts on a service member's career. This helped to capture the organisational climate regarding mental health openness and support. In addition, the section addressed perceived stigma and the risk of discrimination, asking whether personnel believed they might face judgement or adverse treatment from colleagues or commanders. These insights are important for identifying potential cultural and social barriers to seeking help. The survey also explored the use of external mental health services, such as civilian

general practitioners or private providers, along with participants' reasons for seeking help outside the military system. This allowed for a better understanding of potential gaps in internal provision or trust in military healthcare pathways.

Participants were invited to suggest improvements to the Defence Forces' mental health services through open-ended responses. This provided an opportunity for personnel to voice constructive feedback, highlight areas for development, and propose practical reforms. Finally, the section included a question specifically focused on the impact of the COVID-19 pandemic, recognising its global psychological effects and its potential to exacerbate existing mental health challenges within the military community.

Overall, this section addresses a significant gap in understanding how Defence Forces personnel interact with the internal mental health support system. By investigating attitudes towards disclosure, perceptions of stigma, and patterns of service use, it provides valuable insight into the cultural and systemic barriers that influence help-seeking.

5.13 Validity

The concepts of validity and reliability are central to ensuring the rigour and trustworthiness of research findings (Buckingham & Saunders, 2004). Validity refers to the extent to which an instrument or method accurately measures what it is intended to measure (Creswell & Plano Clark, 2018). In this study, validity was a priority and was addressed through the careful selection of instruments that are well-established and widely used in international mental health studies, and international military research.

Content Validity, which ensures that an instrument measures what it is designed to measure accurately, was central to the validation process (Zamanzadeh et al., 2015). Several steps were undertaken to establish and enhance the validity of the scales incorporated into the survey tool:

1. Prominence in Literature: Each scale was selected based on its widespread use and recognition in mental health research within Ireland and internationally. These instruments have consistently demonstrated validity and reliability in diverse contexts.
2. Relevance to Military Studies: The inclusion of most of these scales in previous military studies on mental health added to their credibility and relevance for this research. Most of the instruments have been validated in settings that align with the unique context of military populations.

3. Expert Development: The scales utilised in this study—the Generalized Anxiety Disorder 7-item (GAD-7), Patient Health Questionnaire (PHQ-9), PTSD Checklist (PLC-5) PCL-M Military Version, Alcohol Use (AUDIT-C and DMQ-R), Suicidal Thoughts, Attempts and Self-Harm (CIS-R), Stigma and Barriers to Care, Self-Stigma and Awareness, Emotional Literacy, and the Multidimensional Scale of Perceived Social Support (MSPSS was modified to include a seven-point Likert scale to enhance the validity of responses, as supported by Yurdakul (2018), were all developed by experts in their respective fields. Each instrument is designed to capture specific dimensions of mental health and associated behaviours.

A pilot test of the survey was conducted with 10 volunteer soldiers from the Air Corps to evaluate its clarity, readability, and estimated completion time, which averaged 15 minutes. This was faster than anticipated, though no definitive explanation can be given. Several factors may account for the speed: the concise length of the instrument, participants' familiarity with structured questionnaires, and the disciplined, task-focused approach often characteristic of military personnel. Importantly, the short completion time suggested that the survey was not overly burdensome, thereby supporting its suitability for large- scale administration.

The pilot also identified ambiguities and areas for refinement, ensuring the instrument was both user-friendly and contextually appropriate. Based on participant feedback, improvements included clarifying instructions for Likert scales, simplifying item wording to reduce ambiguity, reordering questions to improve logical flow, and adjusting formatting to enhance readability. In addition, assurances of anonymity were made more prominent in the introductory section to encourage candid responses. These refinements not only improved the clarity and usability of the survey but also strengthened its overall validity by reducing the risk of misinterpretation and encouraging accurate, reliable participation.

5.14 Reliability

Reliability pertains to the consistency and stability of measurements over time. It ensures that the research findings are reproducible under similar conditions (Middleton, 2023) Reliability was assessed through internal consistency measures, such as Cronbach's Alpha, for all quantitative scales

5.14.1 Internal Consistency

Cronbach's alpha is the most widely used statistic for assessing the internal consistency of scale items, indicating the degree to which they measure a common construct (Field, 2018). Although a useful reliability index, it is influenced by factors such as the number of items and sample size, with shorter scales typically yielding

lower coefficients (Morera & Stokes, 2016). As a rule of thumb, values of 0.70 or above are regarded as acceptable, reflecting that at least 70% of the variance is reliable (Taber, 2018).

As shown in Table 6, the internal consistency of the instruments employed in this study was generally strong. The GAD-7 (.875), PHQ-9 (.89), and the Britt and Hoge Stigma Scale (.89) all exceeded the conventional threshold, demonstrating robust reliability consistent with published validation studies. Other measures not presented in the table, such as the Multidimensional Scale of Perceived Social Support (MSPSS) and the Stigma and Self-Stigma Scale (SASS), have also demonstrated satisfactory internal consistency in prior research (α typically > .80), further reinforcing the reliability profile of the study's measures.

The only exception was the Hoge Barriers to Care Scale (.66), which fell below the conventional cut-off. This lower coefficient is not unexpected for a brief five-item measure, since alpha is partly determined by the number of items included. Furthermore, "barriers to care" represent a more heterogeneous construct than anxiety or depression, and responses may therefore vary across individual experiences, service branches, or ranks, reducing item inter-correlation. While the reliability estimate is modest, it remains within the range reported in comparable military studies, and the scale's face validity and established use support its inclusion in the present research.

Table 6 Reliability coefficients of survey instruments within this study

Survey Instrument	Cronbach's Alpha
Generalized Anxiety Disorder 7-Item Scale (GAD-7)	0.875
Patient Health Questionnaire-9 (PHQ-9)	0.89
Britt and Hoge et al. Stigma Scale	0.89
Hoge et al. Barriers to Care Scale	0.66

5.15 Quantitative Data Analysis

The initial step in the quantitative data analysis process involved creating a comprehensive codebook for each variable. This codebook detailed the labelling instructions for all variables, the numerical values assigned to each response, and the scoring method for each scale. It served as a critical reference for understanding the decisions made during the data analysis process (Pallant, 2020). Once the codebook was finalised, all data were downloaded into the Statistical Package for Social Science (SPSS) version 10.2 for analysis (IBM Corp., 2001). Following data entry, the dataset underwent rigorous error-checking procedures,

including a review for missing data, to ensure the accuracy and reliability of the analysis.

Statistical probability, or p-values, indicate whether the findings of a research study are statistically significant, meaning they are unlikely to have occurred by chance. In this study, the threshold for statistical significance was set at 0.05, consistent with widely accepted conventions (Field, 2018). This indicates a 95% confidence level and a 5% probability that the observed results occurred by chance. Exact p-values are reported for values equal to or greater than .001. When a statistical value of .000 was identified, it is reported as $p < .001$, adhering to established reporting conventions (Andrade, 2019). A common challenge in developmental research is the occurrence of incomplete or missing data, often resulting from respondents failing to complete questionnaires in full. This missingness can introduce biases in parameter estimates and potentially mislead the interpretation of findings, a scenario frequently encountered in developmental research (Wood et al., 2024).

In the Stigma and Self-Stigma Scale (SASS) (Dockesy et al., 2022), item nonresponse occurred, as detailed in Section 6.3.6.1. In the hard-copy administration, some respondents left sections blank. In the digital version, where progression required an entry, a minority of participants appeared to input arbitrary values to advance. To protect data quality, only valid responses were included in scoring and analysis, and the total Ns for affected sections were adjusted accordingly. For example, of the 687 completed surveys, only cases with usable SASS data were analysed for SASS outcomes, with the effective sample size reported in chapter 6. Nineteen surveys were excluded from the dataset prior to analysis due to serious completion problems. These cases were largely unfinished, entirely blank, or vandalised with inappropriate or irrelevant entries, rendering them unusable.

The data analysis process involved exporting digital survey responses from Qualtrics directly into IBM SPSS version 10.2, a widely used statistical software for quantitative analysis. Hard copy surveys were manually entered into SPSS by the researcher to ensure completeness and consistency with the digital dataset. Each section was analysed according to a comprehensive codebook, which outlined variable definitions and scoring criteria based on the respective measurement scales. This structured approach supported accuracy and comparability across all data.

For the qualitative open-ended survey questions, which aimed to capture participants' opinions and beliefs, responses were transcribed verbatim into Excel and systematically coded. A total of 223 responses were generated, ranging from a few words to several hundred words in length, producing a substantial qualitative dataset for analysis. Thematic analysis, as outlined by Braun and Clarke (2006), was

then employed to identify, organise, and interpret recurring patterns within the data. This approach was particularly appropriate given the exploratory aims of the study and the breadth of material generated, as it enabled both concise and extended responses to be systematically integrated into coherent themes. The method facilitated the extraction of meaningful insights, offering deeper understanding of participants' perspectives (Chawla et al., 2021)

Descriptive statistics were generated to summarise the sample's characteristics, with cross-tabulations conducted by Rank, Gender, and Branch to highlight differences and trends within these groups. Although the survey included three categories for gender: Male, Female, and Other, only two respondents identified as "Other." Due to the very small number of participants in this category, it was not statistically feasible to include them in gender-based analyses. Consequently, gender comparisons and assessments in this study were conducted solely between the male and female groups.

To test for associations between groups, Pearson's chi-square test for independence was employed. For instance, the test was used to examine the proportions of males and females reporting severe anxiety, officers and other ranks experiencing severe depression, and the branches of the Defence Forces consuming higher levels of alcohol. For variables with more than two categories, such as Branch (Army, Navy, Air Corps), the chi-square test did not always indicate which specific cells contributed to the observed significant differences. To address this, post-hoc tests, including an analysis of standardised residuals, were conducted (Standardised residuals measure the difference between observed and expected frequencies). Field (2018) emphasises that reliability in the context of chi-square tests can be enhanced by converting residuals into z-scores, which are then compared to a critical value corresponding to the alpha level of the analysis. For this study, an alpha level of 0.05 was used, resulting in a critical z-score threshold of +/- 1.96. Residuals exceeding +1.96 indicate cells that are over-represented, meaning the observed number of subjects in these cells is significantly higher than expected. Conversely, residuals below -. 1.96 indicate under-representation, suggesting fewer subjects than anticipated in these cells. In this study, standardised residuals (zresid) were calculated and reported for several variables to pinpoint and interpret these deviations accurately.

Scale scores were assessed for normality using the Kolmogorov-Smirnov (K-S) test. The results for each scale, reported in Chapter 6, demonstrated significant non-normality across the dataset. This conclusion was further supported by visual inspections of normal probability plots. Due to this non-normal distribution, non-parametric tests such as the Mann-Whitney U test were used to compare scale scores and identify any statistical differences across Gender and Rank. For Branch

(Army, Navy, Air Corps), the analysis focused on reporting average scale scores without additional parametric comparisons. A one-way analysis of variance (ANOVA) was conducted to assess whether there were significant differences in scores across the three service branches (Army, Navy, Air Corps). ANOVA is appropriate in this context because the dependent variables under study (e.g., PHQ-9 depression scores, GAD anxiety scores, or stigma measures) are continuous, while the independent grouping variable (branch of service) is categorical with more than two levels. Unlike multiple t-tests, which would increase the risk of Type I error, ANOVA allows for a single omnibus test to determine whether statistically significant mean differences exist between the groups. This method ensures robust comparison across branches and is consistent with standard practice in quantitative research.

Linear regression models, (7) were conducted the independent variables use were Demographic variables Gender, Rank, Age, Branch (Army, Navy, Air Corps), Marital status. Occupational variables, Length of service, Number of missions. Psychological/mental health history variables, Suicidal ideation (seriously thought about suicide), Deliberate self-harm and Previous suicide attempt. The independent variables used in the regression analyses were chosen to reflect three broad domains, demographic, occupational, and psychological/mental health history, each of which is theoretically and empirically relevant to help-seeking behaviours and mental health outcomes in military populations.

- Demographic variables (Gender, Rank, Age, Branch, Marital status): These were included to account for baseline individual characteristics that can influence mental health outcomes and attitudes toward help-seeking. Prior research suggests that demographic attributes such as age and gender are often associated with differences in mental health prevalence and treatment-seeking patterns, while rank and branch may reflect variations in organisational culture and exposure to occupational stressors.
- Occupational variables (Length of service, Number of missions): These variables capture operational exposure and military career progression. Deployment history and length of service have been shown to affect psychological resilience, stress accumulation, and risk of mental health difficulties, making them relevant predictors of depression, anxiety, and stigma.
- Psychological/mental health history variables (Suicidal ideation, Self-harm, Previous suicide attempt): These were included because they represent established risk factors for poor mental health outcomes. The presence of such behaviours is strongly associated with elevated symptoms of depression and anxiety, and with increased stigma surrounding help-

seeking. Their inclusion allows the models to assess whether prior psychological distress explains variance in current mental health outcomes beyond demographic and occupational factors.

By combining these three domains, the regression models provide a comprehensive test of both structural and psychological predictors of mental health outcomes. This multivariate approach allows for a nuanced understanding of how demographic background, occupational demands, and prior psychological history interact to influence depression, anxiety, and stigma among Defence Forces personnel.

5.16 Qualitative Data Phase 2

The second phase of this research comprised a qualitative component, using face-to-face, semi-structured interviews to explore the experiences, views, and interpretations of key Defence Forces stakeholders in relation to mental health and help-seeking behaviour within the Irish Defence Forces. These interviews were a critical complement to the quantitative data gathered in Part 1 and were instrumental in contextualising the survey findings within the lived realities of those operating within the military help-provision system. A commitment to confidentiality was agreed upon by the researcher and the supervisory team during the study's design phase. Initially, it was intended that Part 2 respondents would be identified by their appointments or roles to provide contextual insight into their perspectives. However, in alignment with the principles of the study's theoretical framework, and to safeguard participants' rights to express their views freely, it was ultimately deemed more appropriate to hide their identities by creating pseudonyms . This decision ensured participants could share their opinions openly, without concern for potential professional or personal repercussions.

Semi-structured interviews were chosen for their ability to strike a balance between consistency and flexibility. As described by Adeoye-Olatunde and Olenik (2021), the use of a standardised interview guide ensures that core topics are addressed across all interviews, while still allowing the researcher the freedom to explore issues that emerge organically during the conversation. This methodological flexibility was essential in eliciting richer, more detailed narratives that might not have been captured through closed-question formats alone.

However, while this method offers significant strengths, it is not without challenges. The open-ended and adaptable nature of semi-structured interviews can introduce limitations to validity. As noted by Belina (2023), deviations from structured questioning may hinder comparability across participants and make

data synthesis more complex. Additionally, there is the potential for research bias. Interviewers may unintentionally ask leading questions or respond to participants in ways that influence their answers, an issue referred to as observer bias (Burghardt et al., 2012). Similarly, participants may provide socially desirable responses or tailor their answers based on perceived expectations; a phenomenon known as social desirability bias (Piedmont, 2023). Another consideration is the Hawthorne effect, where individuals modify their behaviour simply because they are aware they are being observed (Elston, 2021).

To minimise the risks inherent in qualitative interviewing, an interview guide (see Appendix 16) was used to ensure consistent coverage of core themes, while neutral prompts were employed to avoid leading participants. All interviewees were reminded of the voluntary and confidential nature of the study, which helped to reduce socially desirable responding. The researcher also maintained reflexive notes during and after interviews to monitor potential bias and enhance the credibility of the analysis.

Developing effective interview questions posed its own challenges. Crafting prompts that balanced a structured framework with scope for in-depth exploration required both methodological sensitivity and a strong understanding of the topic. Participants' varying levels of comfort in discussing sensitive mental health issues further complicated the process, reinforcing the need for a careful and ethically grounded approach. The interview guide focused on several key areas. Participants were first invited to reflect on the quantitative findings, including the reported prevalence of anxiety, depression, PTSD, alcohol misuse, suicidal ideation, and self-harm. They also discussed cultural and systemic factors related to stigma and barriers to care, enabling the researcher to situate the survey data within the organisational and operational context of the Defence Forces. Interviewees then shared their opinions on the current medical model and help-seeking systems, evaluating how these services are perceived, how accessible and responsive they are, and where improvements may be needed. Linked to this, participants reflected on the potential organisational impact of the data, particularly in relation to policy reform, resource allocation, and broader cultural change.

Another area of exploration was mental health training. Stakeholders discussed the feasibility and potential benefits of introducing essential training alongside annual medical evaluations, as well as the challenges of implementation and the role of leadership in promoting mental health education. In addition, participants were asked how the findings of this study could inform the development of a formal Defence Forces mental health policy, bridging the gap between empirical data and practical application. Several themes centred on stigma and disclosure.

Participants suggested strategies for reducing stigma, including fostering open dialogue, increasing the visibility of support systems, and challenging cultural norms that discourage help-seeking. They also reflected on how policy might encourage safe and honest disclosure of mental health difficulties without fear of professional repercussions, highlighting the importance of confidentiality and trust.

Finally, interviewees offered perspectives on investment in help-seeking services, such as the need for greater staffing, increased service capacity, and better integration of mental health professionals. Broader recommendations were also made to improve support for personnel, including cultural shifts, leadership responsibilities, and long-term strategies to enhance wellbeing across the organisation. Despite the challenges of designing and conducting these interviews, the qualitative phase yielded valuable insights into the complex cultural, systemic, and interpersonal factors shaping mental health and help-seeking behaviours in the Defence Forces. By capturing the voices of those directly involved in providing and navigating support, the study not only deepened understanding of the patterns identified in the survey but also informed recommendations grounded in lived realities and operational practice.

5.17 Conducting Face -to- Face Interviews

All five face-to-face interviews were conducted within military installations. To create an environment conducive to open communication, several requests were made by the researcher: the arrangement of two chairs without a table between them, the researcher wearing civilian attire rather than a military uniform, and the use of participants' first names instead of their ranks where appropriate. These measures were implemented to reduce power distance between the researcher and the appointment holders. The researcher held the rank of Corporal, which is classified as a junior rank within the Irish Defence Forces. In contrast, many of the participants recruited for the interviews occupied senior ranks, holding positions of significant authority and responsibility within the organisation, introducing a possible power distance dynamic.

Power distance belief, as described by Hofstede (2003), refers to the extent to which individuals or groups accept the unequal distribution of power within societies or organisations. In military contexts, the formal hierarchical structure often reinforces this dynamic, potentially inhibiting open communication (Daniels & Greguras, 2014). Fear of authority can create barriers, leading to avoidance behaviour rather than engagement (Hao et al., 2022). This issue was particularly relevant in everyday communications in the Defence Forces, where formal

communication protocols are strictly observed between subordinate and superior ranks.

Studies such as Milgram's (1963), on obedience to authority, have demonstrated that individuals often comply with authority figures, even when such compliance might conflict with personal judgments. Furthermore, individuals with high levels of fear of authority may perceive authority figures as inherently correct and professional, which can contribute to cognitive biases (Dai et al., 2022). Such dynamics can hinder honest and critical dialogue in workplace communication, particularly in hierarchical bodies like the military.

As the junior ranked person in the interviews, further mitigations were considered to address these challenges, the researcher aimed to buffer the negative effects of high-power distance beliefs, as recommended by Dai et al. (2022), through Facione's (1990), work on critical thinking, which highlights the importance of adopting a holistic and analytical approach when overcoming the potential fear of authority. Guided by these principles, the researcher maintained a professional yet approachable demeanour throughout the interviews, strictly adhering to the role of researcher by focusing on the survey findings of Part 1 only. Through fostering an environment of mutual respect and neutrality, these measures helped create a setting where participants felt comfortable sharing their perspectives candidly.

The interview settings were carefully prepared in advance, when possible, however, when interviews took place in a room outside of the researcher’s control, any necessary adjustments were made on the day, to ensure consistency throughout all sessions. Prior to the commencement of each interview, the researcher engaged in a reassuring conversation with the participant, emphasising the commitment to confidentiality and providing additional insights into the study's objectives. The recording device was set up and tested to ensure optimal functionality.

Both the researcher and the participant read through the consent forms together to confirm mutual understanding. Participants were explicitly informed of their right to withdraw from the study at any point. They were then invited to sign the consent form if they chose to proceed, and all participants provided their written consent by signing the document. In the case of the remote interview, permission and consent were obtained orally and recorded via video.

Participants were thanked for their contribution, and the guidelines of the interview were clearly outlined including duration of interviews (approximately 1 hour). It was explained that if a participant felt that they made a controversial comment or statement, they would have the option to request its withdrawal.

Confidentiality was discussed in detail, ensuring participants that identifying information would be removed from the transcript.

Participants were given the opportunity to ask questions or seek clarification on any aspect of the key findings. Additionally, they were reminded about the use of the recording device, reassuring them that its purpose was to ensure a comprehensive and accurate analysis of the interview. These guidelines were repeated for all the six interviews including the remote interview. Before each interview, a brief introduction of the researcher's military background and the background of the study was offered as a point of engagement to encourage the flow of dialogue, and in consideration of the power distance, to gain a high level of mutual reciprocity as recommended by Beavin-Bavelas, (2022).

5.18 Interview Development and Safeguarding Consistency

At the beginning of each interview, there was a general conversation regarding the Defence Forces, this was maintained throughout each interview as an icebreaker. Following this general discussion, participants were asked for their opinions and thoughts on the key findings from the survey. These findings covered the prevalence of anxiety, depression, alcohol consumption, suicide attempts, suicide ideation, and self-harm among Defence Forces personnel. Once participants had shared their perspectives on these findings, the interviews focused on help-seeking behaviours.

A concerted effort was made to ensure participants could answer freely, encouraging open and unfiltered responses. However, the use of prompts was occasionally necessary when participants went off topic, particularly when exploring sensitive subjects such as findings related to suicide attempts. This technique proved valuable in maintaining focus while fostering a respectful and supportive atmosphere. Furthermore, participants did give personal accounts of their experience with personnel avoiding help-provision, particularly formal care, due to the stigma, career implications and the impact it may have on their overall military experience. This was very insightful, honest and useful. This perspective was critical for understanding both the operational dynamics of the systems and the lived experiences of those interacting with them.

The single remote interview was conducted from the researcher's office, located within the Irish Air Corps base in Dublin. The participant, who was serving overseas on an operational mission, joined the interview via Zoom from a private office within the United Nations Irish compound. While this interview presented different challenges, the interviewee was very accommodating, and the schedule was followed in the same manner as the face-to-face interviews. To verify the comparability of the remote and face-to-face interviews, a detailed comparison of

the interview transcripts was undertaken. This analysis revealed no significant differences in the depth, tone, or quality of the data collected, demonstrating that the remote interview maintained the same standard of engagement and insight as the in-person discussions.

5.19 Qualitative Data Analysis

Qualitative data analysis requires a rigorous and trustworthy thematic analysis; this process incorporates interpreting and representing the data. In order to display trustworthiness within an analysed dataset, qualitative research must demonstrate precise, consistent, and exhaustive methods of analysis with enough detail to allow the reader to determine whether credibility exists (Nowell et al., 2017). In qualitative data analysis, the researcher is the primary instrument, exercising judgement in coding, theming, and the iterative process of decontextualising and recontextualising the data (Starks & Trinidad, 2007).

Thematic analysis, as defined by Braun and Clarke (2006), was employed as a systematic method for identifying, organising, and reporting patterns across the dataset. Although Braun and Clarke have published updated iterations of thematic analysis (2012, 2019), this study employed their original 2006 framework. The 2006 version remains the seminal reference in the field and provides a clear six-phase process, familiarisation, coding, theme development, reviewing, defining, and reporting, that is widely recognised and consistently applied across social and health research. This structured approach was particularly appropriate for the present study, which required a transparent and replicable framework capable of accommodating both short open-ended survey responses and in-depth interview transcripts within a mixed-methods design. While later reflexive versions emphasise researcher subjectivity and deeper interpretive engagement, this study drew on those insights to remain reflexively aware, but conducted the analysis within the structured, pragmatic framework of the 2006 model. This offered the necessary balance of flexibility and systematic rigour to integrate qualitative insights with quantitative findings.

The analysis was explicitly underpinned by a descriptive qualitative approach, which prioritises the systematic identification and clear presentation of patterns in participants' accounts. This orientation was appropriate given the study's aim to contextualise and explain quantitative findings while grounding the qualitative results in Key stakeholders lived experiences. Whereas interpretive thematic analysis seeks to theorise meaning beyond the surface of participants' accounts, a descriptive approach was chosen here to ensure findings were accessible, transparent, and directly applicable to organisational and policy contexts. While its flexibility is a major strength, thematic analysis can also create risks of inconsistency or fragmentation when developing themes (Holloway & Todres,

2003). To address this, the analysis was aligned with the study's epistemological stance (see Section 4.8.1), ensuring that the themes were not only coherent but also methodologically robust and reflective of the philosophical underpinnings guiding the research.

5.19.1 Braun & Clarke's (2006) 6-step framework.

As Clarke and Braun (2013) assert, when analysing qualitative data, the emphasis should be placed on the practical aspects of conducting qualitative analysis rather than dwelling on assumptions, design, or data collection. Neglecting a rigorous and relevant thematic analysis can undermine the credibility of the research process (Nowell et al., 2017). To address this, the researcher adopted a practical, stage-driven approach to ensure procedural rigour. The primary aim was to identify meaningful patterns within the data that were significant or insightful and then develop these patterns into well-defined themes that provided a deeper understanding of the topic under investigation. By employing Braun and Clarke's (2006) six-step framework for thematic analysis (Appendix 17)., the researcher ensured that the data was not merely summarised and organised but thoroughly and meticulously analysed, adding depth and robustness to the study's findings The stages are listed below

Table 7 Braun & Clarkes 6-phase framework for thematic analysis

Step	Description
Step 1: Become Familiar with the Data	Read and re-read the data to ensure deep immersion and understanding. Note initial observations and ideas that could be relevant for analysis.
Step 2: Generate Initial Codes	Identify and label specific features of the data that appear meaningful. Codes are systematic and relate to the research questions or objectives.
Step 3: Search for Themes	Organise codes into broader patterns or themes that represent significant aspects of the data. Collate related data extracts for each theme.
Step 4: Review Themes	Examine themes for coherence and consistency. Ensure they accurately reflect the coded data and the overall dataset, refining or merging as needed.
Step 5: Define Themes	Clearly articulate the essence of each theme. Define the scope and focus of each theme and identify sub-themes if necessary.

Step	Description
Step 6: Write-Up	Compile the analysis into a cohesive narrative, integrating evidence from the data and explaining the relevance of the themes to the research aims.

5.19.2 Thematic Analysis: Step-by-Step Process

Step 1: Become Familiar with the Data (Data Reduction)

The initial stage of analysis involved immersing oneself in the data by transcribing the interview recordings and then thoroughly reading the transcripts. As the sole researcher, transcribing the interviews verbatim fostered a deep familiarity with the content, allowing for a nuanced understanding of each participant's narrative. Emotional cues and inflections were also noted, enhancing the richness of interpretation. During this phase, detailed margin notes were made to record emerging observations and early analytical insights.

Step 2: Generate Initial Codes

The next stage involved systematically organising the data by reducing large volumes of information into smaller, meaningful units. This was achieved through manual open coding, using pens and highlighters on printed transcripts. Approximately 130 initial codes were generated inductively from the data, following Braun and Clarke's (2006) guidance. These codes were later refined, combined, and organised into broader categories, providing a structured foundation for theme development. A deliberate decision was made to conduct the coding manually rather than using qualitative data analysis software such as NVivo or ATLAS.ti. Given the relatively small sample size (six interviews) and the researcher's preference for working directly with hard-copy transcripts, manual coding was judged more practical. The process involved assigning colour codes to key concepts, annotating margins with emerging ideas, and maintaining a separate coding log to track the consolidation of codes into preliminary themes. This approach ensured close engagement with the data while maintaining systematic organisation. The use of inductive coding allowed insights to emerge from participants' accounts, rather than being constrained by pre-existing categories, while the manual process provided a transparent, replicable pathway from raw data to thematic patterns.

Step 3: Search for Themes

In this step, the researcher examined the codes to identify patterns or recurring ideas that were meaningful in relation to the research objectives. A theme is

defined as a pattern that captures something significant about the data and addresses the research questions (Braun & Clarke, 2006). Codes were grouped into preliminary themes that reflected participants' experiences, perceptions, and shared concerns, with approximately 10–12 themes identified at this stage. Data points irrelevant to the research questions were excluded to maintain analytical focus. This stage represented a move beyond basic categorisation towards a more structured organisation of the data, generating themes that could be further refined in subsequent steps. The analysis remained primarily descriptive, with interpretation applied only insofar as it clarified how themes related to the study's aims (Maguire & Delahunt, 2017).

Step 4: Review Themes

Following the initial identification of themes, the researcher conducted a thorough review to assess the coherence, consistency, and relevance of each theme. This process involved re-reading the transcripts and, where necessary, re-coding sections of text to refine the thematic framework. Manual coding was supported by colour coding on printed transcripts, with emerging sub-themes noted in the margins. Direct quotations were systematically collated in an Excel spreadsheet under their provisional themes and sub-themes, ensuring traceability and a clear evidentiary base for subsequent analysis. At this stage, the preliminary 12 themes identified in Step 3 were reduced and consolidated into a smaller set of more coherent thematic groupings.

Step 5: Define and Refine Themes

The next stage focused on articulating the core meaning, or "essence," of each theme and clarifying the relationships between them. A hand-drawn thematic map was created to visualise connections, overlaps, and potential redundancies. Through this process, themes were refined, with some merged or collapsed to improve coherence. Ultimately, the preliminary themes were

consolidated into three overarching themes, which captured both broad patterns and specific dimensions of participants' experiences. The analysis remained primarily descriptive, with interpretation applied selectively to ensure themes were clearly aligned with the study's aims (Braun & Clarke, 2006).

Step 6: Write up of Findings

The final stage involved synthesising the findings into a coherent narrative. The three overarching themes, together with their associated sub-themes, were integrated into the study's results in a way that highlighted their relevance to the

research objectives. Direct quotations were incorporated throughout the write-up to illustrate and substantiate the themes, ensuring authenticity and transparency. These findings are presented in Chapter 7, where they provide a structured and evidence-based account of the cultural, systemic, and interpersonal factors influencing mental health and help-seeking behaviour within the Defence Forces. Table 8 below provides visual analytic chain of the process.

Table 8 Analytic Progression from Code to Themes

Stage of Analysis	Outcome	Numbers	Description of Process
Open Coding	Initial codes	130	Codes generated inductively from transcripts using manual colour coding and margin notes.
Preliminary Theme Generation	Early thematic categories	10–12	Codes grouped into broader categories that captured shared ideas, experiences, and perceptions.
Theme Review & Refinement	Refined themes and sub-themes	6–8	Themes reviewed for coherence; overlapping categories merged; sub-themes identified.
Final Thematic Framework	Overarching themes	3 overarching themes	Clear thematic map established, representing the essence of participants' accounts, aligned with research objectives.

5.20 Rigor

Rigour in qualitative research concerns the trustworthiness of the study, achieved through transparent, systematic, and well-documented procedures from design to reporting (Leung, 2015; Nowell et al., 2017). Following Lincoln and Guba's criteria, trustworthiness was addressed through credibility, transferability, dependability, and confirmability, supported by explicit reflexivity and ongoing supervision (Lincoln & Guba, 1985; Nowell et al., 2017). Procedures to reduce bias and strengthen quality were planned and documented throughout the project (Patton, 1999; 2002).

5.20.1 Credibility

Credibility was enhanced through several strategies.

- Member checking: During interviews the researcher summarised key points back to participants and invited clarification or correction in real time. At interview close a brief recap of the participant's main messages was offered for confirmation. Full transcripts were not circulated for participant review, so member checking took the form of in-interview verification and end-of-interview confirmation rather than transcript return.
- Methodological triangulation: Semi-structured interviews were used to contextualise and explain patterns identified in the survey, allowing convergence or contrast between quantitative and qualitative insights to be noted.
- Peer debriefing and supervision: Emerging interpretations were discussed regularly with the supervisory team and in doctoral support seminars. Elements of the analysis were also presented at military and international fora for critical feedback. These processes helped surface assumptions, locate alternative explanations, and strengthen the credibility of claims.
- Attention to disconfirming evidence: During theme review the analysis actively searched for cases that challenged the dominant pattern and noted them within sub-themes or exceptions, supporting balanced interpretation.
- Use of verbatim quotations: Findings are illustrated with direct excerpts so that readers can appraise the fit between data and interpretation.

5.20.2 Transferability

Transferability was supported through thick description of the organisational context, sampling frame, participant characteristics, interview settings, and procedural steps. By detailing the Defence Forces environment and study procedures, readers can judge the applicability of findings to other settings (Lincoln & Guba, 1985).

5.20.3 Dependability

Dependability was addressed by maintaining a clear audit trail and using a semi-structured interview guide.

- Audit trail: Versioned documents were retained, including the interview guide and its pilot revisions, recruitment materials, field notes, reflexive

memos, coding logs, theme maps, and minutes or notes from supervisory meetings. This record documents procedural decisions and analytic changes over time.

- Procedural consistency: The same core guide was used across interviews to ensure consistent coverage of topics, while allowing follow-up probes to explore emergent issues.

5.20.4 Confirmability

Confirmability was strengthened through reflexivity, the audit trail, and supervisory oversight.

- Reflexivity: The researcher maintained reflexive notes before, during, and after interviews to document positionality, potential influence on questioning, and analytic decisions. These memos, alongside recorded decision points in coding and theme development, provide a traceable decision path.
- Supervision and peer review: Regular supervisory consultations and peer debriefings provided external checks on interpretations, helping ensure that conclusions were grounded in the data rather than researcher preference.
- Linkage to literature: Iterative comparison with the existing literature on military mental health, stigma, and help-seeking was used to situate findings, note convergences and divergences, and avoid over-interpretation.

These procedures align with Lincoln and Guba's framework and contemporary guidance on establishing trustworthiness in thematic analysis (Lincoln & Guba, 1985; Nowell et al., 2017). They demonstrate how rigour was planned, enacted, and evidenced across the qualitative phase. As shown in Table 9, strategies were applied to address all four of Lincoln and Guba's trustworthiness criteria, with several practices contributing to more than one. Reflexivity, for instance, supported both credibility and confirmability, while triangulation and integration with literature enhanced credibility and strengthened transferability. This overlapping of practices created a layered approach that ensured transparency, consistency, and robustness throughout the analysis.

Table 9 Rigour Practices and Trustworthiness Criteria

Rigour Practice	Description	Trustworthiness Criterion(s)
Audit trail	Maintained throughout the study and available for inspection in Appendix references.	Dependability, Confirmability
Semi-structured guide	Piloted and applied consistently across interviews, with documented refinements.	Dependability, Credibility
Member checking	Conducted through in-interview summarising and end-of-interview confirmation (no transcript return).	Credibility
Peer debriefing and supervision	Regular review of developing analysis with supervisors and peers.	Credibility, Confirmability
Reflexivity	Ongoing use of reflexive memos and positionality reflections to monitor researcher influence.	Confirmability, Credibility
Integration with literature	Findings compared with prior research to test plausibility and scope.	Transferability, Credibility
Triangulation with survey results	Qualitative insights used to contextualise and expand on quantitative patterns.	Credibility, Transferability

5.21 Mixed Methods Quality Criteria

Hirose and Creswell (2022) note that while numerous quality criteria have been proposed for mixed methods research, integrating these multiple elements into a single study is often challenging. To address this, a synthesized shortlist of six core criteria, adapted from Bryman (2014) recommended framework.

The six core criteria applied in this study are as follows:

1. Justification for Mixed Methods Methodology: A clear rationale for using mixed methods is presented in Chapter 4, demonstrating why this approach was the most appropriate for addressing the research objectives.

2. Development of Research Questions and Objectives : The study includes quantitative, qualitative, and mixed methods questions, with a mixed methods aim explicitly outlined in Section 5.3.1. Four objectives focus on quantitative investigations, while one examines qualitative , demonstrating their interdependence in explaining comprehensive findings (Section 5.3.2).

3. Separate Reporting of Quantitative and Qualitative Data : To maintain clarity, the quantitative and qualitative results are presented distinctly. Each phase specifies its instruments, sample size, data collection procedures, and analysis methods, allowing readers to understand the methods and findings of both strands independently.

4. Identification of Mixed Methods Design : The study adheres to a Sequential Explanatory Design, visually represented in Figure 3, while Figure 2 illustrates Pragmatism as a Philosophical Underpinning, highlighting the independent philosophical ideologies of each phase while both are integrated within a unified interpretative framework.

5. Integration of Data in a Joint Display: The integration of findings is systematically presented in Chapter 8, aligning quantitative and qualitative results.

6. Meta-Inferences and Analytical Value : The integration of both datasets led to meta-inferences, demonstrating how the combined analysis enhanced the study's explanatory depth (Chapter 8).

5.22 Ethical Considerations

5.22.1 Principles and relevance to this study

This study followed the core ethical principles of respect for persons, beneficence, and justice, and complied with institutional and national standards. These principles are especially important in military settings where hierarchy and command structures can create perceived pressure to participate. The design therefore prioritised voluntariness, confidentiality, and safeguards for participant welfare.

5.22.2 Ethical approvals and governance

Permission to conduct the study within the Irish Defence Forces was granted on 1 February 2020 by the Officer in Charge of Personnel Support Services. Ethical approval was then obtained from the Faculty of Health Sciences Research Ethics Committee, School of Nursing and Midwifery, Trinity College Dublin, on 28 April

2020 following a Level 2 submission. Research integrity training was completed prior to data collection. Copies of approval letters, participant information materials, and consent documentation are provided in the appendices.

5.23 Applied ethics: what was done in each phase

Voluntary participation and withdrawal

- Phase 1 (survey): Participation was voluntary. The information sheet emphasised that respondents could decline or discontinue at any time without consequences.
- Phase 2 (interviews): Participation was voluntary with the right to withdraw at any point before data consolidation. Non-participation carried no adverse effects.

Consent procedures

- Phase 1 (survey): As the survey was anonymous, written consent was not required. Consent was implied through completion after reading the information sheet at the start of the survey (hard copy and online).
- Phase 2 (interviews): Written informed consent was obtained before interviews, with one online case providing video-recorded oral consent. Participants received a detailed information sheet covering study aims, GDPR compliance, data handling, and their rights.

Recruitment of interview participants

Phase 2 participants were key stakeholders in help-provision systems. As the researcher was an active Defence Forces member familiar with organisational structures, these individuals were identified and contacted directly by email, not through the chain of command. This approach reduced the risk of perceived coercion and ensured that participation was based on voluntary, informed choice.

Confidentiality and data protection

- Phase 1: No identifying data were collected; only rank category and broad demographics were included.
- Phase 2: Identities were kept confidential; pseudonyms were used and potentially identifying role descriptors were removed.

- Both phases**:** Digital files were encrypted and stored securely; hard copies were kept in locked cabinets. Consent forms were stored separately from data. Retention is for seven years, in line with institutional policy and data protection law.

Protection of participants and distress protocols

Because questions addressed sensitive mental health topics, both phases included safeguards:

- Support resource lists (military and civilian services) were provided at the start and end of the survey and given to interview participants.
- The researcher was present during data collection to pause or terminate participation if distress was observed and to signpost participants to services as needed.

5.23 Justice

The principle of justice guided fair treatment of participants and equitable distribution of research benefits. No personal identifiers were collected in surveys. For interviews, pseudonyms and anonymisation were applied consistently, and transcripts were produced by the researcher alone. Reporting avoids descriptions that could reasonably reveal identities.

5.24 Summary

This chapter has outlined the research design adopted in the study, explaining the rationale for a sequential explanatory mixed-methods approach. The quantitative survey incorporated widely recognised mental health instruments to assess the prevalence of anxiety, depression, PTSD, alcohol use, suicidal thoughts, suicide attempts, and self-harm among Defence Forces personnel. It also examined help-seeking behaviours, with particular attention to the avoidance of formal military services and reliance on alternative sources of support.

Sampling strategies and survey administration were described, including the significant adaptations required during the COVID-19 pandemic. Restrictions delayed access to military sites and necessitated a transition from hard copy to digital survey formats, influencing participation patterns and requiring additional safeguards to protect data integrity and participant well-being. These adaptations

illustrate how the study balanced continuity with ethical responsibility in a period of unprecedented disruption. Reflexively, the researcher's dual role as both serving member and academic provided critical contextual knowledge that supported practical navigation of these disruptions but also demanded heightened awareness of potential bias in how access and participation were managed.

The second phase of the study involved semi-structured interviews with key stakeholders, providing contextual insights into the survey findings. Rigour was addressed across both quantitative and qualitative components, with clear reference to mixed-methods integration criteria. Ethical considerations were also detailed, including informed consent, confidentiality, and procedures to safeguard participant well-being when engaging with sensitive topics. These methodological applications established a strong foundation for the presentation of quantitative findings in Chapter 6.

Chapter 6: Survey Findings

6.1 Introduction

This chapter presents the results of Part One of the study, which explored mental health status and help-seeking behaviour among members of the Irish Defence Forces. Surveys were distributed across the Army, Naval Service and Air Corps, yielding 706 responses; after excluding 19 incomplete questionnaires, 687 fully valid surveys remained for analysis. In order to maintain focus and respect the thesis word limit, only findings that directly address the study's first four objectives are reported here:

1. To study what mental health issues are affecting soldiers in the Irish Defence Forces.
2. To investigate how Irish military personnel address mental health concerns.
3. To determine how soldiers of all ranks currently seek help for mental health issues.
4. To investigate factors that impact help-seeking.

The chapter opens with a description of the sample's demographic characteristics, then turns to core mental health outcomes, including depression, anxiety, post-traumatic stress disorder, suicidal ideation, self-harm, and alcohol use. Help-seeking behaviour is examined through measures of perceived stigma and barriers to care, willingness to use services, and participants' emotional literacy. Select qualitative responses to open-ended questions are included to shed light on the

motivations behind individuals' help-seeking decisions. Each survey item is scored and, where relevant, results are disaggregated by rank, gender, and service branch to highlight subgroup differences. Statistical analyses were conducted in SPSS version 10.2 and comprise descriptive statistics (mean, standard deviation), tests of distribution normality, and both parametric and non-parametric inferential procedures. In addition, seven linear regression models were conducted to examine the predictive value of demographic and service variables on key mental health outcomes and help-seeking behaviours, including stigma, barriers to care, and willingness to access services.

6.2 Demographics & Service Insights

The first section of the questionnaire focused on demographic information of the participants. Gender options included male, female, and other, with the latter added to ensure inclusivity for those who do not identify within the male–female binary. Of the 687 soldiers who completed the survey, the majority (87%, n = 606) identified as male, while 11% (n = 79) identified as female, and 2% (n = 2) identified as other.

Rank was divided into two categories to protect individual identity. Officers, defined as commissioned officers, represented 26% (n = 176) of the sample, while Other Ranks, which included non-commissioned officers, privates, airmen and women, seamen and women, recruits, and cadets, accounted for 74% (n = 511). Branch distribution reflected both organisational size and patterns of survey participation. The Army provided the largest proportion of responses (59%, n = 409), followed by the Air Corps (27%, n = 184) and the Navy (14%, n = 94). However, when response rates were compared to the overall strength of each service, a clear disparity emerged. Air Corps personnel were overrepresented, with a 26% response rate, compared with 11.8% for the Navy and just 6.2% for the Army.

Age distribution indicated a predominantly mid-career cohort. Over one-third (34%) of respondents were aged 30–39, followed by 26% aged 40–49 and 25% aged 20–29. A smaller proportion were aged 50 or older (14%), while less than 1% were under 20. Marital status patterns were in line with expectations for a serving population: nearly half were married (47%), 39% were single, and smaller groups were in civil partnerships (7%), separated (4%), divorced (2.6%), or widowed (0.4%). Service length corresponded closely with the age profile. The largest group (21%) reported over 25 years of service, followed by 20% with 15–19 years, 19% with 5–9 years, and 17% with 20–24 years. Those with less than five years' service made up 13% of the sample.

Operational experience was also a significant feature. Two-thirds of respondents reported overseas deployments, with 36% having served on two to five missions, 22% on a single mission, and 15% on more than five missions. A quarter (27%) had no overseas service, suggesting variation in exposure to deployment across the Defence Forces. Finally, the survey examined access to healthcare outside the military system. Overall, 61% of respondents reported being registered with a non-military GP. Gender differences were evident, with 81% of females registered compared to 59% of males. Similar patterns were observed across branches and between officers and other ranks, suggesting that the choice to register with a civilian GP was influenced more by personal preference and accessibility than structural differences.

Table 10 Combined demographics and service profile

Category	Sub-category	Count (n)	%
Gender	Male	606	87%
	Female	79	11%
	Other	2	2%
Rank	Officers	176	26%
	Other Ranks	511	74%
Branch	Army	409	59%
	Navy	94	14%
	Air Corps	184	27%
Age group	Under 20	2	0.3%
	20–29	173	25%
	30–39	235	34%
	40–49	179	26%
	50+	98	14%
Marital status	Married	326	47%
	Single	268	39%
	Civil Partner	48	7%
	Separated	29	4%
	Divorced	13	2.6%
	Widowed	3	0.4%
Length of service	<5 years	89	13%
	5–9 years	128	19%
	10–15 years	68	10%
	15–19 years	139	20%
	20–24 years	116	17%
	25+ years	147	21%
Overseas missions	None	180	27%
	One	153	22%
	Two–Five	252	36%
	>5	86	13%
	>10	16	2%

Table 11 Crosstab Summaries

- **Gender × Rank**

	Male	Female	Other	Total
Officers	145 (82%)	30 (17%)	1 (1%)	176
Other Ranks	461 (90%)	49 (9%)	1 (1%)	511
Total	**606**	**79**	**2**	**687**

- **Branch × Rank**

	Army	Navy	Air Corps	Total
Officers	118 (67%)	27 (15%)	31 (18%)	176
Other Ranks	291 (57%)	67 (13%)	153 (30%)	511
Total by branch	**409**	**94**	**184**	**687**

- **Branch × Gender**

	Army	Navy	Air Corps	Total
Male	352 (58%)	80 (13%)	174 (29%)	606
Female	55 (70%)	14 (18%)	10 (12%)	79

- **Age × Branch**

	Under 20	20–29	30–39	40–49	50+	Total
Army	2 (0.5%)	98 (24%)	136 (33%)	117 (29%)	56 (14%)	409
Navy	0	27 (29%)	35 (37%)	18 (19%)	14 (15%)	94
Air Corps	0	48 (26%)	64 (35%)	44 (24%)	28 (15%)	184
Total	**2 (0.3%)**	**173 (25%)**	**235 (34%)**	**179 (26%)**	**98 (14%)**	**687**

- **Age × Rank**

	Under 20	20–29	30–39	40–49	50+	Total
Officer	1 (1%)	55 (31%)	65 (37%)	37 (21%)	18 (10%)	176
Other Ranks	1 (1%)	118 (23%)	170 (33%)	142 (28%)	80 (15%)	511
Total	**2 (0.3%)**	**173 (25%)**	**235 (34%)**	**179 (26%)**	**98 (14%)**	**687**

Table 12 Survey Participation by Branch:

Branch	Surveys completed (n)	Total personnel	Response rate
Army	409	6,478	6.2%
Navy	94	800	11.75%
Air Corps	184	709	26%

Table 13 Non-military GP registration Branch, Gender, Rank

- **By branch**

Branch	Yes (n, %)	No (n, %)	Total
Army	254 (62%)	155 (38%)	409
Navy	52 (55%)	42 (45%)	94
Air Corps	115 (62%)	69 (38%)	184
Total	**421 (61%)**	**266 (39%)**	**687**

- **By gender**

Gender	Yes (n, %)	No (n, %)	Total
Male	356 (59%)	250 (41%)	606
Female	64 (81%)	15 (19%)	79
Other	1 (50%)	1 (50%)	2
Total	**421 (61%)**	**266 (39%)**	**687**

- **By rank**

Rank	Yes (n, %)	No (n, %)	Total
Officer	107 (60%)	69 (40%)	176
Other Ranks	314 (61%)	197 (39%)	511
Total	**421 (61%)**	**266 (39%)**	**687**

6.3 Mental Health Difficulties

The following section presents participants reported mental health difficulties, as measured by validated survey instruments covering anxiety, depression, post-traumatic stress, alcohol use, suicidal ideation and attempts, and self-harm. These measures were complemented by scales assessing perceived stigma, social support and emotional intelligence. For the purposes of inferential analyses, gender was coded as a binary variable (male, female), since the "other" category yielded only two responses and was therefore too small to support meaningful statistical comparison.

6.3.1 Anxiety

Anxiety was measured using the 7 item, General Anxiety Disorder (GAD) scale. The GAD-7 measures a broad range of anxiety symptoms (e.g., nervousness, fear, worry). The instrument is a brief self-report scale to identify probable cases of GAD. Each of the 7 items is scored from 0 to 3 with scale scores ranging from 0-21. Scores between 0-4 represent minimal anxiety, 5-9 represents mild anxiety, 10-14 represents moderate anxiety and scores above 14 represent severe anxiety (Spitzer, et al., 2006).

Table 14 represents the categorisation of anxiety for the sample. The scale returned a Cronbach's Alpha score of .875 demonstrating good internal consistency**.** The Summary Item Statistics, or the Inter-Item Correlations was .39 to .6.5. This suggests quite a strong relationship among the items. The results set out in Table 14 indicate that 32% of participants are experiencing anxiety at a severe level, however, the largest scores are in the moderate level at 41%. These findings are significant as they are quite high. The mean for the total was 13 (SD 4.1). This places the average participant in the 'moderate anxiety' category.

Table 14 GAD SCORES

Minimal Anxiety	**Score 0-4**	2%
Mild Anxiety	**Score 5-9**	25%
Moderate Anxiety	**Score 10-14**	41%
Severe Anxiety	**>15**	32%

Table 15 below reports that female participants appeared to experience lower levels of anxiety than males except for moderate levels at (47%). Officers experienced anxiety at a higher level than other ranks except for 'severe anxiety'

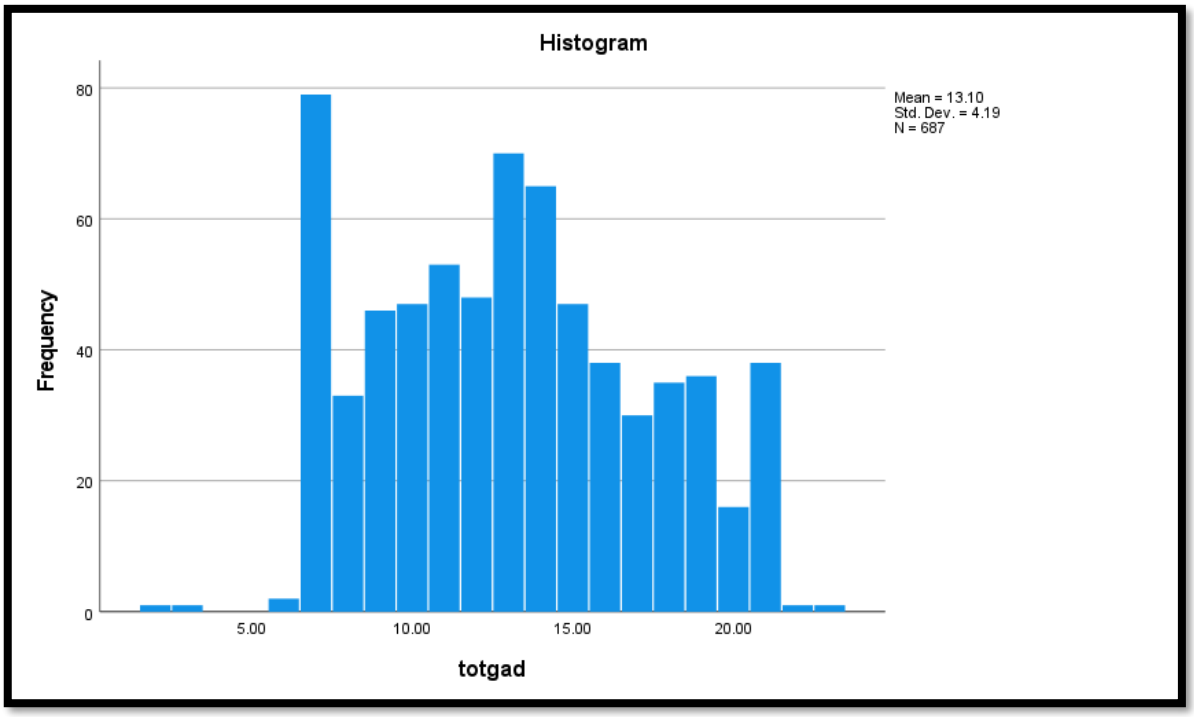
where Other ranks (38%) had a 10% higher level. The Air Corps reported the highest levels of sever anxiety among the 3 branches at (40%). No statistical differences were observed.

Table 15 GAD Scores Gender, RANK & Branch

	Minimal	Mild	Moderate	Severe	Total (100%)	Mean
Gender						
Male	2 (1%)	145 (23%)	245 (40%)	217 (36%)	606	13.1 (SD 4.21)
Female	0	18 (23%)	37 (47%)	24 (30%)	79	12.8 (SD 4.05)
Rank						
Officer	0	47 (27%)	80 (45%)	49 (28%)	176	12.6 (SD 4.06)
Other Ranks	2 (1%)	113 (21%)	203 (40%)	193 (38%)	511	13.2 (SD 4.22)
Branch						
Army	2 (1%)	106 (26%)	163 (40%)	138 (33%)	409	12.8 (SD 4.3)
Navy	0	16 (17%)	47 (50%)	31 (33%)	94	13.3 (SD 3.8)
Air Corps	0	38 (20%)	73 (40%)	73 (40%)	184	13.4 (SD 4.0)

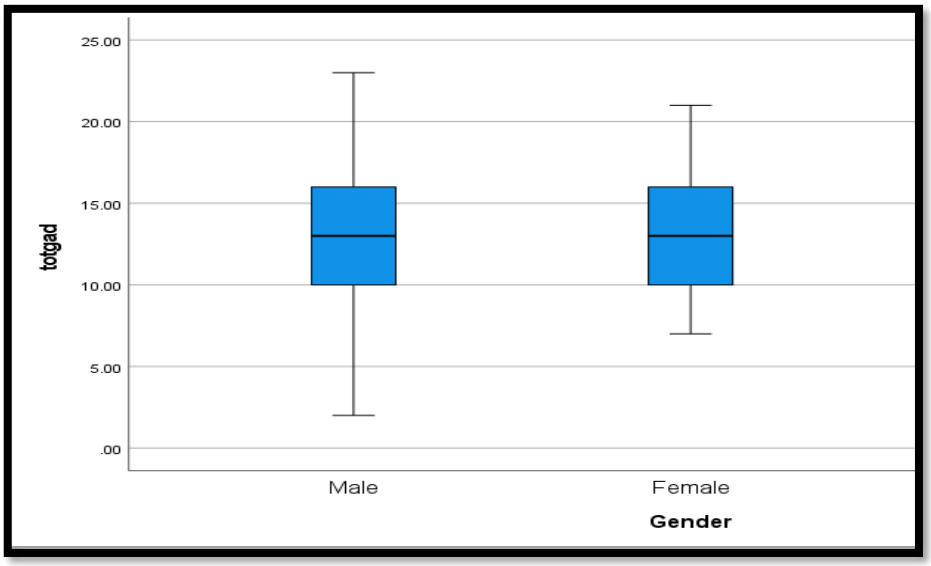
Responses to the scale were assessed for normality distribution using a histogram which can be seen in figure 6.1 The histogram indicated abnormal distribution. Subsequently, the Kolmogorov-Smirnov test was run to further assess the normality of the distribution of scores D (687) = .074, p<.001. The KS test suggests that the distribution was non-normal.

Figure 5 Normality distribution GAD scale



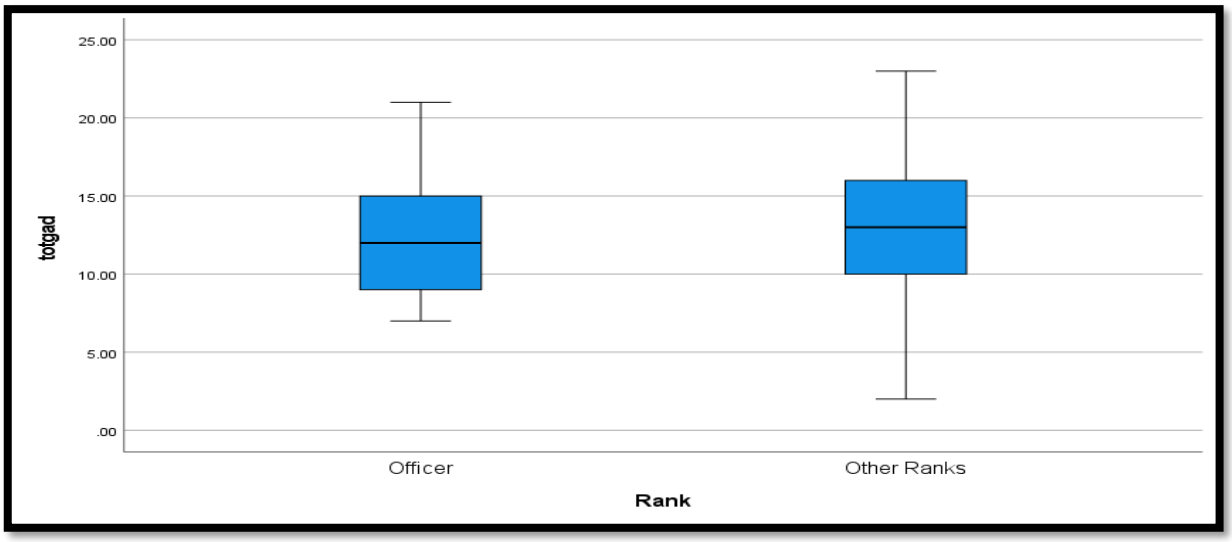
A Mann-Whitney U test was used to examine the difference in scores between males and females, rank, and branch. Figures below report the count and percentages across gender, rank, and branch.

Figure 6 GAD scores for Gender



Results of the Mann-Whitney U test revealed that males (n=606) scored similarly to females (n=79), with no statistical significance found U = 23068, z= .527, p=.598. Males had a mean of 13.1 (SD 4.21) and Females had a mean score of 12.8 (SD 4.05).

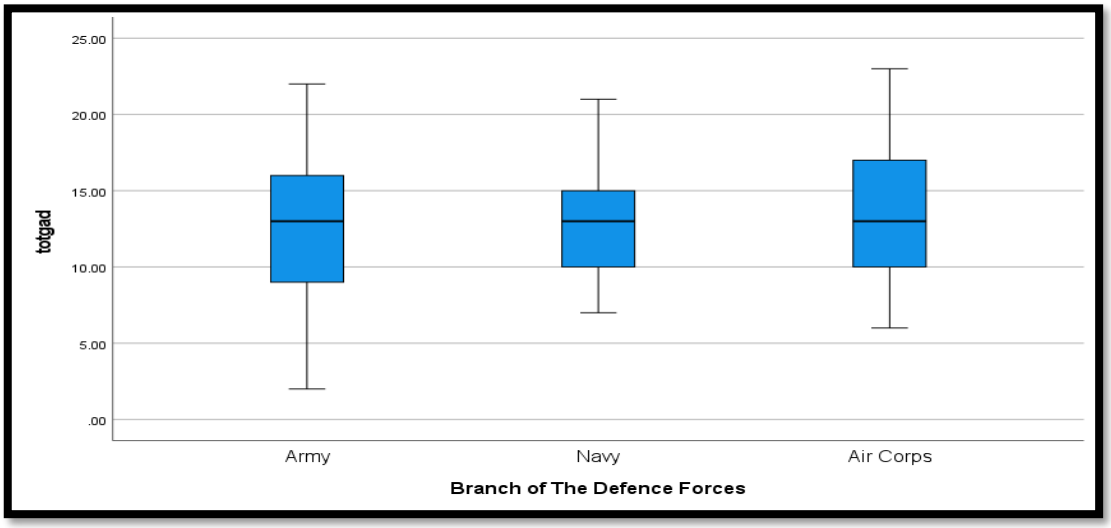
Figure 7 GAD scores for Rank



Results for rank reported that other ranks (n=511) had higher levels of anxiety than officers (n=176) U = 40722, z=1.875, p = 0.61 but no significant statistical difference was noted. Officers had a mean score of 12.6 (SD 4.06) while other ranks had a mean score of 13.2 (SD 4.22). Most participants across the 3 branches scored between 10 -14, reporting that the average experience of Moderate levels of Anxiety for each branch been the most common. A one-way analysis of variance (ANOVA) was conducted to examine potential differences in anxiety scores across

the three service branches. The results indicated that mean anxiety scores were broadly similar, with the Army reporting a mean of 12.8 (SD = 4.3, n = 409), the Navy a mean of 13.3 (SD = 3.8, n = 94), and the Air Corps a mean of 13.4 (SD = 4.0, n = 184). The ANOVA revealed no statistically significant difference in anxiety scores between the branches, $F(2, 684) = 0.52$, $p = .59$, with a negligible effect size ($\eta^2 = .005$). These findings suggest that levels of anxiety did not vary meaningfully according to branch affiliation, with participants across all groups most commonly reporting moderate levels of anxiety.

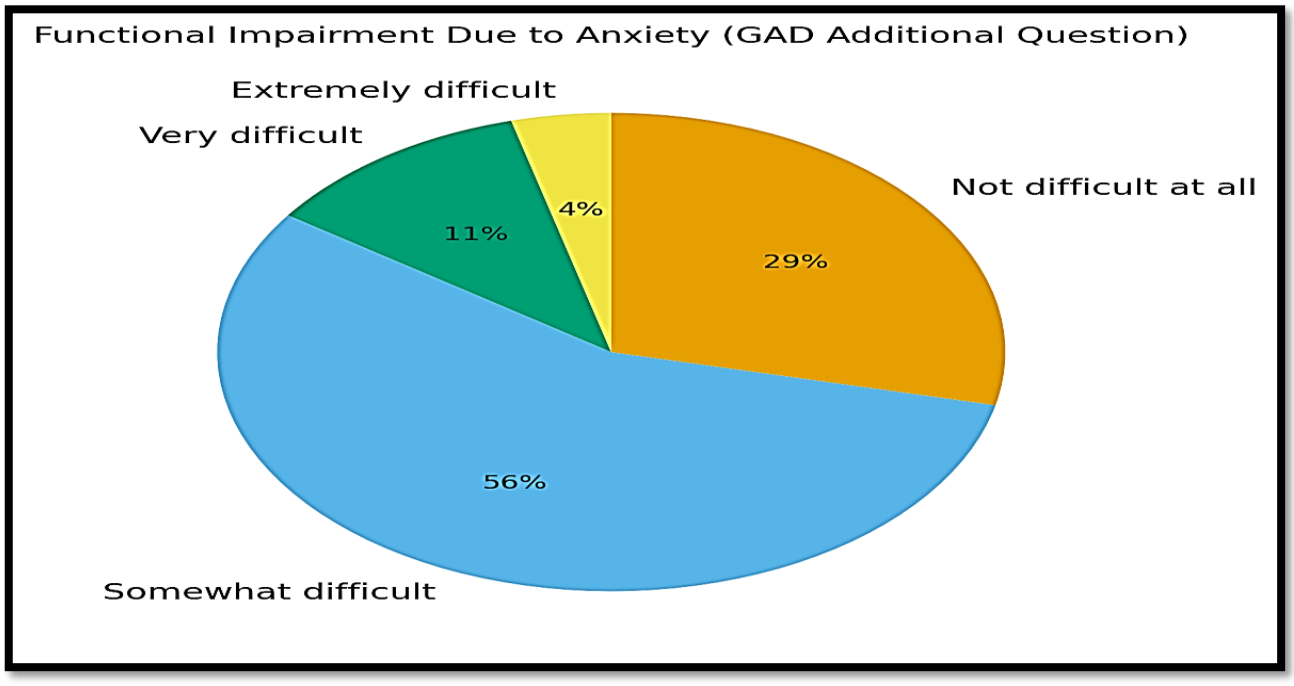
Figure 8 GAD scores for Branch



There was an extra question added to the original 7 items on the scale which was analysed separately. The extra question was: How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? The analysis of the additional GAD question, which assessed functional impairment caused by anxiety, revealed that the majority of participants (55%) reported their difficulties as “somewhat difficult,” while 28% indicated “not difficult at all,” 11% reported “very difficult,” and 4% reported “extremely difficult.”

This means that 15% of the sample experienced a high level of functional impairment in work, home life, or social relationships.

Figure 9 Function impairment due to Anxiety results



Chi-square tests showed no statistically significant differences in functional impairment across gender ($X^2 = 6.699$, $p = .350$), rank ($X^2 = 2.765$, $p = .429$), or

branch of service (X^2 = 12.489, p = .052). Although not significant, a higher proportion of females (19% vs. 11% of males) and officers (15% vs. 10% of other ranks) reported "very difficult" impairment. Similarly, while there were small variations between branches, these differences were not statistically meaningful. Overall, these results suggest that functional impairment due to anxiety is present across the Defence Forces but is not significantly associated with demographic or occupational factors.

A regression analysis was conducted to examine predictors of generalised anxiety disorder (GAD) scores (GAD TOTAL) using demographic variables, service-related characteristics, and history of suicidal thoughts or self-harm. The model was statistically significant (F(10, 674) = 10.317, p < .001) and explained 13.3% of the variance in GAD scores (R^2 = .133, adj. R^2 = .120). Although the overall explanatory power of the model was modest, several significant predictors emerged. Age was negatively associated with GAD scores (B = –.670, p = .030), indicating that younger personnel reported higher levels of anxiety. Similarly, the number of missions was negatively associated with GAD (B = –.443, p = .023), suggesting that greater operational experience might be linked to lower anxiety levels. Most notably, having seriously thought about taking one's life (B = –2.060, p < .001) and having self-harmed (B = –1.996, p < .001) were strong predictors of higher anxiety levels, demonstrating the close link between GAD and suicidal thoughts and behaviours.

In contrast, gender, rank, branch, Marital status, length of service, and prior suicide attempts were not significant predictors (all p > .08). Correlational analysis supported these findings, with GAD scores showing the strongest negative correlations with suicidal ideation (r = –.297) and self-harm (r = –.232). These results highlight that while demographic and service-related factors explain some variation in anxiety, mental health history, particularly suicidal ideation and self-harm, is far more strongly associated with GAD. This underscores the importance of targeted mental health screening and intervention for personnel with a history of psychological distress rather than relying solely on demographic or service-related characteristics.

Table 16 Linear Regression Predicting Anxiety GAD total scores

Dependent Variable: GAD Total

Model	Unstandardized Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig. (p)	95% CI for B (Lower)	95% CI for B (Upper)

Gender	–0.620	0.482	–0.047	–1.285	.199	–1.566	0.326
Rank	0.328	0.358	0.034	0.917	.359	–0.375	1.030
Age Category	–0.670	0.309	–0.160	–2.170	.030	–1.276	–0.064
Marital Status	0.017	0.234	0.003	0.074	.941	–0.442	0.477
Branch	0.056	0.187	0.012	0.299	.765	–0.311	0.424
Length of Service	0.340	0.194	0.140	1.749	.081	–0.041	0.721
No. of Missions	–0.443	0.195	–0.109	–2.273	.023	–0.826	–0.060
Suicide Attempt	–0.298	0.563	–0.020	–0.530	.596	–1.404	0.809
Suicidal Ideation	–2.060	0.342	–0.233	–6.020	<.001	–2.732	–1.388
Deliberate Self-Harm	–1.996	0.527	–0.146	–3.791	<.001	–3.033	–0.959

6.3.2 Depression

The PHQ-9 scores each of the 9 DSM-IV criteria for depression as 0 (not at all), 1. (More than half the day), 2. (several days), 3. (nearly every day). The scale was preceded by a stem question which asked, “Over the past month, how often have you been bothered by any of the following problems? Responses included “Little interest or pleasure in doing things,” and “Trouble falling or staying asleep, or sleeping too often” (Spitzer, et al., 1999).

The scale returned a Cronbach’s Alpha Score of .869 demonstrating good internal consistency. The Summary Item Statistics, or the Inter-Item Correlations was .20 to .55. This suggests quite a strong relationship among the items. The scale had 9 items with a Variance of 58.1 and a standard Deviation of 7.6.

Table 17 PHQ-9 scores for total sample

Depression Severity Scores	Percentage of sample	n

None-Minimal Depression (0-4)	21%	144
Mild Depression (5-9)	21%	144
Moderate Depression (10-14)	20%	137
Moderately Severe Depression (15-19)	17%	117
Severe Depression (20-27)	21%	144
Total	100%	687

Table 17 indicates that 79 % of participants scored at or above the mild depression threshold on the PHQ-9, with both the mild and severe categories each accounting for 21 % of the sample. Across all 687 respondents, the mean PHQ-9 score was 11.57 (SD = 7.4), corresponding to a moderate level of depression . A visual inspection of the score distribution via histogram (Figure 10) suggested significant deviation from normality. This was confirmed by the Kolmogorov–Smirnov test, which demonstrated a non-normal distribution of scores, $D(687) = .078$, $p < .001$.

Figure 10 Normality distribution histogram PHQ-9

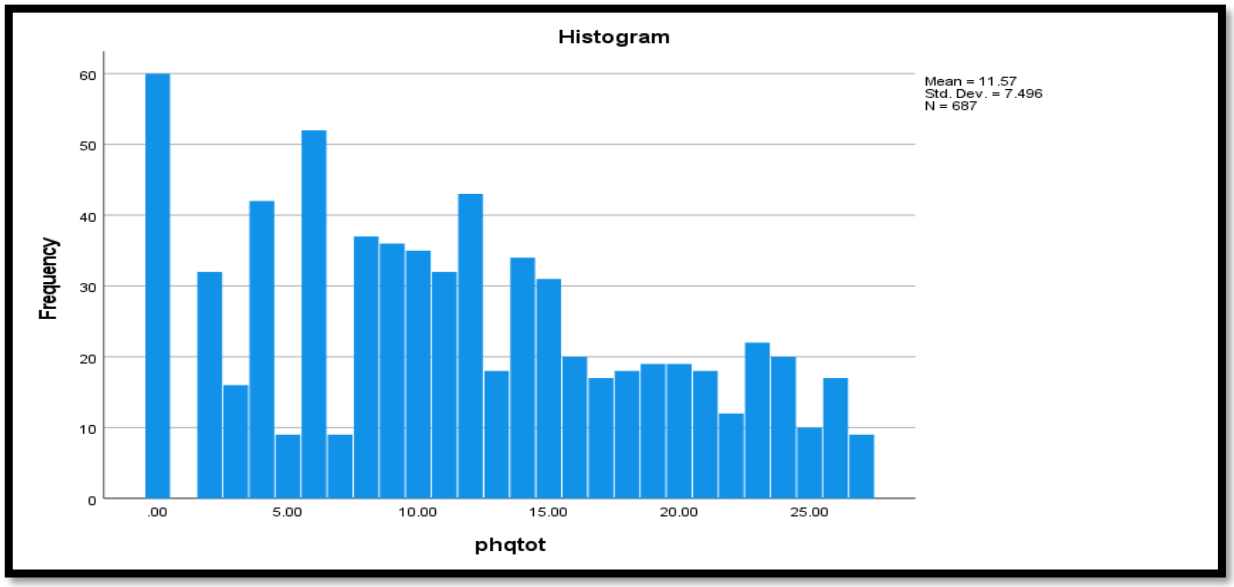


Table 18 PHQ-9 scores Gender & Rank

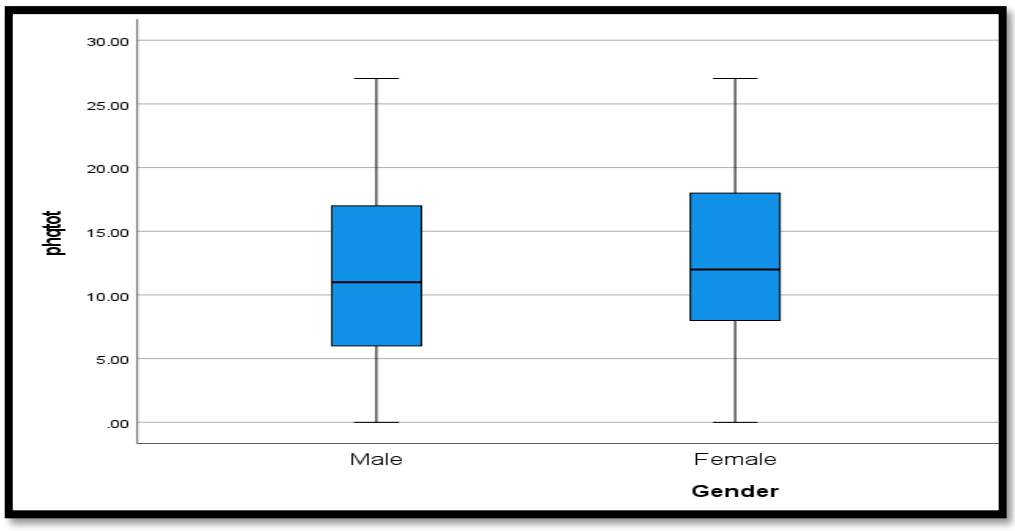
The Patient Health Questionnaire results by Gender & Rank						
	Non-Minimal	**Mild**	**Moderate**	**Moderately Severe**	**Severe Depression**	**Total**

Gender						
Female	12 (16%)	14 (18%)	21 (26%)	16 (20%)	16 (20%)	79 (100%
Male	138 (23%)	129 (21%)	140 (23%)	89 (14%)	110 (19%)	606 (100%
Rank						
Officer	45 (25%)	33 (19%)	49 (28%)	22 (13%)	27 (15%)	176 (100%
Other Ranks	105 (20%)	110 (21%)	113 (22%)	83 (16%)	100 (21%)	511 (100%

Table 18 reports that females score higher in the categories from moderate to severe compared to males.

A Mann-Whitney U test was used to examine the difference in scores between males and females, while female participants scored lower percentages in minimal and mild depression they start to elevate in score from moderate to severe however, statistically, there was no difference between genders. Gender male (n=606) and females (n=79), U=21320, z= -1.58, p = .113

Figure 11 PHQ-9 scores (Gender)



According to Figure 11, males had a mean score of 11.9 (SD 7.5), and the female mean was 12.7 (SD 7.2).

Analysis by rank revealed that enlisted personnel exhibited a greater burden of more severe depressive symptoms than their commissioned counterparts. Specifically, those in other ranks recorded higher proportions of scores in the

"moderately severe" and "severe" categories. This pattern is reflected in Figure 12, where officers averaged a PHQ-9 score of 10.8 (SD = 7.0) compared with a mean of 11.8 (SD = 7.6) among other ranks. In relation to rank, officers reported higher scores in moderate depression, but other ranks reported higher scores in severe depression. The Mann-Whitney U test was used and found no statistical differences between these groups. Rank Officer (n=176) and Other Ranks (n=511), U=41732, z=-1.42, p =.154

Figure 12 PHQ-9 scores (Rank)

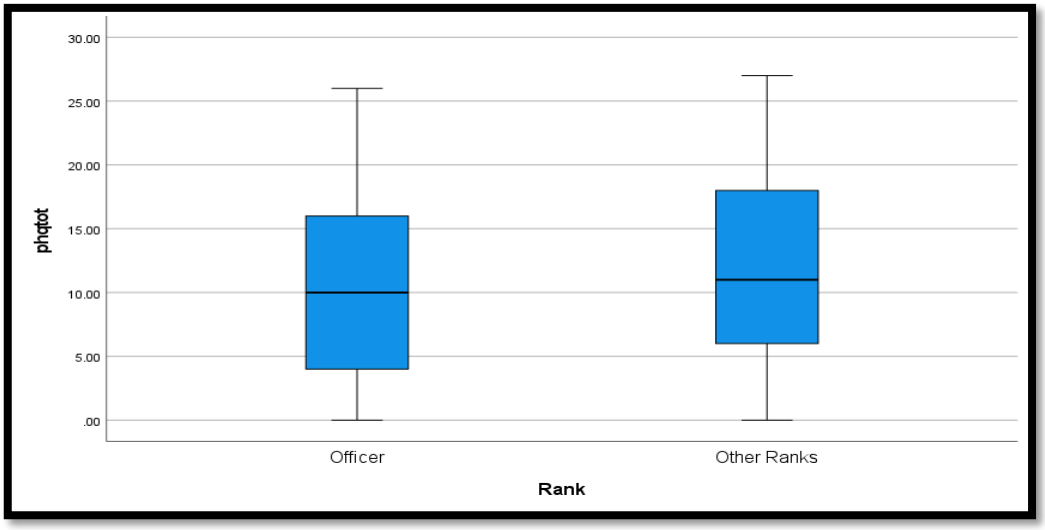


Table 19 reports the Army (19%) has a slightly higher score than the Air Corps (18%) in severe depression with the Navy (16%) slightly behind the other two.

Table 19 PHQ-9 scores for Branch

	Non-Minimal	Mild	Moderate	Moderately Severe	Severe Depression	Total (100%)
Army	93 (23%)	82 (20%)	104 (25%)	52 (13%)	78 (19%)	409
Navy	14 (15%)	22 (23%)	25 (27%)	18 (19%)	15 (16%)	94
Air Corps	43 (23%)	39 (21%)	33 (18%)	35 (20%)	34 (18%)	184

Figure 13 PHQ-9 scores (Branch)

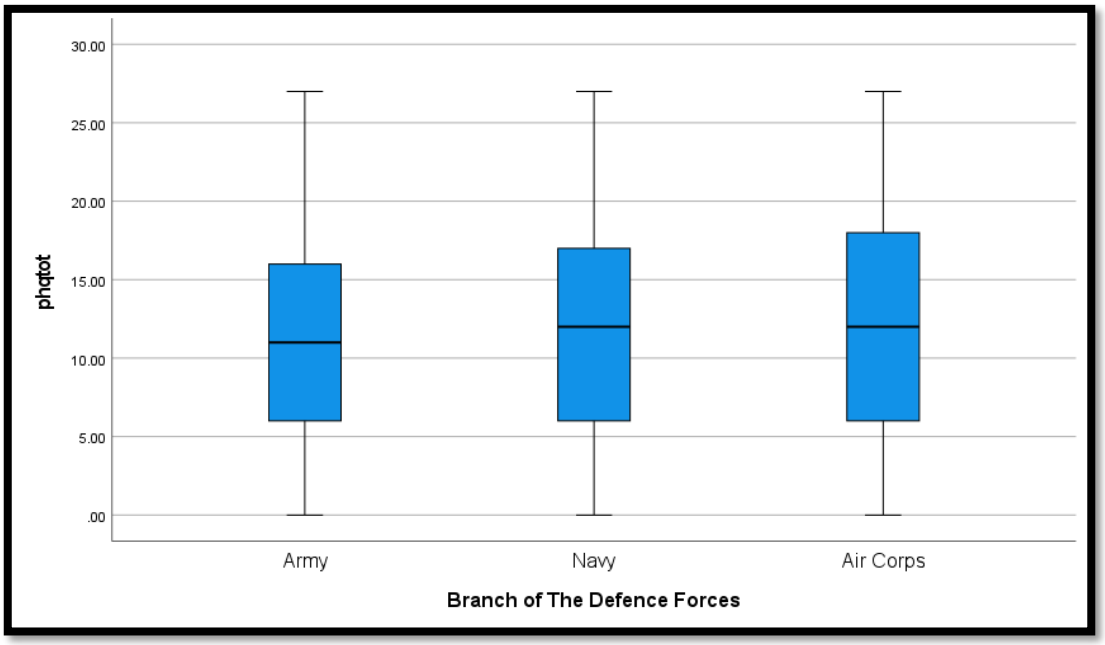


Figure 13 illustrates that levels of depressive symptoms, as measured by the PHQ-9, were virtually identical across all three branches. A one-way analysis of variance (ANOVA) was conducted to assess differences in depressive symptoms, as measured by the PHQ-9, across the three service branches. The Army recorded a mean score of 11.4 (SD = 7.6, n = 409), the Navy 11.8 (SD = 7.0, n = 94), and the Air Corps 11.6 (SD = 7.4, n = 184). These values fall within the moderate symptom range of the PHQ-9. The ANOVA indicated no statistically significant difference in depressive symptoms between branches, $F(2, 684) = 0.25$, $p = .78$, with an almost negligible effect size ($\eta^2 = .001$). These results suggest that branch affiliation had no meaningful influence on levels of depressive symptomatology, with comparable experiences reported across all three groups.

The regression analysis explored the relationship between demographic, occupational, and psychological factors and depression scores, as measured by the PHQ-9 (PHQ-9TOTAL). The overall model was statistically significant ($F(10, 674) = 13.576$, $p < .001$) and accounted for 16.8% of the variance in depression scores ($R^2 = .168$, adjusted $R^2 = .155$), which suggests a moderate explanatory power.

Among the predictors, the most influential factors were the presence of suicidal ideation ($\beta = –.266$, $p < .001$), a history of deliberate self-harm ($\beta = –.132$, $p < .001$), and previous suicide attempts ($\beta = –.077$, $p = .040$), all of which showed significant negative associations with depression scores. These findings indicate that individuals who reported suicidal thoughts, self-harm, or previous attempts had substantially higher depression levels. Additionally, the number of missions was a small but significant negative predictor ($\beta = –.097$, $p = .039$), suggesting that

increased operational experience may be linked to reduced depression scores, although this effect was weaker compared to psychological risk factors.

Demographic and occupational variables, such as gender, rank, age, marital status, branch, and length of time in service, were not significant predictors (all p > .216). This implies that psychological distress and self-harm-related variables are far stronger predictors of depression than structural or demographic characteristics. Overall, these findings highlight the critical importance of addressing self-harm and suicidal ideation in military mental health interventions, as they represent the strongest contributors to elevated depression scores in this cohort.

Table 20 Linear Regression Predicting Depression

Dependent Variable: PHQ-9 Total

Model Variable	Unstandardised Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig.	95% CI for B (Lower Bound)	95% CI for B (Upper Bound)
Gender	0.427	0.845	0.018	0.505	.614	-1.232	2.086
Rank	0.776	0.626	0.045	1.239	.216	-0.453	2.005
Age	-0.622	0.540	-0.083	-1.151	.250	-1.682	0.438
Marital Status	-0.121	0.411	-0.012	-0.295	.768	-0.928	0.686
Branch of Service	-0.193	0.327	-0.022	-0.591	.555	-0.837	0.451
Length of Time in Service	0.108	0.341	0.025	0.316	.752	-0.561	0.777
Number of	-0.706	0.342	-0.097	-2.068	.039	-1.378	-0.034

Missions							
Suicide Attempt (CIS-R)	-2.034	0.986	-0.077	-2.063	.040	-3.972	-0.096
Suicidal Ideation (CIS-R)	-4.195	0.599	-0.266	-7.002	<.001	-5.372	-3.018
Self-Harm without Intent to Die (CIS-R)	-3.214	0.922	-0.132	-3.485	<.001	-5.024	-1.404

6.3.3 Post Traumatic Stress Disorder

The PTSD checklist or PLC-M(military) has 17 items, each scored from 1. Not at all, 2. A little bit, 3. Moderately, 4. Quite a bit and 5. Extremely. The PLC -M is scored from a total range of 17 to 85 summing the score from each response. The Cronbach's Alpha score for this scale was .94 demonstrating very good internal consistency. The Summary Item Statistics, or the Inter-Item Correlations was .31 to .72. This suggests quite a strong relationship among the items. The Mean was 30.2 and the SD was 12.9.

Table 21 PLC - M PTSD Results

Score of less than < 35	75%
Score over > 35	25%

According to the PLC-M, to have a positive score, the participant would need to score more than 35 out of 80. A score above this cut-off indicates the presence of clinically significant PTSD symptoms consistent with a probable diagnosis. It does not represent a formal diagnostic determination, which requires structured clinical assessment, but rather reflects an individual who is likely to meet diagnostic criteria and who may be experiencing functional impairment in occupational, social, or personal domains (Forbes et al., 2001; Weathers et al., 2013). Lower thresholds, such as the >35 cut-off applied here, are commonly recommended in screening contexts where the goal is to maximise sensitivity and ensure that potential cases are not overlooked (Hoge et al., 2004). By contrast,

higher thresholds (e.g., ≥45–50) are sometimes used in clinical settings to maximise specificity. Thus, within the present research, a positive score on the PCL-M is taken as indicative of probable PTSD and as a marker of meaningful symptom burden requiring further professional evaluation. Accordingly, Table 21 reports that 25% of all participants are positive for probable diagnosis and have should have a structured clinical assessment to determine whether the individuals meet the DSM-5 symptom for PTSD criteria.

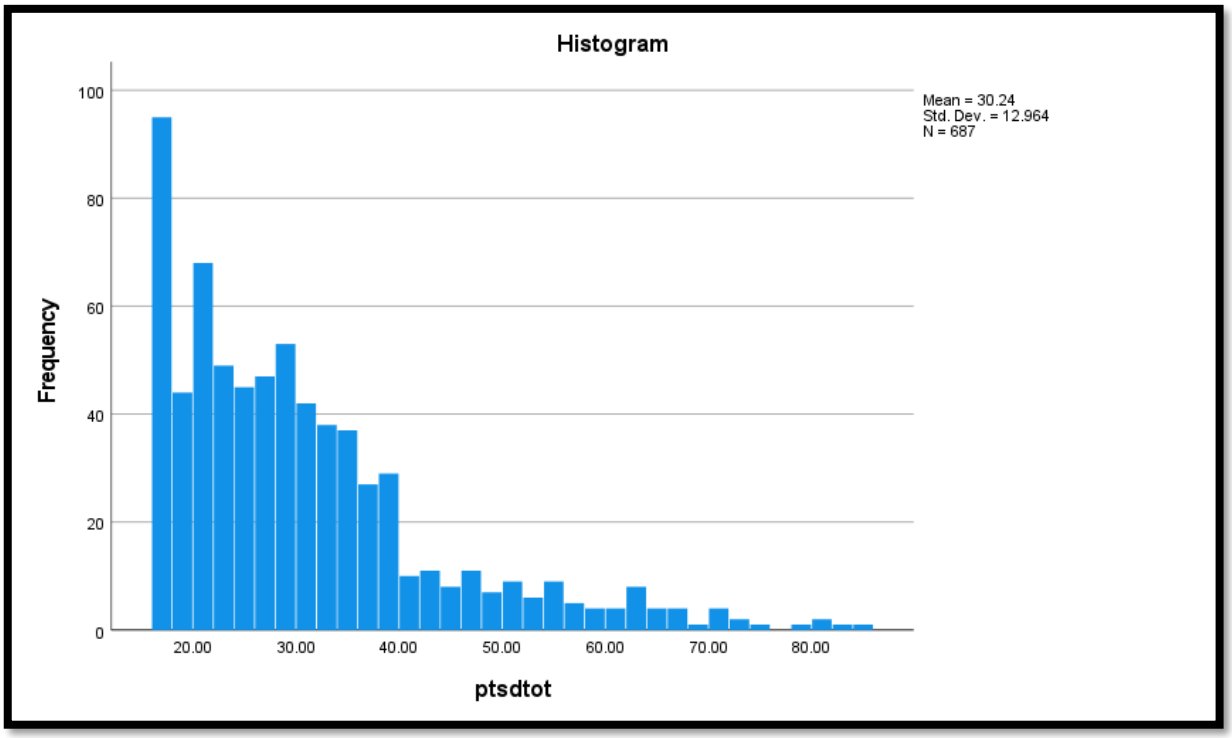
A table displaying the results of the PTSD checklist was developed to illustrate how the positive indication for PTSD was distributed. The difference in scores suggest that females 27% (27) n= 79, had a higher positive score over males 24% (146) n=606, and other ranks 133 (26%) n= 511, scored higher than officers 36 (20%) n=176, while the Air Corps 41 (22%) n=184, had the lowest positive count. After the data was confirmed as non-parametric, a Mann-Whitney U test was conducted for rank and gender to assess if significant statistical differences emerged, the results are below.

Table 22 PTSD Results Gender, Rank & Branch

	< 35	>35 and above	Total (100%)
Gender			
Male	460 (76%)	146 (24%)	606
Female	58 (73%)	21 (27%)	79
Rank			
Officer	140 (80%)	36 (20%)	176
Other Ranks	378 (74%)	133 (26%)	511
Branch			
Army	306 (75%)	103 (25%)	409
Navy	69 (73%)	25 (27%)	94
Air Corps	143 (78%)	41 (22%)	184

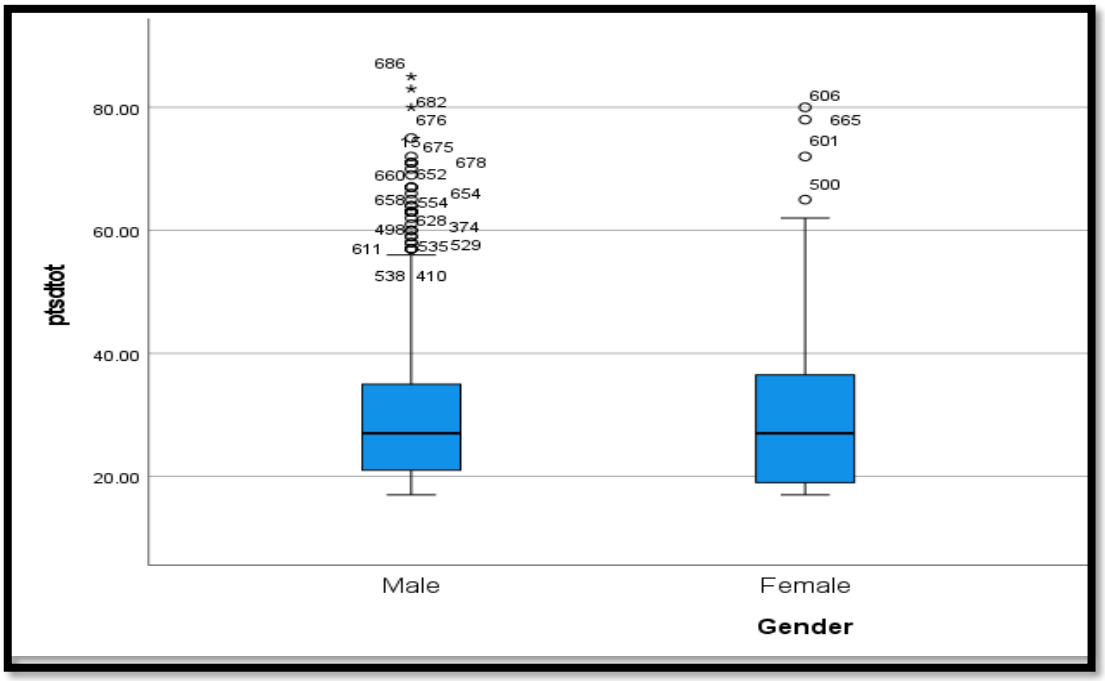
A frequency histogram of total PCL-M scores was generated to assess the assumption of normality. Visual inspection of the distribution revealed a marked departure from the bell-shaped curve expected under normality. This non-normal pattern indicates that parametric analyses relying on normally distributed residuals may not be appropriate for these data.

Figure 14 Normality distribution histogram PCL-17



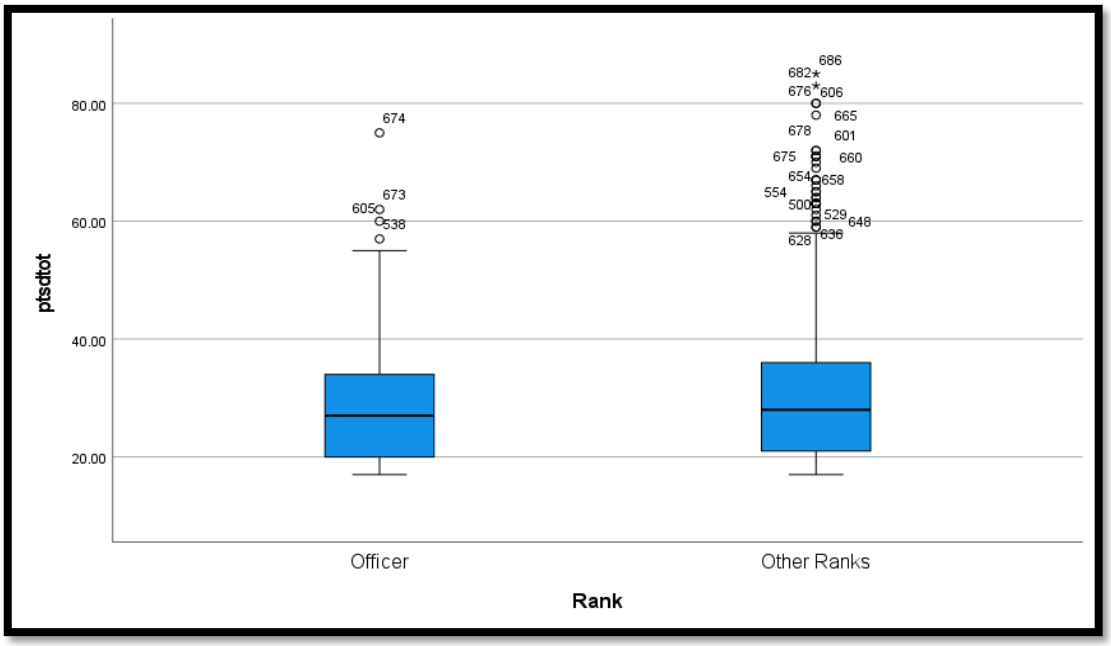
The Kolmogorov–Smirnov test was conducted to formally evaluate the normality of the PCL-M score distribution. The test yielded $D(687) = .154$, $p < .001$, confirming a statistically significant departure from normality. This non-normal distribution further supports the need for non-parametric analytical approaches when examining PTSD symptom scores.

Figure 15 PTSD scores (Gender)



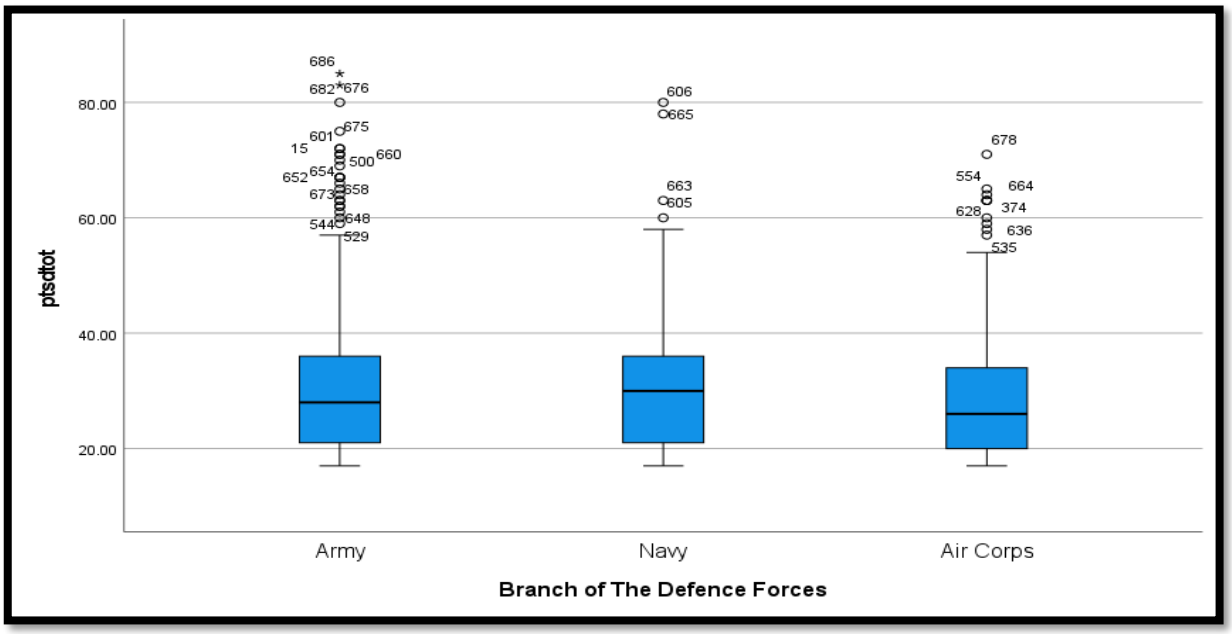
A Mann-Whitney U test was used to examine the difference in scores between males and females, and rank. Males (n=606) scored slightly lower than females when breaching the threshold of > 35, however, no statistical difference was noted (n=79) U=23465, z= -286, p <.775). The mean score for males was 30.1 (SD 12.7) while the female mean was 30.6 (SD 14.6)

Figure 16 PTSD scores (Rank)



Other ranks had a higher number of participants scoring over 35 compared to Officers. Other ranks (n=511) and officers (n=176), U= 41663, z= -1.45, p= .145 this small difference in percentages had no statistical variance according to the Mann-Whitney U test. The mean score for officers was 28.5 (SD 10.9) while other ranks had a mean score of 30.8 (SD13.5).

Figure 17 PTSD scores (Branch)



According to branch, the Air Corps had a mean of 29 (SD 11), while the Army had a mean score of 30.5 (SD 13.4), and the Navy had a slightly higher mean score of 31.2 (SD 12.8) . A one-way analysis of variance (ANOVA) was conducted to assess differences in mean PTSD scores across branches of the Defence Forces. The Air Corps (M = 29.0, SD = 11.0, n = 184), Army (M = 30.5, SD = 13.4, n = 409), and Navy (M = 31.2, SD = 12.8, n = 94) all reported average scores below the clinical threshold of 35, indicating that on average, participants did not meet criteria for a positive PTSD screen. The ANOVA results showed no statistically significant difference between branches, $F(2, 684) = 1.65$, $p = .193$. This suggests that PTSD symptom levels were broadly similar across service branches, with no single branch showing disproportionate risk relative to others.
The regression analysis examined the predictors of PTSD scores (PTSD TOTAL) among military personnel. The overall model was statistically significant ($F(10, 674) = 11.536$, $p < .001$) and explained 14.6% of the variance in PTSD scores ($R^2 = .146$, adjusted $R^2 = .133$). This indicates a modest level of explanatory power, suggesting that while the included predictors contribute meaningfully, other unmeasured factors are also likely to influence PTSD outcomes.

The strongest predictors of PTSD scores were psychological risk factors. Suicidal ideation ($\beta = –.247$, $p < .001$), a history of deliberate self-harm ($\beta = –.161$, $p < .001$), and previous suicide attempts ($\beta = –.095$, $p = .012$) were significantly associated with higher PTSD scores. These findings indicate that individuals with a history of suicidal thoughts, self-harm, or suicide attempts reported considerably more severe PTSD symptoms. In contrast, demographic and service-related variables such as gender, rank, age, marital status, branch, length of time in service, and the number of missions did not significantly predict PTSD scores (all $p > .114$).

Table 23 Regression Table Predictors of Total PTSD Scores

Model	Unstandardized Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig. (p)	95% CI for B (Lower)	95% CI for B (Upper)
Gender	–0.336	1.478	–0.008	–0.227	.820	–3.242	2.570
Rank	1.113	1.095	0.038	1.016	.310	–1.039	3.264
Age Category	–0.238	0.945	–0.018	–0.252	.801	–2.095	1.620
Marital Status	–0.050	0.718	–0.003	–0.070	.944	–1.462	1.362

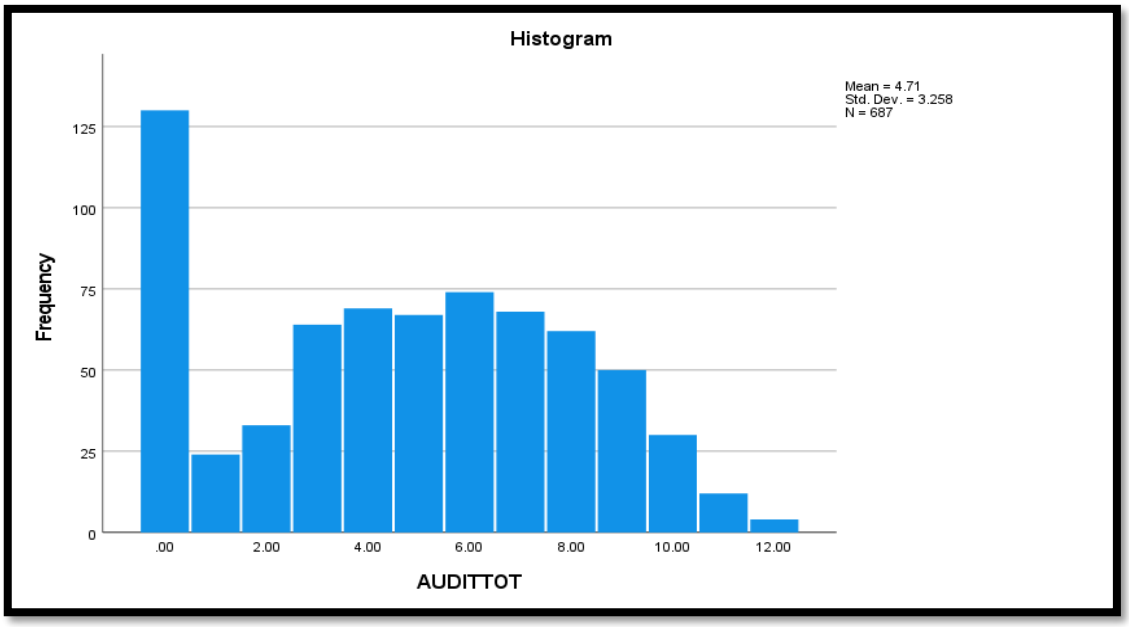
Branch	–0.906	0.573	–0.061	–1.582	.114	–2.030	0.217
Length of Service	0.728	0.596	0.097	1.221	.222	–0.442	1.899
No. of Missions	–0.327	0.598	–0.026	–0.547	.585	–1.502	0.848
Suicide Attempt	–4.337	1.725	–0.095	–2.515	.012	–7.727	–0.948
Suicidal Ideation	–6.743	1.048	–0.247	–6.433	<.001	–8.802	–4.684
Deliberate Self-Harm	–6.773	1.613	–0.161	–4.198	<.001	–9.944	–3.602

Overall, these results highlight that psychological variables are more strongly related to PTSD severity than demographic or occupational factors. This underscores the importance of prioritising mental health screening for suicidal ideation and self-harm history in order to identify those most at risk for heightened PTSD symptoms within military populations.

6.3.4 Alcohol Consumption

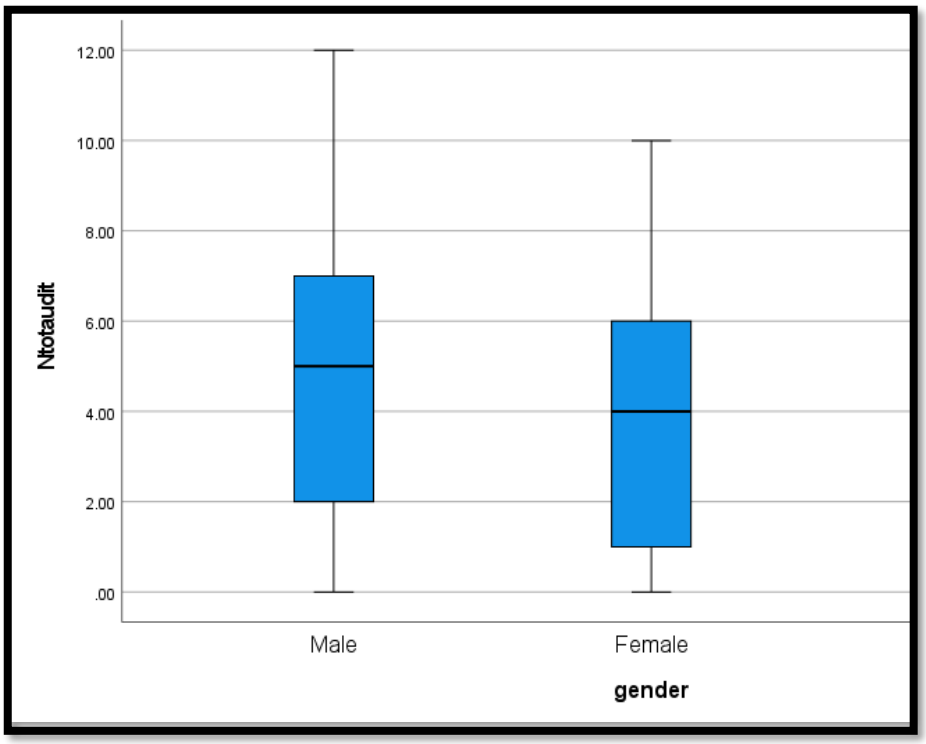
The Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) comprises three items assessing the frequency and quantity of alcohol consumption, with each item scored from 0 to 4 for a total range of 0–12 (where a score of 0 indicates abstinence). To aid accurate reporting, the survey included a graphic illustrating standard “unit” of alcohol across a variety of beverage types. In this study, scores at or above 4 in men and 3 in women were classified as positive for potentially hazardous drinking. Higher AUDIT-C scores correspond to an increased likelihood that alcohol use is adversely affecting health and safety. Examination of the total score distribution via histogram (Figure 18) revealed substantial skewness, indicating a non-normal distribution of drinking behaviours within the sample.

Figure 18 Normality distribution histogram AUDIT-C scores



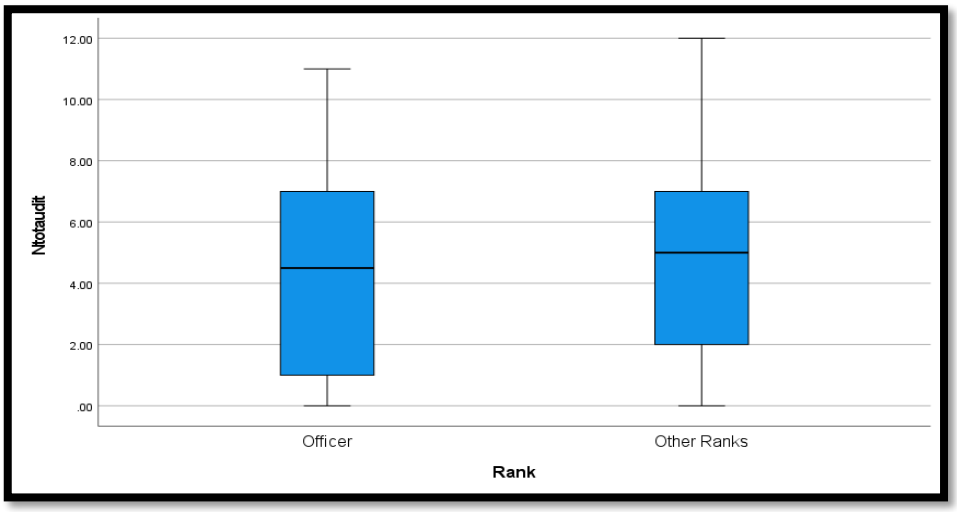
A Kolmogorov-Smirnov test was run to further assess the normality of the distribution of the scales. The scores for the AUDIT-C scale D (687) = .115, p<.001, indicated non-normal distribution. The AUDIT-C scale had an N= 687, with a mean of 4.71 (SD 3.25).

Figure 19 AUDIT-C scores (Gender)



A Mann–Whitney U test was conducted to compare AUDIT-C scores between male and female participants, as the distribution of scores deviated significantly from normality. Male respondents (n = 606) reported a higher average score (M = 5.8, SD = 2.0) than female respondents (n = 79; M = 4.7, SD = 1.7). This difference was statistically significant, U = 18 787, Z = –3.13, p = .002, indicating that, on average, male service members consumed more alcohol over the past year than their female counterparts.

Figure 20 AUDIT-C scores (Rank)



AUDIT-C scores did not differ significantly by rank. Commissioned officers (n = 174) averaged 5.4 (SD = 2.0), while other ranks (n = 511) averaged 5.7 (SD = 2.0). A Mann–Whitney U test confirmed that this small difference was not statistically significant (U = 42 584, Z = –1.05, p = .291), indicating comparable levels of alcohol consumption across hierarchical status.

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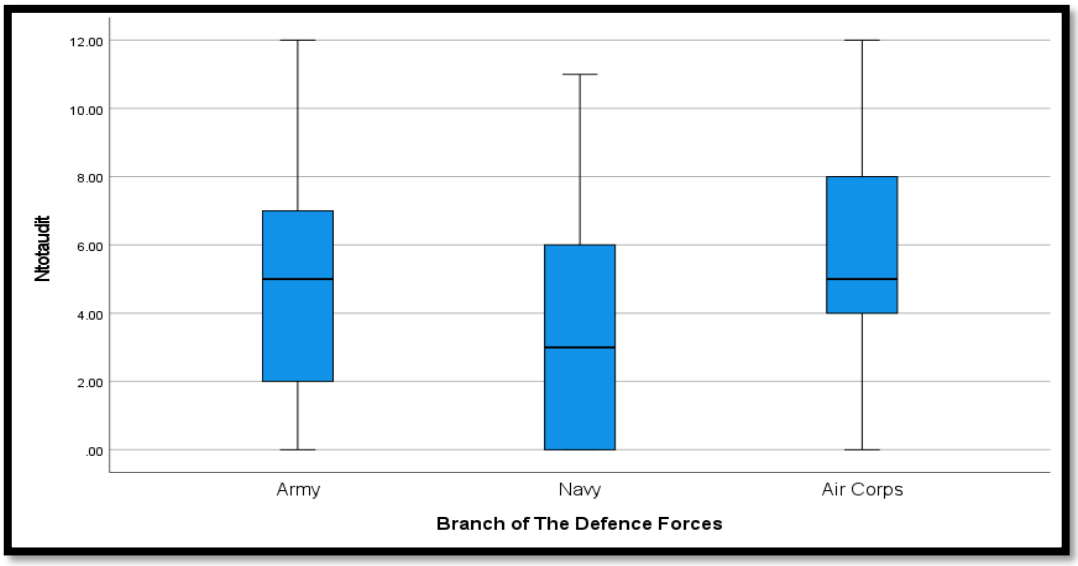
Figure 21 AUDIT-C scores (Branch)



Mean AUDIT-C scores differed modestly by service branch, with Air Corps personnel reporting the highest average consumption (M = 5.9, SD = 1.9), followed by Army members (M = 5.65, SD = 2.0) and Naval personnel (M = 3.6, SD = 1.8). A one-way analysis of variance (ANOVA) was conducted to examine differences in alcohol consumption, as measured by AUDIT-C scores, across the three service branches. The results indicated a statistically significant effect of service branch, $F(2, 684) = 48.40$, $p < .001$. Air Corps personnel reported the highest levels of alcohol consumption ($M = 5.9$, $SD = 1.9$), followed closely by Army personnel ($M = 5.65$, $SD = 2.0$), while Naval personnel reported substantially lower scores ($M = 3.6$, $SD = 1.8$). These findings suggest that alcohol consumption patterns vary meaningfully between branches, with members of the Air Corps and Army displaying greater consumption compared to their Naval counterparts. Post-hoc comparisons using Tukey's HSD test revealed that both Air Corps ($M = 5.9$, $SD = 1.9$) and Army personnel ($M = 5.65$, $SD = 2.0$) reported significantly higher alcohol consumption than their Naval counterparts ($M = 3.6$, $SD = 1.8$), $p < .001$ for both comparisons. However, there was no statistically significant difference between the Air Corps and Army ($p = .423$).

The regression analysis explored the predictors of alcohol-related difficulties (AUDIT-C total scores) among military personnel. The model was statistically significant ($F(10, 540) = 3.104$, $p < .001$) but explained only 5.4% of the variance in alcohol use ($R^2 = .054$, adjusted $R^2 = .037$), indicating a relatively small overall effect. This suggests that while certain factors contribute to alcohol-related difficulties, most of the variance remains unexplained and may be linked to other unmeasured individual or contextual variables.

Among the predictors, gender emerged as the strongest factor, with males reporting significantly higher alcohol use scores ($\beta = -.184$, $p < .001$). Suicidal

ideation was also a significant predictor, with individuals who had seriously considered taking their own lives showing slightly higher alcohol use scores (β = –.110, p = .017). Other demographic and service-related variables, such as rank, age, branch of service, time in service, number of missions, marital status, and self-harm, were not significant predictors. These findings indicate that alcohol-related difficulties within this military sample are influenced by gender differences and psychological factors.

Table 24 Regression Table Predictors of Total AUDIT-C Scores

Model	Unstandardised Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig. (p)	95% CI for B (Lower)	95% CI for B (Upper)
Gender	–1.197	0.280	–0.184	–4.267	<.001	–1.746	–0.648
Rank	0.229	0.205	0.048	1.117	.264	–0.174	0.632
Age Category	–0.182	0.177	–0.090	–1.031	.303	–0.530	0.166
Marital Status	–0.105	0.136	–0.038	–0.768	.443	–0.372	0.162
Branch	0.000	0.104	0.000	–0.005	.996	–0.204	0.204

Length of Service	0.082	0.110	0.070	0.746	.456	–0.134	0.298
Number of Missions	–0.035	0.112	–0.018	–0.308	.758	–0.256	0.186
Suicide Attempt	0.221	0.330	0.030	0.669	.504	–0.427	0.869
Suicidal Ideation	–0.465	0.195	–0.110	–2.388	.017	–0.848	–0.082
Deliberate Self-Harm	–0.336	0.298	–0.052	–1.129	.260	–0.922	0.250

6.3.5 Suicide attempts, Suicidal thoughts, and Self-Harm

This section of the survey used an instrument called the CIS-R. the CIS-R has 3 questions, each one with a reference for the timing of the event. Table 25 reports the findings from question 1. “Have you ever made a serious attempt to take your life, by taking an overdose of tablets or in some other way?” Overall, 9% (60) of total participants n= 687, said yes, they had made a serious attempt to take their own life. Participants were also asked to identify when this occurred Table 25 reports data relating to suicide attempt and timing of that attempt and is broken down into rank, gender, and branch.

Table 25 Suicide attempts Gender, Rank & Branch

Q1. Have you ever made a serious attempt to take your own life?						
	Yes	**No**	**Total 100%**	**In the last week**	**In the last year**	**More than a year ago**
Rank						
Officers	10 (6%)	165 (94%)	176	0	3 (30%)	7 (70%)
Other Ranks	51 (10%)	461 (90%)	511	4 (8%)	14 (28%)	33 (66%)
Total	61(9%)	626 (91%)	687	4 (7%)	17 (27%)	40 (66%)
Gender						
Male	51(8%)	555 (92%)	606	3 (6%)	14 (28%)	33 (66%)
Female	10 (13%)	69 (87%)	79	1 (10%)	2 (20%)	7 (70%)
Total	61 (9%)	624 (91%)	685	4	16	40
Branch						
Army	36 (9%)	373 (91%)	409	3 (8%)	13 (36%)	20 (56%)
Navy	9 (10%)	85 (90%)	94	1 (11%)	1 (11%)	7 (78%)
Air Corps	15 (8%)	169 (92%)	184	0	2 (13%)	13 (87%)
Total	61 (6%)	626 (91%)	687	4 (7%)	16	40 (66%)

Chi-Square tests were used to observe if a statistical difference between each group occurred. According to rank, there was no significant statistical difference

found (X^2 = 2.765 1 df, p = .096). Furthermore, no statistical difference was found between genders, (X^2 = 1.895 2 df, p = .388) or between the 3 branches of the Defence Forces (X^2 = 1.64 2 df, p = .921).

Table 26 displays the results of question 2 which focused on suicide ideation and asked: "have you ever seriously thought of taking your life, even though you would not actually do it? "

Table 26 Suicide Ideation

Suicide Ideation but not actually wanting to die						
Rank						
	Yes	No	Total	**In the last week**	**In the last year**	**More than a year ago**
Officers	45 (26%)	131 (74%)	176	4	15	25
Other Ranks	189 (37%)	322 (63%)	511	13	76	101
Total	234 (34%)	453 (66%)	687	17 (2%)	91 (13%)	126 (18%)
Gender						
Male	204 (33%)	402 (66%)	606	15	80	110
Female	30 (38%)	49 (62%)	79	2	11	17
Total	234(34%)	451(66%)	685	17 (2%)	91 (13%)	127 (18%)
Branch						
Army	137 (33%)	272 (67%)	409	9	54	74
Navy	31 (33%)	63 (67%)	94	3	11	16
Air Corps	66 (36%)	118 (64%)	184	5	26	36
Total	234 (34%)	453 (66%)	687	17 (2%)	91 (13%)	126(18%)

Chi-Square tests were run to identify any statistical difference between gender, rank, and branch. Accordingly, there was no statistical difference between genders (X^2 = 1.615 df 2, p = .466), rank, (X^2 = 7.599 df 1, p = .006), or branch (X^2 = .375 df 2, p = .829).

Table 27 Deliberate Self-Harm

Deliberate self-harm with not intending to die						
Rank						
	Yes	No	Total	In the last week	In the last year	More than a year ago
Officers	16 (9%)	160 (91%)	176	0	4	12

Other Ranks	56 (11%)	455 (89%)	511	3	20	33
Total	72 (10%)	615 (90%)	687	3 (.4%)	24 (3%)	45 (7%)
Gender						
Male	59 (10%)	547 (90%)	606	3	18	38
Female	13 (17%)	66 (83%)	79	0	6	7
Total	71 (10%)	614 (90%)	685	3 (.4%)	24 (3%)	45 (7%)
Branch						
Army	40 (10%	369 (90%)	409	2	14	25
Navy	14 (15%)	80 (85%)	94	0	4	10
Air Corps	18 (10%)	166 (90%)	184	1	6	11
Total	72 (10%)	615 (90%)	687	3 (.4%)	24 (3%)	45 (7%)

A history of self-harm was reported by a total of 10% (72) n=687 participants A Chi-Square test revealed, there was no statistical difference between the ranks (X^2 = .487 1 df, p = .485) or gender (X^2 = 3.599 2 df, p = .165). Finally, while the Navy reported the largest prevalence of self-harm (15%), the Chi-Square test revealed no statistical difference between the branches for self-harm (X^2 = 2.261 2 df, p = .323).

6.3.6 Stigma and Barriers to Care

According to Britt and colleagues (2008), perceptions of stigma can exacerbate both external stressors and the clinical symptoms of mental illness. To assess these perceptions and related barriers to care, participants completed both the Britt and Hoge Stigma Scale and the Hoge Barriers to Care Scale (Britt et al., 2008)

The Stigma and Barriers to Care scales were used to assess attitudes towards seeking psychological help. The scoring works as follows:

- Perceived Stigma: Add (or average) responses to items 1–6. This gives a score between 6 and 30, or a mean score between 1 and 5.
- Barriers to Care: Add (or average) responses to items 7–11. This gives a score between 5 and 25, or a mean score between 1 and 5.

In both cases, higher scores mean stronger perceptions of stigma or more barriers to seeking care. For analysis, average scores were created in SPSS to make interpretation clearer. Across 687 responses, the scale showed strong reliability with a Cronbach's Alpha of .86.

Analysis of the stigma scale revealed that participants scored an average of 1.56 (*SD* = 0.57) on a scale ranging from 1.09 to 3.27, where lower values reflect higher stigma and greater perceived barriers to care. The distribution of scores was skewed towards the lower end, with almost half of respondents (47.2%) recording scores of 1.27 or below, indicative of strong stigma. A further 27.7% fell within the middle range of 1.45 to 1.64, suggesting moderate stigma levels. In contrast, only 12.5% of participants scored 2.00 or above, reflecting relatively low stigma, and just 6.1% achieved the highest observed score of 3.27. These findings indicate that the majority of participants experienced high levels of stigma and barriers to care, with only a small minority reporting lower levels.

Rank and Stigma

A cross-tabulation of rank (Officers vs. Other Ranks) by stigma score category showed a broadly similar distribution: 31.8 % of Officers and 29.7 % of Other Ranks fell into the lowest stigma category (score = 1.09), with gradually fewer in higher categories. The Pearson chi-square test did not reach significance, $\chi^2(12, N = 687) = 18.55$, $p = .100$, indicating no reliable association between rank and stigma levels.

Gender and Stigma

Men and women showed comparable stigma profiles. For example, 30.2 % of male and 31.6 % of female respondents scored in the lowest category (1.09), and proportions in mid and high ranges were similarly aligned. The Pearson chi-square

was non-significant, $\chi^2(12, N = 685) = 10.67$, $p = .557$, indicating no gender differences in stigma scores.

Branch and Stigma

Branch of service was significantly associated with stigma scores, $\chi^2(24, N = 687) = 44.00$, $p = .008$. Army personnel showed the highest concentration in the lowest stigma category (137/409; 33.5 %), whereas Navy personnel were less concentrated there (23/94; 24.5 %) and more represented in the highest category (15/94; 16.0 % scored 3.27). Air Corps participants fell between these extremes (26.1 % at 1.09; 1.6 % at 3.27). This pattern suggests that Navy members report lower perceived stigma and fewer barriers compared to Army and Air Corps colleagues.

Linear Regression Model

The regression analysis examining predictors of stigma related to mental health help-seeking showed that the model explained only 1.5% of the variance in stigma scores ($R^2 = .015$, $p = .317$), indicating that the included variables collectively had limited predictive value. The stigma scale mean was 1.56 (SD = 0.57), suggesting higher stigma and greater perceived barriers to care. Among the predictors, the only statistically significant variable was having made a serious suicide attempt, which had a small positive association with higher stigma scores ($B = 0.198$, $p = .013$). This indicates that participants who reported a past suicide attempt were slightly more likely to endorse stigma-related attitudes.

None of the other factors, including gender, rank, age, service branch, marital status , number of missions, length of service, or having seriously thought about suicide, were significant predictors. Correlation results were consistent with the regression findings, showing very weak relationships between stigma and the other variables. These results suggest that stigma toward mental health help-seeking is not strongly influenced by demographic or occupational characteristics and that suicidal behaviour may be one of the few factors that relate to small variations in stigma scores. This underscores the complexity of stigma in a military context and the need for further research to explore unmeasured psychosocial or cultural factors that may better explain these attitudes.

Table 28 Linear Regression Predicting Stigma

Dependent Variable: Stigma % Barriers to Care Total

Predictor	Unstandardised Coefficients (B)	Std. Error	Standardised Coefficients (β)	t	Sig. (p)	95% CI for B (Lower Bound)	95% CI for B (Upper Bound)
Gender	0.015	0.062	0.010	0.24	.812	–0.106	0.136
Rank	–0.018	0.055	–0.014	–0.33	.739	–0.126	0.089
Age	–0.022	0.038	–0.016	–0.58	.562	–0.096	0.052
Branch	0.019	0.061	0.011	0.31	.754	–0.101	0.139
Marital status	–0.027	0.059	–0.015	–0.46	.645	–0.143	0.089
Length of service	–0.024	0.037	–0.019	–0.65	.516	–0.096	0.048
Number of missions	0.020	0.042	0.018	0.48	.635	–0.063	0.103
Suicidal ideation	0.067	0.054	0.034	1.23	.219	–0.039	0.173
Deliberate self-harm	0.041	0.061	0.020	0.67	.505	–0.078	0.160
Serious suicide attempt	0.198	0.079	0.101	2.48	.013 *	0.042	0.354

6.3.6.1The Stigma and Self-Stigma Scale (SASS)

The Stigma and Self-Stigma Scale (SASS) (Dockesy et al., 2022) was included to examine internalised attitudes toward mental health within the military sample. Of the 687 participants surveyed, 538 (78%) provided complete data on the five-item scale, while 149 (22%) provided no responses and could not be scored. The rate of missing data is noteworthy, as it may reflect discomfort in acknowledging personal stigma, thereby suggesting that non-response itself could be indicative of underlying reluctance to disclose. For all SASS analyses, a complete-case approach was adopted, using the 538 participants with valid item data as the analytical sample. This adjustment reduced the overall sample size from 687 to 538 and implied an approximate 13% increase in standard errors due to the smaller denominator.

Among valid responses on the SASS (*n* = 538), scores spanned the full range from 5 to 25, with a mode of 25 and a median of 18. To illustrate the distribution, several key score points are noteworthy. High self-stigma was common, with 14.7% (*n* = 79) of respondents achieving the maximum score of 25, 13.4% (*n* = 72) scoring 20, and 8.2% (*n* = 44) scoring 18. Together, these groups account for 36.3% of the sample, all scoring in the very high range (≥18). At the opposite end of the scale, only 1.7% (*n* = 9) scored the minimum of 5, indicating that very few participants were free of self-stigma. The remaining respondents were distributed across the intermediate score values, reinforcing the overall skew towards higher levels of self-stigma. Group comparisons revealed no significant differences across demographics: a one-way ANOVA showed no variation by branch, and chi-square tests of independence showed no association with rank, or gender. See table below.

Table 29 Distribution of SASS Scores and Group Comparisons

Statistic / Finding	Value / Result
Sample size (valid cases)	*n* = 538
Score range	5 – 25
Mode	25
Median	18 (upper half of range)
% at maximum score (25)	14.7% (*n* = 79)
% scoring 20	13.4% (*n* = 72)
% scoring 18	8.2% (*n* = 44)

% scoring ≥18	36.3%
% scoring minimum (5)	1.7% (*n* = 9)
ANOVA (by branch)	$F(2, 535) = 1.42$, $p = .24$ (ns)
Chi-square (by rank)	$\chi^2(4, n = 538) = 4.87$, $p = .30$ (ns)
Chi-square (by gender)	$\chi^2(2, n = 538) = 2.11$, $p = .35$ (ns)
Conclusion	No significant differences by rank, gender, or branch; stigma widespread

ns = not significant

Overall, these findings indicate that high levels of internalised stigma are widespread across the Defence Forces and not confined to any one demographic group, highlighting the need for universal rather than targeted stigma-reduction initiatives.

6.3.7 Emotional Intelligence

Emotional intelligence was assessed using a 25-point scale that presents questions based on the critical dimensions of emotional intelligence, the scale has a point system of 0 to 5 (Mc Kee, 2015). The scale returned a Cronbach's Alpha score of .93, demonstrating good internal consistency. The Mean score was 65.38, Total (N) of Items 25 with a variance of 303.248 and a standard Deviation of 17.4

The scale has five critical dimensions or competencies which are intertwined separately throughout the instrument. Each statement is scored from 0 (never) to 5 (always). According to McKee (2015), the average score for each of the five competencies are as follows:

Table 30 Emotional Intelligence Average Scores

Emotional Self-Awareness:	**19 out of 25**
Positive Outlook:	**18 out of 25**
Emotional Self-Control:	**17 out of 25**
Adaptability:	**18 out of 25**
Empathy:	**19 out of 25**

Figure 22 Emotional Literacy Comparison scores

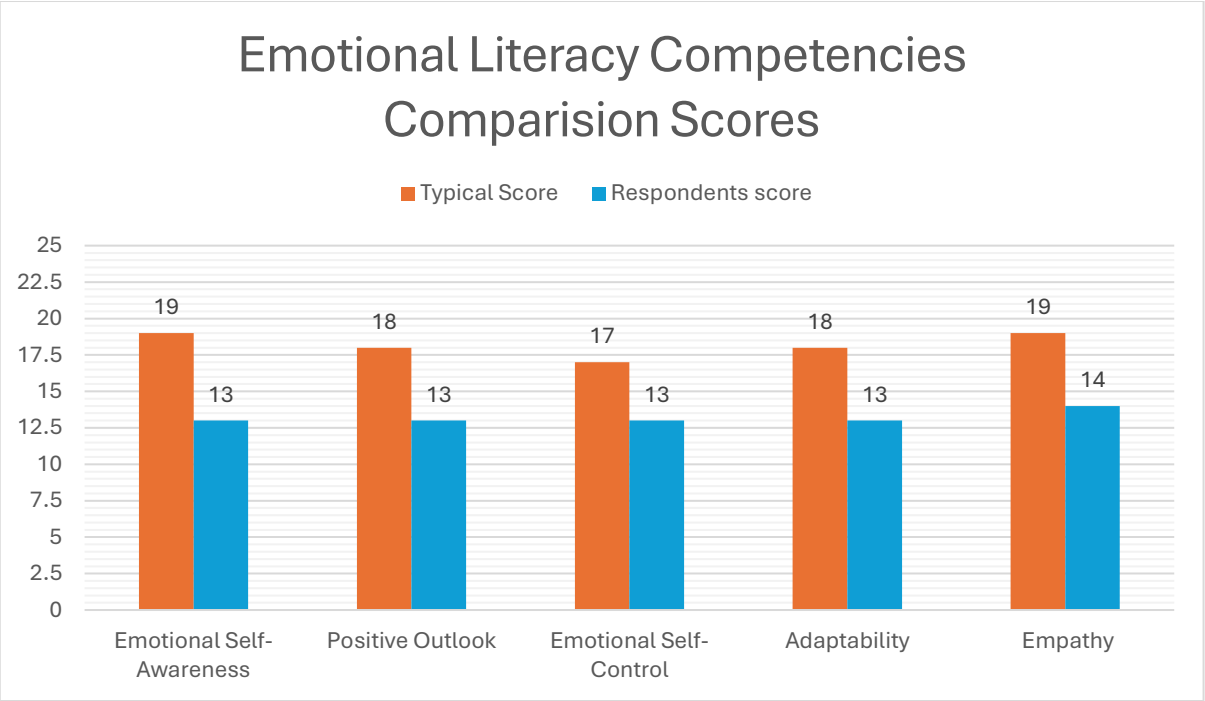


Figure 22 compares the published average scores (red bars) with those obtained from our sample of 687 Defence Forces personnel (blue bars), revealing that participants scored below the normative benchmark in every domain. Prior to subgroup analyses, score distributions for each competency were examined via histograms, skewness and kurtosis statistics and formally tested using the Kolmogorov–Smirnov statistic; in all cases the distributions departed significantly from normality. Consequently, non-parametric tests were employed. Mann–Whitney U tests comparing scores by gender and by rank indicated no statistically significant differences in any of the five competencies. Sample means (and standard deviations) were as follows: Emotional Self-Awareness, 12.8 (SD = 3.8); Positive Outlook, 12.6 (SD = 3.8); Emotional Self-Control, 12.9 (SD = 4.5); Adaptability, 13.5 (SD = 4.1); and Empathy, 13.7 (SD = 3.8). These findings suggest a uniform shortfall in emotional intelligence competencies across all demographic subgroups within the sample.

6.4 Help-Seeking Behaviours of Defence Forces Personnel

The Defence Forces provides services for both physical and mental health issues, these help-provision systems/services are available to all personnel regardless of rank. There are 3 clinical sources: Medical Services, Mental health specialist (clinical psychologist/ psychiatrist), and Inspire (counselling), and 4 non-clinical

providers: Personnel Support Service, Chaplain Service, Social Worker, Chain of Command and Peer support.

Among the 687 service members surveyed, 46% (n = 316) reported that they have sought help for a mental health problem at some point in their military career, while 54% (n = 371) indicated that they have never done so. These figures show that fewer than half of respondents have actually reached out for professional support, even though such resources are available. However, the fact that nearly half reported engaging with some form of help provision is considerably higher than anticipated given the known barriers within military culture. This raises important questions regarding the type of services accessed, specifically, whether participants were more inclined to seek support through informal networks such as peers, family, or chaplains, rather than formal military or civilian mental health services. Understanding this distinction is vital for interpreting the true accessibility and acceptability of available supports within the Defence Forces context.

Rank

In relation to participants who were asked if the used a help-provider for a mental health issue, a chi-square test of independence was conducted on the 2×2 table (N = 687) to examine whether there is an association between Rank and total number of participants who sought help for a mental health issue. The Pearson chi-square results found no statistical difference χ^2 (1) = 1.09, p = .296.

Gender

Among male respondents, 55.3 % (335) had never sought help and 44.7 % (271) had. Among female respondents, 45.6 % (36) had never sought help and 54.4 % (43) had. A Pearson chi-square test showed no significant association between gender and past help-seeking, χ^2 (2, N = 687) = 5.01, p = .082.

Branch

According to Branch, within the Army, 59.2% (242) reported never seeking help and 40.8% (167) reported having sought help. In the Navy, 54.3% (51) reported never and 45.7% (43) reported having sought help. Among Air Corps personnel, 42.4% (78) reported never and 57.6% (106) reported having sought help.

A Pearson chi-square test indicated a significant association between service branch and past help-seeking, χ^2 (2, N = 687) = 14.38, p < .001. No expected cell counts fell below 5 (minimum = 43.24), validating the chi-square approximation. These results show that help-seeking rates differ significantly by branch, with Air Corps members most likely and Army members least likely to have sought mental-health support.

Linear regression model

The regression analysis examining predictors of help-seeking for mental health problems revealed a statistically significant model that explained 10.7% of the variance in help-seeking behaviour ($R^2 = .107$, $p < .001$). Among the predictors, employment branch (B = .077, p < .001), gender (B = .120, p = .038), and having seriously thought about taking one's life (B = –.265, p < .001) emerged as significant factors. Personnel from certain branches and females were slightly more likely to have sought help, whereas those who had seriously contemplated suicide were less likely to have engaged in help-seeking, suggesting the presence of considerable psychological or systemic barriers in this group.

Other variables, including rank, age, marital status, number of missions, and length of service, were not significant predictors. These findings indicate that while some demographic and occupational factors influence help-seeking, suicidal ideation remains a critical area of concern, as it appears inversely associated with accessing support. This suggests that those with the highest level of need may be the least likely to seek help, underlining the importance of targeted interventions to address stigma, fear of repercussions, and cultural barriers within the military context.

Table 31 Regression Model- Predictors of Help-Seeking for Mental Health Problems

Model	Unstandardised Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig. (p)	95% CI for B (Lower)	95% CI for B (Upper)
Gender	0.120	0.058	0.091	2.069	**.038**	0.006	0.234
Rank	0.023	0.041	0.020	0.561	.575	-0.057	0.102
Age Category	-0.017	0.035	-0.019	-0.487	.627	-0.086	0.052
Marital Status	-0.004	0.027	-0.007	-0.148	.882	-0.057	0.049
Employment Branch	0.077	0.020	0.153	3.850	**<.001**	0.038	0.116
Length of Service	0.009	0.022	0.020	0.409	.683	-0.034	0.052
Number of Missions	-0.015	0.020	-0.034	-0.745	.457	-0.055	0.025
Suicide Attempt (Yes/No)	-0.035	0.092	-0.019	-0.383	.702	-0.216	0.146
Suicidal Ideation	-0.265	0.053	-0.197	-5.000	**<.001**	-0.369	-0.161

Below is a breakdown of the data on actual use of services and willingness to use services. Data below is illustrated by two independent charts, Figure 23, and Figure 24 Figure 23 displays the data from the question: have you previously engaged with any of the 8 help-providers within the Defence Forces for a mental health issue. Additionally, Figure 24 displays the data of options of help-providers and asked if participants would be willing to use any of the 8 listed services if they were experiencing a mental health issue.

Figure 23 Engagement with help-providers graph

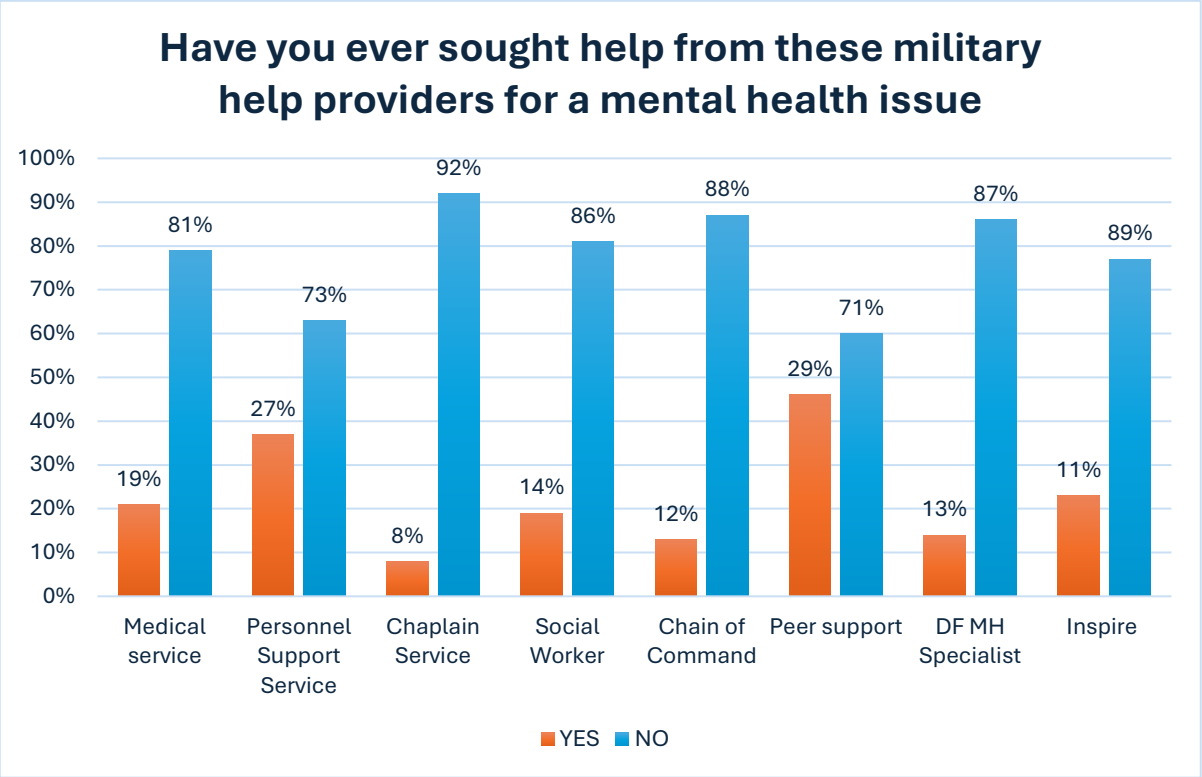


Figure 23 illustrates that Peer Support was the most commonly used source of help provision, reported by 29% (n = 199) of respondents, followed closely by the Personnel Support Service at 27% (n = 186). The Chaplain Service received the lowest level of engagement at 8% (n = 55), followed by the Chain of Command at 12% (n = 82). What is clear from these findings is that Inspire, the civilian counselling provider, was used by only 11% (n = 76), and the Defence Forces Mental Health Specialist service by just 13% (n = 89), indicating that formal mental health care routes remain considerably underused. The data above strongly suggests that informal help-providers are more popular than formal. Section 6.13 uncovers attitudes towards help-providing services that indicate a lack of trust, lack of confidentiality and carer affecting barriers to formal care that don't appear to exist with informal support.

Table 32 summarises the use of clinical and non-clinical support services across demographic groups. For clinical services, consultation with military doctors and Defence Forces Mental Health Specialists showed no gender effects; however, officers were significantly less likely than other ranks to use either service ($\chi^2(1) = 5.868$, $p = .015$; $\chi^2(1) = 10.429$, $p = .001$). In addition, Air Corps personnel were more inclined than Army or Navy colleagues to engage with a Defence Forces

Mental Health Specialist ($\chi^2(2) = 6.350$, $p = .042$). Civilian counselling through Inspire revealed the only gender disparity, with female personnel more likely than males to engage ($\chi^2(2) = 6.943$, $p = .031$).

Among non-clinical supports, officers reported lower engagement with the Personnel Support Service compared to other ranks ($\chi^2(1) = 8.044$, $p = .005$), and Army personnel used it significantly less than their Navy and Air Corps counterparts ($\chi^2(2) = 13.744$, $p = .001$). For the Chain of Command and Peer Support, overall usage was low to moderate, but Army members were again less inclined than Navy or Air Corps personnel ($\chi^2(2) = 7.003$, $p = .030$ for both comparisons). The Chaplain Service and Social Worker support showed no significant variation across demographic groups.

Table 32 Usage of Core Medical, Specialist, and Non-Clinical Supports by Demographic

Support Option	Gender Effect	Rank Effect	Branch Effect
Military Doctors	$\chi^2(2) = 2.363$, p = .307 (ns)	**Officers less likely, $\chi^2(1) = 5.868$, p = .015* (z = –1.9)**	$\chi^2(2) = 2.650$, p = .266 (ns)
DF Mental Health Specialist	$\chi^2(2) = 1.481$, p = .477 (ns)	**Officers less likely, $\chi^2(1) = 10.429$, p = .001** (z = –2.6)**	**Air Corps more willing, $\chi^2(2) = 6.350$, p = .042* (z = 1.8)**
Inspire (Civilian Counselling)	**Females more likely, $\chi^2(2) = 6.943$, p = .031* (z = 1.7)**	$\chi^2(1) = 2.115$, p > .05 (ns)	$\chi^2(2) = 2.110$, p > .05 (ns)
Personnel Support Service (PSS)	$\chi^2(2) = .773$, p = .679 (ns)	**Officers less likely, $\chi^2(1) = 8.044$, p = .005** (z = –2.1)**	**Army less likely, $\chi^2(2) = 13.744$, p = .001** (z = –2.0)**
Chaplain Service	$\chi^2(2)$ p > .076 (ns)	$\chi^2(1)$ p > .076 (ns)	$\chi^2(2)$ p > .076 (ns)
Social Worker	$\chi^2(2)$ p > .076 (ns)	$\chi^2(1)$ p > .076 (ns)	$\chi^2(2)$ p > .076 (ns)
Chain of Command	$\chi^2(2) = 3.040$, p = .219 (ns)	$\chi^2(1) = .912$, p = .340 (ns)	**Army less likely, $\chi^2(2) = 7.003$, p = .030* (z = –1.5)**
Peer Support	$\chi^2(2) = 5.035$, p = .081 (ns)	$\chi^2(1) = .859$, p = .354 (ns)	**Army less likely, $\chi^2(2) = 7.003$, p = .030* (z = –1.4)**

6.4 Assessment on willingness to use help-provision systems within the Defence Forces

All participants were asked about their willingness to engage with the help-provision systems made available to them by the Defence Forces. This question focused on opinion rather than past personal experience. When asked whether they would use mental health services if experiencing a problem, 93.4% (n = 642) said yes, 4.1% (n = 28) said no, and 2.5% (n = 17) responded "don't know." For statistical analysis, the "no" and "don't know" responses were combined into an "unsure/unwilling" category. After recoding into two groups, "yes" versus "unsure/unwilling", 93.4% (n = 642) indicated they would be willing to use mental health services, while 6.6% (n = 45) were unsure /unwilling. Taken together, these findings suggest that although fewer than half of service members have actually sought help to date, the vast majority express a willingness to do so if the need were to arise.

Rank

Among officers, 7.4% (n = 13) were unsure/unwilling to use mental health services, while 92.6% (n = 163) indicated a willingness to engage. Among other ranks, 6.3% (n = 32) were unsure /unwilling, and 93.7% (n = 479) responded positively. A Pearson chi-square test was conducted to examine the association between rank and willingness to use mental health services. The result showed no statistically significant association between the two variables, $\chi^2(1, N = 687) = 0.314$, $p = .575$, indicating that rank did not significantly influence expressed willingness to engage with available mental health services.

Gender

Among male respondents, 5.8% (n = 35) were unsure or unwilling to use mental health services, while 94.2% (n = 571) indicated willingness. Among female respondents, 12.7% (n = 10) were unsure or unwilling, and 87.3% (n = 69) said yes. A Pearson chi-square test showed a significant association between gender and willingness to seek support, $\chi^2(1, N = 685) = 5.39$, $p = .020$, suggesting that female personnel were more likely than their male counterparts to express uncertainty or reluctance about engaging with available mental health services. This finding is somewhat unexpected, as previous literature often suggests that female service members are generally more open to help-seeking than males. The result may reflect specific contextual or cultural factors within the Irish Defence Forces that warrant further investigation.

Branch

Among Army personnel, 5.9% (n = 24) were unsure/ unwilling to use mental health services, while 94.1% (n = 385) said yes. Among Navy personnel, 9.6% (n = 9) were

unsure/unwilling, and 90.4% (n = 85) said yes. Among Air Corps personnel, 6.5% (n = 12) were unsure/ unwilling, while 93.5% (n = 172) indicated willingness. A Pearson chi-square test found no significant difference in willingness across branches, $\chi^2(2, N = 687) = 1.72$, $p = .424$. In summary, willingness to seek help did not differ significantly by rank or branch, suggesting that these demographic factors may play a limited role in shaping attitudes toward mental health support within the Defence Forces.

Linear regression model

The regression analysis examining willingness to use mental health services if needed revealed a non-significant overall model ($R^2 = .021$, $p = .116$), indicating that the included predictors explained only a small proportion of the variance. Among the predictors, only a history of serious suicide attempts demonstrated a statistically significant positive association ($B = .161$, $p = .002$), suggesting that individuals who had previously attempted suicide were more likely to express willingness to use mental health services.

All other variables, including gender, rank, age, marital status, branch, number of missions, length of service, and suicidal ideation without an attempt, were not significant predictors. These findings suggest that demographic and occupational factors have little influence on service willingness, and that prior critical mental health crises may act as a key motivator for future help-seeking intentions. This highlights the potential importance of early intervention strategies to encourage service utilisation before individuals reach a point of acute risk

Table 33 Regression Model- Predictors of Willingness to Use Mental Health Services

Model	Unstandardised Coefficients (B)	Std. Error	Standardised Coefficients (Beta)	t	Sig. (p)	95% CI for B (Lower)	95% CI for B (Upper)
Gender	-0.063	0.046	-0.053	-1.370	.171	-0.153	0.027
Rank	0.043	0.034	0.050	1.273	.203	-0.024	0.110
Age Category	0.000	0.029	-0.001	-0.010	.992	-0.056	0.056

Marital Status	-0.013	0.022	-0.026	-0.585	.559	-0.057	0.031
Employment Branch	-0.010	0.018	-0.023	-0.553	.581	-0.045	0.025
Length of Service	0.002	0.018	0.008	0.089	.929	-0.033	0.037
Number of Missions	-0.005	0.018	-0.013	-0.263	.793	-0.041	0.031
Suicide Attempt (Yes/No)	0.161	0.053	0.122	3.069	**.002**	0.057	0.265
Suicidal Ideation (without attempt)	-0.049	0.032	-0.062	-1.559	.119	-0.111	0.013

Figure 24 displays the individual results for each help-provider. A brief descriptive report is provided for each help provision system in table 34.

Figure 24 Willingness to use help-provision services graph

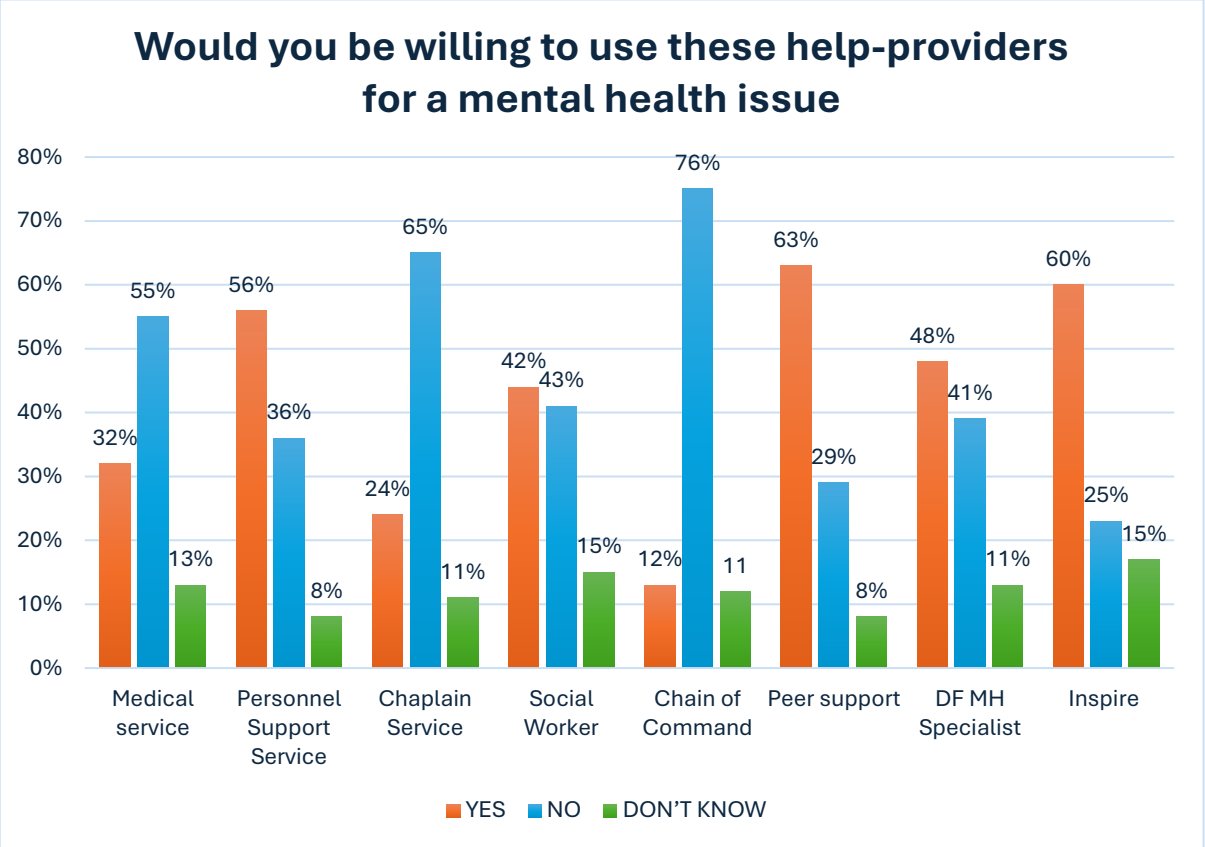


Table 34 summarises willingness to use clinical and non-clinical support services and tests for demographic differences. For clinical services, no significant differences emerged by gender, rank, or branch in willingness to consult military doctors or civilian counselling (Inspire). Willingness to see a Defence Forces Mental Health Specialist was moderate at 48%, with Army personnel significantly less inclined than Navy and Air Corps members ($\chi^2(4) = 11.320$, $p = .023$). Civilian counselling through Inspire was the second most popular clinical option (60% "yes"), again with no demographic variation.

For non-clinical services, several significant patterns were observed. Personnel Support Service engagement (56% overall) was lower among officers compared to other ranks ($z = -1.6$) and among Army personnel relative to Navy and Air Corps members ($\chi^2(4) = 17.703$, $p = .001$). Willingness to use the Chain of Command, the least popular option (12%), was greater among officers compared with other ranks ($z = 2.4$; $\chi^2(2) = 10.085$, $p = .006$). Peer support emerged as the most favoured option (63%), with officers showing significantly stronger preference than other ranks ($z = 1.4$; $\chi^2(2) = 7.936$, $p = .019$). No other gender, rank, or branch differences were statistically significant.

Table 34 Use and Perceptions of Support Services by Demographics

Support Option	Gender Effect	Rank Effect	Branch Effect
Military Doctors	$\chi^2(4) = 2.723$, $p = .605$ (ns)	$\chi^2(2) = 2.230$, $p = .328$ (ns)	$\chi^2(4) = 5.585$, $p = .232$ (ns)
DF Mental Health Specialist	$\chi^2(4) = 3.643$, $p = .457$ (ns)	$\chi^2(2) = .036$, $p = .982$ (ns)	**Army less inclined, $\chi^2(4) = 11.320$, $p = .023$***
Inspire (Civilian Counselling)	$\chi^2(4) = 2.668$, $p = .615$ (ns)	$\chi^2(2) = 1.652$, $p = .438$ (ns)	$\chi^2(4) = 5.236$, $p = .264$ (ns)
Personnel Support Service (PSS)	$\chi^2(2) = 8.109$, $p = .170$ (ns)	Officers less likely ($z = -1.6$), $\chi^2(2) = 8.109$, $p = .170$	**Army less likely, $\chi^2(4) = 17.703$, $p = .001$****
Chaplain Service	$\chi^2(4) = 3.574$, $p = .467$ (ns)	$\chi^2(2) = .171$, $p = .918$ (ns)	$\chi^2(4) = 4.962$, $p = .291$ (ns)
Social Worker	$\chi^2(4) = 3.035$, $p = .552$ (ns)	$\chi^2(2) = .304$, $p = .859$ (ns)	$\chi^2(4) = 5.990$, $p = .200$ (ns)
Chain of Command	$\chi^2(4) = 1.103$, $p = .894$ (ns)	**Officers more likely ($z = 2.4$), $\chi^2(2) = 10.085$, $p = .006$****	$\chi^2(4) = 2.380$, $p = .666$ (ns)
Peer Support	$\chi^2(4) = 5.773$, $p = .217$ (ns)	**Officers more likely ($z = 1.4$), $\chi^2(2) = 7.936$, $p = .019$***	$\chi^2(4) = 5.060$, $p = .281$ (ns)

6.5 Disclosing of mental health problems within the military.

The final section in the survey was a series of opinion related questions that were developed by the researcher to allow participants to express how they felt on issues concerning mental health, stigma, and help-seeking. Some of the questions allowed for opened responses which allowed participants to give their opinions and experiences. This section allowed participants agency to inform the research on their experience with mental health and the help-provision systems. Furthermore, this section explores the participants experience of mental health education and training, their knowledge on mental health company policy, beliefs about discrimination if declaring to have a mental health issue, opinions on members of the Defence Forces living with mental health issues and their ability to serve, changes that the Defence Force could make in help provision and the effect that Covid-19 had on their mental health.

6.5.1 Disclosing a mental health issue to the military medical system.

Participants (N = 687) were asked whether they would disclose a mental health problem to the Defence Forces medical system. Only 22 % (154) answered yes, while 78 % (533) said no. Chi -square tests revealed no significant differences by gender (male 22 % vs. female 20 %; $\chi^2(2)=.702$, p=.704), rank (officer 26 % vs. other ranks 20 %; $\chi^2(1)=2.556$, p=.109) or branch (Army 23 %, Navy 15 %, Air Corps 24 %; $\chi^2(2)=3.223$, p=.200), highlighting widespread reluctance to seek military medical help.

Table 35 Disclosing a Mental Health Issue to the medical System

	Yes	No	Chi-Square Test
Gender			
Male	134 (22%)	472 (78%)	(X^2 = .702 2 df,
Female	16 (20%)	63 (80%)	p = .704).
Rank			
Officer	46 (26%)	130 (74%)	(X^2 = 2.556 1 df,
Other Ranks	104 (20%)	407 (80%)	p = .109
Branch			
Army	92 (23%)	317 (77%)	s (X^2 = 3.223 2
Navy	14 (15%)	80 (85%)	df, p = .200)
Air Corps	44 (24%)	140 (76%)	

6.5.2 Formal training on mental health within the Defence Forces

Only 25 % (n=174) of respondents reported receiving any formal mental health training; 16.7 % (115) of those specified the programme. The most common was suicide awareness (56 mentions), for example)“STORM [Skills Based Training on Risk Management] course.” A participant number (001-687) , Gender (M/F) and rank (O = Officer/OR =Other Rank),is assigned to each quote to help provide an overall sense of the data. identified as Participants noted the following:

> ***P348 (M, O):*** *“Suicide awareness”*
>
> ***P245 (F, OR):*** *“Assist, STORM [Skills Based Training on Risk Management]”*
>
> ***P409 (F, O):*** *“Self-harm mitigation course. STORM Course”*
>
> ***P351 (F, O):*** *“STORM [Skills based Training on Risk Management] course”*

Next was mental health first aid (n=41), noted as “Safe Talk” or “Mental Health First Aid course in 2019.”

> ***P617 (M, OR):*** *“I was a part of a mental health first aid course in 2019”*
>
> ***P263 (F, OR):*** *“SAFE & Mental Health First Aid”*
>
> ***P189 (F, OR):*** *“Mental health first Aid, Safe Talk”*

Fifteen participants cited Personnel Support Service briefs “DCP [Designated Contact Person] Training,” “welfare and wellness lecture in recruit training”),

> ***P255 (M, O):*** *“Personnel Support Service Briefs. DCP [Designated Contact Person] Training”*
>
> ***P148 (F, O):*** *“Mental health and wellness lecture in recruit training”*
>
> ***P383 (M, OR):*** *“Personnel Support Service brief”*
>
> ***P138 (F, OR):*** *“Crew resource management. Human factors”*
>
> ***P580 (M, O):*** *“Briefs for overseas and repatriation”*

Three mentioned Critical Incident Stress Management, and one recalled “WRAP (Wellness Recovery Action Plan)” prior to its 2020 discontinuation in the Defence Forces. This distribution underscores that fewer than one-quarter of personnel received structured mental health education, with suicide awareness and first aid the most prominent offerings.

6.5.3 Opinions on the impact of disclosing a mental health issue for soldiers.

Participants (n = 687) were asked whether telling a military doctor about a mental health problem would harm their career. Table 36 shows that 94 % (644) believed it would, with no significant differences by gender, rank or branch.

Table 36 Disclosing a Mental Health issue

	Yes	No	Chi-Square Test
Gender			
Male	564 (93%)	42 (7%)	(X^2 = 3.956 2 df, p = .138
Female	78 (99%)	1 (1%)	
Rank			
Officer	162 ((92%)	14 (8%)	(X^2 = 1.159 1 df, p = .282
Other Ranks	482 (94%)	29 (6%)	
Branch			
Army	385 (94%)	24 (6%)	(X^2 = .819 2 df, p = .664)
Navy	89 (95%)	5 (5%)	
Air Corps	170 (92%)	14 (8%)	

From the open-ended questions (420 responses), 97 % (397) described only negative outcomes. The most frequent concern, cited 135 times, was lack of trust and confidentiality:

> ***P026 (F, OR):*** *"Huge issues with confidentiality/ GDPR/ respect for the patient/ compassion etc"*
>
> ***P478 (F, OR):*** *"the officers tell each other everything "*
>
> ***P277 (F, OR):*** *"I do not trust the MO…they report back to the senior officers"*

Eighty-one respondents focused on career impact, loss of deployments, medical downgrades and stalled promotion:

> ***P605(F, OR):****"Less chance of deployment"*
>
> ***P016 (M, OR):*** *"Medical downgrades affect your ability to continue in service."*
>
> ***P363 (M, OR):*** *"If you disclosed…you would be labelled weak…not let near a ship, possibly medically downgraded too"*

A smaller group 3 %, (23) saw potential positives, though none were women. Representative quotes include:

> ***P069 (M, O):*** *"I would rather seek help with PSS (Personnel Support Service)…However, if PSS etc. advised…I would have no problem seeking medical attention"*

> ***P032 (M, O):*** *"Mental health is as vital to a service person as their physical health. I have never seen a negative outcome where a subordinate of mine had engaged with mental health supports and treatment"*

> ***P199 (M, O):*** *"You will receive free medication"*

> ***P029 (M, O):*** *"If you visit the doctor for mental health, they can impact your career by helping you enjoy it again"*

Overall, distrust of medical officers, fear of being perceived or labelled as weak and anticipated career penalties emerge as powerful barriers to formal help-seeking, outweighing any perceived benefits

6.5.4. Perceived Discrimination and Fitness to Serve

One of the aims of this research was to investigate how Irish military personnel address mental health concerns. Participants (n = 687) were first asked whether they believed they would face discrimination from co-workers or commanders if their mental health issue became known. As shown in Table 37, 78 % (536) answered "yes" and 22 % (151) "no." Chi-square analyses revealed no significant differences by gender ,rank or branch

Table 37 Results of beliefs on experiencing discrimination from commanders and peers if they knew about your MH issue

	Yes	No	Chi-Square Test
Gender			
Male	470 (78%)	136 (22%)	(X^2 = 1.052 2 df, p = .591)
Female	64 (81%)	15 (19%)	
Rank			
Officer	131 (74%)	45 (26%)	(X^2 = 1.777 1 df, p = .183)
Other Ranks	405 (79%)	106 (21%)	
Branch			
Army	319 (78%)	90 (22%)	(X^2 = 2.967 2 df, p = .227)
Navy	79 (84%)	15 (16%)	

Air Corps	138 (75%)	46 (25%)	

Next, participants were asked whether a soldier living with a mental health issue is fit to serve. An overwhelming majority, 95 % (651), affirmed fitness for duty. Again, no significant differences emerged by gender, rank or branch (Table 38).

Table 38 Are Soldiers Experiencing MH issues Fit to Serve

	Yes	No	Chi-Square Test
Gender			
Male	573 (95%)	33 (5%)	(X^2 = 9.288 2 df, p = .010)
Female	77 (98%)	2 (2%)	
Rank			
Officer	166 (94%)	10 (6%)	(X^2 = .093 1 df, p = .760)
Other Ranks	485 ((95%)	26 (5%)	
Branch			
Army	387 (95%)	22 (5%)	(X^2 = 1.012 2 df, p = .603)
Navy	91 (97%)	3 (3%)	
Air Corps	173 (94%)	11 (6%)	

Overall, these findings indicate that while most personnel fear workplace discrimination upon disclosure, nearly all hold the personal belief, that mental health issues do not compromise one's suitability for military service.

6.5.5 Medication and External Help-Seeking

Defence Forces regulations require military doctors to prescribe any medication taken by personnel, with civilian prescriptions mandatorily reported (Irish Defence Forces, 2015). Nonetheless, 21 % (n=141 of 687) admitted to using mental health

medication not prescribed by a military officer, with no differences by gender, rank or branch (Table 39).

Table 39 Have you taken medication unprescribed by a Medical Officer for a MH issue

	Yes	No	Chi-Square Test
Gender			
Male	124 (21%)	482 (79%)	(X^2 = 1.100 2 df, p = .577)
Female	17 (22%)	62 (78%)	
Rank			
Officer	33 (19%)	143 (81%)	(X^2 = .532 1 DF, P = .466)
Other Ranks	109 (21%)	402 (79%)	
Branch			
Army	86 (21%)	323 (79%)	(X^2 = 2 df, p = .909)
Navy	20 (21%)	74 (79%)	
Air Corps	36 (20%)	148 (80%)	

A larger proportion, 33 % (n=223), reported consulting an external GP or civilian service for mental health issues (Table 40).

Table 40 Have you used external providers to overcome a MH issue

	Yes	No	Chi-Square Test	Standardized Residual
Gender				
Male	184 (30%)	422 (70%)	(X^2 = 10.321 2 df, p = .006)	Y= -.9 N= .6
Female	38 (48%)	41 (52%)		Y= 2.4 N= -1.7
Rank				
Officer	44 (25%)	132 (75%)	(X^2 = 6.006 1 df, p = .014)	Y= -1.7 N= 1.2
Other Ranks	179 (35%)	332 (65%)		Y= 1.0 N= -.7
Branch				
Army	147 (36%)	262 (64%)	(X^2 = 7.649 2 df, p = .022)	Y= 1.2 N= -.9
Navy	31 (33%)	63 (67%)		Y= .1 N= -.1
Air Corps	45 (25%)	139 (75%)		Y= -1.9 N= 1.3

Women were significantly more likely than men to do so. Open-question responses (n = 223) highlighted three dominant themes. The first theme centred on **trust and confidentiality**, with several participants emphasising that they felt safer using services that would not compromise their privacy. As participants explained,

> ***P334 (M, O):*** *"I knew nothing would come back to me, trusted them"*

> ***P162 (M, OR):*** *"Doesn't get written in LA 30 for everyone to see"*

A second theme related to **career protection**, where respondents expressed concern that engaging with military mental health systems could jeopardise professional progression. For instance, participants stated,

> ***P554 (M, OR):*** *"For privacy and to protect my career"*

> ***P403 (F, O):*** *"I used the Inspire service…for fear it would negatively affect my career"*

The third theme reflected **systemic failings** within the Defence Forces' mental health provision, particularly regarding timely access to care. Participants disclosed,

> ***P060 (F, OR):*** *"Inability of Defence Forces to provide treatment in a timely manner"*

> ***P229 (M, OR):*** *"I was told the waiting list for DF support would take another 6 months and I felt I needed help now"*

These responses underscore pervasive mistrust of military medical officers, fear of career repercussions, and concern over delays or inadequacies in military mental health services, factors driving a significant minority of personnel to seek care outside official channels.

6.5.6 Knowledge of a Defence Forces Mental Health Policy

Participants (n = 687) were asked whether they believed a formal mental health policy exists within the Defence Forces, which, in fact, it does not. As shown in Table 41, 60% (n = 410) answered "yes." Officers were significantly more likely than other ranks to believe that a policy exists, while Army and Navy personnel

were more likely than those in the Air Corps to hold this belief. No gender differences emerged.

It is important to acknowledge that posing this question, knowing that such a policy does not exist, may be perceived as a form of "entrapment question" aimed at revealing a knowledge gap, though this was never the intention, rather, it was considered the most effective means of addressing the issue of policy in a context where the Defence Forces is a policy-driven organisation. By framing the question in this way, the study was able to reveal the extent of misunderstanding and misplaced confidence in existing structures.

These misperceptions are concerning. Without an official mental health policy to delineate processes and procedures, service members lack clear guidance on where and how to seek support and help providers have no consistent framework for delivering care. The absence of policy also risks inconsistency and inequity in service provision, whereby access to and quality of support may depend more on individual discretion, local practices, or informal networks than on a standardised organisational framework. This undermines both transparency and fairness in mental health provision and highlights the urgent need for a formalised policy to ensure consistency across the Defence Forces.

Table 41 Do you know if a Mental Health Policy exists within the DF

	Yes	No	Chi-Square Test	Standardized Residual
Gender				
Male	357 (59%)	249 (41%)	(X^2 = 1.466 2	Y= -.2 N= .3
Female	52 (66%)	27 (34%)	df, p = .481)	Y= .7 N= -.9
Rank				
Officer	118 (67%)	58 (33%)	(X^2 = 5.335 1	Y= 1.3 N= -1.5
Other Ranks	292 (57%)	219 (43%)	df, p = .021)	Y= -.7 N= .9

Branch				
Army	258 (63%)	151 (37%)	(X^2 = 12.370	Y= .9 N= -1.1
Navy	62 (66%)	32 (34%)	2 df, p = .002)	Y= .8 N= -1.0
Air Corps	90 (49%)	94 (51%)		Y= -1.9 N= 2.3

6.5.7 Thoughts on the future of mental health care in the Defence Forces

Participants were asked about the future of help seeking services and were invited to suggest changes to Defence Forces help-seeking services: A total 204 (30%) responses were returned. Basic Thematic coding was developed to analyse the findings from this question. Two main themes and associated sub-themes that emerged are illustrated below.

Theme 1. Outsource to Civilian Services (n=87): A large portion of participants called for mental health care to be moved entirely into civilian systems, (87 of 204 respondents), citing deep mistrust of military medical officers, fears over confidentiality and career penalties, and a belief that service doctors lack compassion. Female respondents in particular lacked confidence that disclosure to a military doctor could yield a positive outcome.

> ***P211 (F, OR):*** *"A civilian medical service for general mental health and use of military MO's [Medical Officer] only for operational health assessments"*

P102 (M, OR): *"a mental health service separates to PSS [Personnel Support Service] and medical cell. private and confidential service only"*

P100 (M, O): *"A neutral, non-military mental health support unit with online consultancy to offer discretion"*

P216 (F, OR): *"An independent section to deal with mental health separately to just 'going sick'"*

P652 (F, O): *"An online help service might be something that personnel may feel more comfortable using as it can be utilised discreetly"*

P224 (F, OR): *"An outside service, detached from the military with full confidentiality from anyone bar possibly the medical officer"*

Theme 2. Barriers to Care (n=117): Trust Confidentially: A second theme (117/204) underscored systemic barriers: members of the Defence Forces fear that seeking help will harm their careers, and they question the trustworthiness and discretion of current providers. Across both themes, participants demanded civilianised services, stronger confidentiality safeguards, and educational initiatives to reduce stigma and reassure personnel that accessing support will not threaten their military advancement.

P387 (M, OR): *"Take mental health seriously, implement in command structure, have more resources, not harm people's careers"*

P215 (M, OR): *"Confidential supports that actively help soldiers while not being discriminated and adversely affected within their career as long as they were helped and able to continue in service"*

P065 (M, OR): *"Training Seminars Get rid of the stigma"*

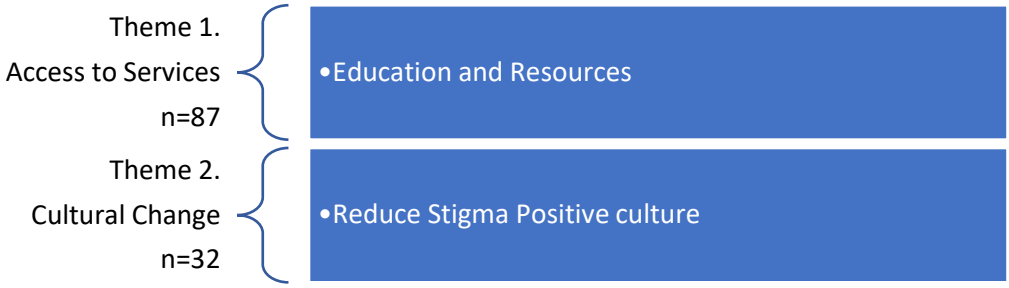
P291 (M, O): *"Remove the fear of careers being affected if you seek help"*

P329 (M, OR): *"I believe we need to Educate DF personal on what services are available both within the DF and with the HSE for a start. And then to*

help them understand that it's OK to go for help without any repercussions"

P320 (M, OR): *"Every soldier should have access to IKON [Defence Forces intranet service] and DF email and be able to contact these services confidentially themselves. Rather than trying to ask others in coy offices or have to go sick and put the eye on themselves"*

The second part of this section asked participants: what changes would you like to see the Defence Forces make in terms of services provided for mental health? 119 (17%) out of 687 participants answered this question. Once again clustering into two main themes.



Theme 1. Access to Services (n=87): Education and Resources : Among the total 117 respondents who proposed changes, two priorities emerged. First, participants called for significantly enhanced access to mental health services: streamlined pathways into confidential care, increased numbers of psychologists and psychiatrists, and adequately funded, well-resourced facilities. They also emphasised the importance of training for commanders and non-clinical staff to recognise psychological distress and intervene early**.**

P233 (M, OR): *"Better access to confidential services"*

P084 (M, O): *"Better access to psychologists"*

P141 (M, OR): *"Better access to psychiatrists and psychologists for people who need it"*

P381 (F, OR): *"Better access to facilities for mental health services"*

P523 (M, OR): *"Easier routes to psychiatrist and more of them on staff"*

P009 (M, OR): *"More appropriate selection process for individuals…required to assist in mental health issues and an overhaul of the PSS staff to bring in more suitable people where required"*

P332 (M, O): *"Better training for lower-level commanders to recognise individuals when may be unnecessary suffering"*

P664 (M, OR): *"Employ more psychologists and psychiatrists to meet the demand. It took me over 2 years to see someone when I looked for professional help"*

P636 (M, OR): *"Employ more staff"*

Theme 2. Cultural Change (n=32): Reduce Stigma and Promote Positivity : Respondents secondly stressed the need for a cultural transformation to destigmatize mental health within the Defence Forces. They advocated regular, organisation-wide education, such as annual lectures and evidence -based courses, to normalise conversations about mental wellbeing, reinforce the message that seeking help does not put one's career at risk, and foster a more supportive, resilient military community.

P109 (M, OR): *"Stigma around mental health to try and make people see there are many forms and it's not always noticeable serious course needs to be addressed which everyone must take"*

P375 (F, OR): *"I think an overall shift in mentality towards people's mental health would be best as the DF seems to have an almost backwards view on mental health. More awareness needs to be raised…easier to access and easier to keep confidential…"*

P629 (F, O): *"Normalising mental health issues"*

P490 (M, OR): *"Have an annual lecture or talk about it every year"*

P440 (F, OR): *"A mental health Syllabus for all defence force personnel which may include the following, inform, signs, dealing with, overcoming etc"*

P227 (M, OR): *"Examples of CBT [Cognitive Behavioural Therapy], mindfulness problem solving and emotional intelligence as part of training. Of people engaged and try it they will better understand it to look for it when its actually required"*

P315 (M, O): *"Areas to relax other than the mess [Recreational area that sells alcohol]. Gyms open in the evenings etc"*

P082 (F, OR): *"Provide a more positive workplace"*

P611 (M, O): *"Promote positive culture"*

P433 (M, OR): *"Promote more that it is ok to have a mental health issue and help is there. Plus, the fact that it would not affect your career"*

Collectively, these detailed recommendations reflect both a profound lack of confidence in existing military medical services and a clear blueprint for reform. Participants envision a future in which mental health care is truly confidential, ideally civilian-run or, at minimum, insulated from career-related repercussions, delivered by adequately resourced specialists, and supported by an organisational culture that actively destigmatises psychological vulnerability.

6.5.8 Covid-19 and its effect of the mental health of the Defence Forces.

The survey's final question asked whether the COVID-19 pandemic and its restrictions had negatively affected respondents' mental health. Of 687 participants, 36 % (250) reported a detrimental impact and 64 % (437) reported that it did not impact their mental health. There were no significant differences by gender (37 % of both men and women) or rank (33 % of officers vs. 38 % of other ranks). However, branch membership was significant, $\chi^2(2, N = 687) = 17.09$, $p = .001$: Air Corps personnel were most likely to report harm 49 %, compared with 32 % of Army and 33 % of Navy respondents.

Table 42 Has COVID-19 and its restrictions affected your MH in a negative way

	Yes	No		Chi-Square Test	Standardized Residual
	Gender				
Male	221 (37%)	385 (63%)		(X^2 = 1.149 2	Y= .0 N= .0
Female	29 (37%)	50 (63%)		df, p = .563)	Y= .0 N= .0
	Rank				
Officer	58 (33%)	118 (67%)		(X^2 = 1.207 1	Y= -.8 N= .6
Other Ranks	192 (38%)	319 (62%)		df, p = .272)	Y= .4 N= -.3
	Branch				
Army	129 (32%)	280 (68%)		(X^2 = 17.094	Y= -1.6 N= 1.2
Navy	31 (33%)	63 (67%)		2 df, p =	Y= -.5 N= .4
Air Corps	90 (49%)	94 (51%)		.001)	Y= 2.8 N= -2.1

6.6 Summary

This chapter demonstrates that while a substantial proportion of Defence Forces personnel present with significant mental health needs, utilisation of formal military mental health services remains comparatively low, with many instead turning to informal or semi-formal sources of support. Personnel reported high levels of symptoms across anxiety, depression and post-traumatic stress, yet patterns of help-seeking showed clear preference for peers and the Personnel Support Service. Open-ended responses explained this divergence in practical terms. Participants prioritised confidentiality and trust, weighed perceived career risks heavily, and described delays or procedural hurdles that reduced confidence in the formal military help provision systems.

Attitudinal measures reinforce these behavioural patterns. Stigma and barriers to care were prominent across the force and did not concentrate meaningfully in any single demographic group. Self-stigma was also widespread. Emotional

intelligence competencies were uniformly below established benchmarks, suggesting a skills gap in self-awareness, emotion regulation, empathy and adaptability that may hinder early recognition of distress and constructive help-seeking.

Willingness to seek help in principle was high, although this stated openness did not translate consistently into past engagement with formal care. Demographic and occupational factors had limited explanatory power for willingness or symptom burden. By contrast, prior psychological distress, including suicidal ideation, self-harm and suicide attempts, was more strongly associated with poorer mental health outcomes and with variations in help-seeking attitudes. This points to a clinical priority for early identification and assertive outreach to those with markers of elevated risk.

Training and education were reported as irregular and largely limited to suicide awareness or first-aid style provision. Participants asked for a stronger, routine programme of mental health literacy for all ranks, clearer guidance for supervisors, and visible leadership messaging that normalises help-seeking and separates clinical care from career decisions. Many advocated for civilian-delivered or meaningfully independent services, with robust confidentiality protections and streamlined access.

Finally, contextual pressures such as COVID-19 restrictions were perceived to have added strain, with some variation across branches. Taken together, the chapter indicates a system characterised by high need, strong informal coping networks, constrained confidence in formal military provision, pervasive stigma, and unclear policy scaffolding. The findings argue for a coherent reform package that includes a formal mental health policy, protected confidentiality pathways, resourced clinical capacity, targeted outreach to high-risk groups, and sustained education to shift norms and reduce stigma across the organisation.

Chapter 7: Qualitative Findings

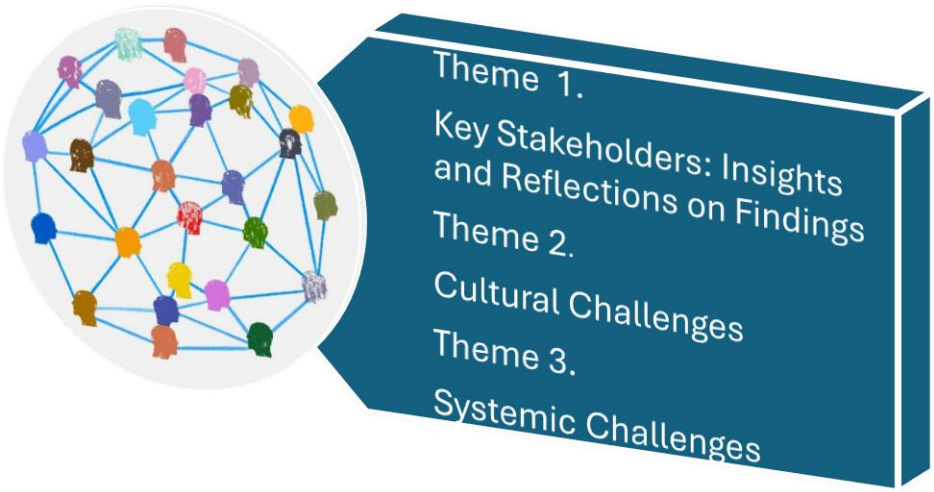
7.1 Introduction

This chapter presents the findings from the second phase of the study, which corresponds to the fifth objective: to explore the perspectives of key stakeholders on mental health and help-seeking behaviours among military personnel. Consistent with the logic of a sequential explanatory mixed methods design, the qualitative phase was conducted to provide context and deeper understanding of the quantitative findings, particularly regarding the low engagement with formal mental health services among soldiers and their reported preference for informal support mechanisms, such as peer support.

The data presented in this chapter are drawn from six semi-structured interviews conducted with senior key stakeholders who occupy central roles in the provision of mental health and support services within the Irish Defence Forces. The interview topic guide was informed by key themes that emerged from the survey data, allowing for a focused and relevant exploration of stakeholder perspectives.

As outlined in Chapter 5, the qualitative data were analysed using the thematic approach proposed by Braun and Clarke (2006), applied within a descriptive qualitative framework. This process led to the development of three overarching themes that reflect shared patterns across participants' accounts. These themes are supported with direct excerpts from interview transcripts to illustrate and substantiate the analysis, and a visual representation of the thematic structure is provided in Figure 25.

Figure 25 Key Themes



7.2 Overview of Respondents Profile

Six interviews were conducted with key stakeholders, representing a range of senior personnel within the Defence Forces who are involved in the provision of health and support services. To protect their identities, pseudonyms were assigned to each participant (Table 43). The stakeholders held both formal and informal roles within the organisation. Formal help-providers, such as those within medical or psychiatric services, require an appointment or referral, resulting in an administrative chain of evidence documenting the soldier's mental health issue, which ultimately becomes part of their medical or personal record. In contrast, informal care providers, such as peer support, social workers (in most cases) and chaplains, operate on a walk-in basis without the need for formal appointments, and these interactions are typically not recorded on an individual's personal or medical file.

Five of the interviews were conducted in person at military installations, and one interview, was completed online. Of the six stakeholders interviewed, two were female and four were male. Each participant received a copy of the key survey findings (Appendix 19) at least one week prior to the interview, allowing them sufficient time to reflect on the results and prepare their responses. The consent package included a list of likely interview questions.

Table 43 Stakeholder Pseudonyms

Participant: 1	John
Participant: 2	Fiona
Participant: 3	Thomas
Participant: 4	Peter
Participant: 5	Jane
Participant: 6	Ryan

7.3 Theme 1. Key Stakeholders: Insights and Reflections on Findings

This section introduces the insights and reflections of the key stakeholders regarding the findings of this study. Their insights are partially grounded in the survey results, which revealed critical issues surrounding mental health and help-seeking behaviours within the Defence Forces, in addition to their personal experiences with the challenges with mental health and help-provision in the Defence Forces generally. The key findings reported elevated levels of anxiety, depression, PTSD, self-harm, and alcohol misuse among personnel, alongside significant barriers to engaging with formal help-provision systems within the

Defence Forces and a general avoidance of support services when experiencing mental health issues.

Key stakeholders were presented with these findings and asked to reflect on the implications, contextualise the results, and offer their professional opinions on the challenges and potential solutions. Their responses provided nuanced perspectives shaped by their roles within both formal and informal help-provision systems, shedding light on, cultural, and systemic structural factors influencing the effectiveness of mental health support in the Defence Forces.

Stakeholders expressed concerns regarding the high prevalence of mental health issues among Defence Forces personnel, particularly in relation to anxiety, PTSD, depression, and self-harm. Some stakeholders contextualised these findings within broader societal trends, noting that external stressors impacting the general population were likely mirrored within the military. However, they also recognised internal systemic barriers, such as stigma, career implications, and fears of confidentiality breaches, that discouraged personnel from seeking formal support.

Stakeholder reflections revealed a nuanced understanding of the cultural and systemic barriers that continue to impede mental health engagement within the Irish Defence Forces. These insights, grounded in both the empirical findings and personal experiences of those involved in help-provision, shed light on the paradoxical dynamics of military life, where strength and solidarity coexist with silence and suppression regarding mental health concerns.

7.3.1 Insights and reflections on the prevalence of Mental Health problems

The survey reported that 19% of participants were experiencing severe anxiety, while 21% experienced severe depression. These findings were both surprising and concerning to the key stakeholders. However, some stakeholders contextualised these results by attributing the elevated levels of anxiety to the broader prevalence of anxiety observed within Irish society.

Thomas discusses the broader societal trend of increasing anxiety, implying that attributing this trend specifically to the Defence Forces without considering the wider context may be limiting. Fiona acknowledges the lack of a reference point within the military, noting that this limitation hinders their ability to fully interpret or contextualise the anxiety findings. For Fiona, a gap in data specific to the military context, makes it challenging to determine whether the observed anxiety levels are typical or unusual compared to other settings. These points are highlighted in the following quotations:

Thomas: "Yeah, I think in general terms there is more anxiety in society as a whole, so I don't think its specific to the Defence Forces. I do think things have gotten more stressful in life generally. I would expect anxiety to be either mild or moderate but not severe."

Fiona: "Anxiety is it military specific? What's triggering that? We have no reference point in our military so it's hard to comment. There is more anxiety and depression among younger people now."

Thomas expressed surprise at the finding that 32% of Defence Forces personnel reported experiencing severe anxiety. His reaction underscores a gap between the prevalence of severe anxiety revealed in the survey and the cases of anxiety that reach his help-provision system, suggesting an underrepresentation of soldiers seeking formal support for this issue.

Ryan was also surprised that the rates of anxiety were so high suggesting that military training might reduce the prevalence. He highlighted that military training is designed to prepare soldiers to remain focused during stressful situations, such as patrolling borders during hostile overseas missions, removing and disarming land mines, or engaging in combat.

Ryan: "Anxiety: it's a very surprising figure because we train for stressful environments."

This perspective appears limited, as it assumes that stress-management training delivered during military preparation is sufficient to prevent or substantially reduce anxiety among personnel. The underlying belief is that structured resilience exercises provided in training camps should adequately equip soldiers to regulate psychological responses under pressure. However, the findings of this study challenge that assumption: 32% of participants reported experiencing severe anxiety, despite having completed such training. This suggests that standardised stress-preparation does not fully address the complex and individualised nature of anxiety, which is shaped not only by operational demands but also by interpersonal dynamics, environmental stressors, and underlying psychological vulnerability.

Respondents also shared concerns over the findings on depression. Some respondents expressed alarm and concern at the findings which were suggestive of a high level of severe depression among survey participants. Peter admitted the high levels of severe depression needed to be urgently addressed and the data presented was indeed problematic.

Peter: "The 21% of severe depression is very alarming. If someone's mental health is not in the right place we have a problem, it's a figure that needs to be looked at."

Jane's observation that severe depression is "rarely seen" suggests that soldiers may not be seeking support from certain health providers when experiencing symptoms.

> *Jane: "We wouldn't see much depression just low mood; we rarely see severe depression."*

In the context of severe depression, Jane also raised a criticism of peer support, noting that if severe depression is being experienced, peer support providers might not fully understand or may underestimate the symptoms disclosed by individuals. This limitation is attributed to the informal nature of peer support and the varying levels of education, training, and experience among peer supporters. She highlights the need for improvements to ensure that individuals with severe depression are recognised.

> *Jane: "The worry is if peer support does not recognise severe depression well. We need to do more work on this."*

In fact, this sentiment is echoed by other respondents, who similarly highlight the organisation's duty to respond to the mental health challenges faced members of the Defence Forces, underscoring the importance of proactive measures such as improved education, training, and support systems.

> *Ryan: "We need to educate people about mental health."*
>
> *Peter: "Mental health training has slowly increased in the last 10 years."*
>
> *Fiona: "I think it's down to Psychosocial education; we need more of it."*

These insights from key stakeholders reinforce the need for both cultural and structural change to improve visibility and access to mental health support.

The survey revealed that 25% of participants reported symptoms of PTSD, a finding that drew particular attention from the key stakeholders during interviews. While several mental health issues were identified in the survey, it was the prevalence of PTSD that interviewees most frequently highlighted and reflected upon. While Fiona suggests that PTSD results may be influenced by individuals conflating military and non-military traumatic experiences, the scale used in this study (PCL-M, Weathers, et al., 2013) is military specific. This should mitigate against a potential limitation in interpreting the data, as it should only reflects trauma solely related to military experiences.

> *Fiona: "PTSD results are high, I think some people are confused and relate to incidents outside the military, we have to take into account personal trauma. I know that the scale is military specific."*

Survey participants may have displayed uncertainty about whether their reported traumatic experiences were military-related, despite the survey's focus on service-specific events. To situate this ambiguity, Hyland et al. (2021) estimate that roughly one in eight Irish adults meets PTSD diagnostic criteria, yet many never engage with mental health services. This sizeable treatment gap underscores broader challenges in accurately identifying and managing PTSD across the population and suggests that some Defence Forces members may enlist with undiagnosed, pre-service PTSD. In light of these findings, routine PTSD screening at enlistment could help distinguish pre-existing conditions from service-related trauma and ensure timely referral to support. Moreover, the unique operational demands and stressors of military life likely place personnel at elevated risk compared to civilian peers, further justifying targeted early assessment and intervention strategies within the Defence Forces. Given the distinct stressors inherent to military life, this suggests that Defence Forces personnel may be at heightened risk compared to civilians.

> *Thomas: "We should be doing better but how much better can we do? The figures that you have discovered warrants a discussion with the mental health team. If we see figures that are way higher than national averages we must ask, are we doing something wrong, and if figures are lower than national averages, what are we doing right?"*

The absence of historical PTSD records within the Defence Forces was a notable point of discussion by the stakeholders. One respondent echoed Thomas's question, pondering whether the findings indicate that the Defence Forces are "doing something right or wrong." This reflection highlights the immediate need for critical inquiry into the effectiveness of existing mental health practices and support systems, suggesting the need for further evaluation of organisational policies and their impact on the mental health of personnel.

> *Fiona: "We don't have core figures on PTSD to know if we are improving or not."*

The key findings prompted a call for action, as Thomas advocated for the mental health team to further investigate the findings on PTSD, highlighting the need for deeper exploration and understanding of this critical issue.

> *Thomas: "25% experiencing PTSD is not to be ignored, and I will have conversations with the mental health team around what do we think of these figures and what action to take including, what do we need to look at further."*

Jane highlights a significant shortcoming in the organisation's mental health practices, specifically the underdiagnosis of PTSD. This observation points to a systemic gap.

> *Jane: "PTSD is massively under diagnosed in the Defence Forces. We don't go looking for it. "*

Additionally, Jane's observation reflects an awareness that many cases of PTSD remain hidden from official recognition and suggests a broader institutional indifference towards proactively identifying the true prevalence of PTSD among personnel. Fiona adds to this by emphasising the presence of a hidden population of soldiers grappling with mental health issues, citing the anonymous nature of the survey data as evidence of the difficulties in fully comprehending the scale of these challenges within the Defence Forces.

> *Fiona: "Your surveys are anonymous so that's why you got those results, people often underreport in the Army. "*

An interesting reflection on the PTSD findings was offered by Ryan, who highlighted the challenging lived experiences associated with overseas service. He suggested that the accumulation of deployments and prolonged service is particularly relevant for personnel experiencing PTSD, noting:

> *Ryan "PTSD at 25% is a very high number. We do come across terrible scenes in our job, especially overseas. A person's length of service will be relevant in this finding."*

However, the statistical analysis in this study indicated otherwise. PTSD was most strongly associated with psychological risk factors, including suicidal ideation, self-harm, and previous suicide attempts. Service-related variables, such as length of service and number of missions, did not significantly predict PTSD. This contrast suggests that while operational exposure is often perceived as the key driver of PTSD, psychological vulnerability may play a more decisive role.

Further endorsement of the relationship between lived experience of Defence Forces personnel and PTSD stemming from military service, is noted by one respondent who states:

> *John: "PTSD is a symptom of military life, but we need to be better at catching people at an early stage. "*

This statement underscores the acknowledgement that PTSD is a symptom of military life, yet the acknowledgement that the organisation's response to effectively addressing it remains insufficient. John provides valuable insight into the lived experiences of Defence Forces personnel grappling with signs and

symptoms of PTSD, shedding light on the specific concerns faced by certain cohorts, particularly officers, when living with the condition. He emphasises that PTSD is more prevalent within the organisation than currently recognised, highlighting a critical gap in awareness, stigma, and response.

> *John: "My experience of PTSD is that officers are better at hiding it, they don't feel they can admit it, I do see quite a few of PTSD officers. 10% of patients I see have proper full-on PTSD. This includes the women of honour[1] type presentations who have PTSD. "*

As the interviews progressed, discussions regarding the collection and management of PTSD-related data within the Defence Forces revealed significant confusion and gaps in practice. This led to further conversation about the PCL-5[2] one of the three versions of the self-assessment tool used to evaluate PTSD in the Irish Defence Forces. While the PCL-M version was utilised in part one of this research, respondents highlighted that the Defence Forces exclusively use the PCL-5 for PTSD[3] evaluations. This discrepancy may help explain the initial ambiguity identified by Fiona, who suggested that participants may have interpreted the questionnaire in a way that included trauma experienced outside the military context.

Respondents familiar with the PCL-5 and its administration shared valuable insights into its application within the Defence Forces. An agreement emerged that the tool was often misunderstood by soldiers, poorly administered, inadequately screened, and misused. Additionally, there were concerns about the lack of proper recording and storage of results, pointing to systemic weaknesses in how PTSD assessments are conducted and managed.

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[1] Women of Honour is an informal group of current and former serving members of the Irish Defence Forces who have been victims of sexual assault while on service. An official investigation was ordered by the Minister of Defence in January 2022. The final report, published in March 2023, made 13 recommendations which government accepted in full

[2] The PCL-5 is a 20 item self-assessment report that assesses the 20 DSM-5 symptoms of PTSD. The purpose of the PCL-5 is to screen individuals for PTSD and make a provisional PTSD diagnosis. The PCL has 3 versions PCL-M (Military), PCL-C (Civilian) and PCL-S (Specific).

[3] At the conclusion of an Irish Defence Forces soldier's overseas deployment, a comprehensive medical examination by a military doctor is required. During this medical, all soldiers are asked to complete the PCL-5, which typically takes 5 to 10 minutes. However, this hard copy assessment is filed in the individual's medical record and is not uploaded to a centralised database or shared with other formal or informal help-providers. This examination is generally the only instance in which a soldier is assessed for PTSD, unless they present themselves to a formal help-provider, such as a medical post.

John: "The PCL-5 is not used correctly overseas its used as a general psychopathology screener and typically guys misunderstand it."

Thomas: "My understanding is that the PCL-5 is scanned onto your medical file. I would have to check who is screening the results. "

Jane: "We do use the PCL- 5 when people are being re-pathed[4], but we are not using it right and it is not recorded. We have been filling it in wrong."

John acknowledges and confirms the challenges associated with managing PTSD within the Defence Forces, emphasising that these challenges stem from systemic issues rather than individual faults.

John: "We are lacking a way of managing people post-traumatic incidents, our system is ad-hoc. "

A recurring theme across the interviews is the shared belief among key stakeholders that Defence Forces personnel are indeed experiencing PTSD. Despite this recognition, there appears to be little organisational initiative or commitment to critically evaluate the effectiveness of existing systems aimed at identifying and destigmatising PTSD. Concerns were raised regarding the absence of efforts to improve data accuracy, address inconsistencies in data collection, or develop targeted strategies to respond to cases of military-induced PTSD. This lack of systematic engagement suggests a broader institutional reluctance to confront the scope and impact of PTSD within the organisation.

In relation to alcohol consumption, the survey revealed that while male soldiers consumed more alcohol than female soldiers, both male and female soldiers consumed more alcohol than the scale average according to their gender. When presented with these findings the key stakeholders immediately spoke about the high prevalence of alcohol consumption generally and drew a line between high levels of drinking and Irish culture. This is highlighted in the following quotation:

Jane: "The drinking culture is reflective of an Irish culture "

The discussion on alcohol consumption brought attention to the role of mess facilities[5], which are established in most military installations across the country. John highlighted a potential link between high levels of drinking and the ready availability of alcohol in these facilities, particularly for soldiers stationed there. He suggested that this accessibility contributes to the issue and should be addressed.

[4] Re-pathed is a colloquial term used to describe the return of a soldier from an overseas mission to their home country.

[5] In military contexts, "mess facilities" denote the designated dining areas where service members convene to eat and socialise. The term "mess hall" derives from the Old French mes, meaning "meal."

Furthermore, he noted that many individuals tend to underestimate their alcohol intake, suggesting that the extent of the problem may be more severe than reported in this study.

> *John: "People understate their alcohol consumption. I think we need to revisit the utilities of mess facilities. The idea that alcohol is available in the workplace is archaic"*

However, there were conflicting opinions about the availability of alcohol in the mess and if this needed to be reduced or removed. This debate centred around the fact the soldiers both live and work in the barracks and are entitled to eat breakfast/lunch/dinner on the mess in addition to socialising there when they are off duty. While the availability of alcohol was seen to be archaic by John, Thomas spoke to the need to treat the solders as adults and recognise that the boundaries between work and personal space are blurred for soldiers, requiring different considerations compared to typical workplace environments.

> *Thomas: "All messes are open almost 365 days a year, for soldiers who live in. Soldiers are given access to these facilities to socialise, if we close them, we are saying we don't trust these adults with alcohol. The barracks is not just a workplace."*

The culture of alcohol misuse was referenced, with a particular focus on military culture rather than broader Irish culture, as previously mentioned. Ryan reflected on a drinking culture that existed within the Defence Forces over 20 years ago. He expressed surprise that, even now, two decades later, the survey still found elevated levels of alcohol consumption among soldiers. This highlights a potential ongoing cultural issue within the Defence Forces, where alcohol use remains prevalent despite societal changes and efforts to reduce its impact. However, there was recognition that despite efforts to reduce alcohol consumption it was acknowledged that it persisted regardless of the rules and regulations preventing it. This observation is suggestive that at least one key stakeholder is aware that soldiers are inclined to break rules when they view it as necessary, particularly in response to perceived systemic limitations.

> *Ryan: "20 years ago, we had a large culture around alcohol, it surprises me now that its high as we reduced mess hours, 80% of our deployed troops cannot drink, but let's not fool ourselves, that can drive alcohol consumption underground."*

Ryan's reflection on restrictive policies, specifically the ban on alcohol when deployed, suggests that such measures can inadvertently encourage concealment of behaviour, reinforcing a broader cultural pattern in which soldiers may prioritise self-preservation over institutional compliance. This perspective is consistent with

findings from this study, which indicate that similar dynamics shape help-seeking for mental health issues. In both cases, the tension between individual needs and perceived organisational expectations leads to behaviour being pushed into informal or hidden channels, undermining transparency and reducing the effectiveness of formal support systems.

Peter further attributed the elevated levels of alcohol consumption among soldiers to its role as a coping mechanism. Notably, the use of the verb *"combat"* to describe addressing various issues reflects a distinctive military vernacular. This phrasing may hint at an unconscious cultural conditioning, possibly revealing how deeply military norms subtly shape stakeholders' perspectives.

> *Peter: "So, people use alcohol to combat relationship issues. They use it to combat mental health issues. They use it to combat financial issues."*

Ryan proposed a recommendation to address alcohol consumption among soldiers by fostering a healthier relationship with alcohol. He suggested offering non-alcoholic beverages as alternatives to traditional alcoholic options in military mess facilities, creating a more balanced and inclusive environment that encourages moderation and responsible choices.

> *Ryan: "We need to do more with non-alcoholic drinks. I don't drink so I have a coke in military mess events where I'd be more comfortable drinking a Heineken 00(alcohol free). "*

Key stakeholders recognised that the organisation is failing to adequately address the issue of excessive alcohol consumption among its personnel. While efforts such as the introduction of non-alcoholic beverages have been made, stakeholders acknowledged that overconsumption of alcohol remains a persistent and unresolved problem within the Defence Forces.

The topic of suicidality was discussed in response to the survey's key findings, which were viewed by the key stakeholders as alarming. The data revealed that 9% of participants reported having made a serious suicide attempt, 34% of participants had experienced suicidal ideation, and 10% of participants had engaged in self-harm without intent to die. Of particular concern was the 6% of participants who reported a suicide attempt within the week prior to taking the survey. These findings raised serious concerns among key stakeholder and their initial reflections centred on the potential risk created by the organisation itself, particularly the routine access that soldiers have to firearms. Stakeholders questioned whether this accessibility may inadvertently increase the likelihood of self-directed violence among personnel.

John: "Suicide: 9% is very high. 6% in the last week is hugely concerning. We are giving these people guns. This is the most significant finding so far. "

Jane, reflecting on the key findings, also expressed particular concern over the 6% of participants who had recently attempted suicide. Her worry, again, centred on the potential that these individuals may have had access to weapons, raising critical questions about risk management.

Jane: "Ideation and self-harm are not as concerning as handing weapons to the 6% suicide attempts declared in the last week."

Her comment draws attention to the risk of individuals experiencing distress having immediate access to firearms. Interpreted in the military context, this suggests that access to lethal means may amplify the danger of suicide attempts compared with civilian populations.

Ryan expressed particular concern over the finding that 34% of participants reported experiencing suicidal ideation. For him, this figure appeared abnormal and raised alarm about its potential implications. He viewed suicidal ideation as a critical warning sign and a possible pathway to more severe mental health crises.

Ryan: "Ideation: I think it high, it's not normal thoughts, if you're thinking about suicide, there is a reason, and that reason can lead to more serious things for that person. "

These concerns raised by key stakeholders, underscore the reality that highly vulnerable individuals are operating within the organisation, yet their mental health struggles remain largely invisible to the system. Furthermore, John's insight into the impact of suicidal behaviour on leadership and decision-making responsibilities among military officers, such as lieutenants and captains, highlights the profound effect this issue has on the core leadership structure within the Defence Forces. His concern underscores the significant risks posed not only to the individual officer but also to their team, particularly in high-pressure or operational environments. This reflection reveals a fundamental structural challenge, as the mental well-being of leaders directly influences their ability to make sound decisions and effectively support their subordinates.

John:" A lieutenant or a captain who is suicidal can't be counted on to make sensible decisions or life preserving decisions of the men under their command. "

While discussions largely centred on mental health challenges in high-stakes environments, particularly where lives are at risk, it was notable that no concrete solutions were proposed to address concerns surrounding suicide, suicide

ideation, and self-harm, unlike the preventative measures suggested for issues such as alcohol consumption. This highlights the complexity of these issues within the military, where systemic and cultural factors likely contribute to the difficulty in formulating effective interventions.

However, one respondent provided a valuable perspective, emphasising the interconnectedness of mental health conditions such as PTSD, depression, and anxiety in increasing suicide risk. They also pointed to a broader systemic issue, namely, the persistent understrength of organisational personnel, which may be exacerbating mental health challenges among soldiers.

> *Ryan:" Suicide is the most disturbing finding and PTSD depression, and anxiety can feed into this. We are understrength so we are away from home more now and the work to home life is unbalanced."*

The link between various mental health challenges and their contribution to the findings on suicide attempts is further emphasised in the following comment.

> *Fiona:" Severe anxiety and severe depression are comparable and linked to suicide. "*

This perspective underscores how conditions such as PTSD, depression, and anxiety may collectively increase the risk of suicide, highlighting the need for a more integrated and proactive approach to mental health support within the Defence Forces.

When examining gender differences in suicide attempts from the key findings, Fiona was the only respondent who identified the findings for female participants as particularly concerning. She contextualised these results by drawing comparisons to existing military literature, suggesting that female personnel may face unique stressors or barriers to support that contribute to their elevated risk.

> *Fiona:" Suicide: It's high for females…. There is an alarming trend among militaries that women have higher numbers of serious suicide attempts. "*

Fiona shared a personal perspective on working with soldiers experiencing suicidal ideation and behaviours, challenging the common belief within military culture that admitting to suicidal thoughts or attempts is a career-ending event. She emphasised that recovery from suicidal symptoms does not necessarily preclude a fulfilling military career. However, while Fiona's account was based on her own experiences, she was unable to provide supporting data from military records to validate this claim or demonstrate broader trends within the Defence Forces.

> *Fiona: "After suicide, if you're symptom free, and you're safe and you're stable on medication for whatever number of months you are back on*

operations. I don't have figures to know how often this does happen, but it does happen. "

Fiona's statement introduces a rare and significant counterpoint to the dominant narrative found across the interviews, by emphasising the potential for recovery and reintegration following a period of suicidal ideation or behaviour. Her acknowledgement that individuals can return to operational duties once symptom-free and stable on medication suggests a more nuanced and hopeful view of mental health recovery within the military context. Notably, Fiona is the only respondent to articulate the possibility of a continued military career after such experiences. This perspective challenges prevailing assumptions that suicidality automatically leads to exclusion from service and highlights the importance of recognising recovery as a viable and supported outcome within military mental health provision systems.

While the findings on self-harm did not prompt extensive discussion among respondents, Ryan expressed concern over the issue but noted that he lacked direct experience dealing with military personnel who had self-harmed.

Ryan: "Self-harm: 10% I have never dealt with anyone in my last 17 years of operational troops. Self-harm means there is a problem, so what is that problem. It's very concerning to me. "

Conversely, Jane was surprised that only 10% of participants reported self-harm, believing the actual prevalence could be higher. She suggested that self-harm might be a common coping mechanism among younger soldiers, indicating that the issue could be more widespread than reflected in the survey findings.

Jane: "Self-harm: I think 10% is a low number, it's a form of coping mechanism, in my experienced the numbers are higher. The younger generation use self-harm as a coping strategy. "

Jane was the only stakeholder unsurprised by the 10% self-harm rate reported in the survey. Based on her experience, she suggested that the true prevalence may be higher than reported, pointing to the likelihood of under-reporting in this area.

7.3.2 Stakeholder Insights into Factors Hindering Engagement with Professional Services

The military environment is traditionally characterised by values such as resilience, discipline, and cohesion. While these traits are essential for operational effectiveness, they may simultaneously discourage expressions of vulnerability. As outlined in Chapters 2 & 3, this cultural paradox undermines help-seeking behaviours by framing psychological distress as a threat to perceived strength and competence. Stakeholders acknowledged this contradiction, noting that fears

surrounding career impact and stigma were anecdotally understood prior to the survey results. The findings reinforced what many already recognised as a deeply ingrained cultural norm.

Thomas, for example, expressed little surprise that personnel avoid using formal services:

> *Thomas: "I'm not surprised 55% of people don't use the medical system."*

Similarly, Ryan and Fiona identified stigma as a significant deterrent:

> *Ryan: "People say no to using medical services because they are protecting their career. There is a stigma to mental health."*

> *Fiona: "I think people are not willing to engage in mental health conversations because of the stigma."*

These perspectives affirm that within the military context, seeking help is often interpreted not as a proactive step towards recovery, but as a risk to professional standing and personal identity.

'In addition to the issue of stigma discussed by participants, Peter offered a more layered view of military culture, acknowledging its potential to both protect and endanger mental wellbeing. His reflection speaks to the structural and psychological dualities that shape mental health engagement in military settings:

> *Peter: "Military culture has both protective and risk factors; sometimes they are both the cause and the solution to a problem."*

This duality is particularly salient in contexts where rigid expectations of strength and stoicism coexist with unspoken struggles. Peter further explained the psychological toll of acknowledging a mental health condition in such an environment:

> *Peter: "A diagnosis of a mental health issue affects self-worth and self-view. If the armour is broken, they feel weak."*

The vernacular use of *"armour"* is particularly revealing. In military culture, armour symbolises protection, strength, and invulnerability, both physically and metaphorically. By invoking this imagery, Peter illustrated how soldiers perceive mental health difficulties not merely as individual struggles but as breaches in their protective identity as resilient service members.

This metaphor highlights how internalised beliefs about weakness and vulnerability become barriers to seeking support. Soldiers who view their *"armour"* as damaged may experience diminished self-worth, fear of exposure,

and reluctance to admit to psychological distress. The framing of mental health through the language of armour underscores the influence of military culture on self-perceptions and shows how deeply ingrained notions of toughness can compound stigma and hinder engagement with professional services.

A recurring concern among stakeholders was the reliance on informal support mechanisms, particularly peer-led interventions which they perceived as a means of avoiding formal documentation ("*no one finds out*"). Peter drew attention to the institutional invisibility of these interactions, pointing to a critical gap in how the organisation monitors and responds to mental health needs:

> *Peter: "Peer support accounting for mental health engagement at 63% sounds right, sure, no one finds out."*

His observation reflects the deliberate avoidance of formal pathways due to concerns about confidentiality and the career implications of having a mental health record. This avoidance is not necessarily indicative of denial or disengagement, but rather a calculated decision to manage risk in a system perceived as punitive, which is supported by the survey findings. Jane supported this view, attributing the avoidance of formal systems to widespread cultural beliefs about the negative consequences of disclosure:

> *Jane: "People do believe there are negative consequences associated with disclosing anything to chain of command."*

This reinforces the idea that silence is not merely a cultural norm but a survival strategy within the military context. Soldiers weigh the potential benefits of support against the perceived costs to their career, reputation, and sense of belonging.

Collectively, the reflections provided by stakeholders offered a broad understanding of the barriers to help-seeking. Their insights highlighted not only the personal and cultural challenges faced by soldiers, but also the organisational structures that reinforce avoidance behaviours. These barriers, rooted in stigma, fear, and institutional silence, have a compounding effect, resulting in the underreporting of mental health issues and reduced engagement with formal services.

The data suggest that meaningful change requires both cultural and structural reform. Addressing the stigma attached to mental health, enhancing psychological safety, and ensuring confidentiality in help-provision systems are all necessary to shift the current trajectory. Stakeholders' contributions in this section reflect the depth of experience within the organisation and illustrate a shared awareness of

the critical need to create an environment where seeking support is not viewed as weakness, but as a protected and respected act of strength.

7.4 The Cost of Mental Health: Cultural Challenges and Barriers to Help-Seeking in the Defence Forces

The reluctance of Defence Forces personnel to access formal mental health support systems emerged as one of the most striking findings in Part 1 of this study. A substantial proportion of respondents reported avoiding professional services altogether: 55% were unwilling to engage with medical services, 41% expressed hesitation about consulting social workers, 75% actively avoided the chain of command, and 39% were reluctant to approach the organisation's mental health specialist. These figures highlight a critical cultural problem embedded within the Defence Forces, one in which stigma, confidentiality concerns, and fear of career repercussions work collectively to deter personnel from seeking support. This section explores these barriers through the lens of stakeholder perspectives and emphasises how entrenched cultural norms within the military institution contribute to the persistence of help-seeking avoidance.

Stigma and the fear of professional consequences are widely recognised issues with help provision for mental health issue. A recurring theme throughout stakeholder interviews was the perceived professional cost of acknowledging a mental health problem. Stigma remains deeply rooted in military culture, functioning as a powerful deterrent to disclosure. The association between mental health difficulties and weakness continues to pervade the organisation, shaping behaviours and reinforcing silence. Ryan described the widespread belief that engaging with formal services may jeopardise a soldier's career trajectory:

> *Ryan: "I'm not surprised that people won't engage with the medical system. It's seen as career ending,"*
> *Ryan: "It's the stigma that people have and the view that if you have a mental health problem and get a diagnosis that it's also career ending."*

The Defence Forces' emphasis on resilience and operational readiness may inadvertently exacerbate this fear, where any indication of psychological vulnerability is interpreted as professional liability. Ryan further highlighted how restrictions on weapon access can undermine an individual's sense of role identity and competence, reinforcing their decision to avoid help-seeking altogether:

> *Ryan: "If you're taken off armed duties, so you don't have the access to the tools to do your job. We don't carry weapons all the time, but you're not allowed to do it. So, you have taken something away that someone has trained for, and they, people effectively see it as career ending."*

Peter echoed this concern, acknowledging that the fear of professional consequences often outweighs the perceived benefits of seeking help:

Peter: "It's very difficult to get away from people not coming forward when they believe their career will suffer."

Fiona offered a particularly insightful perspective, drawing attention to how perceptions of career interruption extend beyond mental health to other personal circumstances such as maternity leave. Her comparison suggests that military culture places high value on uninterrupted service, contributing to a broader institutional climate that penalises personal needs:

Fiona: "The fear of career progression is real you need good 441s[6] for officers. It is a HR problem. It's the same for females when they are on maternity leave … it interferes with their career progression because of the time they lose due to having babies, it's the same for mental health."

Ryan also articulated a cultural distinction in how physical and mental injuries are treated within the Defence Forces, with physical injuries being more socially and professionally acceptable:

Ryan: "There is a perception that if you go sick it will hurt your career. It's ok if you break your arm and go sick, but not if you have a broken head."

These reflections illustrate how mental health continues to be perceived as a stigmatising and professionally damaging issue, signalling a deeply embedded cultural reluctance to accept psychological distress as a legitimate and manageable condition.

Stakeholders also raised concerns about confidentiality concerns and mistrust in the chain of command in the Defence Forces' organisational structure and how it shapes help-seeking behaviour. A dominant theme was the widespread cultural mistrust of the chain of command, particularly with regard to the confidentiality of medical or personal information. Thomas addressed the double function of the chain of command, as both a support system and a gatekeeping authority, and how this dual role contributes to avoidance:

Thomas: "People don't trust the chain of command. Chain of command is a double-edged sword; in all militaries, it allows for a structure, and it facilitates decision making. It is what it is, it's no fault of the organisation, I'm not shocked that people won't go to chain of command in order to protect their rights to medical in confidence, but people don't want to see

[6] An **AF 441** within the Irish Defence Forces is the formal performance appraisal report utilised for officers. It plays a critical role in promotion decisions and personnel evaluations, serving as an official record of an officer's professional conduct, competencies, and overall performance.

the doctor either. I believe it's the consequence or perceived consequence of what will happen that people aren't engaging."

The chain of command was perceived not as a source of support but as a potential threat to one's privacy and professional standing. Fiona reinforced this concern, emphasising the reputational and career-related risks associated with disclosing personal difficulties:

Fiona: "Chain of command has a stigma … people don't have faith in it, don't think they will gain anything from it, even suffer from it."

Jane further highlighted the specific fear of gossip within the organisational hierarchy, where disclosure of mental health issues is viewed not only as professionally risky but socially unsafe:

Jane: "I'm not surprised with low engagement with chain of command, this is down to culture, I don't want the boss man to know. It's perceived as a confidential issue, if you're in trouble the last person you tell is the boss because he will tell everyone else."

These comments reflect a deep erosion of trust in the organisation's capacity to handle mental health disclosures confidentially and compassionately. They reveal that cultural fears around confidentiality are not isolated incidents but widespread and systemic.

Another cultural issue that arose was divergent perspectives on system responsibility. While most stakeholders recognised institutional factors as central to help-seeking avoidance, not all agreed on where responsibility lies. John took a contrasting stance, framing the reluctance to engage with formal services as a personal, rather than organisational, failure:

John: "I don't think the system is failing the people, I think people are failing the system."

He argued that withholding mental health disclosures is unacceptable and that cultural change must include a shift in individual responsibility:

John: "I'm normally sympathetic to the guys with mental health issues but hiding a mental health diagnosis is unacceptable."

While this perspective acknowledges the risks of non-disclosure, it may overlook the lived experience of personnel operating within an environment where help-seeking is culturally and professionally penalised. Thomas echoed a similar concern but with a more empathetic tone, acknowledging the rationality behind help-seeking avoidance while still expressing disappointment:

Thomas: "I'm aware of the reasons why people won't engage with the medical system but I'm disappointed."

Jane raised another important issue: the over-medicalisation of mental health within military culture. She explained that formal help-seeking is often associated with negative consequences, such as being downgraded, further reinforcing avoidance:

Jane: "We over medicalise in the military, and so people think they are going to be punished and downgraded."

This perception of medicalisation as punitive rather than restorative represents another layer of cultural resistance to mental health engagement.

A central concern raised by stakeholders was the need for cultural reform through education and leadership. Stakeholders widely agreed that reform efforts must include comprehensive education and leadership training. Cultural change, they argued, depends not only on structural policy but also on building psychological literacy and empathetic leadership at every level of the organisation. Thomas and Ryan identified leadership training as a vital mechanism for improving support and reducing stigma:

Thomas: "The more people that have an awareness of mental health, the better advice they can give."

Ryan: "I think mental health training has increased in the last 10 years. I want to know how the chain of command can support mental health."

This call for education reflects an understanding that formal systems cannot function effectively in a culture that equates vulnerability with weakness. For meaningful change to occur, military leaders must actively work to normalise mental health discourse, protect confidentiality, and support personnel through evidence-informed practices. Cultural awareness, empathy, and trust must be embedded across all levels of command if the Defence Forces are to move beyond a reactive, compliance-driven model to one that centres on care, dignity, and recovery.

7.5 Navigating Systemic Barriers to Mental Health Support in the Irish Defence Forces

This section presents stakeholder perspectives on the structural and institutional barriers that hinder effective mental health support within the Irish Defence Forces. Drawing on evidence from both the survey and interview phases, several key systemic challenges were identified. These include the rigidity of the medical grading system, the tension between maintaining operational safety and providing psychological support, the over-reliance on peer-led interventions, the absence of a formal mental health policy, fragmented service provision across support systems, and the persistence of institutional stigma. The following analysis explores each of these core issues in detail, beginning with the impact of disclosing a mental health condition on medical grading.

A concerning theme among stakeholders was how the current medical grading system deters personnel from seeking formal help. Medical classification is closely tied to eligibility for career progression, re-enlistment, training, and deployment. Jane noted the inconsistency in medical grading, whereby personnel can perform all duties under a Category 3 grade, yet still be deemed ineligible for contract renewal:

> *Jane: "You can still do everything at cat 3[7] but not be signed back on, it makes no sense."*

This system creates an environment in which disclosure of mental health issues, particularly when medication is prescribed by a civilian GP, is viewed as professionally risky. Thomas explained that many members choose not to disclose such treatments due to the potential impact on their medical status and career trajectory:

> *Thomas: "There is a reluctance to disclose if people are taking medication that was not prescribed by a medical officer because it will affect their medical grade and have consequences on their career potentially."*

He further commented on the prevalence of this issue identified in the survey:

[7] **Category 3** is a classification used within the Irish Defence Forces to describe a soldier's **constitution**, which refers to their overall physical and medical fitness to serve. The term encompasses an assessment of a soldier's general health, resilience, and ability to meet the physical and functional demands of military duties. This classification is typically based on medical evaluations conducted by Defence Forces medical officers and may influence a soldier's eligibility for deployment, training, or certain roles. By codifying constitution in this way, the Defence Forces establish a standardised framework for monitoring and managing the health and operational readiness of their personnel.

Thomas: "32% are on medication from a GP for mental health issue this is very concerning."

Jane talked about active efforts to engage with a representative body to challenge the mandatory medical grade requirement for all applications and appointments. The aim is to decouple career progression and assignments from strict medical grading criteria, thereby reducing barriers to seeking help and mitigating the financial and professional repercussions of medical downgrading.

Jane: "We have been arguing that we should decouple medical grades from service, and we have argued hard for that with PDFORRA[8]."

These findings highlight the critical need to reform the medical grading framework to encourage transparency without penalising personnel for managing their health.

In relation to the topic of operational readiness verses psychological safety, stakeholders reflected on the tension between maintaining universal safety and supporting personnel with mental health difficulties. While there was recognition that not all mental health challenges should be medicalised, there was an agreement that safety must remain paramount when determining access to weapons or operational roles. Fiona advocated for a more flexible personnel structure, proposing specialised appointments that do not require weapons handling:

Fiona: "There should be an alternative pathway for soldiers."

This view was echoed by Thomas, who raised the question of whether the current all-or-nothing approach to military readiness adequately serves those managing mental health conditions:

Thomas: "I think this raises the question of whether people should be streamed, as in not have to do everything, is it all or nothing?"

[8] The **Permanent Defence Force Other Ranks Representative Association (PDFORRA)** is the representative body for enlisted personnel of the Irish Defence Forces, including members of the Army, Air Corps, and Naval Service. Established to protect and promote the interests of its members, PDFORRA engages in collective representation on matters such as pay, conditions of service, welfare, and workplace rights. The association also provides support in resolving disputes, advocating for policy changes, and improving the overall working environment for enlisted Defence Forces personnel. Through structured dialogue with military management and government bodies, PDFORRA serves as a key stakeholder in the development of military employment policies in Ireland

While supporting inclusivity, these perspectives acknowledge the practical and ethical challenges of balancing psychological wellbeing with mission readiness. Thomas further elaborated on the complexities involved:

> *Thomas: "Where is the point that we say this person is safe to have access to a weapon? Does a medical issue need to be reflective in a medical grade/ classification? I think so."*

Thomas advocates for a systemic shift that would allow soldiers to occupy roles that do not require firearm authorisation. However, his perspective is tempered by the organisational imperative to maintain operational readiness, reflecting the tension between individual accommodation and institutional priorities.

> *Thomas: "I'm very empathetic to the individual because we don't want to further harm them or others but, we can't have the organisation or the mission at harm."*

John further underscores the complexity of the issue by drawing attention to the legal obligations associated with mental health disclosures. He adopts a firm stance on the non-disclosure of mental health difficulties by personnel, criticising the Defence Forces for failing to adequately address the matter. He specifically points to a systemic inaction, suggesting that as long as the consequences of non-disclosure remain hidden, the organisation is unlikely to respond. This, he argues, reflects a perception of the issue as a "victimless crime."

> *John: "Every year you are legally bound to declare that they haven't gotten a diagnosis of a mental health illness. An anti-depressant can trigger a manic episode. It's a problem to me that the Defence Forces don't see that it's a victimless crime, so no harm no foul."*

He also addressed how soldiers perceive themselves when confronted with systemic requirements,

> *John: "Soldiers feel uniquely persecuted. There are lots of jobs that require you to have a health standard."*

Although factually correct, there is a lack of empathy, and this view fails to account for the complex psychological impact of disclosing a mental health concern. Moreover, it fails to offer any alternative approach to safeguarding the individual's psychological wellbeing. Similarly, although Fiona highlights the importance of adhering to safety protocols, she too does not propose any viable systemic solution for maintaining the psychological health of the individual concerned:

Fiona: "We must have a system around safety so people who are unsafe with firearms are not deployed."

This section highlights the inherent complexity involved in balancing operational readiness with psychological safety. Regrettably, the current system prioritises operational readiness over the psychological wellbeing of individual personnel, reflecting a structural preference that often overlooks the mental health needs of service members.

Another systemic issue that was discussed by the key stakeholders was the preference for peer support. This discussion revolved around findings from the survey which revealed a marked preference for peer support over formal mental health services. Stakeholders acknowledged that peer-led interventions offer comfort, relatability, and accessibility. However, they also expressed concern that peer support is often used as a substitute, rather than a pathway, to clinical care. Thomas observed:

Thomas: "Mental health issues is a wide phrase and peer support is the base of the pyramid and is the most accessible resource for people. You will feel less uncomfortable with peer support."

While the discomfort with formal support systems is recognised, Jane assumes that peer support functions as the initial stage in the help-seeking process. However, the key findings from Part 1 do not demonstrate a consistent progression from peer support to engagement with formal services. Rather, they show that formal supports are avoided by the majority of survey participants. Her observation that individuals often perceive themselves as the problem, rather than identifying the mental health issue, underscores a critical systemic challenge. This points to a need for reform in how mental health issues are understood and addressed within the organisational structure.

Jane: "Sometimes peer support is enough. If people are struggling you don't go straight to your boss, because you highlight yourself as being a problem. So, I can see why people start at peer support and move up to the specialist counsellors and social workers and only then will it have to become medicalised."

While some respondents acknowledged that peer-led support can provide comfort and relatability, Fiona draws on the key findings related to suicidal ideation, suicide attempts, and self-harm, she questioned the adequacy of relying solely on peer support to address such serious concerns. Fiona underscores that there are alarming levels of suicidal behaviour, suggesting that the existing non-professional support structures are not performing effectively.

Fiona: "So much is invested into field teams' mental health teams and non-professional teams and when we look at suicide ideation, suicide deaths and prevention, it's not really working, it's not translating."

Additionally, stakeholders highlighted the fragmentation of help-provision services and the lack of coordination between formal and informal support providers. Peter called for the development of a seamless, integrated service:

Peter: "PSS[9] needs to keep its own data. We should have a seamless service. There is very little collaboration between the services. How do we get all the services under the same umbrella?"

Jane proposed structural changes to enhance credibility and accessibility:

Jane: "Social workers should be part of a medical team not a non-formal team."

This perspective on holistic care is proposed as a potential solution to counterbalance the prevailing reliance on peer-led support within the Defence Forces. Such a structural shift may enhance, although not necessarily guarantee, the credibility and accessibility of social workers within the broader mental health care framework. Survey findings revealed that only 42% of participants indicated a willingness to engage with social workers, highlighting a gap in trust or understanding of their role. Nonetheless, key stakeholders advocated for a more comprehensive approach to mental health support, one that integrates professional services alongside peer-led initiatives, to ensure that the diverse and complex needs of personnel are adequately addressed.

Another prominent concern raised by stakeholders was the absence of a formal mental health policy within the Irish Defence Forces. Survey findings revealed that 60% of participants believed such a policy already existed, indicating a significant misunderstanding among personnel. In reality, no formal mental health policy is currently in place. Key stakeholders offered candid reflections on how this policy gap negatively affects soldiers' willingness to seek support. Although a mental health strategy exists, its lack of clear operational guidance has contributed to inconsistent implementation and confusion across the organisation. Fiona, in particular, stressed the importance of integrating mental health into a broader, cohesive general health framework.

[9] The **Personnel Support Service (PSS)** in the Irish Defence Forces is a confidential support resource that provides welfare assistance, guidance, and referral services to serving personnel. Staffed by trained professionals, including social workers and counsellors, the PSS aims to promote wellbeing and assist with personal, family, or service-related difficulties.

Fiona: "There is a strategy for mental health but no policy. It should be part of a framework of general health not a mental health alone policy. It would help people to know how it works and what to expect."

John supported the development of a comprehensive policy:

John: "I fully agree we need a policy. A big tent policy, every help-provider involved. Some policies that I operate under have archaic language and needs an update."

The responses from Jane and Thomas underscore the urgent need for a clear, modern, and formalised mental health policy. Such a policy is essential not only for guiding individuals through appropriate mental health care procedures but also for addressing and dispelling harmful misconceptions and false rumours. As Jane noted, the absence of formal guidance contributes to confusion and misinformation, highlighting the importance of a structured policy framework to support both awareness and access to care.

Jane: "We don't have a mental health policy. There is an obligation to support the individual and the people they work with. The clear pathway on mental health care is unclear so the locker room talk is the problem."

Thomas: "We should definitely have a plan whether policy, programme or strategy is the most appropriate word.

Ryan also recognised that the absence of a formal mental health policy significantly undermines the effectiveness of help-seeking systems. He stressed that implementing such a policy could address existing systemic challenges by providing a structured, education-based framework that enhances support and improves outcomes for personnel.

Ryan: "There is no policy but there is a strategy. We need a policy to educate people. Information is required to change the system."

Thomas and Fiona advocated for an inclusive approach to policy development, emphasising the importance of involving all help-providing systems in the creation of a comprehensive mental health policy. They reiterated that a collaborative process would support the development of a more holistic framework, enabling the effective integration of both formal and informal support structures.

Thomas: "We should have a policy on mental health in the Defence Forces, it's not easy as there are so many strands to it. PSS should lead the strategy with input of key enablers such as social workers chaplains etc. We should have a more joined up approach to our mental health delivery in the Defence Forces."

> *Fiona: "All help-providers should have an input; it should be holistic. We need a policy that brings about real change."*

In their view, such an approach would contribute to the establishment of a unified and responsive system that more effectively addresses the mental health needs of Defence Forces personnel.

Stigma around mental health remains both a cultural and systemic issue. Stakeholders recognise and acknowledge the role of systemic policies and procedures in reinforcing stigma. Ryan argued that structural aspects of Defence Forces policies actively discourage disclosure:

> *Ryan: "The stigma is in our practices and procedures laid out by our policies, I'm not talking mental health policy, I'm talking HR strategies, and your career advancement and career paths, promotional prospects, annual appraisal forms. That's where the stigma is. It's a systemic issue."*

John further emphasises the need for Defence Forces help-provision systems to critically examine the stigma effect of automatic assumptions made about individuals experiencing mental health difficulties. His observation highlights the importance of cultivating greater sensitivity and awareness within these systems to prevent the reinforcement of unintentional stigma. This aligns with the wider call for structural reform in mental health support across the organisation. John's perspective draws attention to a fundamental issue: the tendency of formal military support systems to apply rigid and often reductive judgements to soldiers' mental health experiences. He explains that such responses can inadvertently create significant barriers to engagement, ultimately discouraging individuals from disclosing their struggles and increasing the risk of adverse outcomes.

> *John: "We need to be less automatic and more dynamic about our judgments. I don't want to see something bad happen because they didn't disclose their mental health issue."*

Ryan pointed out policy-level barriers that reinforce stigma:

> *Ryan: "We need to review policies; there are policies in place that are stopping people from going sick and reporting mental health issues. It is a difficult space."*

While stigma remains deeply embedded within military culture, Fiona advocated for systemic change to effectively challenge and dismantle its impact. She proposed a "waterfall effect" approach, whereby change is initiated at the highest levels of command and progressively cascades through all ranks and roles. This strategy reinforces the need for structural transformation, specifically targeting the

prevailing military culture, which she identified as a central factor in perpetuating stigma and discouraging help-seeking behaviours.

> *Fiona: "We are aware of mental health stigma, we need to engage in breaking the stigma actively, it must be top down from all levels, with emphasis on all leaders it's our responsibility."*

Another systemic challenge to stigma was identified as the need for improved education and training in mental health across all levels of the organisation. Fiona advocated for equipping leaders at every rank with the skills and knowledge necessary to normalise conversations about mental health and to foster a culture that encourages proactive help-seeking. Her perspective underscores the importance of leadership in shaping attitudes and behaviours within the Defence Forces. As she stated:

> *Fiona: "It's up to us as leaders to encourage engagement. Train them at all levels. Empowering leaders to support people."*

The stakeholders addressed institutionalised stigma and policy-level barriers as concrete; observable issues embedded within the organisational structure of the Irish Defence Forces. By framing these challenges as tangible and systemic rather than solely individual or cultural, they were able to offer clear, actionable solutions grounded in structural reform. This approach moved the conversation beyond abstract discussions of stigma, situating it within the policies, procedures, and leadership practices that shape daily experiences for personnel. The stakeholders address Institutionalised Stigma and Policy-Level Barriers as tangible objects and by doing so offered solutions including systemic reform.

7.6 Summary

This chapter explored the qualitative findings from interviews with six key stakeholders involved in mental health support within the Irish Defence Forces. The aim was to contextualise the survey results and examine systemic, cultural, and institutional factors influencing help-seeking behaviours.

Some stakeholders were surprised by the extent of the concerns revealed in the quantitative phase, particularly the high rates of anxiety, depression, PTSD, and suicidality. They affirmed that cultural stigma, fear of career repercussions, and distrust in formal systems remain major barriers to help-seeking. Although peer support was praised for its accessibility, many acknowledged it can be inadequate for addressing severe mental health crises, such as suicidal ideation.

Structural issues were also highlighted, including the rigidity of medical grading, the lack of a formal mental health policy, fragmented service provision, and the prioritisation of operational readiness over psychological wellbeing. Stakeholders proposed practical reforms, including inclusive policy development, integrated support systems, and leadership training to promote mental health awareness across all ranks.

Overall, the chapter demonstrates that meaningful improvement in mental health support requires both cultural sensitivity and systemic change, with strong leadership and clear policies essential to creating a supportive environment for Defence Forces personnel.

Chapter 8 Discussion

8.1 Introduction

This chapter presents a discussion of the key findings of the study with reference to appropriate empirical and theoretical literature. The study set out to examine the mental health issues affecting soldiers in the Irish Defence Forces, to investigate how personnel address these concerns, to determine how soldiers of all ranks currently seek help, and to explore the factors that influence help-seeking behaviour within the Irish Defence Forces. In addition, the study also aimed to explore the perspectives of senior military management regarding mental health and the help seeking behaviours of soldiers. The mixed methods approach was used to avoid the recognised and unavoidable limitations of a single method. Consequently, the research objectives were achieved through a sequential explanatory mixed methods design. This design required the study to have two distinct but interrelated phases. Part 1, the survey, was responsible for meeting objectives 1-4 regarding the mental health and wellbeing of Irish military personnel, how soldiers seek help, and what impacted the behaviour of soldiers when seeking help. Part 2, the interviews with senior military key stakeholders in mental help systems, focused on their explanations and contextualisation's of survey findings. This interaction created a valuable and unique explanatory dimension to the research. The findings from the mental health section of the survey were explained by the key stakeholders, in addition to findings relating to low levels of engagement with military help providers and the barriers and facilitators to help-seeking.

This study generated extensive findings, and these have been presented in detail in Chapters 6 and 7. This chapter focuses on the findings considered to be the most important and relevant to the study's aims and objectives. The theoretical framework of Hidden Transcripts, set out in Chapter 4, is threaded throughout the sections in this chapter. This framework serves as a structure and support for the justification of the study, the approach to the problem and acts as an anchor for the analysis.

The first section of this chapter details how the theoretical framework of hidden transcripts applies to this study. The second section discusses the prevalence of anxiety, depression, PTSD and suicide. The third section discusses sources of help utilised by soldiers. The fourth section discusses the barriers and facilitators to help-seeking in addition to organisational stressors.

8.2 Applying Hidden Transcripts to the Findings

As set out in chapter 4, hidden transcript theory relates to power and resistance. It refers to forms of resistance and dissent that are kept from those in power. According to Scott, (1990), hidden transcripts do eventually come to the surface, normally during conflict. Scott (1990), further describes the theory as ideological hegemony or 'public transcript', meaning that publicly, people pretend to follow the cultural norms and openly agree to the "cultural format" (*referring to the socially prescribed norms and rituals that signal agreement with authority, even when such compliance masks private disagreement or resistance. Within the Defence Forces, this cultural format is reflected in the public performance of discipline and resilience: saluting officers, repeating formal expressions of loyalty, or presenting oneself as fit for duty*), however, secretly the group disagree with the ideologies that inform the cultural formats. This disagreement directs various forms of thoughts and behaviours that are contrary to the cultural format. Furthermore, these thoughts and behaviours are perceived as a method to stay below the radar for the purpose of remaining safe in the face of power (Scott, 1990).

A descriptive outline of how hidden transcripts theory applies to the distinguished rank groupings identified in this study such as officers[10] and other ranks[11] is offered in chapter 4. However, a brief overview is provided here. The relationship between officers and other ranks is characterised by a distinct hierarchy. Officers typically hold leadership positions and are responsible for planning, decision making, and overall mission success. Other ranks are understood as the backbone of the military, executing tasks and carrying out operations (Irish Defence Forces, 2016). This hierarchy creates a structured environment in which rank carries significant meaning. The military operates under a strict chain of command, where orders flow downward from officers to other ranks. This structure is critical for maintaining discipline, efficiency, and clarity when executing tasks, and it requires a specific social intercourse between these groups. This interaction is one of power and domination and carries its own hidden transcripts. For other ranks, such transcripts often take the form of private dissent, concealed coping strategies, or selective silence around sensitive issues such as mental health. For officers, however, a recent paper highlights that elites also generate concealed discourses,

[10] A military officer holding a commission. Commissioned officers train and lead enlisted soldiers by protecting them, helping to boost morale, leading by example and orchestrating the professional development of their subordinates.

[11] All those who do not hold a commissioned rank. The term includes non-commissioned officers ("NCOs") and ordinary soldiers with the rank of private or regimental equivalent. Also referred to as Enlisted personnel.

often expressed as “transcripts hidden in plain sight” (Massoumi & Morgan, 2024). In a military context, these may be found in coded language around resilience, readiness, or loyalty that appears caring yet subtly reinforces stigma and institutional disinterest. Considering both perspectives demonstrates that hidden transcripts operate across the hierarchy, simultaneously expressing resistance from below and reinforcing power from above.

The Defence Forces operates under a regulatory framework known as the Defence Forces Regulations, which govern actions, behaviours, and all aspects of military culture. These regulations establish the power structure that presides over all ranks and appointments, ensuring that all military personnel are obligated to comply with provisions outlined under military law (Office of the Attorney General, 1954). Serving members are expected to openly adhere to these regulations, a dynamic referred to in this study as the public transcript. A key example of this is the expectation that soldiers will fully disclose any medical information to the military medical system, particularly when seeking treatment from a civilian doctor or local GP outside the military framework.

This structure is designed to be self-sustaining, meaning that the standards set out by the military are consistently enforced, including medical grading requirements. If a soldier cannot meet either the medical or physical grade, they are deemed unfit for duty and subsequently downgraded. While physical health issues are significant, mental health difficulties are often experienced as more complex due to the added challenge of stigma (UNC Health Caldwell, 2022). Findings from this study confirm that such stigma is deeply felt within the Defence Forces: survey participants frequently cited fear of career penalties and medical downgrading as barriers to disclosure, while interviewees described how personnel worried about being perceived as weak or judged negatively by command. These realities demonstrate how the public transcript of compliance with medical regulations carries hidden costs for soldiers with mental health needs. Consequently, many avoid formal disclosure to protect themselves, instead engaging in hidden transcripts such as silence, underreporting symptoms, or seeking external care.

The hidden transcript refers to discourse that occurs outside the direct observation of those in power, serving as a form of resistance against dominant ideologies (Marche, 2011). Within this study, the hidden transcript manifests as a fundamental disagreement with the Defence Forces' official stance on mental health treatment. This silent opposition is reflected in the widespread yet unspoken cultural behaviour of avoiding systemic help providers, indicating a disconnect between organisational policies and the lived experiences of personnel. This dissent is expressed through thoughts and behaviours that foster resistance to institutional control, allowing soldiers to reclaim a sense of

autonomy. In the context of this study, such resistance manifests in the deliberate avoidance of formal military help-provision systems and the preference for seeking mental health support outside official channels. This hidden transcript, where soldiers quietly defy regulations to navigate their military experience in a way that aligns with their personal needs, serves as the central premise for applying the theoretical framework of hidden transcripts throughout this chapter.

8.3 Prevalence and Predictors (8.3.1 Anxiety; 8.3.2 Depression; 8.3.3 Suicidality; 8.3.4 PTSD)

This section is divided into four sub-sections, each addressing the prevalence of a specific mental health issue in the context of both national and international military studies. Table 44 provides an overview of findings from five carefully selected recent studies. These comparators were chosen for their relevance to the Irish context, methodological robustness, and ability to illustrate both serving and veteran perspectives. The Irish study by Mitchell et al. (2022) offers the most immediate national benchmark, while the UK Armed Forces survey (Ministry of Defence, 2022) provides a culturally and structurally comparable reference point. Three U.S. studies (Moradi et al., 2021; Moore et al., 2023; Finnegan & Randles, 2023) were included to capture the breadth of the American literature and, importantly, to incorporate veteran populations. This selection highlights common trends across different military systems while also identifying distinctive features within the Irish Defence Forces.

Within the framework of Hidden Transcript Theory (Scott, 1990), differences between serving and veteran prevalence rates require careful interpretation. In some areas, particularly suicide attempts, veteran populations show higher prevalence (e.g., Moore et al., 2023), which may reflect reduced pressure to maintain the public transcript of resilience once service ends. In other areas, however, veteran figures appear lower than active-duty rates, as in the relatively modest PTSD prevalence reported by Finnegan & Randles (2023). These inconsistencies likely stem from methodological differences, including the use of varied instruments (e.g., PCL-M vs. PCL-5), the absence of standardised denominators in systematic or narrative reviews, and differences in sample composition between active-duty and veteran cohorts.

Interpreted through Hidden Transcript Theory, two possibilities emerge. First, veterans may disclose more openly once institutional surveillance and the career risks of medical downgrading are removed, producing higher post-service prevalence in some studies. Alternatively, the very act of resistance during service, concealing symptoms, avoiding disclosure, and relying on informal or external supports, may imbed patterns of avoidance that persist into civilian life, delaying

engagement with formal care. Both dynamics underline that prevalence differences between serving, and veteran cohorts are not only epidemiological but also cultural, shaped by institutional power, disclosure practices, and the legacies of resistance carried beyond service.

Table 44 Comparison of mental health indicators across military-related studies (non-equivalent designs)

Study / Country	Population / Sample	Anxiety	Depression	PTSD	Suicidality	Design / Data source
This research (Ireland)	N = 687 (serving)	32%	21% (severe)	25%	34% ideation; 9% attempts	Anonymous cross-sectional survey (GAD-7, PHQ-9, PCL-M) + stakeholder interviews
Mitchell et al. (2022, Ireland)	N = 231 (serving; COVID-era duties)	11.4%	20%	19%	**reported suicidality indicator(s)***	Cross-sectional survey (GAD-7, PHQ-9, PCL-5)
Ministry of Defence (UK, 2022/23 or 2023/24)	UK Armed Forces healthcare activity (not prevalence)	0.4% diagnosed anxiety disorder (DCMH caseload)	0.7% diagnosed depressive disorder (DCMH caseload)	**reported in DCMH caseload reporting ****	service-level reporting	Administrative clinical/service utilisation dataset (DCMH/primary care pathways), not survey prevalence
Moradi et al. (2021, global / military)	Multiple studies pooled (2000–2019)	–	23% (pooled)	–	11% attempts (pooled)	Systematic review + meta-analysis of cross-sectional studies with mixed instruments
Moore et al. (2023, US veterans)	Secondary sources (no original N)	15% (estimate)	15% (estimate)	16% (estimate)	18% attempts (estimate)	Narrative/educational clinical review (secondary reporting; VA/DoD estimates)

Study / Country	Population / Sample	Anxiety	Depression	PTSD	Suicidality	Design / Data source
Finnegan & Randles (2023,)	N = 2,449 (primary care records)	–	17.8%	3.4%	–	Retrospective observational study using routine primary healthcare records

** Mitchell et al. (2022). did not operationalise suicidality identically to this study; figures are not directly comparable.*
*** The MoD report presents service use/diagnosed caseload patterns, not population prevalence. Diagnostic proportions reflect those assessed in Defence Community Mental Health Services (DCMH), with most mental health care managed at primary care level.*

While Table 44 provides a useful comparative overview, direct prevalence comparisons must be interpreted cautiously because the included studies differ substantially in design, timeframes, and measurement approaches. The present study used validated self-report screening instruments (PHQ-9, GAD-7 and the military-specific PCL-M) in a cross-sectional anonymous survey, generating point estimates based on symptom thresholds rather than confirmed clinical diagnoses. Mitchell et al. (2022) similarly employed PHQ-9 and GAD-7 but assessed PTSD using the general PCL-5, limiting direct comparability with the PCL-M. In contrast, UK Ministry of Defence reporting is primarily derived from administrative and clinical service utilisation data rather than survey prevalence, meaning its diagnostic figures represent proportions identified within clinical pathways (e.g., primary care referrals and DCMH assessments) rather than population estimates across the entire Armed Forces. Moradi et al. (2021) pooled data from heterogeneous cross-sectional military studies conducted between 2000 and 2019 using varied instruments and diagnostic approaches, producing generalised pooled estimates rather than directly comparable point prevalence. Moore et al. (2023) is best classified as a narrative/educational clinical review that synthesises secondary prevalence estimates rather than collecting original data. Finally, Finnegan and Randles (2023) used primary healthcare records, which may under-detect prevalence relative to anonymous self-report surveys because identification depends on clinical presentation, diagnostic recognition, and coding practices.

Anxiety prevalence in this study (32%) was substantially higher than the closest available Irish benchmark. Mitchell et al. (2022), using a comparable survey methodology and screening instruments, reported a markedly lower rate of anxiety among Irish Defence Forces personnel (11.4%). By contrast, the UK Ministry of Defence figures cited here should not be interpreted as prevalence estimates, as they reflect **service** usage and diagnostic outcomes within military healthcare systems rather than population-level screening. Specifically, in 2023–2024 approximately 13% of UK Armed Forces personnel (n = 19,929) sought medical support for mental health difficulties, and of these, around 2% (n = 3,082) were referred onward to specialist Defence mental health services. Within the specialist cohort, a smaller proportion were clinically diagnosed with anxiety-related disorders (e.g., n = 608). These UK data therefore reflect patterns of clinical presentation and referral pathways, not underlying anxiety prevalence in the force. Nevertheless, when interpreted appropriately, they support the broader explanation emerging from this study: high anxiety burden may coexist with limited disclosure and constrained engagement with formal military systems, particularly where stigma and fear of career repercussion influence whether distress is acknowledged or treated.

Depressive symptoms were reported by 21% of participants in this study, indicating a substantial burden of low mood within the Irish Defence Forces. This figure appears broadly consistent with Mitchell et al. (2022), who reported moderate-to-severe depressive symptoms in 20% of their sample; however, this comparator should be interpreted cautiously, as their study involved a smaller cohort (n = 231) drawn from personnel deployed on COVID-19 duties, which may limit generalisability to the wider Defence Forces population. Moradi et al.'s (2021) systematic review of U.S. military samples similarly reported pooled estimates around 23%, although the included studies differed in measures and timeframes, producing generalised rather than directly comparable point prevalence. In contrast, UK Ministry of Defence mental health reports should not be interpreted as prevalence estimates. Rather than indicating that 35% of UK Armed Forces personnel experience depression, the data reflect diagnostic composition within specialist Defence mental health services: in 2023–2024, depressive episodes accounted for approximately 33% of mood disorders assessed within MOD Defence Community Mental Health Services (DCMH). When expressed against the whole force population, the proportion diagnosed with depression through these specialist services is substantially lower (approximately 0.7%), highlighting the distinction between screening-based prevalence and clinical service caseload data. Veteran estimates are similarly method-dependent; figures ranging from 15% to 18% (e.g., Moore et al., 2023; Finnegan & Randles, 2023) often reflect either synthesised secondary sources or primary healthcare records, both of which can

diverge from anonymous self-report screening. Overall, these comparisons reinforce that depression remains a persistent concern across military populations, while also demonstrating that reported rates vary significantly depending on whether data derive from anonymous survey screening, healthcare utilisation, or diagnostic records. Viewed through Hidden Transcript Theory, these methodological differences may be particularly salient: distress may be more readily disclosed in anonymous settings or post-service contexts, whereas formal reporting within active service may be shaped by institutional surveillance, medical grading concerns, and perceived career risk.

Probable PTSD prevalence in this study was 25%, indicating that one in four respondents scored above the screening threshold warranting further clinical assessment. This level is higher than the 19% reported by Mitchell et al. (2022); however, direct comparison should be made cautiously given differences in sampling and measurement. Mitchell et al. examined a smaller cohort (n = 231) associated with COVID-related Defence Forces duties, and they employed the PCL-5, a general DSM-5 PTSD measure, whereas the present study used the military-specific PCL-M, which may yield different sensitivity profiles when assessing trauma symptoms in military populations (U.S. Department of Veterans Affairs, 2023). UK Ministry of Defence mental health reporting should also not be interpreted as population prevalence. Figures cited within MOD outputs generally reflect **service utilisation and diagnostic activity**, particularly within Defence Community Mental Health Services (DCMH), rather than the true prevalence of PTSD across the whole UK Armed Forces. As such, PTSD-related estimates based on referrals or specialist caseloads are expected to be considerably lower than anonymous screening-based rates and are not directly comparable. Veteran estimates such as those reported in Moore et al. (2023) (approximately 16%) provide a useful contextual comparator but remain method-dependent, often reflecting synthesised secondary evidence rather than a single epidemiological survey. Importantly, the relatively high PTSD rate in the current study, combined with the study's findings on avoidance of military medical disclosure and preference for informal or external support, suggests the presence of a concealed burden of trauma-related distress during active service. Viewed through the lens of Hidden Transcript Theory, PTSD symptoms may remain privately managed or externally treated to avoid institutional consequences, meaning that anonymous survey designs may reveal levels of distress that are not visible within formal organisational medical systems.

In the present study, 9% of respondents reported having made a serious suicide attempt, indicating a clinically significant level of risk within currently serving Irish Defence Forces personnel. This estimate appears broadly comparable to figures reported in Mitchell et al. (2022) and to Moradi et al.'s (2021) meta-analysis of

global military studies; however, these comparisons must be interpreted cautiously due to substantial differences in sampling, context, measurement approach, and timeframe. Mitchell et al. examined a smaller, context-specific cohort (n = 231) linked to COVID-related duties, while Moradi et al. synthesised cross-sectional studies conducted across multiple countries and settings, producing pooled estimates that reflect wide heterogeneity rather than a single directly comparable prevalence figure. The U.S. veteran estimate cited by Moore et al. (2023) should also be treated as contextual rather than equivalent, as it draws on aggregated secondary sources and veteran cohorts whose exposure histories, service contexts, and post-transition risk profiles differ from active-duty populations. Nevertheless, the contrast between serving and veteran contexts remains theoretically meaningful. In the Irish Defence Forces sample, the high rate of suicide attempt history sits alongside strong evidence of avoidance of formal military disclosure systems, suggesting that suicidality may be selectively concealed during service. Viewed through the lens of Hidden Transcript Theory, silence around suicide risk may function as a protective strategy in a regulated environment where disclosure is feared to trigger stigma, medical downgrading, or career impact. This strengthens the case for prevention strategies that prioritise early identification, confidential access pathways, and culturally credible supports that reduce the perceived institutional costs of seeking help. Given the established relationship between depression and suicidality in military populations (Ramsawh et al., 2014), the findings reinforce the need for integrated prevention approaches that address both underlying distress and help-seeking barriers.

8.3.1 Anxiety

Part 1 of this study measured generalised anxiety disorder (GAD) using a self-report scale. According to the DSM-5, GAD is characterised by excessive and uncontrollable worry across multiple domains of life (American Psychiatric Association, 2013). International evidence suggests women are disproportionately affected, with depression and substance misuse often comorbid (Lawhorne-Scott & Philpott, 2015). Although research on mental health in the Irish Defence Forces is limited, relevant findings exist. Mac Mahon et al. (2016), in a qualitative follow-up to the 2015 *Have Your Say* study, reported that 31% of respondents experienced workplace-related anxiety. The present study reflects similar concerns, with 32% of participants reporting severe anxiety and a further 41% reporting moderate symptoms. These levels exceed those reported in Mitchell et al. (2022), where 11.4% of Irish Defence Forces personnel screened positive for anxiety, but align more closely with elevated international military prevalence rates (e.g., Vojvodic & Dedic, 2020). Analysis within this study of demographic patterns revealed that

officers reported higher anxiety than other ranks, while female personnel reported lower levels than their male counterparts. Among the three branches, the Air Corps reported the highest severe anxiety levels. However, none of these differences reached statistical significance. Regression analysis suggested that younger personnel and those with fewer missions reported higher anxiety. This latter association may reflect age effects, as younger members typically have had less operational exposure. More importantly, a history of suicidal ideation and deliberate self-harm emerged as the strongest predictors of anxiety, confirming the close link between generalised anxiety and more severe psychological distress (Bomyea et al., 2013; Conner et al., 2021). By contrast, variables such as gender, rank, branch, employment status, length of service, and past suicide attempts did not significantly predict anxiety.

The high prevalence of anxiety identified in this study was unexpected by several key stakeholders, who attributed the findings to a broader national increase in anxiety. Nationally, 18.5% of the Irish population has been diagnosed with a mental health condition such as anxiety, depression, or alcohol use, placing Ireland among the highest in Europe (Mental Health Ireland, 2016). Specifically, GAD affects approximately 7% of the population, with younger individuals in shift-based, trauma-exposed occupations at greatest risk (Hyland et al., 2022). In military contexts, anxiety can significantly undermine wellbeing and mission performance, contributing to distress, physical symptoms, and retention issues (Moore & Barnett, 2013). Yet, military culture often emphasises stoicism and emotional restraint, rooted in masculine norms, which may obscure anxiety and deter help-seeking (Sherman, 2007). According to Vojvodic and Dedic (2020), military personnel are exposed to higher stress than their civilian counterparts, contributing to increased psychological disturbances such as anxiety, depression, and burnout. Hourani et al. (2006) similarly noted that periods of military downsizing are linked to elevated stress, a finding that resonates in the Irish context where the Defence Forces currently operate at approximately 7,500 personnel, significantly below the recommended strength of 9,500 (Foxe, 2024). This shortfall may be exacerbating stress-related conditions, including anxiety and burnout.

Within this high-pressure environment, the anonymous survey design likely encouraged greater disclosure of mental health challenges. Shielded from institutional oversight, participants may have felt safer revealing personal experiences of anxiety. This dynamic can be interpreted through Scott's (1990) Theory of Hidden Transcripts, which explains how individuals are more likely to reveal discomfort, dissent, or vulnerability when removed from the surveillance of authority. In this case, anonymity provided a temporary space in which the "hidden

transcript" of anxiety could surface , an honest account that would otherwise remain concealed within rigid military structures.

These disclosures provide a rare insight into the psychological state of Defence Forces personnel, highlighting a dimension of distress that is often suppressed in observable settings. As Russell et al. (2022) emphasise, accurately capturing the prevalence of anxiety disorders is essential for ensuring equitable allocation of mental health resources, improving access to treatment, and safeguarding military readiness. Stakeholders interviewed in Phase 2 echoed these concerns, acknowledging that stigma continues to obscure symptoms and calling for more transparent surveillance and earlier interventions (see Chapter 7).

8.3.1(A) Organisational Stressors and Non-Operational Psychological Load

Recent research in occupational psychology has demonstrated that non-operational organisational stressors can exert an equal or greater impact on psychological wellbeing than exposure to operational environments. Chronic under manning is a recognised organisational risk factor that increases workload intensity, role overload and emotional fatigue, patterns that align with the elevated anxiety and exhaustion found in this and previous research within the Irish Defence Forces (Mac Mahon et al., 2016). These findings indicate that under manning and workload intensification are not only present within the Irish Defence Forces but are likely to represent key contributors to the heightened anxiety levels observed in this study. International evidence also shows that staff shortages and resource depletion create conditions in which demands exceed coping capacity, significantly heightening psychological strain and reducing perceptions of organisational support (Schaufeli and Bakker, 2004; Demerouti, Bakker and Leiter, 2014).

As Mac Mahon, et al., (2016) found, job insecurity and unclear career progression processes also emerged as central organisational stressors within the Irish Defence Forces. Contemporary research consistently links job insecurity with increased anxiety, reduced control and uncertainty regarding one's professional future, particularly in organisations undergoing structural change (De Witte, Pienaar and De Cuyper, 2016; Jiang and Lavaysse, 2018). Poor communication during organisational restructuring further exacerbates these effects by amplifying ambiguity and undermining trust in leadership systems. These mechanisms mirror the participant accounts in this study, where disclosing a mental health issue was believed to create ambiguity in promotion pathways and inconsistent communication were prominent contributors to anxiety.

Medical downgrading emerged as a distinct source of distress because of the perceived implications for military identity, career progression and peer

reputation. Contemporary research shows that when clinical processes are believed to carry career consequences, personnel experience heightened anxiety and may avoid formal support even when symptomatic (Sharp et al., 2015; Hines et al., 2020). Evidence from modern military systems further demonstrates that perceptions that clinical engagement can affect deployment eligibility, promotability or occupational classification reduce willingness to seek help, indicating that anxiety surrounding medical downgrading has both structural and cultural origins within military organisations (Sharp et al., 2015; Hines et al., 2020).

When participants were asked about help-seeking for mental health issues, they also described a substantial organisational and administrative load that included bureaucratic complexity, unclear procedural guidance and limited resource availability. Organisational research notes that such environments contribute to cumulative psychological load, particularly when individuals perceive their organisation as a source of stress rather than a buffer against it (Bakker and Demerouti, 2017; Berthelsen, Nielsen and Kristensen, 2018). High organisational demands combined with limited recovery opportunities create conditions associated with chronic anxiety, emotional exhaustion and reduced help seeking behaviours.

When interpreted cumulatively, these organisational stressors offer a comprehensive explanation for the heightened anxiety levels observed in this study. They demonstrate that distress in the Irish Defence Forces cannot be attributed solely to operational exposure but instead arises within a wider organisational landscape characterised by instability, administrative burden, inconsistent communication and perceived threat to career security. Addressing these issues requires organisational level reform that reduces structural strain and enhances predictability, transparency and psychological safety.

8.3.2 Depression

This study identified a 21% prevalence of severe depressive symptoms among participants, with further cases distributed across mild to moderately severe categories. Unlike some international research that reports gender or branch-based differences in depression prevalence (Xue et al., 2015; Iverson et al., 2005), this study found minimal demographic variation: male and female personnel reported similar rates of severe depression, and while prevalence was slightly higher among other ranks compared to officers, differences across service branches were not statistically significant. These findings suggest that depression is a widespread concern within the Defence Forces and not confined to particular demographic groups, reinforcing the notion that structural factors such as gender, rank, or branch may play a relatively modest role in shaping vulnerability.

Regression analysis offered additional insight into predictors of depression. Psychological distress indicators, suicidal ideation, a history of self-harm, and prior suicide attempts, emerged as the strongest predictors of elevated PHQ-9 scores. While this relationship is well established in the wider clinical literature (Ramsawh et al., 2014; Kelley et al., 2017), its confirmation in the current study strengthens the validity of the findings and underscores the close association between depression and prior psychological crises in a military context. Rather than representing a novel discovery, these results highlight the robustness of the survey instruments and the importance of prioritising suicide prevention and early intervention within Defence Forces' mental health strategies. Operational experience also showed a modest association, with personnel reporting more overseas missions scoring slightly lower on depression measures. While this might suggest that exposure builds resilience, it is equally plausible that the effect reflects age differences, since younger personnel tend to have fewer missions and may also be more vulnerable to psychological distress. Thus, any interpretation of operational experience as protective should be treated with caution.

Stakeholder interviews offered a valuable lens through which to interpret these quantitative findings. Many were surprised at the scale of depressive symptoms revealed in the survey, although several acknowledged that the results reflected what they had observed in practice. Importantly, they noted that depression is often underreported within the Defence Forces' medical system, as personnel are reluctant to disclose symptoms for fear of stigma, career repercussions, or medical downgrading. This behaviour can be understood through the lens of Hidden Transcript Theory (Scott, 1990), where public compliance with expectations of resilience masks private struggles that are voiced only in safe or anonymous spaces. The survey's anonymous format may therefore have allowed participants to disclose symptoms they would not ordinarily admit in formal medical settings, offering a rare insight into the "hidden transcript" of depression within the military.

Placing these findings in a national context reveals both alignment and cause for concern. Major depressive disorder affects around 11.9% of adults in Ireland (Hyland et al., 2022), with broader mental health conditions estimated at 18.5% (Mental Health Ireland, 2016), and lifetime prevalence of depression ranging from 12% to 20% (Trinity College Dublin, 2024). Against this background, the 21% prevalence of severe depression in the current study indicates a considerably elevated burden among Defence Forces personnel. These results are consistent with Mitchell et al. (2022), who reported moderate-to-severe depression at 20% within an Irish Defence Forces sample, suggesting that the issue is persistent across different studies and methodologies.

Overall, these findings position depression as one of the most significant mental health challenges facing Irish Defence Forces personnel. The data emphasise that interventions should focus less on demographic targeting and more on addressing stigma, facilitating early disclosure, and providing safe, confidential pathways for care. Moreover, the strong overlap between depression and markers of acute psychological distress highlights the importance of integrated prevention strategies that simultaneously address depression, suicidal ideation, and self-harm. In doing so, the Defence Forces can begin to shift from a culture of suppression and silence to one of proactive mental health support.

8.3.3 Suicidality

A key finding from this study indicated that 1 in 11 participants, or 9%, had made a serious attempt to take their own life. Among officers, 6% reported such attempts, which was lower than the 10% reported by other ranks. Female personnel recorded a slightly higher rate at 10% compared to 8% for males. By branch, the Navy showed a marginally elevated rate at 10%, followed by the Army at 9% and the Air Corps at 8%. However, no statistically significant differences emerged across these groups. In addition, 34% of participants reported experiencing suicidal ideation, while 10% reported engaging in self-harm, with no significant variation across gender, rank, or branch.

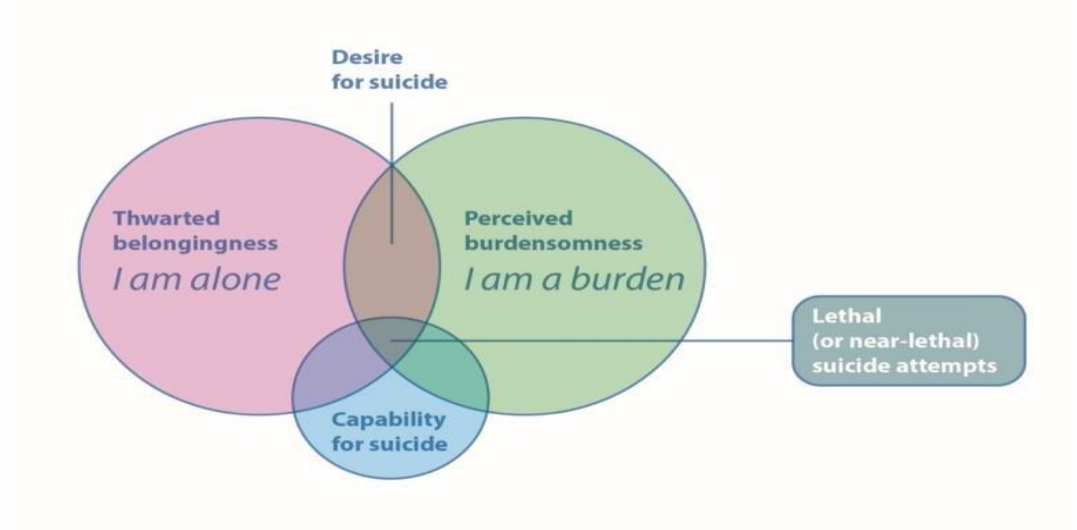
The findings on suicidal behaviour from Part 1 were discussed with key stakeholders in Part 2, who expressed considerable surprise at both the scale and severity of these issues. The 9% of participants who reported a prior suicide attempt was described as being of “critical importance” (see Chapter 7). Some stakeholders also believed that self-harm may have been underreported, pointing to the hidden nature of these behaviours within a military culture that discourages disclosure. This response highlights a disconnect between what is captured in formal systems and what emerges when personnel are afforded the safety of anonymity.

These results must be understood in the broader context of earlier findings from this study. High rates of depression (21% severe) and anxiety (32% severe) are directly relevant, since both conditions are recognised precursors to suicidal ideation and attempts (Ramsawh et al., 2014; Kelley et al., 2017). Furthermore, the elevated PTSD prevalence (25%) adds another layer of risk, as international studies consistently demonstrate a strong association between PTSD and suicidality (Panagioti et al., 2012). This interconnectedness suggests that suicidal behaviours among Defence Forces personnel cannot be viewed as isolated outcomes but

rather as extensions of broader psychological distress patterns already documented in this population.

Although suicide is a complex outcome with multiple pathways, insights from survivors can improve understanding and prevention efforts (Hawton, 2002). However, as Klonsky et al. (2017) note, while depression, hopelessness, and psychiatric disorders strongly predict suicidal ideation, they do not reliably predict which individuals will go on to attempt suicide. This underscores the importance of additional contextual and environmental factors. In military populations, Lim et al.'s (2019) meta-analysis highlights substance abuse and firearm access as key contributors to suicidal behaviour. Both issues emerged in this study: high levels of alcohol consumption were reported, and stakeholders voiced specific concerns about suicidal personnel maintaining routine access to weapons.

Figure 26 The Interpersonal-Psychological Theory model of suicidal behaviour



The Interpersonal-Psychological Theory (IPT) of suicidal behaviour (Van Orden et al., 2010) provides a particularly valid framework for interpreting the findings of this study within the Defence Forces. IPT proposes that suicide risk arises when three constructs converge: thwarted belongingness, perceived burdensomeness,

and acquired capability. Van Heeringen (2018) explains that while no single factor is sufficient on its own, their combination substantially increases the likelihood of suicidal behaviour. This framework is highly applicable in the military context. Thwarted belongingness can emerge where personnel feel isolated from peers or disconnected from the unit ethos, particularly during medical downgrading or career disruption. Perceived burdensomeness may be intensified by the belief that mental health difficulties undermine operational effectiveness or create additional workload for colleagues. The most distinctive dimension of IPT for military populations, however, is acquired capability. As Joiner (2005) notes, acquired capability involves diminished fear of death and an increased tolerance for pain. In the Defence Forces, these traits may be heightened through repeated exposure to traumatic events, rigorous training, and the occupational requirement to overcome fear and endure hardship (Selby et al., 2009). Moreover, Bryan et al. (2010) demonstrate that comorbid conditions such as depression, anxiety, and PTSD , all of which were found at elevated levels in this study , can compound the effects of thwarted belongingness and burdensomeness, thereby strengthening IPT's explanatory power in military populations. In this way, IPT not only contextualises the findings of suicide attempts, ideation, and self-harm in this research but also highlights specific intervention points. Strategies that foster belongingness, reduce perceived burdensomeness, and mitigate occupational desensitisation to pain and death may disrupt the convergence of risk factors and provide a more effective foundation for prevention efforts in the Defence Forces.

Historical evidence illustrates the Defence Forces' specific vulnerabilities. Mahon et al. (2005) found that between 1970 and 2002, the suicide rate among Irish Defence Forces personnel was 15.3 per 100,000, with firearms involved in 53% of cases , a disproportionately higher figure than in the general population (Central Statistics Office, 2021). The overrepresentation of firearms in military suicides highlights the environmental contribution to acquired capability. Mahon et al. (2005) also identified recent medical downgrading as an independent risk factor, linking institutional processes directly to heightened suicide risk. The U.S. military has responded to similar challenges with comprehensive prevention strategies. These include the Military Crisis Line, offering 24/7 confidential access to trained counsellors (Military One Source, 2024), and a broader prevention framework centred on five lines of effort: fostering a supportive environment, improving access to care, addressing stigma, revising suicide prevention training, and promoting lethal means safety (Secretary of Defense, 2023). Such initiatives reflect a systemic recognition of suicide risk factors and the need for coordinated responses. While contexts differ, similar multifaceted strategies may be required within the Irish Defence Forces, particularly given that 9% of participants in this study may be at risk of reattempting suicide.

The issue of self-harm, reported by 10% of participants, is equally significant. Self-harm is frequently used as a coping mechanism for psychological distress, particularly among younger populations (Woodley et al., 2021). Importantly, it rarely occurs in isolation: research shows it is often comorbid with depression, anxiety, and PTSD (Bentley et al., 2015). This reinforces its dual role as both an immediate expression of distress and a marker of heightened suicide risk (Persano, 2022; Long et al., 2013). The cyclical nature of self-harm, whereby individuals may repeatedly engage in self-injury, adds complexity to military mental health management, requiring sustained monitoring and intervention. Effectively addressing self-harm requires systematic data collection efforts, proactive mental health screening, and targeted interventions to ensure timely identification and adequate support for personnel experiencing distress.

The hidden transcript theory provides a further interpretive lens. Soldiers may avoid disclosing suicidality, self-harm, or even severe depression due to fears of medical downgrading, career penalties, or expulsion. Scott (1990) and Gaventa (1982) describe this dynamic as a form of intimidation or "anticipated reactions," where individuals comply outwardly with dominant expectations while concealing dissent or vulnerability. In this study, the reluctance to engage with military medical systems can be understood as a hidden transcript, where silence becomes a survival strategy within rigid hierarchies. This highlights how power, stigma, and institutional regulation shape not only help-seeking behaviour but also the visibility of suicidality itself.

8.3.4 PTSD

This study identified a probable PTSD prevalence of 25%, meaning that one in four participants scored above the threshold at which a structured clinical assessment would ordinarily be warranted under DSM-5 criteria (American Psychiatric Association, 2013). This finding highlights a significant burden of trauma-related symptoms within the Defence Forces and underscores the need for systematic attention to PTSD. Stakeholders interviewed in Part 2 acknowledged the lack of reliable organisational data on this issue, reinforcing the importance of independent research in filling that gap. While resilience training is routinely provided, the high prevalence reported here suggests that such programmes may be insufficient to prevent trauma-related difficulties. Moreover, the strong associations between PTSD, depression, anxiety, and suicidality documented in international research (Forbes et al., 2016; Livingston et al., 2020; Obuobi-Donkor et al., 2022; Judkins et al., 2020) point to the wider implications of these findings for both individual wellbeing and operational readiness.

The regression analysis within this current research identified key psychological risk factors associated with higher levels of PTSD symptoms among military personnel. While the model demonstrated only modest explanatory power, it still provided valuable insights into the predictors of PTSD. The most significant contributors were past experiences of psychological distress, including suicidal ideation, self-harm, and previous suicide attempts. Personnel who had encountered these issues reported notably higher PTSD scores, indicating a clear link between prior mental health struggles and the severity of trauma-related symptoms. In contrast, structural and occupational variables, such as gender, rank, age, branch of service, length of time served, and the number of missions, were not found to significantly influence PTSD outcomes. This suggests that personal psychological history, rather than demographic or service characteristics, plays a more critical role in shaping PTSD severity. These findings emphasise the importance of early identification and support for individuals with a history of psychological distress, as they may be particularly vulnerable to experiencing more severe trauma-related outcomes.

While PTSD screenings are routinely conducted during Irish overseas deployments, stakeholders in this study questioned their effectiveness. They noted that personnel often complete the hard copy forms superficially, treating them as an administrative exercise rather than a meaningful clinical tool. As a result, these screenings may fail to capture the complexity of trauma responses. Moreover, current procedures appear limited in scope: once completed, forms are stored in individual files rather than collated into a broader dataset, reducing opportunities for systematic monitoring or follow-up. This lack of integration contributes to weak referral pathways and undermines the potential for early intervention. More effective screening protocols, combined with structured referral routes into care, could help to ensure that PTSD is identified and addressed at an earlier stage. International research indicates that preventive, trauma-focused strategies delivered prior to deployment, such as resilience training that explicitly addresses psychological as well as physical readiness, can reduce the risk of post-traumatic stress (Forbes et al., 2016). Within the Defence Forces, however, stakeholders observed the absence of targeted education on PTSD, its treatment, and reintegration back into service. This gap reinforces a reactive, rather than proactive, approach to mental health. Challenging this position is critical if screening and prevention are to become effective, moving the organisation away from viewing PTSD as an administrative formality and toward recognising it as a condition requiring ongoing support and systemic change.

The PTSD findings also suggest that the Defence Forces may also benefit from considering applicants' previous trauma exposure during recruitment, as those with a pre-existing history of trauma, specifically suicidality, could be more

vulnerable to developing PTSD during their military careers. Although this study did not explicitly investigate sexual trauma, existing literature indicates that survivors of military sexual trauma (MST) face heightened suicide risks (Blais et al., 2023). Consequently, while the current research cannot conclusively identify all PTSD sources within the Defence Forces, sexual trauma remains a potential contributing factor that warrants further attention.

The link between trauma exposure and mental health disorders is well established, with trauma often preceding the onset of mental health issues (McKay et al., 2021). Benjet et al. (2016) found that 70% of adults in Ireland in 2016 had experienced at least one traumatic event, a figure consistent with global assessments. By 2021, this number increased to 82% of the population in the Republic of Ireland, with high rates of comorbidity between PTSD and major depression or general anxiety, particularly among those diagnosed with Complex PTSD (Hyland et al., 2022). Globally, while 70% of individuals are exposed to traumatic events, only a minority (5.6%) develop PTSD. However, this rate escalates to 15.3% for those exposed to violent conflict or war, and PTSD rates are particularly elevated following incidents of sexual violence (World Health Organization, 2024).

Most key stakeholders in Part 2 agreed that PTSD is underdiagnosed in the Defence Forces, raising concerns about a hidden population of soldiers, particularly officers, who may be operating with undiagnosed PTSD or receiving treatment outside the military without disclosing it. Recent evidence has highlighted the potential of eye movement desensitisation and reprocessing (EMDR) as an effective intervention for post-traumatic stress disorder (PTSD), particularly in populations affected by conflict. Wippich et al. (2024) evaluated the use of EMDR in a large cohort of 268 adults residing in Lebanon, including both local citizens and refugees displaced from neighbouring conflict zones. The study reported significant reductions in PTSD symptoms, alongside improvements in anxiety and depression, with benefits sustained at six-month follow-up. Importantly, these outcomes were observed in participants drawn from socioeconomically disadvantaged and displaced populations, groups that often mirror the heightened vulnerability and occupational stress experienced by military personnel.

The findings of Wippich et al. (2024) carry direct implications for the Irish Defence Forces. While Irish soldiers may not always operate in active conflict zones, many have been deployed to unstable environments where exposure to trauma, moral injury, and operational stressors is common. The demonstrated efficacy of EMDR in conflict-affected civilian and refugee groups suggests its potential transferability to military contexts, where barriers such as stigma, confidentiality concerns, and limited access to tailored psychological services frequently impede help-seeking.

Moreover, the sustained improvements documented in this study reinforce EMDR's promise as a treatment that not only addresses acute symptoms but also provides longer-term psychological resilience.

For the Defence Forces, where mental health policy and service provision remain underdeveloped, EMDR represents a viable therapeutic option that could be integrated into existing structures within the Medical Corps or through external partnerships. Its demonstrated effectiveness in under-researched and resource-constrained settings strengthens the argument for its adoption within a relatively small military such as the Irish Defence Forces. Incorporating EMDR as part of a broader suite of trauma-focused interventions could therefore help to reduce the burden of PTSD among personnel, enhance operational readiness, and signal an institutional commitment to psychological well-being.

8.4 Help-Seeking: Patterns and Determinants

This study is the first to examine factors associated with help-seeking behaviours among military personnel in the Irish Defence Forces. A key finding was that soldiers frequently diverted away from formal internal military mental health services due to fears around confidentiality, stigma, medical downgrading, reduced deployment opportunities, and negative career consequences. Instead, many reported seeking support from peers and externally, often through civilian providers, while concealing this from the military system. This pattern reflects what might be termed selective help-seeking, whereby personnel engage with supports but deliberately avoid internal disclosure. Career concerns and perceived stigma were the primary influences shaping these decisions, echoing findings from other military populations internationally (Cuyler & Guerrero, 2019; Britt et al., 2020; Blais et al., 2023). Informal support networks, including family, friends, and organisational peer support systems, also played a prominent role in help-seeking within this study. This aligns with international research: Boyd (2017) found that informal support was the primary source of help among New Zealand Defence Force personnel, while Stevelink et al. (2019) reported that 86% of UK service members preferred informal sources such as friends and colleagues. These studies reinforce the importance of informal networks in shaping engagement with mental health support. Spiritual fitness has also been recognised as a dimension of resilience and readiness, encompassing personal sources of hope, meaning, and purpose (Worthington & Deuster, 2018; Hufford et al., 2010; Jonas et al., 2010). Within the Defence Forces, this reflects the broader landscape of non-clinical supports available to personnel.

Findings from this study align with Mitchell et al. (2022), who similarly noted that Defence Forces personnel were reluctant to use internal counselling services and often relied on external supports. Mitchell et al. warned that such diversion from military systems heightens vulnerability to psychological distress and undermines organisational effectiveness. Comparable conclusions were drawn by Sturgeon-Clegg and McCauley (2019) and Gould et al. (2010), who identified stigma and career concerns as recurring deterrents to military mental health service use.

Decision-making on seeking help within the military context is significantly influenced by the stigma associated with mental health issues. Despite increasing efforts to challenge this stigma in many countries, it remains a powerful deterrent, particularly for men (Robertson et al., 2018). Within military organisations, where men constitute the majority (Goldstein, 2001), this stigma is further amplified by traditional masculine ideologies embedded in military culture (Silvestrini & Jessica, 2023). Phillips (2005) highlights that Western concepts of masculinity often emphasise stoicism, self-reliance, and a reluctance to seek help. This mindset is intensified in the military, where self-stigmatisation becomes more pronounced thus prioritising the needs of the unit over the needs of the individual, leading soldiers to view mental health struggles as a sign of weakness (Vogel et al., 2007). A further complexity to military formal help-providers are the contradictions faced by military professionals, particularly the dual obligations they hold towards individual service members and military command structures (Waitzkin et al., 2018). This may contradict the doctors Hippocratic Oath of “At first do no harm”, an ethical obligation set out to protect their patient, specifically medical confidentiality (JMIR, 2022), as all military doctors are obliged to disclose certain medical concerns, like suicide ideation, to a non-medical Unit Commander (Irish Defence Forces, 2015)

Survey findings in this study revealed clear patterns in how soldiers accessed support for mental health difficulties. Formal help sources were generally underutilised. Peer support (29%) and the Personnel Support Service (27%) were the most frequently used, while the Chaplain service (8%) and the Chain of Command (12%) had the lowest engagement. Given the relatively high levels of mental health difficulties within the sample, these figures point to significant barriers preventing the use of formal supports.

A comparative perspective is provided by UK armed forces data, which show that 12% of personnel sought help within military healthcare systems for mental health reasons in 2021/2022. Most were managed by their medical officer, a role akin to a civilian GP, with women more likely than men to access care. Conditions most often treated included PTSD, mood disorders, and substance misuse (Ministry of Defence, 2022). However, a limitation of this dataset is that personnel treated

solely by their GP were excluded due to gaps in electronic data management. This omission demonstrates how difficult it can be to fully capture help-seeking prevalence without comprehensive systems in place.

In this study, participants were also asked about their willingness to seek help if they developed a mental health problem. Peer support again dominated, with 63% of respondents expressing preference for this option. External help providers were the next most popular (60%), followed by the Personnel Support Service (56%). In contrast, the Chain of Command (12%), Chaplain service (24%), and military medical system (32%) were least preferred. Most strikingly, 78% of participants stated they would not disclose a mental health issue to the military medical system. This suggests that nearly eight in ten personnel would avoid formal disclosure, underlining widespread reluctance to engage with organisational supports.

These findings strongly resonate with Scott's (1990) theory of hidden transcripts, which distinguishes between the public transcript of outward compliance and the hidden transcript of private resistance. On the surface, soldiers appear to conform to Defence Forces regulations that require engagement with the military medical system. However, the survey data reveal a different reality: the widespread avoidance of disclosure to the military medical service signals an undercurrent of resistance to institutional power. In bypassing official channels, personnel are enacting a covert strategy to preserve a "clean" medical record and safeguard career opportunities, particularly in relation to overseas service and promotion. This silent defiance reflects not an outright challenge to authority but a calculated effort to protect personal and professional interests within a tightly regulated system. In this sense, the preference for peer support or external providers is not simply a matter of convenience but an act of self-preservation that pushes back against the risks embedded in the organisation's medical regime.

Scott (1991, p. 109) argues that forced compliance rarely generates genuine assent; instead, it produces hidden forms of resistance that persist beneath the surface of formal obedience. The Defence Forces' regulations, which mandate disclosure of any civilian medical engagement, exemplify this tension. While compliance can be compelled, it does not erase private beliefs that such rules are unfair or harmful. Rather, the imposition of mandatory reporting requirements may inoculate soldiers against voluntary compliance, encouraging them to conceal or manage their difficulties outside the system when possible. In this study, the reliance on peers, the avoidance of formal disclosure, and even the covert use of civilian-prescribed medication together represents a hidden transcript of resistance. These practices challenge the assumption that military personnel fully

accept the authority of the medical system and reveal how soldiers negotiate autonomy within the constraints of hierarchical power.

Open-ended survey data further illuminated this dynamic. An overwhelming 94% of participants believed that disclosure to a military doctor would result in negative consequences, while only 6% anticipated a positive outcome. Notably, none of the female participants expected a favourable response. Such attitudes are reinforced by Defence Forces regulations, which mandate that any engagement with a civilian doctor regarding mental health must be reported to the military system. Non-disclosure constitutes a breach of military law (Irish Defence Forces, 2015). This compulsory reporting requirement may paradoxically increase concealment of help-seeking, exacerbate stigma and reinforce barriers.

The survey also found that 78% of participants believed they would face discrimination if they revealed a mental health problem to a colleague or commander. This reflects entrenched cultural stigma, where disclosure is equated with weakness and where command expectations encourage personnel to manage difficulties independently (Kaplan, 2019). Military leadership tends to prioritise medicalised responses to mental health, favouring clinical diagnosis and treatment over non-clinical or preventative supports (Fikretoglu et al., 2022),while broader society increasingly recognises the role of spirituality, self-help, and alternative practices in maintaining well-being (Watts, 2022). Military leadership may therefore need to consider more diverse approaches to care that grant personnel a greater sense of agency.

Additional evidence from this study suggests acts of quiet resistance already occur. While 61% of respondents reported being registered with a civilian GP, 21% disclosed taking medication for a mental health problem not prescribed by a military doctor. This direct contradiction of Defence Forces regulations can be interpreted as a form of defiance against institutional constraints, reflecting soldiers' prioritisation of personal well-being and career protection over strict compliance with regulations. Mac Mahon et al. (2016) similarly found that only 42.9% of Defence Forces personnel were satisfied with medical care, while 32.5% expressed dissatisfaction. One significant concern was the perception that medical engagement could negatively affect opportunities for overseas service, an issue particularly salient for personnel with fewer years of service. This suggests that perceptions of career risk play a central role in avoidance of formal care.

These findings demonstrate that barriers to help-seeking are rooted not only in stigma but also in the structural and regulatory frameworks of the Defence Forces. Formal compliance is maintained, but resistance emerges in the form of non-disclosure, avoidance of military medical systems, and reliance on peers, external supports, or covert civilian care. These behaviours highlight a hidden transcript of

defiance that reflects both cultural stigma and rational self-preservation in response to perceived organisational risks

Survey findings revealed that only 32% of participants reported a willingness to engage with the military medical system, indicating a significant gap between need and utilisation. Interviews with key stakeholders further illuminated this avoidance, attributing it to stigma, fear of career repercussions, and concerns about diminished self-worth within a traditionally masculine culture. These deterrents reflect a wider institutional context in which vulnerability is suppressed, limiting access to appropriate care. Stakeholders' reflections were particularly striking given their dual position as both service providers and potential service users. Their recognition of the system's limitations points to a quiet, collective resistance to institutional authority that transcends rank and role. Within this culture, withholding disclosure is not necessarily denial but a calculated protective strategy aimed at preserving career progression and safeguarding one's military experience.

Survey data also revealed that 33% of participants sought support externally. Officers (25%) were statistically less likely to do so compared to other ranks (35%), a reluctance that may be shaped by perceptions of leadership expectations. Research suggests that employees with mental health issues are often viewed as less leader-like, undermining their credibility and effectiveness (Cloutier & Barling, 2023). For officers, whose careers depend heavily on perceptions of strength and competence, this dynamic may intensify self-stigma and discourage disclosure. Group comparisons on the Stigma and Self-Stigma Scale (SASS) revealed no significant differences by branch, rank, or gender, indicating that self-stigma is a pervasive feature of Defence Forces culture rather than one confined to particular subgroups. However, the distribution of scores showed that more than one-third of participants (36.3%) reported very high levels of self-stigma (≥18), with 14.7% reaching the maximum score of 25, suggesting this is a widespread and deeply embedded phenomenon. Within this context, qualitative interviews highlighted that officers may experience these dynamics with particular intensity, as their careers depend heavily on perceptions of strength and competence. While the quantitative data did not show rank-based variation, the qualitative insights suggest that the reputational and career costs associated with disclosure may amplify the lived impact of self-stigma for officers. Interestingly, officers were somewhat more inclined than other ranks to raise concerns through the chain of command, one of the least used help providers in this study. Britt et al. (2019) and Sinclair and Britt (2013) note that officers often perceive mental health symptoms as self-limiting and prefer to manage difficulties independently, reflecting a cultural emphasis on hardiness and self-reliance within the officer corps.

These findings must be considered in the context of military identity. Traits such as masculinity, courage, and resilience have historically been central to military culture (Mathers, 2018). Yet, as Norheim-Martinsen (2016) argues, contemporary social change, including globalisation, shifting missions, and increasing individualism, has created tensions between traditional military values and modern societal expectations. Participation in this anonymous survey itself may reflect an emerging cultural shift: more than 700 Defence Forces personnel engaged with questions that directly addressed mental health, a subject that has historically been neither widely acknowledged nor openly discussed in military contexts (Nash et al., 2009). While anonymity likely reduced perceived risk, the scale of engagement suggests growing recognition of the importance of this issue among serving personnel.

Gender differences provide further nuance. Female soldiers (48%) were statistically more likely to seek external support than male soldiers (30%), suggesting greater willingness to seek help but also highlighting potential barriers within the Defence Forces. Given that women make up less than 7% of personnel, with around half also mothers (Corcoran, 2020), this minority status may exacerbate challenges such as discrimination, gender bias, and limited family support (Adelheid, 2024). These pressures may help explain the preference among female soldiers for external rather than internal sources of support.

Peer support emerged as the most popular form of help-seeking. Its appeal lies in its “invisibility”: interactions leave no formal record and thus avoid potential career implications. While this protects personnel from stigma or repercussions, reliance on peer support also has limitations. Evidence suggests its clinical impact is modest (Smit et al., 2023), and without structured training, peer supporters may lack the skills needed for effective intervention (Mikolajczak-Degrauwe et al., 2023). In the Irish Defence Forces, participation in programmes such as Mental Health First Aid remains voluntary, with no formal qualification requirements for peer supporters. Consequently, soldiers may prioritise preserving a positive military experience over seeking professional medical help, but in doing so, risk compromising the long-term effectiveness of their recovery.

International military mental health practice commonly distinguishes between proactive occupational mental health systems and reactive clinical responses. Proactive approaches conceptualise mental health as an occupational function that supports operational effectiveness, rather than solely as a clinical service accessed once symptoms become severe (Castro et al., 2006). Within this model, early identification and intervention are prioritised in order to prevent the escalation of distress and functional deterioration (Adler et al., 2011; Jones et al., 2010).

Many forces, particularly the United States, the United Kingdom and Canada, operationalise this approach through forward mental health teams or Combat and Operational Stress Control units that embed mental health professionals within operational environments (Benedek et al., 2007; Greenberg et al., 2015). These teams provide rapid assessment, brief intervention, stabilisation and guidance at or near the point of stress exposure, thereby normalising stress reactions and promoting early support within the operational context (Jones and Wessely, 2001).

In contrast, the Irish Defence Forces do not deploy embedded mental health assets and do not operate structured early intervention systems during overseas operations other than deploying a Chaplin with each mission to fulfil this role. Consequently, mental healthcare is typically initiated only when personnel present with functional impairment, acute psychological distress, or when medical classification changes become necessary. This produces a predominantly reactive model of mental health management that differs substantially from the preventative, occupationally integrated approaches employed within several comparable international militaries.

A defining feature of proactive operational mental health is the use of the PIE model, which emphasises Proximity, Immediacy and Expectation of recovery. The model was first developed in military psychiatry during the First and Second World Wars (Artiss, 1966; Jones and Wessely, 2003) and was later refined through its application in subsequent operational environments (Greenberg et al., 2015). PIE principles involve treating stress reactions as close as possible to the frontline, within the shortest possible time frame, and with an expectation of return to duty (Jones and Wessely, 2003). Evidence from both British and American research shows that PIE-based interventions reduce long-term psychiatric morbidity by preventing the crystallisation of acute stress into chronic conditions (Greenberg et al., 2015; Jones and Greenberg, 2021; Benedek, Wynn and Ursano, 2007).

Forward psychiatry or forward mental health teams extend these principles by embedding mental health practitioners within operational theatres. This approach enables rapid assessment, stabilisation, normalisation and graduated return to duty for personnel experiencing acute stress reactions and also supports commanders in identifying early warning signs and implementing stress mitigation strategies across units (Jones et al., 2010; Adler et al., 2011; Greenberg et al., 2015). These capabilities are not currently incorporated into Irish Defence Forces deployment structures. The absence of embedded support means that personnel experiencing operational stress or non-operational strain must wait until symptoms escalate enough to warrant formal referral once home, which is inconsistent with best practice in occupational mental health.

A further distinction between proactive and reactive mental health systems lies in the organisational philosophy applied to psychological care. Proactive approaches include routine psychological preparation before deployment, ongoing monitoring during operations and structured reintegration programmes on return, all of which are recommended elements of contemporary occupational mental health practice in military contexts (Adler, et al. 2011; Greenberg et al., 2014). These approaches are designed to reduce the onset of preventable stress reactions, to promote early intervention and to normalise help-seeking as part of routine military functioning.

Reactive systems, by contrast, tend to respond only when crisis, functional impairment or medical risk has emerged (Jones et al., 2017). Research across the United Kingdom, United States and Canada demonstrate that reactive approaches are associated with delayed presentation, heightened stigma and increased symptom chronicity, partly because personnel perceive mental health engagement as a signal of failure or unfitness rather than as a preventative measure (Jones et al., 2010; Greene-Shortridge, et al., 2007). The findings of this study, including high levels of anxiety and reluctance to seek help until symptoms become severe, reflect these dynamics and align with international evidence that reactive models indirectly reinforce avoidance and exacerbate distress.

Strengthening the Irish Defence Forces' approach to operational mental health therefore requires moving towards proactive, embedded and preventative systems that are widely used in comparable militaries. Such models, which include forward mental health assets, routine psychosocial monitoring and structured reintegration, are associated with better outcomes and reduced long-term psychiatric morbidity (Greenberg et al., 2015; Jones and Wessely, 2003).

8.5 The complex interplay of barriers and facilitators to help-provision

8.5.1 Help-Seeking: Influencing Components

Despite the availability of both medical and non-medical systems of help provision within the Irish Defence Forces, soldiers continue to report a reluctance to engage with these services. Across a sample of 687 service members, fewer than half (46%) reported having sought professional support for a mental health concern at any point during their military careers, while a majority (54%) indicated they had

never done so. This gap between available resources and actual utilisation suggests that substantial barriers, whether cultural, logistical, or perceptual, continue to inhibit help-seeking within the Defence Forces.

When historical help-seeking was examined by rank and gender, no significant differences were identified, with officers and other ranks showing comparable rates of past help-seeking, as did male and female personnel. However, meaningful differences emerged at the branch level. Personnel in the Air Corps reported the highest rate of mental health service use at 57.6%, compared to 45.7% in the Navy and 40.8% in the Army. These disparities suggest that organisational or environmental factors, such as leadership support, unit culture, or the presence of embedded mental health professionals, may influence whether individuals seek help.

Regression analysis supported these patterns, identifying service branch and gender as significant predictors of help-seeking. Air Corps personnel and women were slightly more likely to have accessed support. In contrast, those who had seriously contemplated suicide were less likely to seek help, despite their heightened vulnerability. This inverse relationship highlights a critical concern: the individuals most in need may be the least likely to engage with mental health services. Research suggests that stigma, fear of disclosure, and hopelessness associated with suicidal ideation may discourage help-seeking (Bryan et al., 2014; Hom et al., 2017), while in military contexts additional fears of career repercussions may exacerbate avoidance.

Building on the finding that 93.4% of participants expressed a willingness to use mental health services if needed, further analysis revealed that this openness was consistent across both rank and service branch, indicating broadly positive attitudes toward mental health care across the Defence Forces. However, a gender difference was observed: female personnel were more likely than males to report being unsure or unwilling to seek help, suggesting a need for gender-sensitive approaches to strengthen help-seeking confidence among women in the organisation.

The regression analysis provided further insight. While the overall model accounted for only a small proportion of the variance in willingness to seek help (2.1%), one significant pattern emerged. Individuals who had previously attempted suicide were more likely to report a willingness to use mental health services in the future. This suggests that lived experience of a critical mental health crisis can shift attitudes, making personnel more open to professional support, whereas ideation alone may reinforce avoidance. These findings suggest that while attitudes toward accessing care appear broadly positive, intentions are shaped more by prior experience of distress than by demographic or occupational

variables (Gulliver et al., 2010). This points to the importance of early intervention strategies that reach individuals before crisis points occur, while also addressing the structural and cultural barriers that persist despite high reported willingness.

When examining the differences of willingness to use specific help-provision services between branches of the Defence Forces, Army personnel were found to be statistically less willing to engage with various support systems, including the Personnel Support Service, Defence Forces mental health specialists, Chain of Command, and peer support, compared to their Navy and Air Corps counterparts. This trend may suggest that Army personnel may perceive mental health treatment as less effective or efficient compared to medical help for physical issues, a perception common in military populations internationally (Britt et al., 2018).

Organisational Identity Theory offers an important lens for understanding help-seeking reluctance in military settings. According to this perspective, individuals internalise organisational norms and values as part of their self-concept, creating alignment between personal identity and organisational expectations (Ashforth and Mael, 1989). In the Irish Defence Forces, cultural narratives that valorise toughness, dependability and emotional control form a central part of organisational identity. When personnel consider seeking help, they are not only making a personal decision but also negotiating the potential threat to their sense of belonging and alignment with the organisational ideal. This explains why participants in this study described help seeking as behaviour that risks being perceived as weakness rather than an appropriate response to distress.

Social Identity Theory further strengthens this explanation by emphasising the influence of group membership on behaviour. Military identity functions as a powerful in-group, sustained by shared experiences, interdependence and strong social cohesion (Haslam, 2004). Within such contexts, individuals regulate their behaviour to conform to group norms and avoid behaviours that could jeopardise their acceptance or status. Help seeking may therefore be interpreted as deviation from group expectations, particularly in environments where emotional endurance and reliability are highly valued. This dynamic helps explain the high levels of fear of judgement, reputational harm and career impact reported in this study.

These identity processes interact with the hidden transcripts described earlier. Personnel manage a public identity that aligns with organisational expectations and a private identity that contains fears, distress or dissatisfaction. Help seeking collapses this divide by exposing private struggles to organisational scrutiny. Organisational Identity Theory and Social Identity Theory therefore provide essential insight into why individuals may choose silence, self-management or

avoidance even when experiencing significant distress. They also help explain why formal help providers described hesitancy, concealment and selective disclosure as routine features of interaction within the Irish Defence Forces.

Understanding help seeking through identity frameworks shifts the interpretation from individual weakness to organisational dynamics. It highlights the need for leadership practices and organisational cultures that make help seeking compatible with military identity, rather than in conflict with it. In doing so, these theories support a more integrated explanation of how stigma, cultural norms and organisational structures combine to shape behaviour.

8.5.2 The Dynamics of Masculinity in Military Settings

These findings strongly align with Objective 4 of this study, which sought to investigate the factors impacting help-seeking. One of the clearest cultural barriers is the military construction of masculinity, centred on resilience, stoicism, and self-reliance. By framing psychological distress as weakness, these norms discourage disclosure. This was reflected in the current study, where only 46% of participants reported they have sought help for a mental health problem however, the largest portion of them used the Personnel Support Service which does not record official data on service users, highlighting that the influence of military masculinity extends throughout the organisation.

Goffman's (1961) concept of the 'total institution' helps explain these findings. The Defence Forces embody many of its features: centralised authority, rigid routines, and a prioritisation of institutional goals over individual autonomy. Within this context, acknowledging vulnerability may be seen as failing to uphold the resocialised ideals of toughness and resilience. Soldiers in this study appeared to resist these pressures by bypassing formal systems in favour of peers or external providers, behaviours more consistent with Scott's (1990) hidden transcripts than with Goffman's notion of total compliance. While Goffman is useful for highlighting structural control, he risks underestimating agency; this study demonstrates how personnel actively negotiate these pressures.

Military training reinforces centralised authority. Brookes (2003) and Hale (2008) show how the desire to "knuckle down" and achieve self-improvement is embedded in training. Callahan (2009) and Peterson et al. (2023) explain that deliberate exposure to stress is used to foster self-reliance, duty, and discipline. These processes are essential for military effectiveness but may inadvertently intensify stigma, making help-seeking appear contrary to the very values instilled in recruits. Barrett (1996) and Sjoberg (2009) demonstrate that these norms apply across genders, producing a military masculinity that elevates toughness and emotional control while marginalising empathy and vulnerability. Kulesza et al.

(2015) argue that this hierarchy frames distress as failure, a pattern evident in this study's findings of widespread avoidance of formal care.

Over time, these traits may crystallise into what Locke (2013) terms *hegemonic masculinity*, a dominance maintained through cultural norms and institutional practices. This helps explain why even officers, who hold formal authority, may hesitate to seek help, fearing reputational or career costs. The challenge, then, is whether hegemonic masculinity can be reinterpreted rather than dismantled. Concepts such as egalitarian or inclusive masculinities suggest that resilience, courage, and leadership could be reframed to include openness about mental health without undermining military identity (Clary, Pena & Smith, 2023)

Intersectionality[12] further complicates this picture. Deckha (2008) highlights how gender, race, class, sexuality, and other identities intersect with rank hierarchies to shape personal experience. In the Defence Forces, a male-dominated history (Corcoran, 2020) combines with minority identities to intensify barriers to help-seeking. Connell and Messerschmidt (2005) and Hill Collins and Bilge (2016) argue that reliance on a single axis of power, such as masculinity, fails to capture this complexity. These dynamics link back to Goffman's (1961) total institution. The pressure to conform and the resocialisation process leave little room for individuality, making it difficult to resist dominant expectations. Yet, as Scott (1990) highlights, soldiers carve out hidden spaces of resistance, whether through reliance on peers or seeking external providers. The interaction between hegemonic masculinity, lack of recognition of diversity, and the institutional drive for conformity creates an environment where concealment of mental health struggles becomes adaptive. See thematic diagram below.

[12] Intersectionality is an analytical framework used to study how societies treat people based on their various social and political identities, such as their gender, ethnicity, and sexuality. Depending on those identities, a person may be privileged or oppressed.

Figure 27 Thematic diagram of factors influencing help-seeking in the Defence Forces

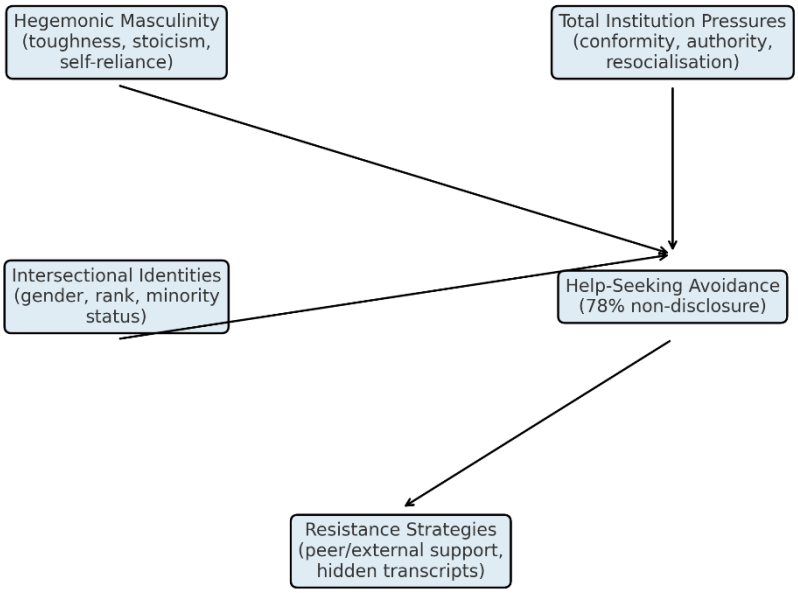


Figure 27 illustrates the factors influencing help-seeking in the Defence Forces. Hegemonic masculinity, total institution dynamics, and intersectional identities reinforce barriers to disclosure, while resistance strategies such as reliance on peers or external supports emerge as alternative pathways. This research suggests that hegemonic masculinity and the absence of recognition of diversity procedure powerful barriers to help-seeking. The Irish Defence Forces face a cultural tension: the very traits that sustain operational effectiveness may undermine psychological openness and care. Addressing this does not require dismantling military identity but reframing it, developing more inclusive masculinities and acknowledging diversity, so that strength and authenticity can coexist with the realities of mental health.

8.5.3 Confronting Cultural Stigma and Barriers in Mental Health Services

Stigma emerged as a consistent barrier to help-seeking in this study. Using the Stigma and Barriers to Care Scale (Britt et al., 2008), the mean score of 1.56 (SD = 0.57) indicated high concern about embarrassment, peer judgement, and career repercussions. These worries were widespread, with no significant differences by rank, gender, or service length. Branch-level variation was noted, however, with Army personnel reporting the highest stigma and the Navy the lowest, suggesting that unit culture and leadership climates shape attitudes.

Regression analysis confirmed the uniformity of these concerns, as demographic and occupational factors explained little variance. Only one predictor reached significance: personnel with a history of serious suicide attempts reported slightly higher stigma, pointing to the paradox that those at greatest risk may also feel most constrained by stigma-related beliefs. Patterns of self-stigma reinforced these findings. On the Self-Stigma of Seeking Help Scale (SASS), nearly one-third of respondents scored high, while 22% did not complete the scale, perhaps reflecting discomfort with self-disclosure. Again, no demographic or branch differences were evident, underscoring the pervasiveness of internalised stigma across the Defence Forces.

The disjunction between reported willingness and actual barriers was prominent while over 90% of participants said they would seek help if needed, most also endorsed fears of stigma, especially when engaging with formal systems such as the medical corps or chain of command. Stakeholder interviews echoed this pattern, identifying career damage, perceptions of weakness, and embarrassment as central deterrents. These dynamics align with international evidence showing that stigma remains embedded in military culture globally (Kaplan, 2019; Bustamante, 2021; McGuffin et al., 2021). To illustrate these patterns more clearly, Table 45 summarises the main findings on stigma and self-stigma. The results highlight the tension between reported willingness to seek help and the persistent fears surrounding disclosure, particularly within formal military systems.

Table 45 Stigma and Self-Stigma Findings in Defence Forces Sample

Measure	Key Findings	Patterns by Demographics/Branch	Implications
Stigma and Barriers to Care Scale (Britt et al., 2008)	Mean score = **1.56 (SD = 0.57)** → high stigma. Army reported highest, Navy lowest.	No significant differences by gender, rank, or service length. Only suicide attempts linked to higher stigma.	Stigma is widespread and cultural rather than subgroup-specific;

Measure	Key Findings	Patterns by Demographics/Branch	Implications
			branch culture may shape levels.
Self-Stigma (SASS adaptation)	~**1/3 scored high**; 22% did not complete the scale (possible avoidance/discomfort).	No differences across gender, rank, or branch.	Self-stigma is deeply embedded and resistant to structural variation, reinforcing silence and concealment.
Willingness vs Reality	>**90% reported willingness** to seek help if needed, but fears of stigma remain pervasive.	Stakeholders confirmed stigma strongest in relation to **formal systems** (medical corps, chain of command).	Demonstrates a clear **implementation gap**: openness in principle, avoidance in practice.

Addressing these barriers will require interventions at multiple levels: branch-specific strategies to reflect cultural differences, visible leadership endorsement, and universal education campaigns to normalise distress. Without such measures, the persistence of stigma and self-stigma risks undermining the Defence Forces' capacity to provide effective mental health support.

8.6 Leadership and Organisational Levers

Leadership plays a pivotal role in shaping how mental health is perceived and addressed within the Defence Forces. In this study, both survey and interview findings underscored leadership as a key determinant of whether personnel feel safe to disclose psychological distress. Survey respondents reported fears of being judged as weak or burdensome (Chapter 6), while stakeholders highlighted that leaders at all levels bear responsibility for reducing stigma and fostering a culture of support.

Emotional intelligence (EI), defined as the ability to recognise and regulate emotions in oneself and others (Mayer & Salovey, 1995), emerged as particularly relevant. Within military contexts, EI supports resilience, empathy, and effective decision-making under pressure (Mula, 2013; Alonazi, 2020; Garcia Zea et al., 2020). Findings from this study suggest that leaders lacking these competencies may reinforce stigma, while emotionally intelligent leaders are better placed to normalise help-seeking and reduce self-stigma, an issue identified across survey

data and stakeholder interviews. Conversely, destructive leadership behaviours such as public shaming or punitive tasking (McGurk et al., 2014) were echoed in stakeholders' accounts of why personnel avoid formal support.

This dynamic reflects the survey finding that Only 25 % of respondents reported receiving any formal mental health training . This finding illustrates how leadership practices can either reinforce or dismantle barriers to help-seeking. To address this, supportive leadership must be combined with a formal Defence Forces mental health policy co-designed with civilian experts and grounded in applied military research (Kidd, 2023; Mattie et al., 2024). This alignment would help move beyond a culture of emotional suppression (Hearn, 1993) and towards one where resilience, courage, and leadership are reframed to include openness about mental health. In relation to Objective 4, which sought to investigate the factors impacting help-seeking, these findings make clear that leadership is one of the most powerful cultural levers. Leaders who model openness and empathy can reduce stigma and foster disclosure, whereas those who perpetuate negative norms intensify barriers.

8.7 Interventions: Education vs System Reform

This study found that 94% of participants believed disclosing a mental health difficulty to a military doctor would negatively impact their career, underscoring how stigma and structural barriers remain deeply embedded within the Defence Forces (chapter 6). Such concerns highlight the trust gap in formal systems and explain why external providers emerged as one of the most preferred sources of support in the survey. Participants argued that civilian services offer greater confidentiality and fewer career risks, and some recommended a hybrid unit combining civilian and military professionals to build credibility and increase uptake. Separating mental health care from the wider military medical system was widely viewed as essential to reducing attitudinal barriers.

International models highlight two distinct but complementary approaches. The first concerns educational initiatives. For example, Psychological First Aid, developed within the U.S. military, has demonstrated effectiveness in reducing acute distress (Hermosilla et al., 2023; Jacobs et al., 2016). The Defence Forces have recently introduced Mental Health First Aid (MHFA), which trains personnel to recognise and respond to psychological problems (MHFA Ireland, 2024). However, unlike in allied contexts where military specialists co-designed delivery (MHFA England, 2016; Mohatt et al., 2017), the Irish programme has not been culturally adapted into a military-specific version, raising questions about its credibility and likely uptake. The second strand relates to systemic interventions. International evidence underscores the importance of multi-level responses that go beyond individual training. Ein et al. (2024) emphasise the value of coordinated

strategies addressing systemic, social, and interpersonal barriers, while PERSEREC (2018) recommends integrating civilian providers within military systems to reduce stigma and strengthen trust. These examples suggest that while educational programmes like MHFA can build awareness and recognition of mental health issues, their impact will be limited unless supported by broader institutional reforms that reshape structures, reduce stigma, and enhance trust in military mental health systems.

Importantly, participants and stakeholders across both phases of this study emphasised that reforms cannot rely on training or service redesign alone but must be reinforced by cultural change. Embedding open conversations about mental health across all ranks was seen as vital for normalising help-seeking and dismantling stigma. International evidence echoes this view: when leaders actively support mental health initiatives and foster supportive unit environments, stigma declines, treatment attitudes improve, and service use increases (Colman et al., 2020; Britt et al., 2020).

8.8 Toward a Holistic Framework

This study revealed a striking contradiction: while 97% of participants believed that colleagues with mental health issues were fit for service, 63% preferred peer support and 60% preferred external civilian services over military systems, signalling distrust in official supports. This disconnect underscores the persistence of cultural stigma and conformity pressures within the Defence Forces. Fears of career harm, disqualification from overseas duties, or being perceived as weak continue to deter engagement with formal systems (Mac Mahon et al., 2016). Scott's (1990) theory of hidden transcripts offers insight into these dynamics. In coercive settings, individuals often publicly comply while privately resisting. In this study, personnel concealed distress or turned to external providers rather than disclose to the military medical system, reflecting a form of silent resistance to institutional expectations of toughness and resilience. Such concealment erodes trust in formal systems, weakens the doctor–patient relationship, and risks long-term resentment (Scott, 1990; Berkowitz, 2011). Stakeholders interviewed in Part 2 echoed these findings, expressing surprise at the extent of avoidance reported in the survey and acknowledging that current systems may inadvertently reinforce stigma.

To overcome these barriers, participants called for confidential, accessible pathways beyond traditional military channels. One proposed solution was a secure digital platform co-developed with civilian professionals, enabling discreet access to information and support (Parkes et al., 2023). Tele-mental health (TMH) also emerged as a promising approach. International evidence shows that audio-visual consultations, peer networks, and psychoeducational resources can mitigate

stigma, protect confidentiality, and improve access for geographically dispersed personnel (Tam-Seto et al., 2020; Grimm et al., 2024). O'Shea et al. (2019) argue that such innovations could be effectively adapted to the Irish Defence Forces, operationalised through collaboration between the Medical Corps and Personnel Support Service to signal leadership commitment to psychological wellbeing.

International models highlight the value of policy reform in reinforcing cultural change. The U.S. Department of Defense has revised Instruction 6490.08 to strengthen confidentiality and reduce stigma, while the Brandon Act (2023), passed following the suicide of a Navy Petty Officer, guarantees confidential mental health access without command involvement (Aker, 2024). Similar measures, adapted for the Irish context, could dismantle structural stigma and build a more trusted, holistic framework.

Overall, these findings point to the urgent need for a culturally attuned, inclusive approach that integrates digital innovation, civilian collaboration, and policy reform. By moving beyond narrow conceptions of conformity and masculinity, the Defence Forces could foster an environment where authenticity, confidentiality, and psychological wellbeing are supported across all ranks and generations (Mathers, 2018; Mushtaq, 2024; Heward et al., 2024).

8.9 Joint Display

Joint displays are powerful tools in mixed methods research, used to simultaneously present and compare quantitative and qualitative findings in a single, cohesive visual or tabular format. By placing different types of data side by side, such as numerical results next to thematic categories, researchers can more readily identify patterns, relationships, and contrasts that might be overlooked when examining each dataset in isolation. As Creswell and Plano Clark (2018) note, joint displays help bridge the divide between quantitative and qualitative approaches by making the connections between statistical trends and contextual explanations clearer.

According to Fetters, (2019), these displays can be created at various stages of the research process: sometimes between distinct research phases to guide further data collection or analysis, and other times after researchers have completed separate analyses of quantitative and qualitative datasets. This flexibility allows joint displays to serve not only as interpretive aids but also as catalysts for subsequent methodological decisions. By organising and visualizing the data in a structured format, researchers can engage in deeper comparisons, draw more nuanced conclusions, and communicate their findings more effectively to diverse audiences. Below is the side-by-side joint display for this research.

Table 46 Joint Display

Research Objectives	Quantitative Findings	Qualitative Findings	Meta inferences
1. Mental health issues affecting DF personnel	High prevalence of anxiety (32%), depression (21% severe), PTSD (25%) and suicidal ideation (34%)"	Mistrust in medical services / Cultural expectations of toughness/ Hidden distress reinforced by stigma	Quantitative and qualitative data converge on a significant hidden burden of psychological distress
2. How do Irish DF personnel address mental health concerns	Majority relied on informal support; low engagement with formal military systems (only 32%)"	Peer support widely preferred due to informality; concerns over confidentiality and trust in formal systems	Low formal engagement and high reliance on peer support suggests systemic distrust and cultural stigma
3. Help-seeking behaviours across all ranks	Junior ranks more likely to seek external help; officers less likely; 78% unwilling to disclose MH issues	More education and resources; cultural change: male officers reluctant to disclose; female soldiers more open but prefer non-military help-provision	Rank and gender affect disclosure rates, influenced by internalised military masculinity norms"
4. Barriers and facilitators to help-seeking	"87% fear negative career impact; 82% feel it would be embarrassing; 66% worry about peer perception	Cultural stigma, rigid hierarchy, and confidentiality concerns noted as primary barriers by stakeholders	Stigma and fear of judgement discourage help-seeking; structural reform needed to reduce perceived risks
5. Stakeholders' perspectives on help-provision and solutions	N/A – Phase 2 qualitative interviews only	Stakeholders acknowledged stigma, lack of trust, and suggested policy reform and cultural change as critical	Stakeholders support the data and call for modernised policy and improved access to confidential support

8.10 Summary

This chapter interprets the study's mixed-methods findings through the lens of Scott's Hidden Transcripts, explaining how power, hierarchy, and culture shape mental health and help-seeking in the Irish Defence Forces. The sequential explanatory design integrated a large, anonymous survey (Part 1) with interviews with senior stakeholders (Part 2), allowing quantitative prevalence estimates to be contextualised by organisational perspectives. Quantitatively, the burden of distress was substantial: severe anxiety (32%), severe depression (21%), probable PTSD (25%), and lifetime suicidal ideation (34%), with 9% reporting a prior suicide

attempt. Demographic and occupational variables explained little of this variance; instead, psychological risk markers (ideation, self-harm, previous attempts) were the strongest correlates, particularly for PTSD, while service-related factors (rank, branch, length of service, missions) generally did not predict outcomes. These patterns point to unmet need rather than subgroup-specific problems.

The chapter further demonstrates that elevated distress is not driven primarily by operational exposure alone, but is strongly shaped by non-operational organisational stressors within the Defence Forces, including under manning, workload intensification, administrative burden, and career-linked medical processes. In contrast to several comparable international militaries that employ embedded and preventative occupational mental health systems, the Irish Defence Forces largely operates a reactive model of care, which may further contribute to delayed presentation and crisis-driven engagement.

Help-seeking data revealed a pronounced implementation gap. Fewer than half had ever accessed professional support, only 32% were willing to engage the military medical system, and 78% said they would not disclose a mental health issue to it. Formal, internal services (medical corps, chain of command, chaplaincy) were least preferred; peer support and external civilian providers were most used and most acceptable. Self-stigma was widespread across rank, branch, and gender, with over one-third reporting very high internalised stigma.

Hidden Transcripts theory helps explain this paradox of high need and low disclosure. Publicly, personnel conform to the "cultural format" of toughness, resilience, and medical compliance; privately, many resist by diverting to peers or civilian care, concealing symptoms, and protecting a "clean" record to preserve deployments and promotion opportunities. Stakeholders recognised this resistance and acknowledged that current systems, particularly mandatory disclosure rules and perceived career penalties, unintentionally reinforce silence.

Culturally, hegemonic military masculinity (stoicism, self-reliance) and the Defence Forces "total institution" dynamics (centralised authority, rigid routines) normalise concealment and make vulnerability seem incompatible with the soldier ideal. Intersectional pressures (rank hierarchy, minority status in a male-dominated force) can intensify this effect. While the survey found self-stigma to be pervasive across groups, interviews suggested officers may feel the career costs of disclosure most acutely given leadership expectations. Leadership emerged as a decisive lever. Emotionally intelligent, supportive leaders can legitimise help-seeking, reduce stigma, and improve uptake; destructive leadership amplifies avoidance. Stakeholders called for a coherent DF mental health policy, co-designed with civilian experts, to anchor practice, referral pathways, confidentiality, and leader responsibilities.

The chapter distinguishes two complementary solution tracks. First, education: initiatives such as Mental Health First Aid or Psychological First Aid can build recognition and early response, provided they are adapted to Defence Forces culture and co-delivered with military specialists. Second, structural reform: integrating trusted civilian providers (e.g., a hybrid external-internal unit), strengthening confidentiality, enabling discreet access (including tele-mental health and secure digital tools), and revising policies that inadvertently penalise disclosure. International models show that multi-level interventions, culture, leadership, access, and policy, work best in combination.

Overall, the chapter concludes that the Defence Forces faces a cultural and structural trust gap: personnel largely accept the principle of care but avoid the system that delivers it. Addressing this gap requires reframing strength to include help-seeking, embedding psychologically informed leadership, and building confidential, credible pathways to support. Doing so would move the organisation from a posture of suppression and silent resistance toward one of authenticity, early intervention, and sustained psychological readiness.

Chapter 9: Limitations, Recommendations and Conclusions

9.1 Study limitations

This study advances understanding of mental health and help-seeking in the Irish Defence Forces, but several limits should be noted.

1. Scope and construct clarity. While the survey covered multiple mental-health indicators, issues such as self-harm, suicidal ideation, alcohol use, and emotional literacy could not be explored in depth. In addition, "mental health" was not formally defined, which may have led to varied interpretations. (Severe psychiatric conditions excluded by Defence Forces regulations were outside the study's intended scope.)

2. Interpreting external GP registration. The finding that 61% of respondents were registered with a civilian GP should not be read as definitive evidence of avoiding the military system. The survey did not ask whether such consultations were disclosed to military medical services (as required), so the extent of any avoidance is unknown.

3. Sampling and mode effects. COVID-19 necessitated a shift from planned, in-person paper surveys to online distribution. This may have introduced selection bias (e.g., digital access/comfort, confidentiality concerns) compared with on-site randomised administration, meaning that collection in person can ensure no participant was coerced into participation through military detail or orders.

4. Representativeness and missing demographics. Despite broad participation, some subgroups may be under-represented. The study did not disaggregate by ethnicity, sexual orientation, or religion, limiting insights into intersectional experiences and the needs of marginalised personnel.

5. Self-report and social desirability. Data rely on anonymous self-report, which can be influenced by recall error and impression management, particularly in hierarchical contexts where disclosure may feel risky.

6. Cross-sectional design. Findings capture a single time point and cannot establish causality. Longitudinal work is needed to track trajectories, policy impacts, and outcomes across careers.

7. Theoretical lens boundaries. Hidden Transcripts Theory helped explain concealment and resistance in a hierarchical system, but it may under-

capture unit-level dynamics (peer norms, local leadership) and recent organisational reforms that also shape help-seeking.

These constraints do not negate the findings; rather, they indicate where future research and more granular data collection would add precision and depth.

9.2 Recommendations

This study examined the mental health and help-seeking behaviours of currently serving personnel within the Irish Defence Forces. Based on the findings, a set of recommendations are proposed across three domains: policy development, cultural and structural reform, and future research. Together, these aim to reduce stigma, strengthen confidentiality, and build a modern, trusted mental health framework.

9.2.1 Overarching Strategic Recommendation: A Defence Forces Wide Mental Health Strategy

The primary recommendation emerging from this research is the adoption of a Defence Forces wide Mental Health Strategy. This strategy should be co-produced with personnel, families, veterans, military leaders and external experts. It should move beyond a purely medical focus and adopt an integrated, preventative and culturally informed approach. A whole-of-organisation strategy is required because the study consistently shows that mental health outcomes are shaped by organisational structures, cultural norms, leadership practices and fear of occupational consequences rather than individual characteristics alone.

This strategy should encompass prevention, early detection, education, operational mental health frameworks, leadership development, peer support, data governance, and confidential access routes. It should also set out standards for the implementation of trauma-informed practice across all levels of command and service delivery. A strategic approach would replace the fragmented, reactive model currently experienced by many personnel and would align the Defence Forces with equivalent international militaries that have successfully embedded proactive mental health frameworks.

9.2.2 Evidence-Based Organisational Reforms

The following recommendations are grounded in the quantitative and qualitative findings of this study and reflect areas where change is supported by existing literature and by personnel testimonies.

1. **Clarify organisational and command boundaries**

Participants reported uncertainty about the respective roles of commanders, medical officers and welfare staff in mental health matters. This lack of clarity intensified fears of disciplinary repercussions and contributed to reluctance to seek help. The Defence Forces should therefore provide clear, written and communicated guidance that distinguishes health-related decision making from disciplinary or administrative processes. This recommendation is directly supported by findings that personnel frequently avoid help due to concern that their difficulties will be interpreted through a disciplinary rather than supportive lens.

2. **Develop and implement a dedicated suicide prevention policy**

Although suicide emerged as a concern in both survey and interview data, there is currently no comprehensive suicide prevention framework. The Defence Forces should adopt a dedicated policy that includes evidence-based screening, risk management protocols, staff training, postvention procedures and monitoring. The need for this policy is reinforced by international evidence indicating that structured organisational responses reduce harm, and by the current absence of coordinated guidance in the Irish context.

3. **Strengthen accountability and data governance**

Participants consistently questioned the integrity and transparency of data handling, particularly in relation to confidentiality and medical grading. This lack of trust undermines help-seeking behaviour. Establishing a clear governance structure with independent oversight would enhance confidence and ensure that information is used only for appropriate clinical and occupational purposes. This step aligns directly with findings showing that poor data practices are perceived as significant barriers to accessing support.

4. **Reform medical grading and career-related processes**

Fear of downgrading or career restriction was one of the strongest predictors of help avoidance in the study. Clearer communication regarding grading criteria, appeal processes and occupational implications is required. Consideration should also be given to separating clinical decision making from career-impact assessments, where feasible, to reduce perceived punitive consequences of seeking support.

5. **Establish an integrated help-provision pathway**

The study found that personnel struggle to navigate a fragmented system involving medical officers, chaplains, peer supporters and external providers. The Defence Forces should adopt an integrated pathway that ensures coordinated care, shared standards and smooth transitions between services. This would directly respond to participant accounts of confusion, inconsistency and duplication within the current system.

6. **Leadership development and organisational culture change**

Leadership emerged as a key determinant of whether personnel felt safe to seek help. Training should therefore focus on psychological literacy, stigma reduction, trauma awareness and equitable decision making. Leaders influence help-seeking behaviour through everyday interactions, and improved training would support the development of a culture where accessing mental health support is understood as a responsible and supported action.

7. **Reform and professionalise the peer support model**

Peer support is widely used but was described as uneven and poorly supported. The Defence Forces should provide evidence-informed training, supervision and boundaries for peer supporters, ensuring they act as part of an integrated system rather than an informal substitute for formal care. This reflects participant experiences of peers shouldering complex emotional burdens without adequate organisational support.

9.2.3 Emerging and Developmental Recommendations

The following recommendations reflect promising international practice and insights generated by this study but require piloting and evaluation within the Defence Forces context before full implementation.

1. **Adopt proactive operational mental health models**

The Defence Forces currently operate a reactive care model. Drawing on international examples, consideration should be given to embedding proactive psychological preparation before deployment, continuous monitoring during operations and structured reintegration afterwards. Forward mental health assets, whether physical or digital, may also be explored. These approaches align with the study's findings on delayed help-seeking and organisational mistrust but require contextual adaptation.

2. **Expand digital and external access options**

Digital mental health services and confidential external referral routes may help address concerns about confidentiality, stigma and accessibility. These options should be piloted to ensure alignment with Defence Forces needs and to evaluate their effectiveness in the Irish context.

3. **Evaluate and adapt trauma-informed interventions**

Specific interventions such as trauma-focused therapies, reintegration programmes or structured decompression have shown promise internationally. Their relevance to Irish missions, service structures and personnel experiences should be tested through evaluation studies before widespread adoption.

9.2.4 Research Priorities

In addition to organisational and developmental reforms, the study identifies critical research needs. These include longitudinal monitoring of mental health trends, systematic examination of medical grading outcomes, evaluation of help-provision systems, investigation of suicide and self-harm patterns, and enhanced understanding of the experiences of women, minorities and soldiers transitioning out of the military. These priorities are necessary to ensure that future policy is evidence-based and responsive to the dynamic nature of Defence Forces service.

9.3 Conclusion

This study provides critical insights into the self-reported mental health experiences of Irish Defence Forces personnel and the systemic barriers that influence help-seeking behaviour. While past research on this subject has been limited, particularly in scope and sample size, the current study offers a broader, more representative analysis of personnel across rank, gender, and service branch. The findings highlight not only the prevalence of anxiety, depression, PTSD, and suicidality, but also the extent to which institutional culture impacts on open engagement with formal support systems.

The reluctance to disclose mental health concerns remains deeply embedded in the organisational framework of the Defence Forces. Soldiers appear to conceal distress out of fear of damaging their careers, being perceived as weak, or losing opportunities such as overseas deployments. These findings are consistent with broader sociocultural trends within hierarchical and masculinised institutions, where mental health struggles are often equated with personal failure. This study makes clear that the absence of a dedicated mental health policy exacerbates this climate of silence and avoidance.

Help-seeking is complicated by structural and cultural dynamics that render it an act of risk rather than one of care. Hidden Transcript Theory provided a lens

through which to understand these dynamics, revealing how power asymmetries and disciplinary systems within military life contribute to covert resistance. Soldiers often mask their psychological distress, using avoidance strategies that compromise early intervention and obscure the true scale of the problem.

Despite growing social awareness around mental health, the Defence Forces remain shaped by outdated assumptions about emotional resilience. Goffman's (1961) work on institutional settings offers a useful reminder that militaries are designed to reshape individuals in ways that may suppress personal expression, including disclosure of vulnerability. Yet this study also found that many personnel are ready for change. Their suggestions point to a desire for inclusive mental health services that protect confidentiality and offer clear, supportive pathways to care.

Key proposals include establishing a dedicated mental health unit staffed by both military and civilian professionals, introducing a formal mental health policy, and normalising open conversations about psychological wellbeing. These changes would not only improve access to care but also rebuild the fractured trust between personnel and the system intended to support them.

This study highlights that mental health in the Irish Defence Forces is shaped not only by individual vulnerabilities or operational pressures but also by organisational structures, cultural expectations and institutional practices. High levels of anxiety, reluctance to seek help, concerns about confidentiality and fear of occupational repercussions demonstrate that mental health outcomes cannot be improved without systemic reform. The Defence Forces therefore have a responsibility to create conditions where personnel are supported, valued and safe to seek help.

The recommendations in this chapter reflect this need and prioritise the development of a Defence Forces wide Mental Health Strategy that is preventative, integrated, co-produced and not purely medical in focus. Such a strategy aligns organisational structures with contemporary understandings of occupational mental health and reflects the lived experiences of personnel who participated in this research. By adopting a preventative and holistic approach, the Defence Forces can create a more supportive environment, strengthen readiness and resilience and ensure that the organisation fulfils its duty of care to those who serve within it.

Ultimately, the findings underscore the urgent need for a cultural and policy-level shift. If mental health continues to be treated as a private problem rather than a shared organisational responsibility, the Defence Forces will remain vulnerable to the long-term consequences of untreated psychological distress. Reform must

therefore prioritise prevention, confidentiality, inclusivity, and leadership-led cultural change, ensuring that no soldier feels they must suffer in silence to remain in uniform.

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Appendices

Appendix 1: Permanent Defence Force Strength, 2019–2025

Permanent Defence Force (PDF) Personnel Strength in Ireland, 2019–2025

Year	Strength (PDF)	Notes	Source
2019	8,828	Year-end reported strength.	Oireachtas Written Answer, 20 June 2023 (PQ No. 66)
2020	8,568	Reported figure in Ministerial reply.	Oireachtas Written Answer, 26 Feb 2025 (PQ No. 15)
2021	8,456	Reported figure in Ministerial reply.	Oireachtas Written Answer, 26 Feb 2025 (PQ No. 15)
2022	7,966	Decline continues; official year-end figure.	Oireachtas Written Answer, 26 Feb 2025 (PQ No. 15)
2023	7,550	End-year figure (December 2023).	Oireachtas Written Answer, 20 Feb 2024 (PQ No. 234)
2024	7,557	End-year figure (December 2024).	Oireachtas Written Answer, 26 Feb 2025 (PQ No. 15)
2025	7,497	Snapshot as of 31 January 2025.	Oireachtas Written Answer, 19 Mar 2025 (PQ No. 234)

Observations

- **Peak to trough:** From 2019 (8,828) to 2022 (7,966), the Defence Forces lost over 860 personnel.
- **Partial recovery:** Small stabilisation was seen in 2023–2024, but by early 2025 numbers fell again.
- **Branch breakdowns:** Additional Oireachtas replies provide partial branch-level data (e.g. Army ~6,100 in 2023; Air Corps ~690; Navy ~720).

Appendix 2: Ethical Permission Defence Forces and Trinity College & Amended Permissions

Óglaigh na hÉireann
DEFENCE FORCES IRELAND

Seirbhís Tacaíochta Pearsanra
Personnel Support Service (J1)

01 FEB 2020

TO: Cpl Dan FITZPATRICK
BPSSO AC PSS
HQ AC
CASEMENT

REQUEST FOR ETHICAL PERMISSION TO CONDUCT RESEARCH WITHIN THE DEFENCE FORCES

1. I refer to your request for permission to conduct your research entitled "Mental Health in the Military: A Mixed Methods Investigation of Mental Health and Help Seeking Behaviours in the Irish Defence Forces"
2. There are NO ethical objections to your proposal and permission to conduct your research is accordingly granted.
3. The Defence Forces retains the right at all times to withdraw from cooperation with your study at any time and without notice.
4. Please use this office as your principle point of contact during the conduct of your work.
5. For your information and action.

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Dan Fitzpatrick
School of Nursing & Midwifery
Trinity College Dublin
24 D'Olier Street
Dublin 2
Ireland

15th June 2020

Ref: 2020404

Title of Study: Mental health in the military: a mixed methods investigation of mental health and help seeking behaviours in the Irish Defence forces.

Dear Dan,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in April 2020. We are pleased to inform you that the above project has ethical approval to proceed.

This study has been ethically approved. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement'

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Jacintha O'Sullivan

Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee

Dan Fitzpatrick,
School of Nursing & Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2,
Ireland

21st March 2023

Ref: 2020404
Title of Study: Mental health in the military: a mixed methods investigation of mental health and help seeking behaviours in the Irish Defence forces.

Dear Dan,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in March 2023, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed. Your approval is pending subject to approval of your local DPO.

Please give specific details of the requested amendment(s):
I am seeking ethical permission to conduct a remote interview with one of my participants. I originally got approval to conduct face to face interviews. The interviewee that wants to take part is on operational duties overseas and cannot hold a face-to-face interview but is willing to do one remotely

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Jacintha O'Sullivan

Prof. Jacintha O'Sullivan
Chairperson Faculty Research Ethics Committee

Appendix 3: Study Information Sheet (Chain of Command Distribution)

Study Title

Mental Health in the Military: A Mixed Methods Investigation of Mental Health and Help-Seeking Behaviours in the Irish Defence Forces

1. Purpose

This study, conducted as part of doctoral research at Trinity College Dublin, seeks to:

- Assess the prevalence of mental health issues among Defence Forces personnel.
- Examine help-seeking behaviours, including willingness to use both military and civilian supports.
- Identify barriers and facilitators to accessing care.
- Generate evidence-based recommendations to inform Defence Forces policy and practice.

2. Procedures

- **Phase 1:** An anonymous survey was distributed to serving members. It included validated mental health screening tools (e.g., PHQ-9, GAD-7, PCL-M, AUDIT-C) and questions on stigma, disclosure, and willingness to engage with supports. Estimated completion time: 40 minutes.
- **Phase 2:** Semi-structured interviews were conducted with senior stakeholders responsible for medical, welfare, and support systems to provide organisational perspectives.

3. Ethical Considerations

- **Approval:** Ethical clearance was granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin, and the Department of Defence, Irish Defence Forces.

- **Voluntary Participation:** All participation was voluntary. Members could withdraw at any time before anonymisation.
- **Confidentiality:** Survey responses were anonymous. Interview data were pseudonymised. All data are securely stored under GDPR and Health Research Regulations 2018.
- **Support Services:** Personnel were reminded of available supports, including the Personnel Support Service, Inspire, and confidential helplines.

4. Dissemination Pathway

The information sheet was formally distributed through the chain of command as follows:

1. **Commanding Officers (COs):** Received the study brief and instructions.
2. **Unit Adjutants:** Tasked with ensuring onward circulation.
3. **Staff Officers:** Responsible for distribution to all personnel within their units.

This process ensured that all members of the Defence Forces were informed of the study in an official capacity and had equal opportunity to participate.

5. Action Required

- Ensure that all unit members are aware of the study.
- Reinforce that participation is voluntary and confidential.
- Direct any queries to the researcher (Corporal Dan Fitzpatrick, School of Nursing & Midwifery, Trinity College Dublin).

Appendix 4: Flyer

Trinity College Dublin
The University of Dublin

Óglaigh na hÉireann
IRISH DEFENCE FORCES

STRENGTHEN THE NATION

Mental Health in the Irish Defence Forces

A research project on mental health is looking for volunteers from **ALL RANKS** to participate in a confidential survey in mental health.

Place:

Date:

Time:

THIS SURVEY IS COMPLETELY ANONYMOUS

1. Participation is open to all permanent members of the Defence Forces **only**.
2. Participation is open **to all ranks and appointments.**

The study is concerned with evaluating the various mental health issues experienced by soldiers and how they interact with military help-providing services.

Fill out your survey today!

Make Your Opinion Count

All DATA WILL BE ANONYMOUS AND STORED IN ACCORDANCE WITH GENERAL DATA PROTECTION REGULATIONS (GDPR)

Appendix 5: Ethical amendment 1

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Dan Fitzpatrick,
School of Nursing & Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2,
Ireland

24th February 2022

Ref: 2020404
Title of Study: Mental health in the military: a mixed methods investigation of mental health and help seeking behaviours in the Irish Defence forces.

Dear Dan,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in February 2022, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed.

We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement.

Please give specific details of the requested amendment(s):

I am seeking ethical permission to amend only, the format of my paper survey to include a digital, online option for potential participants of the Irish Defence Forces to complete the survey.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Jacintha O'Sullivan

Prof. Jacintha O'Sullivan
Chairperson Faculty Research Ethics Committee

Appendix 6: Participant Information Leaflet (For Part 2 of the study)

Name of Study: Mental health in the military: a mixed methods investigation of mental health and help seeking behavior's in the Irish Defence Forces

Site	**Irish Air Corps**
Principal Investigator Supervisors	**Dan Fitzpatrick: Dfitzpa1@tcd.ie** **Dr Louise Doyle , Dr Brian Keogh** louise.doyle@tcd.ie Keoghbj@tcd.ie
Data Controllers	**Trinity College Dublin**
Data Protection Officer	**Data Protection Officer** **Secretary's Office** **Trinity College Dublin** **Dublin 2**

My name is Corporal Dan Fitzpatrick I am a soldier in the Irish Air Corps. I am currently studying for my PhD from Trinity College Dublin, School of Nursing. I am researching the prevalence of Mental Health issues within the Irish Defence Forces. I am also studying the experience of military personal when engaging or avoiding help seeking systems. This study is investigating these issues from the perspectives of current members of the permanent Defence Forces. At present, no literature exists on mental health and help seeking behaviours of Irish Defence Forces Personnel. Electronic surveillance data on mental health within the organisation is very limited. This study endeavours to discover what mental health issues are effecting soldiers in the Irish Defence Forces and how this impacts on soldiers who maybe coping with Mental Health issues. An exploration of what affects help seeking behaviour of soldiers will also be examined.

You are receiving this leaflet because you are a senior commander of either a help seeking system or have responsibility for Defence Forces personnel's wellbeing,

therefore, your thoughts or opinion concerning the collected data is critical to the study.

Before you decide whether or not you wish to take part, please read this information sheet carefully. Please contact Dan Fitzpatrick (01- 4037531: Dfpat1@tcd.ie) with any questions. Don't feel rushed or under pressure to make a quick decision. You should understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. You may wish to discuss it with your family, friends.

This leaflet has five main parts:

Part 1 – The Study
Part 2 – Data Protection
Part 3 – Costs, Funding and Approval
Part 4 – Future Research
Part 5 – Further Information

Part 1 – The Study

Why is this study being done?

This study is being conducted by Dan Fitzpatrick as a requirement for my PhD. I am a Corporal in the Irish Air Corps. My thesis is concerned with better understanding the state of mental health issues pertaining to soldiers in the Irish Defence Forces, and how they behave with help seeking systems contained by the military. The study is the first of its kind and will improve our understanding of the needs of soldiers in the Irish Defence Forces.

Why have I been invited to take part?

- The study is broken into 2 parts, the first, will collect anonymous data on mental health and behaviours of soldiers within the Irish Defence Forces when interacting or avoiding help seeking systems. This data will be analysed and presented to you.
- You have been invited to take part in his study because you are a senior commander of either a help seeking systems, or Defence Forces personnel's wellbeing, therefore your thoughts or opinion concerning the collected data is critical to the study.
- I am looking to interview major stakeholders (Senior Command) of healthcare and individuals in charge of the welfare of personnel within the Irish Defence Forces.

Do I have to take part? Can I withdraw?

- There is no obligation on you to participate in the study. It is voluntary. If you choose to participate you are free to withdraw your consent without having to give a reason. This means you can opt out before, during or after the interview, refuse to answer any question, turn the audio-recording off, or request to stop the interview at any time, if you decide not to participate, or if you withdraw, you will not be penalised in any way.
- Consent can be withdrawn up until the point where your data is analysed. At this stage it will be anonymised and pooled with other data and it will not then be possible to withdraw consent.
- Should you wish to withdraw consent to participate in the study up until the time the data is analysed, please contact me (Dan Fitzpatrick) at 01 4037531 or dfitzpa1@tcd.ie and I will organise this for you. I will no longer use or share your data for research from this point onwards.

How will the study be carried out?

- If you decide to take part in this study, it will involve you giving an interview with myself, Dan Fitzpatrick. Before this interview takes place, the analysed data from part 1 will be made available to you at least 2 weeks before the interview, to allow time for digestion and reflection.
- In this interview, you will be asked to comment and discuss the findings of the analysed data from part 1 of this study. The interview will provide you an opportunity to give your opinion and comment further on the findings of part 1.
- The Interview will take place at a time that is convenient for you. You have the choice of doing this interview in person at my office at the office of the Personnel Support Service, Irish Air Corps, Casement Aerodrome, Dublin 22. If you prefer I can travel to your military location or your preferred military base.

What will happen to me if I decide to take part?

- If you decide to take part in this study, you will first need to sign an explicit consent form which provides your consent for taking part in the study. This form can be sent to you by post with a stamped addressed envelope within which to return it to the researchers. If you prefer, an electronic copy can be emailed to you where you can sign it electronically and return it to the researcher.
- Once the consent form is singed, a date and time suitable for you will be selected for the interview. The interview will be audio recorded so that I can capture all of the points you make. If you do not wish for your interview to be audio recorded, you can let me know and I will do the interview without the audio-recording. The interview should take approximately 45 minutes however you can say as much or as little as you like and determine the length of the interview can finish at any time. You will have time before and after the interview to ask any questions you may have.

Are there any benefits to taking part in this research?

- The participants of part 2 will directly benefit from the data collected on mental health as it will act as an indicator of the effectiveness of current help seeking services. This can be accomplished through comparing the survey data and official medical records on the prevalence of mental health problems within the organisation. Another benefit for the participants of part 2 is it will also shed light on behavioural habits of soldiers when engaging or avoiding these systems. This insight may serve to understand how best to support soldiers who maybe working through mental health issues.

Are there any risks to me or others if I take part?

- There is no foreseeable risk to you being involved in this study

Will I be told the outcome of the study? Will I be told the results of any tests or investigations performed as part of this study that relate to me?

The findings from this study will be included in my thesis for my PhD. At the interview, you will be asked if you would like to receive a copy of the findings chapter. The thesis maybe published or parts of it published in academic journals or at conferences however no information which reveals your identity will be disclosed.

Part 2 – Data Protection

What information about me (personal data) will be used as part of this study?

- No biographical or other personal data will be collected from you as part of the study. The only data that is collected is your opinions and comments, you will be asked what could be done to improve the experiences of soldiers, noted from Key Findings from part 1 of the study.
- The survey data from part 1 is anonymous
- Part 2 of the study will have 6 participants in total

What will happen to my personal data?

- The transcripts of the interviews will be read and any personal information identifying you will be removed before analysis. However, your appointment will be visible as it would be difficult to contextualise you in the absence of your appointment.

- The transcripts will then be assigned a coded along with other transcripts, will be analysed to search for themes which will comprise the findings of the study. The audio recordings will be transcribed by myself, the researcher, Dan Fitzpatrick. The transcripts will be kept for a period of 7 years after which they will be destroyed along with your consent form.

Who will access and use my personal data as part of this study?

- Myself, Dan Fitzpatrick, the student researcher will have access to your transcripts and to your audio-recordings.

- My supervisors listed on the front page of this participant's information sheet will also have access to transcripts.

Will my personal data be kept confidential? How will my data be kept safe?

Your privacy is important to me. I take many steps to make sure that I protect your confidentiality and keep your data safe. Here are some examples of how I do this:

The researcher and supervisors are bound by a contractual code of secrecy, which highlights the importance of confidentiality. Audio-recordings and transcripts of your interview will be kept in a separate double encrypted protected file on the desktop computer of myself, the researcher. The consent forms will be kept in a locked cabinet to which only the researcher has access to. In the writing of the thesis and any subsequent publications, any information which may identify you will be removed. Training in data protection law has been undertaken by the researcher.

What is the lawful basis to use my personal data?

Under the General Data Protection Regulation (GDPR),[13] we can use your personal information for scientific research[14] (in the public interest[15]). We will also ask for your explicit consent to use your data as a requirement of the Irish Health Research Regulations.

What are my rights?

You are entitled to:

- The right to access to your data and receive a copy of it- In this study you can ask for a copy of the transcripts of your interview.
- The right to restrict or object to processing of your data
- The right to object to any further processing of the information we hold about you (except where it is de-identified)
- The right to have inaccurate information about you corrected or deleted
- The right to receive your data in a portable format and to have it transferred to another data controller
- The right to request deletion of your data

By law you can exercise the following rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research.

You can exercise these rights by contacting the researcher [Dan Fitzpatrick 01 4037531: dfitzpa1@tcd.ie] or the Trinity College Data Protection Officer, Secretary's Office, Trinity

[13] The European General Data Protection Regulation (GDPR)
[14] *Article 9(2) (j))*
[15] *(Article 6(1)(e)*

College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Part 3 – Costs, Funding and Approval

Has this study been approved by a research ethics committee?

Yes, this study has been approved by Department of Defence. Research Ethics Committee. Approval was granted on [01 February 2020].
Approval has also been granted by Faculty of Health Sciences, Trinity College Dublin

Who is organising and funding this study? Will the results be used for commercial purposes?

This research is being self- funded at present, the purpose of which is to obtain my PhD. I am not in receipt of a grant. I have an interest in improving conditions for soldiers who may be suffering with mental health problems within the Irish Defence Forces.

Is there any payment for taking part? Will it cost me anything if I agree to take part?

No, I am not paying participants to take part in the study and I am unable to provide reimbursement for expenses incurred by undertaking the interview.

Part 5 – Further Information

Who should I contact for information or complaints?

If you have any concerns or questions, you can contact:

- Principal Investigator: Dan Fitzpatrick 01 4037531 dfitzpa1@tcd.ie Irish Air Corps, Casement Aerodrome, Baldonnel. Co Dublin
- Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

You have the right to lodge a complaint with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie.

Will I be contacted again?

If you would like to take part in this study, you will be asked to sign the Consent Form on the next page. You will be given a copy of this information leaflet and the signed Consent Form to keep.

Appendix 7: Scoring Guidelines for the Generalised Anxiety Disorder Scale (GAD-7)

The **GAD-7** is a widely used, validated screening instrument for the assessment of generalised anxiety disorder (Spitzer et al., 2006). It comprises **seven items**, each rated on a 4-point Likert scale reflecting the frequency of symptoms experienced over the past two weeks.

Scoring Method

- Each item is scored as follows:
    - **0** = Not at all
    - **1** = Several days
    - **2** = More than half the days
    - **3** = Nearly every day
- Total scores range from **0 to 21**.
- Higher scores indicate greater severity of anxiety symptoms.

Cut-off Points for Symptom Severity

GAD-7 Total Score	Symptom Severity	Interpretation
0–4	Minimal	No or very low anxiety symptoms.
5–9	Mild	Possible subclinical anxiety; monitor and consider early intervention if persistent.
10–14	Moderate	Likely clinically significant anxiety; further assessment recommended.
15–21	Severe	High probability of generalised anxiety disorder; referral for diagnostic evaluation warranted.

Clinical Use and Recommendations

- A **cut-off score of ≥10** is commonly used as the threshold for identifying cases of GAD with good sensitivity (89%) and specificity (82%).
- The GAD-7 can also be used to monitor **treatment progress**, with reductions of 4 points or more often indicating clinically meaningful change.
- While primarily designed for GAD, the tool also demonstrates utility in detecting other anxiety disorders (e.g., panic disorder, social anxiety disorder, PTSD).

Application in this Study

In the current research, GAD-7 scores were used to:

1. Estimate the prevalence and severity of anxiety symptoms among Irish Defence Forces personnel.
2. Compare mean scores across demographic and occupational subgroups (e.g., branch, rank, gender).
3. Explore associations between anxiety levels, help-seeking willingness, and actual engagement with support services.

Appendix 8: Scoring Guidelines for the Patient Health Questionnaire (PHQ-9)

The **PHQ-9** is a validated, self-administered screening tool for depression that aligns with the diagnostic criteria of the DSM-IV and DSM-5 (Kroenke et al., 2001). It consists of **nine items**, each assessing the frequency of depressive symptoms experienced during the previous two weeks.

Scoring Method

- Each item is scored as follows:
    - **0** = Not at all
    - **1** = Several days
    - **2** = More than half the days
    - **3** = Nearly every day
- The **total score ranges from 0 to 27**.
- Higher scores indicate greater severity of depressive symptoms.

Cut-off Points for Symptom Severity

PHQ-9 Total Score	Symptom Severity	Interpretation
0–4	Minimal	No or very low depressive symptoms.
5–9	Mild	Possible subclinical depression; monitor and consider preventive support.
10–14	Moderate	Clinically significant symptoms likely; further evaluation recommended.
15–19	Moderately Severe	High probability of major depressive disorder; active treatment indicated.
20–27	Severe	Severe depression very likely; urgent diagnostic evaluation and treatment warranted.

Clinical Use and Recommendations

- A **cut-off score of ≥10** is commonly applied to indicate probable major depression, with sensitivity and specificity both around 88%.
- The PHQ-9 can also be used as a **monitoring tool**: a reduction of 5 points suggests mild improvement, 10 points indicates moderate improvement, and 15 points represents a marked response to treatment.
- Item 9 ("Thoughts that you would be better off dead or of hurting yourself") is of particular clinical importance, as endorsement requires immediate risk assessment.

Application in this Study

Within the Irish Defence Forces survey:

1. The PHQ-9 was used to measure depressive symptom severity across Army, Naval Service, and Air Corps personnel.
2. Group comparisons were conducted to identify demographic and occupational correlates of depressive symptoms.
3. PHQ-9 scores were triangulated with other measures (e.g., GAD-7, PCL-M, AUDIT-C) to explore comorbidity and its effect on help-seeking behaviours.

Appendix 9: Scoring Guidelines for the PTSD Checklist – Military Version (PCL-M)

The **PCL-M** is a 17-item self-report questionnaire developed to assess symptoms of post-traumatic stress disorder (PTSD) in military populations (Weathers et al., 1993). Items correspond directly to the diagnostic criteria for PTSD in the DSM-IV, with reference to stressful military experiences.

Scoring Method

- Each item is scored on a 5-point Likert scale:
    - **1** = Not at all
    - **2** = A little bit
    - **3** = Moderately
    - **4** = Quite a bit
    - **5** = Extremely
- Total scores range from **17 to 85**.
- Higher scores indicate greater symptom severity.

Cut-off Scores and Interpretation

While there is no single universally agreed threshold, cut-offs are typically adapted to the population and context. For military settings, the following are common:

PCL-M Total Score	Interpretation
≤34	Symptoms unlikely to meet PTSD criteria.
35–44	Possible PTSD; further clinical assessment recommended.
45–49	Probable PTSD; likely to meet diagnostic criteria.

PCL-M Total Score	Interpretation
≥50	High probability of PTSD; strong recommendation for clinical referral.

*Note: In the Irish Defence Forces context, a threshold of **≥35** was used in this study as the recommended cut-off for screening, in line with prior military research.*

Symptom Cluster Scoring (DSM-IV Criteria)

In addition to the total score, the PCL-M can be scored against DSM-IV diagnostic criteria:

- **Criterion B (Re-experiencing):** At least 1 symptom scored ≥3.
- **Criterion C (Avoidance/Numbing):** At least 3 symptoms scored ≥3.
- **Criterion D (Hyperarousal):** At least 2 symptoms scored ≥3.
  Meeting all three criteria suggests probable PTSD.

Clinical Use and Recommendations

- The PCL-M is a **screening tool**, not a diagnostic instrument. A structured clinical interview (e.g., CAPS-5) is required for formal diagnosis.
- It is also valuable for **monitoring treatment progress**, with a **5–10 point change** considered reliable and a **10–20 point change** regarded as clinically significant improvement or deterioration.

Application in this Study

Within the Irish Defence Forces survey:

1. The PCL-M was administered to assess PTSD symptom severity across branches and ranks.
2. A cut-off of **≥35** was applied to identify probable cases for prevalence estimation.

3. Results indicated that **25% of participants scored above threshold**, suggesting a clinically significant subgroup requiring further evaluation.
4. Findings were integrated with PHQ-9, GAD-7, and AUDIT-C scores to examine comorbid patterns and their relationship to help-seeking behaviours.

Appendix 10: Scoring Guidelines for the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C)

The **AUDIT-C** is a brief 3-item screening instrument derived from the Alcohol Use Disorders Identification Test. It is designed to identify individuals who engage in hazardous drinking or have active alcohol use disorders.

Scoring Method

Each item is scored from 0 to 4 points:

1. **Frequency of drinking** (from *Never = 0* to *4+ times per week = 4*).
2. **Typical quantity consumed** (from *1–2 drinks = 0* to *10+ drinks = 4*).
3. **Frequency of heavy drinking episodes** (from *Never = 0* to *Daily/almost daily = 4*).

- **Total Score Range:** 0–12
- **Higher scores indicate greater risk of hazardous drinking or alcohol use disorder.**

Cut-off Scores

AUDIT-C Score	Men	Women	Interpretation
0	0	0	Abstinent.
1–3	1–3	1–2	Within recommended limits.
≥4	4+	—	Positive screen for hazardous drinking (men).
≥3	—	3+	Positive screen for hazardous drinking (women).
≥8	8+	8+	Strong likelihood of alcohol dependence.

Note: Cut-offs vary across settings. In this study, ≥4 for men and ≥3 for women were applied as thresholds for hazardous use, consistent with military population guidelines.

Clinical Use and Recommendations

- The AUDIT-C is a **screening tool**, not diagnostic. Positive screens should be followed by a full AUDIT (10-item) or clinical interview.
- **Monitoring use:** It can be re-administered periodically to assess reduction in drinking following intervention.
- **Risk assessment:** Higher scores correlate with increased risk of accidents, health problems, and impaired occupational functioning.

Application in this Study

Within the Irish Defence Forces survey:

1. The AUDIT-C was included to estimate the prevalence of hazardous drinking behaviours across Army, Naval Service, and Air Corps personnel.
2. Findings indicated a **mean score of 5**, placing the sample in the moderate-risk category.
3. Using gender-adjusted cut-offs, **66% of men** and **62% of women** screened positive for hazardous use.
4. These results were triangulated with mental health measures (PHQ-9, GAD-7, PCL-M) to explore comorbidity and implications for help-seeking.

Appendix 11: Scoring Guidelines for the CIS-R Suicidality and Self-Harm Items

The **Clinical Interview Schedule – Revised (CIS-R)** is a structured psychiatric interview designed to assess common mental disorders . Within this study, the focus was on the **suicidality and self-harm items**, adapted for self-report format. These items provide valuable information on suicidal thoughts, suicide attempts, and deliberate self-harm behaviours.

Scoring Method

The CIS-R suicidality module typically uses dichotomous responses (*Yes/No*) supplemented by time frame indicators. In this study, the following items were used:

1. **Suicide Attempt:**
    - "Have you ever made a serious attempt to take your life (e.g., overdose or other method)?"
    - *Yes/No* response, followed by time frame:
        - In the last week
        - In the last year
        - More than a year ago
2. **Suicidal Ideation:**
    - "Have you ever seriously thought of taking your life, even though you would not actually do it?"
    - *Yes/No* response, followed by time frame (same as above).
3. **Deliberate Self-Harm (without intent to die):**
    - "Have you ever deliberately harmed yourself in any way, but not with the intention of killing yourself?"
    - *Yes/No* response, followed by time frame (same as above).

- **Scoring:** Each affirmative response is coded as **1** and can be summed across items. A higher cumulative score reflects greater lifetime prevalence of suicidal behaviours.
- **Time Frame Coding:** Recency is captured categorically (last week, last year, more than a year ago), enabling stratification by acute vs historic risk.

Interpretation

Item	Key Interpretation
Suicide Attempt	Presence of an attempt indicates highest clinical risk.
Suicidal Ideation	Suggests vulnerability; recency is crucial in risk assessment.
Deliberate Self-Harm	Indicates distress and coping difficulties; risk factor for future attempts.

- **Recent behaviours (last week / last year):** Suggest elevated and immediate clinical concern.
- **Historic behaviours (>1 year ago):** Still significant as predictors of vulnerability and help-seeking patterns.

Clinical Use and Recommendations

- The CIS-R suicidality items are not diagnostic but provide a **screening mechanism for risk stratification**.
- Endorsement of any item — especially recent suicidal ideation or attempt — warrants immediate referral to clinical services.
- In research, they allow prevalence estimation and subgroup analysis (e.g., by rank, branch, gender).

Application in this Study

- **Suicide Attempts:** 9% of participants reported a serious attempt, with one-third occurring in the last year.
- **Suicidal Ideation:** 34% reported ideation, with 8% in the past week and 38% within the past year.
- **Deliberate Self-Harm:** 10% reported self-harm without suicidal intent.
- These findings highlighted both acute and chronic risk factors within the Defence Forces population and were cross-analysed with PHQ-9, GAD-7,

PCL-M, and AUDIT-C results to explore comorbidities and help-seeking behaviours.

Appendix 12: Scoring Guidelines for the Stigma and Barriers to Care Scale

The Stigma and Barriers to Care Scale (adapted from Britt et al., 2008; Hoge et al., 2004) assesses reasons why military personnel may avoid seeking mental health support. It captures both perceived stigma (how individuals believe others will view them) and practical barriers (logistical or institutional challenges).

Structure of the Scale

- Items: 20 statements reflecting common barriers and stigma-related concerns (e.g., *"It would hurt my career"*; *"I don't know where to get help"*).
- Response Format: 5-point Likert scale ranging from:
    - 1 = Strongly Disagree
    - 2 = Disagree
    - 3 = Neither Agree/Disagree
    - 4 = Agree
    - 5 = Strongly Agree

Scoring Method

- Item Scores: Each item scored 1–5.
- Subscale Totals: Items grouped into two domains:
    1. Stigma-related barriers (e.g., "My unit leader/bosses might treat me differently," "I would be seen as weak").
    2. Practical/logistical barriers (e.g., "I don't know where to get help," "It's difficult to get an appointment").
- Total Scores: Higher scores indicate stronger perceived barriers. Subscale means are often used to compare across groups.

Interpretation

Score Range (per item)	Interpretation
1–2	Low perceived barrier / stigma.
3	Neutral or uncertain perception.

Score Range (per item)	Interpretation
4–5	High perceived barrier / stigma; significant concern.

- **High stigma subscale scores:** Suggest reluctance to seek help due to fear of career impact, reputational harm, or confidentiality breaches.
- **High practical barrier scores:** Suggest structural or systemic obstacles (e.g., accessibility, time off work, transport).

Clinical and Research Use

- The scale is not diagnostic but identifies specific deterrents to help-seeking.
- Useful for monitoring changes in organisational culture over time.
- High scores highlight areas for targeted intervention (e.g., confidentiality assurance, improved appointment access, leadership messaging).

Application in this Study

1. The scale was administered to all survey participants.
2. Results revealed **career-related stigma** (e.g., fear of downgrading, loss of duties, being seen as weak) as the most powerful deterrent to disclosure.
3. **Practical barriers** such as difficulty getting time off work and uncertainty about where to get help were also frequently endorsed.
4. Findings were triangulated with willingness and actual engagement data, highlighting the discrepancy between intention and action.

Appendix 13: Scoring Guidelines for the Self-Stigma of Seeking Help Scale (SSOSH)

The **Self-Stigma of Seeking Help Scale (SSOSH)** measures the extent to which individuals internalise negative beliefs about seeking psychological support. Unlike perceived stigma (what others may think), the SSOSH focuses on **self-directed stigma** and its potential to deter help-seeking.

Structure of the Scale

- **Items:** 10 statements (e.g., *"If I went to a therapist, I would feel inadequate"*; *"Seeking psychological help would make me feel less intelligent"*).
- **Response Format:** 5-point Likert scale:
    - **1 = Strongly Disagree**
    - **2 = Disagree**
    - **3 = Neutral**
    - **4 = Agree**
    - **5 = Strongly Agree**

Scoring Method

- **Item Scores:** Each item scored 1–5.
- **Total Score Range:** 10–50.
- **Reverse Scoring:** None; all items scored in the same direction.
- **Higher scores** = greater self-stigma regarding help-seeking.

Interpretation

Total Score	Interpretation
10–19	Very low self-stigma; minimal barrier to seeking help.
20–29	Low self-stigma; some hesitation but generally willing.
30–39	Moderate self-stigma; ambivalence likely, may delay seeking help.

Total Score	Interpretation
40–50	High self-stigma; strong internalised barrier, help-seeking unlikely.

Clinical and Research Use

- **Predictive utility:** High SSOSH scores predict avoidance of professional psychological support even when distress levels are high.
- **Complementary measure:** Best used alongside perceived stigma and barriers scales (Appendix 12) to capture both internal and external deterrents.
- **Change over time:** Useful for evaluating the effectiveness of anti-stigma campaigns or leadership interventions.

Application in this Study

1. The SSOSH was administered to all survey participants in parallel with stigma and barriers items.
2. Results demonstrated that **internalised stigma was a significant deterrent**, particularly among Army personnel and junior ranks.
3. High self-stigma scores correlated with reluctance to disclose mental health issues to military doctors.
4. Findings reinforce the need for **cultural change initiatives** that frame help-seeking as a sign of professionalism and resilience rather than weakness.

Appendix 14: Scoring Guidelines for the Emotional Intelligence Self-Assessment (McKee, 2015)

The **Emotional Intelligence (EI) Self-Assessment** developed by McKee (2015) is a self-report tool designed to measure five core domains of emotional intelligence. These domains reflect both intrapersonal and interpersonal competencies relevant to effective functioning in high-demand environments such as the military.

Structure of the Scale

- **Items:** 25 statements, 5 per competency.
- **Competencies Assessed:**
    1. **Emotional Self-Awareness**
    2. **Emotional Self-Control**
    3. **Adaptability**
    4. **Positive Outlook**
    5. **Empathy**
- **Response Format:** 5-point Likert scale:
    - **1 = Strongly Disagree**
    - **2 = Disagree**
    - **3 = Neutral**
    - **4 = Agree**
    - **5 = Strongly Agree**

Scoring Method

- **Subscale Scores:** Each competency scored 5–25 (sum of 5 items).
- **Global EI Score:** Total of all 25 items (range 25–125) or average per item (range 1–5).
- Higher scores = stronger self-perceived competence in that EI domain.

Interpretation

Subscale / Global Score	Interpretation
Low (5–12 per subscale; ≤50 global)	Limited emotional intelligence capacity; may struggle with emotional regulation, awareness, or interpersonal sensitivity.
Moderate (13–19 per subscale; 51–90 global)	Average levels of EI; demonstrates some strengths but with areas for development.
High (20–25 per subscale; 91–125 global)	Strong EI capacity; reflects high self-awareness, adaptability, positive outlook, and empathy.

Clinical and Research Use

- The tool provides insights into **self-perceived emotional competence** rather than clinical diagnosis.
- Useful for identifying developmental needs in leadership, resilience, and interpersonal functioning.
- In military contexts, EI is associated with effective stress regulation, peer support, and constructive help-seeking behaviours.

Application in this Study

1. The EI Self-Assessment was administered alongside mental health screening instruments to examine its relationship with anxiety, depression, and willingness to seek help.
2. Results indicated that higher EI scores were associated with **greater willingness to engage in peer support** and **reduced stigma towards help-seeking**.
3. Subscale analysis showed that **empathy and adaptability** were most strongly linked to positive help-seeking intentions.

4. Findings suggest that emotional intelligence training could be a valuable component of resilience-building within the Defence Forces.

Appendix 15: Scoring Guidelines for the Multidimensional Scale of Perceived Social Support (MSPSS)

The **Multidimensional Scale of Perceived Social Support (MSPSS)** assesses an individual's perception of social support from three distinct sources: **family, friends, and significant others**. It is a widely used and validated measure in both clinical and research settings.

Structure of the Scale

- **Items:** 12 statements (e.g., *"My family really tries to help me"*; *"I can count on my friends when things go wrong"*).
- **Subscales:**
    1. **Family** (4 items)
    2. **Friends** (4 items)
    3. **Significant Other** (4 items)
- **Response Format:** 7-point Likert scale:
    - **1 = Very strongly disagree**
    - **2 = Strongly disagree**
    - **3 = Mildly disagree**
    - **4 = Neutral**
    - **5 = Mildly agree**
    - **6 = Strongly agree**
    - **7 = Very strongly agree**

Scoring Method

- **Item Scores:** Each item scored 1–7.
- **Subscale Scores:** Average of the four items in each domain.
- **Total Score:** Mean of all 12 items (range 1–7).
- Higher scores = greater perceived support.

Interpretation

Score Range (mean)	Interpretation
1.0–2.9	Low perceived social support
3.0–5.0	Moderate perceived social support
5.1–7.0	High perceived social support

Clinical and Research Use

- Provides an index of perceived social connectedness across three domains.
- Can predict resilience, coping, and likelihood of help-seeking.
- Particularly useful in military populations where family separation, unit cohesion, and peer reliance influence wellbeing.
- Subscale scores highlight which source of support (family, friends, significant other) is strongest or weakest for the individual.

Application in this Study

1. The MSPSS was included to measure perceived social support among Army, Naval Service, and Air Corps personnel.
2. Results showed variability across branches: Army personnel tended to report lower family and significant other support compared to Air Corps and Navy participants.
3. High social support scores correlated with **greater willingness to seek help** and **increased reliance on peer support**.
4. These findings suggest that strengthening social networks both inside and outside the military may enhance psychological resilience and reduce barriers to care.

Appendix 16: Interview Guide for Key Stakeholders (Part 2)

Opening Script

Thank you for agreeing to take part in this interview. The purpose of this conversation is to gain your professional perspectives on the findings from Phase 1 of the study on mental health and help-seeking in the Irish Defence Forces. We are particularly interested in your reflections on the survey results and your views on the organisational, cultural, and systemic factors that influence help-seeking. All responses will remain confidential and anonymised in reporting.

Section 1: Reactions to Survey Findings

1. What are your initial thoughts on the overall survey findings?
2. Were you surprised by the reported levels of anxiety, depression, PTSD, or alcohol use?
3. How do you interpret the high rates of suicidal ideation and self-harm among serving personnel?
4. The survey showed a gap between willingness to use services and actual engagement. Why do you think this gap exists?
5. What do you make of the finding that 80% of respondents would not disclose a mental health problem to the military medical system?
6. How do you interpret the fact that peer support and Inspire (civilian counselling) were the most popular supports, while chain of command and chaplaincy were the least?

Section 2: Cultural Challenges

7. In your view, what cultural factors in the Defence Forces most strongly influence help-seeking?
8. How does stigma manifest in practice , for example, perceptions of weakness, fear of peer judgement, or silence from leadership?
9. What role do leaders and commanders play in shaping attitudes towards mental health and disclosure?
10. How might Defence Forces culture contribute to reliance on informal peer networks rather than formal supports?

Section 3: Systemic Challenges

11. To what extent do you think medical grading and the link to career progression affect willingness to disclose?
12. How does the absence of a dedicated mental health policy impact the consistency of care and support across the organisation?
13. What do you see as the biggest structural or resource gaps in the current help-providing system?
14. How important are concerns about confidentiality and trust in discouraging disclosure to military doctors or PSS?
15. How do you think the Defence Forces balance operational safety with protecting the psychological safety of personnel?

Section 4: Policy and Reform

16. What changes would you recommend to reduce stigma and encourage earlier disclosure?
17. Do you think annual mandatory mental health training, aligned with annual medicals, would be effective?
18. What role should policy reform play in shaping a better help-seeking culture?
19. If you could prioritise one key investment (human, financial, educational) to improve Defence Forces mental health provision, what would it be?
20. What would an effective standalone Defence Forces mental health service look like in practice?

Section 5: Closing Reflections

21. Looking back at the survey findings, which result concerns you most , and why?
22. What positive changes do you believe are possible in the short to medium term?
23. What final message would you want conveyed to senior Defence Forces leadership about mental health and help-seeking?

Appendix 17: Sample Codes and Themes – Braun & Clarke's Six-Phase Framework

This appendix illustrates how Braun & Clarke's (2006) six-phase framework for thematic analysis was applied to the stakeholder interviews. It shows the analytic progression from raw data extracts and initial codes through sub-theme development to the final three themes presented in Chapter 7.

Phase 1: Familiarisation with the Data

- All six stakeholder interviews were transcribed verbatim.
- Transcripts were read and annotated repeatedly to capture first impressions, recurrent issues, and notable patterns.
- Initial notes highlighted concerns about confidentiality, leadership influence, reliance on peer networks, and gaps in formal policy.

Phase 2: Generating Initial Codes

A total of **130 codes** were generated inductively from the transcripts. Examples included:

- Fear of medical downgrading
- Confidentiality concerns
- Reliance on peer support
- Leadership influence
- Lack of mental health policy
- Stigma as weakness
- Chain of command not trusted
- Officers more reluctant to seek help
- Need for annual training
- Resource gaps (financial/human)

Phase 3: Searching for Themes

Codes were clustered into potential sub-themes that reflected shared meaning.

Sample Codes	**Candidate Sub-Theme**
Fear of medical downgrading; Risk to promotion; Confidentiality concerns	Career risk and disclosure
Reliance on peer support; Informal coping; Avoidance of formal systems	Informal networks
Stigma as weakness; Fear of judgement; Leadership silence	Cultural stigma
Lack of policy; Inconsistent provision; Resource gaps	Policy and system gaps
Leadership influence; Positive role-modelling; Silence from COs	Leadership and culture

Phase 4: Reviewing Themes

- Sub-themes were tested against coded extracts and the dataset as a whole.
- Overlapping clusters were merged where appropriate (e.g., "confidentiality" codes folded into systemic challenges).
- This refinement ensured each theme was distinct yet comprehensive.

Phase 5: Defining and Naming Themes

Through the refinement process, the analysis was organised into **three overarching themes**:

1. **Key Stakeholders' Insights and Reflections on Findings**
    - Stakeholders contextualised survey results, validating or challenging quantitative patterns.
    - Codes: surprise at prevalence rates; reflections on service use; perceived gaps between willingness and engagement.
2. **Cultural Challenges**

- Military cultural norms shaping stigma, silence, and reliance on peers.
- Codes: stigma as weakness; peer reliance; leadership silence; fear of reputational damage.

3. **Systemic Challenges**
    - Structural and procedural barriers embedded within Defence Forces systems.
    - Codes: medical grading; absence of standalone policy; confidentiality concerns; resource limitations; fragmented service provision.

Phase 6: Producing the Report

- Final themes were presented in Chapter 7 with supporting quotations.
- The write-up highlighted how stakeholder perspectives both reinforced and explained Phase 1 survey findings, offering a comprehensive picture of help-seeking barriers within the Defence Forces.

Worked Coding Table (Examples)

Data Extract	Initial Code	Sub-Theme	Final Theme
"The rates of depression were higher than I expected - but they reflect what I see day-to-day."	Stakeholder reflection	Reactions to findings	**Key Stakeholders' Insights and Reflections on Findings**
"Most will go to a mate before they'd ever think of going to PSS or the MO."	Reliance on peer support	Informal networks	**Cultural Challenges**
"If you disclose to a medical officer, you risk being downgraded."	Fear of downgrading	Career risk & disclosure	**Systemic Challenges**
"There's no proper mental health policy - it's ad hoc at best."	Lack of formal policy	Policy gaps	**Systemic Challenges**
"If leaders don't talk about it, the silence reinforces the stigma."	Leadership silence	Leadership influences	**Cultural Challenges**

Appendix 18: Survey

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Óglaigh na hÉireann
DEFENCE FORCES IRELAND

Mental health in the military: A mixed methods investigation of mental health and help seeking behaviours in the Irish Defence Forces

PhD Candidate: Dan Fitzpatrick BA (Hons), MSc
Mental Health 16308378



Participant Information

Thank you for your interest in this survey. This anonymous survey aims to better understand the mental health issues affecting soldiers in the Irish Defence Forces, and how they interact with military help seeking systems. The study will improve our understanding of mental health needs in the Irish Defence Forces. The survey is being carried out by Dan Fitzpatrick, a representative for the Personnel Support Service. You can contact me should you have any queries about the study (01-4037531: dfitzpa1@tcd.ie).

The aims of this study are:

- To examine what mental health issues are affecting soldiers in the Irish defence forces.
- To explore how Irish soldiers are currently coping with Mental Health issues.
- To determine how soldiers of all ranks currently seek help for mental health issues.
- To investigate the help seeking behaviours of soldiers and what impacts on help-seeking.
- To explore the perspectives of senior management regarding mental health and help seeking behaviour of soldiers and to explore their views on how key issues may be addressed.

The following people can take part in this survey:

- Any serving Permanent member of the Irish Defence Forces.

The survey should take about 20 minutes to complete. The survey asks about

- Non-Identifying information about you (e.g. age, gender, rank, length of Time in Service).
- You are asked to fill out sections on common mental health matters and one on personality characters.
- Your experience with mental health care, stigma, and disclosure.
- Your opinion on existing services and views on what can be done to improve services.

Before you take part I would like to make you aware of the data protection processes that have been followed. Please read these before giving your consent to taking part.

The research has been given ethical approval by both, the Irish Defence Forces and the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin. All the survey data will be stored in accordance with General Data Protection Regulations (GDPR).

Data Processing

Your data will be processed by myself, Dan Fitzpatrick. The data will be stored by the researcher in compliance with GDPR. The survey data will be stored in a double-encrypted electronic folder that is only accessible by myself, the researcher. If you have been affected by this survey please note the help provider's contacts on the last page of the survey. The Personnel Support Service is also available to any member who may want to discuss any personal issues that may arise from completing this survey.

By completing this survey:

- I confirm that I have read the above information. I understand that any information I provide will be used for the purpose of the research only, and not passed onto a third party and will be destroyed after a period of 7 years.
- I understand that my participation in the study is voluntary and I do not have to complete the study.
- I understand that it will not be possible to remove my data from the project once it has been submitted as it is anonymous and cannot be traced back. I agree to take part on this basis.
- I agree that any data (including direct quoting) collected may be used in anonymous form in the report of this study and subsequent academic publications.
- I understand that by filling out this survey, I am consenting to take part in this study

SECTION 1: DEMOGRAPHIC INFORMATION
First, I would like to gather some data on your personal details, please remember all information gathered is anonymous and will be kept strictly confidential. It will be stored securely and not disclosed to anybody.
Please circle the appropriate answer for you

Gender

Male	Female	Other/Prefer not to disclose

Rank

Officer	Other Ranks

Age

Under 20	20 – 29	30 – 39	40-49	50-59

Marital Status

Single	Married	Civil Partner	Separated/Former Civil Partner	Divorced	Widowed/Surviving Civil Partner

Employed by which Branch

Army	Navy	Air Corps

Length of Time in Service

Less than 5years	5-9 Years	15-19 Years	20-24 Years	More than 25 Years

How many overseas missions have you completed?

None	One	Two – Five	Five or more	Ten or more

Are you registered with a local civilian GP?

Yes ☐ No ☐

Do you have children?

Yes No

9a. If yes how many children do you have?

SECTION 2 GENERALISED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE.

Please circle the appropriate answer for you

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Not at all sure	**2. Over half the day**	**3. Several days**	**4. Nearly every day**

1. Feeling nervous, anxious, or on edge	1	2	3	4
2. Not being able to stop or control worrying	1	2	3	4
3. Worrying too much about different things	1	2	3	4
4. Trouble relaxing	1	2	3	4
5. Being so restless that it's hard to sit still	1	2	3	4
6. Becoming easily annoyed or irritable	1	2	3	4
7. Feeling afraid as if something awful might happen	1	2	3	4

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult ____ Very difficult __

_____

Extremely difficult

_____

SECTION 3 PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Please circle the appropriate answer for you				
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**More than half the day**	**Nearly Every day**	**Several Days**
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

SECTION 4. PTSD CHECKLIST

INSTRUCTIONS: BELOW IS A LIST OF PROBLEMS AND COMPLAINTS THAT SOLDIERS SOMETIMES HAVE IN RESPONSE TO STRESSFUL MILITARY EXPERIENCES.

Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Not at all	**2. A little bit**	**3. Moderately**	**4. Quite a bit**	**5. Extremely**

1. Repeated, disturbing memories, thoughts, or images of a stressful military experience?	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful military experience?	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful military experience were happening again (as if reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful military experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful military experience?	1	2	3	4	5
6. Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful military experience?	1	2	3	4	5
8. Trouble remembering important parts of a stressful military experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

SECTION 5 ALCOHOL USE (AUDIT-C HILTON AND DMQ-R)

In section 5 I am going to ask you about your drinking habits and use of alcohol. I understand these questions may be sensitive, please attempt to answer them as honestly and accurately as possible, thank you.

AUDIT C

One unit is 10ml or 8g of pure alcohol. Because alcoholic drinks come in different strengths and sizes, units are a way to tell how strong your drink is.

Please circle the appropriate answer for you
How often do you have a drink containing alcohol?

Never	**Monthly or less**	**2-4 times per month**	**2-3 times per week**	**4 times plus per week**

How many units of alcohol do you drink on a typical day when you are drinking?

1-2	**3-4**	**5-6**	**7-9**	**10+**

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**

DMQ-R

Please select an answer from the box below and circle the appropriate answer for you

1. Never	2. Some of the time	3. Half of the time	4. Most of the time	5. Always

Do you drink?.....					
1. To help you cope with distressing thoughts or feelings	1	2	3	4	5
2. Because of loneliness	1	2	3	4	5
3. To escape from your troubles	1	2	3	4	5
4. To forget the past	1	2	3	4	5
5. To put you at ease with other people	1	2	3	4	5
6. Because your friends put pressure on you to drink	1	2	3	4	5
7. Because it helps you when you feel depressed or nervous	1	2	3	4	5
8. To be sociable	1	2	3	4	5
9. To cheer you up when you're in a bad mood	1	2	3	4	5
10. To get drunk	1	2	3	4	5
11. To fit in with a group	1	2	3	4	5
12. So you won't feel left out	1	2	3	4	5

SECTION 6 SUICIDAL THOUGHTS, ATTEMPTS AND SELF-HARM (CIS-R)

This section will ask some sensitive questions, they deal with suicidal thoughts, attempts and self-harm.

Have you ever made a serious attempt to take your life, by taking an overdose of tablets or in some other way?

Yes ☐ No ☐

If yes, was this

in the last week	in the last year	more than a year ago

Have you ever seriously thought of taking your life, even though you would not actually do it?

Yes ☐ No ☐

If yes, was this

in the last week	in the last year	more than a year ago

Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?

Yes ☐ No ☐

If yes, was this

in the last week	in the last year	more than a year ago

SECTION 7. STIGMA AND BARRIERS TO CARE:
In section 7 I am concerned with your decision to receive mental health services. The list is quite detailed and lengthy, sorry about that, but please bear with me.

1. Strongly Agree	**2. Agree**	**3. Neither Agree/Disagree**	**4. Disagree**	**5.StronglyDisagree**

Please circle the appropriate answer for you
I would not seek help for a mental health problem because:

1. I don't know where to get help	1	2	3	4	5
2. I don't have adequate transport	1	2	3	4	5
3. It's difficult to get an appointment	1	2	3	4	5
4. There would be difficulty getting time off work for treatment	1	2	3	4	5
5. It would be too embarrassing	1	2	3	4	5
6. It would hurt my career	1	2	3	4	5
7. Members of my unit or my colleagues might have less confidence in me	1	2	3	4	5
8. My unit leader/bosses might treat me differently	1	2	3	4	5
9. My leaders/bosses would blame me for the problem	1	2	3	4	5
10. I would be seen as weak (by those who are important to me)	1	2	3	4	5

11. Not wanting a mental health problem to be on my medical Records	1	2	3	4	5
12. Concern about what my friends or family might think	1	2	3	4	5
13. Mental health care doesn't work	1	2	3	4	5
14. I don't trust mental health professionals	1	2	3	4	5
15. My visit would not remain confidential	1	2	3	4	5
16. I would think less of a team member/colleague If I knew he/she was receiving mental health counselling	1	2	3	4	5
17. My leaders/bosses discourage the use of mental Health services	1	2	3	4	5
18. I had a bad previous experiences with mental Health professionals	1	2	3	4	5
19. Wanting to solve the problem on my own	1	2	3	4	5
20. Mental health treatment has harmful side effects	1	2	3	4	5

SECTION 8. SELF-STIGMA AND AWARENESS/WILLINGNESS TO USE SERVICES

Some people do not seek help for problems because they are concerned that seeking help would affect the way they think about themselves. You may or may not react in this way. Please refer to the response options below, rate the degree to which each item describes how you might react in this situation.

Please circle the appropriate answer for you

1. Strongly Agree	**2. Agree**	**3. Neither Agree/Disagree**	**4. Disagree**	**5. Strongly Disagree**

1. I would feel inadequate if I went to a mental health professional for psychological help	1	2	3	4	5
2. Seeking psychological help would make me feel less intelligent	1	2	3	4	5
3. It would make me feel inferior to ask a mental health professional for help	1	2	3	4	5
4. If I went to a mental health professional, I would be less satisfied with myself	1	2	3	4	5
5. I would feel worse about myself if I could not solve my own problems	1	2	3	4	5

6 A. Have you ever sought help from any of the following for a mental health problem? Please mark all the services you have used.

	YES	**NO**
Medical Services		
PSS		
Chaplin Service		
Social Worker		
Chain of Command		
Peer Support within the military (work colleague)		
A mental health specialist (psychiatrist, psychologist)		
Inspire counselling service 24/365 days a year phone line		

6B. Can you please explain what the issue or issues were, and why you choose the support you did?

_____
_____
_____
_____

If you were experiencing a mental health problem would you be willing to use the services listed in the box below? Please mark for each support.

	YES	**NO**	**Don't Know**
Medical Services			
PSS			
Chaplin Service			
Social Worker			
Chain of Command			
Peer Support within the military (work colleague)			
A mental health specialist (psychiatrist, psychologist)			
Inspire counselling service 24hour phone line			

SECTION 9 EMOTIONAL LITERACY.

Please mark the box with an X that best describes your answer.

I understand how other people's experiences affect their feelings, thoughts, and behaviour.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I understand my leadership strengths and weaknesses.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I see people as good and well-intentioned.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I look forward to the future.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I can describe my feelings in detail, beyond just "happy," "sad," "angry," and so on.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I manage stress well

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I focus on opportunities rather than obstacles.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I'm calm in the face of pressure or emotional turmoil.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I feel hopeful.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I control my impulses.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I'm optimistic in the face of challenging circumstances.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I use strong emotions, such as anger, fear, and joy, appropriately and for the good of others.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I'm patient.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I try to understand why people behave the way they do.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I'm adept at managing multiple, conflicting demands.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I readily understand others' viewpoints, even when they are different from my own.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I'm flexible when situations change unexpectedly.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I understand how stress affects my mood and behaviour.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I can easily adjust goals when circumstances change.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I can describe my emotions in the moment I experience them.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

My curiosity about others drives me to listen attentively to them.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I can shift my priorities quickly

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I strive to understand people's underlying feelings

Always	Most of the time	Frequently	Sometimes	Rarely	Never

I adapt easily when a situation is uncertain or ever-changing.

Always	Most of the time	Frequently	Sometimes	Rarely	Never

SECTION 10. MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT
I am also interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.
Please circle the appropriate answer for you

Very Strongly Disagree	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**5. Mildly Agree**	**6. Strongly Agree**	**7. Strongly Agree**

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

SECTION 11: DISCLOSING MENTAL HEALTH PROBLEMS WITHIN THE MILITARY

If you had a metal health problem would you disclose it to the military medical system? Yes No

Have you received formal training from the Defence Forces in mental health? Yes No

If **yes** can you name what type or what training you received?

In your opinion, do you think that disclosing a mental health issue to a military doctor would have negative outcomes for your military career?

Yes	No	Don't Know

In your opinion, do you think that disclosing a mental health issue to a military doctor would have positive outcomes for your military career?

Yes	No	Don't Know

If you answered **yes** or **no** to the above questions, Please give an example of a negative or positive outcome from disclosing a mental health issue to a military medical officer

Do you believe you would be discriminated against if your co-workers and commanders knew you had a mental health issue?
Yes No

Have you ever taken prescription medication for a mental health issue that wasn't prescribed by a military medical officer?
Yes No

Are you aware if a policy on mental health exists in the Defence Forces?

Yes	No	Don't Know

In your opinion, do you think that a soldier living with mental health issues, is fit to serve in the Defence Forces?

Yes	No	Don't Know

Have you ever used an external service or a civilian GP to help you overcome your mental health problem?

Yes ☐ No ☐

If **YES** please explain why you decided to use external services or a civilian GP in this instance:

_____
_____
_____
_____

What would you like to see the Defence Forces implement it terms of help seeking services?

_____
_____
_____
_____

What changes would you like to see the Defence Forces make in terms of services provided for mental health?

_____
_____
_____
_____

12. Has the Covid-19 virus and its associated restrictions affected your mental health in a negative way?

Yes ☐ No ☐

Thank you for taking the time to complete this survey. Your participation will help better understand the current state of mental health of personnel and if the systemic help seeking services are adequately meeting the needs of soldiers within the Irish Defence Forces.

If you have any questions or comments about the survey, please contact me at dfitzpa1@tcd.ie; 01 4037531

If you need emotional support, you can contact the following:

Personnel Support Services, available at every barracks.

Inspire Confidential Service 1800 409 673

Pieta House (Suicide & Self Harm)

National Suicide Helpline (Pieta House) 1800 247 247
www.pieta.ie Tel: 01 623 5606

Irish Advocacy Network (Peer advocacy in mental health)
www.irishadvocacynetwork.com Tel: 01 872 8684

Grow (mental health support and recovery)
www.grow.ie
Tel: 1890 474 474

Appendix 19: Key Findings of the Survey – Stakeholder Briefing Document

Prepared for distribution to key stakeholders prior to Phase 2 interviews

Purpose of Briefing

The following summary highlights the main findings from Phase 1 of the research study *"Mental Health in the Military: A Mixed Methods Investigation of Mental Health and Help-Seeking Behaviours in the Irish Defence Forces."* It is provided to participants in advance of the stakeholder interviews (Phase 2) to guide discussion and enable reflection on the results.

1. Demographic Profile of Respondents

- Total sample: n = 687 serving personnel.
- Branches: Army 59% (n=408), Naval Service 14% (n=94), Air Corps 27% (n=185).
- Rank: Officers 26% (n=176), Other Ranks 74% (n=511).
- Gender: Male 88% (n=606), Female 11% (n=79), Other <1% (n=2).
- Service: 47% married, 39% single, remainder civil partners/separated.
- Average time in service: Over 20 years for one-third of respondents.

2. Mental Health Outcomes

- Anxiety (GAD-7): Mean score 11.2 = *moderate anxiety*.
- Depression (PHQ-9): Mean score 11.8 = *moderate depression*; >50% scored in the moderate to severe range.
- PTSD (PCL-M): 28% scored above cut-off for probable PTSD.
- Alcohol Use (AUDIT-C): Mean score 5 = *moderate risk*; 66% of men and 62% of women screened positive for hazardous drinking.
- Suicidality/Self-Harm (CIS-R):
    - 9% reported a suicide attempt (one-third within the past year).
    - 34% reported suicidal ideation.
    - 10% reported deliberate self-harm without suicidal intent.

3. Help-Seeking Behaviours

- Most used supports:
    - Peer support: 40%
    - Personnel Support Service (PSS): 37%
    - Inspire (civilian counselling): 23%
- Least used supports:
    - Chaplains: 8%
    - Chain of command: 13%
    - Defence Forces mental health specialists: 14%

Gap identified: Willingness to use services was consistently higher than actual engagement (e.g., 63% willing to use peer support vs 40% actual use).

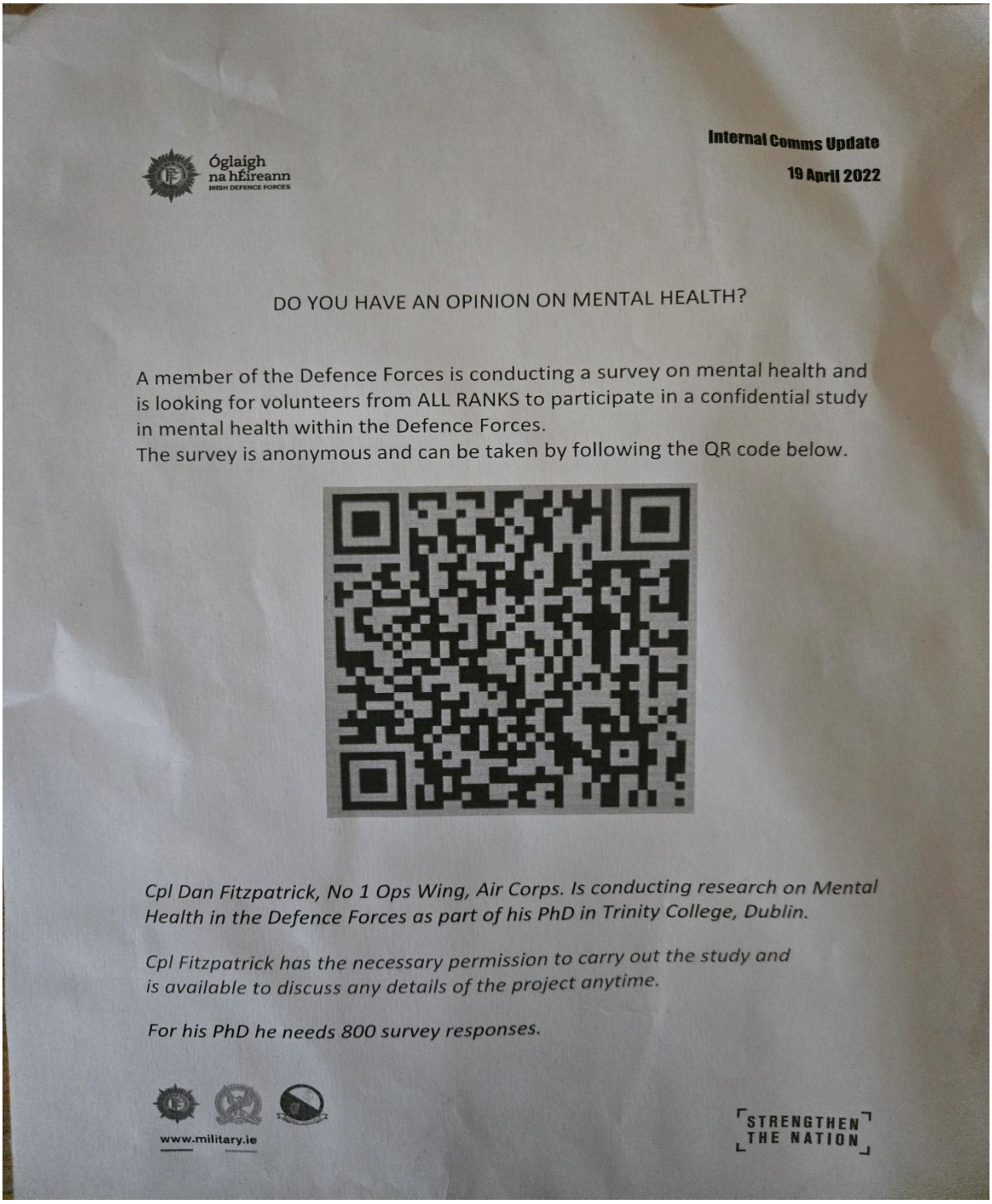
4. Attitudes and Perceptions

- Disclosure: 80% said they would *not* disclose a mental health issue to the military medical system.
- Discrimination: 74% believed disclosure would lead to discrimination or negative career consequences.
- Policy awareness: 40% were unaware of any Defence Forces mental health policy.
- Fitness to serve: 94% believed personnel with mental health problems are still fit to serve.
- Civilian services: 32% reported turning to a civilian GP or counsellor, citing confidentiality and career protection

5. Emerging Barriers

- Occupational risk: Medical downgrading, loss of duties, and promotion barriers.
- Cultural stigma: Perception of weakness, peer judgement, leadership silence.
- Systemic issues: Lack of a dedicated mental health policy, inconsistent provision, confidentiality concerns.

Appendix 20: Survey Notification with QR Code



Óglaigh na hÉireann
IRISH DEFENCE FORCES

Internal Comms Update

19 April 2022

DO YOU HAVE AN OPINION ON MENTAL HEALTH?

A member of the Defence Forces is conducting a survey on mental health and is looking for volunteers from ALL RANKS to participate in a confidential study in mental health within the Defence Forces.
The survey is anonymous and can be taken by following the QR code below.

Cpl Dan Fitzpatrick, No 1 Ops Wing, Air Corps. Is conducting research on Mental Health in the Defence Forces as part of his PhD in Trinity College, Dublin.

Cpl Fitzpatrick has the necessary permission to carry out the study and is available to discuss any details of the project anytime.

For his PhD he needs 800 survey responses.

www.military.ie

STRENGTHEN THE NATION

Appendix 21: Consent Form

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

STUDY NAME: MENTAL HEALTH IN THE MILITARY: A MIXED METHODS INVESTIGATION OF MENTAL HEALTH AND HELP SEEKING BEHAVIOR'S IN THE IRISH DEFENCE FORCES.

Centre ID:

Identification Number for study:

Consent Form

There are 2 sections in this form. Each section has a statement and asks you to initial if you agree. The end of this form is for the researchers to complete.

Please ask any questions you may have when reading each of the statements.
Thank you for participating.

Please Initial the box if you agree with the statement. Please feel free to ask questions if there is something you do not understand.

General	**Initial box**
I confirm I have read and understood the **Information Leaflet** for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that this study **is entirely voluntary, and if I decide that I do not want to take part, I can stop taking part in this study at any time without giving a reason**.	
I understand that I **will not be paid for taking part in this study.**	

I know how to contact the researcher if I need to.	
I agree to take part in this research study having been fully informed of the **risks, benefits and alternatives** which are set out in full in the information leaflet which I have been provided with.	
I agree to being contacted by researchers by email or phone as part of this research study.	
Data processing	**Initial**
I understand that information about me (-personal data), including the transfer of this personal information about me outside of the EU, will be protected in accordance with the General Data Protection Regulation.	
I agree to being contacted by the researcher by email or phone as part of this research study	
I consent to the use of information about me (personal data) for this study	
I agree to allow coded information about me to be shared with third party academic research institutions for the purpose of research relating to the investigation of mental health and help seeking behaviour's in the Irish Defence Forces, as described in the information leaflet.	

Participant Name (Block Capitals) Patient Signature Date

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a way that they could understand. I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.
I have given a copy of the information leaflet and consent form to the participant with contacts of the study team

Researcher name

Title and qualifications

Signature

Date

| |
|

3 copies to be made: 1 for patient, 1 for PI and 1 for hospital records.